# Meeting of the Integrated Care Board

**held in PUBLIC**

## Agenda

Chair: Raj Jain

The ICB Board meeting are business meetings which, for transparency, are held in public. They are not 'public meetings' for consulting with the public, which means that those people who attend the meeting cannot take part in the formal meetings proceedings. The ICB Board meeting is live streamed and recorded.

| AGENDA NO & TIME | ITEM | LEAD | ACTION / PURPOSE | PAGE NUMBER |
|---|---|---|---|---|
| **09:00am** | **Preliminary Business** | | | |
| ICB/23/06/01 | Welcome, Introductions and Apologies<br>• confirmation of quoracy | Chair | Verbal | - |
| ICB/23/06/02 | Declarations of Interest<br>*(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). Register of Interest available at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/* | Chair | Verbal | - |
| ICB/23/06/03 | Minutes of the previous meeting:<br>• 25 May 2023 | Chair | Paper<br>Approval | Page 4 |
| ICB/23/06/04 | Board Action Log | Chair | Paper<br>For note | Page 18 |
| ICB/23/06/05 | Board Decision Log | Chair | Paper<br>For note | Page 21 |
| **09:10am** | **Standing Items** | | | |
| ICB/23/06/06 | Chairs Announcements | Chair | Verbal | - |
| ICB/23/06/07 | Report of the Chief Executive | GPU | Paper<br>For note | Page 25 |
| ICB/23/06/08 | Report of the Place Director | ALE | Paper<br>For note | Page 38 |
| ICB/23/06/09 | Resident / Staff Story | - | Presentation<br>For note | - |
| **09:35am** | **ICB Business Items** | | | |
| ICB/23/06/10 | Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24 | CWA | Paper<br>For approval | Page 57 |
| ICB/23/06/11<br>**09:50am** | Cheshire and Merseyside Mental Health, Community and Learning Disability Provider Collaborative - Annual Work Plan 2023-2024 | JRA | Paper<br>For Endorsement | Page 124 |
| ICB/23/06/12<br>**10:15am** | NHS Cheshire and Merseyside ICB Annual Report and Accounts 2022-23 and Cheshire and Merseyside CCG 3 Month Reports 2022-23 | CWI | Paper<br>For approval | Page 146 |

| AGENDA NO & TIME | ITEM | LEAD | ACTION / PURPOSE | PAGE NUMBER |
|---|---|---|---|---|
| ICB/23/06/13 **10:30am** | Primary Care Strategic framework and update on the Cheshire and Merseyside delivery plan for recovering access to primary care | CWA | Paper<br>For approval | Page 161 |
| ICB/23/06/14 **10:50am** | Winter Debrief and Urgent Emergency Care Improvement Programme | AMI | Paper | Page 241 |
| ICB/23/06/15 **11:00am** | Northwest Specialised Commissioning Joint Committee Terms of Reference | CWA | Paper | Page 254 |
| **11:05am** | **ICB Key Update Reports** | | | |
| ICB/23/06/16 | Executive Director of Nursing & Care Update Report (June 2023) | CDO | Paper<br>For noting | Page 281 |
| ICB/23/06/17 **11:15am** | Cheshire & Merseyside ICB Quality and Performance Update Report (June 2023) | AMI | Paper<br>For noting | Page 287 |
| ICB/23/06/18 **11.25am** | Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee (May 2023) | TFO | Paper<br>For noting | Page 338 |
| ICB/23/06/19 **11:30am** | Cheshire & Merseyside System Month 2 Finance Report | CWI | Paper<br>For noting | Page 346 |
| ICB/23/06/20 **11:40am** | Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Resources Committee (May 2023) | EMO | Paper<br>For noting<br>For approval | Page 373 |
| **11:45am** | **Sub-Committee Reports** | | | |
| ICB/23/06/21 | Report of the Chair of the Cheshire & Merseyside ICB Audit Committee (May 2023) | NLA | Paper<br>For noting | Page 378 |
| ICB/23/06/22 **11:50am** | Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee (May 2023) | CWA | Paper<br>For noting | Page 390 |
| **11:55am** | **Other Formal Business** | | | |
| ICB/23/06/23 | Closing remarks, review of the meeting and communications from it | Chair | Verbal | - |
| **12.00pm** | **CLOSE OF MEETING** | | | |

**Date and time of next meeting:**
**27 July 2023, 09:00am – 11:45am,** Boardroom, The Department, Lewis's Building, 2 Renshaw Street, Liverpool, L1 2SA
**A full schedule of meetings, locations, and further details on the work of the ICB can be found here:** www.cheshireandmerseyside.nhs.uk

**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-Executive Director
- at least one Partner Member; and
- at least one member who has a clinical qualification or background.

## Speakers

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| **ALE** | Anthony Leo, Place Director (Halton), C&M ICB |
| **AMI** | Anthony Middleton, Director of Performance and Planning, C&M ICB |
| **CDO** | Christine Douglas MBE, Director of Nursing and Care, C&M ICB |
| **CWA** | Clare Watson, Assistant Chief Executive, C&M ICB |
| **CWI** | Claire Wilson, Executive Director of Finance, C&M ICB |
| **EMO** | Erica Morriss, Non-Executive Director, C&M ICB |
| **GPU** | Graham Urwin, Chief Executive, C&M ICB |
| **JRA** | Professor Joe Rafferty CBE, Partner Member, C&M ICB |
| **NLA** | Neil Large MBE, Non-Executive Director, C&M ICB |
| **RJA** | Raj Jain, Chair, C&M ICB |
| **TFO** | Tony Foy, Non-Executive Director, C&M ICB |

# Integrated Care Board Meeting held in Public

Held at Ellesmere Port Civic Hall, Civic Way,
Ellesmere Port, Cheshire, CH65 0AZ
Thursday 25 May 2023
9.00am to 11.45pm

## UNCONFIRMED Draft Minutes

| MEMBERSHIP | | |
|---|---|---|
| **Name** | **Initials** | **Role** |
| Raj Jain | RJA | Chair, Cheshire & Merseyside ICB (voting member) |
| Neil Large MBE | NLA | Non-Executive Director, Cheshire & Merseyside ICB (voting member) |
| Hilary Garratt CBE | HGA | Non-Executive Director, Cheshire & Merseyside ICB (voting member) |
| Graham Urwin | GPU | Chief Executive, Cheshire & Merseyside ICB (voting member) |
| Claire Wilson | CWI | Executive Director of Finance, Cheshire & Merseyside ICB (voting member) |
| Christine Douglas MBE | CDO | Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member) |
| Prof. Rowan Pritchard-Jones | RPJ | Medical Director, Cheshire & Merseyside ICB (voting member) |
| Ann Marr OBE | AMA | Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust (voting member) |
| Adam Irvine | AIR | Partner Member, Chief Executive Office, Community Pharmacy Cheshire, and Wirral (CPCW) (voting member) |
| Dr Naomi Rankin | NRA | Partner Member, Primary Care (GP) Partner Member (voting member) |
| Prof. Joe Rafferty CBE | JRA | Partner Member, Chief Executive Office, Mersey Care NHS Trust, (voting member) |
| IN ATTENDANCE | | |
| Dr Fiona Lemmens | FLE | Associate Medical Director, Cheshire & Merseyside ICB (Regular Participant) |
| Anthony Middleton | AMI | Director of Performance and Improvement, Cheshire & Merseyside ICB (Regular Participant) |
| Christine Samosa | CSA | Director of People, Cheshire & Merseyside ICB (Regular Participant) |
| Clare Watson | CWA | Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant) |
| John Llewellyn | JLL | Chief Digital Information Officer, Cheshire & Merseyside ICB |
| Warren Escadale | WES | Chief Executive, Voluntary Sector North West (Regular Participant) |
| Prof. Ian Ashworth | IAS | Director of Public Health representative (Regular Participant) |

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| Louise Barry | LBA | Healthwatch St Helens |
| Laura Marsh | LMA | Interim Place Director Cheshire West |
| Gary Cliffe | GCL | VCFSE Representative |
| Matthew Cunningham | MCU | Associate Director Corporate Governance and Company Secretary |
| Louise Murtagh | LMU | Corporate Governance Manager, Cheshire & Merseyside ICB |

| APOLOGIES NOTED | | |
|---|---|---|
| Erica Morriss | EMO | Non-Executive Director, Cheshire & Merseyside ICB (voting member) |
| Prof. Steven Broomhead | SBR | Partner Member, Chief Executive, Warrington Borough Council (voting member) |
| Tony Foy | TFO | Non-Executive Director, Cheshire & Merseyside ICB (voting member) |
| Councillor Paul Cummins | PCU | Partner Member, Cabinet Member for Adult Social Care, Sefton Council (voting member) |

| Item | Discussion, Outcomes and Action Points | Action by |
|---|---|---|
| 9.000am | Preliminary Business | |
| ICB/05/25/01 | Welcome, Introductions and Apologies | |
| | RJA welcomed all present at the meeting.<br><br>Attendees were advised that this was a meeting held in public.<br><br>Apologies for absence were received from Erica Morriss, Prof. Steven Broomhead, Tony Foy and Councillor Paul Cummins. | |
| ICB/05/25/02 | Declarations of Interest | |
| | There were no declarations of interest made by Members that would materially or adversely impact on matters requiring discussion and decision on the items being considered at today's Board. | |
| ICB/05/25/03 | Minutes of the last meeting – 27 April 2023 | |
| | Members reviewed the minutes of the meeting held on 27 April 2023 and agreed that they were a true reflection of the discussions and decisions made subject to an amendment to Item ICB/04/27/10 Cheshire & Merseyside System Month 12 Finance Report where the words 'system' and 'organisation' needed to be transposed.<br><br>**The Integrated Care Board approved the minutes of ICB Board meeting of 27 April 2023 subject to the amendment requested.** | |
| ICB/05/25/04 | Action Log | |
| | The Board acknowledged the completed actions and updates provided in the document.<br><br>Actions ICB-AC-22-27, 31, and 38 were listed on the log as | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | completed and members agreed to close the entries.<br><br>**The Integrated Care Board noted the Action Log.** | |
| ICB/05/25/05 | Decision Log | |
| | Members reviewed the decision log and confirmed that the information presented was an accurate record of substantive decisions made by the Board.<br><br>It was further noted that there were no emergent actions arising from those decisions that were due for review at this meeting.<br><br>**The Integrated Care Board noted the Decision Log.** | |
| 9.10am | STANDING ITEMS | |
| ICB/05/25/06 | Chair's Announcements (Raj Jain) | |
| | RJA took the opportunity to thank outgoing councillors for their service and welcomed new leaders and councillors.<br><br>Members of the Board would be arranging introduction meetings in due course. | |
| ICB/05/25/07 | Report of the Chief Executive (Graham Urwin) | |
| | GPU presented the Chief Executive Report to the Committee and commented on the following items:<br><br>There were three items to brief attendees on in addition to those listed in the report:<br>• The ICB had received the Silver Award in the Employer Recognition Scheme under the Armed Services Covenant.<br>• All Together Fairer celebrated its 1-year anniversary today<br>• Accommodation of Asylum Seekers on vessels around Birkenhead. There would be a multi-agency forum 26th May that the ICB would attend. Should the scheme proceed discussions would be on-going as to the ICB's legal responsibilities, the monies to be made available to the organisation and to whether there would be adequate health care provision. This would be provided with no detriment to current residents and patients.<br><br>From the report GPU highlighted:<br>Urgent and Emergency Care Improvement – C&M ICB was one of seven ICs in Tier 1, which resulted in the highest level of national support and scrutiny. Two of the four sentinel metrics the ICB performed well against, and members were advised that there was an action plan in place to address the proportion of general and acute beds occupied by patients over a 14-day length of stay.<br>Primary Care Access Recovery Plan – CWA took this item. NHS | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | England published its delivery plan for recovering access to primary care'. The document was entitled primary care, but it only covered general practice. It was seen as good news in general terms but there were challenges for the sector.<br><br>AIR commented on the pharmacy element of the document and how this would be hugely positive for patients, but work was needed how to operationalise findings. Communications had not been made clear to public that some minor ailment services were now available.<br><br>NRA advised that from a GP's perspective the document was a little disappointing. The funding of a new telephone service would not resolve issues. It would help with data collection and reason for demand, but the focus needed to be on actual demand and resources. Actions to reduce bureaucracy across primary and secondary care were key. Access to patient data/records would be key to this.<br><br>Also of note was the danger of destabilising the system by moving staff from one sector to another with pharmacists and paramedics given as examples.<br><br>CWA explained that the plan covered more than general practice or even the whole of primary care, it was about looking at the whole system with signposting to other services.<br><br>Change of ICB Headquarters – the ICB did not hold a lease on the current HQ building and there was a need to designate another location. There were the nine Places but there was a legal need to have a registered HQ.<br><br>**The Integrated Care Board noted the contents of the report.**<br><br>**ACTION: CWA to**<br>**1. review the communications around the minor ailment scheme and work with Healthwatch and other Third Sector colleagues**<br>**2. to bring the Primary Care Strategic Framework to the June 2023 Board meeting** | |
| ICB/05/25/08 | Report of the Place Director – Cheshire West | |
| ICB/05/25/09 | Resident/Staff Story - Learning Disabilities Health Checks | |
| | Place Director's Report was presented by Laura Marsh (LMA) for consideration by the Board. The Cheshire West Place Director report provided an overview of the Cheshire West Place, including successes, partnership working and challenges. | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | The presentation covered demographics for Cheshire West and Chester (CWAC). Attendees were advised that 10.8% of the population experienced deprivation relating to low income with 15% of 0–15-year-olds lived in relative low-income families.<br><br>Life course statistics for CWAC had recently been updated and indicated that there were many areas (22) where Place performance better or the same as the rest of England but there were seven areas that were statistically worse.<br><br>Information was provided on the GP survey results that showed overall Cheshire West provided good access with practices ranked in the top 3 for 9/10 questions and higher than the national and C&M average for all 10 questions.<br><br>The vision, priorities and values for Place were shared as were the governance arrangements in respect of the principle of equal partnership. Place was paramount and the following four slides concentrated on Place transformation ambitions, objectives, alignment, how plans would be monitored and governance arrangements.<br><br>The remainder of the presentation provided examples on areas of local progress and achievements and celebrated success. They covered areas such as commissioning for adults with a learning disability and/or autism and the integrated Home First programme that was helping people to stay in their own homes. Further examples were given in the presentation.<br><br>Cheshire West had a strong and successful record of co-production with local learning disability (LD) residents. Some of these active members attended a Health and Well-being Board to update on the annual LD Conference and the outcomes achieved. They had produced a short video to share their experience of local health, social care and community services including annual LD health checks. This was based on the local philosophy of “Nothing about us, without us”.<br><br>The video was played for attendees, and this provided examples of service users positive experiences in attending dentist appointment, visiting the doctor’s surgery for physiotherapy, using Changing Places and LD health checks.<br><br>Presenters also listed changes that they wanted to see that would lead to further improvements<br>• more hospital passports to be used<br>• receive letters in a way that they understand | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | • VIP bag that identified additional needs<br><br>In total six ways to reduce health inequalities were listed in presentation.<br><br>**The Integrated Care Board thanked LMA for hosting the meeting, for the updates on Cheshire West and applauded the video shown.**<br><br>Discussions moved on to the different metrics that were included in Place presentations and how it was hard to compare like for like. these differed. IAS explained that Local Authorities used different markers than the NHS who used general practice registered populations.<br><br>**ACTION: IAS to work with colleagues to determine if it was possible to develop a standardised way of displaying life course statistics across Cheshire and Merseyside.** | |
| 9.30am | ICB Key Update Reports | |
| ICB/05/25/10 | Executive Director of Nursing & Care Update Report<br>(Christine Douglas) | |
| | CDO's report provided assurance from the Executive Director of Nursing & Care to the Board on the quality, safety and patient experience of services commissioned and provided across the geographical area of C&M.<br><br>The report updated on:<br>• People Governance, Management & Engagement<br>• Organisational Effectiveness Development<br>• Staff Experience & Engagement<br>• Workforce Equality, Diversity & Inclusion<br>• Freedom to Speak Up<br>• HR Service.<br><br>The paper also referenced system wide workforce activities and priorities that were reported via the Cheshire & Merseyside People Board. CDO handed to talk further about the ICB focus on internal staff experience.<br><br>CSA confirmed that the first People Committee had been held on 2nd May and that this forum would receive a range of metrics for review. There was also a need to strengthen interaction with the 1,000 staff working for the ICB. A schematic explaining this was listed in the report at section two.<br><br>Senior workforce posts had now been recruited to and section four of | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | the report showed on-going and planned activity around the staff survey. This covered how the ICB communicated, how it engaged with and cultivated the feeling of us being one new or.<br><br>There was a need to ger the basics right to create an inclusive culture and details of the actions and forums to support this was provided.<br><br>CSA referred to the establishment of the ICB noting that it involved many organisations being brought together and with this there was an array of differing HR policies to standardise. The team was working with CSU colleagues to enable this.<br><br>Appended to the report was a full list of workforce programmes across the whole ICS that had been established.<br><br>**The Integrated Care Board noted the Executive Director of Nursing & Care Update Report.**<br><br>**ACTIONS – there was an acknowledgement that progress regarding internal ICB staff would be monitored through the people board but that the Board requested a direct quarterly update report.** | |
| ICB/05/25/11 | Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton) | |
| | AMI provided an update on 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. The Board was advised that these were considered in great detail at the Quality and Performance Committee.<br><br>The key issues identified were:<br>• urgent and emergency care systems continued to experience significant and sometimes severe pressure across C&M.<br>• Significant reduction in backlogs for both elective and cancer care are to be welcomed.<br>• With respect to elective performance at the end of March there were fewer than 100 patients waiting longer than 78 weeks with majority of these due to patient choice. The target was to reduce the number pf patients waiting more than 65 weeks and the report showed the downward for these patients.<br>• Industrial action – in spite of this, the north west delivered the highest elective activity in the country<br>• Urgent care and that C&M was in tier one under the NHS England Urgent and Emergency Care Plan. This was due to high | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | occupancy rates in the acute and mental health sectors. This would bring support but also scrutiny. The Quality and Performance Committee would be deep diving into individual areas of concerns<br><br>**ACTION: most indicators listed in the report related to symptoms not the cause of the symptoms. These were discussed at committee level and would be incorporated into future Board reports**<br><br>**The Integrated Care Board noted the contents of the report and take assurance on the actions contained.** | |
| | ICB Business Items | |
| ICB/05/25/12 | NHS Cheshire and Merseyside Integrated Care System (ICS) Financial Plan for 2023/24 and Proposed Budgets for the Integrated Care Board (ICB) (Claire Wilson) | |
| | The paper presents the financial plan for C&M ICS for 2023/24 and set out proposed budgets for the (ICB) for the same period.<br><br>Development of the operational plan for the year has been subject to engagement and collaboration across all NHS organisations and was developed in line with the national NHS planning guidance. The final revised plan submission was made on 4th May 2023.<br><br>The Board was asked to note the £51.23m deficit position for C&M ICS which consisted of a £68.96m forecast surplus within the Integrated Care Board (ICB) and a £120.1m deficit within NHS providers.<br><br>Both positions were detailed in the report including the level of savings required in order to achieve this planned deficit position. The risks were highlighted in the report and had been discussed in detail at the Finance and Resources Committee where cost improvements and non-recurrent savings had been noted as high to medium risk.<br><br>There was work on-going on corporate budgets and running cost reductions and details would be brought to Board as and when appropriate. CWI confirmed that there was a significant amount of work needed to deliver over the next 3 years.<br><br>The paper also described the programme expenditure split for budgetary control purposes between 'Central ICB' and 'Place' budgets for the 2023/24 financial year. 90% of expenditure would be at place with the place director holding the budget. Some budgets would be ring-fenced but there was a need to be clear about benefit realisation, and how the ICB consulted with all system partners. | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | Discussions ended with an acknowledgement that finance was a significant priority, but no more important than providing quality services.<br><br>**The Integrated Care Board**<br>• **note the content the report.**<br>• **supported the revised financial plan submission made on the 4 May 2023 by the ICB / ICS in relation to the 2023/24 financial year including resource and expenditure assumptions, particularly noting the level of efficiencies required to achieve the planned deficit position.**<br>• **approved the high-level budgets for 2023/24.**<br>• **approved the proposed split for budgetary control purposes between 'Central ICB' and 'Place' budgets for the 2023/24 financial year resulting in a headline 10% / 90% split respectively.**<br><br>**ACTION: To assign one of the board development days to provide training on a general overview of system finance.** | |
| ICB/05/25/13 | Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative - Annual Work Plan 2023-2024 (Clare Watson) | |
| | The report and accompanying presentation set out CMAST Provider Collaborative's purpose, achievements, and delivery priorities for 2023/04. The delivery areas and targets formed part of the ICB's operational plan and reflected national planning expectations and aspirations.<br><br>Given the nature of the reporting timeframe, development, and the onboarding of project resource CMAST has committed to delivery of an end of Q1 update for deliverables specifically with relation to its workforce and efficiency at scale programme.<br><br>CMAST's work plan included the following areas and targets covering these were provided in the report. Those emboldened were areas of key focus:<br>• **Elective Recovery and Transformation**<br>• **Clinical Pathways Programme**<br>• **Diagnostics**<br>• Waiting Times<br>• Productivity<br>• Health Inequalities<br>• **Workforce**<br>• **Finance, Efficiency and Value (efficiency at scale)** | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | The slides provided details on the work programme for 2023/24 in line with the priority areas already listed.<br><br>Examples of where this collaborative approach was already reaping benefits were discussed as was the importance of validated evidence to enable programmes to be developed. Digital solutions would need to be easily accessible for all and Healthwatch and the VCSE sector would be key partners in shaping delivery.<br><br>**The Integrated Care Board:**<br>• **noted the approach and progress made by CMAST**<br>• **endorsed the commitments made in the workplan as part of C&M's wider delivery undertakings.** | |
| ICB/05/25/14 | Cheshire & Merseyside ICB Board Assurance Framework (BAF) (Clare Watson) | |
| | CWA and MCU presented the Risk Management Strategy that incorporated the board assurance arrangements and set out how the effective management of risk would be evidenced and scrutinised to provide assurance to the Board. The (BAF) was key to this.<br><br>This report presented the initial 2023-24 BAF report and principal risks developed by the Board and ICB Executive Team for adoption and represented those that would significantly impact on the delivery of the ICB's strategic objectives. MCU and CWA thanked Dawn Boyer for her help in developing the framework and its content.<br><br>There were 10 principal risks, including four extreme risks and six high risks. The most significant were listed as risks P5, P6, P7 and P3.<br><br>Mitigation strategies were having an impact on a number of risks, but further action was required to achieve an acceptable level and the controls in place, an assessment of their effectiveness and further control actions planned in relation to all of the principal risks was appended to the report.<br><br>Planned assurances had been identified for each principal risk and would be managed by ICB committees and Board reports. The priority activity was the strengthening and implementation of controls with the aim of reducing the likelihood or potential impact. As progress was made the focus would shift to assuring that key controls were embedded and effective in continuing to mitigate the risk to an acceptable level.<br><br>Appended to the report was an update on the establishment of the ICB Risk Committee, whose Terms of Reference were approved by | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | the ICB Audit Committee at its meeting on 16 May 2023.<br><br>Ensuing discussions referred to the ICB relationships with other partners and how these would be enablers in the mitigation of risks. System risks along with those aligned to reputational risks would be developed over the next year and would be a focus for the newly established Risk Committee.<br><br>**The Integrated Care Board:**<br>• **approved the adoption of the principal risks proposed at appendix A for inclusion in the Board Assurance Framework and consider whether any further risks should be included.**<br>• **noted the current risk profile, proposed mitigation strategies and priority actions for the next quarter and consider any further action required by the Board to improve the level of assurance provided.**<br>• **noted the establishment of the ICB Risk Committee.** | |
| ICB/05/25/15 | Marking NHS@75 years and<br>NHS Cheshire and Merseyside@ 1 year (Clare Watson) | |
| | This report provided an overview of communications and engagement plans to mark the 75 anniversary of the NHS and the first year of operation for NHS Cheshire and Merseyside.<br><br>Some of the key dates and events included<br>• 22 June - 75th anniversary of Windrush - Windrush Day, with NHS organisations encouraged to fly the Windrush flag<br>• 2 July - Together Coalition's National Thank You Day<br>• 5 July - National 75th anniversary events taking place including promotion of national and local achievements, staff event at Westminster Abbey, a parkrun event with MPs and NHS Parliamentary Awards<br>• 8-9 July - National NHS 75 Parkrun<br>• 31 December - Final promotional activity and end of use for the NHS 75 logo<br><br>The report also referenced the activity relating to internal communication and staff engagement.<br><br>**The Integrated Care Board:**<br>• **noted the content of the report, acknowledging that it represented work in progress**<br>• **supported related communications and staff engagement activity in line with plans outlined, particularly through key internal meetings and meetings in public, as well as a series of informal gatherings across the ICS estate** | |

| Item | Discussion, Outcomes and Action Points | Action by |
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| | **ACTION: Windrush was fundamental to the start of the NHS and Windrush Day was the same day as the ICB July Board meeting. The patient/staff story should focus on this**. | |
| 11.10am | Sub-Committee Reports | |
| ICB/05/25/16 | Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee (Christine Douglas) | |
| | The report provided assurance to the Board in regard to key issues, considerations, approvals and matters of escalation considered by the Committee in securing continuous improvement in the quality of services. This included reducing inequalities in the quality of care, coupled with a focus on performance.<br><br>Members were asked to take the report as read but CDO highlighted section four in relation to the outlying status of Cheshire East Trust. The Trust would be invited to a future committee meeting to enable a better understanding of the data and discuss progress around quality improvement.<br><br>RJA added that there had been lengthy discussions at committee, and with the medical director from the Trust outside of the meeting, to try to better understand some of the metrics. The hope was that through the committee further system level support could be offered to the Trust.<br><br>**The Integrated Care Board noted the report.**<br><br>**ACTION: RJA requested that when items were escalated to Board that the risk template was used. This would highlight where and how risks were being mitigated.** | |
| ICB/05/25/17 | Report of the Chair of the Cheshire & Merseyside ICB Audit Committee (Neil Large) | |
| | NLA advised the Board that the Audit Committee had met on 2 2023. The meeting was quorate and able to undertake the business of the Committee. Declarations of interest were noted where applicable.<br><br>Members were asked to take the report as read but NLA highlighted That internal and external audit work was progressing well in terms of the audit of the account of accounts.<br><br>**The Integrated Care Board noted the report.** | |
| ICB/05/25/18 | Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Our Resources Committee (Claire Wilson) | |
| | The Finance, Investment and Resource Committee met on 28 March | |

| Item | Discussion, Outcomes and Action Points | Action by |
|---|---|---|
| | 2023 and 25 April 2023. Both meetings were quorate, and the Committee was able to undertake its business.<br><br>The main items considered at the meetings:<br>• Committee Risk report 23/24. Long discussion around mitigation development<br>• Month 11 financial position<br>• 2023/24 Planning update<br>• People Committee, workforce update and workplan for 23/24<br>• Draft Month 12 financial position and close down of accounts<br>• 2023/24 Planning.<br><br>The committee also met in private in March and April and considered a number of procurement items relevant to the ICB Business and in accordance with the scheme of reservation and delegation.<br><br>**The Integrated Care Board noted the report.** | |
| ICB/05/25/19 | Report of the Chair of the Cheshire & Merseyside ICB System Primary Care Committee (Clare Watson) | |
| | The Board was asked to consider the following business that had been discussed at the System Primary Care Committee (private section Part A and public session Part B) held on 20 April 2023.<br><br>In **Part A -** Draft Minutes of Sub-Committee Meeting 3rd March 2023 Risk Assurance, Escalation of issues from Place, Minutes of Pharmaceutical Services Regulatory Committee PSRC, Extension of (named) Dental Contracts, Finance – Revenue / Capital Update, and Harmonisation of Cheshire & Merseyside Minor Ailments Service.<br><br>In **Part B**, the public section - Update on the operating model and governance, Contracting, Commissioning and Policy Update, Strategic Framework Update / Workforce Steering Group Update, Place update, Digital Update, and System Pressures<br><br>The April meeting was the first to include all four contractor groups in the membership and represented. There was Primary Care Strategy primarily focussed on GPs and pharmacy, but there were plans to develop a Dental Improvement Plan to cover the full dental pathway. This would be taken at the June or July committee and then updates provided to the Board following.<br><br>**The Integrated Care Board noted the report.** | |
| ICB/05/25/20 | Report of the Chair of the Cheshire & Merseyside ICB Women's Services Committee (Raj Jain) | |
| | The Women's Services Committee met in shadow on 25 April 2023 | |

| Item | Discussion, Outcomes and Action Points | Action by |
|---|---|---|
| | and declarations of interest where applicable where recorded.<br><br>Main items considered at the meeting via papers received or verbal update provided included:<br>• Committee TOR. These included impacts on the whole of Cheshire and Merseyside and not just Liverpool<br>• NHS England's three-year delivery plan for maternity and neonatal services.<br>• Programme Risks<br>• Women's Services Programme Working Groups<br>• Options Development – discussion on parameters that will guide the develop of options.<br>• Key Indicators of Safety – initial proposals for metrics that the committee will use to gauge success.<br>• A substantial period of time was given to how we can improve engagement with stakeholders. This would be a significant piece of work for the committee.<br>• Crown Street site – data sharing agreements were now in place that enabled the committee to see the full patient journey including if the patient was subsequently seen at another site<br><br>The next meeting of the Committee is scheduled to be held on 27 June 2023.<br><br>**The Integrated Care Board noted the report.** | |
| 1.40pm | Other Formal Business | |
| ICB/04/27/19 | Closing remarks, review of the meeting and communications from it (Raj Jain) | |
| | The Chair thanked the Board for their participation in the meeting. There had been good discussions around and interrogation of the reports presented.<br><br>The communications team would compile a summary of the meeting. The papers were currently available online and a recording of proceedings would be added following the meeting. | |
| | CLOSE OF MEETING | |
| Date, time, and location of Next Meeting: | | |
| 29 June 2023 9:00am Runcorn Town Hall, Heath Road, Runcorn, WA7 5TD | | |

**End of Meeting**

**CHESHIRE MERSEYSIDE**
**INTEGRATED CARE BOARD**

# ICB Board Action Log 2023 - 2024

**Updated:** **20-Jun-23**

| 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-22-05 | 27/10/2022 | **Continuous Glucose Monitoring Update** | Requested that in 12 months' time the Board be provided with a progress update. | Rowan Pritchard-Jones | 01-Oct-2023 | Added to the forward plan for October 2024 | ONGOING |
| ICB-AC-22-06 | 27/10/2022 | **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 | CMAST workplan cane to May 2023 Board. MHLD Collaborative workplan coming to June 2023 Board meeting | COMPLETED |
| ICB-AC-22-10 | 28/11/2022 | **Cheshire & Merseyside System Month 7 Finance Report** | There was a need for a comprehensive provider organisational integrated performance report to be presented to the Board covering all challenges being faced by organisations. This would be provided in the new financial year. | Claire Wilson | April 2023 | Date tbc | ONGOING |
| ICB-AC-22-11 | 28/11/2022 | **Cheshire & Merseyside System Month 7 Finance Report** | In the absence of a comprehensice provider organisational integrated performance report, members would be sent dashboards that provided the wider financial position and workforce information. | Claire Wilson | Jan 2023 | | ONGOING |
| ICB-AC-22-13 | 28/11/2022 | **ICB Equality, Diversity and Inclusion Update Report** | Members discussed how data collected via WRES, WDES, CORE20, EDS2 and other system would be used and shared with the Board. IAS agreed to bring a further report on Core20Plus to a future Board meeting in relation to this. | Ian Ashworth | TBC | Date to be confirmed when Director of Population Health starts with ICB | ONGOING |
| ICB-AC-22-14 | 28/11/2022 | **Consensus on the Primary Secondary Care Interface** | RPJ confirmed that discharge medicines services were crucial for patients and a future paper would be required at Board to review | Rowen Pritchard-Jones | TBC | Has been added to the Board Forward Plan - date tbc | ONGOING |
| ICB-AC-22-15 | 28/11/2022 | **Consensus on the Primary Secondary Care Interface** | An update report would then be presented to Board over the next 12 months | Rowen Pritchard-Jones | TBC | Has been added to the Board Forward Plan | ONGOING |
| ICB-AC-22-18 | 28/11/2022 | **Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee** | The Primary Care Strategy. This would be presented to the Board in March 2023 | Clare Watson | TBC | National Plan has been published. Update coming to June Board with ICB Plan coming in October 2023 | COMPLETED |
| ICB-AC-22-20 | 26/01/2023 | **NHS 2023/24 Priorities and Operational Planning Guidance** | That the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023 and as such there was a need for review by the ICB Executive Team and Provider Collaboratives. The final submissions would be presented to the Board for approval in March 2023 | Clare Watson | March 2023 | Added to work plan for June 2023 | ONGOING |

# ICB Board Action Log 2023 - 2024

**Updated:** **20-Jun-23**

| 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-22-21 | 26/01/2023 | **Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee** | The Committee had received an Urgent Care presentation and the intention was to return to the Board meeting in March with a full Urgent Care report | Anthony Middleton | March 2023 | Added to work plan for June 2023 | COMPLETED |
| ICB-AC-22-22 | 26/01/2023 | **Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee** | A programme reviewing the current transformational change activity occurring across the Cheshire and Merseyside system and the work to develop priorities, delivery, and governance approaches. A report relating to this would be presented to the Board at a future meeting | Clare Watson | March 2023 | Added to work plan for Setember 2023 | ONGOING |
| ICB-AC-22-23 | 02/03/2023 | **Report of the Chief Executive** | CWA confirmed that a further report would be presented to the Board in March 2023 that would include the terms of reference for these new Committees | Clare Watson | 01-Mar-2023 | Womens Services Committee and Risk Committee TOR being presented at May Board. North West Specialsied Commissioning Joint Committee TOR to come to June Board. | COMPLETED |
| ICB-AC-22-28 | 23/02/2023 | **Cheshire & Merseyside ICB Prioritisation Framework** | CWA confirmed that that the Prioritisation Framework would be presented to the ICB Board in at its April 2023 meeting. | Clare Watson | April 2023 | Date tbc | ONGOING |
| ICB-AC-22-29 | 23/02/2023 | **Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB Update** | A further update report on delegated services would be presented to the Board in six months | Clare Watson | September 2023 | Added to work plan for September 2023 | ONGOING |
| ICB-AC-22-30 | 30/03/2023 | **Report of the Chief Executive (Graham Urwin)** | With regard to the suggestion of a learning event following the end of the industrial action RJA asked RPJ to look into developing this. | Rowen Pritchard-Jones | date tbc | Action is still on-going | ONGOING |
| ICB-AC-22-32 | 30/03/2023 | **Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)** | With regard to the Core20plus5 there were a range of 22 indicators that would be reported through the HCP but could also be presented to this Board. | Andy Thomas | date tbc | | ONGOING |
| ICB-AC-22-33 | 30/03/2023 | **Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)** | The ICB relative performance compared to other ICBs in the Northwest had not improved as much as they have, yet we continue to invest and put a lot of time and attention. Deep dive into this to be undertaken in April, place-based response to the information presented today in the private meeting. Further report to be brought back to the Board at a future meeting. | Andy Thomas | date tbc | | ONGOING |

# ICB Board Action Log 2023 - 2024

**Updated:** **20-Jun-23**

| 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-22-36 | 30/03/2023 | **Northwest Specialised Commissioning Joint Working Agreement (Clare Watson)** | RJA asked CWA to set out a time frame for this board to understand how we will get some benefit out of this structural change. | Clare Watson | tbc | CWA to provide an update at the June Board meeting | COMPLETED |
| ICB-AC-22-37 | 30/03/2023 | **Sub-Committee Reports** | RJA questioned the format of the report used for this type of committee and would like to follow this up with CWA outside of the meeting. | Raj Jain & Clare Watson | tbc | RJA, CWA and MCU to meet to review committee report format. Meeting to be arranged. | ONGOING |
| ICB-AC-22-39 | 27/04/2023 | **Report of the Chief Executive** | Operational System Pressures - no criteria to reside (NCTR) improvement plan to be presented to the Board in June 2023. | Graham Urwin | Jun-23 | On June Board Agenda | COMPLETED |
| ICB-AC-22-40 | 27/04/2023 | **Resident/Staff Story** | CWA to report to be Board on the findings and actions leading from the GP review of unpaid carers/patients | Clare Watson | TBC | | ONGOING |
| ICB-AC-22-41 | 27/04/2023 | **Cheshire & Merseyside System Month 12 Finance Report** | CWI and SBR to work together on the production of a position paper covering social care provision and funding | Claire & Steven Broomhead | TBC | | ONGOING |
| ICB-AC-22-42 | 27/04/2023 | **Intelligence Into Action: Continued provision of ICS digital and data platforms** | Responses to the tabled questions had been drafted and would be shared following the meeting and added to the ICB website | John Llewellyn | TBC | Completed and shared with individual and published | COMPLETED |
| ICB-AC-22-43 | **25/05/2023** | **Report of the Chief Executive** | review the communications around the minor ailment scheme and work with Healthwatch and other Third Sector colleagues | Clare Watson | TBC | | NEW |
| ICB-AC-22-44 | **25/05/2023** | **Report of the Chief Executive** | to bring the Primary Care Strategic Framework to the June 2023 Board meeting | Clare Watson | June 2023 | On the June Board agenda | COMPLETED |
| ICB-AC-22-45 | 25/05/2023 | **Resident/Staff Story - Learning Disabilities Health Checks** | IAS to work with colleagues to determine if it was possible to develop a standardised way of displaying life course statistics across Cheshire and Merseyside | Ian Ashworth | TBC | | NEW |
| ICB-AC-22-46 | 25/05/2023 | **Executive Director of Nursing & Care Update Report** | There was an acknowledgement that progress regarding internal ICB staff would be monitored through the people board but that the Board requested a direct quarterly update report. Add to work progrmme | Chris Samosa | June 2023 | Added to People Committee workplan | COMPLETED |
| ICB-AC-22-47 | 25/05/2023 | **Cheshire & Merseyside ICB Quality and Performance Report** | Most indicators listed in the report related to symptoms not the cause of the symptoms. These were discussed at committee level and would be incorporated into future Board reports | Anthony Middleton | June 2023 | | NEW |
| ICB-AC-22-48 | 25/05/2023 | **ICS Financial Plan for 2023/24 and Proposed Budgets for the ICB** | To assign one of the board development days to provide training on a general overview of system finance. | Claire Wilson | June 2023 | To add to the Board Development programme | ONGOING |
| ICB-AC-22-49 | 25/05/2023 | **Marking NHS@75 years and NHS Cheshire and Merseyside@ 1 year** | Windrush was fundamental to the start of the NHS and Windrush Day should be referred to at the ICB July Board meeting. It would be good if the patient/staff story could focus on this. | Clare Watson | June 2023 | On June Board agenda | COMPLETED |
| ICB-AC-22-50 | 25/05/2023 | **Reports of the Chairs of the Cheshire & Merseyside ICB Committees** | RJA requested that when items were escalated to Board that the risk template was used. This would highlight where and how risks were being mitigated. | All committee chairs | June 2023 | To be added to considerations when reviewing Chairs report template | NEW |

# CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

## *Decision Log 2022 - 2023*

***Updated: 23 March 2023***

| Decision Ref No. | Meeting Date | Topic Description | Conflicts of interest considered and agreed treatment of the conflict | Decision (e.g. Noted, Agreed a recommendation, Approved etc.) | If a 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:-<br>1) Claire Wilson, Director of Finance;<br>2) Professor Rowan Pritchard Jones, Medical Director<br>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:-<br>1) The NHS Cheshire and Merseyside Constitution subject to some agreed updates (see action plan ref: ICB-AC-22-01 for details).<br>2) The Standards of Business Conduct of NHS Cheshire and Merseyside.<br>3) The Draft Public Engagement/Empowerment Framework of NHS Cheshire and Merseyside.<br>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:-<br>1) The Scheme of Reservation and Delegation of NHS Cheshire and Merseyside.<br>2) The Functions and Decisions Map of NHS Cheshire and Merseyside.<br>3) The Standing Financial Instructions of NHS Cheshire and Merseyside.<br>4) The Operational Limits of NHS Cheshire and Merseyside. | |
| ICB-DE-22-06 | 01-Jul-2022 | **ICB Committees** | | The Integrated Care Board approved:-<br>1) The core governance structure for NHS Cheshire and Merseyside.<br>2) The terms of reference of the ICB's committees.<br><br>It also noted the following:-<br>i) The proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board.<br>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:-<br>1) Noted the contractual HR policies that will transfer to the ICB alongside the transferring staff from former organisations.<br>2) Endorsed the decision to adopt NHS Cheshire CCG's suit of policies as the ICB policy suite from 1st July 2022.<br>3) Agreed to establish a task and finish group to set out a proposed policy review process, using the committee structure for policy approval.<br>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.<br>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: 23 March 2023***

| Decision Ref No. | Meeting Date | Topic Description | Conflicts of interest considered and agreed treatment of the conflict | Decision (e.g. Noted, Agreed a recommendation, Approved etc.) | If a 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<br>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<br>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<br>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<br>2) The Board approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role<br>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.<br>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.<br>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.<br>2) Noted that CDO would be taking the Kirkup recommendations to the ICB Quality and Performance Committee for consideration.<br>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<br>2) The Board approved the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28.<br>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: 23 March 2023***

| Decision Ref No. | Meeting Date | Topic Description | Conflicts of interest considered and agreed treatment of the conflict | Decision (e.g. Noted, Agreed a recommendation, Approved etc.) | If a recommend… completion / subsequent consideration |
|---|---|---|---|---|---|
| ICB-DE-22-29 | 27-Oct-2022 | **Provider Collaborative update** | | 1) Noted the content of the report.<br>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.<br>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.<br>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<br>2) Approved the revised terms of reference attached to the paper. | |
| ICB-DE-22-35 | 28-Nov-2022 | **Cheshire and Merseyside ICS Digital Strategy** | | Endorsed the ICS Digital and Data Strategy with a view to formal approval at a subsequent ICB Board meeting. | |
| ICB-DE-22-36 | 28-Nov-2022 | **Consensus on the Primary Secondary Care Interface** | | Endorsed the consensus<br>Agreed on the proposed actions for implementation:<br>ongoing promotion to Secondary Care via the Trust Medical Directors<br>recommendation for the formation of Primary Secondary Care Interface Groups based around Acute Trusts across Cheshire and Merseyside | |
| ICB-DE-22-37 | 28-Nov-2022 | **Report of the Chair of the Finance, Investment and Resources Committee** | | Approved the revised terms of reference attached to the paper | |
| ICB-DE-22-38 | 23-Jan-2023 | **Report of the Chief Executive - Harmonising Clinical Commissioning Policies Update** | | Approved the revised Legal statement as detailed within Appendix Two, as reviewed by Hill Dickinson | |
| ICB-DE-22-39 | 23-Jan-2023 | **Review of Liverpool Clinical Services** | | Noted the content of the report<br>Agreed all the recommendations within the report; however with regards those recommendations to be overseen by CMAST the Board removed from the recommendations the sentence 'the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool.' Only once tangible progress is made within this scope should it be broadened to a wider geography<br>Agreed the implementation plan and associated timescales | |
| ICB-DE-22-40 | 23-Jan-2023 | **Cheshire & Merseyside Integrated Care Partnership Interim Draft Strategy 2023-24** | | Noted the contents of the draft interim strategy<br>Endorsed the next steps agreed by the Health and Care Partnership at the meeting of 17 January 2023; including the ICB using the priorities within the draft interim strategy to inform development of the ICB Five Year Joint Forward Plan | |
| ICB-DE-22-41 | 23-Jan-2023 | **NHS 2023/24 Priorities and Operational Planning Guidance** | | Noted:<br>The content of the 2023-24 NHS planning guidance, including the need to develop both 2-year operational plans and an ICB Joint Forward Plan<br>The approach to developing our Cheshire and Merseyside plans including the role of providers in developing and approving plans as well as the need to engage with the HCP partners and HWB in developing the content of the plans.<br>That the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023.<br>The need for review by the ICB Executive Team and Provider Collaboratives before submission and review, and ratification at the February Board meeting which takes place on the day of submission.<br>That the final submissions would be presented to the Board for approval in March 2023 | |
| ICB-DE-22-42 | 23-Jan-2023 | **Report of the Chair of the Cheshire & Merseyside ICB Audit Committee, including amendments to the ICB SORD & SFIs** | | Noted the items covered during the Audit Committee of 13 December 2022 report.<br>Approved the Operational Scheme of Delegation Update, December 2022 | |
| ICB-DE-22-43 | 23-Feb-2023 | **Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023** | | Approved the annual ICB proposed Equality Objectives 2023 to 2024 (Appendix One, section six) subject to the amendment the fourth Equality objective (Empower and engage our leadership and workforce) explicitly showing 'to address overall inequalities'. | |

# CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

## *Decision Log 2022 - 2023*

***Updated: 23 March 2023***

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|---|---|---|---|---|---|
| ICB-DE-22-44 | 23-Feb-2023 | **Cheshire & Merseyside ICB Risk Management** | | Approved the Risk Management Strategy attached at Appendix One<br>Approved the proposed Board Assurance Framework report format<br>Approved the core statement and risk appetite definitions included in the draft Risk Appetite Statement | |
| ICB-DE-22-45 | 23-Feb-2023 | **Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB** | | Noted and supported the work undertaken to date in relation to the delegation of Ophthalmic and Dental Services on 1 April 2023 | |
| ICB-DE-22-46 | 23-Feb-2023 | **Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee** | | Approved the legacy policies as described at Section 5 of the report | |
| ICB-DE-22-47 | 23-Feb-2023 | **Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Our Resources Committee** | | Approved the updated Committee Terms of Reference | |
| ICB-DE-22-48 | 30-Mar-2023 | **Northwest Specialised Commissioning Joint Working Agreement (Clare Watson)** | | • noted the contents of the report<br>• approve the ICB entering into a Joint Working Agreement and progressing the work to establish statutory joint committee arrangements with NHSE and NHS Greater Manchester and NHS Lancashire and South Cumbria ICBs for the 2023/24 period<br>• approve delegating authority to the Assistant Chief Executive to sign the Joint Working Agreement on behalf of NHS Cheshire and Merseyside to enable these commissioning arrangements to 'go live' from April 2023<br>• note that further engagement will be undertaken with members of the three ICB Boards in developing and agreeing the Joint Committee Terms of Reference. | |
| ICB-DE-22-49 | 30-Mar-2023 | **Cheshire and Merseyside Cancer Alliance Update** | | •noted the contents of this report and ongoing efforts to improve operational performance and outcomes.<br>•approved ongoing constructive conversations with colleagues at place and at corporate ICB around sustaining and embedding some of the improvements discussed.<br>•noted that the alliance is keen to explore how it may support the ICB with its new commissioning duties for specialised cancer services which are to be delegated to the ICB from NHS England. | |
| ICB-DE-22-50 | 27-Apr-2023 | **Intelligence Into Action: Continued provision of ICS digital and data platforms** | | The Integrated Care Board<br>•approved the allocation of funds to support option 2, which will allow for:<br>othe continued provision of the existing population health and data platform and associated shared care record over a transition period of two years.<br>othe continued provision of the integrated (within CIPHA) C2Ai PTL tool across the 10 acute Trusts to support risk-adjusted triage and prioritisation of the Patient Treatment List (PTL). | |
| ICB-DE-22-51 | 27-Apr-2023 | **NHS Cheshire and Merseyside ICS NHS Staff Survey 2022-23: Results and Actions** | | The Integrated Care Board<br>•noted the staff survey results and<br>•endorsed the actions taken to review and respond to the Staff Survey results 2022. | |
| ICB-DE-22-52 | 27-Apr-2023 | **Briefing on the national maternity and neonatal services delivery plan** | | The Integrated Care Board noted the report and endorsed the terms of reference for the Women's Committee. | |
| ICB-DE-22-53 | 25-May-2023 | **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative - Annual Work Plan 2023-2024** | | •noted the approach and progress made by CMAST<br>•endorsed the commitments made in the workplan as part of C&M's wider delivery undertakings. | |
| ICB-DE-22-54 | 25-May-2023 | **Cheshire & Merseyside ICB Board Assurance Framework (BAF)** | | •approved the adoption of the principal risks proposed at appendix A for inclusion in the Board Assurance Framework and consider whether any further risks should be included.<br>•noted the current risk profile, proposed mitigation strategies and priority actions for the next quarter and consider any further action required by the Board to improve the level of assurance provided.<br>•noted the establishment of the ICB Risk Committee. | |
| ICB-DE-22-55 | 25-May-2023 | **Marking NHS@75 years and<br>NHS Cheshire and Merseyside@ 1 year** | | •noted the content of the report, acknowledging that it represented work in progress<br>•supported related communications and staff engagement activity in line with plans outlined, particularly through key internal meetings and meetings in public, as well as a series of informal gatherings across the ICS estate | |

# NHS Cheshire and Merseyside Integrated Care Board Meeting

29 June 2023

# Chief Executive's Report (June 2023)

| | |
|---|---|
| **Agenda Item No** | **ICB/06/29/07** |
| **Report author & contact details** | Graham Urwin, Chief Executive |
| **Report approved by (sponsoring Director)** | - |
| **Responsible Officer to take actions forward** | Graham Urwin, Chief Executive |

# Chief Executive's Report (June 2023)

<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:<ul><li>Operational System Pressures</li><li>Hewitt Review Update</li><li>NHS Mandate 2023-24</li><li>Lucy Letby trial</li><li>New Cheshire and Merseyside Four-year Suicide and Self-harm Prevention Action Plan launched</li><li>Provider Collaborative Innovator Scheme launch</li><li>Cheshire and Merseyside Carers Charter</li><li>COVID-19 inquiry – Every Story Matters</li><li>COVID-19 Update</li><li>VCFSE Transformation Programme</li><li>Joint Statement from the Cheshire and Merseyside Directors of Public Health on vaping</li><li>Decisions undertaken by the Executive Team</li></ul></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:<ul><li>note the contents of the report.</li><li>approve the recommendation to publicly support the</li></ul></td></tr>
<tr><td rowspan="4">Impact (x)<br>(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></td><td colspan="2">X</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">None</td></tr>
<tr><td>Next Steps</td><td colspan="5">None</td></tr>
</table>

# Chief Executives Report (June 2023)

## 1. Introduction

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

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

## 2. Operational System Pressures

2.1 **Junior Doctors strike action.** The junior doctor industrial action last week coincided with a period of very hot weather resulting in high attendance at emergency departments and challenges with flow across the week. However, due to well planned senior medical staffing cover during this period (14-17 June), Trusts managed to maintain flow and avoid admissions as appropriate. We did get reports that there were increased pressures at the weekend following the industrial actions which seems to be the position reported by other areas across the North West. 5419 patients appointments / procedures were cancelled and rebooked as a result of the3 days of industrial action. However it is expected the true figure will be higher due to appointments not yet booked at the time industrial actions dates were notified to the hospitals.

2.2 **Operational Pressure.** Overall, the Cheshire and Merseyside system has remained a level below the highest level of escalation (OPEL 4) at OPEL 3 across the week (up 14-21 June). A slight decrease in levels of 'corridor care' were noted last week - an average of 58 people per day. Corridor care continues to be a big concern for NHS Cheshire and Merseyside and we do need to make progress on improving the flow through the system. Our aim must be to eliminate corridor care altogether, not to accept or normalise it.

2.3 **Long length of stay.** Discharge is a significant ongoing challenge with 19.4% of all beds across Cheshire and Merseyside currently occupied by patients with no criteria to reside against the current target of 10%. The highest number of patients across Cheshire and Merseyside not meeting criteria to reside continue to be on Pathway 1 so are awaiting services to support them in their own home.

2.4 Cheshire and Merseyside continue to have virtual ward capacity along with Urgent Care Response services (UCR) to support both admission avoidance and early supported discharge. There are staff available to support case finding across seven days at each Trust and across public holidays. According to the latest measure virtual ward utilisation is currently at 55% with the equivalent of 156 beds

available to the system across acute respiratory, frailty, heart failure, palliative care, and paediatric pathways.

2.5 Cheshire and Merseyside continue to focus on these three priority actions:

- Home first ethos – with more assessment of patients in their own home and alternative care settings
- reduce the conveyance of patients to emergency departments where care needs can be met in their own home
- continued efforts to reduce the number of long stay patients and the number of patients not meeting the criteria to reside.

## 3. Hewitt Review Update

3.1 The government has published its response to the Hewitt Review of ICS oversight and governance[1] and the Health and Social Care Select Committee's report into ICS autonomy and accountability.[2]

3.2 The review reinforces the work already happening locally and nationally to capitalise on new system arrangements. The Governments response[3] sets out its commitment to helping ICSs develop, to streamlining the number of national level targets and to reviewing the NHS capital regime, and covers a number of themes including:

- targets and priorities for ICSs
- autonomy and support for ICSs
- ICS governance, accountability, and oversight
- assessment and review of ICSs
- prevention and promoting health
- finance and funding.

3.3 We are in the process of working through the Government response and will work with regional colleagues to determine where and when best to adopt the recommendations of the report and will continue to report back to the Board on its progress.

3.4 NHS Providers has produced a useful briefing on the Governments response to the Hewitt Review which can be found at https://nhsproviders.org/resources/briefings.

[1] Government response to the HSCC report and the Hewitt Review on integrated care systems - GOV.UK (www.gov.uk)
[2] Integrated Care Systems: autonomy and accountability - Health and Social Care Committee (parliament.uk)
[3] Government response to the HSCC report and the Hewitt Review on integrated care systems - GOV.UK (www.gov.uk)

## 4. NHS Mandate

4.1 On the 15 June 2023 the Government published its 2023 mandate to NHS England.[4] There were three priority mandate objectives:

- **Priority One – cut NHS waiting lists and recover performance.** This incorporates the delivery requirement to:
  - Deliver the NHS's delivery plan for tackling the COVID-19 backlog of elective care
  - Improving cancer outcomes
  - Building on the existing patient rights to choice
  - Improving A&E and ambulance performance by delivering the urgent and emergency care recover plan
  - Improving GP access by delivering the primary care access recover plan.
- **Priority Two – support the workforce through training, retention and modernising the way staff work**. NHS England, working with Working with DHSC, ICBs and other partners, will lead implementation of the actions in the NHS Long Term Workforce Plan, which will set out actions to put the NHS workforce on a sustainable footing and ensure that it has the workforce to meet the changing needs of patients over the next 15 years
- **Priority Three – deliver recovery through the use of data and technology.** Delivery should include:
  - ensuring innovative, safe, and effective delivery of live services, following transfer of functions from NHS Digital
  - developing and delivering the federated data platform and maximising trust and ICB take up of the platforms and national use case tools
  - transforming the NHS App as the digital front door of the NHS.

4.2 Alongside these objectives, the mandate outlined the expectation that NHS England continues its wider work to deliver the key NHS Long Term Plan ambitions to transform the NHS for the future, in line with NHS England's operational planning guidance and its wider duty to promote a comprehensive health service.

4.3 Alongside the mandate, the Secretary of State has issued financial directions to NHS England[5] setting revenue and capital resource limits for 2023 to 2024. The government expects that NHS England will ensure that overall financial balance is delivered for the NHS each and every year. The mandate objectives reflect the overall aims of NHS England's Long Term Plan and 5 financial tests, and support the following current priorities:

- the NHS will deliver overall revenue and capital financial balance every year
- NHS England will ensure that all ICBs exercise their functions with a view to delivering financial balance. Where deficits occur an agreed recovery plan will be in place to return to financial balance over time

[4] https://www.gov.uk/government/publications/nhs-mandate-2023/the-governments-2023-mandate-to-nhs-england#:~:text=90%25%20of%20NHS%20trusts%20and,in%20place%20by%20March%202024.
[5] https://www.gov.uk/government/publications/2023-to-2024-financial-directions-to-nhs-england

- the NHS should make cash releasing efficiency savings of at least 2.2% in 2023 to 2024. Productivity should continue to be improved back towards pre-COVID-19 levels consistent with commitments to recover patient services, including the elective recovery plan. Ongoing productivity improvement is also an integral part of long-term workforce planning

## 5. Lucy Letby Trial

5.1 Colleagues will be aware of the ongoing trial of Lucy Letby. The trial of former neonatal nurse Lucy Letby – charged with the murder of seven babies and attempted murder of 10 others at the Countess of Chester Hospital NHS Foundation Trust between June 2015 and June 2016 – is due to conclude in July 2023. Judge Mr Justice Goss has advised that the jury is likely to retire to consider its verdicts in the week commencing 03 July 2023, with widespread and ongoing media coverage anticipated.

5.2 NHS England have set up a national incident management team that will oversee the next steps following the verdict of the jury. Chris Douglas, Executive Director of Nursing and Care will be our representative on this team.

## 6. New Cheshire and Merseyside Four-year Suicide and Self-harm Prevention Action Plan launched

6.1 Cheshire and Merseyside Public Health Collaborative (Champs) has published the Cheshire & Merseyside Suicide and Self-harm Prevention Action Plan 2023 – 2027.[6] The action plan has been designed to help deliver the Cheshire and Merseyside Suicide Prevention Strategy.

6.2 The purpose of the action plan is to provide a multi-agency framework for action across the life-course to prevent avoidable loss of life through suicide. It draws on local experience, local services, research, and evidence, on preventing suicide and promoting mental health and wellbeing in Cheshire and Merseyside. The action plan has a specific focus on self-harm in relation to suicide risk, recognising that the relationship between the two is complex.

6.3 The Cheshire and Merseyside Suicide Prevention Partnership Board will work together on the coordination of the integrated multi-agency work on the delivery of the action plan, which aims to contribute to a reduction in the numbers of people that take their own life by suicide and to help tackle the underlying risk factors for suicide.

[6] https://champspublichealth.com/suicide-prevention/

## 7. Provider Collaborative Innovator Scheme Launch

7.1 I attended the Provider Collaborative Innovator Scheme launch, earlier this month, with a number of his national colleagues. Cheshire and Merseyside were invited to this event because CMAST is only one of nine collaboratives across the country to be selected as an innovator which is designed to support national policy development and exposure to this expertise in Cheshire and Merseyside. At the launch I was pleased to hear, Dr Ash Bassi, Endoscopy Lead for Cheshire and Merseyside, address a national audience sharing much of the long-standing progress and development that has taken place within Cheshire and Merseyside and in Endoscopy.

7.2 Further examples of the solid progress CMAST is making for our patients is exemplified by how we are now one of the few systems, nationally, to have completely eradicated 104 weeks (including patient choice and complex cases) and while too many patients are still waiting too long for treatment our performance in reducing the number of patients waiting over 78 weeks is also really strong with only 52 patients currently waiting this long. Over half that number relate to patient choice and 20 related to treatment complexity.

7.3 In diagnostics we also have no 104 week or 78-week waiters for tests in Cheshire and Merseyside and just 19 patients are waiting above 52 weeks. There is a clear focus in reducing waiting times for such tests and a number of complimentary initiatives are taking place to support continued service improvement. A Diagnostic Bank is now live for Endoscopy Staff – with over 160 staff signed up. We believe this is the first Collaborative Diagnostics Staff Bank in England and supports staff retention, deployment, and efficiency.

## 8. NHS@75

8.1 In the run up to the NHS' 75th birthday on 5 July and the first anniversary of NHS Cheshire & Merseyside (1 July) we are sharing our staff stories internally and externally, an initiative we have developed locally to encourage our colleagues to get to know one another and create a sense of connection. We are also holding a Big Tea event across each of our places and encouraging staff to take part in the NHS park run on 8 and 9 July 2023.

8.2 In the birthday week we will be sharing a special staff bulletin thanking colleagues for all their hard work and commitment to the NHS and a special stakeholder bulletin to our partners and public showcasing some of our achievements. Members of our Board and Executive Team will be joining colleagues and teams to mark this occasion.

8.3 Most recently the ICB has supported Carers Week, Talking Therapies recruitment, Diabetes Week, Cervical Screening Week, Blood Donor Day. We have supported

this by sharing local events and services as well as using resources from national toolkits to support these awareness days on our social media channels, website and in our weekly staff brief.

## 9. Cheshire and Merseyside Carers Charter

9.1 The Cheshire and Merseyside Health and Care Partnership Interim Strategy 2023-2028 laid down the vision for all carers in Cheshire and Merseyside to have the support they need and recognition they deserve. A strategic system-wide Carers Partnership Group for Cheshire and Merseyside was established in March 2023 to move this agenda forward, chaired by Dave Sweeney, ICB Director of Partnerships.

9.2 The Carers Partnership Group has provided comprehensive input and feedback for the Cheshire and Merseyside Joint Forward Plan. Supporting Carers is an essential contribution to narrow health inequalities in access, outcomes, and experiences. Furthermore, there is evidence for ethnic and socio-economic inequalities for carers, and that support and inclusion of young carers will lead to better chances in life for children and young people. A detailed workplan and timetable to achieve these ambitions is part of the supporting content of the Joint Forward Plan.

9.3 As a result of the workplan put forward for the improved identification and support to carers in Cheshire and Merseyside, we expect the number of carers identified year on year to increase by 5% for the period of our Joint Forward Plan (2023-28). Outcomes will be measured regularly and reported on. Progress has already been made with the first ever establishment of a baseline of numbers of carers registered with a GP in Q4 2022/23, which was 98,131 adult carers and 811 young carers across Cheshire and Merseyside.

9.4 Furthermore, the Strategic Partnership group is currently co-producing a Carers Charter for Cheshire and Merseyside that will reflect both the ICS-wide and the place-based strategic priorities for carers. It is anticipated that this will go to the Cheshire and Merseyside health and Care Partnership meeting in September for approval. Once this has been signed off, we will invite organisations and individuals to publicly sign-up to the Carers Charter for Cheshire & Mersey.

## 10. COVID-19 inquiry – Every Story Matters

10.1 Earlier this month, the UK COVID-19 Inquiry launched ‘Every Story Matters’, which is an opportunity for everyone across the country to share their experience of the pandeminc directly with the Inquiry. Every Story Matters will support the UK COVID-19 Inquiry’s investigations and help the Chair of the Inquiry make recommendations for the future, by providing evidence about the human impact of

the pandemic on the UK population. It provides an opportunity for those affected by the pandemic to share their experiences without the formality of giving evidence or attending a public hearing.

10.2 Every story shared will be anonymised and will then contribute to important, themed reports. These reports will be submitted to each relevant investigation as evidence. They will be used to identify trends and common threads across the country, as well as particular experiences, which will contribute to the Inquiry's investigations and findings. Every Story Matters will remain open throughout the lifetime of the Inquiry and a final report will be submitted into evidence to make sure every story matters.

10.3 The Inquiry would like as many people as possible to take part in Every Story Matters, joining nearly 6,000 people who have already shared their stories. The Inquiry is working with over 40 organisations to reach as many people as possible, including Age UK, Marie Curie, Shelter, and the Royal College of Midwives, to ensure that the experiences shared are representative of the UK population.

10.4 There are a number of ways people can share their experiences with the Inquiry. The main way is via the Inquiry's Every Story Matters online form on its website at https://COVID-19.public-inquiry.uk/every-story-matters/. For those who cannot use the online form to share their story there will be a range of alternatives made available – including paper versions and later this year a telephone number people can call. Members of the Inquiry team will also be travelling across the UK so that individuals can share their experiences in person at community event.

## 11. Cheshire and Merseyside COVID-19 Update

11.1 The phase 5 spring booster 2023 campaign is now nearing closure and the last day of vaccination will be 30 June 2023. Cheshire and Merseyside met national targets to complete visits in care homes earlier in the programme than we did last Autumn and last Spring. The next steps are to undertake a review and prepare a lessons learned document which will be shared with Region and the national team.

11.2 There will be no offer or access to primary courses or boosters for healthy individuals and no routine offer for pregnant ladies. The offer for healthy 5-11year-olds also comes to an end. Planning will commence over this period for the autumn programme working on likely scenarios for a smaller number of eligible cohorts whilst firm advice is awaited from JCVI.

11.3 From 27 June 2023 ICBs will now have a statutory responsibility[7] for providing access to community-based anti-viral COVID-19 treatments (Paxlovid, sotrovimab and molnupiravir) following NICE guidance.[8] As the Country moves out

[7] https://www.england.nhs.uk/coronavirus/publication/transition-of-COVID-19-treatments-to-routine-pathways/
[8] https://www.nice.org.uk/guidance/TA878/history

of the pandemic and levels of community infection are reducing, the NHS is required to embed COVID-19 treatments into long-term, sustainable pathways to ensure access for highest risk patients.

11.4 Highest risk patients who can be digitally identified will receive a letter explaining the changes, and outlining how these patients will instead now need to contact local NHS services to access assessment and treatment should they test positive for COVID-19 in the future.

11.5 All national reporting requirements will also end on 26 June and, as with other treatments, it will be for ICBs to determine what arrangements are required for monitoring services and standards of care locally

11.6 The ICB will continue to engage with GP practices, community pharmacists, hospital specialists and all other healthcare professions to design and confirm local arrangements and ensure patients can continue to access these COVID-19 treatments.

11.7 The costs of new access arrangements will need to be met through our existing funding allocations, however, existing supplies of the anti-virals will continue to be made available to the NHS free of charge until central stocks are exhausted. Paxlovid and molnupiravir are also now available for routine dispensing through community pharmacies. Continued access to the free of charge molnupiravir stock will be dependent on the outcome of the NICE appeals process and a positive published recommendation on its routine use.

11.8 Finally, current arrangements for access to lateral flow tests from UKHSA for highest risk patients will remain in place until end September 2023. Arrangements that will ensure highest risk patients can access free LFD tests beyond September will be communicated closer to this time.

11.9 **Living Well Buses.** The Living well buses continue to receive national recognition. The Cheshire and Wirral Partnership and COVID-19 Vaccination Response Team were invited to present at the ConfedEXPO and join a panel discussion with Steve Russell the Chief Delivery Officer and National Director for Vaccinations and Screening on 15 June 2023.

11.10 As of 09 June 2023 in this Spring programme the buses have delivered over 150 clinics, 5,000 COVID-19 vaccinations, 980 MECC (Make Every Contact Count) discussions and 2,800 health screenings. The team continue to support the whole system with 15 sites visited each week across the ICB until 30 June 2023. Thereafter plans are in place to build on and develop the living well bus roving offer of MECC and health checks over the summer and also working with additional funding from Section 7a colleagues vaccinating migrant workers with non-COVID-19 vaccines in Liverpool and St Helens as a proof of concept over

July and August 2023. This pilot will be continued up until the commencement of the Autumn 2023 programme.

## 12. VCFSE Transformation Programme

12.1 NHS Cheshire and Merseyside recognise our voluntary, community, faith, and social enterprise (VCFSE) sector as a key partner in shaping and delivering our health and care ambitions. We know that the sector operates at system, place, and neighbourhood footprints and, in Cheshire and Merseyside, consists of over 15,000 organisations, with a workforce of 33,000 WTE staff and 275,000 volunteers and that it draws in over £800m investment per annum for community-centred delivery across Cheshire and Merseyside.

12.2 We have been at the forefront of working with the VCFSE sector since committing to being a cohort 1 VCSE Alliance pilot site over five years ago and we are now highlighted in the 2023 Kings Fund framework on ICS-VCFSE partnership work. While we have changed structures, the strength of partnership has grown and we are now able to make a long-term commitment to this work through investing in a 3 year + 2 VCFSE Transformation Programme equating to just under £2.2m over 5 years.

12.3 This programme will focus on identifying models to address system pressures on hospitals, and community and primary care, drive sector inclusion in our priority workstreams (cancer, prevention, early years, mental health, digital, carers, health inequalities) as well as support our social and economic function and ambitions as an ICS. It will also support models of working, mobilising and innovating VCFSE action at place and health neighbourhood. To be clear, this investment is not a substitute for place investment but it will ensure that we are clearer on the levers and mechanisms for mobilising VCFSE action, pilot mainstream-able initiatives in each Place and provide support and VCFSE intelligence to our incredible Place Directors and the network of VCFSE Strategic Place Leads.

12.4 The programme of delivery has been shaped and developed through a number of our boards and structures, and through sector engagement and the leadership structures of the VS6 Partnership, Cheshire and Warrington Infrastructure Partnership (CWIP) and the Cheshire & Merseyside VCFSE Health & Care Leadership Group. This investment will enable inclusion of these VCFSE networks, governance, and accountability structures, offer us the opportunity to build on the partnership model we have committed to and take our work with the sector to the next level. In reality, the transformation we are aiming for is how we as a board, as system partners, as an executive team and as a diverse VCFSE sector align and grow together and deal with the challenges that alone we cannot hope to address. This programme is not the answer to everything but it is a fundamental building block.

12.5 In terms of our governance, Clare Watson, Assistant Chief Executive, will be the accountable lead for this work, Dave Sweeney, Associate Director of Sustainability and Partnerships, is the day-to-day lead, and Warren Escadale, CEO of VSNW, the contract lead. The cross-partner delivery team meets every two weeks. Reporting will be to the Transformation Board, Health and Care Partnership, the Cheshire & Merseyside VCFSE Health & Care Leadership Group, CWIP and VS6. My thanks go to all involved in getting us to this point.

## 13. Joint Statement from the Cheshire and Merseyside Directors of Public Health on vaping

13.1 Directors of Public Health in Cheshire and Merseyside's nine local council areas – Cheshire East, Cheshire West and Chester, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral – have issued a statement[9] expressing their concern about the increase of the use of vapes in the subregion, and in particular express concern about the increase if vapes amongst children. As a group, the Directors of Public Health are calling for a country-wide ban on sales of disposable vapes, additional restrictions on advertising and marketing of vapes, a significant increase in fines for retailers selling illicit vaping products and vapes to those aged under 18, and a consultation on the licensing and regulation of vapes.

13.3 Board members are asked to approve the recommendation that the ICB publicly supports this statement.

## 14. Decisions taken at the Executive Committee

14.1 Since the last Chief Executive report to the Board in May 2023, 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:

- **Long COVID-19 pathway paper** – the Executive team received a paper outlining that further national ring-fenced funding has been allocated to Cheshire and Merseyside (C&M) to deliver Long COVID-19 services for 2023/24. Funding for 2023/24 is confirmed as £4,596,260 which is a reduction of 8.95% compared to the last financial year. The Executive Team were informed that there been indication from NHS England that from 24/25 funding for Long COVID-19 services will be become part of the core functions and that allocation for the services will go directly to ICBs. Work will progress with the future model for Long COVID-19 services from 24/25 following the removal of the Central Programme Team in NHSE. It is expected that a form of commissioning guidance will be released from the National Team in summer

[9] https://champspublichealth.com/directors-of-public-health-in-cheshire-and-merseyside-condemn-harmful-disposable-vapes-and-disgraceful-targeting-of-children-by-tobacco-companies/

2023 on the requirements of Long COVID-19 services post March 2024. The Executive Team endorsed the revised long COVID-19 pathways and the delivery plan for 2023/24.

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

- Cheshire and Merseyside Joint Forward Plan
- Sustainable hospital Services programme
- Merseyside Police Serious and Organised Crime summit
- Ministry of Defence Employer Recognition Scheme – Silver Award
- Cheshire and Merseyside Single Integrated Service Specification for Pulmonary Rehabilitation
- Cheshire and Merseyside Change and Integration Programme Update.

14.3 At each meeting of the Executive Team, there are standing items on quality, finance, and non-criteria to reside performance where members are briefed on any current issues and actions to undertake.

# NHS Cheshire and Merseyside Integrated Care Board

## *One Halton*

Runcorn Town Hall
Thursday 29 June 2023

# Welcome to Halton Place

Cheshire and Merseyside


1. Halton sits within the County of Cheshire
2. Consists of two towns: Widnes and Runcorn
3. Geographically separated by the River Mersey connected by two bridges
4. Population of approximately 130,000
5. Populations on each side of the river are roughly equal and are served by two PCNs of approximately 65,000.
6. 18 electoral wards
7. 2 parliamentary constituencies
8. Chemical industry heritage

# Quick Facts about Halton's History

- **Runcorn was founded in 915 AD.**
- In 1035 a wooden castle was erected at the highest point in the area – Halton Hill. This was upgraded to a sandstone castle in the 13th Century.
- An Augustinian abbey was established here in 1115 and by 1134 Norton Priory was built.

- **1962 – Opening of Daresbury Labs (now Sci-Tech Daresbury) by Prime Minister Harold Wilson.**
- The activities at the site remain world leading with researchers winning three Nobel prizes.
- Home to the development some of the most advanced technologies in computing, data science and artificial intelligence.

- **May 1972 – Opening of Runcorn Shopping City.**
- At the time it was the largest indoor shopping centre in Europe.
- Location for Halton Health Hub operated by Warrington and Halton Hospitals NHS Foundation Trust in Halton Place.

- **June 2018 – Opening of Mersey Gateway bridge by HM The Queen.**
- Took 3 years to complete and supported jobs, secured inward investment to the area and delivered important regeneration benefits.

# Overview of Halton Place Partners

Cheshire and Merseyside

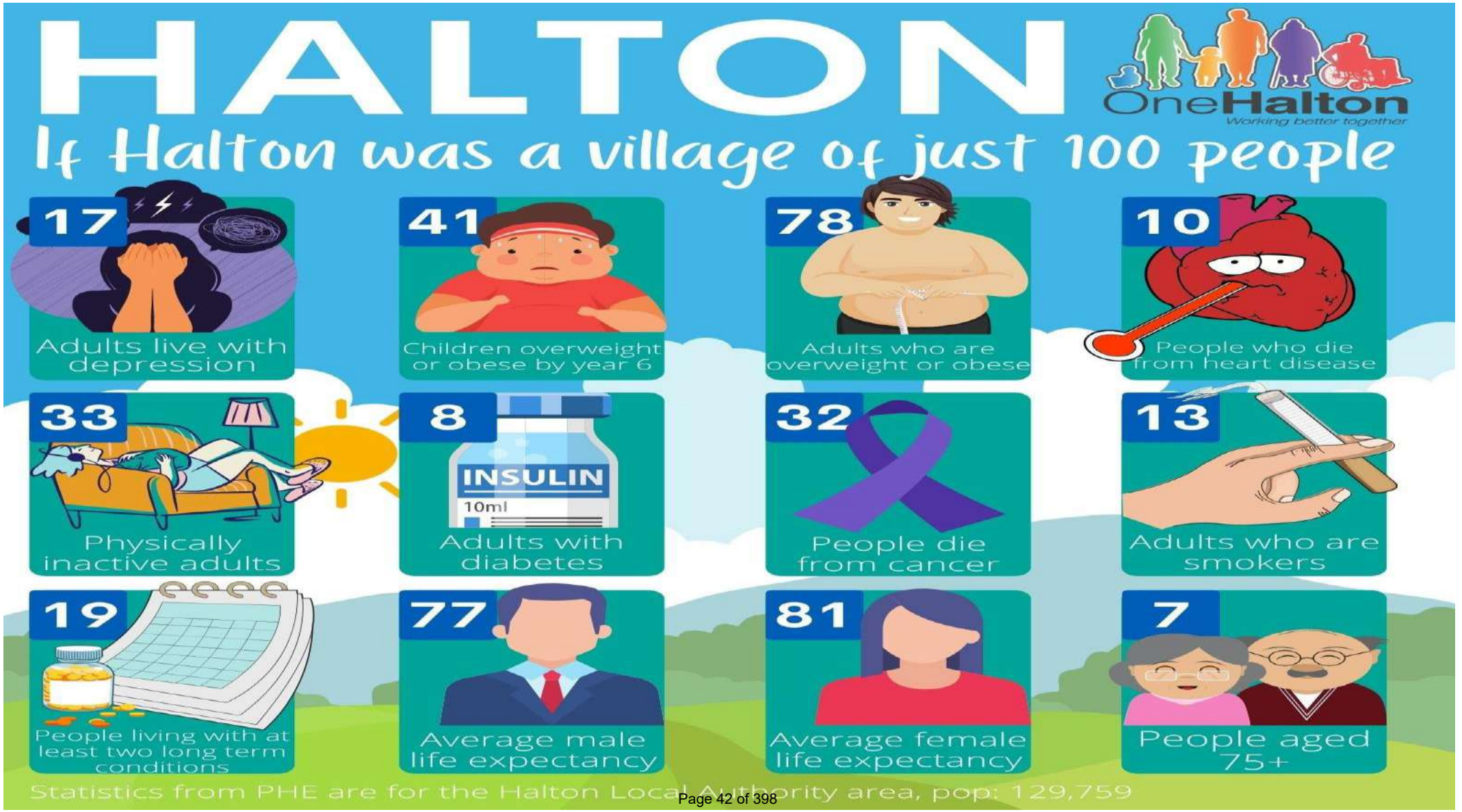
| | | |
|---|---|---|
| 2 x PCNs (14 x GP Practices) | 34 x Community Pharmacies | 1 x Community Trust |
| 2 x Acute Trusts | 1 x Mental Health Trust | NWAS |
| Adult Social Services | Children's Services | 588 x VCFSE Organisations / Other partners |

Serving Halton's c130,000 citizens

| | |
|---|---|
| NHS C&M ICB – Halton Place | |
| Halton Borough Council | |
| Bridgewater Community Healthcare NHS Foundation Trust | |
| St Helens and Knowsley NHS Trust | |
| Warrington and Halton Hospitals NHS Foundation Trust | |
| Mersey Care NHS Foundation Trust | |
| NWAS | Primary Care Providers |
| VCFSE Organisations and Healthwatch Halton Housing | |

# Overview of Halton Place

Cheshire and Merseyside



# Overview of Halton Place

Cheshire and Merseyside

## Halton's life course statistics 2021

A comparison to the North West

* INDICATES NATIONAL DATA COLLECTION HAS BEEN AFFECTED BY COVID-19


## HALTON FACTS

### Population

About **129,400** people live in Halton.

By 2041, this is projected to change:

age 0-14 ↓ 11%
age 15-64 ↓ 5%
age 65+ ↑ 38%

### Deprivation

**48.7%** of Halton's population live in the top **20%** most deprived areas in England.

### Child Poverty

**19.6%** of children aged 0-15 live in relative low income households

## KEY

**Direction of travel**

- ▲ Improved since last period
- ► Similar to last period
- ▼ Worse than last period
- ■ No Comparator

**Statistical significance to North West**

- Better
- No different
- Worse
- Lower

For more information, please contact Halton Borough Council's Public Health Intelligence Team: health.intelligence@halton.gov.uk

Icons made by Flaticon and available here: www.flaticon.com

Concept developed from Gateshead PHAR 2013/14 and Leicestershire PHAR 2015

# Health Inequalities in Halton

Cheshire and Merseyside

## Prioritisation matrix -Electoral ward

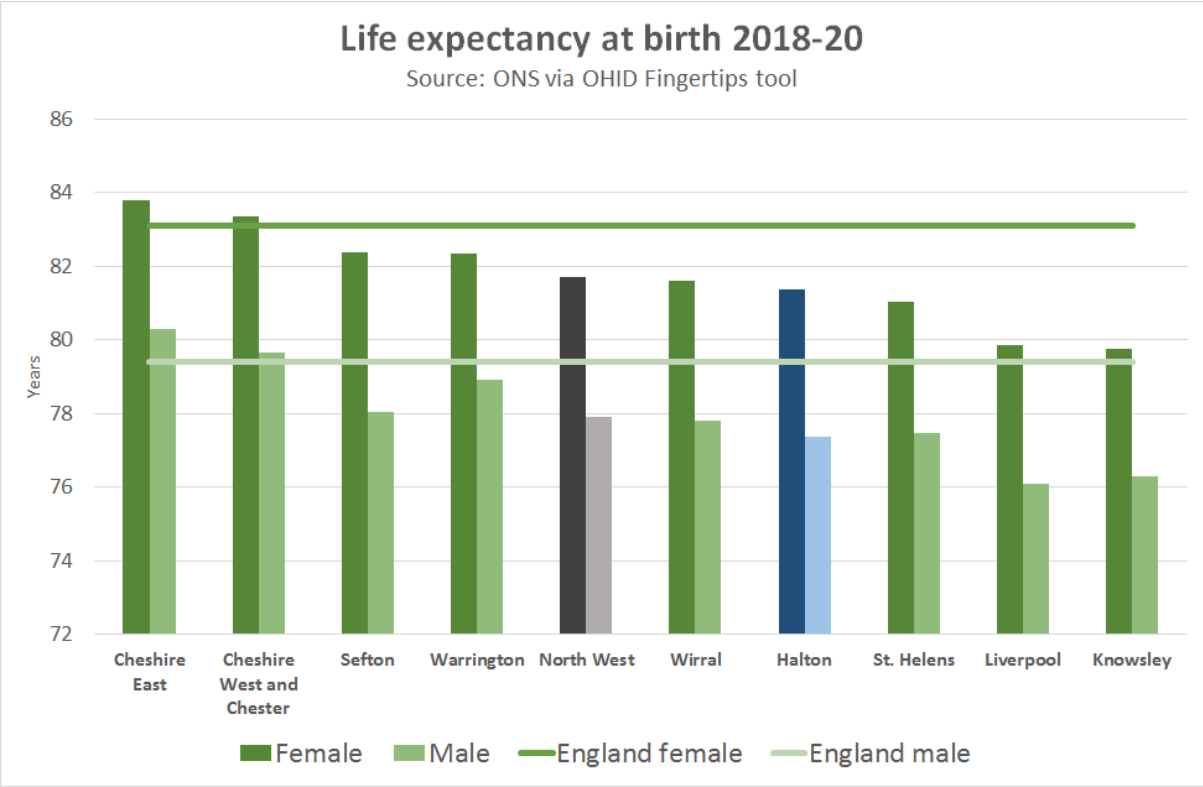
Ward Name
All

| | E05013169 - Appleton | E05013170 - Bankfield | E05013171 - Beechwood & Heath | E05013172 - Birchfield | E05013173 - Bridgewater | E05013174 - Central & West Bank | E05013175 - Daresbury, Moore & Sandymoor | E05013176 - Ditton, Hale Village & Halebank | E05013177 - Farnworth | E05013178 - Grange | E05013179 - Halton Castle | E05013180 - Halton Lea | E05013181 - Halton View | E05013182 - Highfield | E05013183 - Hough Green | E05013184 - Mersey & Weston | E05013185 - Norton North | E05013186 - Norton South & Preston Brook |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BMI-Acorn derived (rate per 1,000) | 292.1 | 329.3 | 23.3 | 8.1 | 306.5 | 308.3 | 48.1 | 170.1 | 20.6 | 361.4 | 408.5 | 415.5 | 182.1 | 72.7 | 485.3 | 277.6 | 328.0 | 440.9 |
| 16-21yr olds (rate per 1,000) | 56.9 | 68.6 | 57.7 | 76.6 | 74.9 | 80.5 | 66.4 | 61.7 | 64.6 | 78.9 | 73.0 | 76.9 | 58.2 | 53.4 | 56.1 | 59.3 | 72.1 | 74.4 |
| Childhood obesity-Acorn derived (rate per 1,000) | 29.8 | 37.5 | 2.7 | 1.3 | 35.7 | 32.6 | 8.7 | 21.1 | 1.0 | 38.4 | 45.9 | 48.0 | 18.2 | 5.7 | 52.2 | 25.5 | 41.5 | 48.5 |
| Complex LTCs (rate per 1,000) | 84.7 | 114.0 | 106.8 | 58.2 | 85.5 | 70.0 | 68.5 | 102.3 | 69.9 | 83.3 | 90.5 | 102.8 | 97.4 | 103.9 | 95.2 | 76.8 | 79.9 | 78.8 |
| Frail patients (rate per 1,000) | 71.2 | 86.0 | 124.1 | 44.7 | 75.5 | 61.9 | 39.7 | 62.7 | 70.5 | 77.3 | 81.0 | 55.5 | 83.8 | 81.2 | 65.1 | 75.9 | 48.9 | 42.4 |
| Injuries due to falls (rate per 1,000) | | | | | | | | | | | | | | | | | | |
| Managed LTCs (rate per 1,000) | 201.7 | 241.0 | 248.8 | 177.8 | 221.8 | 213.6 | 183.5 | 235.3 | 193.2 | 238.6 | 220.9 | 222.0 | 226.0 | 234.2 | 225.7 | 241.2 | 212.3 | 205.9 |
| Multi-comorbidities (rate per 1,000) | 62.7 | 86.3 | 77.4 | 37.6 | 62.3 | 52.0 | 45.4 | 79.7 | 48.7 | 64.9 | 65.7 | 79.1 | 68.4 | 77.7 | 74.8 | 56.7 | 56.5 | 55.8 |
| Pennine Accelerator criteria (rate per 1,000) | 11.7 | 15.7 | 8.7 | 4.4 | 9.5 | 9.0 | 4.5 | 11.8 | 6.3 | 9.8 | 8.9 | 13.5 | 9.6 | 10.2 | 9.7 | 8.9 | 6.7 | 6.7 |
| Respiratory and housing issues (rate per 1,000) | 37.4 | 46.4 | 0.9 | | 43.2 | 44.2 | 2.1 | 41.9 | 6.3 | 47.3 | 55.5 | 58.3 | 27.2 | 15.1 | 52.2 | 29.6 | 37.8 | 43.6 |
| Rural elderly population (rate per 1,000) | 1.8 | 5.7 | 90.2 | 12.3 | 19.5 | 2.3 | 11.4 | 40.6 | 30.4 | 3.3 | 14.3 | 7.1 | 22.7 | 31.2 | 22.5 | 17.2 | 19.5 | 24.0 |
| Morecambe Bay Winter Wellness criteria (rate per 1,000) | 3.3 | 6.2 | | | 4.4 | 3.2 | | 2.4 | | 7.1 | 4.7 | 7.2 | 2.3 | 1.2 | 6.0 | 4.7 | 5.7 | 6.5 |
| Asthma (rate per 1,000) | 47.0 | 61.1 | 49.3 | 41.1 | 49.1 | 47.8 | 38.1 | 60.4 | 41.4 | 51.8 | 53.6 | 47.5 | 52.6 | 58.1 | 58.7 | 47.4 | 46.6 | 44.2 |
| Atrial Fibrillation (rate per 1,000) | 30.3 | 36.0 | 33.6 | 23.4 | 22.8 | 22.0 | 19.2 | 30.2 | 29.0 | 22.9 | 25.3 | 27.1 | 27.9 | 42.0 | 28.4 | 19.6 | 21.1 | 24.1 |
| Cancer (rate per 1,000) | 18.8 | 30.4 | 33.7 | 23.5 | 23.6 | 18.1 | 19.2 | 31.4 | 26.5 | 20.9 | 16.2 | 18.4 | 24.4 | 26.0 | 24.1 | 21.6 | 15.7 | 14.4 |
| CHD (rate per 1,000) | 28.7 | 43.6 | 37.7 | 24.2 | 30.0 | 29.6 | 23.1 | 40.7 | 21.9 | 30.4 | 33.6 | 39.6 | 33.3 | 39.7 | 43.1 | 29.2 | 27.5 | 28.6 |
| Chronic renal issues (rate per 1,000) | 1.5 | 0.8 | | | 0.9 | 0.9 | | 0.6 | 1.4 | 1.4 | 1.2 | 1.6 | 0.8 | 1.7 | | 0.8 | 0.7 | |
| CKD (rate per 1,000) | 32.9 | 42.7 | 38.6 | 18.1 | 24.2 | 23.4 | 27.9 | 40.6 | 26.6 | 26.5 | 31.7 | 37.3 | 35.6 | 39.2 | 33.6 | 22.2 | 29.9 | 31.9 |
| COPD (rate per 1,000) | 20.6 | 26.3 | 14.1 | 6.9 | 20.3 | 18.8 | 10.5 | 29.6 | 11.6 | 19.8 | 24.1 | 24.5 | 17.7 | 18.6 | 28.5 | 17.8 | 19.8 | 20.1 |
| Dementia (rate per 1,000) | 5.3 | 8.3 | 4.2 | 1.1 | 6.2 | 2.1 | 3.9 | 6.4 | 1.6 | 2.6 | 4.0 | 11.6 | 5.2 | 2.6 | 3.7 | 3.5 | 4.1 | 2.8 |
| Depression (rate per 1,000) | 99.5 | 106.2 | 120.5 | 68.8 | 131.0 | 108.0 | 82.6 | 109.8 | 72.2 | 145.5 | 127.0 | 131.9 | 95.7 | 94.9 | 90.7 | 136.9 | 118.1 | 118.7 |
| Diabetes (rate per 1,000) | 32.9 | 45.9 | 41.5 | 21.1 | 35.1 | 31.9 | 24.6 | 45.0 | 25.2 | 41.4 | 32.8 | 40.6 | 36.1 | 40.8 | 48.0 | 38.0 | 34.7 | 29.1 |
| Epilepsy (rate per 1,000) | 9.7 | 10.3 | 6.9 | 6.6 | 6.6 | 10.9 | 4.5 | 10.0 | 7.2 | 8.8 | 9.5 | 11.5 | 8.5 | 11.6 | 11.8 | 8.9 | 5.4 | 6.0 |
| Heart Failure (rate per 1,000) | 20.2 | 25.0 | 23.1 | 16.4 | 18.9 | 16.6 | 20.1 | 21.5 | 17.0 | 15.7 | 20.0 | 23.9 | 23.5 | 22.9 | 26.8 | 17.2 | 18.1 | 14.5 |
| Hypertension (rate per 1,000) | 92.4 | 147.8 | 144.9 | 79.7 | 99.6 | 85.2 | 91.3 | 144.1 | 87.2 | 105.8 | 91.2 | 105.7 | 114.2 | 132.4 | 131.7 | 108.8 | 88.7 | 85.4 |
| Learning disabilities (rate per 1,000) | 6.5 | 6.2 | 6.0 | 1.6 | 6.6 | 5.8 | 1.8 | 5.4 | 4.6 | 5.9 | 9.6 | 8.0 | 9.1 | 8.5 | 2.9 | 6.8 | 6.5 | 5.6 |
| Memory and cognitive problems (rate per 1,000) | | | | | | | | | | | | | | | | | | |
| Mental health (rate per 1,000) | | | | | | | | 1.1 | | | | | | | | | | |
| Osteoporosis (rate per 1,000) | 19.3 | 25.5 | 23.5 | 13.1 | 13.2 | 13.4 | 22.8 | 12.1 | 20.4 | 14.9 | 19.3 | 19.1 | 24.1 | 23.6 | 16.7 | 11.3 | 14.9 | 14.5 |
| Peripheral Arterial Disease (rate per 1,000) | 7.6 | 9.6 | 8.1 | 2.6 | 11.0 | 8.2 | 2.7 | 8.1 | 4.1 | 8.8 | 9.2 | 13.1 | 9.6 | 6.1 | 5.0 | 8.9 | 8.2 | 9.4 |
| Rheumatoid Arthritis (rate per 1,000) | 6.2 | 7.4 | 11.9 | 5.3 | 7.4 | 4.4 | 8.7 | 5.5 | 6.5 | 6.9 | 12.3 | 13.1 | 8.5 | 8.3 | 7.6 | 7.4 | 10.2 | 9.6 |
| Stroke/TIA (rate per 1,000) | 19.5 | 23.1 | 22.7 | 13.2 | 19.2 | 13.5 | 13.8 | 19.5 | 16.0 | 20.0 | 18.0 | 27.0 | 23.0 | 23.8 | 19.6 | 16.6 | 16.7 | 15.5 |
| Elective spells (rate per 1,000) | 104.5 | 161.6 | 154.1 | 116.7 | 105.8 | 96.0 | 104.8 | 117.7 | 108.8 | 98.1 | 125.9 | 122.2 | 114.6 | 141.4 | 134.8 | 105.2 | 121.0 | 120.7 |
| Emergency spells (rate per 1,000) | 119.1 | 129.7 | 59.5 | 69.3 | 79.2 | 108.3 | 67.0 | 117.1 | 74.7 | 84.6 | 91.5 | 115.2 | 111.2 | 100.8 | 121.8 | 80.9 | 80.2 | 79.8 |
| A&E Attendances (rate per 1,000) | 373.1 | 374.6 | 446.4 | 276.8 | 553.5 | 374.8 | | 378.5 | 285.8 | 601.3 | 589.5 | 672.8 | 365.5 | 322.7 | 376.2 | 512.3 | 542.4 | 584.8 |

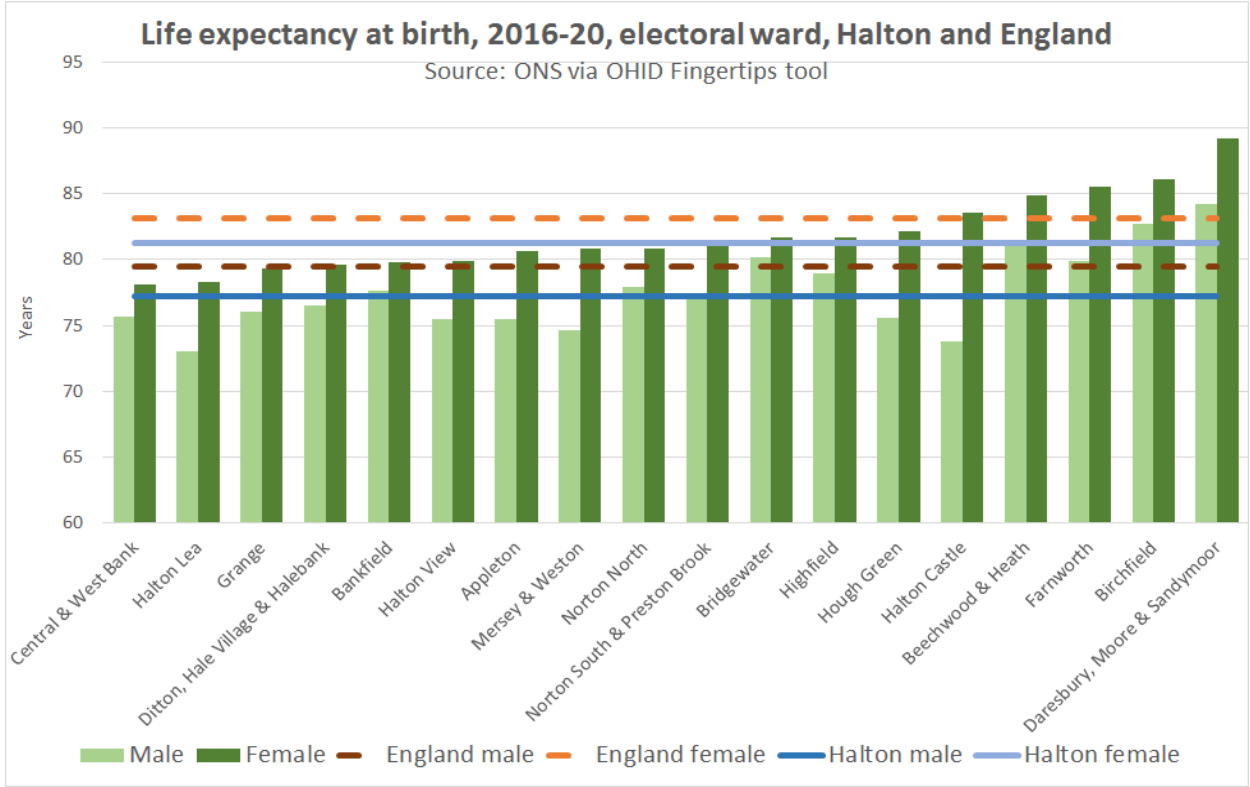
# Health Inequalities in Halton

Cheshire and Merseyside

## Halton compared to England




## Across Halton Electoral Wards




- **Compared to England** life expectancy for **Halton men is 2 years lower** (77.4 compared to 79.4); for **women it is 1.7 years** (81.4 compared to 83.1)
- **Compared to the NW** it is **0.5 years less for men** and **0.4 years less for women**
- **At Halton electoral ward level** there is an **8.6 year difference for men** and **11.1 year difference for women**.

# What is driving Halton's Inequalities?

Cheshire and Merseyside

## Health Conditions:

1. Cancers
2. Respiratory disease
3. Circulatory Disease
4. Digestive disease (inc liver disease)

## Lifestyle Factors:

1. Smoking
2. Unhealthy diet
3. Not enough physical activity
4. Being overweight/obesity
5. Drinking too much alcohol

**Both driven by social conditions**

Poverty
Educational attainment
Employment status and type of job
Housing conditions

# One Halton's Ambition

Cheshire and Merseyside

**"To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community based support and ensuring high quality services for those who need them".**

Our partnership builds on a long **history of working well together**, strengthened by recent experience and therefore fully aware of the challenges brought by the Covid-19 pandemic. The **health reforms have created an exciting opportunity for us the think differently about how we can work together** to support people to live healthy lives, so that people are able to achieve the best for themselves, effectively managing their own lives and health as well as supporting each other.

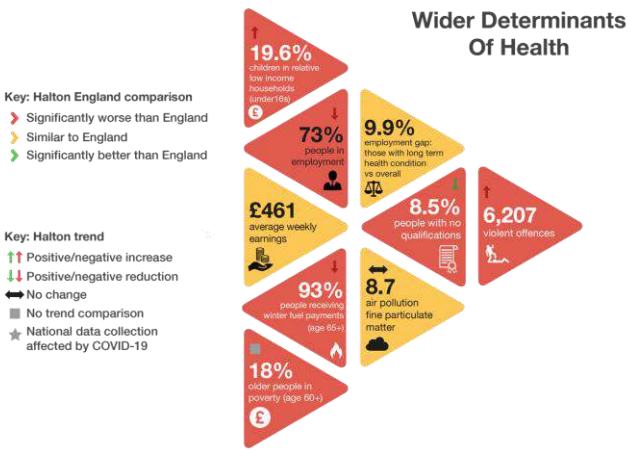
**One Halton is the driver to help achieve this** and will in time become not just an organisational structure but a way of working, the "**One Halton way**".

This means a focus on:

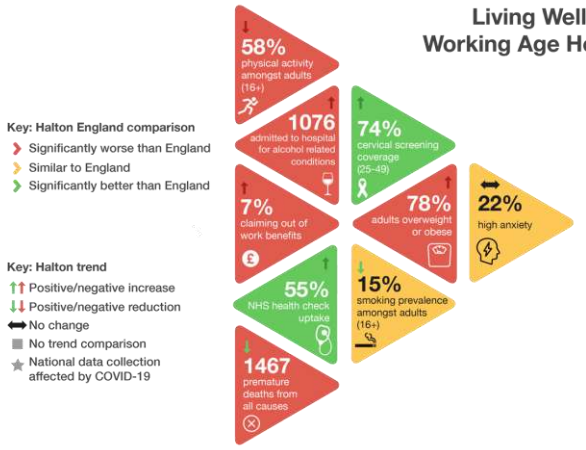
1. Recovery from Covid-19
2. Taking further steps to address unequal access to care
3. Reducing poor care experience
4. Improving outcomes for Halton residents
5. Developing Halton's workforce

# Halton Joint Health and Wellbeing Strategy

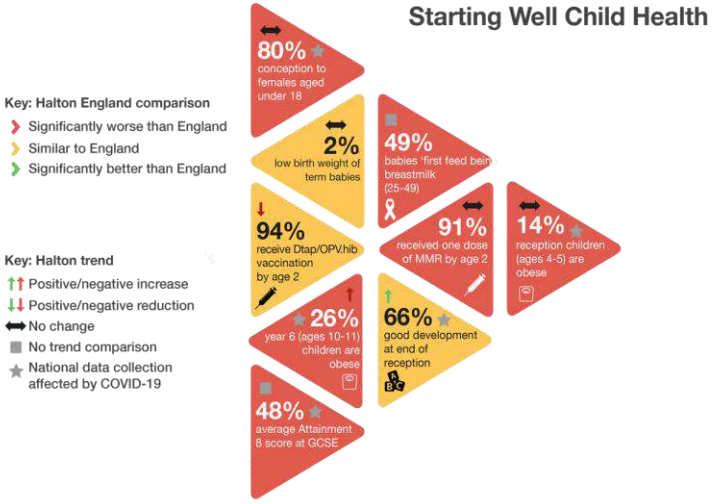
Cheshire and Merseyside



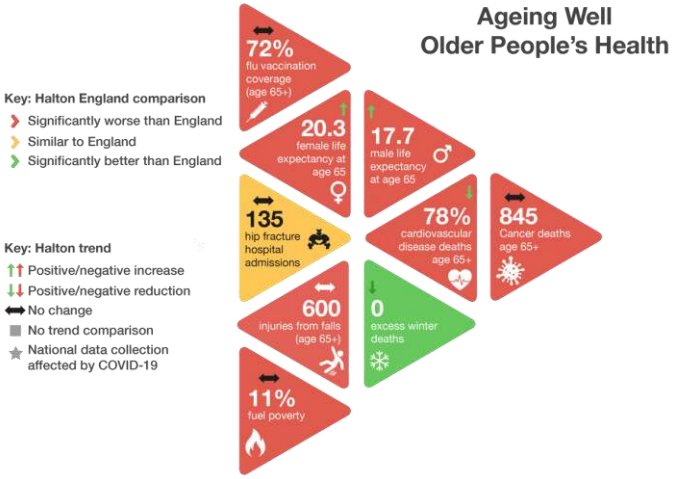

**The Wider Determinants of Health:** Improve the employment opportunities for the people of Halton in particular where it affects children and families.




**Living Well:** Provide a supportive environment where systems work efficiently and support everyone to live their best life




**Starting well:** Enabling children and families to live healthy independent lives




**Ageing Well:** Enabling older adults to live full independent healthy lives

Vulnerable Groups

Marmot and All Together Fairer

Inequalities/PHM/Core20+5

# One Halton

**One Halton's Ambition**

**To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community based support and ensuring high quality services for those who need them**

**Leadership, Oversight and Delivery Arrangements:**

Achievement of our ambition and delivery of our strategic priorities is led and overseen by the One Halton Place Based Partnership Board.

**Our vision for neighbourhood working is greater than just health and social care and moves beyond treating symptoms to addressing the underlying causes of poor health and wellbeing and supporting people to have a good life.**

**Strategic Priorities and Goals:**

| | | | |
|---|---|---|---|
| **Wider Determinant of Health:** Improve the employment opportunities for the people of Halton in particular where it affects children and families. | **Starting Well:** Enabling Children and Families to live Healthy Independent Lives. | **Living Well:** Provide a supportive environment where systems work efficiently and support everyone to live their best life. | **Ageing Well:** Enabling Older Adults to live Full Independent Healthy Lives. |
| **Goal:** A more financially active and enabled community who are employed in good jobs that provide greater financial stability, improves quality of life and provide better health outcomes | **Goal: More financially stable,** informed and supported families with children who have better health outcomes | **Goal**: A more supported and enabled community who are able to understand where to go to get the support and care they need in time. | **Goal:** A more active and independent older population who are able to live at home or are supported to get the care they need. |

**Integrated Neighbourhood Working:**

**One Halton partners have also agreed that the development of an integrated neighbourhood way of working as fundamental to our success.**

Building on the good work completed to date including learning from the pandemic



Delivering both the NHS Operational Plan and the Long Term plan

# Addressing the Challenges in Halton

Cheshire and Merseyside

**We want to:**

Create a better understanding the impact of poverty and health inequalities within local communities

Focus on wider determinants using Marmot priorities

Focus on delivery of CORE20PLUS5

Focus on prevention to tackle the drivers of the life expectancy gap locally

Social Prescribing

**Some early One Halton Partnership priorities. Further work being undertaken.**

## STARTING WELL

**Family Hubs**
(infant feeding; perinatal MH; Parenting; Parent and Carer Panels; Start for Life)

## LIVING WELL

**Prevention**
(screening, healthy weight, CVD)
**Mental health and Wellbeing**
(self-harm, talking therapies)
**EMI Health Checks**

## AGEING WELL

**End of Life**

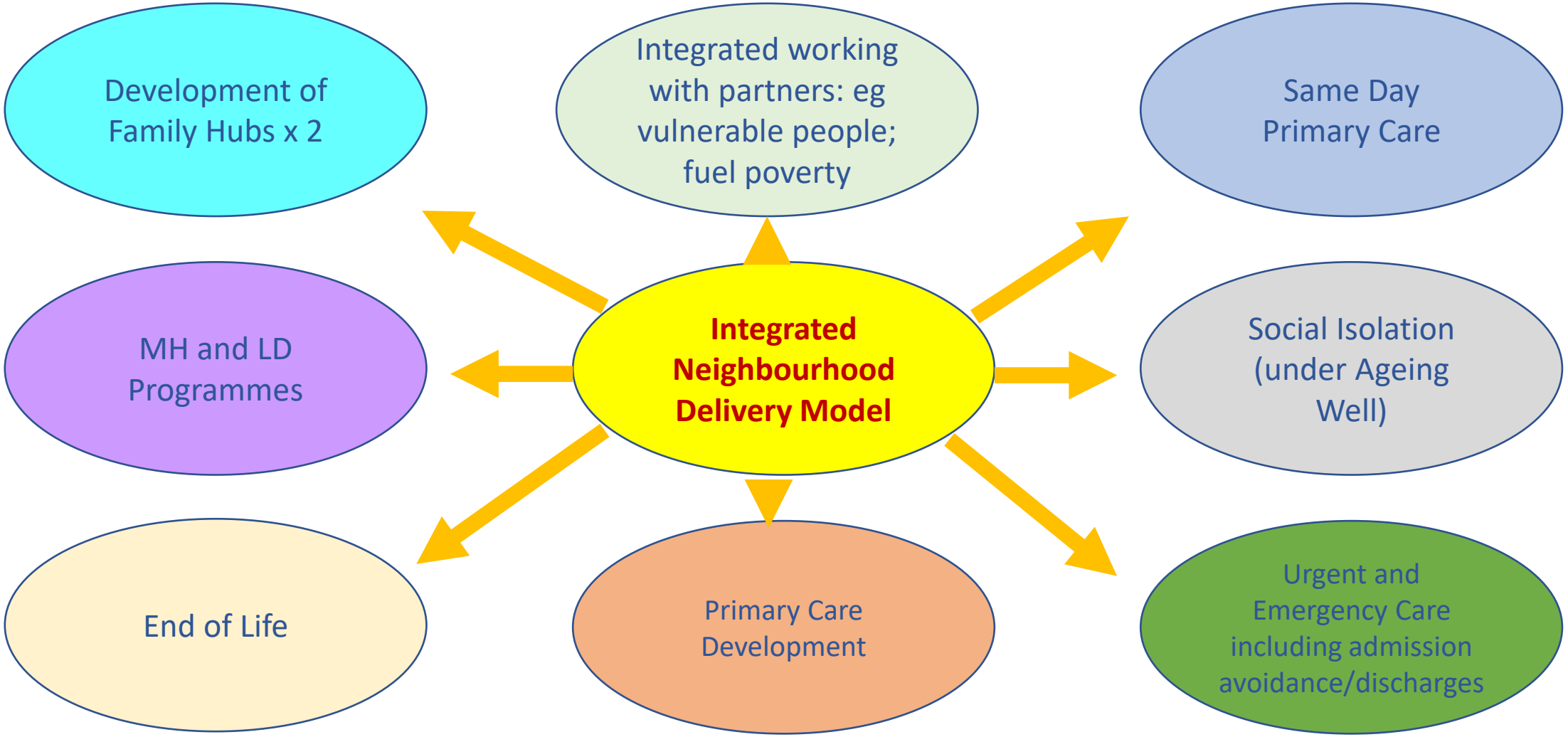
**Social Isolation**

## Integrated Neighbourhood Delivery Model

**Same Day Primary Care**

Addressing Health Inequalities

# Some examples of things we are working on:



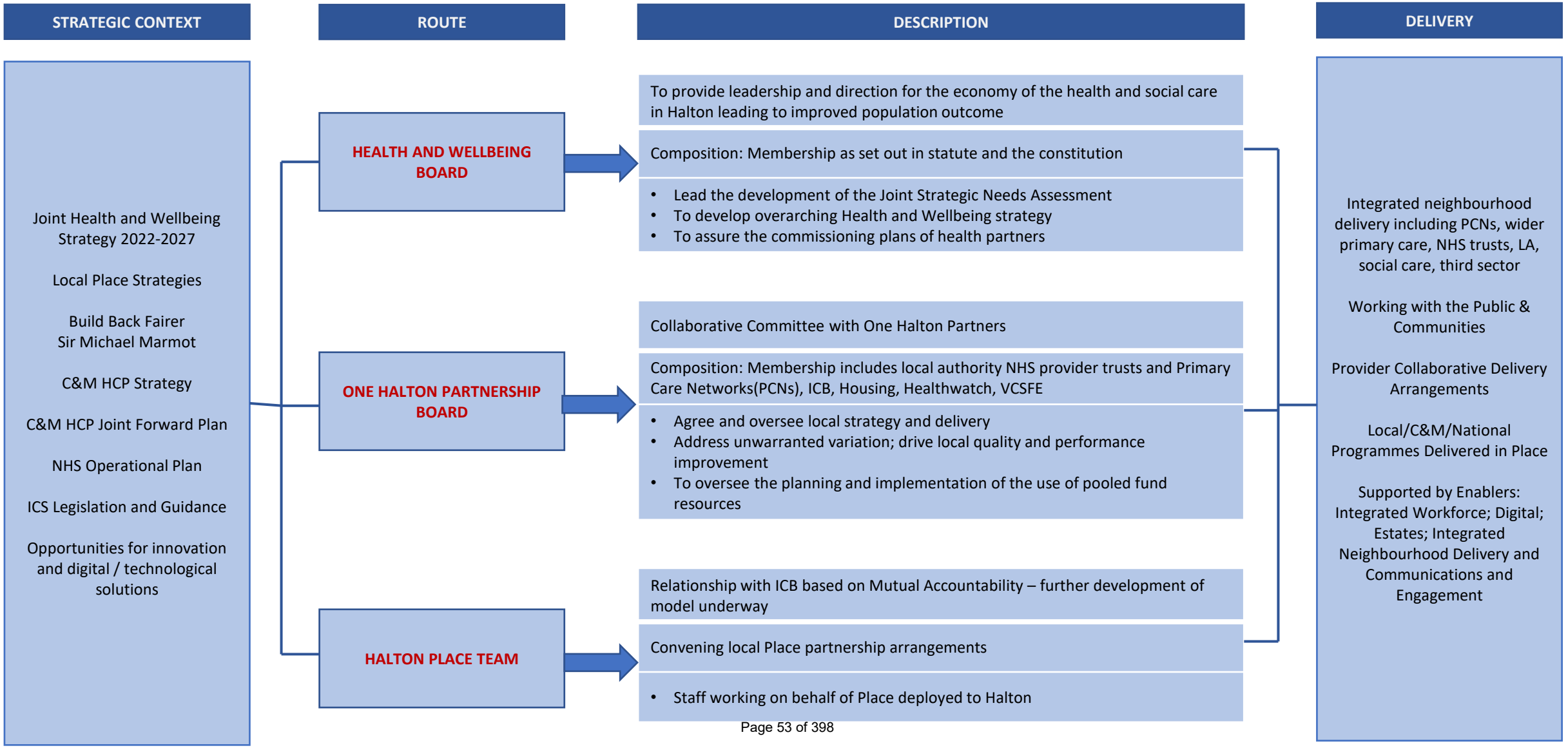

Financial Maturity Framework  Digital Strategy  Estates and Assets Strategy

# Summary: working together in Halton to:

1. Deliver **NHS Operational Planning Priorities 2022/23** and local **Place priorities** and **Halton Joint Health and Wellbeing Strategy**.
2. Improve the **employment opportunities** for the people of Halton in particular where it affects children and families.
3. Enable **Children and Families** to live Healthy Independent Lives.
4. Provide a **supportive environment** where systems work efficiently and support everyone to **live their best life**.
5. Enable **Older Adults to live Full Independent Healthy Lives**.
6. Ensure that **primary care** is fully integrated into delivery mechanisms in Halton.
7. Mitigate the impact of **cost-of-living** increases on our population and **support the most vulnerable**.
8. Maximise the use of **public sector estate** and ensure that this is linked to Halton Council's local plans and regeneration work.

# Framework for Delivery

Cheshire and Merseyside

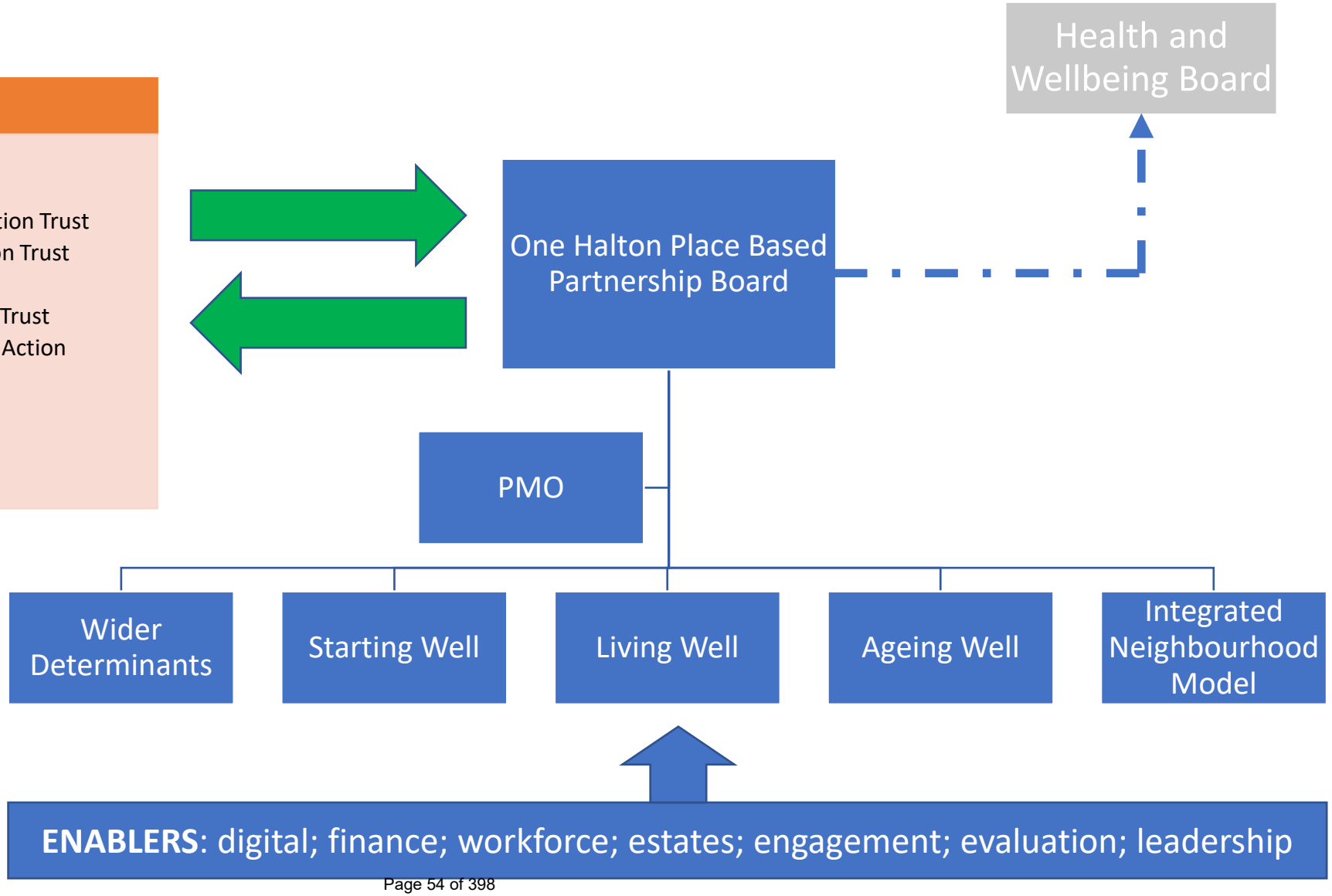


# One Halton – Delivery Structure

Cheshire and Merseyside

**Partner Organisations**

- NHS Cheshire and Merseyside
- Halton Borough Council
- Bridgwater Community Healthcare NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Healthwatch Halton
- St Helens and Knowsley Teaching Hospitals NHS Trust
- Halton and St Helens Voluntary and Community Action
- Widnes Primary Care Network
- Runcorn Primary Care Network
- Mersey Care NHS Foundation Trust
- Halton Housing



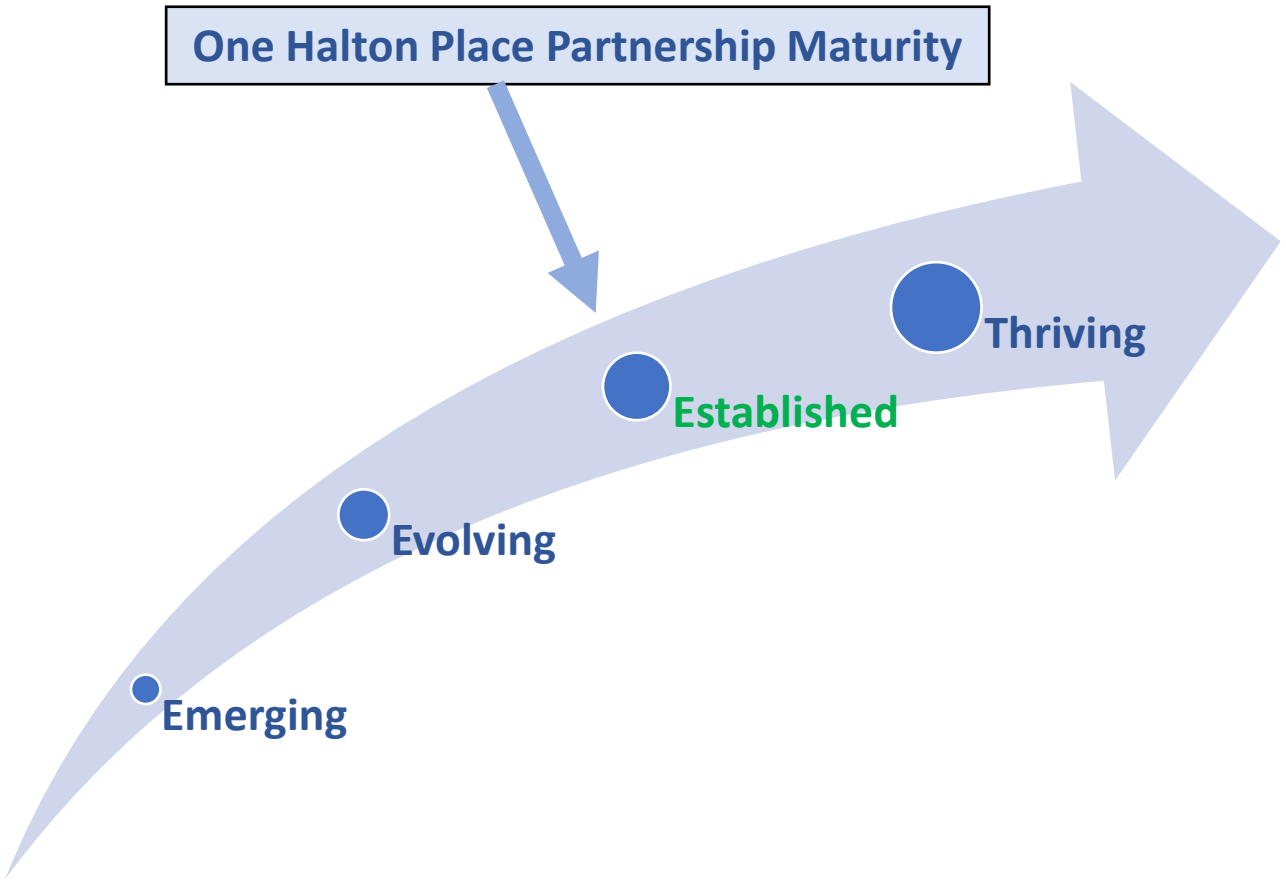
# One Halton Place Partnership

## One Halton Partnership

## Our work is framed by what we want to achieve?

We want to **work together to address those things that get in the way of great care**
and
to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community based support and ensuring high quality services for those who need them.

# One Halton Partnership's Development Journey




One Halton Partnership self-assessed as **ESTABLISHED**

**Last assessment identified the following domains for further work:**

1. Financial framework
2. Delivery of integrated Services
3. Digital
4. Estates and Assets

**Latest progress:**

1. Financial Maturity Framework – early draft
2. Integrated Neighbourhood Model principles agreed across Place with examples of integrated delivery - HICAFS
3. Draft Digital Strategy
4. Mapped Halton Place Estates and Assets

**Adopt a structured approach to identify areas for further development towards thriving and evaluation of impact**

**How will we know when we have been successful?**

# NHS Cheshire and Merseyside Integrated Care Board Meeting

29 June 2023

## Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24

| | |
|---|---|
| **Agenda Item No** | ICB/06/23/10 |
| **Report author & contact details** | Neil Evans, Associate Director of Strategy and Collaboration (neilevans@nhs.net or 07833685764)<br>Stephen Woods, Head of Strategy (stephen.woods4@nhs.net or 07826513643) |
| **Report approved by (sponsoring Director)** | Clare Watson Assistant Chief Executive |
| **Responsible Officer to take actions forward** | Neil Evans Associate Director of Strategy and Collaboration |

# Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24

| | |
|---|---|
| **Executive Summary** | • This paper outlines the content contained within, and the process for developing, the Cheshire and Merseyside Joint Forward Plan (JFP) for 2023-28. This includes the Delivery Plan for 2023-24.<br><br>• NHS England issued guidance in December 2022. The guidance described the statutory requirement of the ICB, and partner NHS providers, to develop a Joint Forward Plan (JFP), which must be published by June 2023.<br><br>• The guidance encourages systems to use the JFP as a shared delivery plan for the integrated care strategy (developed by the Cheshire and Merseyside Health and Care Partnership - HCP) and the joint local health and wellbeing strategies (JLHWS) along with the NHS universal priorities and compliance with the statutory duties of an ICB.<br><br>• The JFP has been developed following the nationally defined statutory and advisory requirements identified in the NHS England Guidance on developing the JFP. This has resulted in a significant amount of content and detail in our plans.<br><br>• In reflection of the importance of the document being accessible to stakeholders, including our residents, a summary JFP document is being published but with links to the more detailed content to allow the reader to access this when interested.<br><br>• Learning from the production of this first JFP it is intended to align future iterations more closely with the final HCP Strategy, when produced later this year. This would make the document more reflective of a system wide HCP delivery plan with whole system ownership of the JFP. NHS specific plans would be outlined as part of an annual delivery plan that would sit alongside the JFP. This approach would be implemented for the 2024-29 JFP to be published in March 2024. |

| **Purpose (x)** | **For information / note** | **For decision / approval** | **For assurance** | **For ratification** | **For endorsement** |
|---|---|---|---|---|---|
| | X | X | | | X |

| | |
|---|---|
| **Recommendation** | **The Board is asked to:**<br><br>• **Approve** publication of the 2023-28 Joint Forward Plan on 30th June, including the 2023-24 delivery plan<br><br>• **Endorse** developing the Joint Forward Plan for 2024-2028 to be a document more aligned as a delivery plan for the final Cheshire and Merseyside HCP Strategy with the use of an annual NHS Cheshire and Merseyside ICB delivery |

<table>
<tr><td></td><td>plan to reflect any additional NHS specific content which sits outside of the shared priorities within the HCP Strategy.</td></tr>
<tr><td>Key issues</td><td>The HCP Strategy is currently an interim document requiring further work to finalise and prioritise the document which as it is completed may materially change the focus of the JFP.<br><br>It is recognised that in responding to the nationally mandated content the JFP includes a range of content which may not reflect the priorities of the wider partners in our HCP and lead to confusion as to the relationship between our HCP and NHS Cheshire and Merseyside priorities.</td></tr>
<tr><td>Key risks</td><td>The volume of work to develop plans in a limited timescale may mean our plans require further refinement.<br><br>A number of the enabling programme plans e.g., finance, are still being developed and may impact on the ability to deliver some of the plans contained in the JFP.</td></tr>
<tr><td>Impact (x)<br>(Further detail to be provided in body of paper)</td><td>
<table>
<tr><th>Financial</th><th>IM &T</th><th>Workforce</th><th>Estate</th></tr>
<tr><td>x</td><td>X</td><td>x</td><td>x</td></tr>
<tr><th>Legal</th><th>Health Inequalities</th><th>EDI</th><th>Sustainability</th></tr>
<tr><td>x</td><td>X</td><td>x</td><td>x</td></tr>
</table>
</td></tr>
<tr><td>Route to this meeting</td><td>The approach follows national guidance on the development of a Joint Forward Plan. The work that has taken place in Cheshire and Merseyside to develop our approach to responding to this guidance – has previously been to the board and developing documents have been shared for feedback.<br><br>A Planning Oversight Group has been formed which is developing the approach to planning in Cheshire and Merseyside and includes colleagues from corporate and place ICB teams as well as from our provider collaboratives. This group has overseen development of plan content.<br><br>The content has been shared widely through Place Partnerships, Health and Wellbeing Boards and NHS providers.</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>None identified</td></tr>
<tr><td>Patient and Public Engagement</td><td>Much of the content of the JFP has been developed through existing programmes, who have established mechanisms for engagement in developing the plans.<br><br>A public survey was undertaken in March/April 2024 to look at the content of the draft Interim Cheshire and Merseyside HCP Strategy with the results assessed as part of developing the JFP. The guidance indicates that where JFP’s are built on existing plans and strategies there is not a requirement to formally consult.</td></tr>
<tr><td>Equality, Diversity, and Inclusion</td><td>This report describes the JFP planning process communicated in guidance from NHS England. As detailed plans are produced EIA are/will be produced to assess the impact of the plans in line with our existing EDI policy.</td></tr>
<tr><td>Health inequalities</td><td>The national planning guidance does include the importance of reducing health inequalities, as do local Health and Wellbeing and Health and Care Partnership Strategies as primary objectives – there is a strong thread throughout the JFP.</td></tr>
<tr><td>Next Steps</td><td>• The Joint Forward Plan is to be published on 30th June</td></tr>
</table>

| | |
|---|---|
| | • Agreement of a revised system wide approach with partners across our Health and Care Partnership for the development of the 2024-29 JFP to be published in March 2024 which reflects the content in the final HCP Strategy.<br>• Continue work around the detailed content of actions within the Annual Delivery Plan that describes the action the outcomes and actions in the JFP, as well as ensuring that robust monitoring processes are embedded to track implementation. |
| **Appendices** | Appendix 1: Cheshire and Merseyside Joint Forward Plan 2023-28<br>Appendix 2: Summary version of the Joint Forward Plan "Delivery Plan" |

| Glossary of Terms | Explanation or clarification of abbreviations used in this paper |
|---|---|
| VCFSE | Voluntary, Community, Faith, and Social Enterprise Sector |
| DHSC | Department of Health and Social Care |
| HCP | Cheshire and Merseyside Health and Care Partnership |
| ICB | Integrated Care Board |
| ICP | Integrated Care Partnership in Cheshire and Merseyside we refer to the ICP as a Health and Care Partnership (HCP) |
| ICS | Integrated Care System |
| JFP | Five Year Joint Forward Plan |
| LTP | NHS Long Term Plan |
| NHS | National Health Service |

# Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24

## 1. Executive Summary

1.1 This paper outlines the content contained within, and the process for developing, the Cheshire and Merseyside Joint Forward Plan (JFP) for 2023-28. This includes the ICB Delivery Plan for 2023-24.

1.2 NHS England issued guidance in December 2022. The guidance described the statutory requirement of the ICB, and partner NHS providers, to develop a Joint Forward Plan (JFP), which must be published by June 2023.

1.3 The guidance encourages systems to use the JFP as a shared delivery plan for the integrated care strategy (developed by the Cheshire and Merseyside Health and Care Partnership - HCP) and the joint local health and wellbeing strategies (JLHWS) along with the NHS universal priorities and compliance with the statutory duties of an ICB.

1.4 The JFP has been developed following the nationally defined statutory and advisory requirements identified in the NHS England Guidance on developing the JFP. This has resulted in a significant amount of content and detail in our plans.

1.5 In reflection of the importance of the document being accessible to stakeholders, including our residents, a summary JFP document is being published but with links to the more detailed content to allow the reader to access this when interested.

1.6 Learning from the production of this first JFP it is intended to align future iterations more closely with the contents of the final HCP Strategy, when produced later this year. This would make the document more reflective of a system wide HCP delivery plan with whole system ownership of the JFP. NHS specific plans would be outlined as part of an annual delivery plan that would sit alongside the JFP. This approach would be implemented for the 2024-29 JFP to be published in March 2024.

## 2. Introduction / Background

2.1 On 23rd December 2022 NHS England issued guidance to the NHS in relation to Operational Planning for 2023-24 and the production of Five-Year Joint Forward Plans (JFP). The two documents are concise at 20 and 23 pages in length with a reduced number of national objectives included.

2.2 The JFP is a nationally mandated document which will combine the Cheshire and Merseyside delivery plans to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of NHS resources.

2.3 The JFP outlines our commitment to working on all three of these aims simultaneously to best meet our population's needs. Throughout the document, we also describe how the ICB fulfils the statutory duties that we are responsible for.

2.4 In April 2023, the Hewitt Review was published which considers the future national direction for the development of ICS. The implications of the review have been considered in the JFP content and supports our focus in these plans for a whole system approach to positively impacting on the wider determinants of health and fits with our existing statutory duty and local commitment to integrate services to benefit our population. The review identifies a number of drivers for change with systems which have been incorporated where appropriate:

- a focus on good health rather than treating illness.
- a system which holds itself to account for delivering the priorities for our population and being a self-improving system
- unlocking the potential in primary and social care and developing a skilled sustainable workforce
- ensuring we focus on the value we achieve from our financial investment rather than simply the costs we incur, in order to maximise the outcomes, we are delivering for our population for every £ we invest.

2.5 The JFP document will be refreshed annually in order to reflect our development as a system and the evolving content required of our plans. The next update on our JFP is required by March 2024.

2.6 Whilst the plan covers a five-year time frame the document focuses more on the early part of this time period and includes the key actions identified in our plans for the year 2023-2024

## 3. Approach to the development of the Joint Forward Plan 2023-28

3.1 We have adopted a collaborative approach drawing on the wide range of expertise, knowledge, and experience of our health and care professional leaders and partners to integrate services and our collective ambitions to shape better outcomes for our people, to inform innovations and future plans.

3.2 In developing our JFP, we have engaged with our nine Places, including a summary of the plans developed locally by each, in order to reflect the Joint Health and Wellbeing Strategy and other identified local priorities. As required in the guidance Health & Wellbeing Boards are also being asked to provide a statement confirming the JFP does achieve this.

3.3 In January 2023, our Health and Care Partnership (HCP) published a draft Interim HCP Strategy with the intention of undertaking further work with stakeholders, including the public, to refine the strategy before finalising it. This includes prioritising the content of our HCP strategy, which will in turn impact on the priority focus areas within our Joint Forward Plan. At the Health and Care Partnership (HCP) meeting of 17th January a number of next steps were agreed in relation to the interim strategy, including prioritising the contents to develop a final strategy and inform annual delivery plans, which would be included within the 2024-29 JFP.

3.4 The analysis to inform the HCP priorities has been carried out with a review of existing population health data and other sources of intelligence to identify those areas of our strategy with the greatest opportunity for improvement when compared with other parts of the country. A workshop of HCP members was completed on the 7th of March to further refine these priorities and these have subsequently been shared with members of the board and feedback has been reflected into the JFP. The output of this work has been reflected in the 2023-28 JFP.

3.5 The 2023-28 HCP Strategy will be finalised during 2023 which can then be used to inform the production of future JFPs, alongside a number of key enabling strategies and plans in development e.g., Workforce, Clinical and Care, and Finance over the course of this year the priorities and plans will mature and can be reflected in the updated 2024-29 JFP (publication March 2024).

3.6 Building from the approach over recent NHS planning cycles a Planning Oversight Group was formed, chaired by the ICB Executive Director of Finance, and including a range of subject matter experts in relation to both themes within the planning guidance and the production of the planning documents themselves.

3.7 The Planning Oversight Group included Transformation Programme leads, representation from Place Teams and our two Provider Collaboratives; recognising:

- the need to engage with wider ICS partners (as referenced above), including Health and Wellbeing Boards and constituent stakeholders including local authorities and primary care on plans. With a key consideration the specific requirement to consult Health and Wellbeing Boards on our JFP further supporting a Place led engagement process and for a statement confirming the JFP is reflective of the local Joint Health and Wellbeing Strategy.
- that the NHS Operational Plan submissions, Joint Forward Plan and Capital Plan are a shared statutory responsibility of the ICB, and our NHS Provider partners; and the Collaboratives helped support the development of plans.
- a number of the planning themes have been led from either Place or Provider Collaborative teams.

3.8 Drafts of the document have been shared iteratively with the Planning Oversight Group, Place teams, including Health and Wellbeing Board members, NHS providers and the ICB Executive Team and Board. Feedback has been

incorporated into the document including the production of a much shorter summarised JFP for publication in response to the consistent view that the original document was too lengthy and detailed to be accessible.

3.9 In line with the statutory requirement during May and June copies of the final draft JFP have been shared with Health and Wellbeing Boards for consideration and each has been asked to provide a statement confirming that the document reflects the local priorities.

3.10 As part of this process, we have carried out a review of our JFP compared with peer ICS's (both locally and nationally). This included a peer review of our emerging JFP supported by NHS England with Greater Manchester, and Lancashire and South Cumbria ICBs. It was recognised that there was a variety of approaches taken although the JFPs reviewed are fairly lengthy documents in order to comply with the national content requirements.

3.11 NHS England reviewed the JFP in April and the feedback was positive with no significant material changes required. However, we have used the feedback provided to make a small number of amendments.

## 4. The content in our Joint Forward Plan

4.1 The 2023-28 JFP can be seen in Appendix One[1] and builds on the Vision and Mission statements and current strategic objectives and plans from within the draft Interim HCP Strategy:


4.2 It focuses on how we will work as partners for the benefit of our population and includes how we plan to:

- Tackle inequalities in outcomes, experience, and access
- Improve population health and healthcare
- Enhance productivity and value for money
- Support wider social and economic development.

*[1] The version in Appendix One is the draft content as of 16th June 2023. There are a small number of wording changes not included at this point which will be reflected in the final version.*

4.3 Recognising the “draft interim” status of the HCP Strategy a set of key priorities have been included in the JFP which maps to these strategic objectives and where we would intend to make early progress in 2023-24. This aims to show the commitment towards making an immediate contribution to delivering the strategic objectives shown in 4.2.

4.4 In addition, we outline a timeline for the development of the enabling plans referenced earlier in figure 3.5.

4.5 The JFP describes how we work as partners and outlines a commitment to the principle of subsidiarity and making decisions as locally as possible. It outlines how we will enable local communities in our nine Place based partnerships to develop services which meet the needs of their local population, whilst also encouraging a sharing of learning and good practice to spread these benefits including the integral role of our communities, including Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) in designing and delivering solutions and services.

4.6 Complementary to this principle of subsidiarity, the JFP outlines how our large ICS provides opportunities to work at scale where appropriate. This enables us to share best practice and to work collectively to deliver efficiencies and manage change. In particular, the work plans of our two NHS Provider Collaboratives supporting our NHS providers to work together to deliver service improvement priorities and enhance service sustainability.

4.7 The national requirements of a JFP include confirming how the statutory duties of an ICB are to be delivered, but additionally the JFP outlines how we will work together as partners and also includes content on the following:

- Workforce (plans align with operational and financial plans)
- Performance (trajectories/milestones aligned to NHS operational planning requirements and NHS Long Term Plan)
- Digital/data (steps to increase digital maturity and reduce digital inequality in an integrated health and care system)
- Estates (plans for improved health and care infrastructure aligned with financial and capital plan)
- Procurement/supply chain (plans to deliver more efficient procurement and best value; can describe governance and supporting technology & infrastructure)
- Population health management (prevention and personalised care models through data, address inequalities and model future demand and service/financial impacts to support redesign and integrated models
- System development (How the system will operate e.g., governance, emphasising the importance of Place partnerships, provider collaboratives, clinical and care professional leadership, system OD)
- Supporting wider social and economic development (approach to social, environmental, and economic factors impacting health and wellbeing e.g., Anchor Institute plans within communities)

4.8 The JFP also includes:

- A summary and link to a copy of each “Place Plans” reflecting the priorities agreed within each Place and aligned to the Place Health and Wellbeing Strategy
- Plans in relation to a wider range of local programmes that are described in the interim draft Cheshire and Merseyside Health and Care Partnership Strategy e.g., existing C&M transformational programmes such as elective recovery, disease/condition specific programmes or priorities e.g., diabetes, cardiovascular disease, mental health or carers
- Key ICB organisational programmes for example the NHS England delegation of Specialised Services to the ICB
- Links to partner strategic documents/sections on NHS provider and local authority websites

4.9 Each of the sections has been developed with the appropriate lead and/or subject experts to ensure that the content reflects the key local, regional, and national drivers, outcomes, and priority areas of focus. Where possible this has included timescales for delivery.

4.10 This content has then been used to develop a delivery plan which will allow us to track progress in delivering the programmes of work and associated benefits; this can be found in Appendix Two. This progress in delivery would be reported through the relevant Board sub-committee and Quality and Performance update reporting to the ICB Board.

4.11 Work to align and enhance reporting on the delivery plan progress, NHS System Oversight Framework (SOF) and operational planning metrics is in development with Strategy team working with Planning and Performance and Business Intelligence Teams. This will include delivery against “in year” trajectories.

4.12 Equality Diversity and Inclusion (EDI) leads have reviewed the documents and comments have been incorporated. It is expected that each of the programmes included will follow our policy and processes in assessing EDI impact within their plans. This will include development of any associated Equality Impact Assessments (EIA’s) and use of the health Inequalities HEAT map tool.

## 5. Document Style

5.1 We have worked with colleagues in the Communication and Engagement Team and Midlands and Lancashire Commissioning Support Unit (MLCSU) to produce the JFP. The intention is to publish The JFP as a circa 30-page summary document on the Cheshire and Merseyside ICB website. This will have the functionality for readers to click through to the detailed plans sat behind this. Accessibility checks are also being undertaken before publication.

5.2 As part of the process, we have reviewed the use of acronyms and abbreviations. This has included the updating of the Cheshire and Merseyside website glossary.

MLCSU are also supporting a full accessibility review of both documents, this will be completed once all amendments have been completed.

## 6. How we intend learning from our first JFP process

6.1 We have received feedback from system partners, including Health and Wellbeing Boards, in relation to future Joint Forward Plan documents being more closely aligned to being a delivery plan for the HCP Strategy when it is finalised. This would result in less focus on the NHS mandated content and feel more of a "joint" plan as an ICS system.

6.2 As part of the drafting of the final HCP Strategy, which is proposed to more closely align with the All Together Fairer Strategy (Marmot Community) we will develop the associated JFP for 2024-29 that we would publish by March 2024.

6.3 As an appendix to this the NHS Cheshire and Merseyside ICB, and NHS partners, would produce an annual delivery plan (operational plan) which will outline some of the areas which would fall outside of the HCP shared priorities, including delivery of statutory duties and the nationally defined NHS priorities.

## 7. Recommendations

7.1 The Board is asked to:

- **Approve** publication of the 2023-28 Joint Forward Plan on 30th June, including the 2023-24 delivery plan

- **Endorse** developing the Joint Forward Plan for 2024-2028 to be more aligned as a delivery plan for the final Cheshire and Merseyside HCP Strategy with the use of an annual NHS Cheshire and Merseyside ICB delivery plan to reflect any additional NHS specific content which sits outside of the shared priorities within the HCP Strategy.

## 8. Next Steps

8.1 The Joint Forward Plan to be published on 30th June.

8.2 Agreement of a revised system wide approach with partners across our Health and Care Partnership for the development of the 2024-29 JFP to be published in March 2024.

8.3 Continue work around the detailed content of actions within the Annual Delivery Plan that describes the action the outcomes and actions in the JFP, as well as ensuring that robust monitoring processes are embedded to track implementation.

## 9. Officer contact details for more information

Neil Evans, Associate Director of Strategy and Collaboration
(neilevans@nhs.net or 07833685764)

Stephen Woods, Head of Strategy
(stephen.woods4@nhs.net or 07826513643)

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24

**Appendix One: Joint Forward Plan v1.6**

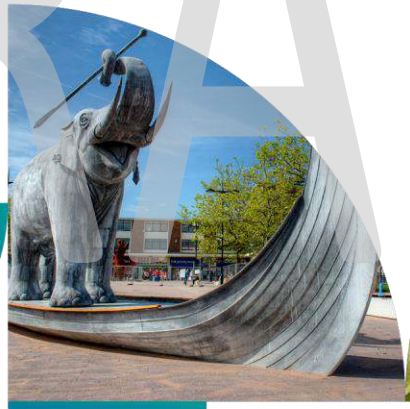
NHS
Cheshire and Merseyside

# Cheshire and Merseyside

# Joint Forward Plan

SUMMARY – DRAFT VERSION 1.6



# Foreword

Joining up health and care is nothing new - we have been working towards this for many years. There is much that has been excellent. But there is so much more that the health and care system must do together to play its full part in enabling citizens, patients and service users to thrive and achieve their full potential.

The creation of our Health and Care Partnership (The HCP) provides a platform on which all partners can challenge their mindsets, share learning and work differently to optimise our collective contribution to people's lives.

This Joint Forward Plan is driven by the ambitions of the Cheshire and Merseyside Interim HCP Strategy, which is built around four core strategic objectives:

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money
- Helping to support broader social and economic development.

The challenges faced by our citizens and communities are immense, but so is their passion to overcome them. The Integrated Care Board and our partners are committed to working with all communities to support them to improve their health and wellbeing, reduce inequalities, agree what constitutes good experience and deliver on this and improving health and wellbeing outcomes in targeted areas. Intrinsic to our ambition is to optimise the opportunities for supporting social and economic development.

A core principle is to treat every £ of funding as a precious asset, driving out waste and doing the things that matter to people so that we maximise the value that our communities gain from our plans and delivery.

We also strongly believe that it is our local communities and front-line teams are best at knowing what matters most and to determine the best way to make improvements. We will support this by encouraging decisions are made as locally as possible and ensuring that our plans are co-produced to ensure they truly meet the needs of our population. It will be the case that Learning, Spreading Best Practice and Innovation will be core to all we do.

Sometimes, operating at scale or standardisation will be the best solution. Our commitment is that the communities we serve will be provided with the opportunity to question these options and seek the relevant assurances.

We know we need to be different and work differently; our plans describe our ambitions in a range of areas and based on what our population has said matters to them, including:

- Supporting all our children to have a good start to life both in terms of their health and wellbeing and educational attainment to enable them to go on to live long and happy lives.
- Raising the number of years people live in good health whilst narrowing the gap we see between those in the most and least deprived communities.
- Ensure that our care communities transform how services work for residents to offer world leading primary and community care.

- Working with our provider collaboratives to build a strong and sustainable NHS provider sector that delivers services which offer consistently high levels of access and quality.
- Making sure we maximise the positive role we play as employers and as anchor institutions in contributing to our local communities.

We have some of the best organisations in the country who have committed to work together with common purpose. The variety of organisations, Local Authorities, VSCE, NHS and Private Sector, have huge talent and passion to make a difference. We have a once in a generation opportunity to make significant and lasting difference to people's lives. Let's not waste this opportunity and we urge you to join us our mission.

Graham Urwin, Chief Executive

Raj Jain, Chair

# 1. About this document

**We know that people's lives are better when organisations that provide health and care work together, particularly at the times when people need care most.**

This document – our Joint Forward Plan (JFP) – describes how Cheshire and Merseyside Integrated Care Board (ICB), our partner NHS trusts and our wider system partners will work together to arrange and provide services to meet our population's physical and mental health needs.

This Joint Forward Plan contains the actions we will take as an Integrated Care System (ICS) to deliver the priorities identified in:

- The Cheshire and Merseyside draft interim Health and Care Partnership Strategy
- The Joint Local Health and Wellbeing Strategies of our nine Place based Health and Wellbeing Boards
- The priorities outlined by NHS England in The NHS Long Term Plan and the national NHS Planning guidance for 2023-24 (Appendix 1)

### Our Joint Forward Plan aims to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of our resources.

We are committed to working on all three of these aims simultaneously to best meet our population's needs and to reduce inequalities in access and outcomes.

These aims also align to our statutory duties as an ICB. The details of these statutory duties can be **found here**.

Our Joint Forward Plan aligns with the recently published Hewitt Review (April 2023), which considers the future development of Integrated Care Systems in England. The review supports taking a 'whole system approach' to addressing wider determinants of health, and a shift of focus away from treating problems towards maintaining good health. These two themes align with our statutory duty and also our local commitment to integrate services to benefit our population.

# Our approach to developing this Joint Forward Plan

The Cheshire and Merseyside Integrated Care Board was formally established in July 2022. We have already made significant progress, but we are still in a developmental phase and we have considerable work to do to further develop our plans and priorities. This Joint Forward Plan should be read in this context.

Whilst the responsibility to develop this plan sits with NHS Cheshire and Merseyside, and our NHS Providers, we have adopted a collaborative approach to developing this plan. We drew on the wide range of expertise, knowledge, and experience of our health and care professional leaders and partners to help us identify ways to improve integration and innovation. This will help us to deliver better outcomes for our population.

This 2023-2028 Cheshire and Merseyside Joint Forward Plan describes at a summary level the approach we are taking to tackle the current challenges we face in recovering access to services following the Covid 19 pandemic.

It also outlines a programme of radical transformation across our health and care system to address longstanding issues of inequalities in outcomes and financial sustainability.

This JFP builds on our draft interim Health Care Partnership Strategy. The strategy is built around four core strategic objectives:

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money
- Helping to support broader social and economic development.

These objectives support us to work towards achieving our vision and mission. The draft interim Health Care Partnership Strategy is broadly focused and contains many priorities. The HCP recognise the need to decide what to prioritise to enable progress to be made. Our residents provided feedback on the draft interim strategy during March and April 2023 which supported this view.

*Figure 1: Cheshire and Merseyside Health Care Partnership Vision and Mission*

The HCP Strategy is currently in draft form and will be finalised later in 2023, in recognition of this ongoing work we have identified a number of priorities which contribute to making early progress against the ambitions outlined in the draft interim Strategy.

When the priorities in the HCP Strategy are finalised, we will refresh these priorities in our updated Joint Forward Plan, which will be published in March 2024.

*Figure 2: Cheshire and Merseyside Priorities*

| HCP Strategic Objectives | Cross reference to the HCP areas of focus | Priorities | Core plans * | Metric |
|---|---|---|---|---|
| **Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)** | • Give every child the best start in life<br>• Enable all children, young people and adults to maximise their capabilities and have control over their lives<br>• Ensure a healthy standard of living for all<br>• Tackle racism, discrimination and their outcomes<br>• Pursue environmental sustainability and health equity together. | All our Places are actively engaged in the All Together Fairer Programme | **2** | Increase % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage<br>Reduce hospital admissions as a result of self-harm (15-19 years) |
| | | Supporting the safety of vulnerable Women and Children | **2** | Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls |
| **Improve population health and healthcare** | • Improve early diagnosis, treatment and outcome rates for cancer<br>• Improve satisfaction levels with access to primary care services<br>• Provide high quality, accessible safe services<br>• Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support. | In relation to preventing ill Health we will focus on:<br>• Increase rates of Early detection of Cancer<br>• Work towards MECC (Making Every Contact Count)<br>• Encourage *'Healthy Behaviours'* with a focus on smoking/alcohol/ physical activity<br>• Ensure access to safe, secure, and affordable housing | **1,2,3** | Core20PLUS5 priorities including cancer, cardiovascular disease and children and young people's mental health services |
| | | | **2,3** | Increased sign up to the NHS prevention Pledge |
| | | | **2,3** | Reduction in Smoking prevalence.<br>Reduction in the % drinking above recommended levels.<br>Increase the % who are physically active.<br><br>TBD |
| **Enhancing productivity and value for money** | • Develop a financial strategy focused on investment on reducing inequality and prioritise making greater resources available for prevention and wellbeing services | Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years | **1** | Financial strategy and recovery plan in place by Sept 2023 |
| **Helping to support broader social and economic development** | • Embed, and expand, our commitment to social value in all partner organisations<br>• Develop as key Anchor Institutions in Cheshire and Merseyside, offering fair employment opportunities for local people<br>• Implement programmes in schools to support mental wellbeing of young people and inspire a career in health and social care | Develop as key Anchor Institutions and progress advancing at pace the associated initiatives. | **2** | Grow the number of anchor framework signatories to 25 |
| | | Embed and expand our commitment to Social Value | **2** | Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%) |
| | | • Developed focused work in schools around encouraging careers in Health and Social Care<br>• Ensure a Health and Care workforce that is fit for the future. | **2** | To be finalised in advance of the final publication in June 2023<br><br>Publish a Strategic Workforce Plan by March 2024 |
| | | Achieve Net Zero for the NHS carbon Footprint by 2040 | **2** | For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032. |

***1. Delivery against NHS Operational plan and Long-Term Plan (See appendix 1)**

***2. Delivery against the Marmot Beacon Indicators / All Together Fairer (See appendix 2)**

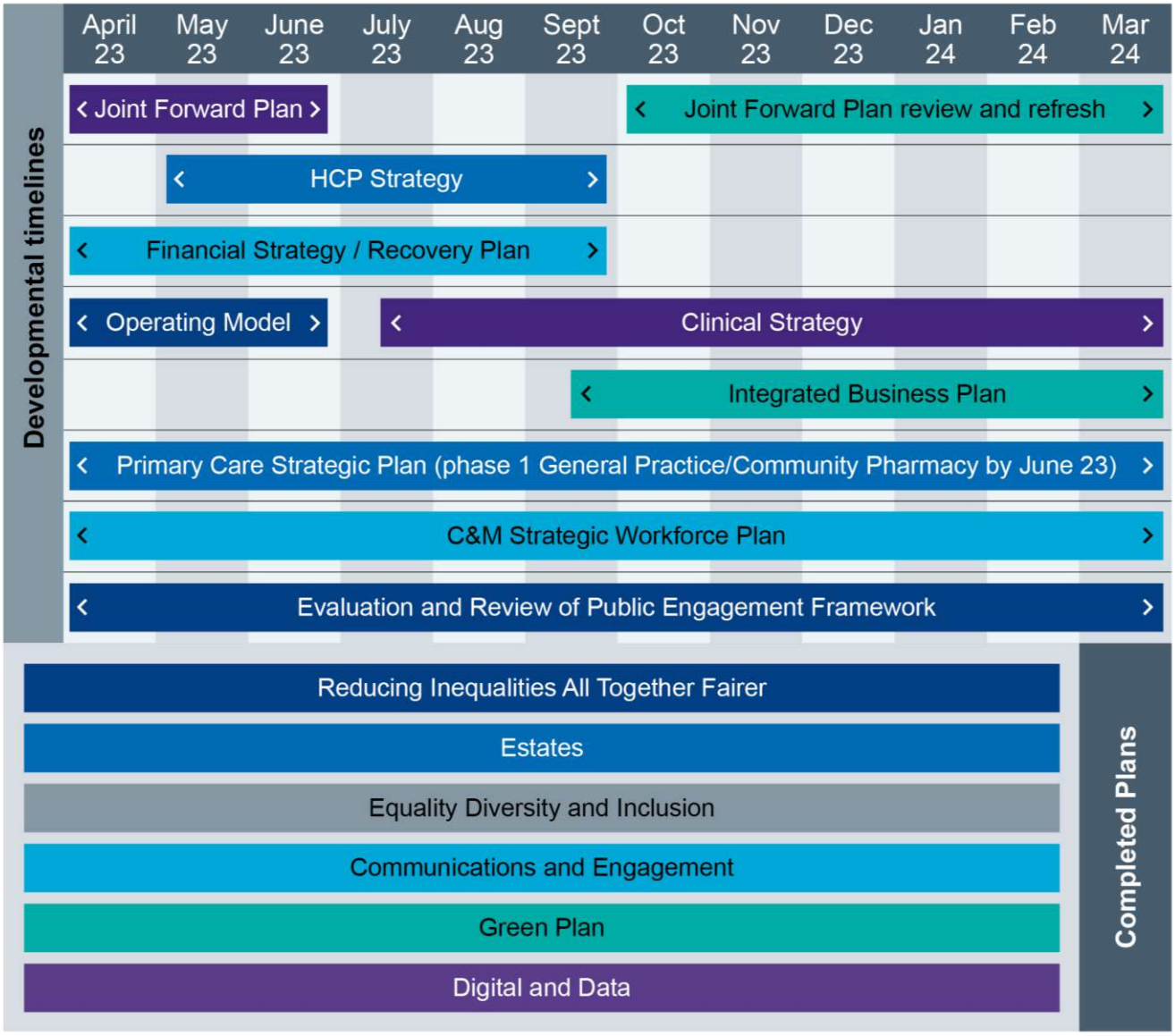
***3. Core20PLUS5 (See appendix 3)**

Whilst this summary document is relatively short, it is underpinned by significant activity across all of the priorities included in the table above. There are various links within this document which provide access to more detail about specific work programmes.

In developing this Joint Forward Plan, we recognise that we are in a developmental phase as an Integrated Care System and that there are some key pieces of planning and strategy work which we will need to align.

Alongside this plan we have developed an Annual Delivery Plan the summary plan can be accessed HERE.

We intend to develop a fully integrated business plan during 2023/24 that will incorporate the key strategic plans we have either already developed or intend to develop during this year. These will be reflected in the next iteration of this Joint Forward Plan in March 2024.The table below shows our completed plans and outlines our developmental timeline for 2023/24.



# 2. How we work as partners for the benefit of our population

**Cheshire and Merseyside is one of the largest Integrated Care Systems in England, with a large number of stakeholders working together to improve the health and care of our population.**

The figure below illustrates how we are configured at a Cheshire and Merseyside level. Some of the ways we come together in the Cheshire and Merseyside system are:

- The Cheshire and Merseyside Health and Care Partnership (HCP). This is a statutory joint committee between NHS Cheshire and Merseyside Integrated Care Board and our nine Local Authorities which also includes a wide range of partners from across the health and care system. This Board works together to support partnership working and is responsible for producing our Health and Care Partnership Strategy
- The NHS Cheshire and Merseyside Integrated Care Board. This is a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services whilst supporting the integration of NHS services with our partners.
- Our nine Place Based Partnerships. These work locally to support the integration of health and care services in support of local Joint Health and Wellbeing Strategies
- In 2023-24 we will work with Healthwatch to establish a Cheshire and Merseyside wide forum to ensure engagement with each of the 9 teams.

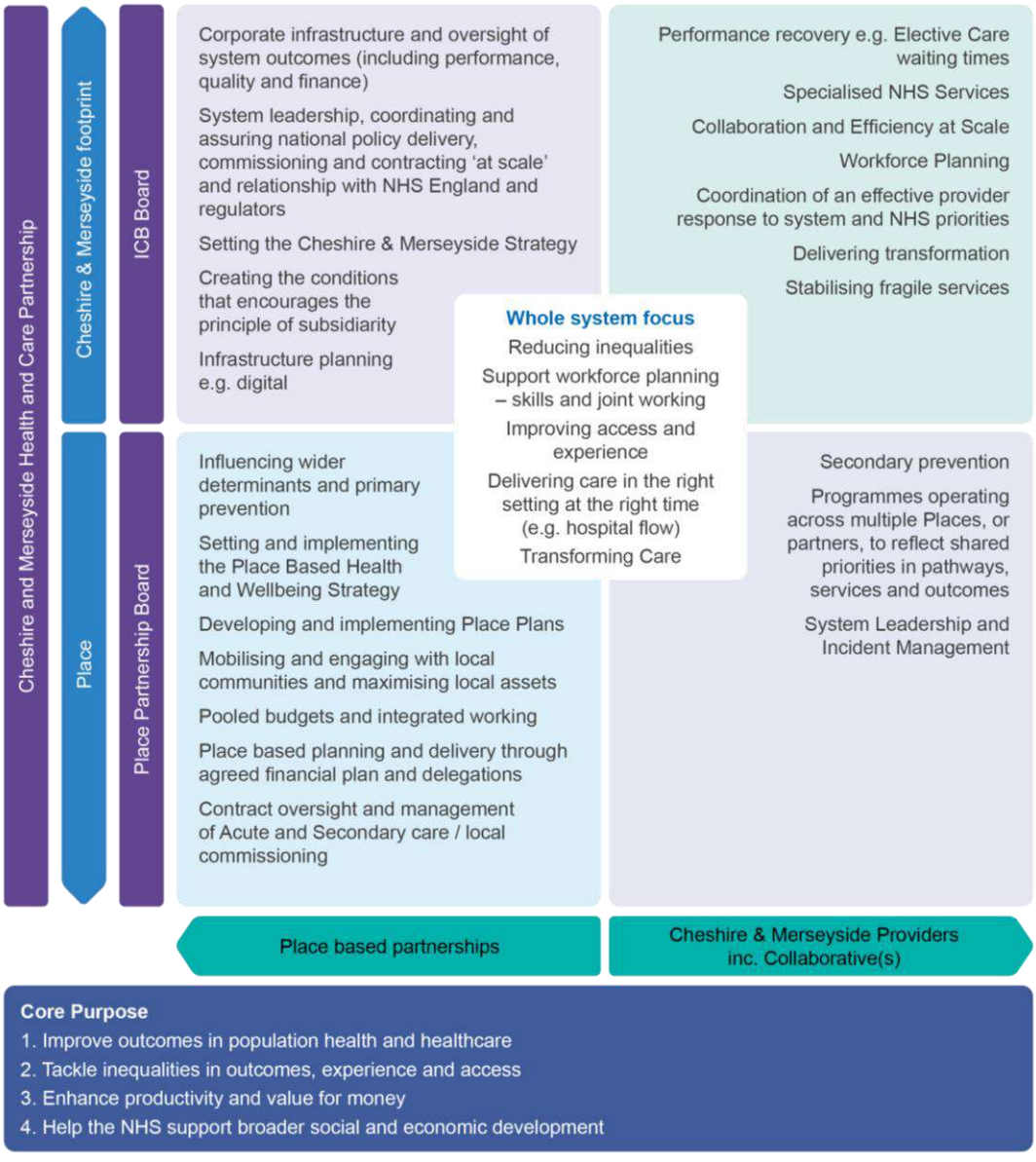
*Figure 3: Cheshire and Merseyside Integrated Care System*

Through our Place based partnerships and the communities within them we are committed to the principle of subsidiarity. This means that we want to make decisions as locally as possible. Our Places and communities are the 'engine room' which drive change by designing and delivering services around the needs of the local population.

Complementary to this principle of subsidiarity, our large ICS provides opportunities to work at scale where appropriate. This enables us to share best practice and to work collectively to deliver efficiencies and manage change. As an example, our two NHS Provider Collaboratives support our NHS providers to work together to deliver service improvement and enhance sustainability.

The picture below shows how we apply the principle of subsidiarity to decision making in our Places and the communities within them, whilst realising the benefits of working at scale in certain areas through our Health and Care Partnership, or ICS wide programmes or through our two Provider Collaboratives.

*Figure 4: Decision making and subsidiarity in Cheshire and Merseyside*



## Communications and Engagement

As system partners we are committed to engaging with people and communities. We know that harnessing the knowledge and experience of those who use and depend on the local health and care system can help improve outcomes and develop better, more effective services including removing or reducing existing barriers to access.

We are committed to working with those with lived experience to understand the impact of health inequalities and to support us in designing and implementing solutions to address these. For example supporting unpaid carers is an essential contribution to narrow health inequalities in access, outcomes & experiences. Our vision is for all carers in Cheshire and Merseyside to have the support they need and recognition they deserve.

## Our Green Plan

Climate change poses a threat to our health as well as our planet. Across Cheshire and Merseyside, we are committed to achieving net zero by 2040 (or earlier). The ICB and NHS Trusts and many Local authority partners have well established plans to achieve this.

Complementary to these local plans, NHS Cheshire and Merseyside has a strong system level Green Plan, and we work collaboratively as system partners to maximise the impact of our initiatives.

Our planet will continue to warm until circa 2060 we will continue climate adaptation / mitigation work to ensure we can continue to provide access to quality health and care for our population even as the climate changes. Including work to tackle air pollution, increased access to mental health services, coastal and other flooding, vector-borne diseases / prep for changing patterns of disease / sustained heat and high temperatures / impact on patients and on workforce, etc.

**We will:**

**Reduce the emissions we control directly (the NHS Carbon Footprint), achieving net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.**

## Supporting wider social and economic development

Supporting social and economic development is one of our strategic objectives. We are working together on a plan for improving health including addressing wider determinants. Wider determinants, also known as social determinants, are a diverse range of social, economic, and environmental factors which impact on people's health.

We can ensure we contribute both in terms of the services that are delivered but also as employers and as part of our local communities.

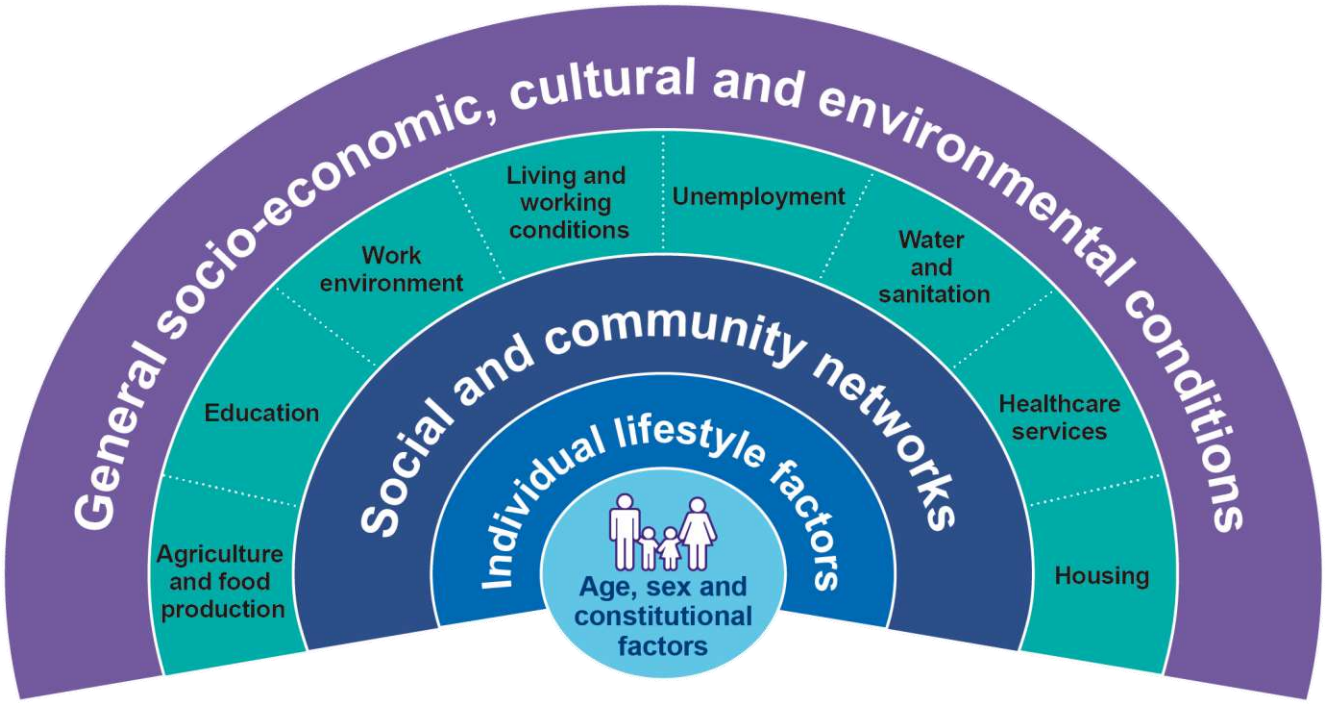
**We will:**

**Increase the number of Anchor Framework signatories to 25 by the end of March 2024**

**And:**

- **Embed, and expand, our commitment to social value**
- **Develop as key Anchor Institutions within Cheshire and Merseyside**
- **Use an asset and strengths-based approach to planning**
- **Share data and insights, so resource can be targeted**
- **Ensure service, pathway and care model redesign is undertaken in collaboration**
- **Develop outcomes-focused funding models and contracts**
- **Support health and care professionals to think about care and support holistically**
- **Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%).**
- **We will maximise our efforts in relation to regeneration and planning including work to support the levelling up agenda.**

*Figure 5: Wider social determinants of health and health inequalities, Dahlgren and Whitehead 1991*



## Safeguarding our population

Safeguarding is a shared responsibility across the health and care economy. Our teams work with colleagues from across the NHS, Local Authorities, the Police, and other partner agencies to drive improvements through local and regional partnership working to embed responsive safeguarding practice. This enables us to address national and local priorities and influence safe and effective care and commissioning.

Effective safeguarding at both system and organisational levels relies on systems that ensure safeguarding is integral to daily business.

**We are committed to:**

- Strengthening Collaboration and Communication
- Improving Training and Awareness
- Early Identification and Intervention
- Strengthening Partnership Working
- Enhancing Monitoring and Evaluation
- Empowering Service Users
- Promoting a Culture of Safeguarding

**We will:**

**Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls.**

# 3. Our approach to improving Population Health

**Our established Population Health Board oversees our Population Health programme of work. The aims of this are to improve health outcomes and reduce health inequalities by embedding a sustainable system-wide shift towards focusing on prevention and reducing health inequality. Our newly appointed Director of Population Health plays a key leadership role in this work.**

Figure 6 provides a summary of the areas which our analysis tells us that our population experience worse outcomes when compared to the "England average", and where our people have told us their experience of accessing care does not meet their expectations.

We know that it is often the wider social determinants of health which are the cause of these poorer outcomes and this is why we are committed to addressing these wider determinants and to promote good health.

In line with the Hewitt Review recommendations, as an ICB we intend to increase year on year the proportion of our budget being spent on prevention. Over time we expect that this will improve the health of our population, whilst helping to address the variation and inequality in access and outcomes we see across Cheshire and Merseyside.

The following programmes describe how we are approaching this.

*Figure 6: Population Health needs and cross cutting prevention themes in Cheshire and Merseyside*

## Strategic Intelligence

Strategic business intelligence is vital to underpin, inform and drive a coordinated and sustainable population health management approach across ICS programmes.

As outlined in our Digital and Data Strategy, we will build on our CIPHA and System P Programmes to enhance our strategic intelligence functionality. This will enable us to better identify areas for targeted interventions and monitor progress.

## All Together Fairer

The primary objective of the draft interim Health Care Partnership Strategy is to reduce health inequalities, this commitment is at the heart of all of our programmes of work. This includes through our established All Together Fairer programme where we aim to improve population health and reduce population level inequalities in health, by focussing on the social determinants of health across Cheshire and Merseyside and supporting action at Place level. The All Together Fairer programme supports the eight Marmot principles, which 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.

An example is how we will work together to support our population to access safe, secure, and affordable housing.

> We know that access to safe, secure, and affordable housing has a huge impact on the health of our population, and also that providing the right accommodation in the community supports people with a mental health condition or learning disability to access services in a more appropriate environment. A number of partners across our Health and Care Partnership provide excellent services which support our population to meet their housing needs.
>
> Within the NHS many of our services such as community nursing services often involve visiting people at home. We can 'Make Every Contact Count' by using these interactions as opportunities to sign-post people to other local services which can help improve the environment they live in, impacting positively on their overall health and wellbeing.

We will measure the success of the All Together Fairer programme in the 2023-28 period against the 22 beacon indicators in the Marmot indicator set *(Appendix 2)*.

**We will:**

- **Increase the % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage**
- **Reduce hospital admissions as a result of self-harm (15-19 years)**

## Core20PLUS5: System-wide action on healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities. It identifies focused clinical areas requiring accelerated improvement. Making progress against these areas is a cross-cutting, system-wide responsibility, and delivery against priority clinical area objectives sits with respective ICS programmes and workstreams.

Our Population Health Programme strategic intelligence and system leadership will strengthen the oversight and monitoring of progress against the Core20PLUS5 clinical priorities *(Appendix 3)*.

**We will: Focus on delivery of the CORE20PLUS5 clinical priorities with an emphasis on:**

- **Increasing the proportion of cancers diagnosed at an early stage (stage 1 or 2)**
- **Increasing the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024**
- **Improving access, and equity of access, to Children and Young Peoples Mental Health services (0-17).**

## System-wide action on Prevention and Making Every Contact Count

We are committed to working collaboratively as a system. As part of this commitment, we are embedding the philosophy of Making Every Contact Count. This is an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. This can support people in making positive changes to their physical and mental health and wellbeing.

We are also focusing on evidence-based and high impact interventions which include:

- Reducing smoking prevalence
- Reducing harm from Alcohol
- All Together Active Physical Activity Strategy
- Promoting Healthy Weight
- Increasing Health Checks
- Mental Wellbeing.

We will monitor our progress against key system objectives using an integrated framework that is currently being co-produced by system partners, and will incorporate key metrics in ICS, ICB and Marmot (All Together Fairer) dashboards.

**We will:**

- **Reduce smoking prevalence**
- **Reduce the % drinking above recommended levels**
- **Increase in the % who are physically active.**

## NHS Prevention Pledge

Our providers are delivering against the 14 core commitments in the NHS Prevention Pledge. We are strengthening our focus on prevention, social value, and inequalities, embedding Making Every Contact Count (MECC) at scale, and supporting participating Trusts to achieve Anchor Institution charter status.

We are also exploring how we interpret the Pledge in a primary care setting, which involves considering how it may apply to colleagues such as GPs, dentists, optometrists, and pharmacists. This may provide further opportunities for partners to take early action to support health and wellbeing across a broader range of health and care settings.

**We will:**

**Increase sign up to the NHS Prevention Pledge.**

## Screening, Immunisation and Vaccination

We plan to work with NHS England, UK Health Security Agency (UKHSA) and Place based commissioning teams to strengthen screening, vaccination and immunisation uptake, and to reduce inequalities.

**We will:**

**Work with partners to strengthen screening, vaccination and Immunisation uptake and reduce inequalities.**

# 4. How we will improve our services and outcomes

**We have adopted a life course (starting well, living well, ageing well) approach to improving services and outcomes.**

We are working hard to improve services and outcomes for our residents through a wide range of programmes. We want world leading services across our system, from GPs to highly specialised hospital care.

The table below summarises our core areas of focus. Further details of our work can be accessed by clicking against the appropriate link.

| Theme | Heading | Focus | Drivers | Link | Cross Cutting |
|---|---|---|---|---|---|
| Starting Well | **Maternity & Women's Health** | Reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury.<br>Deliver the actions from the Ockenden report<br>Workforce development<br>All women have personalised and safe care<br>Reduce inequalities in access and outcomes<br>Women's Health and Maternity (WHaM) programme<br>Gynaecology Network<br>Estate - Women's Health Hubs | Core20PLUS5<br>All Together Fairer<br>Long Term Plan | Click to Access | Prersonalised Care and supporting Self Care<br>Supporting Our Carers and Vulnerable Groups |
| | **Children and Young People Beyond Programme** | Emotional wellbeing and mental health<br>Learning difficulties, disabilities and autism<br>Diabetes<br>Epilepsy<br>Respiratory / asthma<br>Healthy weight and obesity<br>Oral health<br>Estate - Women's Health Hubs | Core20PLUS5<br>All Together Fairer<br>Long Term Plan | Click to Access | |
| Living Well<br><br>Ageing Well | **Physical Health** | Cancer<br>Cardiovascular Disease (CVD)<br>Community health services<br>Diabetes<br>Elective Recovery<br>Neurosciences<br>Respiratory<br>Stroke<br>Urgent & Emergency Care<br>Accessing Adult Social Care | Core20PLUS5<br>NHS Operational Plan<br>Long Term Plan | Click to Access | |
| | **Mental Health** | Improving Mental health access and outcomes<br>Continued investment in Mental Health<br>Improved choice<br>A new community-based Mental Health offer<br>PCNs to have Mental Health Practitioners<br>More comprehensive crisis pathways<br>Improved access for children and young people<br>Suicide Prevention<br>Dementia | Core20PLUS5<br>NHS Operational Plan<br>Long Term Plan | Click to Access | |
| | **Neurodiversity** | Learning Difficulties, Disability & Autism (LDDA)<br>Attention Deficit Hyperactivity Disorder (ADHD) | | | |
| | **End of Life Care (EOLC)** | Access to information to support EOLC<br>Access and sustainability palliative /EOLC services<br>Specialist Workforce development<br>Engaging with people | Long Term Plan | Click to Access | |
| Cross Cutting | Primary Care - General Practice / Dental / Optometry /Community Pharmacy<br>Diagnostics - Priority supporting Recovery and Restoration | | | | |

# 5. Our Workforce

**Our plans recognise the importance of investing in our workforce.**

We recognise the skills, abilities and dedication that our staff show each day and the importance of maintaining their Health and Wellbeing.

To achieve Cheshire and Merseyside Health and Care Partnership's strategic priorities we need to change the way we work. We will have new teams, new roles, and we will need to work across multiple organisations and Places.

In 2022/23 the Cheshire and Merseyside People Board, which has a broad membership across Cheshire and Merseyside stakeholders, agreed a set of ambitious Workforce Priorities for 2022-25 (see below).

Our system Workforce Strategy and the programme to support delivery of these priorities will be further developed during 2023/24.

| Systemwide Strategic Workforce Planning to: | Creating New Opportunities across C&M to: | Promoting Health and Wellbeing to: | Maximising and valuing the skills of our staff to: | Creating a positive and inclusive culture to: |
|---|---|---|---|---|
| • Ensure a health and care workforce that is fit for the future<br>• Smarter workforce planning linked to population health need<br>• Creation of a 5-, 10- and 15-year integrated workforce plan<br>• Developing a greater triangulation and monitoring between workforce / productivity / activity / finance. | • Grow our own future workforce<br>• Increased focus on apprenticeships<br>• Embed New Roles<br>• Review barriers to recruitment<br>• Work with the further and higher education sector<br>• PCN Development<br>• Greater links with social care and primary care<br>• Ensuring an effective student experience. | • Ensure appropriate health and wellbeing support for all staff<br>• Ensure good working environment<br>• Focus on retention.<br>• Preventing burnout<br>• Ensuring appropriate supervision and preceptorship is available. | • Understand the impact of 5 generations working together/ changing expectation of the workforce<br>• Developing career options at different stages of our lives and across health and social care<br>• Responding to reviews / staff surveys and recommendations in a positive manner. | • Ensure proactive support of inclusion and diversity as a priority<br>• Collaborative and inclusive system leadership<br>• Understanding the barriers for staff / future employees<br>• Development of learning and restorative practice. |

## Developing our culture and leadership

We plan to adopt, apply, and invest in the following areas to develop our culture, workforce, and ways of working as a system.

**We will:**

- **Ensure a Health and Care workforce that is fit for the future.**

  **And:**

- **Publish a Strategic Workforce Plan by March 2024**
- **Create new opportunities across health and care providers**
- **Promote health and wellbeing of all our workforce**
- **Maximise and value the skills of our workforce**
- **Create a positive and inclusive culture**
- **Ensure digital upskilling for the whole workforce**
- **Further develop our partnerships with Health Education Institutes (HEI's), further education providers and school**

### Cultural transformation

- Organisational and system redesign necessary for integration
- Competence and capability development to deliver integrated ways of working.
- Team cohesion to drive resource optimisation through sustainable collaboration.
- Growth mindset to stimulate systems leadership thinking and practice.
- A shared cultural identity values and behaviours premised on the principles of public service founded by the NHS Constitution, Equality Act and Nolan Principles

### Talent management

- Talent management for effective capacity, demand and supply planning mapped to population health / market trends.
- Robust succession planning strategies for business-critical roles and hard to fill roles specifically.
- Reward and recognition strategies to ensure that success is rewarded and celebrated and improve staff engagement and retention.

### Leadership development

- Resilient collective (systems) leadership evidenced in the continual enablement of integration for improved health and care integration.
- Compassionate and inclusive leadership cultures towards improving health inequalities.
- Culturally competent leadership to drive cultural competence in decision making for integration.
- Clinical leadership for integration towards health creation models of care

# 6. System development

**Our Integrated Care System is geographically large and comprises a wide range of partners. This is reflected in how we apply our intention to distribute leadership to the most appropriate point in the system, which in many cases is as locally as possible.**

In line with the concept of a "self-improving system" described in the Hewitt Review we intend to develop our capabilities and be ambitious in developing our leadership, workforce and improvement approaches alongside the plans already outlined in this document.

In early 2023/24 we will be delivering work to develop and embed an agreed operating model for our system, working alongside system partners. Part of this will involve considering how we can work more efficiently as a system to enable the integration of services across health, care and our wider partners and communities, within our Places and our communities to prosper whilst working collectively at a Cheshire and Merseyside level when it makes most sense to do so.

**It will:**

- **shift the paradigm from reactive to proactive healthcare**
- **integrate clinical and care professionals in decision-making at every level of the ICS, creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities**
- **provide a return on our investment in improving health will be evidenced through measures of both quality and effectiveness**
- **influence the wider determinants of health through collaboration, education and modernisation**

## Clinical and Care Professional leadership

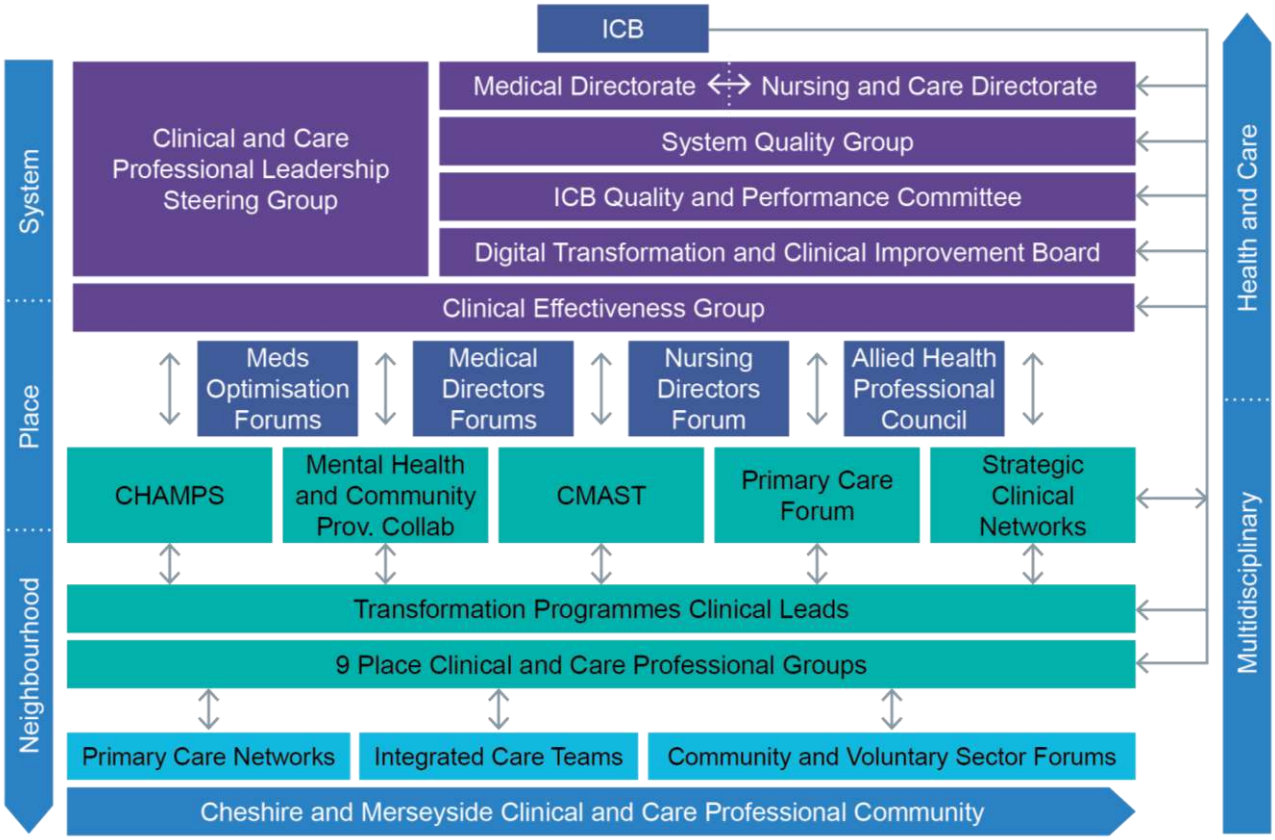
We have developed a Clinical and Care Constitution which describes a set of principles that underpin all we do. It has been written by clinicians with input from clinical and care colleagues to support Cheshire and Merseyside ICS develop with our partners, an overarching population health approach, driven by the needs of our communities with a clear focus on addressing Health Inequalities.

Our Constitution sits alongside our established Clinical and Care Leadership Framework (see figure 7) which outlines how clinical and care leaders across Cheshire and Merseyside will be involved in the key aspects of ICS decision making.

**We will:**

**Implement the commitments and pledges within our Constitution .**

*Figure 7: Clinical and Care Leadership in Cheshire and Merseyside*




# Quality Improvement

The government and public rightly expect Integrated Care Boards and their respective systems to ensure that the services we commission provide the highest standards of care. The development of our system quality strategy is being informed by the National Quality Board (NQB) guidance. The NQB publication 'Shared Commitment to Quality' provides a nationally agreed definition of quality and a vision for how quality can be effectively delivered through ICSs.

## Quality Principles

We will work together as a system to improve quality and use the key principles for Quality Management, as set out by the NQB, in developing our approach to deliver care that is:

- Safe
- Effective
- A Positive Experience
- Responsive and Personalised
- Caring
- Well-led
- Sustainably Resourced
- Equitable

# Our Provider Collaboratives

Effective collaboration and system working provides us with an opportunity to continually evolve, develop, improve and partner to further embed progress and capacity within the ICS and ultimately to provide extended and better care to our residents and patients.

In Cheshire and Merseyside, we have two provider collaboratives:

- Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST)
- Mental Health, Community and Learning Disability and Community Provider Collaborative (MHLDC)

Our collaboratives are leading a range of work programmes which support delivery of the Cheshire and Merseyside HCP strategic priorities.

Our Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST) programmes and key areas of focus are listed below:

- Elective Recovery and Transformation
- Clinical Pathways
- Diagnostics
- Finance, Efficiency and Value
- Workforce

Our Mental Health Learning Disabilities and Community Provider Collaborative (MHLDC) is a joint working arrangement between the nine providers of community, mental health and learning disabilities services. The work programme priorities for 2023/24 are:

- Community urgent care:
  - Urgent community response teams
  - Intermediate care
  - Roll out of Urgent Treatment Centre specification
  - Virtual Wards
- Community services for children and young people
- Access to care, fragile services and community waiting times
- Population health and prevention
- Mental health transformation
- Workforce transformation

**We will:**

**Work with Our collaboratives on a range of work programmes which support delivery of the HCP strategic priorities.**

# Our VCFSE Transformation Programme

In Cheshire and Merseyside we are fortunate to have a strong and engaged Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector across our nine Places. This is supported by established local infrastructure organisations providing skills, knowledge, and capacity to enable two-way communications and engagement between local neighbourhoods and the health and care system.

The new health and care structures which have recently been established provide an opportunity to transform services and make a lasting difference to patients and communities. VCFSE partners will play a vital role in transformation programmes.

NHS Cheshire and Merseyside's draft Public Engagement Framework was co-produced with Healthwatch and the Voluntary, Community, Faith and Social Enterprise Sector and published in July 2022.

**We will:**

**Focus on embedding the VCFSE as a key delivery partner.**

**And**

- **Supporting investment in the VCFSE both financially and organisationally**
- **Building on VCFSE infrastructure and assets**

# Our Places

Our nine Cheshire and Merseyside Places have been working collectively since before the formation of ICS in 2022, working through local partnership arrangements to deliver against the priorities in their local joint health and wellbeing strategies.

We have used a 'Place Development Assessment Framework' to support our Place Partnerships in their development, applying learning from other geographies. There are 4 key domains:

- Ambition and Vision
- Leadership and Culture
- Design and Delivery
- Governance

Place Partnerships have developed detailed plans to improve local services and outcomes.

**We will:**

**As part of our Operating Model, we will enable our nine Places to most effectively deliver functions and decision making at a local level.**

# Evolving our Commissioning and Corporate Services

We are developing a single suite of commissioning policies across Cheshire and Merseyside by March 2024, and we will publish new policies as soon as these are completed and have been through the relevant engagement and governance processes required.

The Health and Care (2022) Act has created provisions for NHS England to delegate functions relating to the planning/commissioning of certain services to Integrated Care Boards. In April 2023 the ICB took on responsibility for dental, ophthalmic and pharmacy services, and we are planning for future delegation of Specialised Services from April 2024.

We have a number of programmes of work designed to support our system to improve consistency and value for money as its functions evolve. These include:

- Corporate infrastructure: we are reviewing the licenses and applications in use across our nine places, to improve consistency and realise operational and financial efficiencies.
- Commissioning support functions: we are reviewing all services currently provided to the ICB by Midlands and Lancashire Commissioning Support unit for consistency and value for money.

# Research and Innovation

As described in our draft interim Health Care Partnership Strategy we have an ambitious vision for research in Cheshire and Merseyside. Our ICS is investing in the clinical leadership to realise this ambition with Director and Deputy Director of Research to work closely with our stakeholders to develop the best performing research network in the country.

We are working closely as a system involving the CHAMPS public health collaborative, our academic institutions, HCP partners (including population health), research partners (including National Institute for Health and Care Research, National Cancer Research Institute and Academic Health Science Network) and industry.

**We will:**

- **Establish a Cheshire and Merseyside Research Development Hub**
- **Create a network of research champions across our system**
- **Deliver annual learning events to showcase latest research and to enable the sharing of skills, toolkits and research to support in-house evaluation of projects**
- **Contribute to the development of a North West Secure Data Environment for research.**

# Digital and Data

Cheshire and Merseyside ICS published its three year Digital and Data Strategy in November 2022 following endorsement from the NHS Cheshire and Merseyside Board. We are committed to using digital and data to improve outcomes and services for our residents.

The strategy describes an ambition to improve the health and well-being of our region now and into the future by incorporating 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 to ensure we successfully support all we serve.

We are committed to turning 'intelligence into action' by using increasingly sophisticated ways of understanding the health and care needs of our population, and then finding and intervening for those in greatest need to improve their health and care outcomes in an equitable way.

**We will:**

**Work in partnerships to deliver the goals outlined in the Digital and Data Strategy, including making the Share2Care (shared care record) platform available in all NHS and Local Authority Adult Social Care providers, by March 2024.**

# Effective use of resources

In line with many other systems Cheshire and Merseyside faces significant financial challenges. As a system, we are spending more money on health and care services then we receive in income. We must take action to improve the long-term sustainability of the Cheshire and Merseyside health and care system by managing demand and transforming the way we use services, staff, and buildings.

As part of the Cheshire and Merseyside draft interim Health Care Partnership Strategy there is a commitment to developing a system-wide financial strategy during the first half of 2023-24 to:

- Determine how we will best use our resources to support reduction in inequalities, prevention of ill health and improve population health outcomes
- Support health and care integration
- Identify key productivity and efficiency opportunities at both a Place and ICS footprint
- Outline system-wide estates and capital requirements and plans

As recommended in the Hewitt Review, we are focussed on ensuring we are getting best value from our investments and increasing the proportion of our ICB budgets allocated to prevention of ill health.

**We will:**

**Agree a financial strategy and recovery plan by September 2023 which details how we will move to a sustainable system-wide financial position in Cheshire and Merseyside.**

# Finance Efficiency and Value Plans

As part of our wider development of a system financial strategy, we have established an Efficiency at Scale programme. One of our provider collaboratives, CMAST, is hosting the programme on behalf of the ICB. The programme works across the NHS and links with partners from the wider system as appropriate.

The key areas of focus for the Efficiency at Scale programme are:

- Consolidating financial systems, approaches and capacity across organisations where appropriate, including financial ledgers.
- Delivering a structured procurement workplan to reduce influenceable spend across all providers.
- Building on existing medicines optimisation projects to deliver a more sustainable approach to pharmacy capacity and resourcing across Cheshire and Merseyside.
- Specific discrete workforce projects, for example a collaborative staff bank for Health Care Assistants.

This complements wider work on our financial strategy and recovery plan where system partners work to reduce costs, through ICB, Place, provider and partner led plans.

# Capital plans

We have developed a Capital Plan which describes how we will use available capital funding to invest in our buildings and infrastructure. The dedicated page is publicly available to view at: Capital Plan

Our capital plans will be routinely shared with members of the Cheshire and Merseyside Health and Care Partnership and the nine Health and Wellbeing Boards in Cheshire and Merseyside.

**We will:**

**Continue working in partnership to deliver against our Capital plans.**

# Estates

Cheshire and Merseyside Health and Care Partnership's Estates Strategy sets out our system commitment for the next five years. We are committed to the NHS, local government and other agencies working together to deliver our Estates Plan and take steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them.

Our focus for delivery will primarily be in eight key areas:

- Fit for Purpose
- Maximising Utilisation
- Environmentally Sustainable
- Value for Money and Social Value
- Services and Buildings in the right place
- Flexibility
- Technology
- Working in Partnership

**We will:**

**Support our nine Place Partnerships and Primary Care Networks to ensure our focus areas translate into deliverable local plans.**

# All Age Continuing Health Care

The ICB is accountable for the fair and equitable commissioning of NHS All Age Continuing Health Care (AACC) to support the assessed needs of our residents. We are accountable for the quality, safety and financial assurance of the continuing care provided.

We have recently reviewed the services we provide to people who receive Statutory funded continuing care. This review will have a range of benefits. It will improve the appropriateness of the care provided, meaning care is of higher quality. By providing more appropriate solutions, we also expect to improve the value for money of the services we provide meaning our funding can go further.

**We will:**

**Complete the review and work with partners to establish an equitable model for delivery of services across Cheshire and Merseyside.**

# 7. Our Place Plans

Further detail on the plans will be published on the Cheshire and Merseyside Website.

Health and Wellbeing Boards were asked to provide a statement outlining whether the Joint Forward Plan includes the relevant priorities within the Joint Local Health and Wellbeing Strategy. These will be published on the Cheshire and Merseyside Website.

# 8. Glossary

An online glossary of terms has been developed by NHS Cheshire and Merseyside and can be accessed through this link:

**cheshireandmerseyside.nhs.uk/get-involved/glossary/**

# 9. Summary of Outcomes

In addition to the priorities outlined in Section 1 there are a range of additional outcomes the plans outlined in this document will deliver and can be accessed by clicking here (link to be added).

# 10. Links to our partners plans

Links to the strategic plans of our NHS Provider and Local Authority Partners will be published on the Cheshire and Merseyside Website.

# Appendix 1 NHS Operational Plan and Long-Term Plan

| NHS Operational Plan and Long-Term Plan Objectives and Metrics | | | | |
|---|---|---|---|---|
| **Area** | **2023/24 Planning Objective** | **Metric** | **Target Value** | **Cheshire and Merseyside position** |
| **Urgent and emergency care*** | Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 | Percentage of attendances at Type 1, 2, 3 A&E departments, excluding planned follow-up attendances, departing in less than 4 hours | 76% | 76.9% |
| | Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 (NWAS target set at 33 mins) | Ambulance Response Times - Category 2 | National 00:30:00 NWAS 00:33:00 | N/A |
| | Reduce adult general and acute (G&A) bed occupancy to 92% or below | Average number of overnight G&A bed occupancy - adult | 92% | 94.3% |
| | | Average number of overnight G&A bed occupancy - Total (Adult & Paediatrics) | | 92.8% |
| **Community health services** | Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard | Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours | 70% | 2022/23 YTD = 74%. 14,985 UCR Contacts planned, 36% increase compared to 2022/23 FOT |
| | Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals | No specific metric defined | | |
| **Primary care*** | Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need | % Appointments booked same day | | Total GP Appoints 14.98m. Increase of 4.9% compared to 2021/22 |
| | | % Appointments booked within 1-14 days | | |
| | | % Appointments booked over 14 days | | |
| | Continue the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 | Current gap to local ambition (down arrow indicates closing the gap) | | |
| | Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 | Direct Patient Care (DPC) Roles in General Practice and PCNs (NB - manifesto commitment changed from ARRS to DPC roles, trajectory only available at region level) | | 57.9% |
| | Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels | 2019/20 Baseline scheduled monthly % of usual annual contracted UDAs | | 83% below 19/20 |
| | | 2022/23 scheduled monthly % of usual annual contracted UDAs | | |

| | | | | |
|---|---|---|---|---|
| **Elective care** | Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) | Total waiting over 65 weeks | 0 | 0 |
| | Deliver the system- specific activity target (agreed through the operational planning process) | 2022/23 Value Weighted Activity including adjustment for advice and guidance (NB - this measure will change for 2023/24) | 105% | 108.5% |
| **Cancer** | Continue to reduce the number of patients waiting over 62 days | The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site-specific symptoms | | 1,095 |
| | Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days | % Patients with diagnosis communicated within 28 days | 75% | 75.1% |
| | Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 | Percentage of stageable cancers diagnosed at stage 1 and 2 (NB - data are Cancer Alliance not ICB footprint) | 75% | 80.0% |
| **Diagnostics** | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% | % Patients receiving diagnostic test within 6 weeks | 95% | 89.5% |
| | Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition | Acute Trust Diagnostic activity as % of baseline (current month v baseline month for 15 tests in DM01) | | 116.4% |
| **Maternity** | Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury | Stillbirths per 1,000 total births | | |
| | | Neonatal deaths per 1,000 total live births | | |
| | Increase fill rates against funded establishment for maternity staff | Workforce data | | |
| **Use of Resources** | Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years | Financial strategy and recovery plan in place by Sept 2023 | | |
| **Workforce** | Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise | Total workforce | Publish a Strategic Workforce Plan by March 2024 | |
| **Mental health** | Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) | Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact | | 23/24 = 135,601 Q4 = 37,590 |
| | Increase the number of adults and older adults accessing IAPT treatment | Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period. | | 23/24 = 72724. 100% of target |

| | | | | |
|---|---|---|---|---|
| | Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services | Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses | 5% | Q4 23/24 = 20,600 Target achieved |
| | Work towards eliminating inappropriate adult acute out of area placements | Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider | | Q4 23/24 = 900 |
| | Recover the dementia diagnosis rate to 66.7% | Dementia Diagnosis Rate | 66.7% | 66.7% |
| | Improve access to perinatal mental health services | Number of women accessing specialist community PMH and MMHS services in the reporting period | | Q4 23/24 = 2,357 372 short of ambition |
| **People with a learning disability and autistic people** | Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 | % of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register in the period | 75% | 75.0% |
| | Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults are cared for in an inpatient unit | Learning Disability Inpatient Rate per Million ONS Resident Population. | <30 | **36.5** |
| | Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit | | 12 to 15 | 14.0 |
| **Prevention and health inequalities** | Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 | | 77% | |
| | Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% | | 60% | |
| | Continue to address health inequalities and deliver on the Core20PLUS5 approach | No specific metric defined | | |
| **Activity** | Elective day case spells | Planned Activity Volumes 23/24 | | 363,244 |
| | Elective ordinary spells | Planned Activity Volumes 23/24 | | 54,466 |
| | RTT Clock Stops (admitted and non-admitted) | Planned Activity Volumes 23/24 | | 879,054 |
| | Number of requests for A&G | Planned Activity Volumes 23/24 | | 417,246 |
| | Outpatient attendances (all TFC; consultant and non-consultant led) - First attendance | Planned Activity Volumes 23/24 | | 1,330,322 |
| | Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance | Planned Activity Volumes 23/24 | | 3,357,568 |

| | | | | |
|---|---|---|---|---|
| | Follow Up Outpatient Attendances without procedure | Planned Activity Volumes 23/24 | Reduce by 25% | 2,487,559 |
| | Number of episodes moved or discharged to PIFU pathway | Planned Activity Volumes 23/24 | | 171,366 |
| | Number of attendances at all type A&E departments. | Planned Activity Volumes 23/24 | | 1,181,165 |
| | Non-elective spells | Planned Activity Volumes 23/24 | | 398,629 |

# Appendix 2 Marmot 8 principles and 22 Beacon indicators

The tables below highlight the principles describing how we intend reducing inequalities and the indicators we will use to measure progress.

| Marmot 8 principles | |
|---|---|
| 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. |

*22 Beacon Indicators*

| Life expectancy | | Frequency | Level | Disagg. | Source |
|---|---|---|---|---|---|
| 1 | Life expectancy, female, male | Yearly | LSOA | IMD | ONS |
| 2 | Healthy life expectancy, female, male | Yearly | LA | IMD | ONS |
| **Give every child the best start in life** | | | | | |
| 3 | Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)* | Yearly | LA | NA | DfE |
| 4 | Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception) | Yearly | LA | FSM status | DfE |
| **Enable all children, young people and adults to maximise their capabilities and have control over their lives** | | | | | |
| 5 | Average Progress 8 score** | Yearly | LA | FSM status | DfE |
| 6 | Average Attainment 8 score** | Yearly | LA | FSM status | DfE |
| 7 | Hospital admissions as a result of self-harm (15-19 years) | Yearly | LA | NA | Fingertips, OHID |
| 8 | NEETS (18 to 24 years) | Yearly | LA | NA | ONS |
| 9 | Pupils who go on to achieve a level 2 qualification at 19 | Yearly | LA | FSM status | DfE |
| **Create fair employment and good work for all** | | | | | |
| 10 | Percentage unemployed (aged 16-64 years) | Yearly | LSOA | NA | LFS |
| 11 | Proportion of employed in permanent and non-permanent employment | Yearly | LA | NA | LFS |
| 12 | Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter*** | - | - | - | NHS, local government |
| 13 | Percentage of employees earning below real living wage | Yearly | LA | NA | ONS |
| **Ensure a healthy standard of living for all** | | | | | |
| 14 | Proportion of children in workless households | Yearly | LA | NA | ONS |
| 15 | Percentage of individuals in absolute poverty, after housing costs | Yearly | LA | NA | DWP |
| 16 | Percentage of households in fuel poverty | Yearly | LA | NA | Fingertips OHID |
| **Create and develop healthy and sustainable places and communities** | | | | | |
| 17 | Households in temporary accommodation**** | Yearly | LA | NA | MHCLG / DLUHC |
| **Strengthen the role and impact of ill health prevention** | | | | | |
| 18 | Activity levels | Yearly | LA | IMD | Active lives survey |
| 19 | Percentage of loneliness | Yearly | LA | IMD | Active lives survey |
| **Tackle racism, discrimination and their outcomes** | | | | | |
| 20 | Percentage of employees who are from ethnic minority background and band/level*** | - | - | - | NHS, local government |
| **Pursue environmental sustainability and health equity together** | | | | | |
| 21 | Percentage (£) spent in local supply chain through contracts*** | - | - | - | NHS, local government |
| 22 | Cycling or walking for travel (3 to 5 times per week)~ | Yearly | LA | IMD | Active lives survey |

** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.*

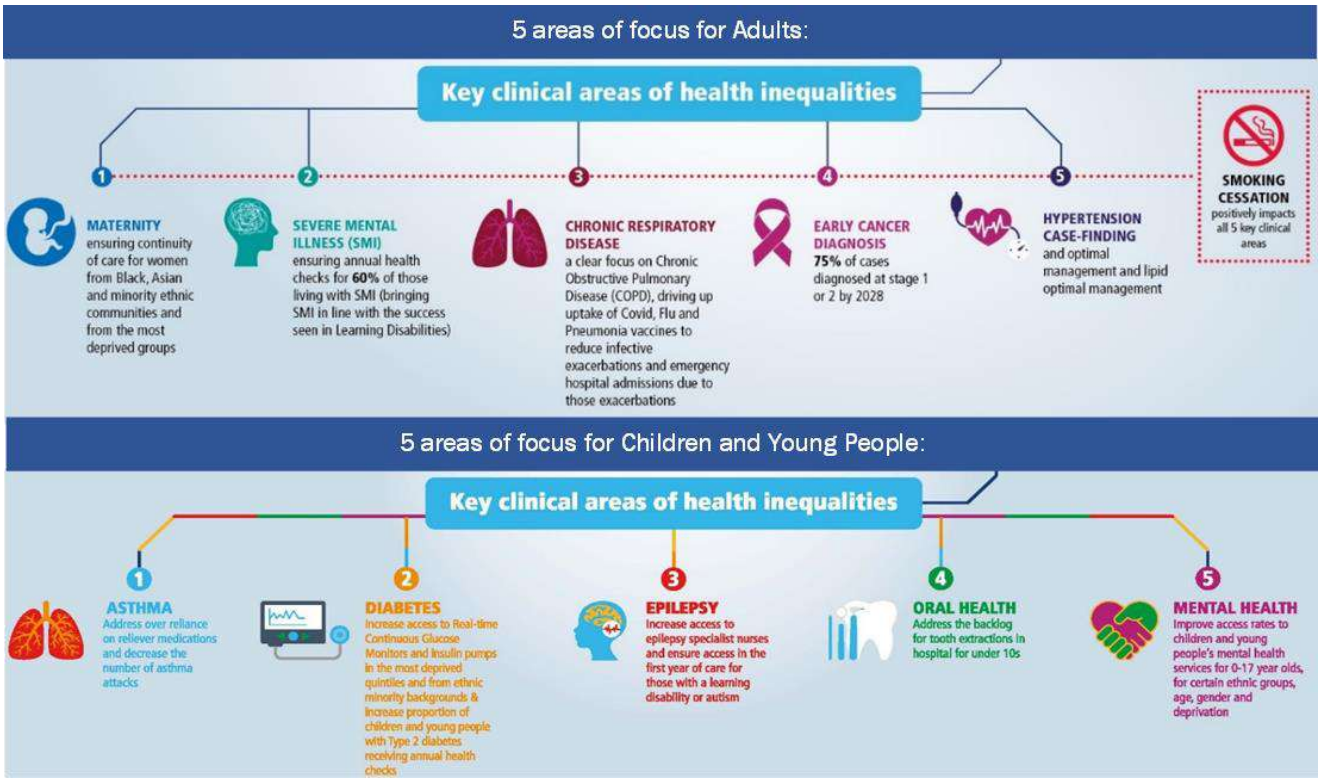
*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a neg ative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

**** These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

***** To be used to demonstrate annual changes, interpretation to factor in population changes.*

*~ Active Lives Survey states the length of continuous activity is at least 10 minutes.*

# Appendix 3 Core20PLUS5



# NHS Cheshire and Merseyside Integrated Care Board Meeting

## Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24

**Appendix Two:** **Summary Version of the Joint Forward Plan Delivery Plan**

| Annual Delivery Plan - Summary Document (note detailed workplans and delivery milestones sit underneath this summary) includes summary of Place plans. | | | | | |
|---|---|---|---|---|---|
| **Service Programme** | **Focus Area (* and bold indicates links through to NHS Operational planning Metrics)** | **Delivery By** | **Primary (BAF) risk mitigation **(descriptor below table)** | **Reporting route** | **Executive/Board Lead** |
| **How we work as partners for the benefit of our population** | Delivery of actions around communications and engagement and compliance with the guidance on working with people and communities for example development of the Citizens panel and partnerships work with the VCFSE sector. | **Mar-24 or earlier** | **BAF-P1** | **Transformation Committee** | **Clare Watson** |
| | Delivery our Equality Diversity & Inclusion (EDI) obligations including development of a system wide EDI framework and strategy, in line with national, regional and local policy. Embedding EDI/implementing recommendation 2 of the Messenger Review | **Mar-24 or earlier** | **BAF-P1** | **Q&P Committee** | **Clare Watson /Chris Samosa** |
| | Board/Exec/Senior Leadership teams will develop their EDI capacity in order to make decisions through an EDI Lens and effectively influence the system. | **Mar-24 or earlier** | **BAF-P1** | | |
| | Our Green Plan - Continue to deliver against Green Plan targets with a focus on systemwide initiatives to drive a joined-up approach to delivery | **March -24 Net Zero by 2040** | **BAF-P10** | **Transformation Committee** | **Clare Watson** |
| | **Deliver a programme of work to support wider social and economic development inc. Social Value/Anchor Institutions/regeneration, planning and including work to support the levelling up agenda.** | **Mar-24** | **BAF-P1/P10** | **HCP** | **Clare Watson** |
| | Delivery plans to ensure the Safeguarding our population with a focus on Safe at Home, Safe in our Communities and Safe Safeguarding Systems across C&M | **TBD** | **BAF-P4** | **Q&P Committee** | **Chris Douglas** |
| | **Develop an action plan to address Equality Human Rights Commission priorities to steps are being taken to tackle the inappropriate detention of people with a learning disability and autism and also at action to tackle disproportionate rates of detention of ethnic minority people under the Mental Health Act 1983'. Will need senior SRO / Feb. 2024** | **Mar-24** | **BAF-P1** | **Q&P Committee** | **Clare Watson /Chris Samosa** |

| | | | | | |
|---|---|---|---|---|---|
| **Population Health** | CM Population Health Board provides system leadership to support Place, Partners and Programmes to drive improvements in population health outcomes and reduce inequalities | **New programme established by March 2024, Ongoing delivery to 2028** | **BAF-P1** | **Transformation Committee (Population Health Board)**<br><br>**HCP (ATF Board)** | **Clare Watson / Prof Ian Ashworth** |
| | Social determinants of health: Continue to deliver the 5 year **All Together Fairer** (Marmot) Programme with a focus on development of a Children and Young People's Health Equity Framework, Supporting Anchor and Social Value Organisations, Improved utility of the Beacon indicators and delivery of All Together Inspired, a development programme on the Social Determinants of Health for system leaders. | **2028 (March '25 for CYP Health Equity Framework and dynamic measurement tool)** | **BAF-P1** | | |
| | Establish a C&M **Prevention Framework and network** to strengthen coordinated and collaborative system-wide action on health, wellbeing and healthy behaviours (including smoking, alcohol, overweight & obesity, physical activity, mental wellbeing and MECC). | **Framework established by March 2024 and ongoing to 2028** | **BAF-P1** | | |
| | **Reduce harm from alcohol** through strengthened integration of alcohol care (PROACT programme), development of an Alcohol CIPHA dashboard, digital Identification and Brief Advice (IBA), expansion of early detection and outreach projects, Blue Lights pilots to support those with complex lives, advocacy and inpatient detoxification. | **Reduced hospital admissions for alcohol-related conditions by 2028** | **BAF-P1** | | |

| | | | | | |
|---|---|---|---|---|---|
| | Develop a whole-system **C&M 'Smoke Free' strategy**, including but not limited to improved delivery of the NHS Treating Tobacco Dependency Programme, to strengthen delivery against the Smoke-free 2030 ambition. | **Strategy by March 2024 Improved TDD delivery March 2024 Ambition: Smokefree (<5%) by 2030** | **BAF-P1** | | |
| | Drive a whole-system approach to increase **physical activity,** with a focus on those facing the greatest health inequalities | **150,000 inactive people more physically active by 2026** | **BAF-P1** | | |
| | **Establish C&M oversight and accountability for Core20PLUS5** (adult and Children and Young People) and the **Healthcare Inequalities Improvement (HIIP)** programme. | **Mar-24** | **BAF-P1** | | |
| | Screening Vaccinations and Immunisations: C&M system roles and responsibilities regarding Section 7a oversight and assurance updated in line with NHSE restructure and ICB requirements. | **TBC** | **BAF-P1** | | |
| | System **strategic intelligence functionality & capacity** aligned to drive and monitor population health management at Place and across programmes. | **Mar-24** | **BAF-P1** | | |
| | Cross-cutting enablers support CM population health priorities, including communications, workforce development and research and development**.** | **Mar-24** | **BAF-P9** | | |
| | | | | | |
| **Children & Young People (CYP)** | Emotional Wellbeing and Mental Health - reducing MH admissions, improving access and equity of services, reduction in delayed discharges and development of a single Digital point of access. | **Mar-25** | **BAF-P2/P4/P5** | **CYP Board (Beyond Programme Board)** | **Chris Douglas** |

| | | | | | |
|---|---|---|---|---|---|
| | Healthy Weight and Obesity - Flattening the curve on obesity rates for CYP at both Reception and Year 6 assessments and increasing physical activity. | **March-25 March-28** | **BAF-P1** | | |
| | Learning Difficulties, Disabilities and Autism: (LDD&A) - Increased number of neurodevelopmental & Autism CYP Referrals where reasonable adjustments are made with a care plan and or intervention (2023/24) | **Mar-24** | **BAF-P1/P4** | | |
| | Epilepsy - Delivery of support plans including alignment with line with Core20PLUS5 | **Mar-24** | **BAF-P1/P4** | | |
| | Diabetes - Delivery of support plans including alignment with line with Core20PLUS5 | **Mar-24** | **BAF-P1/P4** | | |
| | Respiratory - Delivery of support plans including alignment with line with Core20PLUS5 | **March 2024 Mar-25** | **BAF-P1/P4** | | |
| | Oral Health - Delivery of support plans including alignment with line with Core20PLUS5 | **Mar-25** | **BAF-P1/P4** | | |
| | Implement the NHS Universal Family (Care Leaver Covenant) Programme so that care experienced young people have opportunities to be supported into roles within the NHS by October 2023. | **Oct-23** | **BAF-P1/P4** | | |
| | | | | | |
| **Women's Health & Maternity** | **Reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. Implement actions from the 3-year Delivery plan for Maternity and Neonatal services including the actions from the Ockenden report, personalised care plans for 100% of women, grow and retain the workforce and tackle inequalities*** | **Mar-24** | **BA - P1/P4/P9** | **Transformation Committee (Programme Board via DTACAB)** | **Chris Douglas** |
| | Embedding measures to improve health and reduce inequalities in 2023/24 | **Mar-24** | **BAF-P1** | | |
| | Work to support Special interest groups including menopause, Paediatric and Adolescent Gynaecology and Endometriosis. | **TBD** | **BAF-P4** | | |
| | Continued development of a Women's Health Strategy | **First Draft May-23** | **Multiple** | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Workforce - development work including the development of a gap analysis, development of a Gynae Nurse Network and sharing good practice. *** | **TBD** | **BAF-P4/P9** | | |
| | Women's health engagement - development of a Women's Voices Network, Women's Health App and Women's Health Champions. | **TBD** | **BAF-P1** | | |
| | Programmed work to support standardisation including a Referral triage SOP, Primary and Secondary care interface policy, mutual aid and joint procurement | **TBD** | **BAF-P4/P6** | | |
| | Improving access including estates work and the development of Women's Health Hubs | **TBD** | **BAF - P1** | | |
| | | | | | |
| **Diabetes** | Development work to support the 8- Care processes (8CP) / Treatment Targets. | **Mar-24** | **BAF-P4** | **Transformation Committee (Diabetes Strategic Oversight Group DTACAB)** | **Fiona Lemmens** |
| | NHS National Diabetes Prevention Programme (NDPP) decrease variation in uptake across the ICB and we will also deliver a robust communications plan. | **Ongoing** | **BAF-P4** | | |
| | Development and delivery of a Structured Education (SE) | **Mar-24** | **BAF - P1** | | |
| | Diabetes Type 1 Disordered Eating Programme (T1DE) - established T1DE programme providing this joint clinical service as one of 8 centres nationally. | **Ongoing** | **BAF - P1** | | |
| | Continuous Glucose Monitoring (CGM) and Flash glucose monitoring with a focus on reducing the variation across the ICB and improve the uptake of this technology. | **Ongoing** | **BAF-P2/P4** | | |
| | Development of Multi-Disciplinary Footcare Team provision (MDFT) to reduce major and minor amputation rates. | **Ongoing** | **BAF-P4** | | |
| | DISN provision ensure sufficient Diabetes Inpatient Specialist Nurse (DISN) provision to meet the advised national ratio of 1 nurse for every 250 inpatients in the hospital settings across the ICB | **Ongoing** | **BAF-P9** | | |
| | Continued work to reduce Health Inequalities | **Ongoing** | **BAF - P1** | | |
| | | | | | |
| **Diagnostics** | **Increase the percentages of patients that receive a diagnostic test within six weeks in line with March 2025 ambition of 95%. *** | **Mar-25** | **BAF-P3/P4** | **Q&P Committee (CMAST)** | **CMAST (Ann Marr)** |

| | | | | | |
|---|---|---|---|---|---|
| | Support plans to address elective and cancer backlogs and the diagnostic waiting time ambition. * | | **BAF-P3/P4** | | |
| | **Continued work to support expanding CDC's** | | **BAF-P3/P4** | | |
| | Network productivity - Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostics investments | | **BAF-P3/P4** | | |
| | | | | | |
| **Personalised Care** | Embedding personalised care approaches in our Virtual Ward services | **March-24 To March-28** | **BAF-P4** | **Q&P Committee** | **Clare Watson** |
| | Access & use of Personal Health Budgets (PHBs) delivery of the 5-year plan is to achieve an increase in uptake of PHB's so that 12000 PHB's are in place by 27/28. | | **BAF-P4** | | |
| | Service review and redesign plans implemented | | **BAF-P4** | | |
| | Peer support - work to Increase confidence in personalisation conversations to achieve a PHB offer and thereby uptake (March 2024) | | **BAF-P4** | | |
| | Consistency of access - Improve efficiency and effectiveness of facilitative third party PHB providers across Cheshire and Merseyside through consolidation of commissioning arrangements (March 2026) | | **BAF-P4** | | |
| | Innovative solutions - Development of shared workplan for innovative care solutions with VCFSE | | **BAF-P4** | | |
| | | | | | |
| **Primary Care** | Delivery of the ICBs plan response to address the national Delivery plan for recovering access to primary care and deliver overall programme of work related to the national policy | **Plan to ICB Board October 2023** | **BAF-P3/P4/P5/ P6/P9** | **System Primary Care Committee** | **Clare Watson** |
| | | **Other detailed actions as per programme plan** | | | |
| | Post Pandemic Restoration /and increase of available General Practice appointments in line with the NHS planning guidance | **Mar-24** | **BAF-P3/P4/P5/P6** | | |

| | | | | | |
|---|---|---|---|---|---|
| | Improving access to Dental Services including post pandemic restoration/increase in number of UDAs in line with the NHS planning guidance and delivery of our local Dental Recovery Plan and ambitions | **Mar-24** | **BAF - P1/P4/P5/P6** | | |
| | Community Pharmacy Consultation Service - Increased participation in the Community Pharmacist Consultation Service in line with the NHS Planning Guidance | **Mar-24** | **BAF-P3/P5** | | |
| | | | | | |
| **Cardiovascular** | **Delivery Programme around CVD Prevention including work address health inequalities and deliver on the Core20PLUS5 approach. *** | **TBD** | **BAF-P1** | **Transformation Committee (Cardiac Network Board via DTACIB)** | **Fiona Lemmens** |
| | Focused plans to support deliver against National Pathways to ensure better quality and safety of care across the pathway leading to better outcomes | **TBD** | **BAF-P4** | | |
| | Work with NHS England Specialised Services to redesign Renal pathway | **Mar-24** | **BAF-P4** | | |
| | Expanding access for Familial Hypercholesterolaemia (FH); enabling us to diagnose and treat those at genetic risk of sudden cardiac death | **To Board July -23** | **BAF-P4** | | |
| | | | | | |
| **Community Health Services** | **Recovery plans to meet or exceed the 70% 2-hour Urgent Community Response (UCR) increasing utilisation of UCR by 20%, develop virtual wards and ensure utilisation*** | **Mar-24** | **BAF-P3/P4/P5** | **MHLDC Q&P Committee** | **MHLDC (Joe Rafferty)** |
| | Work on Community Waiting times to eliminate waits of over 52 weeks for community care and reduce patients waiting over 18 weeks for a 1st appointment in a community clinic by 25%* | **Mar-24** | **BAF-P3/P4/P5** | | |
| | Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals | **Mar-24** | **BAF-P2/P3/P4/P5** | | |
| | | | | | |
| **Elective Recovery** | **Delivery the Elective Recovery plan to eliminate 65 week waits*** | **Mainly March 2024** | **BAF-P3/P4/P5** | **CMAST Q&P Committee** | **CMAST (Ann Marr)** |
| | Onward Referrals work towards targeting a 30% reduction in the number of onward referrals and reduce outpatient follow up activity by 25% against 2019/20 baseline | | **BAF-P3/P4/P5** | | |

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| | Increase in day case activity, targeting 85%, in line with Cheshire and Merseyside Plan | | **BAF-P3/P4/P5** | | |
| | Work to improve Theatre Utilisation - deliver planned, system average Theatre utilisation of at least 80% | | **BAF-P3/P4/P5** | | |
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| **Neurosciences** | Access to acute neurological care - increase access to acute neurological care for patients to be assessed in a timely manner by an appropriate expert, to guide appropriate investigations. | **TBD** | **BAF-P3/P4** | **Transformation Committee (DTACIB)** | **Fiona Lemmens** |
| | Best Practice Pathways - roll out best practice pathways to other providers in Cheshire and Merseyside. | | **BAF-P3/P4** | | |
| | Stroke - Increase numbers of patients receiving thrombectomy treatment year on year and to maximise efficiency in the pathway. | | **BAF-P3/P4** | | |
| | Work with NHS England Specialised Services to redesign Neurorehabilitation pathway | **Mar-24** | **BAF-P3/P4** | | |
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| **Respiratory** | Diagnostic & Treatment Pathways - focused work to improve the effective management of respiratory long-term conditions and specifically COPD. | **Dec-24 to Apr-27** | **BAF-P3/P4** | **Transformation Committee (Respiratory Network via DTACIB)** | |
| | Spirometry Restart focus on increasing the number of clinicians trained to Association for Respiratory Technology & Physiology (ARTP) Standards for delivery and interpretation of spirometry | **Apr-25** | **BAF-P3/P4** | | |
| | Pulmonary Rehab - Targeted work to increase appropriate referrals, reduce referral to assessment waiting times and increase completion rates for Pulmonary Rehab, | **Jun-24** | **BAF-P3/P4** | | |
| | Greener inhalers - improve the long-term management of patients with COPD and Asthma (via the Pathways work) which will reduce reliance upon high use of short acting bronchodilators | **Dec-24** | **BAF-P10** | | |
| | Early detection & proactive management - improve patient and family/carer education and supported self-management for people living with long term Respiratory conditions | **Dec-24** | **BAF-P3/P4** | | |
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| **Stroke** | **National Optimal Stroke Imaging Pathway (NOSIP) - implementation of Computed Tomography Angiography (CTA) and Computed Tomographic Perfusion (CTP) at all appropriate Hyper Acute Stroke Services** | **Jul-23** | **BAF-P3/P4** | **Transformation Committee (Integrated Stroke Delivery Network (ISDN) Board via DTACIB)** | |
| | **Delivery against NOSIP guidelines.** | **Dec-24** | **BAF-P3/P4** | | |
| | **North Mersey Stroke Service Transformation - increase the bed base for stroke patients in North Mersey and provide patients with the correct facilities to enable appropriate rehabilitation to be offered and provided by completing the estates transformation work** | **Jul/ Aug 23** | **BAF-P3/P4** | | |
| | **Sentinel Stroke National Audit Programme (SSNAP) Data - all routinely admitting stroke services to achieve SSNAP score of "B" or above.** | **Mar-24** | **BAF-P2** | | |
| | **Hyperacute Stroke Services & Thrombectomy - increase the percentage of stroke patients receiving thrombectomy to 4.5% and increase ambulance triage. (Working with NHS England Specialised Services)** | **Mar-24** | **BAF-P3/P4** | | |
| | Planned work to further develop Integrated Community Stroke Services | Mar-25 | **BAF-P3** | | |
| | **SQuIRe (Stroke Quality Improvement in Rehabilitation) - delivery of all 6 catalyst funded projects** | **Mar-24** | **BAF-P3/P4** | | |
| | **Prevention - reduce the inequalities in secondary prevention of stroke through joint working with the CVD Prevention Programme. *** | **Ongoing** | **BAF-P1** | | |
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| **Urgent and Emergency Care** | **Delivery of the Urgent and Emergency Care recovery plan to support A&E waiting times, improve bed occupancy rates, support work around NCTR, UCR and LOS, development of Virtual Wards and improve ambulance response times. *** | **Mar-24** | **BAF-P3/P4/P5** | **Q&P Committee** | **Anthony Middleton** |
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| **Mental Health** | Priority national objectives for 2023/24 - improving access to services including IAPT, increase in the numbers supported by community mental health services, eliminate inappropriate OOA placements, recover the dementia diagnosis rate to 66.7% and Improve access to perinatal mental health services* | **Mar-24** | **BAF-P3/P4/P5** | **MHLDC Q&P Committee** | **MHLDC (Joe Rafferty)** |

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| | NHS 111 'select MH option' - ensure that a single national 3-digit number exists for mental health crisis | **Mar-24** | **BAF-P3** | | |
| | Continue work to support Addressing Section 136 delays | **Mar-24** | **BAF-P3/P4** | | |
| | **Dementia - work towards exceeding the national standard of 66% of expected dementia diagnosis rates, support carers and increase the use of digital technology. *** | **01/03/2024 others TBC** | **BAF-P2/P3** | **Transformation Committee (DTACIB)** | **Fiona Lemmens** |
| | Suicide Prevention focus areas: a) increased awareness of suicide risks, promotion of suicide prevention messaging. b) Increased awareness of referrals to the commissioned 'postvention service'. c) Enhanced Real Time surveillance system embedded. d) Extended workforce (Capability). | **Mar-24** | **BAF-P1/P9** | **HCP (NO MORE Suicide Partnership)** | **Clare Watson Prof Ian Ashworth Ruth du Plessis SRO for MHW, SP, SB for C&M Public Health collaborative** |
| | | | | | |
| **Learning disability & autism** | **Annual Health Checks - deliver on Annual Health Checks for people aged 14years plus*** | **Mar-24** | **BAF-P1** | **Q&P Committee** | **Chris Douglas (Simon Banks)** |
| | Continued work around Housing Needs Assessments and associated development and delivery | **Mar-24** | **BAF-P1** | | |
| | Inpatient Care - reduce reliance on inpatient care, while improving the quality of inpatient care* | **Mar-24** | **BAF-P3** | | |
| | Care and treatment reviews - ensure CTR's take place within the required timescales. | **Mar-24** | **BAF-P3** | | |
| | An Autism Community Forensics Service will be developed in 23/24 which will support the discharge of people from forensic settings and ensure they are supported in the community. | **Mar-24** | **BAF-P3** | | |
| | Positive Behaviour Support plan to develop in collaboration with place commissioners a Positive Behaviour Support specification for adults and CYP that will meet the needs of our population that is more targeted and accessible. | **Mar-24** | **BAF-P3** | | |
| | The Transforming Care Programme will continue to align itself to the developments within the CYP Mental Health Programme | **TBD** | **BAF-P3** | | |

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| | Attention Deficit Hyperactivity Disorder (ADHD) - Our population will have consistent access to the diagnostic and support services. | **TBD** | **BAF-P3** | **Place Transformation Group** | **TBC** |
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| **End of Life Care** | Recognising people are coming to the end of their life - planned work to identify individuals and ensure care is planned to include Advance Care Planning education and training for health and care staff. | **Mar-24** | **BAF-P3** | **Transformation Committee (Palliative and End of Life Care Programme Board via DTACTC** | **Fiona Lemmens** |
| | Enabling information to be available electronically to support end of life care | **Mar-25** | **BAF-P3** | | |
| | Access and sustainability - Population Based Needs Assessment (PBNA) completed for each of our Places to inform strategic direction and service planning | **Mar-24** | **BAF-P8** | | |
| | Workforce action plans to address workforce gaps, developed for each of our places across Cheshire & Merseyside | **Mar-24** | **BAF-P9** | | |
| | Engaging with people to identify the issues, related to end-of-life care, which are important to the people of Cheshire & Merseyside through engagement events and ensure they are reflected in the delivery plan | **Jun-23** | **BAF-P3** | | |
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| **2022-25 Workforce priorities** | Systemwide strategic workforce planning to ensure a health and care workforce that is fit for the future. (Cross reference to Leadership actions below) | **Five-year plan by August 2024** | **BAF-P3/P5/P9** | **People Board** | **Chris Samosa** |
| | **Creating New Opportunities across C&M to grow our own workforce through the enhancements of our apprenticeship programmes, embed new roles, remove recruitment barriers, support work with Education, PCN development and foster greater links with primary and secondary care.** | **Strategy and development plan by December 2023** | **BAF-P3/P5/P6/P9** | | |
| | **Focus on Promoting health and wellbeing to ensure appropriate health and wellbeing support for all staff** | **Sep-23** | **BAF-P9** | | |
| | **Maximising and valuing the skills of our staff** | **Apr-24** | **BAF-P9** | | |
| | **Cultivating a positive and inclusive culture** | **Oct-23** | **BAF-P9** | | |

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| | Focus on Workforce programmes and planning for example graduate schemes, international recruitment, workforce dashboard development etc. | **Dec-23 to Mar-25** | **BAF-P9** | | |
| | Ensuring work is delivered around the digital upskilling for the wider workforce | **Mar-23 Others TBD** | **BAF-P2/P9** | | |
| | **Leadership and system organisational development with a focus on cultural transformation, talent management and leadership development (cross reference to strategic workforce planning)** | **Sep-23** | **BAF-P9** | | |
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| **System Development** | Delivery work to develop and embed an agreed operating model for our system, working alongside system partners. | **Mar-24** | **BAF-P10** | **Executive Team** | **Graham Urwin** |
| | Clinical and Care Professional leadership - work via the CCPL Steering Group (led jointly by the Nursing and Care, and Medical Directorates) to develop our Cheshire and Merseyside Clinical Strategy which will outline our shared strategic system wide priorities. | **Mar-24** | **BAF-P3** | **DTACIB** | **Fiona Lemmens** |
| | Quality improvement work with our partners to ensure that we have an aligned Clinical Quality Strategy and associated improvement plans | **TBD** | **BAF-P3** | **Q&P Committee** | **Chris Douglas** |
| | Support the delivery plans of Our Provider Collaboratives CMAST and MHLDC | **Mainly March 2024** | **BAF-5** | **Transformation Committee** | **CMAST/ MHLDC** |
| | Deliver our VCFSE Transformation Programme | **Mar-24** | **Multiple** | **Transformation Committee** | **Clare Watson** |
| | Continue work with Places to support the delegation of functions, establishing the oversight and assurance requirements which evidence and demonstrate Place leadership and discharge of the delegated duties. | **Mar-24** | **Multiple** | **Executive Team** | **Place Directors/Clare Watson/ Claire Wilson** |
| | Support system development by evolving our Commissioning and Corporate Services | **Mar-24** | **BAF-P10** | **Executive Team** | **Clare Watson** |
| | Further develop our Research and Innovation plans including the establishment of a Cheshire and Merseyside Research Development Hub. | **Mar-24** | **Multiple** | **DTACIB** | **Rowan Pritchard Jones** |

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| | Digital and Data - Implementation of the 3 goals outlined in ICS Digital and Data Strategy published in November 2022. | **Mainly from March 2024 to Mar-25** | **BAF-P2** | **DTACIB** | **John Llewelyn** |
| | Further develop our plans to support Increasing Digital Inclusion. | **Mar-23 to Mar-25** | **BAF-P2** | | |
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| **Effective Use of Resources** | **Development and delivery of a Cheshire and Merseyside a system wide financial strategy during the first half of 2023-24. *** | **Sep-23** | **BAF-P7/P8** | **Finance Investment and Resources Committee** | **Claire Wilson** |
| | Delivery of the Finance Efficiency & Value Programme plans | **March 2024 many TBD** | **BAF-P7/P8** | | **CMAST/Claire Wilson** |
| | Development and delivery of the Capital Plans | **Mar-24** | **BAF-P2/P7/P8** | | **Claire Wilson** |
| | Development of system Estates plans to deliver a programme to review and rationalise our corporate estates. | **Mar-24** | **BAF-P7/P8** | | **Claire Wilson** |
| | All Age Continuing Care- Design and implementation planning of an optimised Hybrid operational structure to enable effective, efficient, and equitable performance for Cheshire and Merseyside. | **Nov-23** | **BAF-P4/P8** | **Executive Team** | **Chris Douglas** |
| | Clinical Policy Harmonisation - Develop and implement a single suite of commissioning policies across Cheshire and Merseyside so that the commissioning of these services is consistent and applicable across Cheshire and Merseyside. | **Oct-24** | **BAF-P4/P8** | **Executive Team** | **Clare Watson** |
| **Our Place Plans (Detail on delivery dates see Place plans)** | | | | | |
| | **Core Areas of Focus** | **Delivery By** | | **Enablers** | **Place Director** |
| **Cheshire East** | Cheshire East is a place that supports good health and wellbeing for everyone | Detail in Place Plans | | People and Leadership (Workforce), Digital Solutions, Business Intelligence, | **Mark Wilkinson** |
| | Our Children and Young People experience good physical and emotional health and wellbeing. | | | | |
| | The mental health and wellbeing of people living and working in Cheshire East is improved | | | | |

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| | That more people live and age well, remaining independent and that their lives end with peace and dignity in their chosen place | | Communications and Engagement, Estates and Finance. | |
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| **Cheshire West and Chester** | Increasing Self-Care and Peer Support – supporting Communities to flourish and managing people in their own homes. | Detail in Place Plans | People, Finance/Resources, Communications and Engagement (including the development of a Local Voices Framework), Estates, Business Intelligence and Digital | **Laura Marsh** |
| | Building Community Care - development of Integrated multi-disciplinary teams and supporting people in crisis to remain at home, enabling safe discharge. | | | |
| | Reducing reliance on the Acute sector/bed-based care – Improving flow including Health led interventions to reduce admissions. | | | |
| | Complete Clinical Services Review and implement any recommendations | | | |
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| **Halton** | To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community-based support and ensuring high quality services for those who need them. | Detail in Place Plan | One Halton Place Based Partnership Board<br><br>Leadership, Oversight and Delivery | **Anthony Leo** |
| | **Wider Determinant of Health:** Improve the employment opportunities for the people of Halton in particular where it affects children and families. | | | |
| | **Starting Well:** Enabling Children and Families to live Healthy Independent Lives. | | | |
| | **Living Well:** Provide a supportive environment where systems work efficiently and support everyone to live their best life. | | | |
| | **Ageing Well:** Enabling Older Adults to live Full Independent Healthy Lives. | | | |
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| **Knowsley** | Enabling people to live healthier more independent lives through high quality seamless care. | Detail in Place Plan | Knowsley Healthier Together Board Planning, Estates, Finance, Digital and Medicines Management. | **Alison Lee** |
| | With a thriving inclusive economy with opportunities for people and business | | | |
| | With welcoming vibrant neighbourhoods and town centres | | | |
| | Where people are active and healthy and have access to the support, they need | | | |
| | Where people of all ages are confident and reach their full potential | | | |
| | Where safe and strong communities can shape their future | | | |
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| **Liverpool** | System redesign of the whole urgent care pathway to improve flow, patient experience and sustainability – right care, right place, right time | Detail in Place Plan | One Liverpool<br><br>Engagement and Co-Production, Research and Innovation, Data & Digital, Estates and Quality & Performance | **Mark Bakewell** |
| | Improve population health and reduce inequalities through prevention and anticipatory care, focused on 5 cohorts of our population | | | |
| | Implement the opportunities identified in the Liverpool Clinical Services Review of acute and specialist services. The objective of the Liverpool Clinical Services review is to realise opportunities for greater collaboration between acute and specialised trusts to optimise clinical pathways in acute care in Liverpool. There are three critical priorities out of the 12 opportunities | | | |
| | Strengthen integrated working arrangements at place with system partners to align plans, resources, governance to support delivery | | | |
| | Making best use of resources for financial sustainability | | | |
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| **Sefton** | A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future | Detail in Place Plan | Clinical and Care Leadership<br>Communications and Engagement<br>Digital<br>Estates | **Deborah Butcher** |
| | Reducing health inequalities: We recognise there are stark differences in the quality and length of life across Sefton and that we need to work together to prioritise those who stand to gain the most. | | | |

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| | Service transformation: We know our provider partners are under increasing pressure and that we have to radically transform how we deliver services to local people.<br>Community first: We recognise our communities have a vital role in improving their health and wellbeing and we are committed to working with them and co-producing solutions together. | | Medicines Optimisation<br>Organisational Development<br>Population Health Management | |
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| **St Helens** | One Place, One System, One Ambition - Improving people's lives in St Helens together.<br>Bringing people closer together, by tackling health inequalities in St Helens<br>Ensure Children and Young People Have a Positive Start in Life<br>Promote Good Health Independence and Care Across Our Communities<br>Create Safe and Strong Communities and Neighbourhoods for All<br>Support a Strong, Thriving, Inclusive and Well-Connected Local Economy<br>Create Green and Vibrant Places That Reflect our Heritage and Culture<br>Be a Responsible Council | Detail in Place Plan | Digital Transformation<br>Population Health Management<br>Workforce | **Mark Palethorpe** |
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| **Warrington** | **Starting Well:** Every child should have the best start in life. The best start in life is about good physical and mental health for every child, about children being safe and growing up in settled families, about getting the best from school and education so they can lead successful adult lives. We want Warrington to be a place where children enjoy their childhoods and go on to achieve great outcomes.<br>**Staying Well:** Tackling the wellbeing factors and wider determinants that impact poor health including obesity and alcohol, focussing on improving outcomes for people experiencing poor mental health and | Detail in Place Plan | Communication and Involvement, Digital, Estates, Workforce and Business Intelligence. | **Carl Marsh** |

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| | those with learning disabilities and/or autism, additionally we will support those that are experiencing poverty. | | | |
| | **Ageing Well:** Supporting people to live at home for longer. This theme will focus on<br>developing the Single Front Door to support the delivery of interconnected services by directing residents/patients to services who have the skills, expertise, and capacity to care for them. Embedding a proactive care approach, maximising virtual wards, enhancing care in care homes, ensuring successful transfer of care when people move between care interfaces and supporting people to die with dignity. | | | |
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| **Wirral** | The Wirral Health and Care Plan is a collaborative plan for how as health and care organisations we will work together to progress with our agreed priorities. | Detail in the Place Plan | Workforce, Digital maturity, Estates and sustainability and Medicine Optimisation. | **Simon Banks** |
| | Organise services around the person to improve outcomes. | | | |
| | Maintain independence by providing services the closest to home. | | | |
| | Reducing Health Inequalities across the Wirral population | | | |
| | Provide seamless and integrated services regardless of organisational boundaries | | | |
| | Maximise the Wirral Health and Care Pound | | | |
| | Strengthen the focus on wellbeing including greater focus on prevention and Public Health | | | |
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| ** Board Assurance Framework (BAF) Principal Risks | |
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| **Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access, and Experience** | |
| P1: The ICB is unable to meet its statutory duties to address health inequalities | |
| P2: The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities | |
| **Strategic Objective 2: Improving Population Health and Healthcare** | |
| P3: Service recovery plans for Planned Care are ineffective in reducing backlogs and meeting increased demand which results in poor access to services, increased inequity of access, and poor clinical outcomes | |
| P4: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience | |
| P5: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals, and social care) results in patient harm and poor patient experience | |
| P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population | |
| **Strategic Objective 3: Enhancing Quality, Productivity and Value for Money** | |
| P7: The Integrated Care System is unable to achieve its statutory financial duties | |
| P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services | |
| P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives | |
| **Strategic Objective 4: Helping the NHS to support broader social and economic development** | |
| P10: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population | |

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## 29 June 2023

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| **Agenda Item No** | ICB/06/23/11 |
| **Report author & contact details** | Tony Mayer – Provider Collaborative Director - Mental Health, Learning Disabilities and Community Services Provider Collaborative |
| **Report approved by (sponsoring Director)** | Professor Joe Rafferty, Partner Member |
| **Responsible Officer to take actions forward** | Tony Mayer via ICB executive group |

# Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24

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| **Executive Summary** | The report sets out Cheshire and Merseyside Mental Health, Learning Disabilities and Community Service (MHLDC) Provider Collaborative's delivery priorities for 2023/24.<br><br>The delivery areas form part of the ICB's operational plan and reflects national planning expectations and aspirations.<br><br>The work programme has been discussed extensively with system Partners including the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST), Place teams, Local Authority and Primary Care. There has been effective dialogue over the past 12 months and this engagement will continue and increase as work progresses.<br><br>The work plan detailed within this paper is a result of stakeholder interviews and workshops with key system partners to understand and align priorities and to ensure that the collaborative identify the right areas that will support activity where an at scale approach is beneficial.<br><br>Whilst the need for ongoing engagement is recognised it is clear that there is now widespread acceptance of the potential benefits of working at scale and of the opportunities that the MHLDC provider collaborative can offer within the Cheshire and Merseyside Integrated Care System (ICS).<br><br>This paper describes the work of the collaborative, the next areas of focus and the requirement for further and ongoing discussions with system partners<br><br>The MHLDC work plan consists of six programmes of work with the following objectives:<br><br>**Access to Care**<br>i. Addressing waiting times for adult and children and young people community and mental health services through the development of comparable waiting time data and monitoring processes across organisations with a planned reduction in overall wait times.<br><br>ii. A documented gap analysis of the unwarranted variation across Cheshire and Merseyside to be delivered to Place teams for information and consideration. This gap analysis will also identify fragile services within community and mental health services that |

are at risk of failing to deliver contractual requirements if no action is taken. The MHLDC provider collaborative will provide information to the ICB via Place on potential solutions to these issues for consideration and discussion that may in some cases require an at scale response

**iii.** The development of clinical networks between small and vulnerable services that allows the sharing of best practice between specialist practitioners and reduces the risk of services being unable to deliver due to short or medium term staffing issues

**Community Urgent Care:**

i. Continued delivery of the Cheshire and Merseyside wide intermediate care project recognising the multi-agency / multi-sector involvement required for delivery and the need to work with place. This will deliver a consistent approach to intermediate care data for the system and a platform from which improvements in the efficiency and efficacy of intermediate care can be made.

ii. Increasing utilisation of urgent community response (UCR) services and providing a navigable pathway for North West Ambulance Services and other service users that will allow direct access to appropriate services within the community across Cheshire and Merseyside. The provider collaborative will provide shared accountability for the provision of UCR services

iii. Reduce response time for access to the Urgent Community Response service to meet the local and national requirements

iv. Working with the CMAST Provider collaborative to identify future areas or system initiatives that will help to reduce avoidable admissions into acute care and allow patients to remain safe and well in their usual place of residence.

**Community Services for Children and Young People (CYP)**

i. Identify areas of unwarranted variation in children's community services and provide information to commissioning authorities of the service and, where available, evidence of opportunity for improvement through adoption of best practice.

ii. As a partner within the Beyond programme and the emerging Children's Board for Cheshire and Merseyside, work with partners to reduce waiting times for community and mental health services and improve the quality safety and sustainability of children's services delivered by the provider collaborative member organisations

**Mental Health Transformation**

i. Delivery of the MH Long Term Plan objectives for Cheshire and Merseyside
ii. Increased access to mental health crisis teams to reduce avoidable inpatient admissions and deliver early intervention treatment and support within the community

iii. Align performance data for mental health services between the three providers within Cheshire and Merseyside to allow comparison of outcomes and a risk sharing approach to mental health services in Cheshire and Merseyside

iv. Work with wider system partners on addressing the current and emerging pressures within MH delivery and reduce the adverse outcomes and duplication of effort from previous models of disparate practice

v. Utilise the benefits of partnership working to ensure the best use of inpatient facilities and reduce out of area placements.

**Population Health Management**

i. Working within the ICB population health management workstream to bring expert knowledge and experience from providers of community, learning disability and mental health services to the joint programme

ii. Utilise SystemP data to identify population cohorts who would most benefit from enhanced community and MH services and provide information to Providers and Place teams.

iii. Review areas of best practice within community and MH services related to reducing health inequalities and share this with member organisations.

**Workforce:**

i. Develop new community and mental health roles, introducing competency frameworks and rotations to build flexibility and providing new models of support for clinical placements.
ii. Identified opportunities for training and development delivered at scale, and will work with education providers to design new approaches to the delivery that meet the needs of the future community, mental health and LD workforce.
iii. A focus on future workforce supply, developing a cadet scheme to bring young people from diverse backgrounds into our services at the earliest opportunity

<table>
<tr><td></td><td colspan="5">iv. Work with our wider community partners across all the Cheshire & Merseyside places, including social care, primary care and the third sector, to maximise the impact and flexibility of the community workforce in its widest sense, exploring opportunities for expanding new initiatives such as Community Support Workers, putting prevention and health promotion at the heart of our approach.<br>v. We will identify specific health and wellbeing issues affecting mental health, learning disability and community staff and test out effective solutions to roll out across the region<br>vi. Collaborative recruitment campaigns and removal of competitive practice between organisations in attracting staff<br><br>In addition to the six programmes of work described, the MHLDC Provider collaborative will work with the CMAST collaborative on the joint Efficiency at Scale Programme:<br><br>Finance, Efficiency and Value (efficiency at scale):<br>i. Medicines management will deliver an estimated £10m of savings in 2023/4<br>ii. Procurement initiatives have the potential to deliver savings of up to £5m in 2023/4<br>iii. The finance workstream has the potential to release up to £1m in savings in 2023/4.</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>X</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:<br>• NOTE the approach and progress made by the MHLDC Provider Collaborative and to ENDORSE the commitments made in the work plan as part of C&M’s wider delivery undertakings.</td></tr>
<tr><td>Key issues</td><td colspan="5">Outlined within the Executive Summary</td></tr>
<tr><td>Key risks</td><td colspan="5">Competing urgent operational pressures – Operational pressures within all provider organisations limits the ability to be able to focus on transformational work and therefore progress is dependent upon available capacity of existing workforce.<br><br>Programme resource is impacted by financial constraints imposed on the system. Delivery is also influenced by wider system dependents such as increased activity, revised national and regional directives.<br><br>Partnership working – Community and MH services are often delivered in collaboration with other system partners such as primary care, local authority, voluntary sector, and acute hospital providers. The requirement for joint working and engagement can, at times, delay progress.</td></tr>
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| | Any further or continuing industrial action also has the potential to disrupt planned delivery. |
| **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 |

| | |
|---|---|
| **Route to this meeting** | The information within this report has been considered by the collaborative's member organisations subsequent to wider stakeholder mapping and engagement work. The collaborative's work plan has been discussed extensively in one-to-one interviews and through a number of workshops conducted throughout 2022 / 2023.<br><br>Key stakeholders who have helped to inform and develop this work plan have been primary care leaders, Place teams, local authority chief executives, directors of adult social care and directors of children's services and the ICB executive.<br><br>Many of the objectives are included within and drawn from the Cheshire and Merseyside operational plan which has required and been built from substantial engagement including pan Cheshire and Merseyside teams, ICB and Place representatives. |
| **Management of Conflicts of Interest** | It is not considered that there are any conflicts of interest in delivery and development of this report. |
| **Patient and Public Engagement** | The MHLDC provider collaborative works with and through its members who are key parts of their local communities and Place. The MHLDC collaborative is a delivery partner within the ICS and as such engages with the ICB and Place on their communication of delivery imperatives and priorities such as those within the C&M operational plan.<br><br>The work plan does not contain matters of substantial service change or variation and as such does not require consultation.<br><br>The majority of our activities are focused on improving service resilience, enhancing choice and access, and reducing patient waiting times for treatments and therefore reducing service inequalities and increasing equity. |
| **Equality, Diversity, and Inclusion** | It is not considered that an EIA needs to be completed to support the work plan. An equalities focus is embedded within our programmes. Further commentary on our delivery on equalities is noted above. |
| **Health inequalities** | As above |
| **Next Steps** | The work programme delivery is ongoing and in train, a regular monthly update to partners is planned for 2023/24 detailing progress against the work plan and associated key metrics |
| **Appendices** | **Appendix One:** MHLDC Position Statement & Annual Work Plan |

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## MHLDC Annual Work Plan

**Appendix One:** **MHLDC Position Statement & Annual Work Plan**

Alder Hey Children's NHS Foundation Trust | Bridgewater Community Healthcare NHS Foundation Trust | Cheshire and Wirral Partnership NHS Foundation Trust | Countess of Chester Hospital NHS Foundation Trust | East Cheshire NHS Trust | Mersey Care NHS Foundation Trust | Mid Cheshire Hospitals NHS Foundation Trust | St Helens and Knowsley Teaching Hospitals NHS Trust | Wirral Community Health and Care NHS Foundation Trust

# CHESHIRE AND MERSEYSIDE
# Mental Health, Learning Disabilities and Community Services (MHLDC)

# POSITION STATEMENT
# And
# WORK PLAN 2023/24

## 1. Introduction

The health and care system in England was designed in 1948 to deliver episodes of care to normally healthy people. Despite massive social, economic, technological and demographic change since then, the health system of today is still based on this premise, with an implicit focus on hospital-based care and separate organisations (17 NHS provider trusts in Cheshire and Merseyside) treating patients as a series of separate episodes of care. We see increasing demand for hospital care compounded by the lack of alternative provision in the community. As a system we are not geared to caring for the most frequent users of the NHS - those with more than one long-term condition.

Mental health, learning disability and community health services play a key role in our health and care system. They keep people well at home and in community settings close to home, and support people to live independently. Providing highly-specialist care and treatment, they safely manage vulnerability and high levels of clinical risk day-in, day-out within our health and care system. Mental health, learning disability and community services develop long term relationships with service users and their carers, making them well placed to support behaviour change and enable people to do more for themselves, in turn reducing their dependency on acute hospital services. NHS providers of community, Learning disabilities and mental health services have, through necessity, built up a network of collaboration between organisations over recent years and are keen to continue to develop these relationships to improve the quality, safety and efficiency of our services.

Community services in Cheshire and Merseyside have evolved in diverse ways and have been often formed from a coalescence of what local hospitals are not doing rather than their own strategy and purpose. Together, the Cheshire and Merseyside Mental health, learning disability and community services (MHLDC) provider collaborative has formed a partnership of NHS provider organisations to ensure our services are fit to meet the health and care challenges of the future and make a significant contribution to place and system-wide transformation.

The NHS organisations that make up the membership of the MHLDC provider collaborative are:

1) Bridgewater Community Healthcare NHS Foundation Trust
2) Alder Hey Children's NHS Foundation Trust
3) Cheshire and Wirral Partnership NHS Foundation Trust
4) Countess of Chester Hospital NHS Foundation Trust
5) East Cheshire NHS Trust
6) Mersey Care NHS Foundation Trust
7) Mid Cheshire Hospitals NHS Foundation Trust
8) St Helens and Knowsley Teaching Hospitals NHS Trust
9) Wirral Community Health and Care NHS Foundation Trust

The Collaborative offers a wide range of opportunities for the ICB as we align priorities and operate across organisational boundaries. By bringing together the combined expertise of nine organisations to share best practice we will reduce duplication, provide expert advice, deliver cross organisational pathways of care, and reduce the inequalities in provision that represent a legacy of fragmented commissioning and provider competition.

Collectively we will galvanise the power of community services to help rebalance our health and care system by continuing to secure sustainable services as an alternative to hospital care and maximize the impact of our services to improve population health in Cheshire and Merseyside.

The MHLDC Collaborative is now at a stage of maturity whereby the benefits of the collective efforts of member organisations working together can be demonstrated. To capitalise on this success the Collaborative will set out our ambitions and aspirations for the next 12-18 months in line with the national planning requirements, the HCP strategy, and the Joint Forward Plan. The plans will focus on areas of work where benefits can be realised from an at scale approach whilst fully recognising the primacy of place and that local variation can in many cases be warranted.

The Collaborative does not seek to implement a once size fits all approach to community and mental health services and recognises that in some instances organisations working independently of one another or in bi-lateral or tri-lateral arrangements will be necessary and/or beneficial. A system architecture whereby Place provides the expertise in *what* is needed, and the Collaborative is able to provide the answer to the question of *how* it can be delivered will provide some clear benefits for Cheshire and Merseyside ICS. Providers bring expertise which when connected at scale is powerful and must be harnessed to plan and design care both across the system and in places. The relationship between the Collaborative and the nine places is pivotal to our, and their success.

The member organisations are clear about what the Collaborative can bring to the ICS that otherwise would not exist, member organisations collectively agree on the significant opportunity that the Collaborative represents with regards to increasing access, improving standards of care, sharing risk and providing mutual aid in an area that has historically struggled to attract policy attention and growth. There is agreement between members that whilst this paper focuses on priorities for the next 12-18 months there are many future opportunities to work co-operatively with partners and also to attract resource through research and development or through opportunities to bid for national programmes of work or vanguard schemes that will benefit all.

Cheshire and Merseyside benefits from the existence of two provider collaboratives that bring specific value and expertise. Each collaborative has legitimacy, and each must be respected for the distinct contribution they can make.

## 2. Our strategic objectives

The MHLDC provider collaborative represents an agreement between nine NHS provider organisations in C&M to share information and to work together in situations where it is beneficial to do so.

The strategic objectives of the Collaborative are:

- We will level-up the standards and outcomes of community, mental health and learning disability services ensuring they make a leading contribution to place and system-wide transformation.
- We will work towards a rebalance of the system by raising the clinical profile and securing investment in community based services to reduce demand for hospital services, in partnership with CMAST and other parts of the system.
- We will use population health data to understand inequalities across the system and work with commissioners and place colleagues to help address these.
- We will support the system to address the financial position through efficiencies derived at scale from our collaborative work.
- We will operate as a trusted and reliable partner in our system and with our places.
- We will transform our workforce to meet the future health and care challenges of our system.

## 3. Governance arrangements

As one of the largest ICBs nationally the system architecture of Cheshire and Merseyside is complex, the MHLDC collaborative will ensure that the governance arrangements that allow effective oversight and escalation or our work are kept to a minimum with an infrastructure that does not add additional complexity or bureaucracy.

The nature of the collaborative as a group of NHS providers working together does however require a system of clinical governance and risk management and therefore requires a formal support team that will manage a number of task and finish groups and is accountable to the collaborative for the delivery of the work programme. Other partnerships that informally engage are not being asked to make any financial contribution to this arrangement.

The task and finish groups will be made up of representatives from member organisations and, where applicable, wider stakeholders / system partners. The task and finish groups will seek to align the work of the collaborative to the current ICB infrastructure so as to ensure that there is no duplication of effort and each group is clear on its objectives, scope and remit.

The task and finish groups will report into the MHLDC Provider Collaborative Forum, made up of the chief executives (or their representative) of the nine member organisations. At this stage the Forum will hold no delegated authority from the member organisations other than that provided by the authority of its individual members. The forum will provide a route of escalation for the work stream groups and act as an advisory body.

The Forum will also oversee the mental health transformation programme, and the three lead provider collaboratives (LPCs)

Initially, membership of the forum will comprise:

- An NHS trust member chair, as chair of this Forum
- Chief Executives or their representative of each constituent NHS Trust.
- Non-executive members - drawn from the constituent NHS trusts on a rotational basis
- The Provider Collaborative Director

Additional membership of the Forum will be further discussed with stakeholders

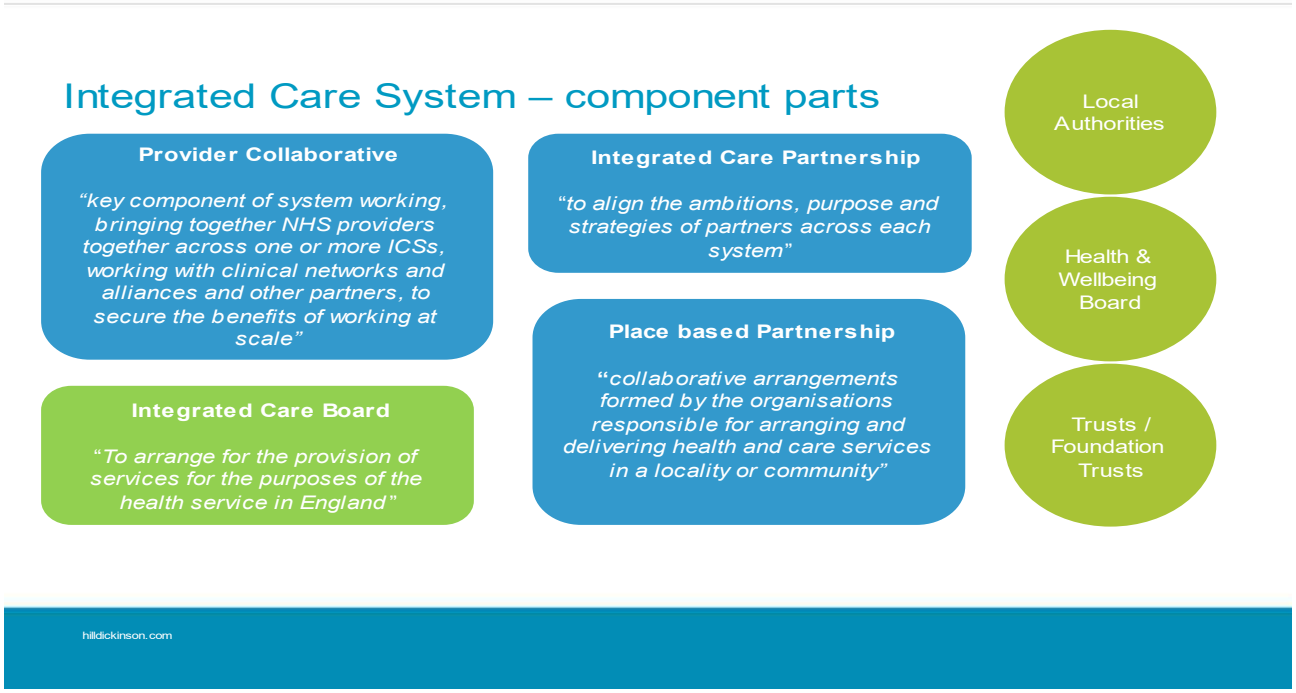
The collaborative Forum will account to the ICB, the nine Places it serves and the boards of its member

organisations. Each member organisation will continue to have statutory duties to deliver and uphold, will continue to manage their own risks, operate their own Board Assurance Frameworks, and will operate their own governance arrangements as now.

## 4. Effective engagement: making the collaborative matter to partners in place and across the system

Provider Collaboratives are an important part of the Integrated Care System structure with a requirement that all Acute and Mental Health Trusts are part of a formal Provider Collaborative and that Community Trusts are part of a collaborative when this is beneficial to service delivery.

The Component parts of an effective integrated care system are provided below:

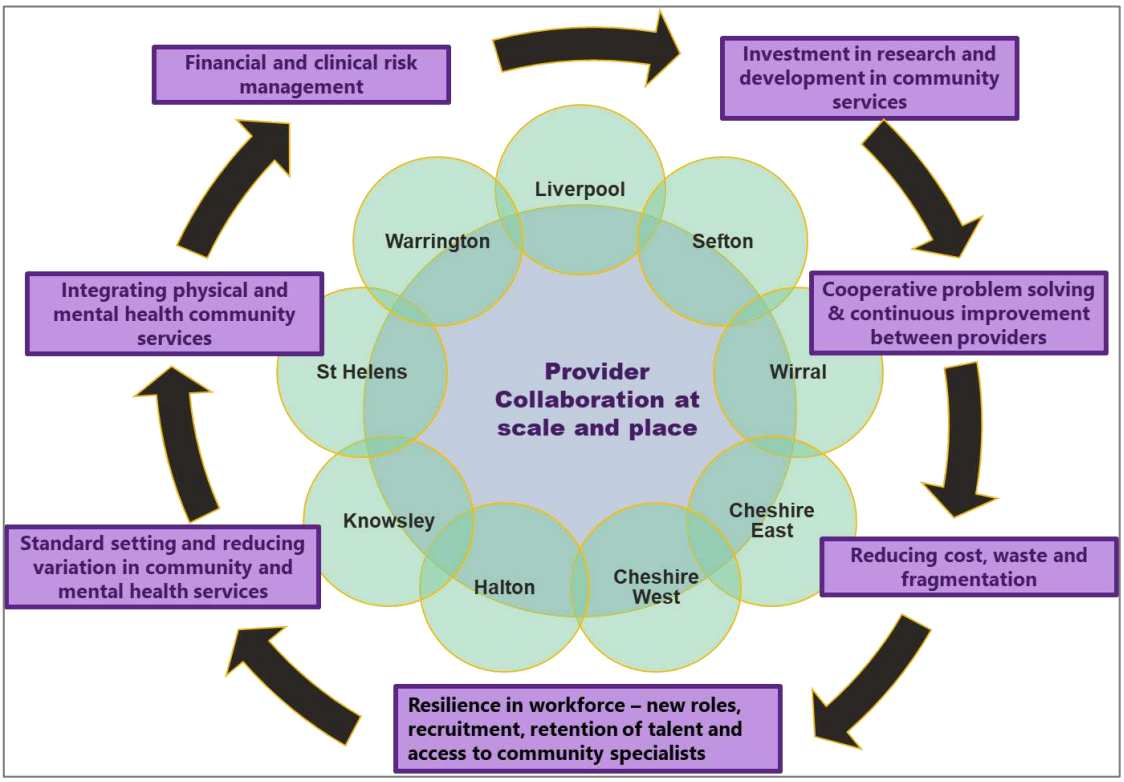



The Collaborative will seek to engage routinely with partners and stakeholders. The views of partners in primary care, local government, the voluntary sector and the acute sector are important influences.

The essence of the Collaborative will be one of facilitator and enabler of better services in Place. Each member is a partner in Place - some in several - and all activity will have been informed and influenced by the strategies and plans that have been developed by the members with their partners in Place. Collaborative priorities reinforce Place partnerships and vice versa – mutually reinforcing.

The Collaborative are committed to continuing on an ongoing basis the engagement and communication with partners, recognising the intersect between health and social care and the requirement to align priorities with the directors of adult social care and directors of children's services.

The Collaborative provides a solid foundation for the delivery of sustainable services and a resilient platform from which to hold and manage risk on behalf of the nine Places. The key areas are reflected in the diagram below.




Engagement with partners will be further enhanced through the production of a monthly bulletin for system partners and a balance scorecard demonstrating progress on key metrics.

There are a number of areas of overlap with the CMAST Collaborative particularly in relation to some of the work described later in this document related to patient flow which cannot be achieved without the support of all place partners. The synergy between the two Cheshire and Merseyside collaboratives will be described in section eight. In order to ensure the continued collaboration between all acute, community and mental health providers a regular joint Chief executive meeting has been established chaired jointly by a CEO from each of the two collaboratives with the first of these joint Collaborative Meetings set for Summer 2023.

## 5. Current work programmes

Since the autumn of 2021, the Collaborative has developed a programme of work that is predominantly focused on national priorities. This is in part a reflection of the status of the wider ICS, as it manages the transition from the previous competitive structure to one founded on integration of services at Place. It is also a pragmatic approach, supporting the development of the Collaborative as a group and increasing the confidence of members to work together on defined priorities. These include better management of capacity in its services and of flow between acute and community-based care, recovery

of community services and waiting times post-pandemic, review, and development of new models of care for urgent care services (walk-in centres / UTCs), mobilisation of national priority services (e.g., urgent community response) and design and delivery of new Covid treatments. In November 2022 the Collaborative formally adopted the Mental Health Programme for C&M that was initially established in 2016 in order to lead on those areas of MH where it was considered that an at scale approach would be beneficial.

More recently, the Collaborative has demonstrated progress with some key areas of focus such as:

*IV therapy*

The Collaborative have agreed a single site across member organisations to provide elastomeric devices to all IV at home services that will allow patients requiring more than a single treatment each day to self administer thereby increasing the availability of community nursing workforce and improving patient experience.

*Community waiting times*

The community service waiting time workstream has allowed the sharing of data on all community services between providers. The identification of areas of pressures in different areas has facilitated mutual aid and sharing of best practice approaches that have resulted in a reduced waiting time for a number of keys services. The Collaborative have worked with AQUA to align the information collected as part of the Community services Data Set (CSDS) to allow comparison of data across not just C&M but also with Greater Manchester and Lancashire and Cumbria ICBs

*Urgent Community response service*

The MHLDC Collaborative have worked with partner organisations to ensure that the Urgent community response (UCR) service meets the trajectory for the number of patients accessing the service and the achievement of the 2hour access standard. More recently the collaborative have worked with NWAS to facilitate provider organisations gaining access toe the NWAS system to allow them to identify appropriate patients at the point of contact with ambulance services as opposed to a referral after an avoidable paramedic attendance

*Intermediate care*

Optimisation of Intermediate care services is a substantial programme of work led by the Collaborative in partnership with the ICB and CMAST. It will strip back and rebuild data compiled and used during Covid 19 and identify the key messages/themes/gaps in the data required for the future. This new data profile will then support how to rebuild a new complete data set and provide the evidence for the nine Places across C&M on which to make decisions for Place or collaboration for the future of ICS. Currently it is in the deconstruction and design phase. The programme will draw from a clinical reference group comprising representation from primary, secondary, tertiary and community services and partners at Place, to agree the future definitions and design outcomes for ICS. The reference group is also connected to the national working group via its Chair.

*Mental Health Programme*

The mental health programme has made progress in a number of areas over the past 12 months:

- A single model of care for Mental Health Crisis Care (FRISS) currently being rolled out with three new Mental Health Ambulances being procured nationally due for delivery Q3 23/24

- C&M IAPT supervision hub developed to overcome supervision limitations and facilitate recruitment of required number of trainees to ensure access rates increase.
- Continued to increase access to specialist community perinatal MH services which were first established in 2018 as a single networked model for Cheshire and Merseyside
- C&M was approved as a national 'fast follower' for maternal mental health services. Co-produced with people with experience and VCSE providers to mobilise 7 months ahead of national objective
- Trainee Associate Psychological Practitioner (TAPPs) cohort two implementation commenced across C&M system improving mental health care in PCN settings

*Workforce*

The collaborative workforce group has allowed the collaborative to work together to start to address some key challenges related to workforce for community and mental health organisations. Early work has included opportunities for shared training and competency documentation as well as an agreement on the use of HEE funding to benefit member organisations as well as the wider system.

The current work programme is not enough to meet the ambitions of the Collaborative's members in respect of the level of transformation that is needed to address the significant health and care gaps that are experienced by the C&M population. We believe that the Collaborative can do much more to support the ICB's objectives in developing the strategy and planning of community, mental health and learning disability service provision in alignment with the ICB and Place.

## 6. 2023/24 work programme

The Collaborative work programme focuses on the areas identified by member organisations as opportunities to enhance the delivery of clinical services as well as the specific areas of focus detailed within the C&M HCP strategy and Joint Forward Plan. The HCP strategy links directly into the Collaborative's work programme for 2023/24 in areas such as supporting fragile services, delivering services at scale and addressing inequality through the principles in the CORE20Plus 5 Approach.

The work programme priorities for 2023/24 are:

The following sections provide further detail around the priority areas, some of which are continuing from 2022/23, some of which are new for 2023/24.

**Community Urgent Care**

The Collaborative has a vital contribution to make to the management of demand for hospital services, particular in delivering high quality, accessible alternatives to hospital admission and sharing good practice across all nine places. The following are key components of the wider community urgent care work programme.

- Urgent community response teams

  Capacity needs to be enhanced in urgent community response (UCR) teams and core two-hour access standards delivered consistently across the system. The issues being faced across all hospitals are well understood. The change required cannot be delivered by secondary care providers working independently as the solution lies outside of the hospital. Achieving this goal of improved patient flow is reliant on the system's ability to deliver care to patients in a community or home environment and to support patients who have had to be admitted to return to an appropriate place of care as safely and efficiently as possible. In Cheshire and Merseyside we will continue to strengthen the relationship between UCR teams and virtual wards.

- Intermediate care

  The Intermediate care workstream is well established and the work to date is described earlier in this document. Continuation of this workstream is essential in order to maximise the potential opportunities that can benefit the whole of the system by improving the flow of patients out of an acute hospital into an appropriate community setting. There is a significant amount of work to be undertaken within this workstream and multiple partner involvement is essential.

**Community Services for Children and Young People**

As a partner in the system with responsibility for the delivery of some aspects of CYP service the MHLDC collaborative will be an active part of the C&M CYP Board that acts as a sub-committee of the ICB with a remit to provide oversight of all of the complexity of the CYP programmes across the ICS. This CYP Board recognises the need to align the work of the two collaboratives and the Beyond programme, and will highlight the importance of children and young people as a population cohort, both in creating healthier future generations, and as a necessity for a more sustainable future system. The CYP Board will provide a central voice, addressing the complex CYP system and reducing fragmentation by connecting transformation, health and care delivery, strategic commissioning and statutory CYP requirements, with CYP and family voices and participation.

There is, in particular, a need to create a better vision for CYP community services and a real focus on what good community services should look like; the mental health and community collaborative is the ideal vehicle to take this forward and feed into the CYP Board. The benefits of this approach will be to focus specifically on the needs of children, young people and their families, identifying areas of good

practice from across providers and areas where improvement is required. By focusing on agreed outcomes, including access times, several areas that require review have emerged including SaLT, ASD, ADHD, Community nursing/virtual wards and community dentistry. In addition, the CYP Board could have oversight of all Children's Mental Health services across Cheshire and Mersey, linking in with the collaborative on delivery and supporting a more focused approach recognising the connection between mental and physical health, and Local Authority services whilst maintaining the formal governance routes required of the MH programme Board regionally and nationally.

**Access to Care, Fragile Services and Community Waiting Times**

The disparate commissioning of community and MH services through CCGs has led to a significant variation in the model and availability of clinical services across Cheshire and Merseyside, whilst this fact is recognised the extent and the detail of what this looks like and how it impacts on population health outcomes is not necessarily fully understood. The MHLDC collaborative have begun to map services in order to provide a detailed picture of community and MH services and where gaps exist. This information will help to inform ICB and Place plans and focus future resource opportunities on addressing inequality based on sound evidence.

Some of models of service collaboration may well require a new approach that allows and rewards a joint arrangement between organisations that reduces duplication or benefits from utilisation of a shared resource. An example of where this has approach been successful is the three Lead Provider Collaboratives (LPCs) for specific areas of mental health.

The length of time that patients wait for a community appointment has a direct impact on primary and hospital care as well as on the outcome for patients. It is well recognised that delays in early intervention community care will often result in the need for a hospital admission and /or an elective procedure that could have been avoided. Despite this, the waiting times for many community services are not visible or collectively monitored at a system level. The Collaborative have developed a work programme to ensure the accurate collection of waiting time data and to share best practice of areas where waiting times are lower. There is also an opportunity for mutual aid and clinical support between organisations where particular issues with prolonged waits are experienced.

**Population Health Management**

The Cheshire and Merseyside *Joint Forward Plan* highlights priority areas and opportunities to improve population health, the ability to deliver these opportunities is however often restricted by the need to address urgent daily operational issues related to emergency care. The CMAST Collaborative have rightly prioritised their work programme around urgent and emergency care access and elective recovery, this however will allow little time to focus on longer term goals of health inequality. Community and mental health providers historically have a closer relationship with Primary Care, VCSFE and Local Authority and are in a strong position to help Place based teams to tackle inequalities in population health outcomes.

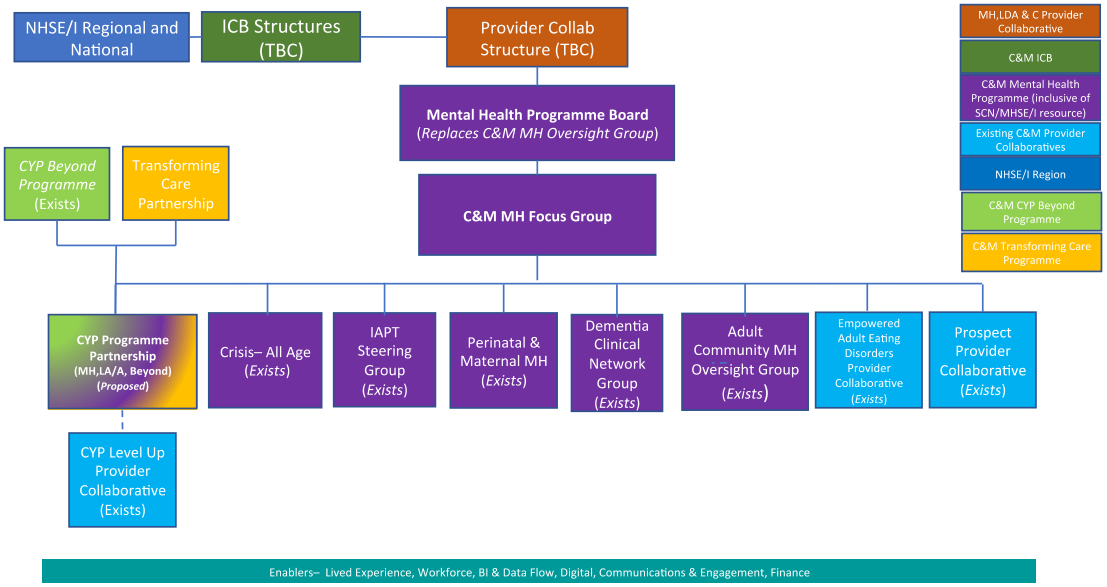
The collaborative through its membership have significant expertise and experience of designing services around the needs of population cohorts and can play a vital role working with system partners in addressing our joint responsibility to improve access to underserved communities.

The MHLDC collaborative have helped to develop the SystemP approach in Cheshire and Merseyside in addressing multiagency, multisector challenges that negatively impact population health and will help to deliver transformational change in service provision through collaborative working.

## Mental Health Transformation

The mental health transformation programme is a long standing transformation scheme focusing on those mental health service areas best delivered ‘at scale’ The programme board has responsibility to maintain and oversee all of the mental health Long Term Plan (LTP) ambitions being delivered at Place level.

The workstreams are provided in the structure below:




The programme will improve the access, experience and outcomes for groups facing inequalities in mental health and rapidly improve monitoring. Specific work is being undertaken to tackle the wider determinants of mental health, including improving access to Individual Placement and Support (IPS) Services that help people with severe mental illness find and sustain employment.

The majority of the workstreams delivered by the programme align with the Core20Plus5 and Marmot focus areas. For example, an annual health check for people with Severe Mental Illness (SMI) is one of the five key clinical priority areas for the Core20Plus5. The Mental Health programme leads liaise closely with the Core20Plus5 programme leads to ensure that combined efforts are maximised, not duplicated and both programmes are working to achieve the same objectives. Non-recurrent national funding has been received by C&M mental health to deliver tailored outreach services to support people with SMI and a task and finish group has been established to share best practice and support the development of Place-based plans to meet LTP ambitions.

## Workforce Transformation

In common with many parts of the NHS, there is a crisis in the level of clinical vacancies in some professions. Within collaborative trusts we have over 22% vacancy rates in some areas such as mental health and health visiting, coupled with sharply declining numbers of community nursing staff. Community therapy staff are becoming increasingly harder to recruit and the significant number of small specialist services, run by small teams of clinicians across substantial geographical areas, also leads to fragility due to turnover and absence. This impacts on our ability to plan and deliver services effectively, as well as affecting the morale of our valuable workforce.

In order to deliver on our wider strategic objectives as a collaborative we are committed to tackling these workforce challenges in a new and collective way. We will do this through the development of a workforce programme that seeks to build on and share existing good practice, identify shared challenges and develop solutions together rather than competitively, and use our collective resources and expertise in community and mental health services to benefit the wider workforce. The opportunities to do things together more effectively are numerous, and include:

- We will develop new community and mental health roles, introducing competency frameworks and rotations to build flexibility and providing new models of support for clinical placements.
- We will identify opportunities for training and development delivered at scale, and will work with education providers to design new approaches to the delivery, which meet the needs of the future community, mental health and LD workforce.
- We will focus on future workforce supply, developing a cadet scheme to bring young people from diverse backgrounds into our services at the earliest opportunity.
- We will work with our wider community partners across all the Cheshire & Merseyside places, including social care, primary care and the third sector, to maximise the impact and flexibility of the community workforce in its widest sense, exploring opportunities for expanding new initiatives such as Community Support Workers, putting prevention and health promotion at the heart of our approach.
- We will identify specific health and wellbeing issues affecting mental health, LD and community staff and test out effective solutions to roll out across the region

## 7. Work Programme Deliverables

The emerging workstreams for the MHLDC provider collaborative will deliver clear benefits to the C&M system and whilst the associated metrics of measurement are in development and therefore not yet available there are a number of deliverable programme outcomes for each workstream:

| | | |
|---|---|---|
| **Access to Care** | i. | Reduction in waiting times for Patients awaiting a community appointment |
| | ii. | Mutual aid agreement and establishment of clinical networks to stabilise and secure fragile services |
| | iii. | Provision of information and data to place teams that identifies areas of significant variance in the community offer potentially impacting on population health outcomes |
| **Community Urgent Care** | i. | Production of unified live data covering all Intermediate Care services |
| | ii. | Increased utilisation of Urgent Community Response (UCR) and a shared provider accountability framework for the delivery of the UCR service |
| | iii. | Enhanced UCR response times |
| | iv. | Implementation of best practice models of reducing demand on hospital services with demonstrable reduction in ambulance conveyance |
| **CYP Services** | i. | Shared clinical standards across providers for community and mental health services for children and Young People |
| | ii. | Improved waiting times for community and mental health services for children and Young people |
| **Mental Health** | i. | Delivery of the MH Long term plan objectives |

| | | |
|---|---|---|
| | ii. | Increased access to mental health crisis teams |
| | iii. | Reduction in out of area placements |
| | iv. | Aligned operational performance data for MH services within C&M |
| | v. | Improved access to care for CAMHS tier 3 / tier 4 patients |
| **Population Health Management** | i. | Work with the ICB population health team to bring expert knowledge and experience from providers of community, learning disability and mental health services to the joint programme |
| | ii. | Utilise system P data to identify population cohorts who would most benefit from enhanced community / MH services and identify opportunities to Place |
| | iii. | Review areas of best practice within community and MH services related to reducing health inequalities and share this with member organisations |
| **Workforce** | i. | Develop new community and mental health roles, introducing competency frameworks and rotations to build flexibility and providing new models of support for clinical placements |
| | ii. | Identified opportunities for training and development delivered at scale, and will work with education providers to design new approaches to the delivery which meet the needs of the future community, mental health and LD workforce |
| | iii. | A focus on future workforce supply, developing a cadet scheme to bring young people from diverse backgrounds into our services at the earliest opportunity |
| | iv. | Work with our wider community partners across all the Cheshire & Merseyside places, including social care, primary care and the third sector, to maximise the impact and flexibility of the community workforce in its widest sense, exploring opportunities for expanding new initiatives such as Community Support Workers, putting prevention and health promotion at the heart of our approach |
| | v. | Removal of competitive recruitment processes |

## 8. Joint Working with Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST)

Some members of the Collaborative are also members of CMAST as they are organisations that provide both acute and community health services. Whilst the Collaborative and CMAST have a significant shared agenda related to the prevention of acute hospital admission and timely discharge as examples, both have significant areas of focus unique to their sectors. Both collaboratives see opportunities within the shared agenda to support improvement in the delivery of services for local communities.

A particular area of focus will be continuing the work to shift those services that do not need to be in an acute hospital into community settings, including the person's own home, and to prevent people from being admitted at all whenever possible. Within the acute sector there is considerable focus on addressing the growing waiting list for elective care. For all acute trusts the ability to undertake elective activity at the volume and case mix planned is imperative for them to meet their planned activity. Often

this is not possible as non-elective activity has overflowed into capacity being held for elective care. Community and Mental health providers are a very significant part of answer to this challenge.

A joint approach between CMAST and the Collaborative will create a vibrant, dynamic, pro-active yet responsive set of community services that enables people to leave hospital when ready to do so and only be admitted when acutely unwell. Virtual wards and urgent community response, are examples of initiatives that raise the clinical risk threshold that can be managed in the community with an integrated approach between secondary and community care clinicians offering very successful mitigation. Connected services between community and secondary care will have a bigger impact in freeing up capacity for elective care than many pure elective recovery schemes.

The collaborative will work closely with CMAST in service delivery, strategy development, Workforce transformation, financial recovery and research, and innovation.

The synergies between the two Collaboratives are clear and have been reviewed and discussed. Agreement has been reached that a joint meeting between the two collaborative Boards at regular intervals will help to ensure that the work is aligned without risk of duplication of effort and ensuring that oversight of programmes is robust.

The table below demonstrates the totality of the two collaboratives work programmes and where/how the work will be managed.

*This table is provided for illustrative purposes related to project management arrangements only, it is recognised that there are interdependencies in all of the work programmes that will require consideration as each project progresses*.

<table>
<tr><th>Joint</th><th>Aligned</th><th>Independent</th></tr>
<tr><td>Virtual wards</td><td rowspan="2">Urgent community response<br>Intermediate Care<br>Community services for CYP<br>Health Inequalities<br>Workforce - Community and MH</td><td>Fragile services - Community<br>Community Access to care<br>Levelling up – Community services<br>Mental Health Transformation</td></tr>
<tr><td rowspan="2">Diagnostics<br>Efficiency at Scale</td><td rowspan="2">Elective Recovery and Transformation</td></tr>
<tr><td>Workforce - Acute and Specialist<br>Clinical Pathways</td></tr>
</table>

- C&M MHLDC Collaborative work programme
- C&M Acute and Specialist Trust Collaborative Work Programme

## 9. Next steps

Through our partnership and our joint expertise the provider collaborative are determined to deliver positive change and are committed to setting high clinical standards of care and in holding each other

to account. The ongoing engagement with partners including Local Authority, the voluntary sector and Place leadership teams is recognized and this will help to inform future workstream opportunities

The Collaborative will work jointly with CMAST on areas of shared focus that are relevant to both acute / specialist and community / MH Trusts and will connect the two Boards on a minimum of four times per annum.

The Collaborative will commence the production of a monthly update for partners on the work being performed and the resulting impact on some key deliverables via a provider collaborative performance scorecard with well-defined metrics.

# NHS Cheshire and Merseyside ICB Board Meeting

29 June 2023

## CCG Quarter 1 2022/23 Annual Report and Accounts

| | |
|---|---|
| **Agenda Item No** | ICB/23/06/12 |
| **Report authors & contact details** | Charlotte Hinchliffe, Senior Finance Manager - Planning |
| **Report approved by (sponsoring Director)** | Claire Wilson, Executive Director of Finance |
| **Responsible Officer to take actions forward** | Matthew Cunningham, Associate Director of Corporate Affairs and Governance<br>Niall O'Gara, Head of Financial Services |

# CCG Quarter 1 2022/23 Annual Report and Accounts

| | |
|---|---|
| **Executive Summary** | NHS bodies are required to publish, as a single document, an Annual Report and Accounts (ARA) prepared in accordance with the Department of Health and Social Care Group Accounting Manual. The key requirements for Quarter 1 2022/23 are that CCGs:<br><br>• Provide a draft unaudited ARA to NHS England and the CCG's external auditors by 9am on 27 April 2023<br><br>• Provide a full audited and signed annual report, as approved in accordance with the ICB (as the successor body of the CCGs) scheme of delegation and signed and dated by the Chief Executive and appointed auditors, to NHS England by 9am on 30 June 2023.<br><br>The 9 CCG's draft unaudited ARA were submitted to NHS England and external audit on 26 April 2023, in advance of the deadline. A further draft was reviewed by each Associate Director of Finance – Place in June.<br><br>The final report has been reviewed internally and externally and is recommended by the Audit Committee for approval by the Board (as the successor body) as required by the Scheme of Reservation and Delegation. |

| **Purpose (x)** | **For information / note** | **For decision / approval** | **For assurance** | **For ratification** | **For endorsement** |
|---|---|---|---|---|---|
| | | X | | | |

| | |
|---|---|
| **Recommendation** | **The ICB Board Committee is asked to:**<br>• **APPROVE** the 9 CCG Annual Reports and Accounts for submission to NHS England by 30 June 2023. |
| **Key issues** | The 9 CCG's are required to prepare and submit an Annual Report and Accounts which meet the requirements of the Department of Health Group Accounting Manual 2022-23 and directions issued by NHS England. Section 2 of the report sets out further details of these requirements and sections 3 and 4 describe the work which has been undertaken to complete the final drafts of the Annual Report and Accounts, attached at appendix 1. |
| **Key risks** | There is a risk that the ICB as the successor body is unable to meet the submission deadlines or that the CCG reports submitted does not meet the requirements. The report describes the arrangements put in place to deliver the requirements to the deadline, including the internal review process, scrutiny by NHS England and external audit to ensure requirements are met prior to final submission. |

| **Impact (x)** (further detail to be provided in body of paper) | **Financial** | **IM &T** | **Workforce** | **Estate** |
|---|---|---|---|---|
| | X | | X | |
| | **Legal** | **Health Inequalities** | **EDI** | **Sustainability** |
| | | X | X | X |

| | |
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| **Route to this meeting** | A working group led by the Head of Corporate Affairs and Governance and including representatives from Finance and Communications and Engagement has overseen the compilation of the draft Annual Report and Accounts. |
| **Management of Conflicts of Interest** | The recommendations do not present any potential conflict of interest for any members of the ICB Board. |

| | |
|---|---|
| **Patient and Public Engagement** | The Annual Report describes how the CCG's have met their statutory duties to involve the public in Quarter 1 2022/23. |
| **Equality, Diversity, and Inclusion** | The report concerns the production of the CCG's Annual Reports (and Accounts) which will not directly impact on the population or staff. |
| **Health inequalities** | The report concerns the production of the CCG's Annual Reports (and Accounts) which will not directly impact on health inequalities. |
| **Next Steps** | Following approval by the Board, the reports will be signed by the Accountable Officer and the external auditors. The full audited and signed Annual Reports and Accounts will be submitted to NHS England by the 30 June 2023 deadline. |
| **Appendices** | 9 CCG Annual Report and Accounts Quarter 1 2022/23<br>**Cheshire:** https://www.cheshireandmerseyside.nhs.uk/media/wjomcc4q/cheshire-ccg-annual-report-accounts-q1-22_23.pdf<br><br>**Knowsley:** https://www.cheshireandmerseyside.nhs.uk/media/2kvnbbo5/knowsley-ccg-annual-report-accounts-q1-22_23.pdf<br><br>**Liverpool:** https://www.cheshireandmerseyside.nhs.uk/media/pqmamnl3/liverpool-ccg-annual-report-accounts-q1-22_23.pdf<br><br>**Southport & Formby:** https://www.cheshireandmerseyside.nhs.uk/media/csykueq1/sfccg-annual-report-accounts-q1-22_23.pdf<br><br>**South Sefton:** https://www.cheshireandmerseyside.nhs.uk/media/ejccpd4z/ssccg-annual-report-accounts-q1-22_23.pdf<br><br>**St Helens:** https://www.cheshireandmerseyside.nhs.uk/media/tzaj43ne/st-helens-ccg-annual-report-accounts-q1-22_23.pdf<br><br>**Wirral:** https://www.cheshireandmerseyside.nhs.uk/media/vtijx2f2/wirral-ccg-annual-report-q1-22_23-v2.pdf<br><br>**Halton:** https://www.cheshireandmerseyside.nhs.uk/media/24za0ups/halton-ccg_annual-report-accounts-q1-22_23_draft-updated-236.pdf<br><br>**Warrington:** https://www.cheshireandmerseyside.nhs.uk/media/n15prqiy/warrington-ccg-annual-report-accounts-22-23_m03_draft-updated-236.pdf |

# CCG Quarter 1 2022/23 Annual Report and Accounts

## 1. Executive Summary

1.1 NHS bodies are required to publish, as a single document, an Annual Report and Accounts (ARA) prepared in accordance with the Department of Health and Social Care Group Accounting Manual. The key requirements for Quarter 1 2022/23 (period end 30 June 2022) are that CCGs:

- Provide a draft unaudited ARA to NHS England and the ICB's external auditors by **9am on 27 April 2023**

- Provide a full audited and signed annual report, as approved in accordance with the ICB (as the successor body of the CCGs) scheme of delegation and signed and dated by the Chief Executive and appointed auditors, to NHS England by **9am on 30 June 2023**.

1.2 The 9 CCG's draft unaudited ARA were submitted to NHS England and external audit on 26 April 2023, in advance of the deadline. A further draft has been reviewed by each Associate Director of Finance – Place in June 2023.

1.3 The final report has been reviewed internally and externally and is recommended by the Audit Committee for approval by the Board (as the successor body) as required by the Scheme of Reservation and Delegation.

## 2. Introduction / Background

2.1 The Department of Health Group Accounting Manual 2022/23 (GAM) was issued in January 2023. This sets out the requirements for NHS bodies, to publish, as a single document, a 3-part annual report and accounts (ARA).

2.2 NHS England issued further guidance regarding the process and timescales for NHS England, CCG and ICB annual reports and accounts together with an annual report template which CCGs should use. The key requirements are that each CCG:

2.2.1 Prepare an ARA in accordance with the HM Treasury's Financial Reporting Manual for the period end 30 June 2022, taking account of the application guidance contained in the Department of Health Group Accounting Manual.

2.2.2 Provide a draft of its unaudited ARA to NHS England and the CCG's external auditors by 9am on 27 April 2023

2.2.3 Provide a full audited and signed annual report, as approved in accordance with the ICB (as the successor body of the CCGs) scheme of delegation and signed and dated by the Chief Executive and appointed auditors, to NHS England by 9am on 30 June 2023.

2.3 The content and format of the reports is set out in the GAM and must comprise 3 parts as follows:

2.3.1 The Performance Report which must include an overview and a performance analysis

2.3.2 The Accountability Report which must include a Corporate Governance Report, a Remuneration and Staff Report, and a Parliamentary Accountability and Audit Report

2.3.3 The Financial Statements.

2.4 The Chief Executive is required to sign and date each part of the ARA. Authority to approve the CCGs Annual Report and Accounts is reserved to the ICB Board as the successor of the CCGs. The Audit Committee is responsible for recommending approval and the Executive Director of Finance has operational responsibility.

2.5 Assurance has been provided to the Executive Director of Finance from each Place Associate Director of Finance that they have reviewed the Annual Report and Accounts and to the best of their knowledge, the Annual Report and Accounts are a true and fair reflection of the activities for the period and that all audit queries are resolved.

## 3. Annual Report

3.1 For the CCGs in practice the production of the Annual Report was led by the Place Corporate Affairs and Governance functions, with the production of the Annual Accounts and the audited parts of the Annual Report being led by the Finance department, both teams working closely together to produce a cohesive and comprehensive report meeting all requirements

3.2 The 9 CCG draft Annual Accounts (Financial Statements) were submitted to NHS England and to the auditors by the deadline of 9:00 am on 27 April.

3.3 During May and June NHS England and the CCG's external auditors have reviewed each of the Annual Reports and provided comments. These comments have been taken on board and implemented where appropriate into the final draft presented in this paper.

3.4 The Audit Committee are asked to review and endorse the 9 final draft CCG Annual Reports in advance of the recommendation for approval by today's Board meeting.

## 4. Annual Accounts

4.1 The 9 CCG draft Annual Accounts (Financial Statements) were submitted to NHS England and to the auditors by the deadline of 9:00 am on 27 April.

4.2 The Annual Accounts are for the period 1 April 2022 to the period end 30 June 2022 and consist of:

- the primary Financial Statements, which are:
  - the Statement of Comprehensive Net Expenditure, showing how much money the CCG spent in the year
  - the Statement of Financial Position, showing the assets and liabilities of the CCG at 30 June 2022
  - the Statement of Changes in Taxpayers' Equity, which shows the reserves of the CCG, and
  - the Statement of Cash Flows, which shows how the sources of funds for the CCG and how these were disbursed on a cash basis.
- the accounting policies, setting out the policies adopted for including figures in the accounts, and
- the notes to the accounts, which sets out more detail on the figures included in the primary Financial Statements.

4.3 There are some noteworthy features of the 9 CCG Annual Accounts as follows:

4.3.1 Although the CCGs were abolished as at 30 June 2022, the financial statements of each CCG for the three months ended 30 June 2022 has been therefore prepared on a going concern basis. The Health and Care Act allowed for the ICB to take on the commissioning functions of CCGs. Therefore, as a result, the functions, assets and liabilities of each CCG transferred to the ICB meaning the services continued to be provided (using the same assets, by another public sector entity) from 1 July 2022.

4.3.2 Each of the CCGs Annual Accounts include a note detailing 'Part Period Post Balance Sheet Events', this note explains the demise of the CCGs as at 30 June 2022 and details the amounts transferred to the ICB as at 1 July 2022.

4.3.3

4.3.4 As detailed above the CCGs financial statements have been prepared for the three-month period 1 April 2022 to 30 June 2022. Comparative figures within the financial statements are for a full year and therefore not truly comparative with this shortened accounting period.

4.3.5 This is the first year that IFRS 16 has been adopted in the public sector and therefore assets that are held under lease or "right of use" such as rented buildings are capitalised (i.e. shown as assets on the balance sheet at an estimated cost/value) and a corresponding liability is shown for future payments of rent. Rent is no longer shown as an expense, but the depreciation of the asset and imputed costs of financing lease liabilities is included expenses instead.

4.4 For two of the CCG's; Liverpool and Wirral there is a 'Prior Period Adjustment' note, the note details the reason for the adjustment and outlines the restated values for 2021/22. Although CCGs were given an allocation to deliver a balance position as at 30 June 2022, the impact of Wirral's prior period adjustment has meant Wirral no longer has a balance position. As a consequence of this Wirral CCG has received a non-standard audit report.

## 5. Recommendations

5.1 The ICB Board is asked to:

- **APPROVE** the 9 CCG Annual Reports and Accounts for submission to NHS England by 30 June.

## 6. Next Steps

6.1 Following approval by the Board, the reports will be signed by the ICB's Chief Executive and the external auditors. The full audited and signed Annual Reports and Accounts will be submitted to NHS England by the 30 June 2023 deadline.

## 7. Officer contacts details for more information

**Charlotte Hinchliffe**
Senior Finance Manager – Planning
NHS Cheshire and Merseyside ICB
charlotte.hinchliffe@knowsleyccg.nhs.uk

**Niall O'Gara**
Head of Financial Services
NHS Cheshire and Merseyside ICB
n.ogara@nhs.net

# NHS Cheshire and Merseyside ICB Board Meeting

29 June 2023

## ICB Annual Report and Accounts 2022-23

| | |
|---|---|
| **Agenda Item No** | ICB/23/06/12 |
| **Report authors & contact details** | Dawn Boyer, Head of Corporate Affairs and Governance<br>Niall O'Gara, Head of Financial Services |
| **Report approved by (sponsoring Director)** | Matthew Cunningham, Associate Director of Corporate Affairs and Governance |
| **Responsible Officer to take actions forward** | Matthew Cunningham, Associate Director of Corporate Affairs and Governance<br>Dawn Boyer, Head of Corporate Affairs and Governance<br>Niall O'Gara, Head of Financial Services |

# ICB Annual Report 2022-23

<table>
<tr><td>Executive Summary</td><td colspan="5">NHS bodies, including ICBs, are required to publish, as a single document, an Annual Report and Accounts (ARA) prepared in accordance with the Department of Health and Social Care Group Accounting Manual. The key requirements for 2022/23 are that ICBs:<br><br>• Provide a draft unaudited ARA to NHS England and the ICB's external auditors by 9am on 27 April 2023<br><br>• Provide a full audited and signed annual report, as approved in accordance with the ICB scheme of delegation and signed and dated by the Accountable Officer and appointed auditors, to NHS England by 9am on 30 June 2023.<br><br>The draft unaudited ARA was submitted to NHS England and external audit on 26 April 2023, in advance of the deadline. The audit of the Accounts and required elements of the Annual Report has been concluded and the outcome is reported as part of today's agenda.<br><br>The final report has been extensively reviewed internally and externally and is recommended by the Audit Committee for approval by the Board as required by the Scheme of Reservation and Delegation.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td></td><td>X</td><td></td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The ICB Board Committee is asked to:<br>• APPROVE the Annual Report and Accounts for submission to NHS England by 30 June.</td></tr>
<tr><td>Key issues</td><td colspan="5">The ICB is required to prepare and submit an Annual Report and Accounts which meets the requirements of the Department of Health Group Accounting Manual 2022-23 and directions issued by NHS England. Section 2 of the report sets out further details of these requirements and sections 3 and 4 describe the work which has been undertaken to complete the final draft of the Annual Report and Accounts, attached at appendix 1.</td></tr>
<tr><td>Key risks</td><td colspan="5">There is a risk that the ICB is unable to meet the submission deadlines or that the report submitted does not meet the requirements. The report describes the arrangements put in place to deliver the requirements to the deadline, including the internal review process, scrutiny by NHS England and external audit to ensure requirements are met prior to final submission.</td></tr>
<tr><td rowspan="3">Impact (x)<br>(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>Route to this meeting</td><td colspan="5">A working group led by the Head of Corporate Affairs and Governance and including representatives from Finance and Communications and Engagement has overseen the compilation of the draft Annual Report and Accounts</td></tr>
</table>

| | | |
|---|---|---|
| **Management of Conflicts of Interest** | The recommendations do not present any potential conflict of interest for any members of the ICB Board. | |
| **Patient and Public Engagement** | The Annual Report describes at section 3.2 how the ICB has met its statutory duties to involve the public in 2022-23. | |
| **Equality, Diversity, and Inclusion** | The report concerns the production of the ICB's Annual Report and Accounts which will not directly impact on the population or staff. The Annual Report describes in section 3.3.5 how the ICB has met its statutory duties in relation to equality, diversity, and inclusion. | |
| **Health inequalities** | The report concerns the production of the ICB's Annual Report and Accounts which will not directly impact on health inequalities. The Annual Report describes in section 3.3 how the ICB has met its statutory duties in relation to reducing health inequality. | |
| **Next Steps** | Following approval by the Board, the report will be signed by the Accountable Officer and the external auditors. The full audited and signed Annual Report and Accounts will be submitted to NHS England by the 30 June 2023 deadline. | |
| **Appendices** | **Appendix 1** | ICB Annual Report and Accounts 2022-23<br>**CLICK HERE TO VIEW** |

# ICB Annual Report and Accounts 2022-23

## 1. Executive Summary

1.1 NHS bodies, including ICBs, are required to publish, as a single document, an Annual Report and Accounts (ARA) prepared in accordance with the Department of Health and Social Care Group Accounting Manual. The key requirements for 2022/23 are that ICBs:

- Provide a draft unaudited ARA to NHS England and the ICB's external auditors by **9am on 27 April 2023**

- Provide a full audited and signed annual report, as approved in accordance with the ICB scheme of delegation and signed and dated by the Accountable Officer and appointed auditors, to NHS England by **9am on 30 June 2023**.

1.2 The draft unaudited ARA was submitted to NHS England and external audit on 26 April 2023, in advance of the deadline. The audit of the Accounts and required elements of the Annual Report has been concluded and the outcome is reported as part of today's agenda.

1.3 The final report has been extensively reviewed internally and externally and is recommended by the Audit Committee for approval by the Board as required by the Scheme of Reservation and Delegation.

## 2. Introduction / Background

2.1 The Department of Health Group Accounting Manual 2022-23 (GAM) was issued in January 2023. This sets out the requirements for NHS bodies, including ICBs, to publish, as a single document, a 3-part annual report and accounts (ARA).

2.2 NHS England issued further guidance regarding the process and timescales for NHS England, CCG and ICB annual reports and accounts together with an annual report template which ICBs should use. The key requirements are that each ICB:

2.2.1 Prepare an ARA in accordance with the HM Treasury's Financial Reporting Manual for the relevant financial year, taking account of the application guidance contained in the Department of Health Group Accounting Manual and additional integrated care board reporting requirements specified in the NHS Act 2006 (as amended) and by NHS England

2.2.2 Provide a draft of its unaudited ARA to NHS England and the ICB's external auditors by 9am on 27 April 2023

2.2.3 Provide a full audited and signed annual report, as approved in accordance with the ICB scheme of delegation and signed and dated by the Accountable Officer and appointed auditors, to NHS England by 9am on 30 June 2023.

2.3 The content and format of the report is set out in the GAM and must comprise 3 parts as follows:

2.3.1 The Performance Report which must include an overview and a performance analysis
2.3.2 The Accountability Report which must include a Corporate Governance Report, a Remuneration and Staff Report, and a Parliamentary Accountability and Audit Report
2.3.3 The Financial Statements

2.4 The Accountable Officer is required to sign and date each part of the ARA. Authority to approve the ICB Annual Report and Accounts is reserved to the Board. The Audit Committee is responsible for recommending approval and the Director of Finance has operational responsibility.

2.5 In practice the production of the Annual Report is led by the Corporate Affairs and Governance function, with the production of the Annual Accounts and the audited parts of the Annual Report being led by the Finance department, both teams working closely together to produce a cohesive and comprehensive report meeting all requirements.

## 3. Annual Report

3.1 The ICBs Annual Report has been compiled in accordance with the GAM and NHSE/I guidance, and using the template and standard wording mandated by NHSE/I. Each section of the report has been drafted by an appropriate lead officer, collated, and edited by the Communications and Engagement Team to produce the report.

3.2 The draft unaudited Annual Report was reviewed by the ICB Executive Team and the Audit Committee, prior to submission with the Annual Accounts, to NHS England and external audit on 26 April 2023, in advance of the deadline.

3.3 This final draft report has been reviewed by the ICB Executive Team, the Audit Committee, NHSE/I and the ICB's external auditors. The report has been reviewed and updated a number of times to reflect feedback and final verified performance, staffing and financial information. Staffing and remuneration information included

in the report is, where indicated, subject to formal audit and the report of the external auditors is included on today's agenda.

3.4 The Audit Committee have been asked to review and endorse this final draft Annual Report in advance of the recommendation for approval by today's Board meeting.

## 4 Annual Accounts

4.1 The annual accounts have been prepared by management, reviewed by the audit committee in April and on 27 June and have been subject to audit by our external auditors.

4.2 The accounts consist of:

- the primary statements, which are:
  - the Statement of Comprehensive Net Expenditure, showing how much money the ICB spent in the year
  - the Statement of Financial Position, showing the assets and liabilities of the ICB at 31 March 2023
  - the Statement of Changes in Taxpayers' Equity, which shows the reserves of the ICB, and
  - the Statement of Cash Flows, which shows how the sources of funds for the ICB and how these were disbursed on a cash basis.
- The accounting policies, setting out the policies adopted for including figures in the accounts and
- the notes to the accounts, which sets out more detail on the figures included in the primary statements.

4.3 There are some noteworthy features of the first accounts of the ICB as follows:

4.3.1 Assets and liabilities of the legacy CCGs are treated as "absorbed" by the ICB on 1 July 2022 and are transferred in as an adjustment to reserves in the Statement of Changes in Taxpayers' Equity.

4.3.2 The Statement of Financial Position is the only statement to contain comparatives, and this consists of the assets and liabilities transferred in on 1 July 2022.

4.3.3 This is the first year that IFRS 16 has been adopted in the public sector and therefore assets that are held under lease or "right of use" such as rented buildings are capitalised (i.e. shown as assets on the balance sheet at an estimated cost/value) and a corresponding liability is shown for future payments of rent. Rent is no longer shown as an expense, but the depreciation of the asset and imputed costs of financing lease liabilities is included expenses instead.

4.3.4 The ICB receives a spending allocation and therefore the accounts show net expenditure and there is no “surplus” shown.

4.3.5 Although the General Fund in the Statement of Financial Position show negative reserves, public sector organisations are considered to be a going concern where the continued provision of a service is anticipated.

4.3.5 The ICB is required to make specific disclosures in relation to exit packages agreed in the financial year and these are shown in note 4.

4.3.6 Public sector organisations are required to report their compliance with the Better Payment Practice Code and this is shown in note 6.

4.3.7 Note 13 shows cash and equivalents, including a bank overdraft. This arises because the ICB has to account for any BACs run that has been made but will not clear in the bank until after the year end. The ICB met the cash target laid down for cleared cash at the 31 March.

4.3.8 The ICB inherited provisions (see note 15) from legacy CCGs. The Redundancy Provision was unutilised as the individual to whom it related secured a role elsewhere in the NHS and the Continuing Care provision was released as the accounting for this was not consistent with the accounting adopted in other legacy CCGs.

4.3.9 Note 20 shows joint arrangements which are primarily the ICB’s share of expenditure in relation to various Better Care Funds (section 75 arrangements) with local councils. The ICB accounts for its share of the spend.

4.3.10 Note 21 shows details of Related Party transactions.

4.3.10 Note 24 shows that the ICB met its financial targets in relation to spending allocations.

## 5 Recommendations

5.1 The ICB Board is asked to:

- **APPROVE** the Annual Report and Accounts for submission to NHS England by 30 June.

## 6 Next Steps

6.1 Following approval by the Board, the report will be signed by the Accountable Officer and the external auditors. The full audited and signed Annual Report and Accounts will be submitted to NHS England by the 30 June 2023 deadline.

## 7 Officer contacts details for more information

**Dawn Boyer**
Head of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB
dawn.boyer@knowsleyccg.nhs.uk

**Niall O'Gara**
Head of Financial Services
NHS Cheshire and Merseyside ICB
n.ogara@nhs.net

# NHS Cheshire and Merseyside Integrated Care Board Meeting

29 June 2023

## Primary Care Strategic Framework and the Primary Care Access Recovery Plan

| | |
|---|---|
| **Agenda Item No** | ICB/06/23/13 |
| **Report author & contact details** | Chris Leese, Associate Director of primary Care, Dr Jonathan Griffith, Associate Medical Director (Primary Care) |
| **Report approved by (sponsoring Director)** | Clare Watson, Assistant Chief Executive |
| **Responsible Officer to take actions forward** | Clare Watson, Assistant Chief Executive |

# Primary Care Strategic Framework and the Primary Care Access Recovery Plan

| | | | | | |
|---|---|---|---|---|---|
| **Executive Summary** | | | | | |
| **Purpose (x)** | **For information / note** | **For decision / approval** | **For assurance** | **For ratification** | **For endorsement** |
| | X | X | | | X |
| **Recommendation** | **The Board is asked to:**<br>• note the paper and draft Primary Care Strategic Framework and comment on the content<br>• note the engagement that has taken place and comment on this, describing any potential gaps.<br><br>The Board is asked to:<br>• approve the first two chapters of the Framework<br>• approve ongoing work to develop the final two chapters<br>• approve the development of a workplan based on the Framework to inform ongoing plans<br>• note that the final Framework with all chapters be brought to Board within the next 6 months.<br><br>The Board is also note the presentation on the Primary Care Access recovery Plan | | | | |
| **Key issues** | . | | | | |
| **Key risks** | . | | | | |
| **Impact (x)** (Further detail to be provided in body of paper) | **Financial** | **IM &T** | **Workforce** | **Estate** | |
| | x | X | x | x | |
| | **Legal** | **Health Inequalities** | **EDI** | **Sustainability** | |
| | | | | | |
| **Route to this meeting** | The detail within this paper and presentation has been discussed in detail at the cheshire and Merseyside System Primary Care Committtee. | | | | |
| **Management of Conflicts of Interest** | Members of the Committee, specifically those with an interest in GP Primary Care, will be required to raise any declarations of interest at the meeting. | | | | |
| **Patient and Public Engagement** | HealthWatch have been engaged, but no other patient engagement to date | | | | |
| **Equality, Diversity, and Inclusion** | n/a | | | | |
| **Health inequalities** | n/a | | | | |

| | | |
|---|---|---|
| **Next Steps** | Board to provide feedback, approval of work done to date, approval to continue with the final two chapters. There is then a need to create a workplan to deliver on this strategic framework<br><br>Further detail will come back to the Board at its meeting in September or November 2023. | |
| **Appendices** | **Appendix One** | Draft Cheshire and Merseyside Primary Care Strategic Framework |
| | **Appendix Two** | Cheshire and Merseyside Primary Care Strategic Framework Action List |
| | **Appendix Three** | Primary Care Access Recovery Plan Presentation |

# Primary Care Strategic Framework and Update on the Primary Care Access Recovery Plan

## 1. Executive Summary

1.1 This Primary Care Strategic Framework (Appendix One) has been written to inform future planning relating to the commissioning of Primary Care services across Cheshire and Merseyside. Ultimately the Framework will encompass all Primary Care provider, namely General Medical (GP), Community Pharmacy, Dentistry and Optometry. We have focused initially on General Medical and Community Pharmacy, with plans to quickly add Dentistry and Optometry once the initial two chapters completed. The Framework will allow us to create a Primary Care workplan to deliver on the proposed actions.

1.2 The Primary Care Access Recovery Plan has been published by NHS England. This can be viewed here: NHS England » Delivery plan for recovering access to primary care. We will provide a presentation at Board to outline our approach to delivering on this plan.

## 2. Introduction / Background

2.1 Significant engagement has taken place in the creation of the Strategic Framework. Drafts have been taken on more than one occasion to the Primary Care Providers Leadership Forum, have been discussed with Local Medical Committees as well as Local Pharmaceutical Committees and Local Pharmaceutical Networks. In addition we hosted a meeting where all Primary Care Network Clinician Directors were invited to discuss the framework and contribute thoughts. A survey has also been sent to all General Practitioners and Community Pharmacists and the results used to inform the paper. We have also spoken with Healthwatch, with the Place Clinical Directors and Place Directors have been invited to comment. Feedback from all of the groups and individuals outlined above have been taken into account as the document has been drafted.

2.2 We are grateful to the Innovation Agency who have helped significantly in terms of their help in hosting meetings, distributing the questionnaire and collating responses as well as help in pulling together the document into the format we now see.

## 3. Main Body

3.1 The Framework is set out as four chapters, one each for the four Primary Care Contractor Groups. Each chapter is then subdivided into Framework Topics. Each

topic has two pages, the first of which outlines the issue, our ambition, the challenges and links to any relevant guidance. The second page describes our aims, both at a system level and with suggestions for Place based plans.

3.2 The Framework Topics are as follows:

- Commissioning, contracting and funding of Primary Care Services
- Population Health and Health Inequalities
- Improving Access
- Quality, performance, assurance and safety
- Role of General Practice
- Integration and partnership working
- Workforce and OD
- Infrastructure and intelligence
- Working with patients
- Research, innovation and future models of delivery.

3.3 The Framework is intended to be a living document that will need to flex according to prioritised needs as well as to reflect any national policy changes.

3.4 There are a number of aims and intentions for the ICB described in the Framework. These have been pulled together into a single list (Appendix Two) which outlines intended timelines. While this appears to be a very long, potentially unachievable list we believe that a number of the actions are already being considered either within the Primary Care Team or with or teams such as Medical Directorate, Digital, Quality etc

3.5 The Primary Care Access Recovery Plan can be seen referenced in the relevant sections of the Strategic Framework. There are key asks of NHSE to the ICB with regard to this plan. We will provide a presentation (Appendix Three) to Board outlining our approach to this.

## 4. Recommendations

4.1 The Board is invited to:

- Note the paper and draft Primary Care Strategic Framework and comment on the content
- Note the engagement that has taken place and comment on this, describing any potential gaps.

4.2 The Board is asked to:

- Approve the first two chapters of the Framework
- Approve ongoing work to develop the final two chapters

- Approve the development of a workplan based on the Framework to inform ongoing plans
- Note that the final Framework with all chapters be brought to Board within the next 6 months.

4.3 The Board is also asked to note the presentation on the Primary Care Access recovery Plan.

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## Primary Care Strategic Framework and the Primary Care Access Recovery Plan

**Appendix One:** draft Primary Care Strategic Framework

# Cheshire & Merseyside Integrated Care Board

## *Draft*

## Primary Care Strategic Framework

29th June 2023

# Contents

# Introduction

Most NHS contacts take place within Primary Care which has an important role in managing both minor illness and chronic, complex conditions. There is also a much-needed gatekeeper function without which secondary care would be quickly overwhelmed.

This Primary Care Strategic Framework will encompass all of primary care and not just General Practice. We will need all NHS services to be working well together to deal with the challenges being faced. This framework is therefore made up of 'Chapters' to cover all Primary Care contractor groups.

Significance engagement has taken place in the development of this framework. This has included LMCs, LPCs, LPNs, Healthwatch, the Primary Care Providers Leadership Forum, PCN Clinical Directors and Place Directors and Clinical Directors. Responses from questionnaires sent to all GPs and Community Pharmacists has also been incorporated. We are presenting this as a framework which will then allow each Place to create their own strategy able to address the individual needs they will have.

The following topics are thought to be key for our framework. They can be grouped as 'Service Delivery Elements' and 'Enabling Themes'.

## Framework Topics

| Service Delivery Elements |
| --- |
| Commissioning, contracting and funding of General Medical/Dental/Optometry/ Community/Pharmacy services |
| Population health and health inequalities |
| Improving Access |
| Quality, performance, assurance and safety |
| Role of General Practice/Community Pharmacy |

| Enabling Themes |
| --- |
| Integration and partnership working |
| Workforce and organisational development |
| Infrastructure and intelligence |
| Working with patients |
| Research, innovation and future models of delivery |

Jonathan Griffiths

**GP and Associate Medical Director, Primary Care**

**Cheshire & Merseyside ICB**

# Vision for Primary Care

Primary Care is the beating heart of the NHS. With around 90% of all NHS contacts taking place in Primary Care (over 1.3 million contacts in General Practice alone during March 23, our latest reported month) it is vital that we acknowledge the essential healthcare delivered in these settings. While providing an essential gate-keeper role into secondary care, Primary Care is so much more than simply 'admission avoidance' providing a service that assesses, investigates, diagnoses and manages both acute presentations and long-term conditions.

Our vision for Primary Care in Cheshire and Merseyside is for high quality services that are responsive and accessible for patients at their point of need. Traditionally Primary Care has enjoyed high levels of satisfaction and trust from patients, although we must acknowledge that recently there has been greater dissatisfaction.

There have been a number of nationally produced reports on Primary Care and specifically General Practice published recently. These include the Fuller Report, the report from the House of Commons Health and Social Care Committee and the Hewitt Report. There has also been a change to the GP Contract as well as the publication of the Delivery Plan for Recovering Access to Primary Care.

Our Primary Care Strategic Framework needs to be read in the context of the above reports and noting that fact that demand is at an all time high, with falling numbers of GPs and high levels of reported stress and burnout. It is notable that the House of Commons Health and Social Care Committee report stresses that 'general practice is in crisis'. We need to respond to this crisis and our framework outlines the areas we believe need to be focussed upon.

We will only achieve the ambitions within the Framework through true whole-system working including primary and secondary care, commissioners, local authority, our population and other key partners. The publication of the Framework does not bring this piece of work to a close, rather it launches our approach.

Together, we aspire for Cheshire and Merseyside to have the highest quality primary care that is accessible, sustainable and delivering outstanding health outcomes for our population.

NHS England » Next steps for integrating primary care: Fuller stocktake report

The future of general practice - Health and Social Care Committee (parliament.uk)
Hewitt Review: an independent review of integrated care systems - GOV.UK (www.gov.uk)

NHS England » Changes to the GP Contract in 2023/24

NHS England » Delivery plan for recovering access to primary care

# NHSE Delivery plan for recovering access to primary care

## Summary action points

**Empower patients** by rolling out tools they can use to manage their own health, and invest up to £645 million over two years to expand services offered by community pharmacy.

1. Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024. *aligned to section 1.9 action point 1.9.5*
2. Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance. *aligned to section 1.9 action point 1.9.6*
3. Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation. *aligned to section 2.6 action point 2.6.4 and section 2.8 action point 2.8.1*
4. Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription only medicines for seven common conditions. This, together with OC and BP expansion, could save 10 million appointments in general practice a year once scaled, subject to consultation. *aligned to section 2.1*

**Implement 'Modern General Practice Access'** so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message. We are re-targeting £240 million – for a practice still on analogue phones this could mean ~£60,000 of support over 2 years.

5. Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023. **aligned to section 1.3 action points 1.3.6, 1.3.9 & 1.8.20*
6. Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025. **aligned to section 1.8 action point 1.8.21*
7. Deliver training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme. **aligned to section 1.10 action point 1.10.1*

**Build capacity** so practices can offer more appointments from more staff than ever before.

8. Make available an extra £385 million in 2023/24 to employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 (compared to 2019). *NHSE action point*
9. Further expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England. *NHSE action point*
10. Encourage experienced GPs to stay in practice through the pension reforms announced in the Budget and create simpler routes back to practice for the recently retired. *NHSE action point*
11. Change local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated. *NHSE action point*

**Cut bureaucracy** to give practice teams more time to focus on their patients' clinical needs.

12. Reduce time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn. **aligned to section 1.6 action point 1.6.1*
13. Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat. *NHSE action point*
14. Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators. *NHSE action point*

# CHAPTER ONE - General Practice

## Service Delivery Elements

## 1.1 Commissioning, contracting and funding of General Medical Services

**Core Ambition:**

**We will develop commissioning models that ensure quality of service provision, joined up cross discipline working and that address unwarranted variation in service across C&M.**

**We will understand the variation in primary care funding across the ICS and develop system wide agreements to ensure equitable financial allocation that best meets the needs of local populations.**

Background:

- We need to ensure quality of service provision and eliminate unwarranted variation in service delivery.
- We need ensure that all routine chronic disease management is restored following Covid-19 and maximise NHS Health Checks as prevention or early intervention measure.
- As all parts of primary care will be commissioned by the same body there is an opportunity to assess financial flows to ensure best service provision for patients
- Large elements of Primary Care funding are set within national contracting arrangements. For General Practice this includes GMS/QOF/PCN DES/IIF/ARRS. There are Local Enhanced Services and monies invested in Primary Care from Place initiatives. There is variation across Cheshire and Merseyside with regard to these monies that has arisen from historical CCG funding decisions.
- There are different models of funding across C&M and we need to ensure that deprived areas are not worse off.

**Planning Guidance Cross Reference**

*NHSE will publish the general practice access recovery plan in the new year, as well as the themes for further engagement that will inform the negotiations for the 2024/25 contract. Delivery will be supported by funding as part of the five-year GP contract, including the Additional Roles Reimbursement Scheme. Integrated care board (ICB) primary medical allocations are being uplifted by 5.6 per cent to reflect the increases in GP contractual entitlements*

**GP Questionnaire key feedback- Investment and funding**

⇒ Equitable funding of primary care across the ICS

⇒ Early sight of investment opportunities

⇒ People need incentivising to work together towards PCN outcomes

⇒ Streamline processes for investment in estates

Future of General Practice report cross reference:

NHS England should revise the Carr-Hill formula to ensure that core funding given to GP practices is better weighted for deprivation. NHS England must also review new PCN funding mechanisms to ensure that they do not inadvertently restrict funding for areas which already have high levels of need.

## 1.1 System level actions

### Commissioning, contracting and funding of General Medical Services

| | |
|---|---|
| 1.1.1 | As an ICS we will explore and outline how future monetary allocations will be distributed – either fair shares to Place or according to need across the whole system. |
| 1.1.2 | In the first two years we will explore different funding models (such as the John Hopkins alternative to the Carr-Hill Formula) to determine the best model for our practices |
| 1.1.3 | We will lobby the central NHSE team regarding the clear need for increased funding and support to General Practice through the GP contract. |
| 1.1.4 | An innovative contracting at scale pilot to be performed within the next 3 years |
| 1.1.5 | We will urgently undertake a review of all core and non-core General Practice spending to understand the variation including a review of discretionary payments. Following this we will produce a plan describing how we will reduce this variation |
| 1.1.6 | Consider the feasibility of a pilot of gain sharing so that PCNs and Practices reducing secondary care spend can share in the financial gains |

## 1.1 Actions for Place based plans

### Commissioning, contracting and funding of General Medical Services

| | |
|---|---|
| 1.1.7 | Develop local commissioning models that are equitable across place footprints, support the areas of greatest need and deprivation and enable joined up working across disciplines, drawing on the ICB Population Health Programme. |
| 1.1.8 | Liaise with local authorities and the Cheshire & Merseyside Directors of Public Health around locally commissioned services, ensuring equity of provision and to inform prioritisation that tackles health inequalities in outcomes, experiences and access (our eight All Together Fairer principles). |
| 1.1.9 | Engage practices and the Health & Care Partnership in the work above around exploring new funding models and variation in funding across Cheshire and Merseyside |

Future of General Practice reference

*NHS England should support Integrated Care Systems to implement gain sharing so that Primary Care Networks and individual practices that support the reduction of secondary care expenditure, such as through reducing unplanned admissions, are able to share in the financial gains*.

# 1.2 Population Health and Health Inequalities

## integration with local authorities and Public Health

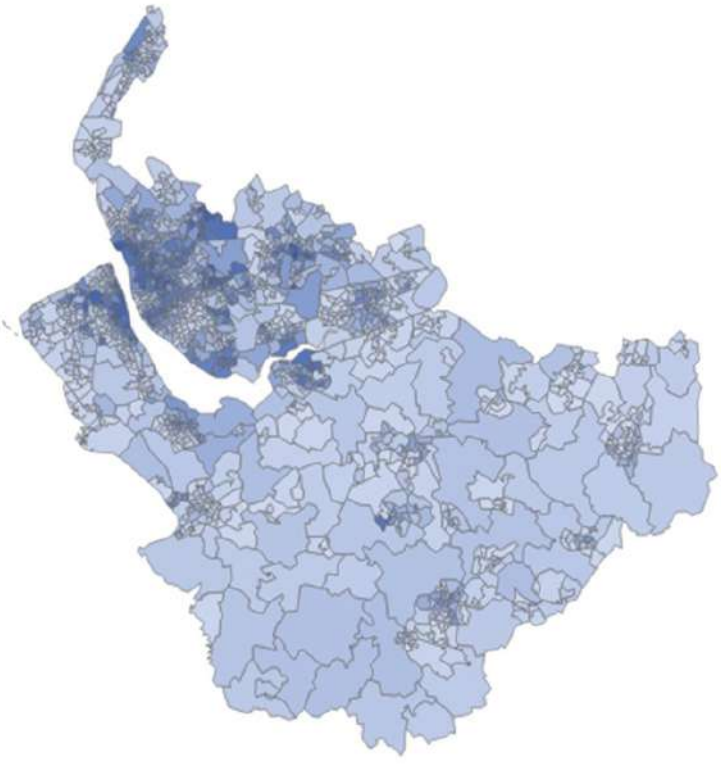
**Core Ambition:**

**Our ambition is for Primary Care Networks to develop closer and integrated working with local authority and public health teams, to contribute to the population health programme and system wide effort in tackling the wider determinants of health.**

**Background:**

- Primary Care is ideally placed to contribute to the population health programme and in tackling the causes of ill-health, to improve population health and healthcare.
- By increasing system wide collaboration with local authority and public health we can look to improve the health of the people that we serve.
- Cheshire and Merseyside ICS is recognised as a Marmot Community working to be an exemplar for system-level work on inequalities, including coordinated, consistent approaches to building healthy and inclusive economies and tackling the wider determinants of health and reducing health inequalities.
- The CIPHA data platform is a powerful tool that we can use to identify where best to focus our work to tackle the wider social determinants of health and to reduce health inequalities
- Let us acknowledge that holistic, relationship based care can deliver on tackling health inequalities through providing long term preventative medicine

INDEX OF MULTIPLE DEPRIVATION (IMD) SCORE BY LSOA



**GP Questionnaire key feedback- population health and health inequalities**

⇒ Increase focus on prevention

⇒ Target resources to reduce health inequalities

⇒ Increased business intelligence and public health support for PCNs around population health activities

⇒ GPs need to have a greater amount of time to focus on prevention chronic disease management

⇒ Focus on long term projects that may not lead to immediate change and ensure that these are funded and supported in the longer term

## 1.2 System level actions
### Population health and health inequalities

| | |
|---|---|
| 1.2.1 | Close working with Public Health teams to understand population need as well as system level integration, communication and support for PCNs to succeed. |
| 1.2.2 | The ICB will support the Deep End Cheshire and Merseyside initiative, linking this with the Population Health board and encouraging practices to engage |
| 1.2.3 | Review and develop a criteria for resource allocation based on population need and health inequality data. |
| 1.2.4 | Consider system projects to embed upstream prevention approaches in primary care.<br>For example NHS Health check Pilot learning. Collaborate with the Primary Care Prevention Pledge development, following successful NHS Trust Prevention Pledge work. |
| 1.2.5 | ICB will facilitate sharing of best practice in relation to tackling health inequalities across the ICS footprint |

## 1.2 Actions for Place based plans
### Population health and health inequalities

| | |
|---|---|
| 1.2.6 | A commitment that PCNs focus on priority prevention/inequalities conditions, as highlighted by the ICS emerging priorities, NHS operational guidance 23/24 and core20plus5. In the 2023/24 NHS operational planning document, the 'prevention and inequalities' section highlights the following ambitious goals:<br>https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/<br>• Increase percentage of patients with **hypertension treated to NICE guidance** to 77% by March 2024<br>• Increase the percentage of patients aged between 25 and 84 years with a **CVD risk score greater than 20 percent on lipid lowering therapies** to 60%<br>• Continue to address health inequalities and deliver on the **Core20PLUS5** approach as relevant to children and young people and adults. PLUS groups will be determined by each of the 9 local places in C&M. |
| 1.2.7 | Local areas will require the ability to flex their approach to align with population needs and adequate funding for this work will need to be identified |
| 1.2.8 | We will address health inequalities arising from discrimination based on any protected characteristic and link to System and Place Equality, Diversity and Inclusion work. |
| 1.2.9 | Support PCNs with consistent business intelligence/CIPHA to better understand their population health needs—working with system-wide data and intelligence capacity to maximise the use of Population Health Management information to inform local practice, decision making, and best practice research.<br>Explore how PCNs and practices can work with local system partners to tackle the wider social determinants of ill health, and address health inequalities in line with our All Together Fairer recommendations. |
| 1.2.10 | **A commitment across primary care to towards delivering population health priorities that include**<br>• smoking cessation, contributing to the SmokeFree 2030 ambition, as part of an overarching whole system strategy and pathway (to be developed)<br>• Digital Weight Management referrals<br>• Targeted NHS health checks- Build on learning from recent pilots to increase uptake of NHS HCs in priority groups with high CVD risk but low levels of engagement in preventative checks (areas of deprivation, ethnic minority groups, patients with SMI and LD)<br>• Increase uptake of annual physical health checks for patients with SMI, building on learning from innovative pilots<br>• **All Together Active**. Supporting implementation of the All Together Active strategy aimed at increasing physical activity as a way of improving population health through GP practises<br>• **Population Health Intelligence**. Utilisation of CIPHA and other tools to underpin, inform and drive a coordinated and sustainable population health management approach targeting the most impactful cohorts for prevention and high impact measures<br>• **Reducing Harm from Alcohol**. Supporting the strategic across Cheshire and Merseyside deliver preventative and treatment interventions that reduce alcohol harm and drug dependency.<br>• **Making Every Contact Count**. Embedding the philosophy of Making Every Contact Count, an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. |

# 1.3 Improving Access

**Core Ambition:**

**We want to support the national ambition to deliver best care for our patients. We want to work together with our practices to support them in ensuring that patients requiring care receive appointments within an appropriate timescale. This includes supporting practices and patients to facilitate easy contact with their practice and aspire for them to receive an appointment within two weeks.**

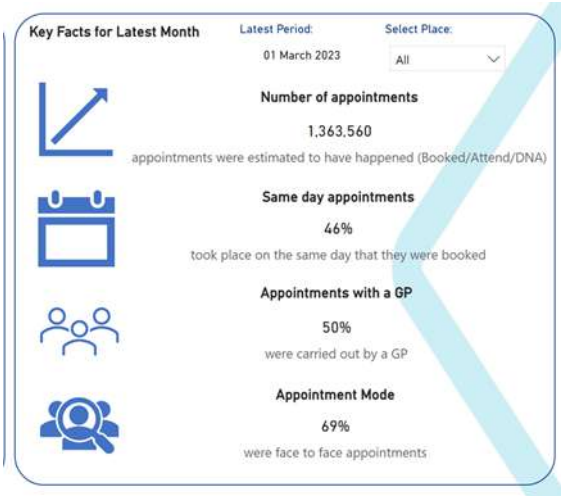
**Our ambition is for resilient services that are enabled to respond to demand spikes and with appropriate ICS escalation plans to support this.**

Background:

- In order to provide the services we offer, patients need to be able to access them.
- We need to use accurate and appropriate data to understand our access.
- Improving outcomes for patients includes improving their experience of services.
- Holistic, relationship based care helps with access

**Fuller Framework Action Point #1**

Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face




**Planning Guidance Cross Reference**

Make it easier for people to contact a GP practice, including supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need

Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024

**Reference to GP Contract Change**

NHSE has imposed changes to the GP Contract 2023-24 requiring all patients to be either signposted to a more appropriate service or receive an assessment of need on the day. This is supported by Primary Care Access Recovery Plan.

## 1.3 System level actions

### Improving Access

| | |
|---|---|
| 1.3.1 | The ICB aims to see increased satisfaction on GP Patient Survey regarding access indicators |
| 1.3.2 | The ICB will work with media to promote GP access routes to the public and inform about multidisciplinary care models. |
| 1.3.3 | The ICB will ensure enhanced system level BI modelling to allow real time data on appointment activity, demand and capacity, enabling the service to identify and respond to demand spikes. |
| 1.3.4 | The ICB will support Place and PCNs with the NHSE Primary Care Access Recovery Plan |
| 1.3.5 | The ICB will run a series of workshops around access to share best practice and explore alternative models of access into surgery e.g. Access workshop series, action learning sets, University of Manchester model of access |
| 1.3.6 | Undertake a telephony review across PCNs and support the adoption of digital telephony (aligned to GP recovery plan action point 5) |
| 1.3.7 | Improve access, triage and referral across first-contact NHS organisations including general practice (reference from House of Commons Report) |

## 1.3 Actions for Place based plans

### Improving Access

| | |
|---|---|
| 1.3.8 | Explore alternative models of access into General Practice including digital options |
| 1.3.9 | Support practices in procuring Cloud Based Telephony (aligned to GP recovery plan action point 5) |
| 1.3.10 | Develop BI modelling for activity, demand and capacity |
| 1.3.11 | Develop a local response to the national Access Recovery Plan which will include supporting practices to develop their plans for improving access in accordance with the IIF for 23-24 |

Case Study

Wilmslow Health Centre have developed a digital first triage model that works well for their patients. A clinician working alongside an admin colleague reviews all requests on the day and allocates them to the most appropriate assessment modality which could be a face to face, telephone or text response. They have high patient satisfaction rates and utilise their whole team effectively.

# 1.4 Quality, Performance, Assurance and Safety

**Core Ambition:**

**The ICB aims to have General Practice of the highest quality. We will work with Places and Practices to monitor performance and improve outcomes.**

**Background:**

- There are many metrics recorded with regard to General Practice Performance. This includes GP Access Data, prescribing data, QOF and IIF targets and CQC inspection reports.
- It has sometimes been difficult to identify which metrics should be used to best provide a measure of quality.
- The System Quality and Performance Committee and the System Primary Care Committee already receive reports relating to Primary Care.

| 1.4 | System level recommendations<br>Quality, Performance, Assurance and Safety |
|---|---|
| 1.4.1 | The ICB will produce a single dashboard bringing together relevant metrics describing GP quality and performance |
| 1.4.2 | The ICB will provide data for assurance to the System Quality and Performance Committee |

| 1.4 | Recommendations for Place based plans<br>Quality, Performance, Assurance and Safety |
|---|---|
| 1.4.3 | Places to support practice where any performance or safety issues are identified and to escalate to System where required |
| 1.4.4 | Place to monitor prescribing data and support clinicians with quality prescribing |
| 1.4.5 | Places to consider educational activities for clinicians to improve quality of care |

# 1.5 Role of General Practice

**Core Ambition:**

- **The ICB aims to have high functioning General Practice delivering quality GMS and APMS services.**
- **The ICB also aims to see high performance in QoF and IIF indicators and engaging well with other national or local enhanced services**

**Background:**

- The scope of tasks that General Practice *could* be asked to undertake is almost unlimited. GPs are therefore asking for clarity around what they *should* be doing. This includes tackling the perceived shift of work from secondary care.
- The 2018 Kings Fund publication 'Innovate Models of General Practice' describes 5 attributes that underpin General Practice (person-centred, holistic care; coordination; continuity; community focus). The paper also discussed innovative, new models of care that could be considered. These new models of care need to be reconsidered now in the light of the impact of the Covid-19 Pandemic.
- The ambition around primary care networks is complicated by a national contract that requires GPs to maintain their own practice, in effect there are individual businesses that are being asked to collaborate. Encouraging practices to work together as a PCN is a key priority. Methods to encourage PCN working need to be developed that benefit all involved.

House of Commons report Reference

*NHS England should provide Primary Care Networks with additional funding to appoint a 'continuity lead' for at least one session per week, and additional admin staff funding to support the lead in the role. The role of the continuity lead GP would be to support practices within their network to increase the proportion of patients consulting with their named or regular GP, learning from best practice around the country. There should be a specific uplift for areas of high deprivation.*

Consensus on the Primary Secondary Interface

The ICB has published it's Consensus on the Primary Secondary Care Interface. This provides high level principles that all clinicians are encouraged to follow. If adhered to this consensus would be expected to reduce unnecessary work being passed to Primary Care and streamline pathways. The consensus has been endorsed by the RCGP and received national recognition. Consensus on the Primary and Secondary Care Interface - NHS Cheshire and Merseyside

| 1.5 | System level actions<br>Role of General Practice |
|---|---|
| 1.5.1 | Within 1 year ICB to articulate a clear vision for the role of General Practice |
| 1.5.2 | ICB to identify key pathways where clarity is required regarding responsibilities. |
| 1.5.3 | The ICB will work with secondary care to deliver the 'Cutting Bureaucracy' element of the Primary Care Access Recovery Plan. |

| 1.5 | Actions for Place based plans<br>Role of General Practice |
|---|---|
| 1.5.4 | Local Primary Secondary Care Interface groups will be formed around appropriate hospital footprints to consider the Consensus document and provide clarity on local pathways |
| 1.5.5 | Encourage job-shadowing of GPs by ICB Place managers as well as secondary care colleagues. |
| 1.5.6 | Consider supporting PCNs to introduce 'continuity leads' as per the House of Commons report. |

**Quote from GP Questionnaire Response (anon):**

*"The unique role of GPs and the wider practice team is deliver person-centred care that focuses on prevention, optimization and safety. This role is enhanced and more effective when patients and families build and maintain continuity with their practice and individual clinicians. The 'Needs' are -*

*• Need #1: To jointly improve and enhance the level of holistic, person-centred care in the management of common long term conditions and frailty. This in turn will provide clarity to the wider system of the common substantial offer from all General Practices across our places.*

*• Need #2: To work collaboratively between practices, on PCN wide local or Place footprints to deliver core and enhanced general practice where needed to deliver preventative, pro-active, routine and urgent general medical care.*

*• Need #3: To develop our clinical skills and workforce, and our infrastructure to meet the changing needs of the population through collaboration and integrated working."*

# General Practice Enabling Themes

## 1.6 Integration and Partnership

Primary care networks, care communities and the interface with secondary care

**Core Ambition:**

**The ICB will work with and support PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community**

**For patients to have a streamlined experience when moving between Primary and Secondary Care and for actions to be taken by the most appropriate service in a timely way**

**The ICB to support ongoing development of Care Communities/Neighbourhood Teams**

**Develop high functioning ICB medicines management teams that work in an integrated manner with primary and secondary care**

**Background:**

- Primary Care Networks are new and essential parts of the NHS landscape. They are in prime position to improve the health of the people living in the community of their PCN geography.
- Currently there is little meaningful PCN engagement with Dentistry, Optometry or Community Pharmacy.
- The development of PCNs has created a new cohort of clinical leaders. Consideration needs to be given to how we develop these leaders and describe their role in the future clinical leadership of the ICS.
- There can be issues at the interface between Primary and Secondary Care and patients can find themselves stuck in the gaps between services.

**Fuller Framework Action Point #3**

*Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams.*

**Fuller Framework Action Point #4**

Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates.

**Primary Care Access Recovery Plan Reference**

**'Cut Bureaucracy'**

*Reduce time spent liaising with hospitals – by requiring ICBs to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn.*

**House of Commons Report Reference**

*The Government should commission a review into short-term problems that constrain primary care including, but not limited to: the interface between primary and secondary care, prescribing from signing to dispensing, administrative tasks e.g. reports and sick notes, day-to-day usability of IT hardware and software, and reviewing of bloods, pathology and imaging reports.*

## 1.6 System level actions

### Integration and Partnership

| | |
|---|---|
| 1.6.1 | Report progress on improving the interface between primary and secondary care to the ICB board (aligned to GP recovery plan action point 12) |
| 1.6.2 | The ICB will support Place and PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community |
| 1.6.3 | We commit to the nurturing and development of PCN leaders and to describe their role in the future clinical leadership of the ICS |
| 1.6.4 | Consider developing a reporting tool for GPs to report inappropriate workload transfer |
| 1.6.5 | To provide proactive support for the Consensus on the Primary secondary Care Interface |
| 1.6.6 | The ICB to develop an ICB medicines management target operating model |

## 1.6 Actions for Place based plans

### Integration and Partnership

| | |
|---|---|
| 1.6.7 | Clearly articulate what is being asked of PCNs against what is being asked of General Practice |
| 1.6.8 | Support practices in identifying service areas where they can work together |
| 1.6.9 | Assess the areas where we can support PCNs to develop a model of health care delivery that is proactive rather than reactive. |
| 1.6.10 | Developing joined up care pathways and considering multidisciplinary ‘one stop shop’ clinics, working together to overcome barriers. This could include streamlined information sharing and referrals—reducing bureaucracy |
| 1.6.11 | Exploring the possibility of shared contracts to enable partners to work better together |
| 1.6.12 | Encourage ongoing development of Care Communities/Neighbourhood teams to work with local partners and address local needs and the wider determinants of ill health |
| 1.6.13 | Develop primary secondary care interface groups (as 1.5.4) |
| 1.6.14 | Implement the ICB medicines management target operating model across Place when agreed |

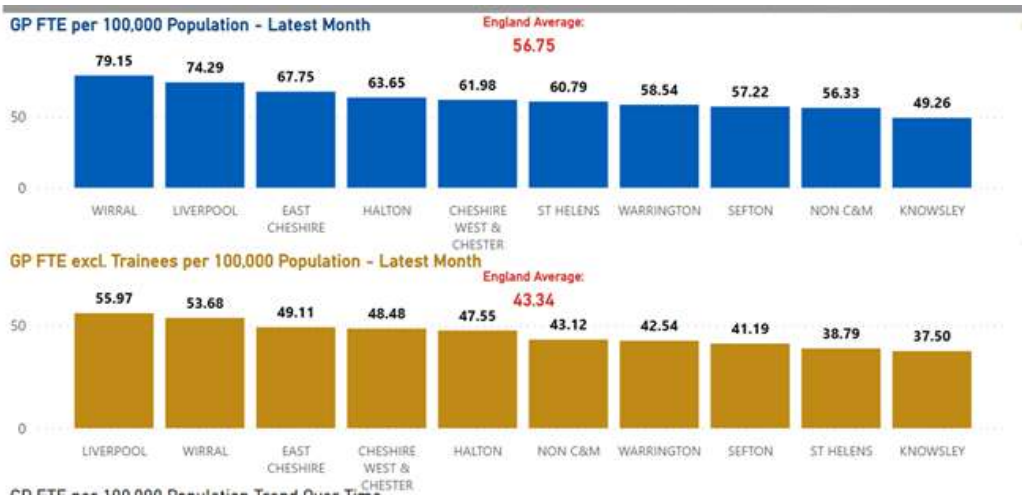
# 1.7 Workforce and Organisational Development

## Core Ambition:

**We will develop a system level primary care workforce plan, understanding the current situation and forecasting for future delivery models. System plans will be created to address expected gaps in workforce provision. Our primary care workforce will be embedded throughout our ICS governance and leadership to influence and support system planning.**

## Background:

- We have a Primary Care workforce crisis and we need to determine how the C&M system can support the workforce challenge. We need to understand the current situation, map ahead to forecast our likely future state and plan for any expected gaps.
- Four key enablers for action derived from the NHS People Plan have been identified to cultivate the landscape for a one workforce / whole systems approach to primary care workforce resilience; Looking after our people, belonging in the NHS, growing for the future and new ways of working and delivering care.
- The PCN Clinical Director workload has increased hugely and it is difficult to divide PCN CD role and GP role.
- There is variation in the GP FTE from place to place which may contribute to differing access rates across C&M.




## Planning Guidance Cross Reference

Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024

## GP Questionnaire key feedback - Workforce

- ⇒ Focus on retention including flexible working opportunities
- ⇒ Make GP a more attractive working environment e.g. portfolio careers
- ⇒ Develop a primary care workforce strategy
- ⇒ Looking after our staff is vital
- ⇒ Multidisciplinary staff roles with the right patient seeing the right professional

**Future of General Practice Reference**

*The Government should accelerate plans to allow GP partners to operate as Limited Liability Partnerships or other similar models which limit the amount of risk to which GP partners are exposed.*

Case Study

Merepark Surgery in Alsager have recognised the importance of investing in their staff. Through a positive appraisal process for employees and regular team-building/social activities they have a happy, sustainable workforce.

**Fuller Framework Action Point #6**

Embed primary care workforce as an integral part of system thinking, planning and delivery. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.

## 1.7 System level actions

### Workforce and Organisational Development

| | |
|---|---|
| 1.7.1 | A system level primary care workforce plan including future delivery models will be co-produced and based upon accurate primary care workforce data analytics and activity modelling. |
| 1.7.2 | Targeted recruitment campaigns will be developed including promoting C&M as an attractive place to work |
| 1.7.3 | We consider the feasibility of developing C&M recruitment incentive schemes including schemes that align GP careers with secondary care to give a more flexible/portfolio career. |
| 1.7.4 | Consider developing flexible working practices for primary care staff, including more joint roles and opportunities for rotational roles. Enable the flexible deployment of staff across employing organisation, network & system boundaries using digital solutions |
| 1.7.5 | Consider the development of a collaborative primary care staff bank to increase capacity across primary care and create a new offer for local GPs / nurses etc wanting to work flexibly. |
| 1.7.6 | Embed the primary care workforce throughout the ICS governance and leadership applying the CCPL framework. |
| 1.7.7 | We have the strategic intent to continue with PLTs for GP practices and to get out from it what practices really need. |
| 1.7.8 | We will establish clear links with regional and national education and training organisations to support primary care workforce development. This will include close working with the Training Hub |
| 1.7.9 | Build PCN clinical leadership capability to drive transformation and innovation across primary care. |
| 1.7.10 | Provide Clinical Leadership Coaching. |
| 1.7.11 | Consider process to allow GP partners to operate as Limited Liability Partnerships or other similar |

## 1.7 Actions for Place based plans

### Workforce and Organisational Development

| | |
|---|---|
| 1.7.11 | Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. |
| 1.7.12 | Support PCNs in developing their clinical, workforce and OD strategies for how they can best use ARRS staff. |
| 1.7.13 | Embed the primary care workforce throughout Place governance and leadership |
| 1.7.14 | Primary care networks and their staff will be supported with clear OD and professional development opportunities. |
| 1.7.15 | Embed principles of Equality, Diversity and Inclusion in all workforce programmes |
| 1.7.16 | Work collaboratively with ICS workforce and OD leads to progress the 4 themes of the C&M People Plan and associated primary care focussed actions across PCNs. |

# 1.8 Infrastructure and Intelligence

**Core Ambition:**

**Digital infrastructure, solutions and services that support improved and equitable access to primary care services will be provided. This digital infrastructure will empower self-care and easy, equitable access to clinical and non-clinical care and support.**

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

**A C&M wide primary care estates plan will be developed that will support a primary care estate that is fit for the future, maximises the use of our available locations and that shapes an estate that supports all primary care teams to provide effective services that patients can easily access.**

**Provide strong clinical and digital leadership to enable digital transformation, supporting and promoting the accelerated and widespread adoption of digital tools by General Practice. This will enable more efficient, flexible and resilient ways of working. This will Support practices to meet growing demand from patients by providing choice of digital channels, supporting transformation and innovation for modern general practice.**

Background:

- We need excellent digital infrastructure and associated support services if we are to develop Primary Care into what it needs to be for future care
- We will also need a range of advanced digital solutions to improve productivity and efficiency, clinical safety and access to primary care services, plus a range of solutions to help manage demand and improve patient self-care
- The ICS has a digital and data strategy, endorsed by the ICB Board in November 2022, to which digital and data developments in primary care align
- There has been significant work to understand and start to address the issues associated with digital exclusion which may impact the public's ability to engage with 'digital first' primary care services
- Nationally, the NHS app is to become the digital 'front door' to NHS services which will ultimately replace a variety of other patient access portals through solutions such as EMIS access, Patients Knows Best and so on
- A ICB wide online/video consultation platform has been procured and is being implemented in a planned manner across PCNs / Places
- There are issues with the public's understanding and the usability of appointment booking and triage solutions.
- Improved business intelligence is required to support planning, identify data led priorities and the cohorts of patients where resource and effort needs to be focussed.
- Nationally, the NHS app is to become the digital 'front door' to NHS services which will ultimately replace a variety of other patient access portals through solutions such as EMIS access, Patients Knows Best and so on
- There is significant variation in the Primary Care estate. In order to be fit for the future we need to understand the estates we currently have and our future need.
- The PCN Service and Estate Planning Toolkit has been launched and PCNs are already engaging with this to produce both clinical and estates strategies.
- The communication with the public around the primary care digital solutions on offer could be improved to raise awareness and manage expectations. For example there has limited public engagement around the roll out of online triage and video consultation software.

**Fuller Framework Action Point #10**

Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a 'one public estate' approach and maximising the use of community assets and spaces.

## 1.8 System level actions - Infrastructure and intelligence

| | |
|---|---|
| 1.8.1 | Every member of primary care staff that needs access to digital equipment to undertake their role will have access to reliable and fit for purpose access devices. |
| 1.8.2 | Every member of staff in primary care has access to reliable, seamless and secure network infrastructure to enable them to deliver their role, wherever they are working in Cheshire and Merseyside |
| 1.8.3 | Clinical systems that are reliable, responsive, meet clinical requirements safely and seamlessly connected to peripheral systems such as document management software, orders and results systems, remote monitoring solutions etc. |
| 1.8.4 | Provide responsive business intelligence to PCNs and practices |
| 1.8.5 | Primary Care clinical systems that are connected with the Place based (where available) and system wide shared care record, allowing two-way access for all while clearly complying with Information Governance requirements). |
| 1.8.6 | Functionality of primary care based patient engagement portals accessible via NHS App for all |
| 1.8.7 | Integration with patient communication systems to allow two-way communication and messaging (asynchronous communication). |
| 1.8.8 | Increased rollout of remote monitoring to support improved long term condition management in primary care (e.g. hypertension). |
| 1.8.9 | Hardware and software to allow online and video consultation using a system wide standard digital platform. |
| 1.8.10 | 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. |
| 1.8.11 | Align Primary Care Digital provision with ICB net zero / sustainability strategy |
| 1.8.12 | Strategic alignment with Primary Care solutions for patients |
| 1.8.13 | Provision of standard Digital support provision, providing effective Incident resolution of ICB locally commissioned services |
| 1.8.14 | Support Practices / PCNs with contract and service provision advice as part of PCN Digital development ambitions. |
| 1.8.15 | Provide contract and supplier management of underpinning ICB Digital Primary Care Commissioned contracts |
| 1.8.16 | Provide support for Practice merger as required as part of PCN Estates considerations |
| 1.8.17 | Co-ordinate Digital Bids to support Estates expansion and PCN working hub models and provision of Digital initiatives. |
| 1.8.18 | Scope available capital funding streams for C&M, understanding access routes and communicate funding opportunities to place when they become available. |

## 1.8 Actions for Place based plans

### Infrastructure and intelligence

| | |
|---|---|
| 1.8.19 | Embed system wide online/video consultation platform across PCNs |
| 1.8.20 | Support all practices on analogue lines to move to digital and cloud based telephony, including call back functionality. - *aligned with GP recovery plan action point 5* |
| 1.8.21 | Provide all practices with the digital tools and care navigation training for Modern General Practice Access. - *aligned with GP recovery plan action point 6* |
| 1.8.22 | Improved utilisation of other ICB wide tools such as Ardens clinical decision support and the ORCHA app library |
| 1.8.23 | Review LTC management plans to increase utilisation of remote monitoring where an appropriate remote monitoring service is available |
| 1.8.24 | Access to and utilisation of Place based shared care record (and other tools if available such as care coordination technology) where this exists |
| 1.8.25 | Develop investment plans for 'levelling up' digital maturity infrastructure at place level |
| 1.8.26 | Work with local authority colleagues at Place to develop a digital inclusion plan |
| 1.8.27 | Develop plans to utilise the whole of the available place primary care estate, supporting increased access |
| 1.8.28 | Provide support to explore estate within local stakeholders e.g. One Public Estate |
| 1.8.29 | Develop plans to ensure that there is estate available for ARRS staff across general practice. |
| 1.8.30 | Review the PCN Service and Estate Planning Toolkit responses to develop place based clinical and estates strategies. |

**GP Questionnaire key feedback - infrastructure and intelligence**

- ⇒ Support for net zero and reducing carbon footprint
- ⇒ Make it easier for practices to co-locate with other organisations
- ⇒ Greater IT integration throughout primary-secondary care interface
- ⇒ Invest in better telephony
- ⇒ Define and measure meaningful outcomes in primary care

# 1.9 Working with Patients

## supporting greater self-care and proactive care @ home

**Core Ambition:**

**A communication and engagement plan of activity with patients and the public will be produced to promote services, share positive examples of service improvement, explain to patients how to access services and expectations around care.**

**Background:**

We will continue to improve our communication with the public. Promoting our excellent quality services with positive examples of how Primary Care has worked together will help rebuild the reputation.

For wider Primary Care services it is not always clear to patients which elements are covered by the NHS offer, and which elements are part or fully self-funded.

- A broad suite of initiatives will be developed looking at empowering patients to monitor their own health together with clear pathways back to the GP when support is needed.
- A key opportunity to aid with the demand and access challenges will be to empower individuals to self-care for minor self-limiting illness and also to be more involved in the care of their chronic disease.
- Consideration needs to be given to the development of Making Every Contact Count across primary care.

**GP Questionnaire key feedback - Communication**

⇒ Strong and supportive communication from ICB around primary care

⇒ There is work to be done to change the mindsets of patients only wanting to see a GP

⇒ Greater patient education around health management and routes into services

⇒ It is essential that primary care has a strong voice within the ICB with two way communication

**Case Study**

Working with our Primary Care teams to lead on the development of a pack around accessing healthcare services for asylum seekers who have been placed across hotels and accommodation. We worked closely with the primary care team, Clinical Lead as well as the Stay Well team to produce a pack containing information to help this vulnerable cohort of people. These packs were printed and displayed across the public areas of the accommodation and also sent digitally to those people with access to a mobile phone. The council also were able to translate the packs into 18 other languages. We have been advised by the council that: “The Asylum Seekers Self Care Pack has been very well received and has made a huge difference to being able to communicate information about our Health care system and various infections and illnesses to this vulnerable and poorly informed cohort of people. We have received very positive feedback from the Asylum seekers and the partners who are hosting them.”

## 1.9 System level actions - Working with patients

| | |
|---|---|
| 1.9.1 | Develop external communications to explain how all primary care services can be accessed, what patients can expect relating to the types of appointment offers and which services should be accessed (as 1.3.2) |
| 1.9.2 | Develop positive communication campaigns to inform the public around the range of care professionals in place at GP practices to raise the publics awareness and manage expectations (as 1.3.2) |
| 1.9.3 | Bring together our Primary Care engagement groups (PPGs, PCNs, Neighbourhoods, Care Communities) together to share best practice and ideas. The ICB are committed to making this conference happen once a year at a venue in Cheshire or Merseyside whilst broadcasting to those unable to attend. |
| 1.9.4 | We will bring the Primary Care engagement groups together for this Exchange with the following aims:<br>• Provide an update on Primary Care engagement across the ICB<br>• Provide best practice examples of how Primary Care engagement has worked well in practice<br>• Allow an open space to better understand how you, our local patients want to work with us |

## 1.9 Actions for Place based plans

### Working with patients

| | |
|---|---|
| 1.9.5 | Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024. (Aligned to GP recovery plan action point 1) |
| 1.9.6 | Enable the expansion of self-referral pathways. (Aligned to GP recovery plan action point 2) |
| 1.9.7 | Work closely with Health Watch in the development of communication messages and methods that the public can understand. |
| 1.9.8 | Local engagement with print media to encourage positive GP stories |
| 1.9.9 | Ensure proactive care @ home programmes is flourishing within Places including BP@Home |
| 1.9.10 | Leverage the power of local clinicians producing content for the public regarding self care |
| 1.9.11 | Create a space for PPG support information due to the vast amount of support and information available from NHS England, National Association of Patient Participation and at a place level that has been designed, bespoke to that area. |
| 1.9.12 | Engage with clinical leads about their requirements for training and support on communications and engagement for primary care teams from the ICB |
| 1.9.13 | Develop specific training/ masterclasses to support PCNs understand of their duty to involve, including case studies |
| 1.9.14 | Support and facilitate place partnerships in their development of their communication and empowerment collaborations, ensuring PCNs are an equal partner |

# 1.10 Research and Innovation

## Future models of delivery

**Core Ambition:**

We aim to see innovation spread across primary care services that meet our local needs and that deliver best in class services without variation. We aim to build the cultures and capability across our workforce that embrace innovation and enterprise and where new ways of working can be grown and flourish.

**Background:**

- For our primary care system to remain effective and responsive to changing population health needs, we must be innovative and flexible to adapt our services, practices and priorities and act on new knowledge and technology.
- Innovation is a key enabler to the sustainability of our health and care system and critical for achieving improved and joined up primary care services.
- One of the key strengths in Primary Care is the ability to innovate and change. In order to tackle inequalities we need to change the way we offer and provide services to those who most need them.
- Primary Care will need support and resources to enable the adoption of innovation as well as some much needed 'head-space' to consider this. The Innovation Agency are well placed to support this work.
- The ICS also needs to ensure we have a suitable environment for Primary Care to flourish. Place based partnerships will need to work closely with Primary Care in creating their plans and providing across their footprints.
- It can be helpful to consider at which 'layer' services are required; Local/PCN/Place/ICS. The ICS and Place both have a role in exploring this with Primary Care.

**Fuller Framework Action Point #5**

Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place based boards.

**Fuller Framework Action Point #12**

Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.

**Fuller Framework Action Point #13**

Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.

## 1.10 System level actions - Research and Innovation

| | |
|---|---|
| 1.10.1 | Deliver training and transformation support to all practices through the new National General Practice Improvement Programme - *aligned to GP recovery plan action point 7* |
| 1.10.2 | The ICB to work with PCN Clinical Directors to develop a proposal for how they will work together to support innovation adoption. |
| 1.10.3 | Develop system forums where new primary care ideas can be shared, developed and grown and for enabling best practice sharing, innovation spread, co-creation and networking. |
| 1.10.4 | Develop joint KPIs across primary care and shared results/remuneration to allow shared investment and innovation across services to happen (as 1.1.6) |
| 1.10.5 | The ICB to facilitate conversations with Place and PCNs around at which 'layer' primary care innovation should be focussed; Community/PCN/Place/ICS. |
| 1.10.6 | The ICB will appoint clinical leads for research (inclusive of Primary Care) to promote and endorse research within Primary Care |
| 1.10.7 | Cheshire and Merseyside will become a flagship ICB for Primary Care research and innovation |

## 1.10 Actions for Place based plans
### Research and Innovation

| | |
|---|---|
| 1.10.8 | Support primary care services in delivering new and innovative services that previously may have been provided elsewhere e.g. 'trusting' pharmacists to deliver primary care services that have historically been completed in general practice |
| 1.10.9 | Enable shared decision making for innovation adoption with 'bottom up' development rather than 'top down' instruction . |
| 1.10.10 | Build collaboration between primary and secondary care to develop new cross-discipline services beyond CPCF and IIF which support the shift of patient care out of hospital and support ICS priorities. |
| 1.10.11 | Consideration of whole of primary care when developing new services to improve access to patients and utilisation of the whole primary care workforce. |
| 1.10.12 | The standardisation of a locally commissioned services framework will allow places to activate services at an appropriate level for their own needs. |
| 1.10.13 | Care communities and Place need to be key in ensuring that patients do not slip between the gaps between services and work to streamline care across the health and care system. |

**GP Questionnaire key feedback - R&I**

- ⇒ Importance of continuity of care
- ⇒ Give permission to innovate and be innovative
- ⇒ Explore options for frailty and falls services
- ⇒ Address barriers at the primary-secondary care interface
- ⇒ Develop consistent pathways across localities
- ⇒ What is the USP of General Practice?

# CHAPTER TWO - Community Pharmacy

## Service Delivery Elements

## 2.1 Commissioning

### Core Ambition

**To maximise the opportunity within National and Local Commissioning of Community Pharmacy services ensuring that the patient offer and contribution to Primary Care is maximised . Transformational ways of working across PCNs to fully integrate Community Pharmacy into patient pathways increasing the breadth of offer of services to patients in a planned and managed service design , meeting the identified needs of the local population. All ICB commissioning will be in line with eh Community Pharmacy 5 Year plan and other national strategic documents including the recovery and Access Plan.**

### Background:

Commissioning needs to be based on local population needs. However, there is a strong need for some services to be developed over the whole ICS footprint (i.e. standardisation of Pharmacy First over the system, but the ability for a place/PCN to develop a service on a more local level.) Service standardisation (common specs, PGDs and funding across an ICS region) would allow development of a C&M service framework allowing places to activate services to an appropriate level, support improvements to quality, delivery and uptake of CP locally commissioned services.

Increased use the community pharmacy offering to support prevention, screening, urgent care, early diagnosis and health inequalities.

The use of SLAs linked to the national contract is an efficient contracting mechanism however Place should have primacy with managing the local contractual arrangements with support from the ICB Community Pharmacy contracting team when contractual concerns require managing via regulatory mechanisms.

The commissioning of the National Services for Pharmacy is agreed by the DHSS and is published as the Community Pharmacy Contractual Framework: 2019 to 2024. (The 5 Year Plan). The priorities for the year 5 settlement have also been published as part of the Recovery and Access agenda and include the following key elements :

- Launch of New Advanced Service—Common Conditions Service (PGD led service covering 7 minor illnesses)
- Expansion of the Hypertension case finding Service and Contraceptive Service
- Improvements to IT infrastructure and interoperability between CP and GP
- Amendment to legislation to give more options about how to deploy staff to release pharmacists time for increased patient facing services

**Planning Guidance Cross Reference**

*NHSE will publish the general practice access recovery plan in the new year, as well as the themes for further engagement that will inform the negotiations for the 2024/25 contract. Delivery will be supported by funding as part of the five-year GP contract, including the Additional Roles Reimbursement Scheme. Integrated care board (ICB) primary medical allocations are being uplifted by 5.6 per cent to reflect the increases in GP contractual entitlements*

## 2.1 System level actions

### Commissioning - Community Pharmacy

| | |
|---|---|
| Same as GP 1.1.1 | As an ICS we will explore and outline how future monetary allocations will be distributed – either fair shares to Place or according to need across the whole system. |
| Same as GP 1.1.3 | We will lobby the central NHSE team regarding the clear need for increased funding and support to Community Pharmacy through the Global Sum and national Commissioned CP Framework |
| 2.1.1 | The ICB will continue to work with the National pharmacy Integration fund to explore opportunities for transformation of CP services and development of new innovative clinical CP services. |

## 2.1 Actions for Place based plans

### Community Pharmacy - Community Pharmacy

| | |
|---|---|
| Same as GP 1.1.7 | Develop local commissioning models that are equitable across place footprints, support the areas of greatest need and deprivation and enable joined up working across disciplines, drawing on the ICB Population Health Programme. |
| Same as GP 1.1.8 | Liaise with local authorities and the Cheshire & Merseyside Directors of Public Health around locally commissioned services, ensuring equity of provision and to inform prioritisation that tackles health inequalities in outcomes, experiences and access (our eight All Together Fairer principles). |
| 2.1.3 | Engage practices in the work above and around opportunities to support patients via referral to CP services that can support their management if minor illnesses and the self care agenda, management of hypertension and access to Contraception.<br>Identifying suitable cohorts of patients and ensuring that staff are trained on how and who to refer will support patients accessing timely clinical interventions and increase access |
| 2.1.4 | Ensure that plans for commissioning of services include all 4 contractor groups and that CPs are commissioned to deliver services to patients when best suited to do so. |

# 2.2 Population Health and Health Inequalities

## integration with local authorities and Public Health

**Core Ambition:**

**Our ambition is for Primary Care Networks to develop closer and integrated working with local authority and public health teams, to contribute to population health management and support in tackling the wider determinants of health.**

**As a Marmot ICS we will strive to reduce health inequalities across Cheshire and Merseyside**

**Community Pharmacy has a defined mechanism to collaborate and support working cross sector with our Local Authority Colleagues via the Local Pharmacy Networks. Commissioning of services by Local Authorities by Community Pharmacy is long established and the contribution CPs make to the Public Health agenda is well recognised.**

**Maximising opportunities within the national contract of support for public health and public health campaigns is prioritised locally.**

Background:

- Primary Care is ideally placed to contribute to population health and tackle the causes of ill-health.
- By increasing integration with local authority and public health we can look to improve the health of the people that we serve.
- The Pharmacy Local Professional Networks have representation by Public Health Teams to ensure collaboration and innovation is being supported by pharmacy in the PH agenda in C&M
- Cheshire and Merseyside ICS is a recognised Marmot ICS working to reduce health inequalities.
- Holistic, relationship based care can deliver on tackling health inequalities through providing long term preventative medicine and Community Pharmacy are well placed to support patients with such advice
- Community pharmacy is a recognised contributor to the Public Health agenda and delivers significant input to local and national public health priorities.
- Community Pharmacy is well placed to support the delivery of public health messages to ensure inequalities are managed and vulnerable groups are supported due to their physical locations and siting of their contracts often in the most deprived communities. As such Community Pharmacy is one of the most accessible services

| 2.2 | System level actions<br>Population health and health inequalities - Community Pharmacy |
|---|---|
| Same as GP 1.2.3 | Review and develop a criteria for resource allocation based on population need and health inequality data. Resources to be targeted at services best placed to deliver services including community pharmacy where appropriate |
| Same as GP 1.2.5 | ICB will facilitate sharing of best practice in relation to tackling health inequalities across the ICS footprint and across all potential providers of services including community pharmacy to increase innovation in tackling inequality. |

| 2.2 | Actions for Place based plans<br>Population health and health inequalities - Community Pharmacy |
|---|---|
| Same as GP 1.2.7 | Local areas will require the ability to flex their approach to align with population needs and adequate funding for this work will need to be identified . Working cross sector to identify needs and opportunities for outreach |
| Same as GP 1.2.8 | We will address health inequalities arising from discrimination based on any protected characteristic and link to System and Place Equality, Diversity and Inclusion work across all providers |
| Same as GP 1.2.9 | Support PCNs with business intelligence/CIPHA to better understand their population health needs to inform developing and prioritisation of services across all providers |
| Same as GP 1.2.10 | Explore how PCNs and practices can work with local partners to tackle wider determinants of ill health recognising strength of key partners e.g community pharmacy in their in reach to vulnerable communities, their relationship with communities and their increased access and availability. |
| 2.2.1 | PCNs to work with CPs on PH campaigns either as part of the national framework of campaigns or via any locally agreed to ensure a cohesive PH message is delivered consistently across stakeholders. The PCN networks can assist in this development. |

# 2.3 Improving Access

**Core Ambition:**

We want to support the national ambition to deliver best care for our patients. We want to work together with our practices to support them in ensuring that patients who clinically require urgent care receive same day care. This includes supporting practices and patients to facilitate easy contact with their practice and receive an appointment within two weeks.

Our ambition is for resilient services that are enabled to respond to demand spikes and with appropriate ICS escalation plans to support this.

Community pharmacy services can support this ambition by ensuring patients are seen by the most appropriate clinician within the PCN. Increased access and referral to GPCPCS, CP Hypertension Services and CP Contraceptive services can ensure that GP appointments are freed up to service a wider cohort of patients at key times. Ensuring patient path ways are designed to maximise access to CP services can ensure the widest opportunity for access to clinical services for patients.

These ambitions are clearly articulated in the Recovery and Access agenda and planning specifically in the Empowering Patients element however also will contribute strongly to over all access to services for

Background:

- In order to provide the services we offer, patients need to be able to access them—CP services support patient access to services via service delivery in traditionally OOH periods—late night and weekends
- PCNs could understand CP access by working with their CPs locally to map access and availability of services to inform system wide usage and maximise capacity
- National IT developments in 23/24 will include access to BARS for GPs to refer in to and book patients into CP services.
- Improving outcomes for patients includes improving their experience of services.
- Holistic, relationship based care helps with access

**Fuller Framework Action Point #1**

Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face. Triaging of non urgent patients in to CP services can assist with patient flow and ensure that patients with minor ailments or less pressing issues are dealt with in a timely manner by an appropriate local clinician.

**Planning Guidance Cross Reference**

Make it easier for people to contact a GP practice, including supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need

Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024

**Reference to GP Contract Change**

NHSE has imposed changes to the GP Contract 2023-24 requiring all patients to be either signposted to a more appropriate service or receive an assessment of need on the day. This will be supported by a GP Access recovery Plan due for publication soon.

## 2.3 System level actions

### Improving Access - Community Pharmacy

| | |
|---|---|
| As GP 1.3.2 | The ICB will work with media to promote healthcare access routes to the public. This will support patients in seeking support from Community Pharmacy and stress the “Pharmacy First” message. |
| As GP 1.3.3 | The ICB will ensure enhanced system level BI modelling to allow real time data on appointment activity, demand and capacity, enabling the service to identify and respond to demand spikes. This will also inform use of the GP referral mechanisms available via EMIS and later via BARS to ensure patients at key times are triaged in to supplementary services . This planning should be undertaken in tandem with a mapping of Community Pharmacy availability and service delivery capacity to ensure that Community Pharmacists are not overwhelmed at key times, can manage workload safely and appropriately and that patient experience of triage and referral is positive. |
| 2.3.3 | Complete a review of all access related content on practice websites to inform a ‘top tips’ document to support practices in improving access patient communication and processes. Practice websites to reflect the Pharmacy First message and information on Minor Ailments and the Self Care agenda. |
| 2.3.4 | Utilisation of the Recovery and Access plans to capture the planned innovation in Community Pharmacy for year 5 of the Contractual Settlement in line with the announcements made as part Empowering patients workstream to increase delivery of key Community Pharmacy services. Innovate IT to support booking and referral as well as increased clinical information sharing with COPs to support Community Pharmacy clinical services. Commissioning of the Common Conditions Service, a PGD led service to support 7 key common conditions at first point of contact and reduce requirements for Community Pharmacists to send patients to GP for prescription only medicines. |

## 2.3 Actions for Place based plans

### Improving Access - Community Pharmacy

| | |
|---|---|
| Same as GP 1.3.8 | Explore alternative models of access into General Practice including digital options and IT solutions for patient access to and referral in to services from other providers including Community Pharmacy in line with nationally announced IT programme |
| Same as GP 1.3.10 | Develop BI modelling for activity, demand and capacity across all providers within a PCN setting |
| Same as GP 1.3.11 | Develop a local response to the national Access Recovery Plan which will include supporting practices to develop their plans for improving access in accordance with the IIF for 23-24 |
| 2.3.5 | Support Practices to understand CP Services and their offer to patients and how this could support the Recovery and Access plans locally. |
| 2.3.6 | Support Practices to ensure that staff have the training necessary to understand who / how to refer patients in to CPs to ensure the offer of these services is consistent, informs patient pathways where appropriate and opportunities maximised to drive access |

# 2.4 Role of Community Pharmacy

**Core Ambition:**

- **The ICB aims to have high functioning Community Pharmacy Services delivering quality Nationally and Locally Commissioned services.**
- **The ICB also aims to see high performance in quality indicators demonstrating PCN practices engaging well with CPs to deliver advanced and enhanced services, integrated into patient pathways within a PCN model**

**Background:**

- Community Pharmacy is commissioned via the National Regulatory Framework to deliver Essential, Advanced , Enhanced and National Enhanced Services via nationally agreed contractual arrangements.
- Community pharmacy is also commissioned at ICB level and Place level to deliver a range of Locally commissioned services.
- There is an agreement to address inequality by looking at a potential harmonisation of locally commissioned services across the ICB , where deemed suitable, to harmonise and standardise this commissioning.
- The intensions of and recommendations of the Kings Fund - Developing place-based partnerships: the foundation of effective integrated care systems Developing place-based partnerships |Developing place-based partnerships | The King's Fund (kingsfund.org.uk) identifies that Place based Partnerships will be key in delivering transformation of care for Patients within primary care and ensuring of an enhanced and cohesive offer at place and PCN level.
- The ambition around primary care networks is complicated by a national contracts contractors , who are individual businesses , to collaborate. Encouraging practices to work together as a PCN and as a PCN to include and collaborate with other providers e.g. Community Pharmacy and Dental services, is a key priority. Methods to encourage cross sector PCN working need to be developed that benefit all involved.

Consensus on the Primary Secondary Interface

The ICB has published it's Consensus on the Primary Secondary Care Interface. This provides high level principles that all clinicians are encouraged to follow. If adhered to this consensus would be expected to reduce unnecessary work being passed to Primary Care and streamline pathways. The consensus has been endorsed by the RCGP and received national recognition. Consensus on the Primary and Secondary Care Interface - NHS Cheshire and Merseyside

Community Pharmacy can assist with this Primary and Secondary Care interface via the National Essential service for Discharge Medicines Service and the Smoking Cessation Service. Trusts should be encouraged to utilise these services to support patients on Discharge to understand and manage changes in their medication and facilitate the secondary to primary care transfer of care. Currently there is variable uptake between Trusts on utilisation of these services

A CQUIN is in place for the DMS service and a CQUIN for next years contracts is in discussion nationally re the Smoking Cessation Service

| 2.4 | System level actions<br>Role of Community Pharmacy |
|---|---|
| 2.4.1 | ICB to identify key pathways where Community Pharmacy can support patients within the ICB or PCN structures and offer of clinical service |
| 2.4.2 | Within 1 year ICB to articulate a clear vision for Community Pharmacy |
| 2.4.3 | The ICB, as part of it's elective recovery programme, will ensure Trusts are engaging with all services that can support patients with interface between secondary and primary care including CP services e.g. DMS and Smoking Cessation Service |

| 2.4 | Actions for Place based plans<br>Role of Community Pharmacy |
|---|---|
| Same as GP 1.5.4 | Local Primary Secondary Care Interface groups will be formed around appropriate hospital footprints to consider the Consensus document and provide clarity on local pathways which will include CP services and referral in to these |
| Same as GP 1.5.5 | Encourage job-shadowing of Primary Care Clinicians by ICB Place managers as well as secondary care colleagues. This will improve understanding of the role of Primary Care Clinicians and pressures currently being faced. There is an example of the "Walking in my Shoes" programme that supports GPs and Community pharmacists to experience each others roles and pressures. |

## 2.5 Quality, Performance, Assurance and Safety

**Core Ambition:**

**The ICB aims to have Community Pharmacy providers of the highest quality. We will work with Places and Contractors to monitor performance and improve outcomes.**

Background:

- There are many metrics recorded with regard to Community Pharmacy Performance. This includes PQS submissions, CPAF submissions and Contract Monitoring Visits, as well as service delivery information and metrics and service claims data.
- It has sometimes been difficult to identify which metrics should be used to best provide a measure of quality—the ICB will look to develop a relevant dashboard establishing KPIs appropriate to deliver regular assurance on performance.
- The System Quality and Performance Committee and the System Primary Care Committee already receive reports relating to Primary Care.
- The Pharmaceutical Services Regulations Committee manages the quality and performance of community pharmacies via The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended and the NHS England framework for managing the regulations and nationally commissioned contractual framework.

| 2.5 | System level actions<br>Quality, Performance, Assurance and Safety - Community Pharmacy |
|---|---|
| Same as GP 1.4.1 | The ICB will produce a single dashboard bringing together relevant metrics describing community Pharmacy quality and performance |
| 2.5.1 | The ICB will work through the PSRC using regulatory mechanisms to monitor and support Community pharmacy Contractual delivery and quality |

| 2.5 | Actions for Place based plans<br>Quality, Performance, Assurance and Safety - Community Pharmacy |
|---|---|
| Same as GP 1.4.3 | Places to liaise with the Pharmacy Contracting team where any performance or safety issues are identified and to inform local systems where intervention or assistance is required to resolve. |
| Same as GP 1.4.5 | Places to consider educational activities for clinicians to improve quality of care– educational events can be delivered cross sector to support joint working and collaboration. |

# 2.6 Enabling Themes - Community Pharmacy

## 2.6 Integration and Partnership -

Primary care networks, care communities and the interface with secondary care

### Core Ambition

**The ICB will work with and support PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community. This integration will include all aspects of Primary care including Community pharmacy and dentistry**

**For patients to have a streamlined experience when moving between Primary and Secondary Care and for actions to be taken by the most appropriate service in a timely way**

**Use of all services to support patient transfer between secondary and primary care will be supported and developed including CP services of Discharge medicines service and Stop Smoking service. Delivery of CQUIN and metrics will be sued to support the Trusts in understanding their delivery of these services.**

**The ICB to support ongoing development of Care Communities/Neighbourhood Teams**

### Background

The integration of Community Pharmacy nationally commissioned services into PCNs is essential. These services include;

- NMS—to support medicines optimisation and improve adherence and safety.
- CPCS—to support the self care agenda
- Hypertension case finding—including access to in clinic BP check and Ambulatory BP checks
- Contraceptive Services—to support women with access to oral contraception

Work at PCN level to actively increase referral rates to all CP services and joint working at PCN level to map and manage capacity for these services.

Further integration and support for referrals into the Community Pharmacist Consultation Service (routes at present: 111 telephony, nhs.uk online, General Practice with UEC/A&E .

### Planning Guidance Cross Reference

Transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the Community Pharmacist Consultation Service.

### Fuller Framework Action Point #4

Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.

## 2.6 System level actions

### Integration and Partnership - Community Pharmacy

| | |
|---|---|
| 2.6.1 | Report progress on the interface across a PCN between providers including GP Practice, CP and Dentistry to the ICB Board *(aligned to GP recovery plan action point 12)* |
| Same as GP 1.6.2 | The ICB will support Place and PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community |
| 2.6.2 | To provide clarity on the role and function of primary care providers and how they work together to deliver a primary care offer to patients |
| 2.6.3 | The ICB to develop an ICB medicines management target operating model and develop how this model will interact with Community pharmacy |
| 2.6.4 | Increasing GP practices use in 4 specific areas of the NHS Community Pharmacy Advanced Services;<br>1) **The Community Pharmacist Consultation Service** (GP-CPCS)<br>2) **The Community Pharmacy Hypertension case-finding service** (clinic checks and ABPM referrals)<br>3) **The Pharmacy Contraception Service**<br>4) **The NHS Discharge Medicines Service (DMS)**<br>That requires;<br>• ICB enhanced deployment for GP-CPCS (see below)<br>• ICB targets for referrals in to CP services e.g blood pressure (clinic check and ABPM) referrals per 1,000 population per practice<br>• Direct booking for patients for all CP Clinical Services—National Development expected early 2024<br>• Full roll-out of the new NHS CP contraception service |
| 2.6.5 | Enhanced deployment of the NHS Discharge Medicines Service (DMS) and Smoking Cessation Service to maximise hospital utilisation<br>ICB support includes;<br>• ICB to support Trusts with high level influence regarding utilisation of these services from trust at management / Chief Pharmacist Level<br>• Support for Trust to Trust peer support and learning<br>• Full uses of 0.2 FTE DMS Champion funding<br>• KPIs for Trust in line with CQUIN |
| 2.6.6 | Increasing pharmacy participation in the Community Pharmacy Consultation Service, Hypertension case finding Service and Contraception Service -<br>• increasing referral rates / routes of referral<br>• ICB wide CP PGD based MAS scheme to overlay with GP-CPCS<br>• PCN focus on levels of service referrals per 1,000 population per practice.<br>• Training and implementation support for expansion of services via referrals from practice / supporting practice staff on who /when to refer and what the service will deliver for the patients.<br>• Support for implementation of National Common Conditions Service and Locally Commissioned Minor Ailments service to increase resolution of CPCS referral for patient in single point of care.<br>• Roll out of UEC referral in to CPCS |

## 2.6 Actions for Place based plans

### Integration and Partnership - Community Pharmacy

| | |
|---|---|
| 2.6.7 | Clearly articulate what is being asked of PCNs against what is being asked of individual providers |
| Same as GP 1.6.8 | Support practices in identifying service areas where they can work together as practices and across providers with other sectors |
| Same as GP 1.6.9 | Assess the areas where we can support PCNs to develop a model of health care delivery that is proactive rather than reactive. Involving patient pathways that access services across providers including Community pharmacy |
| Same as GP 1.6.10 | Developing joined up care pathways and considering multidisciplinary 'one stop shop' clinics, working together to overcome barriers. This could include streamlined information sharing and referrals—reducing bureaucracy and supporting patients to navigate access in to services across the PCN and provided by other providers including community pharmacy |
| 2.6.8 | Exploring the possibility of shared contracts to enable partners to work better together—explore cross sector working for pharmacists to increase joint working and employment satisfaction - portfolio working |
| Same as GP 1.6.12 | Encourage ongoing development of Care Communities/Neighbourhood teams to work with local partners and address local needs and the wider determinants of ill health |
| Same as GP 1.6.13 | Develop primary secondary care interface groups which encompass all providers working with patients at the interface between secondary are and primary care including CPs |
| 2.6.9 | Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. In engagement with CP services and referrals in to CP Services. |
| 2.6.10 | Work with PCN Lead Pharmacists and LPC locally to understand and maximise local opportunity with cross sector working—establish patient pathways that maximise referral and direct patients in to appropriate services. |

# 2.7 Infrastructure and Intelligence

## Core Ambition:

**Digital infrastructure, solutions and services that support improved and equitable access to primary care services will be provided. This digital infrastructure will empower self-care and easy, equitable access to clinical and non-clinical care and support.. This system will allow self referral for patients and assisted referral by GP practices in to Community Pharmacy services and support.**

**A digitally empowered Cheshire and Merseyside population taking increased control of their own physical and mental health and well-being accessing the full range of primary care services and support across all providers.**

**A C&M wide primary care estates plan will be developed that will support a primary care estate that is fit for the future, maximises the use of our available locations and that shapes an estate that supports all primary care teams to provide effective services that patients can easily access.**

**Provide strong clinical and digital leadership to enable digital transformation, supporting and promoting the accelerated and widespread adoption of digital tools by General Practice. This will enable more efficient, flexible and resilient ways of working. This will Support practices to meet growing demand from patients by providing choice of digital channels, supporting transformation and innovation for modern general practice.**

## Background:

- We need excellent digital infrastructure and associated support services if we are to develop Primary Care into what it needs to be for future care . This infrastructure will support collaboration and data flow cross sector where appropriate to support patients and clinicians in providing services to patients.
- We will also need a range of advanced digital solutions to improve productivity and efficiency, clinical safety and access to primary care services, plus a range of solutions to help manage demand and improve patient self-care and access across all providers of primary care
- The ICS has a digital and data strategy which supports all providers including community pharmacy, endorsed by the ICB Board in November 2022, to which digital and data developments in primary care align
- There has been significant work to understand and start to address the issues associated with digital exclusion which may impact the public's ability to engage with 'digital first' primary care services
- Nationally, the NHS app is to become the digital 'front door' to NHS services which will ultimately replace a variety of other patient access portals through solutions such as EMIS access, Patients Knows Best and so on
- A ICB wide online/video consultation platform has been procured and is being implemented in a planned manner across PCNs / Places. Community Pharmacy have engaged to some extend with virtual consultation and should be supported to explore innovation and new ways to support access.
- There are issues with the public's understanding and the usability of appointment booking and triage solutions.
- Improved business intelligence is required to support planning, identify data led priorities and the cohorts of patients where resource and effort needs to be focussed. This can include identification of cohorts of patients where community pharmacy services could be employed to increase access and availability of services in a locality.
- Nationally, the NHS app is to become the digital 'front door' to NHS services which will ultimately replace a variety of other patient access portals through solutions such as EMIS access, Patients Knows Best and so on
- The PCN Service and Estate Planning Toolkit has been launched and PCNs are already engaging with this to produce both clinical and estates strategies.
- National plans for CP IT Infrastructure announced 2023/24 and any innovation and opportunity for IT must be capitalised on an used to the full advantage of clinicians and patients as part of local plans.

**Fuller Framework Action Point #10**

Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a 'one public estate' approach and maximising the use of community assets and spaces.

## 2.7 System level actions

### Infrastructure and intelligence - Community Pharmacy

| | |
|---|---|
| Same as GP 1.8.1 & 2 | Every member of staff in primary care has access to reliable, seamless and secure network infrastructure to enable them to deliver their role, wherever they are working in Cheshire and Merseyside—this includes infrastructure and systems that allows data flow and clinical information cross sector to support patients accessing and receiving services in all settings. This also requires infrastructure for data flow back to GP systems regarding services provided at settings outside the practice. (As GP action) |
| Same as GP 1.8.3 | Clinical systems that are reliable, responsive, meet clinical requirements safely and seamlessly connected to peripheral systems such as document management software, orders and results systems, remote monitoring solutions etc. (As GP action) |
| Same as GP 1.8.5 | Primary Care clinical systems that are connected with the Place based (where available) and system wide shared care record, allowing two-way access for all while clearly complying with Information Governance requirements). Sharing of the Shared Care record with all clinicians involved in patient care including Community Pharmacy. |
| Same as GP 1.8.6 | Functionality of primary care based patient engagement portals accessible via NHS App for all (As GP action) |
| Same as GP 1.8.7 | Integration with patient communication systems to allow two-way communication and messaging (asynchronous communication). (As GP action) |
| Same as GP 1.8.8 | Increased rollout of remote monitoring to support improved long term condition management in primary care (e.g. hypertension) and how this may link in with other services e.g Hypertension Case Finding Service in CP. |
| Same as GP 1.8.10 | Increasing digital inclusion to ensure that as service provision becomes increasingly digitised, more people are able to experience the benefit of digital investment in their health and care services and no-one experiences reduction in access to services. Including support for patients to self refer digitally in to CP services. |
| 2.7.1 | ICB to support the community pharmacy strategic planning and delivery with contract and service provision advice as part of PCN Digital development ambitions. |
| Same as GP 1.8.15 | Provide contract and supplier management of underpinning ICB Digital Primary Care Commissioned contracts |
| Same as GP 1.8.12 | Strategic alignment with Primary Care solutions for patients |
| Same as GP 1.8.13 | Provision of standard Digital support provision, providing effective incident resolution of ICB locally commissioned services |
| 2.7.2 | Opportunity to commission digital infrastructure as ICB giving an economy of scale rather than each place managing a smaller contract—potentially 9 contracts across C&M footprint. This would also support harmonisation and equity of approach. |
| Same as GP 1.8.18 | Scope available capital funding streams for C&M, understanding access routes and communicate funding opportunities to place when they become available. |

## 2.7 System level actions (continued)

### Infrastructure and intelligence - Community Pharmacy

| | |
|---|---|
| 2.7.3 | Support for National roll out of an integrated referral and booking pathway between General practice and CP |
| 2.7.4 | Roll out of Shared care records and enhanced access to clinical records for community pharmacies to support delivery of clinical services in the CP setting |
| 2.7.5 | Ensure access to additional content within patients GP records to include test results and patient observations |
| 2.7.6 | Sending of structured content back to patients GP records following a pharmacy consultation (e.g. meds supplied via PGD) |
| 2.7.7 | Incorporation of CP Digital plans into ICB digital strategy |

## 2.7 Actions for Place based plans

### Infrastructure and intelligence - Community Pharmacy

| | |
|---|---|
| Same as GP 1.8.23 | Review LTC management plans to increase utilisation of remote monitoring where an appropriate remote monitoring service is available—also consideration of support outside of G Practice e.g. referral in to CP clinical services for LTC support e.g. hypertension or contraceptive services |
| Same as GP 1.8.24 | Access to and utilisation of Place based shared care record (and other tools if available such as care coordination technology) where this exists—expansion of this system to allow access for Community Pharmacy to allow clinical data to support CP based clinical services. |
| Same as GP 1.8.25 | Develop investment plans for 'levelling up' digital maturity infrastructure at place level and to include community pharmacy in levelling up plans |
| Same as GP 1.8.26 | Work with local authority colleagues at Place to develop a digital inclusion plan which encompasses all elements of primary care |
| Same as GP 1.8.27 | Develop plans to utilise the whole of the available place primary care estate, supporting increased access |
| Same as GP 1.8.30 | Review the PCN Service and Estate Planning Toolkit responses to develop place based clinical and estates strategies across the whole of the PCN including Community Pharmacy and how increased digital links can support the patient pathways |
| 2.7.1 | Provide all practices with the digital tools and care navigation training for Modern General Practice Access. Highlighting opportunities for increased access via triaging of patients in to local services and the digital solutions to support these referrals. (Aligned to GP Recovery Plan Action 6) |
| 2.7.2 | Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. In engagement with CP services and referrals in to CP Services. |
| 2.7.3 | Support Practice based staff to understand referral mechanism and when / how to use to support patients to access services |
| 2.7.4 | Work with PCN Lead Pharmacists and LPC locally to understand and maximise local opportunity with cross sector working—establish patient pathways that maximise referral and direct patients in to appropriate services. |

# 2.8 Working with Patients

supporting greater self-care and proactive care @ home

**Core Ambition:**

**A communication and engagement plan of activity with patients and the public will be produced to promote services, share positive examples of service improvement, explain to patients how to access services and expectations around care..**

**Support patents with active referral in to existing additional services available via community pharmacy and create patient pathways that actively seek to refer patients in to these additional services e.g. GPCPCS, Hypertension and Contraceptive services.**

**Background:**

We will continue to improve our communication with the public . Promoting our excellent quality services with positive examples of how Primary Care has worked together will help rebuild the reputation.

This is consummate with the “empowering patients” workstream of the recovery and Access plan.

For wider Primary Care services it is not always clear to patients which elements are covered by the NHS offer, and which elements are part or fully self-funded.

A broad suite of initiatives will be developed looking at empowering patients to monitor their own health together with clear pathways back to the GP when support is needed. Community Pharmacy commissioned services will form part of this offer to patients about alternative routes to monitor and manage their care.

The community Pharmacy National Contract required CPs to be proactive in supporting patients with their self Care.

The Locally commissioned Minor Ailments Service supports the self care agenda where inequalities or demographics of deprivation may hinder a patient in proactively seeking a self care option.

New opportunities regarding the community pharmacy National Contract regarding the launch of a PGD based Common Conditions Service will augment the locally commissioned Minor Ailments Service and encourage 1st point of care solutions for patients seeking self care.

A key opportunity to aid with the demand and access challenges will be to empower individuals to self-care for minor self-limiting illness and also to be more involved in the care of their chronic disease.

Consideration needs to be given to the development of Making Every Contact Count across all providers of primary care.

PCNs developing clear patient pathways actively referring patients in to self care options will be developed to maximise the patient offer of GPCPCS, Hypertension Case Finding Service, Contraception Service Minor Ailments and the Common Conditions Service

## 2.8 System level actions

### Working with patients - Community Pharmacy

| | |
|---|---|
| 2.8.1 | Enable the expansion of self-referral pathways by September 2023 to include the new offer of the Common conditions Service and referral via GP CPCS and also in to Community Pharmacy services for Hypertension and Contraception. (Aligned to GP Recovery Plan Actions 3 & 4) |
| Same as GP 1.9.1 | Develop external communications to explain how all primary care services can be accessed, what patients can expect relating to the types of appointment offers and which services should be accessed which includes the full Primary care offer including Community Pharmacy and Dentistry. One communication message should be used by all providers to show a common approach and advice re self care across wider primary care. |
| Same as GP 1.9.2 | Develop positive communication campaigns to inform the public around the range of care professionals in place at GP practices and across all aspects of primary care to raise the publics awareness and manage expectations |
| Same as GP 1.9.3 | Bring together our Primary Care engagement groups (PPGs, PCNs, Neighbourhoods, Care Communities) together to share best practice and ideas. The ICB are committed to making this conference happen once a year at a venue in Cheshire or Merseyside whilst broadcasting to those unable to attend. |
| Same as GP 1.9.4 | We will bring the Primary Care engagement groups (encompassing all of primary care) together for this Exchange with the following aims:<br>• Provide an update on Primary Care engagement across the ICB<br>• Provide best practice examples of how Primary Care engagement has worked well in practice<br>• Allow an open space to better understand how you, our local patients want to work with us |

## 2.8 Actions for Place based plans

### Working with patients - Community Pharmacy

| | |
|---|---|
| Same as GP 1.9.7 | Work closely with Health Watch in the development of communication messages and methods that the public can understand that can be used by all sectors in primary care |
| Same as GP 1.9.8 | Local engagement with print media to encourage positive GP / Community Pharmacy / Dentistry stories |
| Same as GP 1.9.9 | Ensure proactive care @ home programmes is flourishing within Places including BP@Home— encouraging links to CP Hypertension service to support BP@Home or developing pathways that CP can support the BP@home agenda more closely |
| Same as GP 1.9.10 | Leverage the power of local clinicians , across all sectors, producing content for the public regarding self care and access to support via Community Pharmacies to encourage this |
| Same as GP 1.9.11 | Create a space for PPG support information due to the vast amount of support and information available from NHS England, National Association of Patient Participation and at a place level that has been designed, bespoke to that area. |
| Same as GP 1.9.14 | Support and facilitate place partnerships in their development of their communication and empowerment collaborations, ensuring PCNs and all primary care providers are an equal partner |

# 2.9 Research and Innovation

## Future models of delivery - Community Pharmacy

**Core Ambition:**

We aim to see innovation spread across all primary care services that meet our local needs and that deliver best in class services without variation. We aim to build the cultures and capability across our workforce that embrace innovation and enterprise and where new ways of working can be grown and flourish.

**Background:**

- For our primary care system to remain effective and responsive to changing population health needs, we must be innovative and flexible to adapt our services, practices and priorities and act on new knowledge and technology. This should capitalise on the provision by all primary care providers ensuring the best use of clinical skills and workforce.
- Innovation is a key enabler to the sustainability of our health and care system and critical for achieving improved and joined up primary care services.
- One of the key strengths in Primary Care is the ability to innovate and change. In order to tackle inequalities we need to change the way we offer and provide services to those who most need them.
- Primary Care will need support and resources to enable the adoption of innovation as well as some much needed 'head-space' to consider this. The Innovation Agency are well placed to support this work. Leaders from all sectors should be supported and encouraged to support this transformation—PCN funding for leaders from all sectors of primary care should be mandated
- The ICS also needs to ensure we have a suitable environment for Primary Care to flourish. Place based partnerships will need to work closely with all providers of Primary Care in creating their plans and providing development of services and patient pathways across their footprints.
- It can be helpful to consider at which 'layer' services are required; Local/PCN/Place/ICS. The ICS and Place both have a role in exploring this with Primary Care.

**Fuller Framework Action Point #5**

Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place based boards.

**Fuller Framework Action Point #12**

Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.

**Fuller Framework Action Point #13**

Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.

## 2.9 System level actions

### Research and Innovation - Community Pharmacy

| | |
|---|---|
| Same as GP 1.10.2 | The ICB to work with PCN Clinical Directors to develop a proposal for how they will work together to support innovation adoption exploring options for the wider primary care offer as well as at GP practice level. As per GP action |
| Same as GP 1.10.3 | Develop system forums where new primary care ideas can be shared, developed and grown and for enabling best practice sharing, innovation spread, co-creation and networking. Engagements with LPNs to share best practice and learning and locally across providers of primary care at PCN level. |
| Same as GP 1.10.4 | Develop joint KPIs across primary care and shared results/remuneration to allow shared investment and innovation across services to happen - measure engagement with all services includng referral rates into CP services |
| Same as GP 1.10.5 | The ICB to facilitate conversations with Place and PCNs around at which 'layer' primary care innovation should be focussed; Community/PCN/Place/ICS involving all providers of primary care at each layer of development. |
| Same as GP 1.10.7 | Cheshire and Merseyside will become a flagship ICB for Primary Care research and innovation involving all sectors in opportunities for innovation and transformation |
| 2.9.1 | The ICB will continue to work with the national Integration Fund for Pharmacy to look at opportunities to pilot innovative ways of working or new clinical services in Community Pharmacy. |

## 2.9 Actions for Place based plans

### Research and Innovation - Community Pharmacy

| | |
|---|---|
| Same as GP 1.10.8 | Support primary care services in delivering new and innovative services that previously may have been provided elsewhere e.g. supporting wider primary care the system to understand the high quality Community pharmacy clinical Services commissioned nationally and locally |
| Same as GP 1.10.9 | Enable shared decision making for innovation adoption with 'bottom up' development rather than 'top down' instruction inclusive of all sectors of primary care |
| 2.9.1 | Build collaboration between primary and secondary care to develop new cross-discipline services beyond CPCF and IIF which support the shift of patient care out of hospital and support ICS priorities. Utilise existing services to support patients with discharge including the Discharge Meds Service and Stop Smoking services that trusts can refer patients into for support on discharge. |
| Same as GP 1.10.11 | Consideration of whole of primary care when developing new services to improve access to patients and utilisation of the whole primary care workforce. |
| Same as GP **1.10.12** | The standardisation of a locally commissioned services framework will allow places to activate services at an appropriate level for their own needs. |
| Same as GP 1.10.13 | Care communities and Place need to be key in ensuring that patients do not slip between the gaps between services and work to streamline care across the health and care system. |

# 2.10 Workforce and Organisational Development

## Core Ambition

**We will develop a system level primary care workforce plan that covers all spects of primary Care including Community pharmacy , understanding the current situation and forecasting for future delivery models. System plans will be created to address expected gaps in workforce provision. Our primary care workforce will be embedded throughout our ICS governance and leadership to influence and support system planning.**

## Background

- We have a Primary Care workforce crisis and we need to determine how the C&M system can support the workforce challenge. We need to understand the current situation, map ahead to forecast our likely future state and plan for any expected gaps.
- Four key enablers for action derived from the NHS People Plan have been identified to cultivate the landscape for a one workforce / whole systems approach to primary care workforce resilience; Looking after our people, belonging in the NHS, growing for the future and new ways of working and delivering care.
- There needs to be identified funding to support the role of PCN Lead Pharmacists as a distinct and identified role to support transformation and joint working cross sector. This funding is required to support the delivery of the role in coordinating and designing services at PCN level and for clinical and professional development.
- HEE have developed and will shortly publish the Community Pharmacy Workforce Survey. The ICBs workforce group should respond to the findings when published as to the impact of the workforce issues in the N West and specifically C&M
- Utilisation of the whole of the primary care workforce by utilising pharmacy professionals in all settings to improve access. Create opportunities via direct referral for patients and patient education / promotion re ability for patients to attend a pharmacy for an intervention to improve access, utilising existing opportunities for GPCPCS, Hypertension and Contraceptive services and building on this with national commissioning developments e.g common conditions service.
- Maximise the clinical skills of the community pharmacy workforce to help address. This may also reduce the shift of roles from community pharmacy to PCN and therefore help stem the flow of professionals out of community pharmacy. More use of rotational / split roles so people do not move away from one discipline of pharmacy but can flex back and forth. We need to acknowledge and help towards the recruitment / retention crisis within Community Pharmacy at present which has significant cost implications on primary care delivery.
- Consider a shared continuity plan to share pharmacy staff resources for the greater good of primary care services rather than resorting to knee-jerk reactions and panic. Utilise and train the whole workforce to work cross-sector so we have a workforce that can deliver without much notice.
- Utilisation of independent pharmacist prescribers – from 2025 every pharmacy graduate will have a prescribing qualification and we will need to capitali9se on this opportunity to support patients in a non traditional manner.
- Participation in the ICB in the National pathfinder for CPIPs will support local development of services that can utilise this skill and support PCN clinical priorities.
- Joint training between sectors to allow multiple primary care settings to be able to provide services to patients. Backfill for pharmacy teams to be able to leave the pharmacy for daytime events. So PCN/ practice pharmacists learning with community pharmacists. Standardised training approach across all healthcare sectors. Or HEE to standardise/assure the relevant training providers (CPPE RCGP…) so these can be recognised in other settings. Could include joint events with other primary care colleagues to stimulate collaboration and support integration as part of resourced protected learning time.

**Fuller Framework Action Point #6**

Embed primary care workforce as an integral part of system thinking, planning and delivery. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.

## 2.10 System level actions

### Workforce and Organisational Development - Community Pharmacy

| | |
|---|---|
| Same as GP 1.7.1 | A system level primary care workforce plan including future delivery models will be co-produced and based upon accurate primary care workforce data analytics and activity modelling. |
| Same as GP 1.7.1 | Targeted recruitment campaigns will be developed including promoting C&M as an attractive place to work with consideration being given to portfolio ways of working including all sectors of pharmacy and opportunity for "portfolio" employment cross sector. |
| Same as GP 1.7.2 | Develop flexible working practices for primary care staff, including more joint roles and opportunities for rotational roles. Enable the flexible deployment of staff across employing organisation, network & system boundaries using digital solutions. Develop a collaborative primary care staff bank to increase capacity across primary care and create a new offer for local GPs / nurses / pharmacists etc wanting to work flexibly. |
| Same as GP 1.7.3 | Embed the primary care workforce throughout the ICS governance and leadership applying the CCPL framework. |
| Same as GP 1.7.1 | We have the strategic intent to continue with PLTs for GP practices and for get out from it what practices really need.. This PLT could be extended to other primary care professionals including CPs to support and encourage joint working and education. |
| Same as GP 1.7.4 | We will establish clear links with regional and national education and training organisations to support primary care workforce development. This will include close working with the Training Hub to develop training that can be delivered jointly to all sectors |
| Same as GP 1.7.5 | Build PCN clinical leadership capability to drive transformation and innovation across primary care. |
| Same as GP 1.7.5 | Provide Clinical Leadership Coaching to all sectors of primary Care—supporting and developing the Role of the PCN Lead Pharmacist |

## 2.10 Actions for Place based plans

### Workforce and Organisational Development - Community Pharmacy

| | |
|---|---|
| | Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. |
| Same as GP 1.7.6 & 7 | Support PCNs in developing their clinical, workforce and OD strategies for how they can best use ARRS staff. Including how they work well with other clinicians in their vicinity e.g community pharmacists and dentists |
| Same as GP 1.7.8 & 9 | Embed the primary care workforce throughout Place governance and leadership including cross sector working to resolve gaps |
| | Primary care networks and their staff will be supported with clear OD and professional development opportunities. |
| Same as GP 1.7.10 | Embed principles of Equality, Diversity and Inclusion in all workforce programmes |
| Same as GP 1.7.11 | Work collaboratively with ICS workforce and OD leads to progress the 4 themes of the C&M People Plan and associated primary care focussed actions across PCNs. |
| | Work to ensure that all primary care staff are informed as to how other staff work and what their role is in supporting patients across the primary care offer whatever sector they work in |

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## Primary Care Strategic Framework and the Primary Care Access Recovery Plan

**Appendix Two:** draft Primary Care Strategic Framework Action list

| Ref | System level actions | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| **Commissioning, contracting and funding** | | | | | | |
| 1.1.1 | Explore and outline how future monetary allocations will be distributed | 2yrs | ✓ | ✓ | | |
| 1.1.2 | Explore different funding models (such as the John Hopkins) | 2yrs | ✓ | | | |
| 1.1.3 | Lobby central NHSE team re need for increased funding to Primary Care via contract | 1yr | ✓ | ✓ | | |
| 1.1.4 | An innovative contracting at scale pilot to be performed | 3yrs | ✓ | | | |
| 1.1.5 | Review core and non-core General Practice spending. Produce a plan describing how we will reduce this variation | 1-2 yrs | ✓ | | | |
| 1.1.6 | Consider pilot of gain sharing | 3yrs | ✓ | | | |
| 2.1.1 | The ICB will continue to work with the National pharmacy Integration fund to explore opportunities for trans-formation of CP services and development of new innovative clinical CP services. | Every yr | | ✓ | | |
| **Population health and health inequalities** | | | | | | |
| 1.2.1 | Close working with Public Health teams to understand population need as well as system level integration, communication and support for PCNs to succeed. | 2yrs | ✓ | | | |
| 1.2.2 | The ICB will support the Deep End Cheshire and Merseyside initiative | 2yrs | ✓ | | | |
| 1.2.3 | Develop a criteria for resource allocation based on population need and health inequality data. | 3yrs | ✓ | ✓ | | |
| 1.2.4 | Consider system projects to develop using health inequalities funding | 2yrs | ✓ | | | |
| 1.2.5 | ICB will facilitate sharing of best practice in relation to tackling health inequalities across the ICS footprint | 2yrs | ✓ | ✓ | | |
| **Improving Access** | | | | | | |
| 1.3.1 | See increased satisfaction on GP Patient Survey regarding access indicators | Every | ✓ | | | |
| 1.3.2 | Work with media to promote GP & CP access routes and inform about multidisciplinary care | 1yr | ✓ | ✓ | | |
| 1.3.3 | BI modelling to allow real time data on appointment activity, demand and capacity, | 1yr | ✓ | ✓ | | |
| 1.3.4 | The ICB will support Place and PCNs with the NHSE Primary Care Access Recovery Plan | 1yr | ✓ | | | |
| 1.3.5 | The ICB will run a series of workshops around access to share best practice and explore alternative models of access into surgery e.g. Access workshop series, action learning sets, University of Manchester model of | 1yr | ✓ | | | |

| Ref | System level actions | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| 1.3.6 | Undertake a telephony review across PCNs and support the adoption of digital telephony | 1yr | ✓ | | | |
| 1.3.7 | Improve access, triage and referral across first-contact NHS organisations including general practice (reference from House of Commons Report) | 2yr | ✓ | | | |
| 2.3.3 | Practice websites to reflect the Pharmacy First message and information on Minor Ailments and the Self Care agenda. | 2yr | | ✓ | | |
| 2.3.4 | Utilisation of the Recovery and Access plans to capture the planned innovation in Community Pharmacy for year 5 of the Contractual Settlement in line with the announcements made as part Empowering patients workstream to increase delivery of key Community Pharmacy services. Innovate IT to support booking and referral as well as increased clinical information sharing with CPs to support Community Pharmacy clinical services. Commissioning of the Common Conditions Service, a PGD led service to support 7 key common conditions at first point of contact and reduce requirements for Community Pharmacists to send patients to GP for prescription only medicines. | 1yr | | ✓ | | |
| **Quality, performance, assurance and safety** | | | | | | |
| 1.4.1 | The ICB will produce a single dashboard bringing together relevant metrics describing GP quality and performance | 2yr | ✓ | ✓ | | |
| 1.4.2 | The ICB will provide data for assurance to the System Quality and Performance Committee | 1yr | ✓ | | | |
| 2.5.1 | The ICB will work through the PSRC using regulatory mechanisms to monitor and support Community phar- | 1yr | | ✓ | | |
| **Role of General Practice / Community Pharmacy** | | | | | | |
| 1.5.1 | Within 1 year ICB to articulate a clear vision for the role of General Practice | 1yr | ✓ | | | |
| 1.5.2 | ICB to identify key pathways where clarity is required regarding responsibilities. | 2yrs | ✓ | | | |
| 1.5.3 | Deliver the 'Cutting Bureaucracy' element of the Primary Care Access Recovery Plan | 1yr | ✓ | | | |
| 2.4.1 | ICB to identify key pathways where Community Pharmacy can support patients within the ICB or PCN structures and offer of clinical service | 2yr | | ✓ | | |
| 2.4.2 | Within 1 year ICB to articulate a clear vision for Community Pharmacy | 1yr | | ✓ | | |
| 2.4.3 | The ICB, as part of it's elective recovery programme, will ensure Trusts are engaging with all services that can support patients with interface between secondary and primary care including CP services e.g. DMS and | 1yr | | ✓ | | |

| Ref | System level actions | Time | GP | CP | De | Opt |
|---|---|---|---|---|---|---|
| **Integration and Partnerships** | | | | | | |
| 1.6.1 | Report progress on the Primary Secondary Care Interface to the ICB board | 6mth | ✓ | | | |
| 1.6.2 | Support Place and PCNs to evolve into something fully inclusive of all components in Primary Care and integrated within the community | 3yr | ✓ | ✓ | | |
| 1.6.3 | We commit to the nurturing and development of PCN leaders and to describe their role in the future clinical leadership of the ICS | 2yr | ✓ | | | |
| 1.6.4 | Consider developing a reporting tool for GPs to report inappropriate workload transfer | 2yr | ✓ | | | |
| 1.6.5 | To provide proactive support for the Consensus on the Primary secondary Care Interface | 1yr | ✓ | | | |
| 1.6.6 | The ICB to develop an ICB medicines management target operating model | 2yr | ✓ | | | |
| 2.6.1 | Report progress on the interface across a PCN between providers including GP Practice, CP and Dentistry to the ICB Board *(aligned to GP recovery plan action point 12)* | 1yr | | ✓ | | |
| 2.6.2 | To provide clarity on the role and function of primary care providers and how they work together to deliver a primary care offer to patients | 2yr | | ✓ | | |
| 2.6.3 | The ICB to develop an ICB medicines management target operating model and develop how this model will interact with Community pharmacy | 2yr | | ✓ | | |
| 2.6.4 | Increasing GP practices use in 4 specific areas of the NHS Community Pharmacy Advanced Services;<br>1) **The Community Pharmacist Consultation Service** (GP-CPCS)<br>2) **The Community Pharmacy Hypertension case-finding service** (clinic checks and ABPM referrals)<br>3) **The Pharmacy Contraception Service**<br>4) **The NHS Discharge Medicines Service (DMS)**<br>That requires;<br>• ICB enhanced deployment for GP-CPCS (see below)<br>• ICB targets for referrals in to CP services e.g blood pressure (clinic check and ABPM) referrals per 1,000 population per practice<br>• Direct booking for patients for all CP Clinical Services—National Development expected early 2024 | 1yr | | ✓ | | |

| Ref | System level actions | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| 2.6.5 | Enhanced deployment of the NHS Discharge Medicines Service (DMS) and Smoking Cessation Service to maximise hospital utilisation<br><br>ICB support includes;<br>ICB to support Trusts with high level influence regarding utilisation of these services from trust at management / Chief Pharmacist Level<br><br>Support for Trust to Trust peer support and learning<br><br>Full uses of 0.2 FTE DMS Champion funding<br><br>KPIs for Trust in line with CQUIN<br><br>Increasing pharmacy participation in the Community Pharmacy Consultation Service, Hypertension case finding Service and Contraception Service -<br>increasing referral rates / routes of referral<br><br>ICB wide CP PGD based MAS scheme to overlay with GP-CPCS | 1yr | | ✓ | | |
| 2.6.6 | PCN focus on levels of service referrals per 1,000 population per practice.<br><br>Training and implementation support for expansion of services via referrals from practice / supporting practice staff on who /when to refer and what the service will deliver for the patients.<br><br>Support for implementation of National Common Conditions Service and Locally Commissioned Minor Ailments service to increase resolution of CPCS referral for patient in single point of care. | 2yr | | ✓ | | |
| **Workforce and Organisational Development** | | | | | | |
| 1.7.1 | Co-produce a system level primary care workforce plan | 1yr | ✓ | | | |
| 1.7.2 | Targeted recruitment campaigns will be developed including promoting C&M as an attractive place to work | | | | | |
| 1.7.3 | Consider the feasibility of developing C&M recruitment incentive schemes | 1-2yr | ✓ | | | |
| 1.7.4 | Consider developing flexible working practices for primary care staff, | | | | | |
| 1.7.5 | Consider the development of a collaborative primary care staff bank | | | | | |
| 1.7.6 | Embed the primary care workforce throughout the ICS governance and leadership | 1yr | ✓ | | | |

| Ref | System level actions | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| 1.7.7 | Continue with PLTs for GP practices and for get out from it what practices really need. | | | | | |
| 1.7.8 | Establish clear links with education and training organisations | 1yr | ✓ | | | |
| 1.7.9 | Build PCN clinical leadership capability to drive transformation and innovation across primary care. | 3yr | ✓ | | | |
| 1.7.10 | Provide Clinical Leadership Coaching. | | | | | |
| **Infrastructure and Intelligence** | | | | | | |
| 1.8.1 | Access to reliable and fit for purpose devices for every member of primary care staff that needs them | 1yr | ✓ | ✓ | | |
| 1.8.2 | Access to reliable, seamless and secure network infrastructure across all sites | 1yr | ✓ | ✓ | | |
| 1.8.3 | Clinical systems that are reliable, responsive, meet clinical requirements safely and seamlessly connected to peripheral systems | 1yr | ✓ | ✓ | | |
| 1.8.4 | Provide responsive business intelligence to PCNs and practices | 2yr | ✓ | | | |
| 1.8.5 | Primary Care clinical systems connected with the Place based (where available) and system wide shared care record | 3yr | ✓ | ✓ | | |
| 1.8.6 | Functionality of primary care based patient engagement portals accessible via NHS App | 2yr | ✓ | ✓ | | |
| 1.8.7 | Integration with patient communication systems to allow two-way communication and messaging (asynchronous communication). | 1yr | ✓ | ✓ | | |
| 1.8.8 | Increased rollout of remote monitoring to support improved long term condition management in primary care (e.g. hypertension). | 2yr | ✓ | ✓ | | |
| 1.8.9 | Hardware and software to allow online and video consultation using a system wide standard digital platform. | 1yr | ✓ | | | |
| 1.8.10 | 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. | 3yr | ✓ | ✓ | | |
| 1.8.11 | Align Primary Care Digital provision with ICB net zero / sustainability strategy | 2yr | ✓ | | | |
| 1.8.12 | Strategic alignment with Primary Care solutions for patients | 3yr | ✓ | ✓ | | |

| Ref | System level actions | Time | GP | CP | De | Opt |
|---|---|---|---|---|---|---|
| 1.8.13 | Provision of standard Digital support provision, providing effective Incident resolution of ICB locally commissioned services | 2yr | ✓ | ✓ | | |
| 1.8.14 | Support Practices / PCNs with contract and service provision advice as part of PCN Digital development ambitions. | 2yr | ✓ | | | |
| 1.8.15 | Provide contract and supplier management of underpinning ICB Digital Primary Care Commissioned contracts | 2yr | ✓ | ✓ | | |
| 1.8.16 | Provide support for Practice merger as required as part of PCN Estates considerations | 1yr | ✓ | | | |
| 1.8.17 | Co-ordinate Digital Bids to support Estates expansion and PCN working hub models and provision of Digital initiatives. | 1yr | ✓ | | | |
| 1.8.18 | Scope available capital funding streams for C&M, understanding access routes and communicate funding opportunities to place when they become available. | 2yr | ✓ | ✓ | | |
| 2.7.1 | ICB to support the community pharmacy strategic planning and delivery with contract and service provision advice as part of PCN Digital development ambitions. | 2yr | | ✓ | | |
| 2.7.2 | Opportunity to commission digital infrastructure as ICB giving an economy of scale rather than each place managing a smaller contract—potentially 9 contracts across C&M footprint. This would also support harmonisation and equity of approach. | 3yr | | ✓ | | |
| 2.7.3 | Support for National roll out of an integrated referral and booking pathway between General practice and CP | 2yr | | ✓ | | |
| 2.7.4 | Roll out of Shared care records and enhanced access to clinical records for community pharmacies to support delivery of clinical services in the CP setting | 3yr | | ✓ | | |
| 2.7.5 | Ensure access to additional content within patients GP records to include test results and patient observations | 2yr | | ✓ | | |
| 2.7.6 | Sending of structured content back to patients GP records following a pharmacy consultation (e.g. meds supplied via PGD) | 2yr | | ✓ | | |
| 2.7.7 | Incorporation of CP Digital plans into ICB digital strategy | 2yr | | ✓ | | |
| **Working with Patients** | | | | | | |
| 1.9.3 | Bring together our Primary Care engagement groups (PPGs, PCNs, Neighbourhoods, Care Communities) together | 1yr | ✓ | ✓ | | |

| Ref | System level actions | Time | GP | CP | De | Opt |
|---|---|---|---|---|---|---|
| 1.9.4 | We will bring the Primary Care engagement groups together for this Exchange with the following aims:<br>• Provide an update on Primary Care engagement across the ICB<br>• Provide best practice examples of how Primary Care engagement has worked well in practice | 1yr | ✓ | ✓ | | |
| 2.8.1 | Enable the expansion of self-referral pathways by September 2023 to include the new offer of the Common conditions Service and referral via GP CPCS and also in to Community Pharmacy services for Hy- | 1yr | | ✓ | | |
| **Research and Innovation** | | | | | | |
| 1.10.1 | Deliver support through the new National General Practice Improvement Programme | 1yr | ✓ | | | |
| 1.10.2 | Work with PCN Clinical Directors to develop a proposal to support innovation adoption. | 3yr | ✓ | ✓ | | |
| 1.10.3 | Develop system forums where new primary care ideas can be shared | 2yr | ✓ | ✓ | | |
| 1.10.5 | The ICB to facilitate conversations with Place and PCNs around at which 'layer' primary care innovation | 2yr | ✓ | ✓ | | |
| 1.10.6 | Appoint clinical leads for research (inclusive of Primary Care) | 1yr | ✓ | ✓ | | |
| 1.10.7 | C&M will become a flagship ICB for Primary Care research and innovation | 3yr | ✓ | | | |
| 2.9.1 | The ICB will continue to work with the national Integration Fund for Pharmacy to look at opportunities to pilot innovative ways of working or new clinical services in Community Pharmacy. | 2yr | | ✓ | | |

| Ref | Actions for Place based plans | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| **Commissioning, contracting and funding** | | | | | | |
| 1.1.7 | Develop local commissioning models that are equitable across place footprints, support the areas of great- | 2yrs | ✓ | ✓ | | |
| 1.1.8 | Liaise with local authorities around locally commissioned services | 2yrs | ✓ | ✓ | | |
| 1.1.9 | Engage practices in the work above around exploring new funding models and variation | 2yrs | ✓ | | | |
| 2.1.3 | Engage practices around opportunities to support patients via referral to CP services that can support their management if minor illnesses and the self care agenda, management of hypertension and access to Contraception. | 1yr | | ✓ | | |
| 2.1.4 | Ensure that plans for commissioning of services include all 4 contractor groups and that CPs are commissioned to deliver services to patients when best suited to do so. | 2yr | | ✓ | | |
| **Population Health and Health Inequalities** | | | | | | |
| 1.2.6 | PCNs to focus on priority prevention/inequalities conditions as per operational planning document:<br>• Increase percentage of patients with **hypertension treated to NICE guidance** to 77% by March 2024<br>• Increase the percentage of patients aged between 25 and 84 years with a **CVD risk score greater than 20 percent on lipid lowering therapies** to 60%<br>• Continue to address health inequalities and deliver on the **Core20PLUS5** approach as relevant to children and young people and adults. PLUS groups will be determined by each of the 9 local places in C&M. | 2yr | ✓ | | | |
| 1.2.7 | Local areas will require the ability to flex their approach to align with population needs and adequate funding for this work will need to be identified | 3yr | ✓ | ✓ | | |
| 1.2.8 | Address health inequalities arising from discrimination based on any protected characteristic | 2yr | ✓ | ✓ | | |
| 1.2.9 | Support PCNs with consistent business intelligence/CIPHA to better understand their population health needs | 2yr | ✓ | ✓ | | |

| Ref | Actions for Place based plans | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| 1.2.10 | Explore how PCNs and practices can work with local system partners to tackle the wider social determinants of ill health, and address health inequalities in line with our All Together Fairer recommendations.<br>**A commitment across primary care to towards delivering population health priorities that include**<br>• smoking cessation, contributing to the SmokeFree 2030 ambition, as part of an overarching whole system strategy and pathway (to be developed)<br>• Digital Weight Management referrals<br>• Targeted NHS health checks- Build on learning from recent pilots to increase uptake of NHS HCs in priority groups with high CVD risk but low levels of engagement in preventative checks (areas of deprivation, ethnic minority groups, patients with SMI and LD)<br>• Increase uptake of annual physical health checks for patients with SMI, building on learning from innovative pilots<br>• **All Together Active**. Supporting implementation of the All Together Active strategy aimed at increasing physical activity as a way of improving population health through GP practises<br>• **Population Health Intelligence**. Utilisation of CIPHA and other tools to underpin, inform and drive a coordinated and sustainable population health management approach targeting the most impactful cohorts for prevention and high impact measures<br>• **Reducing Harm from Alcohol**. Supporting the strategic across Cheshire and Merseyside deliver preventative and treatment interventions that reduce alcohol harm and drug dependency.<br>• **Making Every Contact Count**. Embedding the philosophy of Making Every Contact Count, an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. | 1yr | ✓ | ✓ | | |
| 2.2.1 | PCNs to work with CPs on PH campaigns either as part of the national framework of campaigns or via any locally agreed to ensure a cohesive PH message is delivered consistently across stakeholders. The PCN networks can assist in this development. | 3yr | | ✓ | | |
| **Improving Access** | | | | | | |
| 1.3.8 | Explore alternative models of access into Primary Care including digital options | 1yr | ✓ | ✓ | | |
| 1.3.9 | Support practices in procuring Cloud Based Telephony | 1yr | ✓ | | | |
| 1.3.10 | Develop BI modelling for activity, demand and capacity | 1yr | ✓ | ✓ | | |
| 1.3.11 | Develop a local response to the national Access Recovery Plan | 1yr | ✓ | ✓ | | |
| 2.3.5 | Support Practices to understand CP Services and their offer to patients and how this could support the Recovery and Access plans locally. | 2yr | | ✓ | | |
| 2.3.6 | Support Practices to ensure that staff have the training necessary to understand who / how to refer patients in to CPs to ensure the offer of these services is consistent, informs patient pathways where appropriate and opportu- | 2yr | | ✓ | | |

| Ref | Actions for Place based plans | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| **Quality, performance, assurance and safety** | | | | | | |
| 1.4.3 | Support practices with performance or safety issues and escalate to System where required | On-going | ✓ | ✓ | | |
| 1.4.4 | Place to monitor prescribing data and support clinicians with quality prescribing | On-going | ✓ | | | |
| 1.4.5 | Places to consider educational activities for clinicians to improve quality of care | On-going | ✓ | ✓ | | |
| **Role of General Practice / Community Pharmacy** | | | | | | |
| 1.5.4 | Form local Primary Secondary Care Interface groups around appropriate hospital footprints | 1yr | ✓ | ✓ | | |
| 1.5.5 | Encourage job-shadowing of GPs by ICB Place managers as well as secondary care colleagues. | 3yrs | ✓ | ✓ | | |
| 1.5.6 | Consider supporting PCNs to introduce ‘continuity leads’ | 2yrs | ✓ | | | |
| **Integration and Partnerships** | | | | | | |
| 1.6.7 | Clearly articulate what is being asked of PCNs against what is being asked of General Practice | 1yr | ✓ | | | |
| 1.6.8 | Support practices in identifying service areas where they can work together | 2yr | ✓ | ✓ | | |
| 1.6.9 | Support PCNs to develop a model of health care delivery that is proactive rather than reactive. | 3yr | ✓ | ✓ | | |
| 1.6.10 | Develop joined up care pathways and consider multidisciplinary ‘one stop shop’ clinics | 2yr | ✓ | ✓ | | |
| 1.6.11 | Explore the possibility of shared contracts to enable partners to work better together | 3yr | ✓ | | | |
| 1.6.12 | Encourage ongoing development of Care Communities/Neighbourhood teams | 2yr | ✓ | ✓ | | |
| 1.6.13 | Implement the ICB medicines management target operating model across Place when agreed | 1yr | ✓ | ✓ | | |
| 2.6.7 | Clearly articulate what is being asked of PCNs against what is being asked of individual providers | 1yr | | ✓ | | |
| 2.6.8 | Exploring the possibility of shared contracts to enable partners to work better together—explore cross sector working for pharmacists to increase joint working and employment satisfaction - portfolio working | 3yr | | ✓ | | |

| Ref | Actions for Place based plans | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| 2.6.9 | Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. In engagement with CP services and referrals in to CP Services. | 2yr | | ✓ | | |
| 2.6.10 | Work with PCN Lead Pharmacists and LPC locally to understand and maximise local opportunity with cross sector working—establish patient pathways that maximise referral and direct patients in to appropriate services. | 2yr | | ✓ | | |
| **Workforce and Organisational Development** | | | | | | |
| 1.7.11 | Develop Place primary care workforce plans | 1yr | ✓ | ✓ | | |
| 1.7.12 | Support PCNs in developing their clinical, workforce and OD strategies for ARRS staff. | 1yr | ✓ | ✓ | | |
| 1.7.13 | Embed the primary care workforce throughout Place governance and leadership | 1yr | ✓ | | | |
| 1.7.14 | Support PCNs and their staff with clear OD and professional development opportunities. | 3yr | ✓ | | | |
| 1.7.15 | Embed principles of Equality, Diversity and Inclusion in all workforce programmes | On-going | ✓ | ✓ | | |
| 1.7.16 | Work collaboratively with ICS workforce and OD leads to progress the 4 themes of the C&M People Plan and | 2yrs | ✓ | ✓ | | |
| **Infrastructure and Intelligence** | | | | | | |
| 1.8.19 | Embed system wide online/video consultation platform across PCNs | 1yr | ✓ | | | |
| 1.8.20 | Support all practices on analogue lines to move to digital and cloud based telephony, including call back functionality. - *aligned with GP recovery plan action point 5* | 1yr | ✓ | | | |
| 1.8.21 | Provide all practices with the digital tools and care navigation training for Modern General Practice Access. - *aligned with GP recovery plan action point 6* | 1yr | ✓ | | | |
| 1.8.22 | Improve utilisation ICB wide tools such as Ardens and the ORCHA app library | 1yr | ✓ | | | |
| 1.8.23 | Review LTC management plans to increase utilisation of remote monitoring | 2yr | ✓ | ✓ | | |
| 1.8.24 | Access to and utilisation of Place based shared care record where this exists | 3yr | ✓ | ✓ | | |
| 1.8.25 | Develop investment plans for 'levelling up' digital maturity infrastructure at place level | 2yr | ✓ | ✓ | | |

| Ref | Actions for Place based plans | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| 1.8.26 | Work with local authority colleagues at Place to develop a digital inclusion plan | 2yr | ✓ | ✓ | | |
| 1.8.27 | Develop plans to utilise the whole of the available place primary care estate, supporting increased access | 2yr | ✓ | | | |
| 1.8.28 | Provide support to explore estate within local stakeholders e.g. One Public Estate | 3yr | ✓ | | | |
| 1.8.29 | Develop plans to ensure that there is estate available for ARRS staff across general practice. | 2yr | ✓ | | | |
| 1.8.30 | Review the PCN Service and Estate Planning Toolkit responses to develop place based clinical and estates strategies. | 1yr | ✓ | ✓ | | |
| 2.7.1 | Provide all practices with the digital tools and care navigation training for Modern General Practice Access. Highlighting opportunities for increased access via triaging of patients in to local services and the digital solutions to support these referrals. (Aligned to GP Recovery Plan Action 6) | 1yr | | ✓ | | |
| 2.7.2 | Develop Place primary care workforce plans including understanding the current place situation, required future models and plans for addressing gaps. In engagement with CP services and referrals in to CP Services. | 2yr | | ✓ | | |
| 2.7.3 | Support Practice based staff to understand referral mechanism and when / how to use to support patients to access services | 1yr | | ✓ | | |
| 2.7.4 | Work with PCN Lead Pharmacists and LPC locally to understand and maximise local opportunity with cross sector working—establish patient pathways that maximise referral and direct patients in to appro- | 2yr | | ✓ | | |
| **Working with Patients** | | | | | | |
| 1.9.5 | Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024. *Aligned to GP recovery plan action point 1* | 1yr | ✓ | | | |
| 1.9.6 | Enable the expansion of self-referral pathways. *Aligned to GP recovery plan action point 2* | 2yr | ✓ | | | |
| 1.9.7 | Work closely with Health Watch in the development of communication messages | 1yr | ✓ | ✓ | | |
| 1.9.8 | Local engagement with print media to encourage positive GP stories | 1yr | ✓ | ✓ | | |
| 1.9.9 | Ensure proactive care @ home programmes is flourishing within Places including BP@Home | 1yr | ✓ | ✓ | | |

| Ref | Actions for Place based plans | Time | GP | CP | Den | Opt |
|---|---|---|---|---|---|---|
| 1.9.10 | Leverage the power of local clinicians producing content for the public regarding self care | 2yr | ✓ | ✓ | | |
| 1.9.11 | Create a space for PPG support information at a place level that has been designed for that area. | 2yr | ✓ | ✓ | | |
| 1.9.12 | Engage with clinical leads about their requirements for training and support on communications and engagement for primary care teams from the ICB | 1yr | ✓ | | | |
| 1.9.13 | Develop specific training/ masterclasses to support PCNs understand of their duty to involve, including case studies | 3yr | ✓ | | | |
| 1.9.14 | Support and facilitate place partnerships in their development of their communication and empowerment collaborations, ensuring PCNs are an equal partner | 2yr | ✓ | ✓ | | |
| **Research and Innovation** | | | | | | |
| 1.10.8 | Support primary care services in delivering new and innovative services that previously may have been | 2yr | ✓ | | | |
| 1.10.9 | Enable shared decision making for innovation adoption with 'bottom up' development rather than 'top down' instruction . | 2yr | ✓ | | | |
| 1.10.10 | Build collaboration between primary and secondary care to develop new cross-discipline services | 2yr | ✓ | | | |
| 1.10.11 | Consideration of whole of primary care when developing new services to improve access to patients and utilisation of the whole primary care workforce. | 3yr | ✓ | | | |
| 1.10.12 | Consider creation of a standardised locally commissioned services framework | 2yr | ✓ | | | |
| 1.10.13 | Care communities and Place working to ensure that patients do not slip between the gaps between services and work to streamline care across the health and care system. | 3yr | ✓ | | | |
| 2.9.1 | Build collaboration between primary and secondary care to develop new cross-discipline services beyond CPCF and IIF which support the shift of patient care out of hospital and support ICS priorities. Utilise existing services to support patients with discharge including the Discharge Meds Service and Stop Smoking services that trusts can refer patients into for support on discharge. | 2yr | | ✓ | | |

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## Primary Care Strategic Framework and the Primary Care Access Recovery Plan

**Appendix Three: Primary Care Access Recovery Plan presentation**

NHS
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# Delivery plan for recovering access to primary care

Christopher Leese, Associate Director of Primary Care – June 2023

https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/ released 9th May 2023

# Recovering Access to Primary Care

NHS Cheshire and Merseyside

**Key Ambitions**

- *Primarily* aimed at General Practice and Community Pharmacy
- Tackling the 8AM rush to ensure patients can receive same day support and guidance from their local practice
- Enabling patients to know how their needs will be met when they contact their practice
- A step toward delivering the vision set out in the Fuller Report Next Steps for Integrating Primary Care

"*There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it." Fuller Stocktake Report - May 2022*

- ICBs have to ensure their plans are submitted to Boards in October/November
- To tackle the increasing demands on Primary Care, the plan focuses on **four** areas to alleviate pressure and support general practice further

1. Empowering patients

2. Implementing Modern General Practice Access

3. Building Capacity

4. Cutting Bureaucracy

# 1. Empowering patients

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**SRO Tom Knight**

- **Improving Information and NHS App Functionality**
- **Increasing self directed care**
- **Expanding Community Pharmacy**

1. Empowering patients

**Recommendations**

**Improving information and NHS App functionality**

- Enable patients in over 90% of practices to access core functions on the NHS App
- All practices to enable prospective medical record access for patients access by November 2023, enabling them to view information on immunisations, test results and consultations

**Increasing self-directed care**

- Increase the number of self-referral options for patients - up to 50% more patients self-referring by March 2024
- Increase use of digital tools and remote monitoring eg. blood pressure control through home monitoring devices
- ICBs to support development of link worker role, connecting people to activities and community-based services

**Expanding community pharmacy**

- Pharmacy First to launch before the end of 2023, enabling pharmacists to: i) supply prescription-only medicines and (ii) treat common health conditions
- Expand community pharmacy capacity to provide blood pressure checks and manage ongoing oral contraception
- Improve IT infrastructure and interoperability between community pharmacy and general practice
- Changes to various legislation to give community pharmacy contractors more choice about how they deploy staff and release pharmacists' time for more patient-facing services

# 2. Implementing Modern General Practice Access

**SRO Tony Leo**

NHS
Cheshire and Merseyside

- **Better digital telephony**
- **Simpler online requests**
- **Faster navigation, assessment and response**

2. Implementing Modern General Practice Access

**Recommendations**

**Better digital telephony**

- All practices to transition to digital telephony by December 2025 to make full use of i) multiple call management; (ii) call-back functionality; (iii) call-routing and (iv) integration with clinical systems
- NHSE to support transition to digital telephony to those practices that commit by 1st July 2023
- 1000 practices to be utilising this technology by the end of 2023

**Simpler online requests**

- NHSE to provide general practices with high quality online-consultation, messaging and booking tools by July 2023
- ICBs, Primary Care Networks and GPs to agree most appropriate tools to support transition to new model

**Faster navigation, assessment and response**

- NHSE to invest in new National Care Navigation Training programme for up to 6500 staff starting in May 2023
- NHSE to fund higher-quality tools that enable the shift to online requests and enable all practice team to contribute to rapid assessment and response
- NHSE to support practices committing to transformation with extra capacity over the next two years - £13,500 per practice

# 3. Building capacity

**SRO Christopher Leese**

NHS
Cheshire and Merseyside

3. Building Capacity

- **Larger multidisciplinary teams**
- **Increase in new doctors**
- **Retention and return of experienced GPs**
- **Primary Care estates**

**Recommendations**

**Larger multidisciplinary teams**

- 26,000 more professionals in general practice and 50 million more appointments by 31 March 2024
- Funding for up to £385m for Additional Roles Reimbursement Scheme (ARRS) in 2023/24
- All primary care staff to be able to access suite of health and wellbeing offers and the Practitioner Health Service

**Increase in new doctors**

- Up to £35 million of SDF funding available for GP fellowships in 2023/24
- Further expansion of GP specialty training – and make it easier for newly trained GPs who require a visa to remain in UK
- NHSE to work with partners to identify opportunities for other doctors, eg SAS doctors, to work in general practice multidisciplinary team

**Retention and return of experienced GPs**

- DHSC agreement to make retire and return easier and protect NHS staff from higher tax charges driven by inflation
- Encourage experienced GPs to stay through the pension reforms announced in the Budget
- NHSE to launch campaign to encourage GPs to return to general practice and invest in GP retention schemes

**Primary care estates**

- ICBs to work with local partners to better anticipate where housing developments are putting pressure on existing services
- Changes to local authority planning guidance this year to ensure due consideration of primary care capacity

# 4. Cutting bureaucracy

**SRO Dr Jonathan Griffiths**

- **Improving the primary/secondary care interface**
- **Building on the bureaucracy busting concordat**

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4. Cutting Bureaucracy

**Recommendations**

**Improving the primary – secondary care interface**

- Secondary care to prioritise onward referrals to ensure referrals are not sent back to general practice and resulting in further delays
- NHS trusts to provide accurate and up to date fit notes and discharge letters, highlighting clear actions for general practice
- NHS trusts to establish their own call/recall systems for patient follow ups
- ICBs to ensure providers establish single routes for general practice and secondary teams to communicate rapidly
- ICBs to report progress on improving the interface with primary care

**Building on the Bureaucracy Busting Concordat**

- Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing with the Bureaucracy Busting Concordat
- Examples include, working with the aviation industry to encourage clear, proportionate and pragmatic processes, so passengers with medical conditions who need to fly with medication/medical equipment can do so easily

# Progress

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- A programme board chaired by CW with SRO leads and cross cutting theme leads for Finance, Digital, Workforce. Communications and BI has been set up meeting fortnightly
- Overall action plan/Project Management Officer structure, risk register and oversight in place, each SRO will manage their own ‘workstream’
- Place/System actions denoted/under discussion (but need refinement over time)
- Service Development Funding  (SDF) – to support delivery, guidance now released, being worked through with agreement at Execs as to final funding allocations
- ICB first level GP retention plan (completed by each place) submitted
- Support Programmes for Practices and PCNs  - practices already being referred
- 2 training sessions for place staff on the SLF (Support Level Framework) in train / discussion with LMC colleagues
- First key action – cloud telephony, in train
- PCNs working through their Capacity / Access improvement plans for submission to place by end of June (these will underpin the final ICB plan)

# What is ‘the plan’ ?

NHS
Cheshire and Merseyside

- The national Delivery Plan sets out specific actions and asks of ICBs
- This should be brought together by the ICB through a **‘system-level access improvement plan**’.
- This system-level plan should set out how the ICB will meet the ambitions in the Delivery Plan to deliver modern general practice access, including ;
  - how it will provide the necessary support to primary care to make improvements to service delivery
  - support demand and workload management
  - help with staff recruitment and retention.
- The overall aim of this work is to deliver an improved experience of access for patients, better continuity of care where most needed and improved job satisfaction for staff.
- The ICB plans should bring together the actions to be taken at practice and PCN level with those required at system level taking high level direction from the Delivery Plan
- Plan should be tailored to specific local needs, challenges and context
- Should also set out the work that will be done using SDF (Service Development) transformation funding
- Plan covers 23/24 and beyond
- NHSE working on a further ‘standard template plan’
- For C and M our action plan will be the basis of ‘the final improvement plan’ – progress, metrics, narrative and achievements already being captured – clearly need to define ‘our improvement’
- Current aim is to Plan to Board in October (as per Guidance)/ SPCC in October – update in Feb’24

Taken from ;https://www.england.nhs.uk/publication/primary-care-service-development-funding-and-general-practice-it-funding-guidance-2023-24/

# Next steps/challenges

NHS
Cheshire and Merseyside

- Some national documents still awaited – workforce plan, further guidance/template for ICB  improvement/final ‘plan’, contract clauses
- ‘Actions’ of other bodies/national policy negotiations, still in train
- Resourcing the plan – scale of challenge (people)
- Funding the plan – ensuring SDF is in right place in system to support and agreeing SDF priority areas
- ‘Metric heavy’ expectations
- Agreeing our ambitions for improvement, working with place/key stakeholders
- Patient communications/expectations
- Finalising our plan/production and measurable improvements/outcomes

NHS
Cheshire and Merseyside

# Questions?

# NHS Cheshire and Merseyside ICB Board Meeting

## 29 June 2023

# Winter Debrief / Urgent Emergency Care Improvement Programme

| | |
|---|---|
| **Agenda Item No** | ICB/06/23/14 |
| **Report author & contact details** | Claire Sanders, AD of UEC Ops and Improvement |
| **Report approved by (sponsoring Director)** | Anthony Middleton, Director of Performance and Planning |
| **Responsible Officer to take actions forward** | Claire Sanders, AD of UEC Ops and Improvement |

# Winter Debrief / UEC Improvement Programme

| | | | | | |
|---|---|---|---|---|---|
| **Executive Summary** | • This report provides a review of the Urgent and Emergency Care 22/23 Winter De-brief conducted April 2023 by the ICB System Coordination Centre (SCC) and Emergency Preparedness, Resilience and Response (EPRR) teams.<br>• The report highlights findings, lessons learned, preparations in readiness for Winter 23/24, and the establishment of an Urgent Care Improvement Group which will report via the Transformation Committee to Board. | | | | |
| **Purpose (X)** | **For information / note** | **For decision / approval** | **For assurance** | **For ratification** | **For endorsement** |
| | X | | X | | |
| **Recommendation** | **The Board is asked to:**<br>• Note the contents of this report, in particular the establishment of the Urgent Care Improvement Programme and associated governance. | | | | |
| **Key issues** | N/A | | | | |
| **Key risks** | The work of the Urgent Care Improvement Group described will be a key element of the ICB's approach to the mitigation of BAF Risk P5, around lack of urgent and emergency care capacity and restricted flow across all sectors. | | | | |

| **Impact (X)** (further detail to be provided in body of paper) | **Financial** | **IM&T** | **Workforce** | **Estates** |
|---|---|---|---|---|
| | X | X | X | |
| | **Legal** | **Health Inequalities** | **EDI** | **Sustainability** |
| | | X | | |

# Winter De-brief / UEC Improvement Programme

## 1. Executive Summary

1.1 Cheshire and Merseyside (C&M), in line with systems nationally, experienced a challenging winter period. This is evidenced by several key quality and safety indicators referenced in this report.

1.2 Typically, all Acute Hospitals see significantly reduced occupancy over the Christmas period. However, in December 2022 higher occupancy was experienced both nationally and locally, resulting in a shortage of bed capacity as demand surged post-Christmas.

1.3 Nationwide systems were under a great deal of pressure ahead of Christmas due to a higher than average proportion of paediatric patients related to cases of invasive group A streptococcus disease, adult respiratory presentations and in increase in lower acuity patients.

1.4 Covid Bed Occupancy peaked at 438 (7% of bed stock) on the 30th December 2022.

1.5 Primary Care, Mental Health, community, social care, and voluntary sectors all reported increasing demand and complexity to varying degrees.

1.6 In response additional monies were released nationally during January which the C&M system deployed to increase capacity, predominantly social care to mitigate the risk of patient safety across all aspects of service provision but workforce remained a key challenge to mobilisation.

1.7 To assist the overview and balancing of pressure C&M established a System Coordination Centre in December which during times of industrial action transitioned to a formal Incident command centre as part of Emergency preparedness, response, and resilience.

1.8 The ICB has established a Cheshire and Merseyside UEC improvement programme to take the learning of winter, feedback from national visits regarding discharge, and as part of winter 23/24 preparations.

## 2. Winter De-brief Approach

2.1 EPRR facilitated the debriefing process with providers capturing lessons identified, notable practice and key recommendations.

2.2 SCC conducted a review of the situational reporting data captured since inception on 1st December 2022.

2.3 Provider feedback and data was triangulated to identify themes and correlations to inform recommendations and follow-on actions.

## 3. De-brief Process Findings

3.1 Providers were asked to:

Identify lessons in relation to the planning, response and / or recovery arrangements for Winter 22/23.

- IPC surges have a significant impact on flow and there are limited options to mitigate
- Actions to be taken regarding escalation and decision points are sometimes unclear (i.e., around system involvement and mutual aid)
- Workforce deficits across the system cause bottlenecks through pathways
- UEC reporting, whilst essential, could be improved re: auto-population and operational narrative input
- Winter was approached using standard improvement processes, a winter planning meeting was established and agreed set of improvement priorities and associated metrics. This ran through to Feb 23. Pressure remained funding for the additional schemes especially urgent treatment centres
- It was useful receiving the Winter monies comparatively earlier than in previous years
- Frequent requests from the ICB and NHSE for assurance; often asking for the same information in different formats was unhelpful.

Identify any notable practice in relation to the planning, response and / or recovery arrangements.

- System Coordination Centre (SCC) model worked well with good system engagement but a challenge to secure responses during out of hours
- One site conducted a length of stay (LOS) refresh and saw a considerable reduction in the number of super stranded patients
- Virtual ward, in excess of 19 children admitted at height of winter
- The establishment of the SCC was useful in being able to escalate concerns and understand the overall regional position.

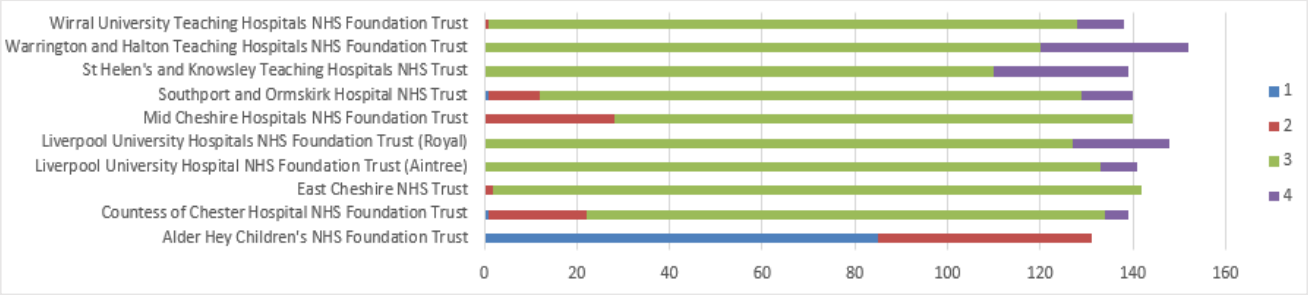
Identify key recommendations.

- Circulate System Escalation Response documentation (EMS/OPEL) with clarity around links to EPRR Incident status to ensure a consistent model across the ICB
- Review UEC report format to secure a balance between data that can be automated and operational informed narrative on the in-day sit rep position
- Start planning in June / July, agree funding streams and schemes, use established learning sets to agree focus and metrics
- Early identification and allocation of Winter monies crucial to getting schemes set up and established in time for Winter, particularly if there is a lead in time for recruitment.

## 4. Analysis of SCC Data

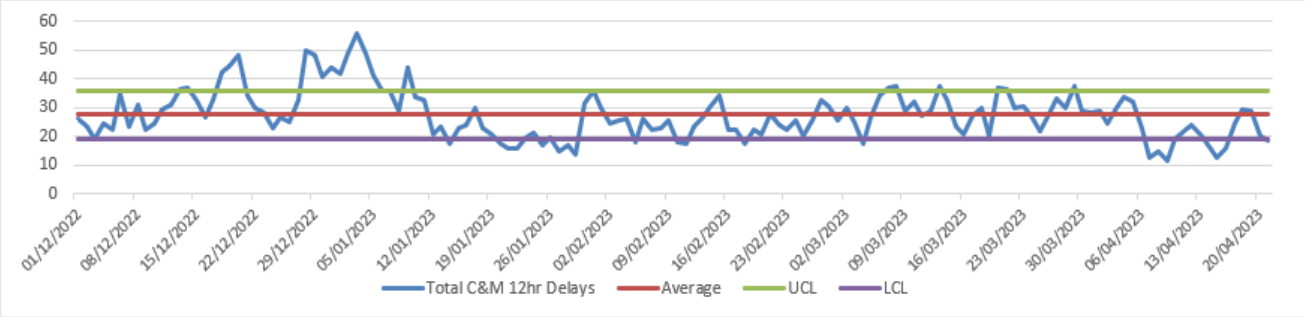
4.1 The following data has been obtained from daily provider submissions into the SCC. Please note that the SCC data is unvalidated, operational data, provided as a snapshot to the SCC is received at 11am each day. As such, the numbers presented here may differ to other reports. Unless stated otherwise, the period covered is from 1st December 2022 to 20th April 2023.

4.2 **Operational Pressure Escalation Levels (OPEL Levels).** OPEL 3 accounted for 78% of all declarations. Four out of the ten provider sites did not declare a status lower than OPEL 3 throughout the entire period: Aintree, Royal, St Helen's and Knowsley and Warrington and Halton. Alder Hey Children's Hospital (AHCH) was a notable exception to this trend with 65% of its 131 declarations being of an OPEL level 1 status and the remaining 35% of declarations being of an OPEL level 2 status.



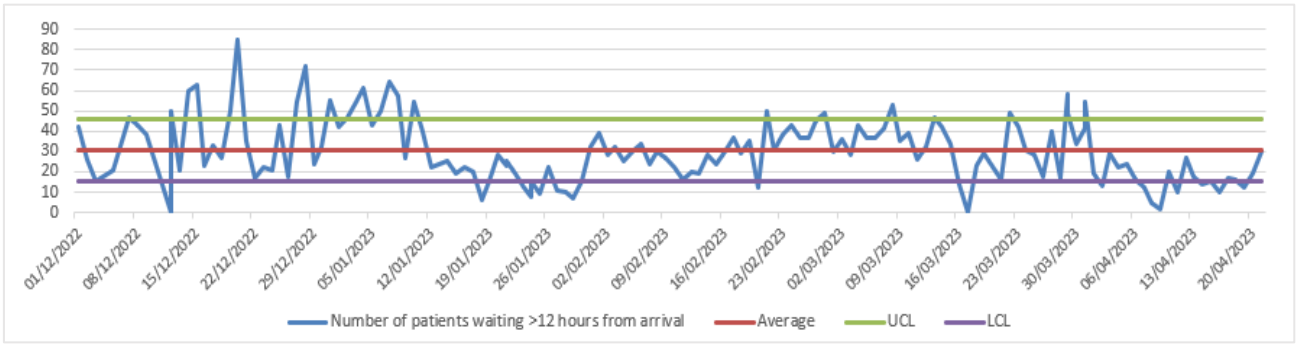

4.3 **12 Hours Delays.** There was a notable improvement in the number of 12hr delays in mid-January and a further improvement in early April. These improvement points are consistent across all acute provider sites, with the exception of AHCH which frequently reports zero 12hr delays.

C&M 12hr Delays



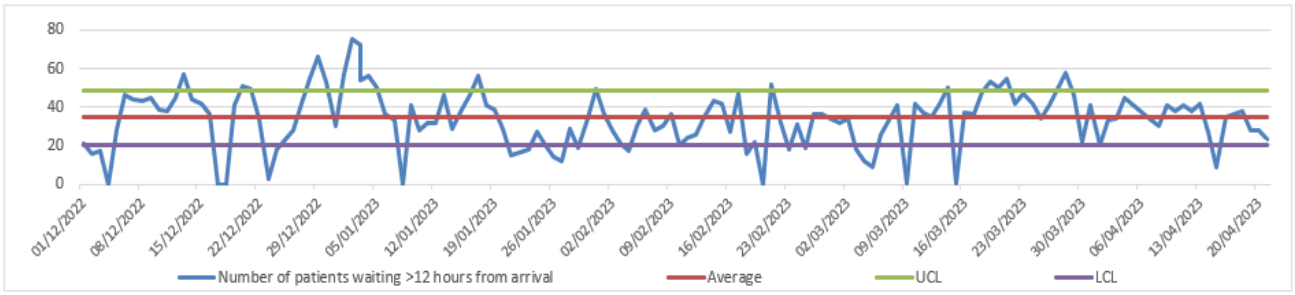
4.4 The extent and duration of improvement varies. The January improvement was sustained in Aintree for several weeks.

Aintree 12hr Delays



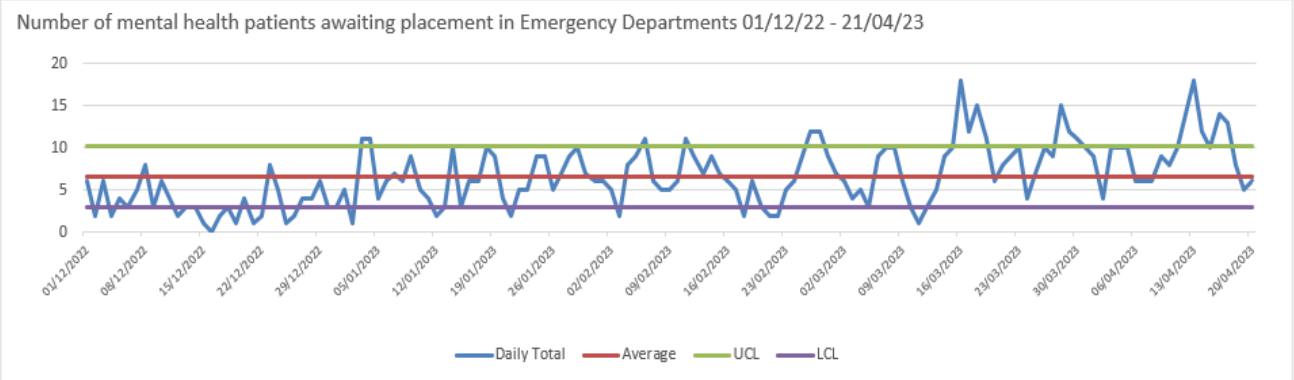

Improvement at the Countess of Chester was sharp but only briefly sustained. This suggests that a combination of external factors (e.g., IPC bed closures) combined with internal factors (e.g., operational improvements).

Countess of Chester 12hr Delays

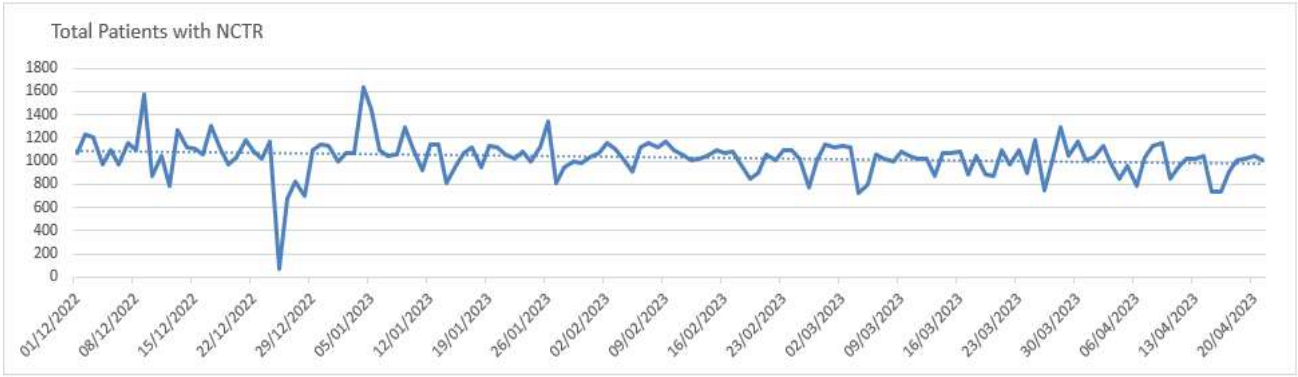



4.5 **Occupancy Levels (All Hospitals).** Occupancy levels did not fall below 90% across the entire reporting period. With the lowest reported level at 91% on 25th December 2022. General & Acute bed occupancy remained above 96%.

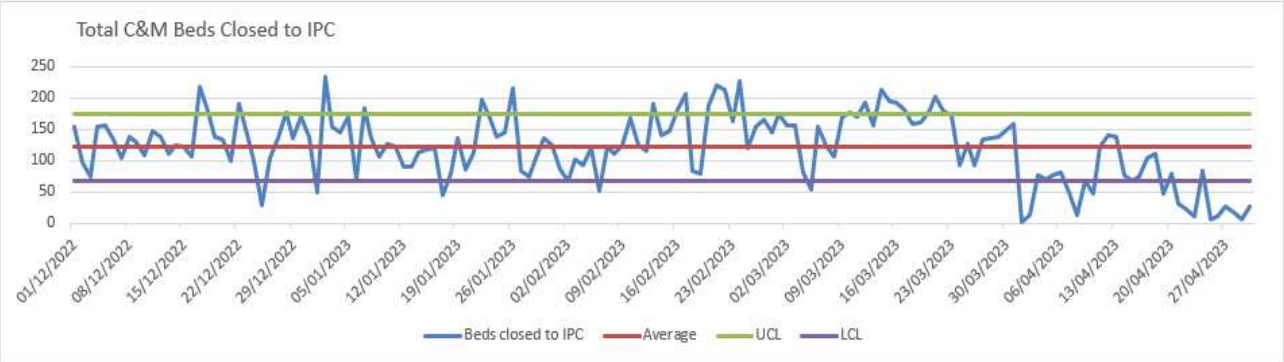
4.6 **Mental Health Patients treated in Emergency Departments.** The number of mental health patients being treated in Emergency Departments has increased from the 1st December, with 11 cases of special cause concern since 16th March. Both mental health providers regularly report issues relating to high levels of occupancy and poor exit flow from their inpatient facilities during the daily SCC calls. Patients were not only delayed awaiting placement in ED but also in community along with a number of patients residing in out of area facilities.

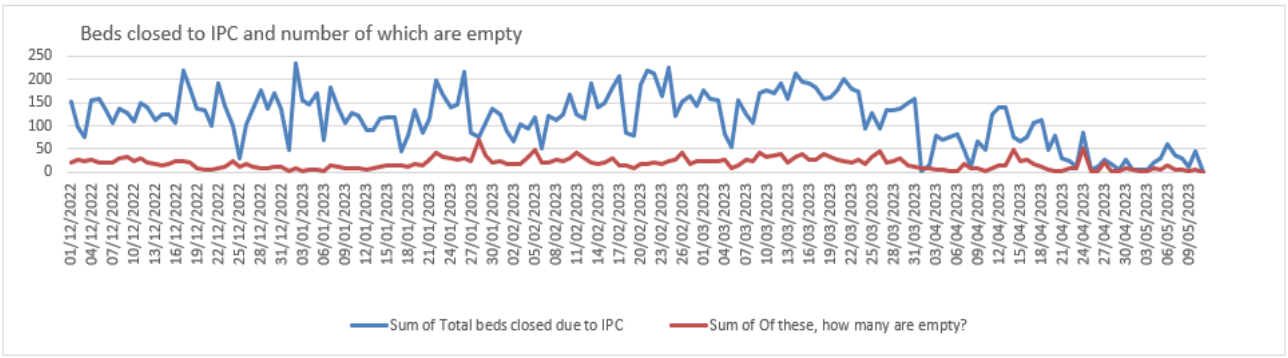



4.7 **Number of beds occupied by patients with no criteria to reside.** The total number of C&M beds occupied by patients with no criteria to reside is now trending down but at the peak of pressures account for over 25% of the general and acute bed stock.

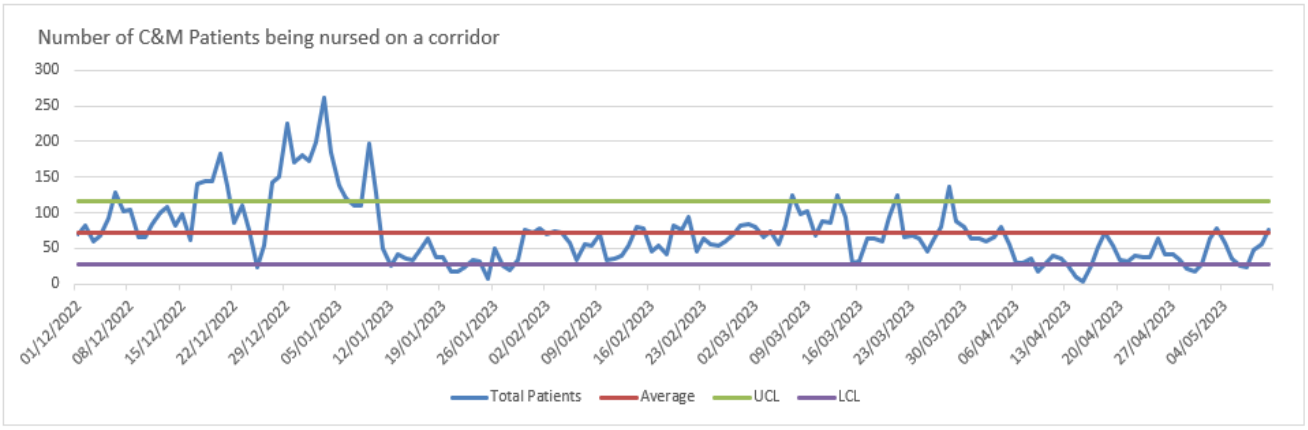



4.8 **Infection Prevention and Control (IPC).** An average of 121 C&M beds were closed due to IPC throughout the December 2022 – March 2023 period. This metric has shown signs of improvement since the start of April. The majority of beds affected by IPC remained occupied. The average number of unoccupied beds throughout the period was 19. The number of peaked at 69 on 28th January 2023.




4.9 Corridor Care. Two main peaks (deteriorations) in the number of C&M patients being cared for on a corridor. The first peak was 17th to 22nd December. This was followed by a brief recovery and then a second, longer peak from 27th December 2022 to 11th January 2023.



## 5. Other

5.1 Outside of the operational, clinical, and analytical analysis 4 key themes emerged from general feedback from service providers:

- Service providers are feeling burdened by reporting
- There is confusion and inconsistency regarding escalation levels
- Mental Health flow needs to be a specific area of focus for system improvement
- Service providers are struggling to make sustainable improvements with short-term funding.

5.2 **Reporting Burden.** Overall, the System Control Centre was seen as a positive addition to the C&M urgent care landscape. Providers stated it was useful to have a point of escalation and provide narrative to support the key indicators being reported. However, data flows to support the SCC has added to the already significant data burden that providers are faced with. Some trusts across Merseyside have adopted EMS from Midlands and Lancashire CSU. This is an internal tool which uses manual data input to derive an EMS score. These scores do not align to the national OPEL scores and therefore, although providers report to find the EMS helpful, its functionality is limited due to lack of adopted across the region as a whole.

5.3 **Escalation levels**. Providers reported some confusion about escalation processes and the SCC identified a combination of different metrics being used in providing daily reports. Providers in Merseyside will often use escalation management scale (EMS) when talking about provider escalation levels and then OPEL levels when referring to place escalation levels. Providers in Cheshire tend to always use OPEL levels when referring to both provider and place escalations. In analysis of the data, the SCC found that OPEL 3 is almost a default position for many providers, despite significant variation in some of the key metrics (e.g., 12hr delays, IPC closures and corridor care).

5.3 **Mental Health.** The number of mental health patients being cared for in Emergency Departments (EDs) is increasing and both ED and mental health providers frequently report significant challenges with getting patients to the right place at the right time.

5.5 **Funding.** The analysis of the data in this report shows that, despite funding injections to support winter pressures, there are still significant improvements to make to improve the quality and safety or urgent care services in Cheshire and Merseyside. Providers told us that the type of funding (i.e., ad-hoc, non-recurrent funding issued at short notice) is a factor hindering their ability to implement sustainable change.

## 6. Operational Planning 2023/24

6.1 As part of the 2023/24 operational planning settlement, the additional bed capacity equivalent to 205 beds for Cheshire & Merseyside, which had been funded non-recurrently on a part year basis for £13.7m, was funded on a full year basis.

6.2 As part of the planning process, all trusts were required to set plans in relation to overall bed occupancy levels, length of stay, and proportion of patients no longer meeting the criteria to reside in hospital.

6.3 A national ambition was set that bed occupancy be reduced to 92% on the basis that this level of occupancy would facilitate urgent and emergency are flow and would also protect elective and cancer services.

6.4 As part of the C&M planning process, each Place Director convened system wide discussions with a view to agreeing plans to minimise be occupancy over the course of 2023/24, taking in to account all existing resources deployed as well as additional social care funding. These plans were co-produced and presented by systems as part of the development of ICB level plans.

6.5 It should be recognised that at the time of planning, the majority of Trusts were operating at close to, or even in excess of 100% bed capacity, against the backdrop of extreme UEC pressures and industrial action, and therefore setting a plan to reduce to 92%, and the large reductions in length of stay and NCTR that would support this, was not considered to be realistic. Trusts have planned on the basis of bringing adult overnight general and acute occupancy down to just below 95%, at 94.3% in March 2024, with only marginal reductions in NCTR and long stays. This view seems to be borne out by Q1 performance to date, as reported in the Quality & Performance report, where slight reductions in NCTR and a corresponding reduction in occupancy have been seen, but where NCTR, at around 20%, remains higher than other NW ICBs and the England level of 14.5%.

6.6 The broad consensus was that if 95% or better occupancy could be achieved, this would be consistent with the achievement of the national ambition for 76% of people attending A&E to be admitted, discharged, or transferred within 4 hours of arrival, and delivery of improved Cat 2 ambulance response times.

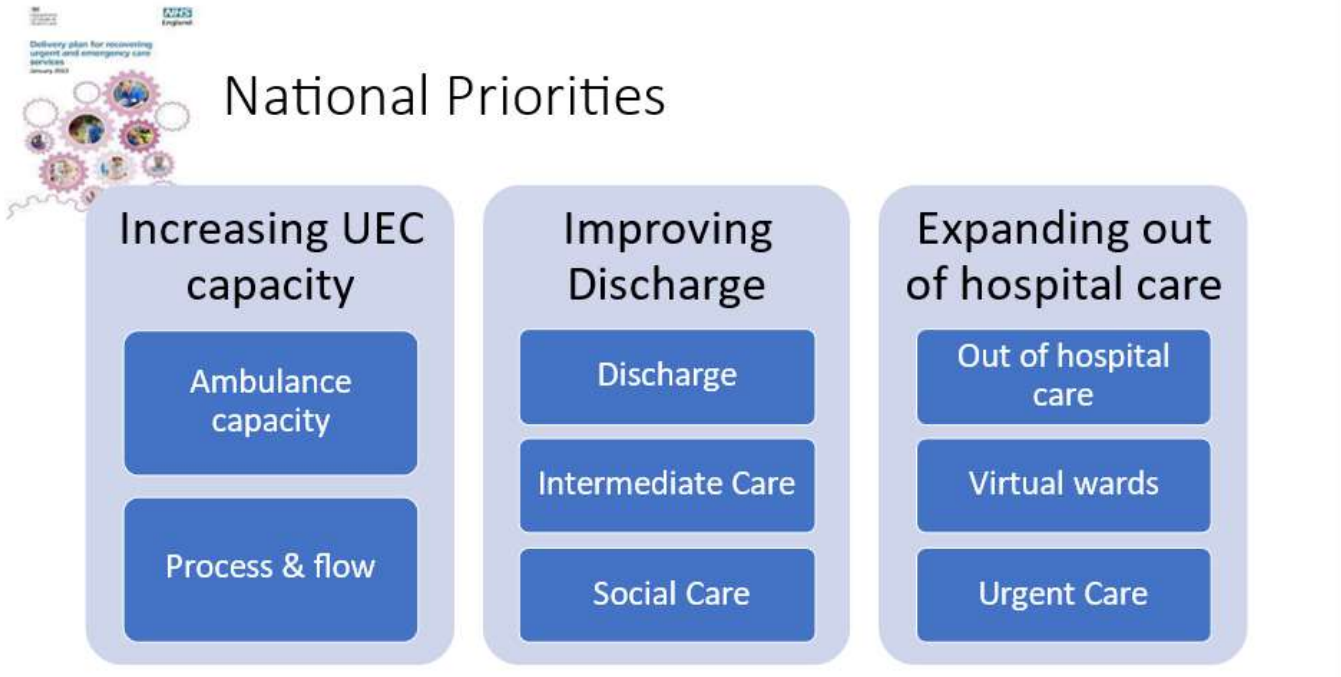
6.7 The OPEL escalation framework is currently being reviewed nationally, looking at both OPEL triggers and responses. Cheshire and Merseyside SCC have input into these discussions which is anticipated will bring a shift towards Place OPEL reporting rather than the sole focus on acute providers. This refresh is due to be shared in August 2023 for implementation this winter.

6.8 North West region have developed a mental health escalation framework which requires implementation and localisation to Cheshire and Merseyside. The SCC has worked closely with Mental health leads and providers to operationalise this framework through testing out the framework across one provider and one place. Applying an improvement approach to implementation is allowing the system to learn quickly and to adopt new ways of working. The SCC plays a significant role in supporting the operationalisation of the framework and will be the central point to hold the information and oversight, allowing themes to emerge and to be fed into the mental health strategy. It is important for the SCC to maintain this central function as the UEC operational arm of the system. Implementation of the

framework will also lead to less duplication of effort in chasing up information daily with an agreed approach to escalation.

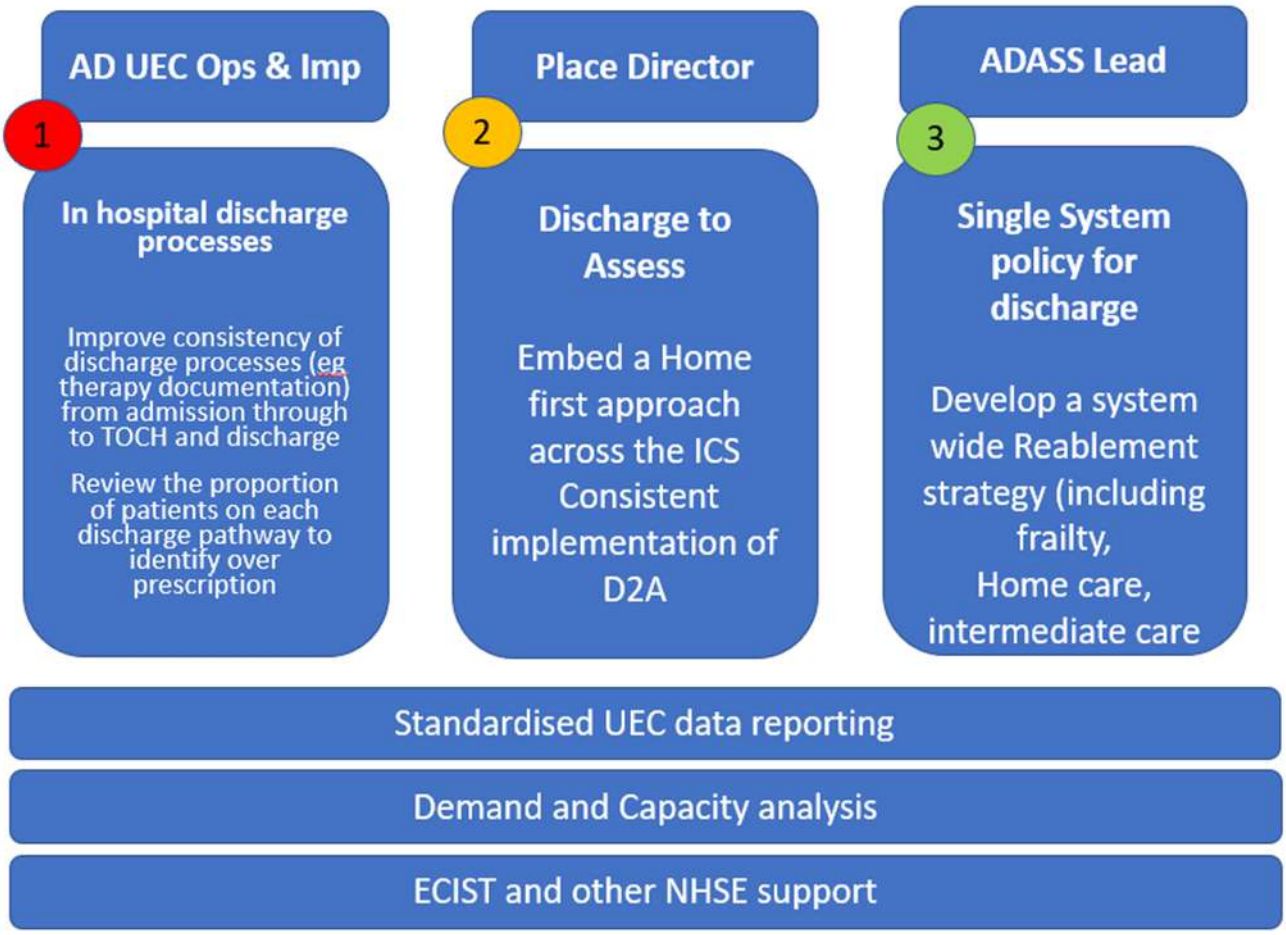
## 7. UEC Improvement Programme

7.1 In order to provide the maximum coordination of improvement efforts across the system. The ICB is establishing an Urgent Care Improvement Group which will report via the transformation committee to Board. This will encapsulate all the national priorities, local objectives, and existing regional improvement programmes e.g., Ambulance Handover Programme. This will provide appropriate governance and transparency enabling assurance to national teams.




7.2 During Q1 of 23/24 Cheshire and Merseyside hosted a visit from the national discharge team and have held a number of discussions with the newly formed national UEC Tiering Team. Both of which, have recognised the system view that improving discharge is the highest priority for Cheshire and Merseyside.

7.3 The focussed programme for discharge improvement was launched on 12th June and consists of three workstreams with representation across the system including Acute, Mental Health, Community, VCSE, Place, and Social Care. The programme has objectives to improve discharge on 8-week and 12-week time scales ahead of Winter. This is alongside, the longer-term objectives.




7.4 Feedback from the first meeting highlighted the need for an enabling digital repository for the Programme with enhanced visibility of both local and national UEC data sets to support standardisation of reporting. This has now been set-up and is in development with BI.

7.5 National and regional colleagues are working closely with Cheshire and Merseyside to support the system with improvement plans. Several meetings have already taken place and are re-occurring including missed opportunities audits, a planned roll-out of national discharge communications, a rapid review of delayed discharges with focus on patients awaiting a therapy decision, monthly regional SCC Development meetings and weekly national discharge meetings.

7.6 As a complex system, C&M recognise that there is no consistent methodology of analysis to understand capacity and demand, particularly from the transition to social care. This was echoed in the national discharge visit in April 2023 and was highlighted as a recommended improvement activity. C&M as part of its designation as a Tier 1 system has been liaising with the national team to access support from a company which is recognised as a national leader in these analytics and whom are commissioned nationally. A response to this request is expected by the end of June.

7.7 Other support offers are available from national teams and the ICB is welcoming of any meaningful support but is impressing of the need to coordinate such support and assurance that is sought from systems at national level.

## 8. Recommendations

8.1 The board is asked to note the findings of the winter debrief, the highlights of the operational planning round and the establishment of the urgent care improvement programme and associated governance.

8.2 Further progress towards the development of the winter plan can be brought to the Board at a date to be agreed.

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## 29 June 2023

## North West Specialised Services Update

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|---|---|
| **Agenda Item No** | **ICB/06/23/15** |
| **Report author & contact details** | Matthew Cunningham, Associate Director of Corporate Affairs and Governance |
| **Report approved by (sponsoring Director)** | Clare Watson, Assistant Chief Executive |
| **Responsible Officer to take actions forward** | Clare Watson, Assistant Chief Executive |

# North West Specialised Services Update

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| **Executive Summary** | At its meeting in March 2023 the Cheshire and Merseyside ICB Board agreed to enter into a Joint Working Agreement with NHS England and the two other Integrated Care Boards (ICBs) in the North West for the 59 specialised services that have been identified as being appropriate for more integrated commissioning from 1 April 2023.<br><br>At this meeting a draft Terms of Reference was provided, for information, for the North West Specialised Services Joint Committee that was required to be established between all four partners to oversee the Joint Working Agreement and to be responsible for making decisions on the specialised services within scope of the Agreement.<br><br>The Committee met for the first time in shadow form on the 1 June 2023. At this meeting the draft Terms of Reference for the Committee was agreed by its members to be taken to the Boards of each North West ICB for approval.<br><br>The Board of NHS Lancashire and South Cumbria ICB will consider the Terms of Reference at its meeting on 05 July 2023.The Board of NHS Greater Manchester ICB will consider the Terms of Reference at its meeting on 19 July 2023.<br><br>The next meeting of the Committee is scheduled for 07 September 2023. | | | | |
| **Purpose (x)** | **For information / note** | **For decision / approval** | **For assurance** | **For ratification** | **For endorsement** |
| | x | x | x | | |
| **Recommendation** | **The Board is asked to:**<br>• **note** the update provided on the first meeting of the shadow North West Specialised Services Joint Committee<br>• **approve** the Terms of Reference for the North West Specialised Services Joint Committee<br>• **approve** the recommendation regarding delegating authority to the Assistant Chief Executive to approve any minor amendments to the Terms of Reference that may be required following consideration by the other two North West ICB Boards. | | | | |
| **Key issues** | None identified | | | | |
| **Key risks** | No key risks identified with committing to approving the Terms of Reference | | | | |
| **Impact (x)** (further detail to be provided in body of paper) | **Financial** | **IM &T** | **Workforce** | **Estate** | |
| | | | | | |
| | **Legal** | **Health Inequalities** | **EDI** | **Sustainability** | |
| | x | | | | |

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| **Route to this meeting** | North West Specialised Services Committee 01 June 2023 | |
| **Management of Conflicts of Interest** | Members of the Board will need to state any conflicts at the Board meeting. | |
| **Patient and Public Engagement** | As a formal committee of ICBs and NHSE, the Joint Committee will also be required to observe the duties placed on NHS bodies regarding effective engagement with stakeholders, including patients and the public, and involving them in decision making. The Joint Committee however is not subject to the Public Bodies (Admissions to Meetings) Act 1960. | |
| **Equality, Diversity, and Inclusion** | In undertaking its role, the Committee will be required to be informed by and pay due regard to the impact of its decisions in relation to equality, diversity, and inclusion. | |
| **Health inequalities** | A core role of the Committee is to support the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and providing a forum that enables collaboration to integrate service pathways, improve population health and services and reduce health inequalities. | |
| **Next Steps** | Subject to approval by all three ICB Boards, the final version of the Terms of Reference will be published on the ICB website. | |
| **Appendices** | **Appendix One** | North West Specialised Services Joint Committee Terms of Reference |
| | **Appendix Two** | Transformation Priorities |

# North West Specialised Services Update

## 1. Executive Summary

1.1 At its meeting in March 2023[1] the Cheshire and Merseyside ICB Board agreed to enter into a Joint Working Agreement[2] with NHS England and the two other Integrated Care Boards (ICBs) in the North West for the 59 specialised services that have been identified as being appropriate for more integrated commissioning from 1 April 2023. The Board also agreed that Clare Watson, Assistant Chief Executive would be the designated voting member on the Joint Committee for NHS Cheshire and Merseyside. Neil Large is also the nominated Non-Executive Director from NHS Cheshire and Merseyside who, alongside other nominated Non-Executive Director representatives from the other two North West ICBs, will form part of the independent scrutiny requirements as outlined within the draft Terms of Reference.

1.2 At the March 2023 Board meeting a draft Terms of Reference was provided, for information, for the North West Specialised Services Joint Committee ('the Joint Committee') that was required to be established between all four partners to oversee the Joint Working Agreement and to be responsible for making decisions on the specialised services within scope of the Agreement.

1.3 The Joint Committee met for the first time in shadow form on the 1 June 2023. At this meeting the draft Terms of Reference for the Committee (Appendix One) was agreed by its members to be taken to the Boards of each North West ICB for approval.

1.4 Once the Terms of Reference has been approved by all three ICBs then it will be published separately within the Corporate Governance Handbook section on the ICB website.

## 2. June 2023 meeting of the Joint Committee

2.1 The Committee met for the first time in shadow form via MSTeams on the 01 June 2023. Meetings of the Joint Committee will be held in person and via MSTeams on a rotating basis with each ICB area 'hosting' the meeting. The ICB area that hosts the meeting has its named representative as named Chair for that meeting until such time as a designated Chair is appointed. Clare Watson chaired the first meeting of the Joint Committee.

[1] https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/march-30th-2023/
[2] https://www.cheshireandmerseyside.nhs.uk/media/ma5juvbv/joint-working-agreement-specialised-services-north-west-final-030423-cm.pdf

2.2 At this meeting, members covered the following areas:

- **Joint Committee Terms of Reference** – members agreed the name and membership of the Joint Committee, that each ICB area would identify one of their Non-Executive Directors as regular attendees to meetings of the Joint Committee, agreed the roles and responsibilities of the Joint Committee, and agreed that the Joint Committee would meet quarterly interspersed with development sessions.
- **Timeline** – Committees members received a report on the key timelines and the milestones that need considering by Committee during 2023-24 ahead of formal delegation to ICBs of a number of specialised services, and the continuation of the North West Joint Committee.
- **Performance reporting** – Committee members received an update on the development of an integrated performance report, which will be a key paper for this Committee. This will cover finance, quality, and delivery against strategic priorities. The aim is for the report to contain easily accessible but meaningful data. A draft will be available to test at the planned August development session and will be followed by a live document from September. This will also provide assurance to the respective Boards in support of delegation from April 2024.
- **Specialised Commissioning Financial Framework and Delegated Services Financial Plan 2023/24** - this paper provided context and scene setting for Committee members regarding the key changes to the specialised services financial framework and how this links to delegation. Committee members noted that there would be established a Finance Sub-group of the Committee
- **Transformation priorities** – a paper was shared with members that provided detail on agreed shared SMART priorities and prompted discussion on an approach to working on the shared areas together. NHS Planning Guidance stated that ICBs and NHS England are required to identify at least three transformation priorities for joint working throughout 2023/24. This paper detailed the outcome of the work done within each system to identify these joint priorities. These priorities have been drawn from national, regional and ICB priorities which means there is some commonality across the ICBs (Appendix Two). Committee members asked that the North West Commissioning Integration Working Group could produce a proposal for how this transformation work is taken forwards, with the proposal coming back to the September meeting of the Joint Committee.
- **Development Session Planning** – Committee members discussed proposed development sessions for Committee members as well as wider ICB Board members and partners, recognising that there is a need for other ICB members to fully understand the risks and financial pressures associated with Specialised Services. There will be further engagement with Committee members to help shape the development sessions, with the first development sessions scheduled for 03 August 2023. The intention is that on the first instance the development sessions for the Committee are anticipated to focus on specific
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issues related to Committee business. This will be supported by broader development for senior individuals across the ICBs.

2.3 All three North West ICBs are due to take the draft Terms of Reference for the Joint Committee to their respective Boards, with the Board of NHS Lancashire and South Cumbria ICB meeting on 05 July 2023 and the Board of NHS Greater Manchester ICB meeting on 19 July 2023. It is not anticipated that there will be any significant changes proposed by either Board, however if there are any minor changes proposed by either Board then **it is recommended that the Board delegate authority to the Assistant Chief Executive to approve these minor changes** to enable consensus by all three ICBs and for the Terms of Reference to be approved and published on all three North West ICB websites. Any minor changes agreed by the Board of NHS Cheshire and Merseyside at its June 2023 Board meeting will also be communicated to the other two ICBs and NHS England ahead of their meetings.

2.4 If any changes proposed by either of the three ICBs are deemed to be significant then these proposals will need to be considered by the Joint Committee at its next meeting with a view to resubmit the revised Terms of Reference to each Board at their September 2023 meetings.

## 3. Legal Underpinning

3.1 Section 65Z5 of the NHS Act 2006 (inserted by the Health and Care Act 2022) permits NHS organisations to enter joint working and delegated arrangements in respect of their statutory functions, and this will be outlined within the Joint Working Agreement.

3.2 The Joint Committee will be established pursuant to section 65Z6 of the NHS Act 2006 and is established so the joint working can be exercised through this body. Section 65Z6 also enables partners to establish a pooled fund, however for 2023/24 ICBs are not required to financially contribute to the Specialised Commissioning Budget and the Partners forming the NWSCC do not intend to create a pooled fund or joint budget for the purpose of the 2023/24 Agreement.

3.3 For the 2023/24 period, NHS England shall hold the Specialised Commissioning Budget and shall be responsible for paying for the Joint Specialised Services from the Specialised Commissioning Budget pursuant to the Specialised Services Contracts. NHS England will establish and maintain the financial and administrative support necessary to meet any auditing regulations applicable to NHS England.

3.4 Apart from what is set out in the Joint Working Agreement, the Joint Committee does not affect the statutory responsibilities and accountabilities of the Partners.

## 4. Next Steps

4.1 Subject to approval of the Terms of Reference by the Board, approval will be communicated to the other two North West ICBs and NHS England.

4.2 Following approval by all three ICBs, the Terms of Reference will be published on the ICB website.

4.3 The next meeting of the Committee is scheduled for 07 September 2023. A further update report will be brought back to the Board at its September 2023 meeting.

4.4 Dates and the outline of development sessions for all Board members will be communicated once they have been agreed.

## 5. Recommendations

5.1 The Board is asked to:

- **note** the update provided on the first meeting of the shadow North West Specialised Services Joint Committee
- **approve** the Terms of Reference for the North West Specialised Services Joint Committee
- **approve** the recommendation regarding delegating authority to the Assistant Chief Executive to approve any minor amendments to the Terms of Reference that may be required following consideration by the other two North West ICB Boards.

## 6. Officer Contact details for more information

Clare Watson
Assistant Chief Executive
clare.watson@cheshireandmerseyside.nhs.uk

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## North West Specialised Services Update

**Appendix One: Joint Committee Terms of Reference**

# North West Specialised Services Committee

## Terms of Reference

Version 2.0, 1 June 2023

# Contents

# Introduction

## Background/context

From April 2023, a joint working model has been established between NHS England and ICBs. This arrangement introduced joint decision-making between NHS England and ICBs for specialised services that are suitable and ready for greater ICB involvement as approved by NHS England's Board on 2 February 2023.

A Joint Working Agreement *(Agreement in relation to the establishment and operation of joint working arrangements, May 2023)* has been developed to legally underpin the joint working model in 2023/24 for statutory joint committees between multi-ICBs and NHSE for the 59 services that are appropriate for more integrated commissioning. These arrangements will be implemented using NHS England's powers under section 65Z5 of the NHS Act 2006.

This model:

- introduced a North West Specialised Services Committee (NWSSC) to facilitate collaboration and decision-making in relation to specialised services that have been determined by NHSE as suitable and ready for greater ICB involvement.
- will support the transition to fully delegated commissioning arrangements for appropriate services in future.
- will support a managed transition towards full delegation in the future. For 2023/24 finances, liability and contracting will remain with NHS England, overseen by the NWSSC.

These terms of reference should be read in conjunction with the Agreement in relation to the establishment and operation of joint working arrangements in support of the joint working model described above.

# Document management

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|---|---|---|---|
| **Document name:** | | Terms of Reference for the North West Specialised Services Committee | |
| **Senior Responsible Owner (SRO):** | | Andrew Bibby, Regional Director of Health and Justice and Specialised Commissioning (North West) | |
| **Lead:** | | Elizabeth Stillibrand - NHS AGEM | |
| **Version** | 2.0 | **Date:** | 01/06/2023 |

## Revision history

| Version | Date | Summary of changes |
|---|---|---|
| 1.0 | 08/03/23 | Voting option agreed. Option of face to face or virtual meetings agreed |
| 1.1 | 05/04/23 | Due to the single- and multi- ICB arrangements for delegation, the agenda will need to be structured appropriately. |
| 1.4 | 09/05/23 | Membership updated |
| 1.4 | 11/05/23 | Rotational chair of 3 ICB core members agreed |
| 2.0 | 01/06/23 | Drafting notes and comments removed following agreement at the North West Specialised Services Committee (01/06/2023).<br>Introduction added. |

## Approved by

This document must be approved by the following people:

| Name | Signature | Title | Date | Version |
|---|---|---|---|---|
| Clare Watson | | Assistant Chief Executive | | 2.0 |
| Andrew Bibby | | Regional Director of Health & Justice and Specialised Commissioning | | 2.0 |
| Rob Bellingham | | Director of Primary Care and Strategic Commissioning | | 2.0 |
| Professor Craig Harris | | Chief of Health and Care Integration | | |

## Related documents

| Title | Owner | Location |
|---|---|---|
| Agreement in relation to the establishment and operation of joint working arrangements | All partners | Copies with all ICBs and NHSE |
| Next steps on the delegation of specialised services commissioning (NHS England Board Paper) | NHS England | NHS England Board Paper (Feb 2023) |
| Roadmap for Integrating Specialised Services | NHS England | NHS England Publication |

### Document control

*The controlled copy of this document is maintained by NHS England. Any copies of this document held outside of that area, in whatever format (e.g. paper, e-mail attachment), are considered to have passed out of control and should be checked for currency and validity.*

# Terms of Reference

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| **Introduction and purpose** | From April 2023, Integrated Care Boards (ICBs) entering joint working agreements with NHS England will become jointly responsible, with NHS England, for commissioning the Joint Specialised Services set out in Schedule 3 of the Agreement, and for any associated Joint Functions set out in Schedule 4.<br><br>NHS England and ICBs will form a statutory joint committee to collaboratively make decisions on the planning and delivery of the Joint Specialised Services, to improve health and care outcomes and reduce health inequalities. Joint Committees are intended as a transitional mechanism prior to ICB taking on full delegated commissioning responsibility.<br><br>Subject to Clauses 7.1 and 7.2 of this Agreement (Further Collaborative Working), the Partners may, to such extent that they consider it desirable, table an item at the Joint Committee relating to any other of their functions that is not a Joint Specialised Service or a Joint Function to facilitate engagement, promote integration and collaborative working.<br><br>The Partners may, from time to time, establish sub-groups or sub-committees of the Joint Committee, with such terms of reference as may be agreed between them. Any such sub-groups or sub-committees that are in place at the commencement of this Agreement may be documented in the Local Terms (Schedule 9). |
| **The Terms of Reference** | These Terms of Reference provide a template to support effective collaboration between NHS England and ICBs acting through Joint Committees in 2023/24.<br><br>The Terms of Reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the Agreement between the ICB and NHS England.<br><br>It is acknowledged that Joint Working Arrangements aim to give ICBs greater involvement in the commissioning of Specialised Services to better align and transform pathways of care around the needs of local populations. |

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| | The Joint Committee will operate as the decision-making forum for exercising the agreed Joint Functions in accordance with the Agreement.<br><br>By agreement, the Partners may use an alternative title for the Joint Committee that reflects local arrangements, for example, 'Commissioning Committee.'<br><br>In the North West Region the Joint Committee will be known as the North West Specialised Services Committee (NWSSC) |
| **Statutory Framework** | The Partners have arranged to exercise the Functions jointly pursuant to section 65Z5 of the NHS Act 2006.<br>The Joint Committee is established pursuant to section 65Z6 of the NHS Act 2006.<br>Apart from as set out in the Agreement, the Joint Committee does not affect the statutory responsibilities and accountabilities of the Partners. |
| **Role of the Joint Committee** | The role of the Joint Committee is to provide strategic decision-making, leadership and oversight for the Joint Specialised Services and any associated activities. The Joint Committee will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these Joint Specialised Services through the following key responsibilities:<br><br>▪ Determining the appropriate structure of the Joint Committee;<br><br>▪ Making joint decisions in relation to the planning and commissioning of the Joint Specialised Services, and any associated commissioning or statutory functions, for the population,for example, through undertaking population needs assessments;<br><br>▪ Making recommendations on the population-based Specialised Services financial allocation and financial plans;<br><br>▪ Oversight and assurance of the Joint Specialised Services in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the |

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| | approach to intervention with Specialised Services Providers where there are quality or contractual issues;<br><br>▪ Identifying and setting strategic priorities and undertaking ongoing assessment and review of Joint Specialised Services within the remit of the Joint Committee, including tackling unequal outcomes and access;<br><br>▪ Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and providing a forum that enables collaboration to integrate service pathways, improve population health and services and reduce health inequalities. This includes establishing links and working effectively with Provider Collaboratives and cancer alliances, and working closely with other ICBs, Joint Committees and NHS England where there are cross-border patient flows to providers;<br><br>▪ Ensuring the Joint Committee has effective engagement with stakeholders, including patients and the public, and involving them in decision-making;<br><br>▪ Ensuring the Joint Committee has appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks;<br><br>▪ Commencing longer-term planning, particularly in view of the ICB(s) receiving full delegated commissioning responsibility in future;<br><br>▪ Discussing any matter which any member of the Joint Committee believes to be of such importance that it should be brought to the attention of the Joint Committee;<br><br>▪ Where agreed by the Partners, overseeing the Collaborative Commissioning Agreements set out in the Joint Working Arrangement;<br><br>▪ Otherwise ensuring that the roles and responsibilities set out in the Agreement between the Partners are discharged.<br><br>The Partners must implement such arrangements as are necessary to demonstrate good decision-making and compliance with all statutory duties, guidance and good practice, including ensuring that the Joint Committee has |

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| | sufficient independent scrutiny of its decision-making and processes.<br><br>Further information on independent membership of the NWSSC is contained in the Membership Section.<br><br>The NWSSC will also be used as a forum for NHS England and ICBs to discuss the development of Retained Specialised Services. NHSE North West retains decision making responsibility for these services.<br><br>The NWSSC will oversee and endorse the development plan for 2023/24 that will support the delivery of delegation of Specialised Services from 1st April 2024<br><br>The NWSSC will oversee and endorse a Target Operating Model (TOM) setting out how the functions and responsibilities will be discharged from April 2024.<br><br>The Joint Committee must adhere to these Terms of Reference but may otherwise regulate its own procedure. |
| **Accountability and reporting** | The Joint Committee will be formally accountable to the Board of NHS England through the relevant NHS England regional governance structure for Specialised Services.<br><br>In the North West the NWSSC will report to the NHS England Board via the North West Regional Management Team (RMT) and the North West Regional Commissioning Committee. Reporting will also be to the North West Regional Leadership Group (RLG), which includes ICB Chief Executives.<br><br>In addition, the NWSSC will report separately to each of the three ICBs via the following Committees:<br><br>NHS Lancashire and South Cumbria ICB – via Lancashire and South Cumbria Specialised Services System Board<br><br>NHS Greater Manchester ICB – via Greater Manchester Specialised Services System Board<br><br>NHS Cheshire and Mersey ICB – via Cheshire and Mersey ICB Board |

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| | The Joint Committee may report to the Delegated Commissioning Group (DCG) for Specialised Services on its proceedings and decisions.<br><br>The Joint Committee's Chair(s) or, at the Chair's discretion, another member of the Joint Committee, may attend the DCG and report to the DCG on its proceedings.<br><br>Where the DCG requests that the Joint Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale. |
| **Membership** | <u>Core Membership</u><br><br>Each of the Partners must nominate one Authorised Officer to be their representative at meetings of the Joint Committee. The Authorised Officers nominated by the Partners and present at a meeting of the Joint Committee comprise the voting membership of the Joint Committee.<br><br>Each of the Partners may nominate a named substitute to attend meetings of the Joint Committee if its Authorised Officer is unavailable or unable to attend or because they are conflicted.<br><br>Each of the Partners must ensure that its Authorised Officer (and any named substitute) is of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint Committee.<br><br>The Authorised Officers (or any substitute(s) appointed) form the Core Membership of the Joint Committee.<br><br><u>Discretionary Membership</u><br><br>Each of the Partners may be represented at meetings of the Joint Committee by representatives (who may be officers or, in the case of an ICB, non-executive members of the ICB) who may observe proceedings and contribute to the Joint Committee's deliberations as required, but these representatives will not have the right to vote.<br><br>The Partners may identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint Committee's deliberations as required. These representatives will not have the right to vote. |

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| | Independent Membership and Independent Scrutiny<br><br>Each ICB will appoint one Non-Executive Director by way of ensuring independent scrutiny. This arrangement will be reviewed ahead of formal delegation arrangements.<br><br>The Non-Executive Directors (Independent Members) will not have voting rights on the NWSSC, their role is:<br><br>• To provide constructive impartial challenge in the decision-making process;<br>• To support the Partners to reach a consensus position wherever possible;<br>• To support the NWSSC to exercise the Functions with reference to the statutory framework, good practice and the Triple Aim; and<br>• To encourage the Partners to undertake effective stakeholder engagement and to have regard to the outcome of engagement exercises.<br>• To role model and support a regional perspective in relation to Specialised Services<br><br>Term of membership<br><br>Each member of the Core Membership (and any substitute appointed) will hold their appointment until 31st March 2024 or until the NWSSC is superseded by governance arrangements in relation to the delegation of Specialised Services. Members will be eligible to be reappointed for further terms at the discretion of the Partners.<br><br>Membership lists<br><br>The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and that this list is made available to the Partners. |
| **Chair** | At the first meeting of the Joint Committee in each financial year, the Core Membership shall select a Chair, or joint Chairs, from among the membership.<br><br>The incumbent(s) in the role / position of Chair shall hold office until such time as an individual is formally confirmed at the first meeting of the Joint Committee in that financial year and be eligible for re-appointment for 2 further terms. At the first scheduled Joint Committee meeting after the expiry of the Chair's term of office, the Core Membership will select a Chair, or joint Chairs, who will assume office at that meeting and for the ensuing term. |

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| | The chairing of the NWSSC will be undertaken by the 3 ICB core members and on a rotational basis throughout the year.<br><br>If the Chair(s) is/are not in attendance at a meeting, the Core Membership will select one of the members to take the chair for that meeting. |
| **Remuneration** | The Partners shall prepare a scheme for the remuneration of any external members and for meeting the reasonable expenses incurred by other classes of membership of the Joint Committee.<br><br>The scheme shall be reviewed on an annual basis. |
| **Meetings** | The Joint Committee shall meet quarterly, as a minimum.<br><br>At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule").<br><br>Meetings of the Joint Committee can be conducted electronically where this is felt to be appropriate.<br><br>The Chair(s) (or in the absence of a Chair, the Partners themselves) shall see that the Schedule is notified to the members.<br><br>Either:<br><br>▪ NHS England, or<br><br>▪ The ICBs acting collectively,<br><br>may call for a special meeting of the Joint Committee outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair(s) may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than 1 weeks' notice of the special meeting. |
| **Quorum** | A Joint Committee meeting is quorate if the following are in attendance:<br><br>▪ the Authorised Officer (or substitute) nominated by NHS England;<br><br>▪ each of the Authorised Officers (or substitutes) appointed by the ICBs. |

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| **Decisions and voting arrangements** | The Joint Committee must seek to make decisions relating to the exercise of the Joint Functions and Joint Specialised Services on a consensus basis.<br><br>The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations between Partners to take place.<br><br>In preparation for future delegation of Specialised Services and collaboration between them for this purpose, the ICBs should seek to adopt a common position on any matter to be decided.<br><br>Decisions must be ratified by the Core Membership of the Joint Committee.<br><br>Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter before the Joint Committee, the Chair(s) may require the decision to be put to a vote in accordance with the following provision.<br><br>Where voting is required there will be equal voting rights with NHS England casting vote: each ICB has a single vote and NHS England has a number of votes equal to the number of ICB votes. Where there is deadlock, NHS England has a casting vote at the meeting of the Joint Committee.<br><br>In the event that the Regional Director of Specialised Commissioning uses their casting vote, this will be communicated to the NHSE Regional Director.<br><br>The agenda of the Joint Committee will be constructed in such a way that members vote only where there is a legitimate interest in the decision being made. |
| **Conduct and conflicts of interest** | Members of the Joint Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies.<br><br>The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/<br><br>Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). See: https://www.gov.uk/government/publications/the-7-principles-of-public-life. |

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| | Members should refer to and act consistently with the NHS England guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*. See: https://www.england.nhs.uk/ourwork/coi/.<br><br>Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, either by participating in discussion or by voting. A Partner whose Authorised Officer is conflicted in this way may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that member. |
| **Confidentiality of proceedings** | The Joint Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the Joint Committee is at the discretion of the Partners.<br><br>All members in attendance at a Joint Committee are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners. |
| **Publication of notices, minutes and papers** | The Partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint Committee.<br><br>The Chair(s) (or in the absence of a Chair, the Partners themselves) shall see that notices of meetings of the Joint Committee, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners 1 week (or, in the case of a special meeting, 2 days) prior to the date of the meeting.<br><br>The proceedings and decisions taken by the Joint Committee shall be recorded in minutes, and those minutes circulated in draft form within 2 weeks of the date of the meeting. The Joint Committee shall confirm those minutes at its next meeting. |
| **Review of the Terms of Reference** | These Terms of Reference will be reviewed annually. |

# Annex A – Membership of the Joint Committee

**Core Members**

| Partner Organisation | Name | Role |
|---|---|---|
| NHS Cheshire and Merseyside Integrated Care Board | Clare Watson | Assistant Chief Executive |
| NHS England | Andrew Bibby | Regional Director of Health & Justice and Specialised Commissioning<br>North West Region |
| NHS Greater Manchester Integrated Care Board | Rob Bellingham | Director of Primary Care and Strategic Commissioning |
| NHS Lancashire and South Cumbria Integrated Care Board | Professor Craig Harris | Chief of Health and Care Integration |

## Discretionary Members

| Partner Organisation | Name | Role |
|---|---|---|
| NHS Cheshire and Merseyside Integrated Care Board | Mark Bakewell | Place Director for Liverpool |
| NHS Cheshire and Merseyside Integrated Care Board | Dr Fiona Lemmens | Deputy Medical Director |
| NHS Cheshire and Merseyside Integrated Care Board | TBC | Provider Collaborative |
| NHS England | Carol Stubley | North West NHSE Director of Commissioning Finance |
| NHS England | Dr Richard Preece | North West NHSE Medical Director |
| NHS Greater Manchester Integrated Care Board | Phillip Kemp | Associate Finance Director |
| NHS Greater Manchester Integrated Care Board | Claire Lake | Deputy Chief Medical Officer |
| NHS Greater Manchester Integrated Care Board<br>The Christie NHS FT | John Wareing | Interim Director of Strategy |
| NHS Lancashire and South Cumbria Integrated Care Board | Katherine Disley | Finance Lead |
| NHS Lancashire and South Cumbria Integrated Care Board | Dr David Levy | Chief Medical Director |
| NHS Lancashire and South Cumbria Integrated Care Board<br>Lancashire Teaching Hospitals NHS FT | Gary Doherty | Director of Strategy |

## Independent Members

| Partner Organisation | Name | Role |
|---|---|---|
| NHS Cheshire and Merseyside Integrated Care Board | Neil Large | Non-Executive Director |
| NHS Greater Manchester Integrated Care Board | TBC | Non-Executive Director |
| NHS Lancashire and South Cumbria Integrated Care Board | TBC | Non-Executive Director |

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## North West Specialised Services Update

**Appendix Two:  Transformation Priorities**

# Transformation priorities

| ICB | Priority 1 | Priority 2 | Priority 3 | Priority 4 |
|---|---|---|---|---|
| Lancashire and South Cumbria | Urology cancer surgery – reconfiguration of provision | Optimising Stroke Pathways – aim to transition to 24/7 mechanical thrombectomy service | Neurorehabilitation - case management and new models of care | Medical paediatrics – speciality based specialty paediatrics |
| Cheshire and Mersey | Renal Service Transformation Programme (RSTP) | Optimising Stroke Pathways – from 999 to thrombectomy | Neurorehabilitation – case management and new models of care | Transition from specialised paediatric services to adult services |
| Greater Manchester | Renal Service Transformation Programme (RSTP) | Lung cancer pathway improvement- enabling faster diagnostic pathways and treatment | Neurorehabilitation – case management and new models of care | Trauma pathway improvement – implementation of major trauma receiving site |

# NHS Cheshire and Merseyside Integrated Care Board Meeting

29 June 2023

## The Director of Nursing & Care's Report

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| **Agenda Item No** | ICB/06/23/16 |
| **Report author & contact details** | Kerry Lloyd – Deputy Director of Nursing & Care |
| **Report approved by (sponsoring Director)** | Chris Douglas – Executive Director of Nursing & Care |
| **Responsible Officer to take actions forward** | Kerry Lloyd – Deputy Director of Nursing & Care |

<table>
<tr><td>Executive Summary</td><td colspan="5">The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks, issues and highlights that have an impact on quality and safety within the Cheshire and Merseyside ICS footprint.<br><br>The report will feature updates that include:<br><br>• Industrial Action<br>• System Improvement Board for Countess of Chester Hospital NHS Foundation Trust<br>• System Improvement Board Liverpool University Hospital NHS Foundation Trust<br>• Rapid Quality Review for Cheshire and Wirral Partnership NHS Foundation Trust<br>• Patient Safety Incident Response Framework (PSIRF)<br>• Special Educational Needs & Disabilities update (SEND).</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:<br>• Note the content of the report and request additional information / assurance as appropriate.</td></tr>
<tr><td>Key issues</td><td colspan="5">Preparation and planning have been ongoing since the first wave of industrial action (IA) in December 2022. The ICS established a governance framework that aligned to both national and regional architecture. Reducing the impact on the quality and safety during periods of IA continues to be a priority for ICS partners.<br><br>The ICB has a responsibility to support all NHS Trusts within Cheshire & Merseyside to improve and/or maintain their System Oversight Framework (SOF) positions. In addition, the ICB is also accountable for continuous monitoring of the Trusts, making adjusted and proportionate responses, working with the organisations themselves to provide assurance and in light of this, the ICBs own SOF position is a reflection, in part, of its effectiveness in achieving the above, and working with the entire system to provide safe, high-quality health and care<br><br>Through the routine quality oversight governance processes that are in place, the ICB identified several focus areas that met the threshold for a more detailed review within Cheshire & Wirral Partnership NHS Foundation Trust of what could be done differently to improve quality.</td></tr>
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|---|---|
| | The nationally mandated Patient safety Incident Response Framework needs to be implemented by Autumn 2023. There is a trajectory for sign off and a planned timetable for implementation.<br><br>Annual Special Educational Needs and Disabilities data has been published and it currently being reviewed to inform areas of good practice or gaps. |
| **Key risks** | The ongoing impact of IA has the potential to impact upon the quality and safety of services. |

| **Impact (x)** (further detail to be provided in body of paper) | | | | |
|---|---|---|---|---|
| **Financial** | **IM &T** | **Workforce** | **Estate** |
| x | x | x | x |
| **Legal** | **Health Inequalities** | **EDI** | **Sustainability** |
| x | x | x | x |

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|---|---|
| **Route to this meeting** | Not Applicable |
| **Management of Conflicts of Interest** | No conflict of interest identified |
| **Patient and Public Engagement** | Not Applicable |
| **Equality, Diversity, and Inclusion** | The nature and content of the paper does not require an Equalities Health Impact assessment (EHIA) to be undertaken. |
| **Health inequalities** | Not Applicable |
| **Next Steps** | Reporting will continue via the established governance routes. |
| **Appendices** | None |

# Director of Nursing and Care Report

## 1. Executive Summary

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

1.2 The report will feature updates that include:

- Industrial Action
- System Improvement Board for Countess of Chester Hospital NHS Foundation Trust
- System Improvement Board Liverpool University Hospital NHS Foundation Trust
- Rapid Quality Review for Cheshire and Wirral Partnership NHS Foundation Trust
- Patient Safety Incident Response Framework (PSIRF)
- Special Educational Needs & Disabilities update (SEND).

## 2. Industrial Action

2.1 There have been IA taken by The British Medical Association in relation to 'junior doctors' terms and conditions on the 14th -17th June 2023.Preparation and planning have continued via the established clinical/workforce cell. The cell comprises Nursing, Human Resource and Medical senior leaders. The cell continues to meet on a regular basis, determined by intensity and frequency of IA and acts as a conduit for escalation and communication with ICS and regional partners.

2.2 The cell continues to gather insight and impact feedback from all affected organisations within C&M and has developed a tracker for oversight of any associated patient harm. An industrial action lessons learnt event was held on the 20th June to share the learning across the system.

## 3. System Improvement Board for Countess of Chester Hospital NHS Foundation Trust

3.1 The enhanced oversight process from a System Improvement Board remains in place and monthly meetings with NHSE, the Care Quality Commission and the ICB continue with the Trust's interim Chief Executive and Trust leadership team.

3.2 The System Improvement Board has agreed a set of exit criteria that need to be achieved to facilitate conclusion of this oversight assurance mechanism. A detailed plan for how the ICB at Place will oversee delivery against these exit criteria has been approved by NHSE. This includes the use of a methodology for rating progress that could be used to support a standardised approach across Cheshire and Merseyside ICB.

## 4. LUFT System Improvement Board

4.1 LUHFT remains in SOF 4 and has a System Improvement Board (SIB) in place to support and sustain improvement with six clearly defined exit criteria which once achieved will enable step down into SOF 3. LUHFT is keen to be able to provide a suite of evidence in the next few months to demonstrate by early Autumn that they have achieved the requirements of the exit criteria. The LUHFT exit criteria are:

1. NO outstanding actions arising from regulatory notices (HEE, GMC, CQC, HSE).
2. Demonstrable robust systems and process relating to safety and quality.
3. Evidence of effective systems and processes to support the delivery of NHS Constitutional standards.
4. Demonstrable commitment to developing a culture of safety, compassion, and inclusivity with high engagement
5. Demonstrable robust organisation wide governance structure in place
6. Agreement of long-term clinical and financial sustainability plan for LUHFT that contributes to the system financial plan and plan for sustainable services.

4.2 To support this process, the Trust has completed a timeline to demonstrate when the evidence will be available for the SIB to consider and make a judgement whether the evidence provides assurance against the following ratings:

| Score | Assessment category |
|---|---|
| 0 | Insufficient evidence to support action progress / action incomplete / not yet commenced |
| 1 | Action commenced |
| 2 | Action significantly progressed |
| 3 | Action completed but not yet tested |
| 4 | Action complete, tested and embedded |
| 5 | Can demonstrate a sustained improvement |

4.3 In addition, where appropriate and relevant, aspects of the evidence related to quality within Exit Criteria numbers 1,2 3, 4 and 5 have been overseen over time by the Clinical Quality & Performance Group (CQPG) to provide critical oversight and challenge which can be evidenced via the minutes of the monthly meetings.

## 5. Rapid Quality Review for Cheshire and Wirral Partnership NHS Foundation Trust

5.1 Through the routine quality oversight governance processes that are in place, the ICB identified several focus areas that met the threshold for a more detailed review of what could be done differently to improve quality. This process of increased focus involves partners from across a range sector including local authorities and regulators. Progress on delivering improvements is being tracked against an action plan. The ICB Place governance is providing oversight of the majority of actions via contract schedules, as using existing processes mitigates against onerous reporting processes.

## 6. Patient Safety Incident Response Framework

6.1 PSIRF is nationally mandated and needs to be implemented by Autumn 2023. To date there is one provider (Merseycare) out of 17 who has been signed off by the ICB and are planning to implement PSIRF from 1st July. There is a timetable in place for sign off and draft dates for implementation for the remaining providers.

6.2 Support is currently being provided from the ICB via drop-in sessions and an implementation group to share best practice and lessons learnt. In addition, a transformation bid has been submitted as part of the Cheshire & Merseyside Efficiencies at Scale programme to support providers in this transformational change.

## 7. SEND Update

7.1 Annual SEND data has been published recently. Local Authorities are currently analysing this alongside health colleagues at Place Education, health and care plans, Reporting year 2023 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

7.2 Warrington remains the only local area in Cheshire and Merseyside to be inspected under the new SEND Inspection Framework and Handbook 2022 to date: https://www.gov.uk/government/news/improving-outcomes-for-children-and-young-people-with-send

7.3 The Warrington DCO along with commissioning colleagues has supported development of the action plan relating to areas for improvement highlighted by the inspection.

7.4 Six inspection letters nationally have been published under the new framework to date, with outcomes being collated by the SCU to inform future SEND inspection preparation at Place:

https://reports.ofsted.gov.uk/provider/44/80575?utm_source&utm_medium=email&utm_campaign=report

## 8. Recommendations

The Board is asked to:

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

## 9. Officer contact details for more information:

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

# NHS Cheshire and Merseyside ICB Board Meeting

Date: 29th June 2023

*Quality & Performance Report*

| | |
|---|---|
| **Agenda Item No** | ICB/23/06/17 |
| **Report author & contact details** | Andy Thomas (contact details in body of report) |
| **Report approved by (sponsoring Director)** | Anthony Middleton, Director of Performance and Planning |
| **Responsible Officer to take actions forward** | Andy Thomas, Associate Director of Planning |

# Quality & Performance Report

| | | | | | |
|---|---|---|---|---|---|
| **Executive Summary** | The attached presentation provides on overview of key sentinel metrics drawn from the 2023/24 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:**<br>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 and sometimes severe pressure across the whole of NHS Cheshire & Merseyside.<br>• Significant reduction in backlogs for both elective and cancer care are to be welcomed. | | | | |
| **Key risks** | • Impact on ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience.<br>• Long waits for cancer and elective treatment could result in poor outcomes.<br>• Workforce, encompassing recruitment, retention, skill mix/shortages, across health and social care. | | | | |

| **Impact (X)** (further detail to be provided in body of paper) | **Financial** | **IM&T** | **Workforce** | **Estates** |
|---|---|---|---|---|
| | | | X | |
| | **Legal** | **Health Inequalities** | **EDI** | **Sustainability** |
| | | X | | |

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|---|---|
| ***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 |
| ***Next Steps*** | n/a- regular report |
| **Appendices** | |

| **Glossary of Terms** | **Explanation or clarification of abbreviations used in this paper** |
|---|---|
| | |

# NHS Cheshire and Merseyside ICB
# Quality & Performance Report

## 1. Urgent and Emergency Care

1.1 The urgent and emergency care (UEC) system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside. All acute hospitals across the system report daily against a nationally defined set of Operational Pressures Escalation Levels (OPEL). The majority of Trusts across C&M have been consistently reporting at OPEL 3 for an extended period during 2022 and 2023 to date. OPEL 3 is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'.

1.2 A national tiering system for urgent and emergency care delivery was announced in May in which all Trusts and ICBs were placed within a Tier based on UEC performance. Cheshire & Merseyside has been identified as a Tier 1 system alongside 6 other ICS areas and 1 ambulance provider, and therefore will be the recipient of national improvement resources.

**Sentinel Metrics**

1.3 The 4 key metrics that determine the UEC Tier are 76% delivery against the A&E 4-hour standard, attainment of the 30-minute Category 2 ambulance response time standard, alongside the 12-hour time in Emergency Department measure and the proportion of general and acute beds occupied by patients over a 14-day length of stay.

1.4 During May, 73.7% of patients being admitted, transferred, or discharged within 4 hours against trajectory of 65.6% and a year-end national recovery target of 76%. Current performance is significantly better than anticipated at the time of setting 2023/24 plans.

1.5 The May 2023 Category 2 mean ambulance response time was 25 minutes and 30 seconds. The national recovery target is for the response time to be within 30 minutes in 2023/24. NWAS has set a plan to achieve 33 minutes across the year reflecting operational pressures in 2022/23.

1.6 The percentage of patients spending over 12 hours in A&E from arrival has slightly improved from April, reducing from 13.9% to 13.6% in May, however this is higher than both the NW regional average of 10.9% and the national position of 8.6%. There is no defined national target, however for the purposes of tiering a RAG rating based on relative performance is given, and C&M is one of 4 ICB areas nationally rated as Red.

1.7 The percentage of beds occupied by patients with a length of stay over 14 days is currently running at 36.8% as at 12 June 2023, whilst length of stay over 21 days continues to account for around a quarter of occupied beds. There is no defined national target, however for the purposes of tiering a RAG rating is given, and again C&M is one of 4 ICB areas nationally rated as Red.

1.8 Long length of stay (as reported above in 1.7) is a significant factor in the persistently high levels of bed occupancy, and there also continues to be a significant number of patients no longer meeting the criteria to reside in hospital. Provisional data indicates that the proportion of people not meeting the criteria to reside in May was 20.6%, compared to 20.1% in April and remains significantly higher than the England average (14.7% in April), and the C&M ambition of 12%. Within this there is also significant variation across Trusts. The number of patients not meeting the criteria to reside within Trusts across Cheshire and Merseyside remains around 1,000 on any given day with the majority awaiting packages of support to enable their discharge home.

1.9 In addition, a wider range of metrics are scrutinised across Cheshire & Merseyside as key indicators of UEC system flow or as part of 2023/24 operational plans as follows.

1.10 Ambulance handover delays over 60 minutes in Cheshire and Merseyside deteriorated to 874 in May 2023 from 721 in April with the majority of these at occurring at Whiston (241), Arrow Park (198) Countess of Chester (143) Aintree (118) Delays between 30 and 60 minutes remain high at 1,777

1.11 Overall adult G&A bed occupancy for May 2023 stood at 91.4% compared to trajectory of 95.2%. This represents an improvement from Q4 of 2022/23, when most C&M acute Trusts reported bed occupancy in a range from 96%-100% throughout March 2023. Operational plans for 2023/24 assume that occupancy will remain a challenge and that occupancy will be 93.4% by year end, against the national ambition to reduce occupancy to 92%.

1.12 Bed occupancy in adult mental health remains very high, running at or close to 100%, impacting on the ability of mental health trusts to accommodate patients who attend an acute emergency department and require admission, with significant pressure seen throughout March and April. As with acute care, a significant number of adult mental health beds are occupied by patients who are ready for discharge but are awaiting supported accommodation, care homes, nursing placements and further non-acute input.

1.13 Cheshire and Merseyside are currently implementing the Mental Health Escalation Framework which has been introduced via NHS England North West region. This framework includes all patients delayed waiting for access to, or discharge from, mental health services. This will provide daily visibility of mental health flow which will enable systems to understand operational pressures and support strategic direction. The framework is being tested in Wirral with the aim of scaling this up across the system by winter 2023.

1.14 Cheshire and Merseyside hosted a visit from the National Discharge Team in May 2023. Following this, system wide UEC improvement work is due to start in June 2023 and looks to create a Cheshire and Merseyside approach to 'Home First' and discharge to assess. This will need to be enabled through the streamlining of in-hospital processes and practice as well as the community response to discharge support via the transfer of care hubs and Reablement services. This system wide programme will bring together the recommendations from the national discharge visit, the national UEC recovery plan published in January 2023 and the NHSE Tiering structure for UEC announced in early May.

1.15 The System Control Centre (SCC) continues to operate 7 days a week from 8am to 8pm with daily reporting across the system and to the national team. The operating model is being reviewed both locally and nationally with a new 'minimum viable product' due to be released in August 2023 for implementation by October 2023, alongside a national requirement for the SCC to move to real time reporting which will require significant changes to current processes, but which will deliver benefits, enabling the SCC and wider system to have real time oversight of pressures which will allow the system to become more proactive in its support offer.

1.16 Place Directors are working closely with their respective Local Authorities to facilitate discharge. Given the extraordinary level of pressure this winter and in the following months, this response has focused on increasing and maintaining the run rate of hospital discharges.

## 2. Elective Care

2.1 The key metrics for Elective Care are the elimination of waits of over 65 weeks by March 2024, and to deliver a system specific elective recovery activity target.

**Sentinel Metrics**

2.2 Patients waiting over 65 weeks fell from 4,674 in March 2023 to 4,492 in April. The April 2023 C&M trajectory is for 7,129 therefore performance is well ahead of plan.

2.3 In terms of elective care activity, this is measured in terms of value-weighted elective activity compared to 2019/2020. The national target set for C&M is 105% with C&M setting an ambition of 108.5%. No 2023/24 published data is yet available, however provisional data in the attached tables indicates end of May performance at 101.8%.

2.4 Looking at 2023/24, within the overall waiting list in the over 65-week cohort, as at the end of May there are 150,464 patients currently waiting over 16 weeks that could potentially breach 65 weeks if not seen and/or treated before the end of March 2024. Based on current 6-week average clearance rate of 6,646 per week, hospitals in C&M are on track to treat all these patients before the end of 2023/24.

2.5 In terms of reducing and eliminating the number of patients waiting longer than 78 weeks, which remains a key national ambition for the first quarter of 2023/24, C&M has made significant progress in reducing the numbers of patients waiting 78 weeks or longer. In the 29 weeks to the end of March 2023 Cheshire and Merseyside NHS trusts cleared 39,576 patients in this cohort, and at year end 349 patients registered to General Practices in Cheshire and Merseyside were reported as having waited over 78 weeks. Provisional data report 290 patients at the end of May, all waiters are due to complexity and patient choice

2.6 The system wide focus on long waits continues with Trusts through the mutual aid hub and weekly meetings with each Trust to review their waiting list and support to access all possible capacity (including diagnostics, independent sector, and sourcing capacity out of area) to maintain clearance rates.

## 3. Diagnostics

3.1 Within the NHS priorities for elective care for 2023/24 set out in May, there is a focus on increasing ensuring that Community Diagnostic Centre (CDC) and acute diagnostic capacity is used to best effect to reduce long waits for elective care and to reduce cancer backlogs.

**Sentinel Metrics**

3.2 In line with this, the system has set activity and associated productivity plans to increase utilisation of diagnostic capacity and ensure that no more than 10% of patients wait for longer than six weeks for their diagnostic by March 2024. For April 2023, this figure was 22.1%.

3.3 In April 2023, Cheshire & Merseyside hospitals completed 95,127 tests. During 2022/23 the total number of tests completed was higher than the number completed in 2019/20 (pre-pandemic) by 4%. Activity increased despite industrial action and winter pressures.

3.4 In addition to the above, focus has been placed on ensuring those that have very long waits are seen. Some patients were previously waiting in excess of 104 weeks for a diagnostic test, however C&M can now report that no patient is waiting in excess of 79 weeks, with plans in place to ensure that this is reduced to a maximum 52 week wait.

3.5 System capacity is reviewed on a weekly basis with neighbouring trusts asked to support each other where waiting times vary, mutual aid has been used to good effect for many modalities and the following initiatives are in place to further reduce waiting times:

- Increasing productivity: Installing Advanced Acceleration Technology (AAT) on 19 MRI scanners which reduces the scan time by 10%; reducing the number of patients cancelled on the day in endoscopy; reducing the number appointments that are missed by patients for imaging and endoscopy; reducing the appointment slot times for echocardiographs in line with national guidelines.
- Reducing Demand: Ensuring that FIT (faecal immunochemical test) is used where appropriate prior to scope referral; offering a CT Colon where appropriate instead of a colonoscopy; ensuring that national referral guidelines for Echocardiographs are applied; rolling out digital connectivity such as with the single PACS (Picture Archiving and Communication) system for images so scans do not have to be duplicated.
- Increasing Activity: 6 Community Diagnostic Centres (CDCs) are providing additional activity with a further 3 CDCs due to open in the coming weeks. In addition, a regional Transnasal Gastroscopy Service has been introduced, giving patients the option to have a scope inserted nasally rather than orally, delivering increased capacity and giving patients a choice, which many report to be less uncomfortable than traditional methods.

3.6 In May 2023, the C&M Diagnostics Programme was asked to present its Echocardiography Recovery Plan to a national conference so that others can learn from the work delivered in C&M. As a result of the plan the percentage and number of patients waiting 6 weeks or more for an Echocardiograph decreased to 17.33% (1323 patients) in March 2023 compared to 38.84% (3837 patients) in March 2022, while the total number of patients waiting has decreased from 9878 patients in March 2022 to 7635 patients in March 2023.

## 4. Cancer

4.1 The key national priorities for cancer services are to further reduce the number of patients waiting longer than 62 days for treatment, and achieving the Faster Diagnosis Standard.

**Sentinel Metrics**

4.2 62-day cancer performance remains below the operating standard at 63.6% in April 2023 compared with 67.4% in March and 61.5% in February. C&M continues to perform better than the North West and England averages.

4.3 These key targets have been built into 2023/24 operational plans and the 75% 28-day faster diagnosis standard and the reduction of the over 62-day backlog. As at 11 June 2023 there are 1,624 patients, we are currently 106 ahead of our planning trajectory towards meeting the 1,095 by the end of year.

4.4 28-day faster diagnosis performance remains challenged due to high referral volumes. Performance in April 2023 was slightly lower than the previous month, moving from 70.4% to 67.3%.

4.5 Cancer services are busier than ever, seeing and treating more patients each month than ever before. Conversion rates have not significantly changed, and the number of new cancers diagnosed has increased. This suggests that, in most cases, the increase in demand (i.e. GP cancer referrals) is genuine and appropriate.

4.6 In April 2023 urgent suspected cancer GP referrals in Cheshire and Merseyside continued to be high at 131.5% of 2019/20 levels compared with 121.6% nationally. More patients than ever are being seen within target time, however, performance against the 14-day standard remains below target at 76.0%, which is lower than the previous month (77.7%)

4.7 However, although a greater number of patients have been seen and treated within target times, high volumes have meant that significant numbers of patients have experienced

delays, as reflected in the 62-day performance. The impact will continue to be monitored through patient experience surveys and clinical harm reviews.

4.8 3,000 additional cancer first appointments are being provided each month compared with 2019 to manage increased demand. The Cancer Alliance is supporting improved efficiency and productivity with funding and project resources through the faster diagnosis programme.

4.9 Lower GI (LGI) cancer pathways are under significant pressure in most providers as a combined result of increased referrals and diagnostic capacity constraints. LGI referrals in 2022/23 YTD are 160% of pre-pandemic (2019) levels. LGI pathways continue to be the focus of targeted support, primarily through the Alliance's faecal immunochemical testing (FIT) programme and the Endoscopy Network's improvement programme.

4.10 Capital investments, training & education (in both primary and secondary care) and a pipeline of innovation are all building resilience and supporting recovery. However, significant further investment in the cancer workforce is required to meet demand.

## 5. Mental Health

5.1 Operational plans for 2023/24 have focused on maintaining contact with people with severe mental illness, the reduction of out of areas placement bed days, improving access to psychological therapies, community perinatal mental health and dementia diagnosis. Targets are set and reported on a quarterly basis therefore March 2023 outturn is currently the validated position.

5.2 As previously reported, data quality issues continue to impact adversely on national reporting against MH access targets for 2022/23 in a number of service areas for, notably for children and young people mental health access and eating disorder access metrics.

**Sentinel Metrics**

5.3 There has been a significant increase in physical health checks for people with severe mental illness during the last quarter of 2022/23 with all sub ICBs increasing the percentages of health checks delivered. However, access fell short of the ambition to deliver checks for 17,673 people by 3,058, with only Warrington meeting the target levels.

5.4 The number of out of area placement bed days has increased again this month to 1,885 from 1,195 due to continued high demand. All out of area activity relates to Cheshire and Wirral Partnership NHS Foundation Trust who are experiencing issues with staffing levels in inpatient services and high numbers of delayed discharges which are impacting adversely on acute care flow. Lack of supported housing, nursing homes and suitable community placements are the most significant reasons for delays.

5.5 Access to Talking Therapies (IAPT) access improved in March 2023 from 4,185 to 5,115 remaining below target levels in terms of the numbers of people entering treatment. The planned national communications campaign is now not expected until quarter 3, however, a local population-based campaign is imminent to prompt self-referral.

5.6 The waiting time target of 75% of people having access to Talking Therapies (IAPT) within 6 weeks continues to be exceeded at ICB level and within seven out of nine places, with Sefton and Warrington the exceptions. The 18-week NHS Talking Therapies target is being achieved across the whole of Cheshire & Merseyside.

5.7 Talking Therapies (IAPT) recovery rates have been achieved overall at a Cheshire and Merseyside level for the second consecutive month and within eight out of nine places, compared with six in the previous period. For the area where the recovery rate is not being achieved, namely Liverpool, a recovery rate of 48% has been delivered which is a 1% increase on the previous month.

5.8 Specialist community perinatal services have exceeded the agreed recovery target of 2,357 by year end with local data evidencing increased access across all areas. Perinatal MH services have provided access of 2,250 and maternal MH services 205

5.9 As detailed above in the UEC section, the new NW Region Escalation Framework for adult mental health is being piloted for Wirral from week commencing 5th June with a view to rolling out across the ICS and ensuring robust oversight via the System Control Centre.

## 6. Learning Disabilities and Autism

**Sentinel Metrics**

6.1 In terms of Learning Disabilities local data indicated that the number of Annual Health Checks (AHC) for people aged 14+ with a Learning Disability in Cheshire and Merseyside surpassed the target of 75%, accomplishing 80.40% by year end, March 2023, this represents a positive improvement on the previous year of 71.7%. The 75% target remains the same for 2023/24.

6.2 The increased uptake in AHCs has been achieved through various routes: GP Practices were encouraged to begin with patients they did not see last year (outstanding AHCs continue to be targeted in 2023/24), use of a dedicated risk assessment tool to identify those patients who need face to face AHCs, most practices made at least three contacts with the patient to encourage them to come in using a variety of ways between phone, text messaging and easy read letters, individual reasonable adjustments are provided where needed, easy read letters to patients who DNA, or have not responded to any call or messages, Learning Disability Health Facilitators follow up non-attendance and flexible solutions have been sought in terms of location and provision of dedicated space to better enable reasonable adjustments.

6.3 Work is also ongoing to minimise the use of inpatient settings for adults with a Learning Disability and/or Autism. There were 25.38 adults per million registered population inpatients in Cheshire and Merseyside with a Learning Disability and/or Autism in Q2 2022/23, the national target for the end of 2023/24 is 17.76 per million. The main challenge in this area is delayed discharge caused by difficulty identifying suitable housing, making essential adaptations, and workforce to support patients in the community.

6.4 Transforming Care staff are helping with the backlog of Care and Treatment Reviews (CTR's) within Specialised Commissioning, where further delayed discharges have been identified. Weekly calls are being held to address delayed discharges and active cases with both Cheshire and Wirral Partnership (CWP) NHS Foundation Trust and Mersey Care NHS Foundation Trust.

6.5 Similarly, for Children and Young People (CYP), there is a target to reduce reliance on inpatient care to 13.99 per million by quarter 4 of 2023/24. A Dynamic Support Register has been developed to enable early the identification of children and young people at risk of admission to ensure admissions are appropriate.

6.6 Key workers in post have started to make a difference, utilising the escalation process to avoid inappropriate admissions or reduce Length of Stay. As of May 2023, Cheshire and Merseyside has seen strong performance regarding discharges, which has brought the ICB within trajectory for all cohorts for the first time.

## 7. Primary Care

7.1 Operational plans for 2023/24 have focused on making it easier for people to contact a GP practice, to continue the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 and continue to recruit additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024

**Sentinel Metrics**

7.2 Overall demand remains high for all GP appointments, patients continue to benefit from continued and increased access to appointments with activity remaining higher than the same pre-pandemic period. April reported 133.8% total appointment delivered against pre covid baseline which is an increase of 7.1% compared to the previous month.

7.3 The roll out of the GP appointment toolkit in 2023/24 to practices has helped place colleagues, working with practices/PCNs to understand demand and outcomes in terms of appointments. Further work supporting correct coding of appointment types is ongoing.

7.4 Appointment data, qualitative actions and overall access, are reported and overseen at the System Primary Care Committee (bimonthly) where assurance is given on actions to support this at place and corporate level.

7.5 Since last month's report NHSE has released the national plan for recovering access to primary care which can be found here: https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/. This contains a number of must do actions for ICBs, which will be reported through System Primary Care Committee from the newly set up Programme Board which will oversee the delivery of the final plan. A presentation on the plan is scheduled to go to the June Board, with the final plan due to go to Board in October.

## 8. Community Health Services

8.1 The overall number of patients awaiting a community appointment reduced during 2022/23 from 66,037 in April 2022 to 56,587 in March 2023. Further work is being taken forward through the mental health and community service provider collaborative with all provider organisations working together to share best practice and provide mutual aid.

8.2 The Urgent Community Response (UCR) service capacity and activity continued to grow consistently throughout 2022/23 from 550 in April 2022 to 1,650 in February 2023 and surpassed the target of 70% of referrals being met within 2 hours, with performance ranging between 72% (April 2022) and 83% (February 2023).

## 9. Summary/Recommendations

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

NHS
Cheshire and Merseyside

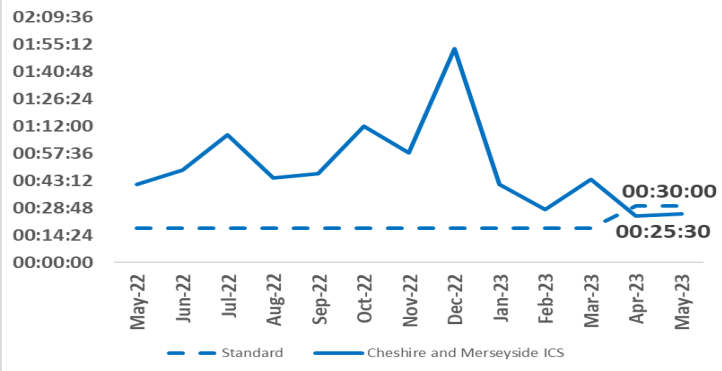
# Performance Report

# Section I: Urgent Care

NHS Cheshire and Merseyside

## Ambulance Response times – Cat 2

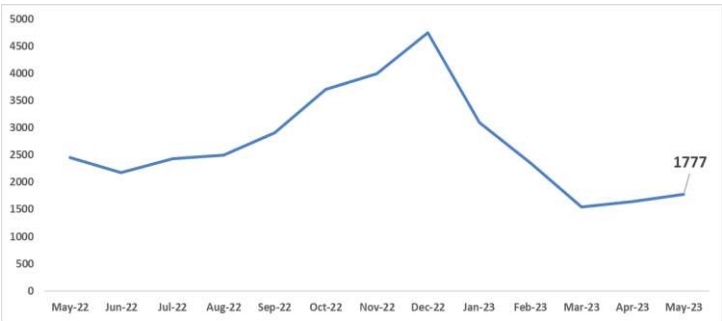
Tier 1 Metric




| Organisation | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|
| Cheshire & Merseyside | 00:43:54 | 00:24:39 | 00:25:30 |
| North West | 00:30:57 | 00:20:36 | 00:22:02 |
| England | 00:39:33 | 00:28:35 | 00:32:24 |

Note:
- 30 Minute response time to be achieved over 23/24
- North West & England figures published nationally
- C&M figures from Senior Programme Director

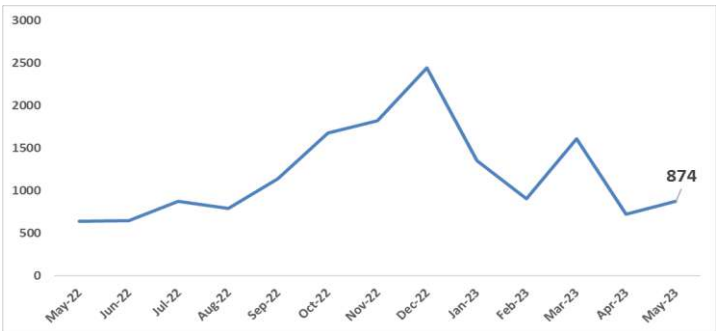
## Ambulance Arrival to handover 30 to 60 mins




| Organisation | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|
| Cheshire & Merseyside | 1539 | 1647 | 1777 |
| North West | 5336 | 4723 | 4871 |
| England | 52120 | | |

Note: England not yet published for 2023/24

## Ambulance Arrival to handover >60 mins




| Organisation | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|
| Cheshire & Merseyside | 1612 | 721 | 874 |
| North West | 3651 | 1610 | 2031 |
| England | 38878 | | |

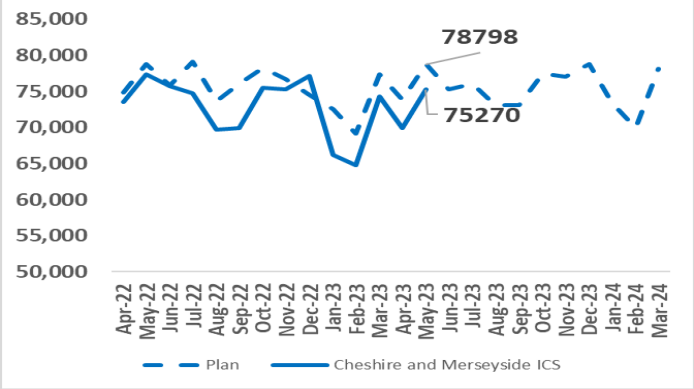
Note: England not yet published for 2023/24

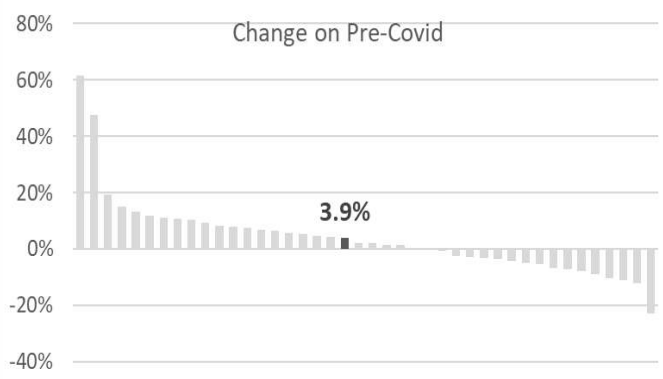
| | May-23 | | | |
|---|---|---|---|---|
| | Total measureable arrivals | >60 min arrival to handover | % attends over 60 mins | Change |
| Aintree University | 1958 | 118 | 6% | ▼ |
| Alder Hey | 1 | 0 | n/a | ▶ |
| Arrowe Park | 977 | 198 | 20% | ▲ |
| Countess of Chester | 929 | 143 | 15% | ▼ |
| Leighton | 856 | 25 | 3% | ▲ |
| Macclesfield General | 87 | 11 | 13% | ▲ |
| Royal Liverpool University | 1567 | 25 | 2% | ▼ |
| Southport District General | 1043 | 18 | 2% | ▶ |
| Warrington | 1375 | 95 | 7% | ▲ |
| Whiston | 1266 | 241 | 19% | ▲ |

# Section I: Urgent Care

NHS Cheshire and Merseyside

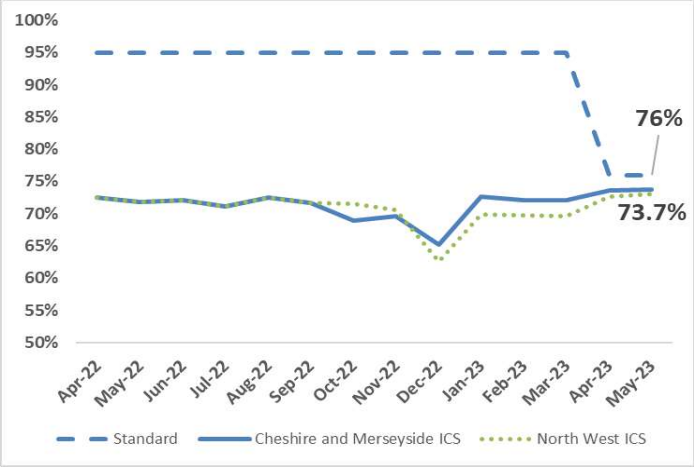
## A&E Attendance (Type 1)




## A&E 4 Hour Standard

Tier 1 Metric

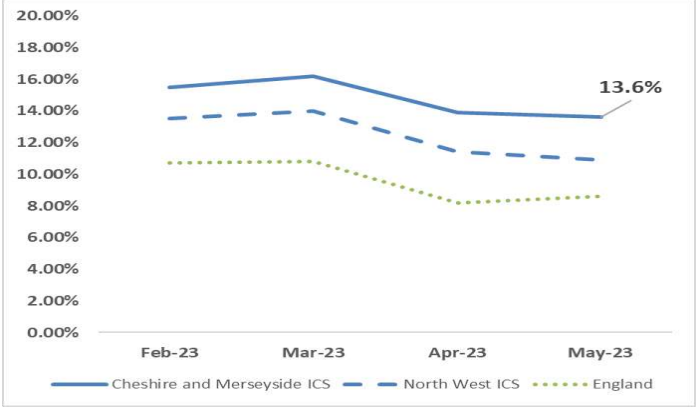



| Organisation | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|
| Cheshire & Merseyside | 72.0% | 73.6% | 73.7% |
| North West | 69.6% | 72.7% | 73.1% |
| England | 74.6% | 74.6% | 74.0% |

Note: Target for this metric is to achieve 76% by March 2024. The 95% standard remains, however 76% is the recovery ambition for 2023/24, with further improvement towards the standard expected thereafter.

## A&E 12 hours in A&E from arrival

Tier 1 Metric



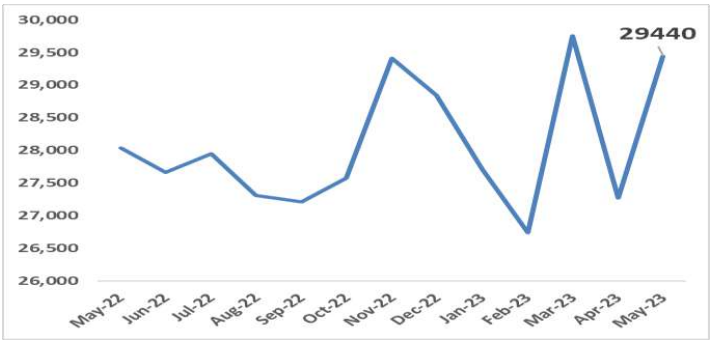

| Organisation | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|
| Cheshire & Merseyside | 16.2% | 13.9% | 13.6% |
| North West | 14.0% | 11.4% | 10.9% |
| England | 10.8% | 8.2% | 8.6% |

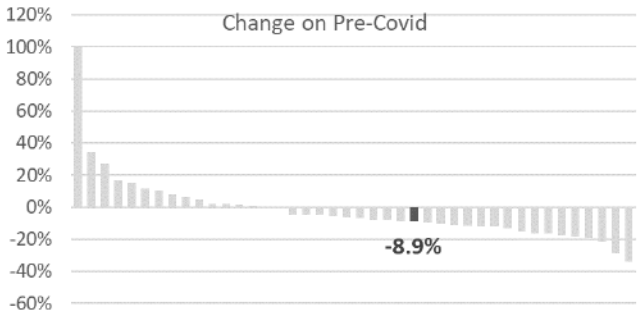
Note: Data only published from February 2023 onwards

# Section I: Urgent Care

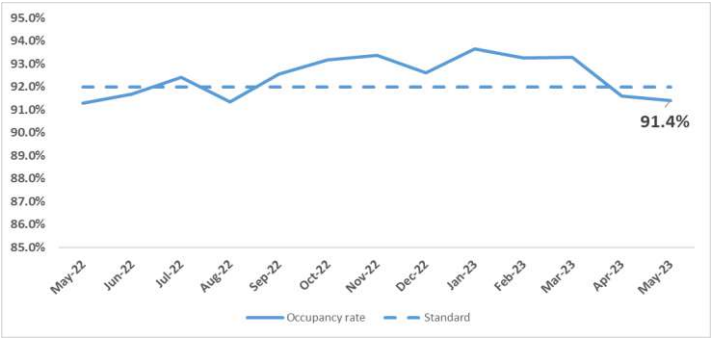
NHS Cheshire and Merseyside

## Total Emergency admissions



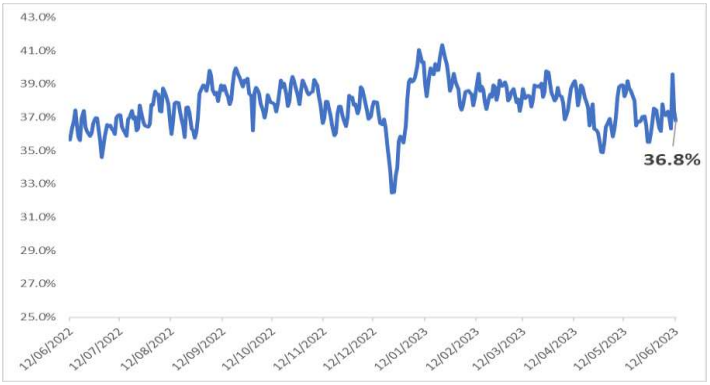

## Bed Occupancy General & Acute




| Organisation | Mar-23 | Apr-23 | May-23 |
|---|---|---|---|
| Cheshire & Merseyside | 93.3% | 91.6% | 91.4% |
| North West | 93.3% | 92.1% | 92.5% |
| England | 94.1% | 92.6% | 93.2% |

## Bed Occupancy General & Acute 14+ day LOS

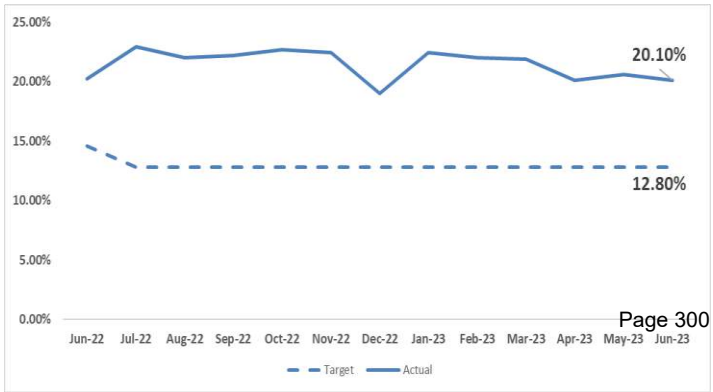
Tier 1 Metric




| Organisation | 30/04/23 | 22/05/23 | 12/06/23 |
|---|---|---|---|
| Cheshire & Merseyside | 36.1% | 37.3% | 36.8% |

Note: Nationally published metric is not available. Data shown here is from local calculation

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




| Organisation | Apr-23 | May-23 | Jun-23 |
|---|---|---|---|
| Cheshire & Merseyside | 20.1% | 20.6*% | 20.1*% |

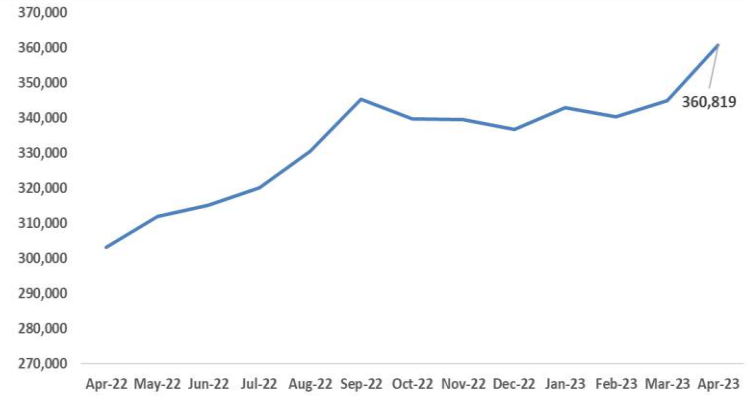
Jun 23: C&M Av 5th to 11th June
Apr 23: England Av 14.7%

| No Criteria to reside - Trust | 21/05/2023 | 11/06/2023 | Change |
|---|---|---|---|
| Countess of Chester Hospital | 13.40% | 20.20% | ▲ |
| East Cheshire Hospitals | 20.20% | 15.30% | ▼ |
| Liverpool University Hospitals | 24.60% | 26.60% | ▲ |
| Mid Cheshire Hospitals | 16.40% | 16.00% | ▼ |
| Southport & Ormskirk Hospital | 19.40% | 15.90% | ▼ |
| St Helens & Knowsley Hospital | 19.97% | 17.70% | ▼ |
| Warrington & Halton Hospital | 20.70% | 19.80% | ▼ |
| Wirral University Teaching Hospital | 23.40% | 19.00% | ▼ |

# Section II: Planned Care (Elective)

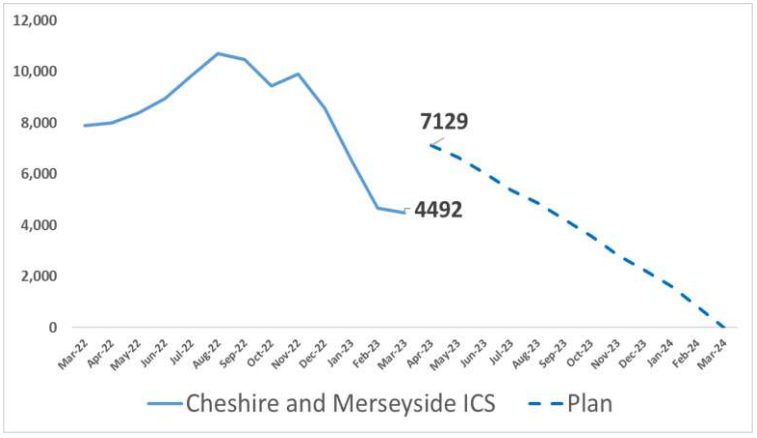
NHS Cheshire and Merseyside

## Total Waiting List Size – Apr 23



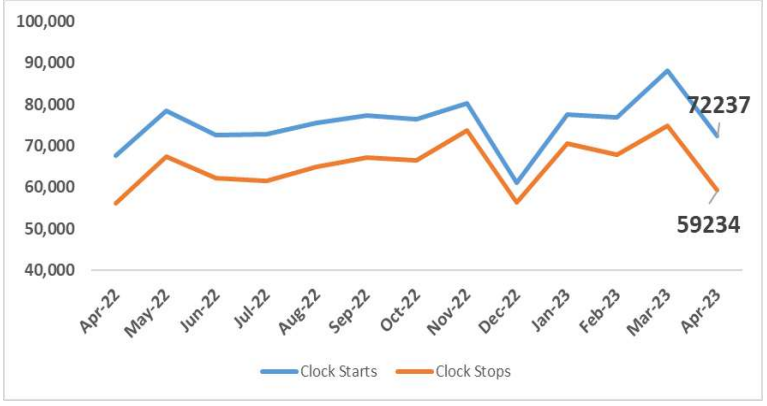

| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 340,484 | 344,912 | 360,819 |
| North West | 971,021 | 984,533 | 1,053,492 |
| England | 6,691,140 | 6,796,618 | 7,198,184 |

## The number of people waiting 65 Weeks or more – Apr 23




| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire & Merseyside | 6515 | 4674 | 4492 |
| North West | 22925 | 17307 | 21149 |
| England | 123739 | 95813 | 95944 |

## RTT – Clock Starts & Clock Stops




| Cheshire & Merseyside | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Clock Starts | 76762 | 88095 | 72237 |
| Clock Stops | 67786 | 74743 | 59234 |

Note: Clock starts and clock stops for RTT treatment give a broad but not complete picture of additions and removals from the waiting list, as waiting lists are also subject to ongoing data validation.

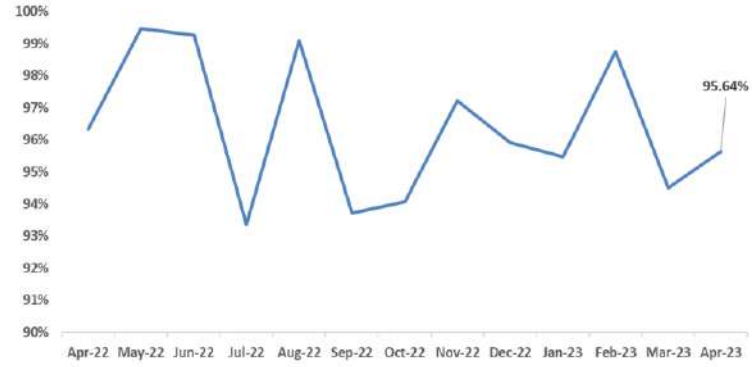
# Section II: Planned Care (Elective)

NHS Cheshire and Merseyside

## Outpatient First % of pre-COVID activity – Apr 23 (comparison with 2019/20)

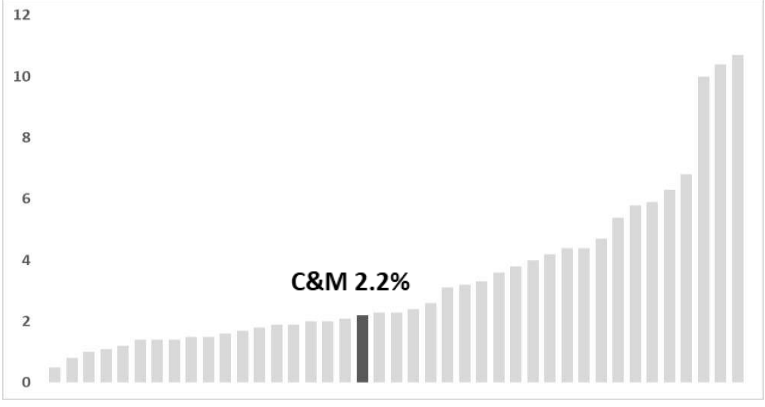

| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 99.44% | 100.72% | 102.34% |
| North West | 91.80% | 95.95% | 93.34% |
| England | 98.11% | 100.35% | 99.53% |

## Outpatient Follow-up % of pre-COVID activity – Apr 23 (comparison with 2019/20)




| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 98.75% | 94.51% | 95.64% |
| North West | 94.99% | 88.81% | 90.00% |
| England | 101.28% | 95.75% | 96.28% |

## Patient Initiated Follow-up (PIFU) ICS Benchmark – Apr 23

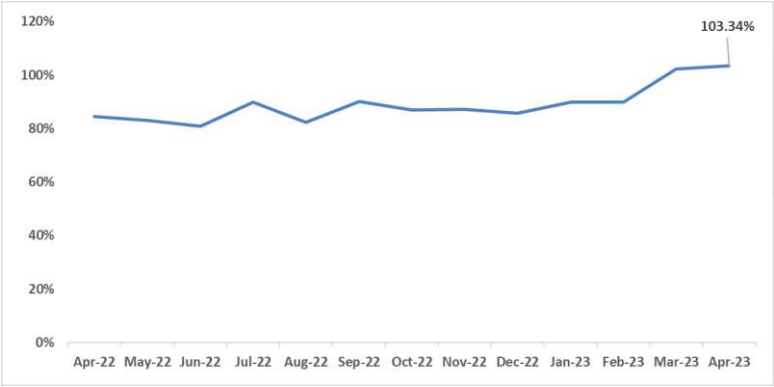



| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 2.2% | 2.2% | 2.2% |
| North West | 1.8% | 2.1% | 2.3% |
| England | 2.2% | 2.3% | 2.6% |

# Section II: Planned Care (Elective)

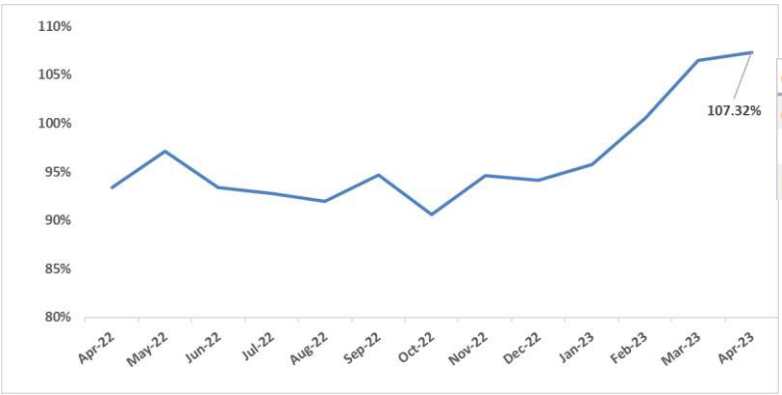
NHS Cheshire and Merseyside

## Elective inpatient admissions % of pre-COVID activity – Apr 23 (comparison with 2019/20)




| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 89.75% | 102.30% | 103.34% |
| North West | 87.57% | 99.07% | 100.69% |
| England | 85.25% | 95.57% | 95.52% |

## Day cases % of pre-COVID activity – Apr 23 (comparison with 2019/20)




| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 100.53% | 106.47% | 107.32% |
| North West | 94.32% | 100.25% | 98.68% |
| England | 99.18% | 101.70% | 101.45% |

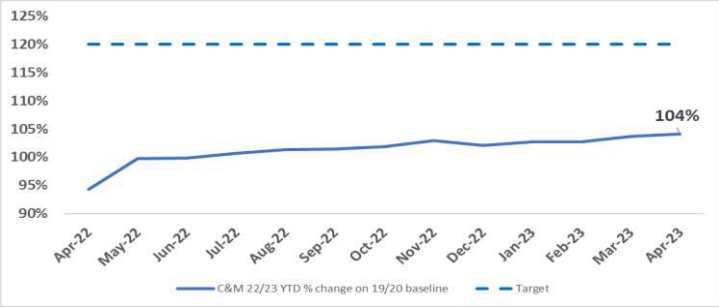
## Elective Recovery Fund – Value-weighted elective activity*

| SUS Value + A&G (est) | 31-Mar-23 | 09-Apr-23 | 16-Apr-23 | 23-Apr-23 | 30-Apr-23 | 07-May-23 | 14-May-23 | 21-May-23 | 28-May-23 |
|---|---|---|---|---|---|---|---|---|---|
| **North West** | **90.1%** | **92.7%** | **90.5%** | **89.0%** | **88.5%** | **87.3%** | **94.3%** | **96.1%** | **98.2%** |
| ***LANCASHIRE AND SOUTH CUMBRIA ICB*** | ***93.7%*** | ***96.0%*** | ***93.7%*** | ***92.5%*** | ***90.2%*** | ***88.8%*** | ***95.7%*** | ***96.2%*** | ***99.5%*** |
| ***GREATER MANCHESTER ICB*** | ***84.2%*** | ***87.2%*** | ***85.1%*** | ***84.3%*** | ***85.3%*** | ***84.7%*** | ***91.6%*** | ***93.5%*** | ***94.6%*** |
| ***CHESHIRE AND MERSEYSIDE ICB*** | ***94.3%*** | ***97.6%*** | ***95.4%*** | ***93.0%*** | ***91.7%*** | ***90.0%*** | ***97.1%*** | ***99.2%*** | ***101.8%*** |
| *WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST* | *96.3%* | *106.3%* | *101.8%* | *97.9%* | *96.3%* | *96.1%* | *107.9%* | *110.1%* | *112.7%* |
| *ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST* | *94.5%* | *95.6%* | *97.2%* | *95.5%* | *96.0%* | *94.9%* | *100.8%* | *101.6%* | *100.8%* |
| *LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST* | *94.0%* | *109.0%* | *114.7%* | *113.3%* | *112.3%* | *111.5%* | *112.1%* | *110.8%* | *114.7%* |
| *ALDER HEY CHILDREN'S NHS FOUNDATION TRUST* | *95.1%* | *98.0%* | *96.2%* | *93.1%* | *91.5%* | *89.7%* | *99.5%* | *105.5%* | *108.3%* |
| *MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST* | *97.4%* | *94.2%* | *87.8%* | *87.2%* | *84.0%* | *83.2%* | *94.9%* | *95.3%* | *96.7%* |
| *LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST* | *91.7%* | *98.6%* | *95.8%* | *92.4%* | *92.0%* | *89.7%* | *94.9%* | *98.2%* | *101.0%* |
| *THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST* | *132.5%* | *128.9%* | *129.5%* | *125.8%* | *122.8%* | *116.9%* | *126.6%* | *133.8%* | *133.8%* |
| *LIVERPOOL WOMEN'S NHS FOUNDATION TRUST* | *91.6%* | *98.5%* | *87.0%* | *84.3%* | *85.5%* | *79.0%* | *87.2%* | *85.6%* | *83.8%* |
| *THE WALTON CENTRE NHS FOUNDATION TRUST* | *106.3%* | *89.2%* | *86.8%* | *84.4%* | *86.8%* | *85.0%* | *89.3%* | *92.9%* | *102.6%* |
| *EAST CHESHIRE NHS TRUST* | *76.9%* | *77.6%* | *77.8%* | *73.2%* | *73.8%* | *73.4%* | *77.0%* | *79.5%* | *83.0%* |
| *COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST* | *84.7%* | *82.2%* | *78.1%* | *77.6%* | *74.5%* | *73.0%* | *80.5%* | *81.3%* | *84.6%* |
| *SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST* | *92.3%* | *97.6%* | *93.9%* | *90.2%* | *85.1%* | *84.3%* | *95.4%* | *77.6%* | *84.2%* |
| *WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST* | *85.4%* | *84.7%* | *84.0%* | *83.6%* | *83.7%* | *84.2%* | *90.1%* | *89.8%* | *90.7%* |
| **England** | **91.1%** | **91.5%** | **89.3%** | **88.2%** | **89.3%** | **88.4%** | **95.3%** | **96.4%** | **97.5%** |

# Section II: Planned Care (Diagnostics)

NHS Cheshire and Merseyside

## Diagnostic Activity: YTD activity performance % of 19/20 activity

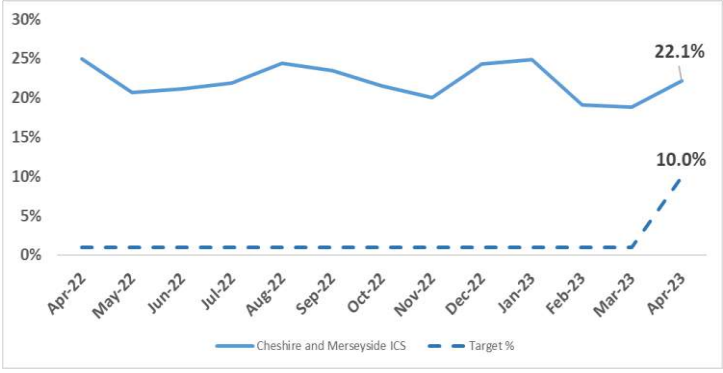



| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire & Merseyside | 103% | 104% | 104% |
| North West | 104% | 105% | 105% |

Note:

- A previous data issue has been corrected, 19/20 activity was previously understated due to use of in-month activity rather than year to date activity.
- April 23 data not yet published.

## Diagnostic 6 week wait – objective no more 10% by end of March 2024

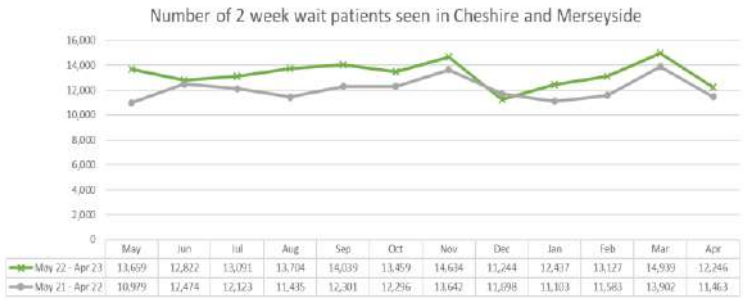



| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire & Merseyside | 19.1% | 18.9% | 22.1% |
| North West | 22.3% | 23.3% | 26.1% |
| England | 25.0% | 25.0% | 26.6% |

# Section III: Cancer Care

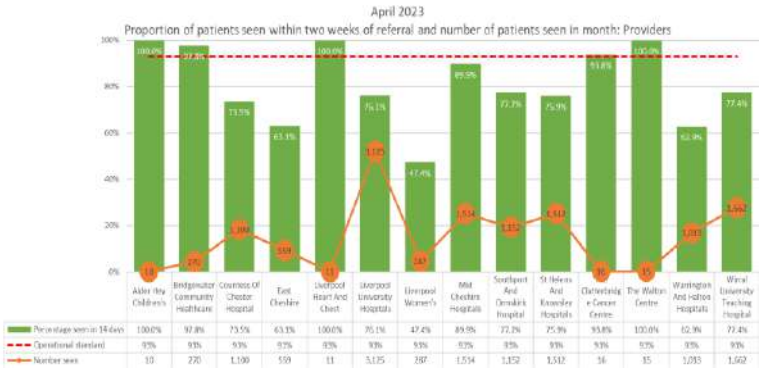
NHS Cheshire and Merseyside

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



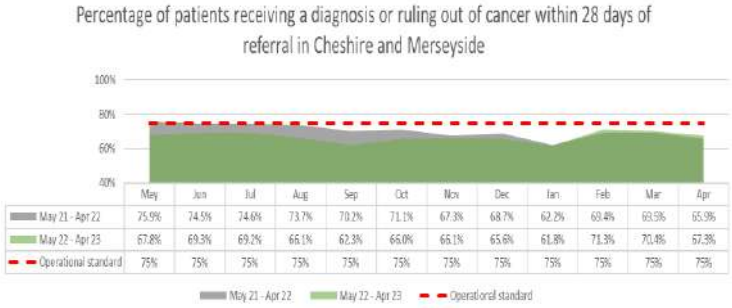

Note: This metric shows numbers of patients seen in Cheshire & Merseyside, meaningful comparisons to numbers seen in the North West or England cannot be made.

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



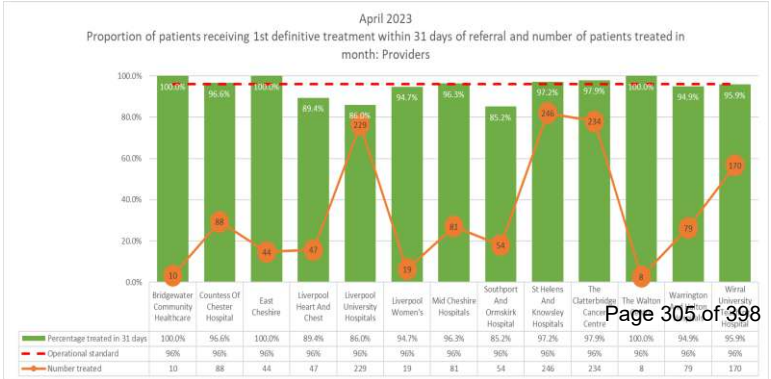

| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseysi | 80.4% | 77.7% | 76.0% |
| North West | 84.8% | 83.1% | 79.6% |
| England | 86.1% | 83.9% | 77.7% |

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




| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseysi | 71.3% | 70.4% | 67.3% |
| North West | 72.8% | 73.0% | 70.2% |
| England | 75.0% | 74.2% | 71.3% |

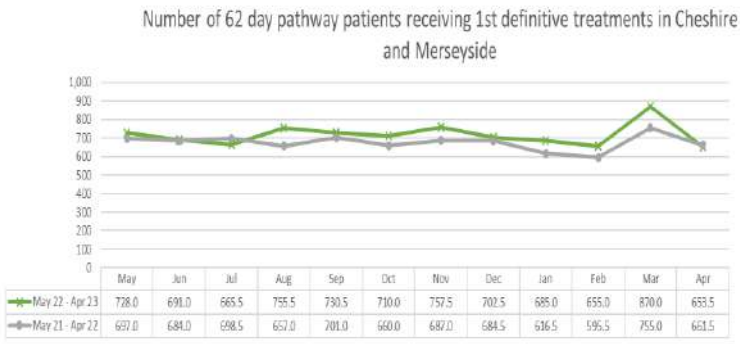
## % of patients diagnosed with cancer receiving treatment within 31 days of diagnosis




| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseysi | 94.2% | 94.8% | 94.3% |
| North West | 92.8% | 91.4% | 91.2% |
| England | 92.0% | 91.9% | 90.5% |

NHS Cheshire and Merseyside

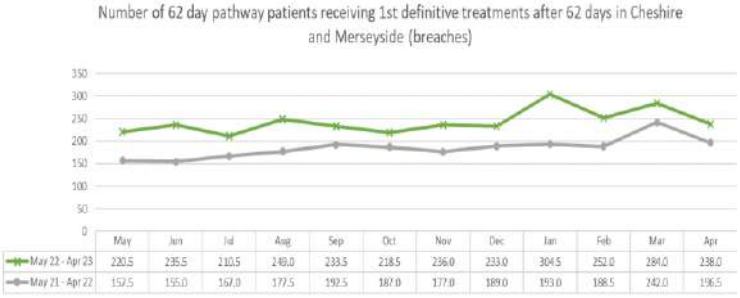
## Number of patients receiving treatment for cancer treatment by their GP waiting on 62 day pathway




| | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| May 22 - Apr 23 | 728.0 | 691.0 | 665.5 | 755.5 | 730.5 | 710.0 | 757.5 | 702.5 | 685.0 | 655.0 | 870.0 | 653.5 |
| May 21 - Apr 22 | 697.0 | 684.0 | 698.5 | 657.0 | 701.0 | 660.0 | 687.0 | 684.5 | 616.5 | 595.5 | 755.0 | 661.5 |

Note: This metric shows numbers of patients seen in Cheshire & Merseyside, meaningful comparisons to numbers seen in the North West or England cannot be made.

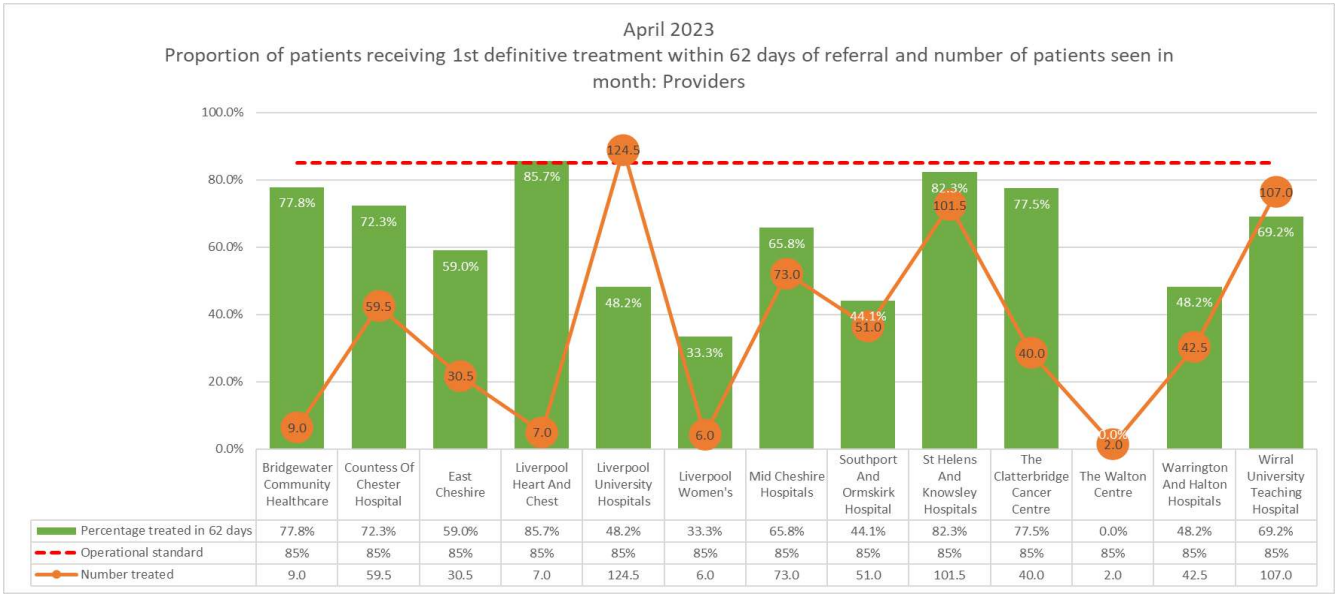
## % Patients referred for cancer treatment by their GP waiting more than 62 days for treatment to start




| | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| May 22 - Apr 23 | 220.5 | 235.5 | 210.5 | 249.0 | 233.5 | 218.5 | 236.0 | 233.0 | 304.5 | 252.0 | 284.0 | 238.0 |
| May 21 - Apr 22 | 152.5 | 155.0 | 167.0 | 177.5 | 192.5 | 187.0 | 177.0 | 189.0 | 193.0 | 188.5 | 242.0 | 196.5 |

| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseysi | 61.5% | 67.4% | 63.6% |
| North West | 59.2% | 63.8% | 61.9% |
| England | 58.2% | 63.5% | 61.0% |

## % Patients referred for cancer treatment by their GP waiting more than 62 days for treatment to start - Providers

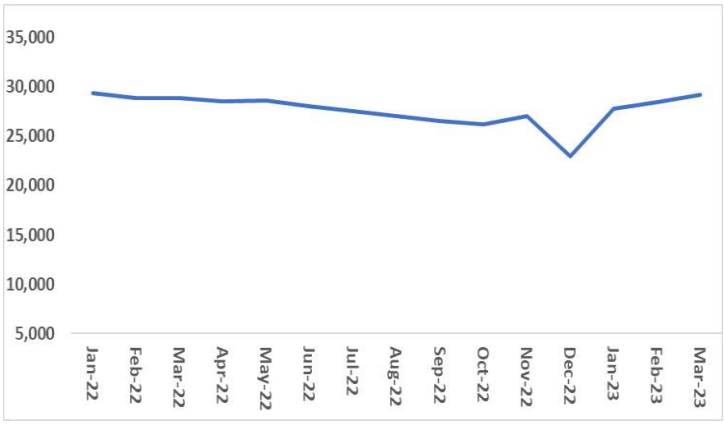



| | Bridgewater Community Healthcare | Countess Of Chester Hospital | East Cheshire | Liverpool Heart And Chest | Liverpool University Hospitals | Liverpool Women's | Mid Cheshire Hospitals | Southport And Ormskirk Hospital | St Helens And Knowsley Hospitals | The Clatterbridge Cancer Centre | The Walton Centre | Warrington And Halton Hospitals | Wirral University Teaching Hospital |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage treated in 62 days | 77.8% | 72.3% | 59.0% | 85.7% | 48.2% | 33.3% | 65.8% | 44.1% | 82.3% | 77.5% | 0.0% | 48.2% | 69.2% |
| Operational standard | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| Number treated | 9.0 | 59.5 | 30.5 | 7.0 | 124.5 | 6.0 | 73.0 | 51.0 | 101.5 | 40.0 | 2.0 | 42.5 | 107.0 |

# Section IV: Mental Health

NHS
Cheshire and Merseyside

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

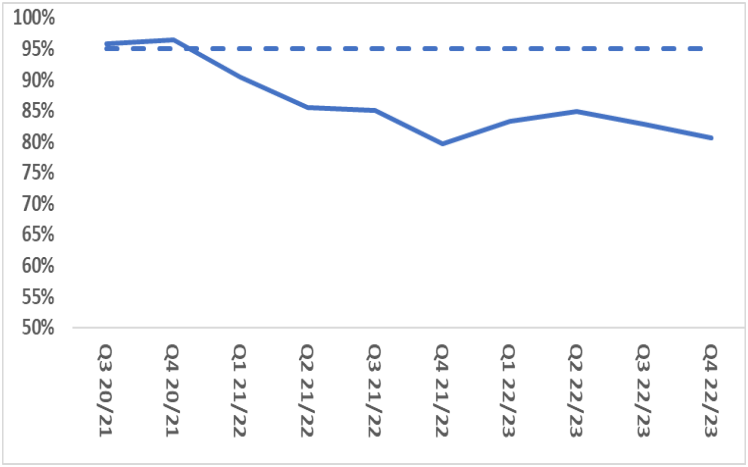



| Organisation | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|
| Cheshire and Merseyside | 27,815 | 28,435 | 29,180 |
| North West | 98,835 | 100,875 | 103,415 |
| England | 715,869 | 720,817 | 721,506 |

*source: NHS futures core data pack*

Note: Dec 22 performance impacted by Mersey Care data issue. This is be updated in the end of year refresh on NHS futures

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

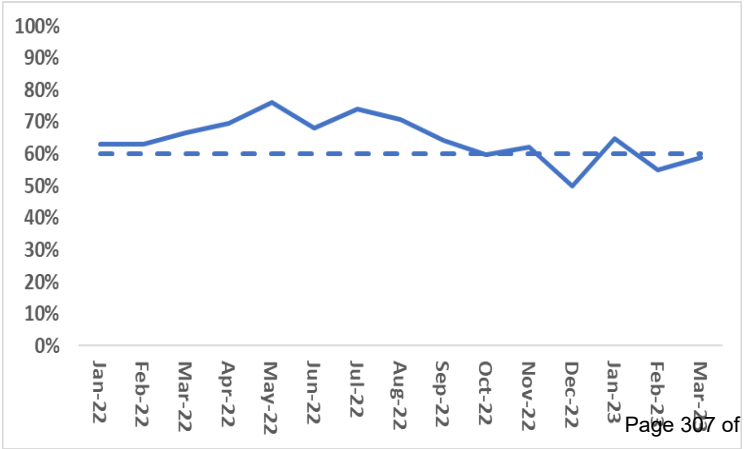



| Organisation | Q2 22/23 | Q3 22/23 | Q4 22/23 |
|---|---|---|---|
| Cheshire and Merseyside | 84.80% | 82.80% | 80.60% |
| North West | - | 86.80% | 91.40% |
| England | 67.10% | 77.50% | 77.70% |

** 12 months to end of quarter*

Note: A cyber incident affected NHSE ability to process national level data from August 22 onwards, national level data cannot be considered an accurate reflection of activity. NHS Digital has produced estimates for the affected months

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



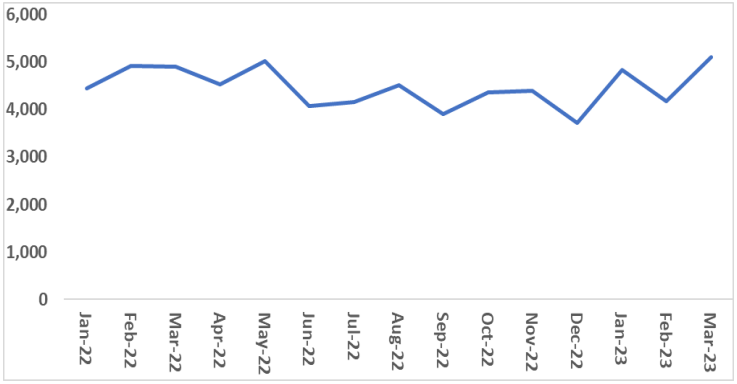

| Organisation | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|
| Cheshire and Merseyside | 64.70% | 55.10% | 58.80% |
| North West | 58.70% | 53.10% | 55.80% |
| England | 69.60% | 69.10% | 70.80% |

Note: Dec 22 performance impacted by Mersey Care data issue. This is be updated in the end of year refresh on NHS futures

# Section IV: Mental Health

NHS Cheshire and Merseyside

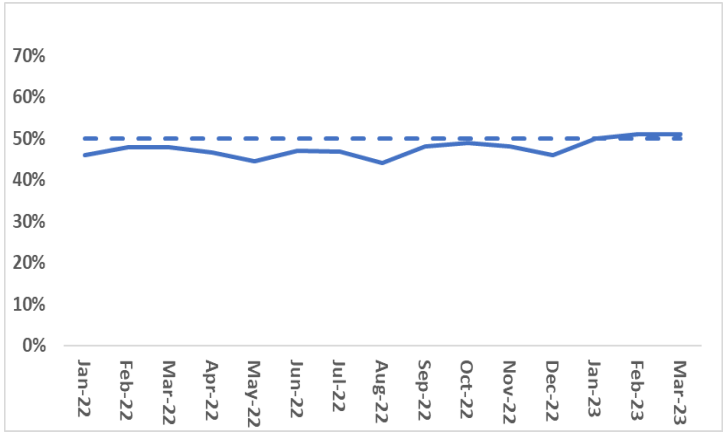
## IAPT access: No of people entering NHS funded treatment




| Organisation | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|
| Cheshire and Merseyside | 4,845 | 4,185 | 5,115 |
| North West | 14,575 | 13,225 | 14,725 |

*Source: NHS futures MH Core Data Pack*

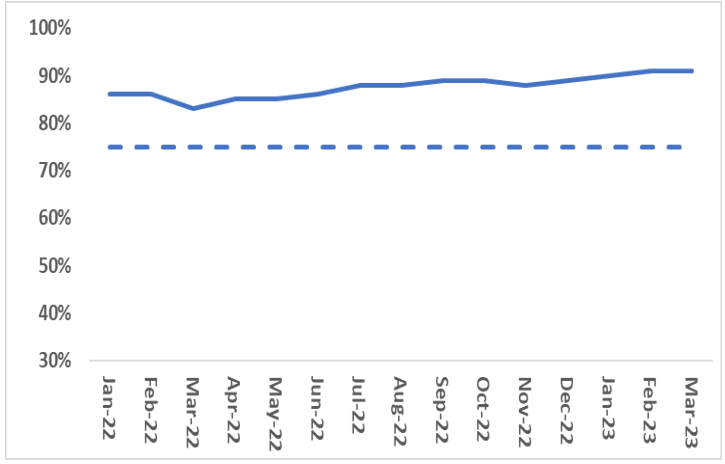
## IAPT recovery: % of people that attended at least 2 treatment contacts and are moving to recovery




| Organisation | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|
| Cheshire and Merseyside | 50.0% | 51.0% | 51.0% |
| North West | 50.0% | 50.0% | 51.0% |
| England | 49.7% | 50.2% | 51.2% |

*Source: NHS futures MH Core Data Pack*

## IAPT 6 week waits: * % finished treatment in the reporting period who had first treatment within 6 weeks



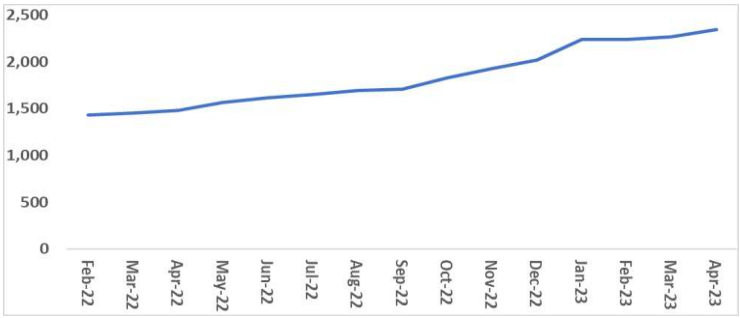

| Organisation | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|
| Cheshire and Merseyside | 90.0% | 91.0% | 91.0% |
| North West | 83.0% | 84.0% | 84.0% |
| England | 90.1% | 90.3% | 90.2% |

*Source: NHS futures MH Core Data Pack*

# Section IV: Mental Health

NHS Cheshire and Merseyside

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

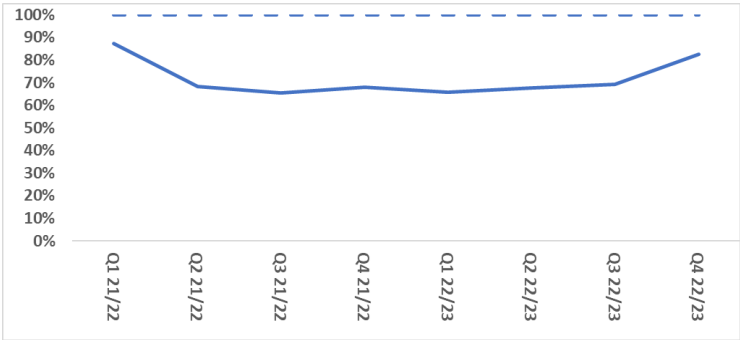



| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 2,235 | 2,265 | 2,345 |
| North West | 6,190 | 6,080 | 6,050 |
| England | 47,805 | 48,085 | 48,150 |

*Source: Perinatal dashboard NHS Futures*

Note: The perinatal performance uses the latest MHSDS and therefore Mersey Care data issue from Dec 2022 has been rectified in this metric.

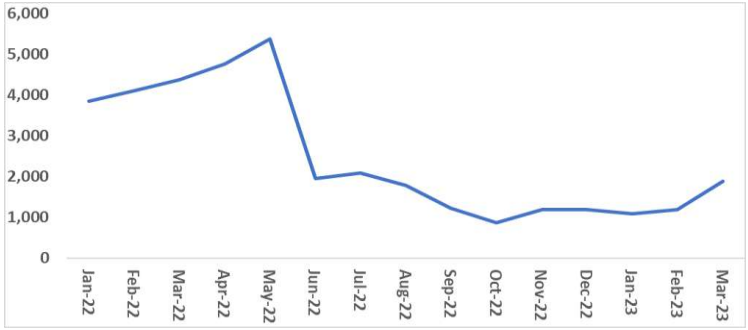
## Physical health checks for people with severe mental illness




| Organisation | Q2 22/23 | Q3 22/23 | Q4 22/23 |
|---|---|---|---|
| Cheshire and Merseyside | 67.6% | 69.3% | 82.7% |
| North West | 73.9% | 74.7% | 90.6% |
| England | 74.5% | 76.5% | 90.5% |

Note: Metric calculation has changed in line with SOF definition – denominator is LTP indicative trajectory (weighted share of national LTP ambition 22/23)

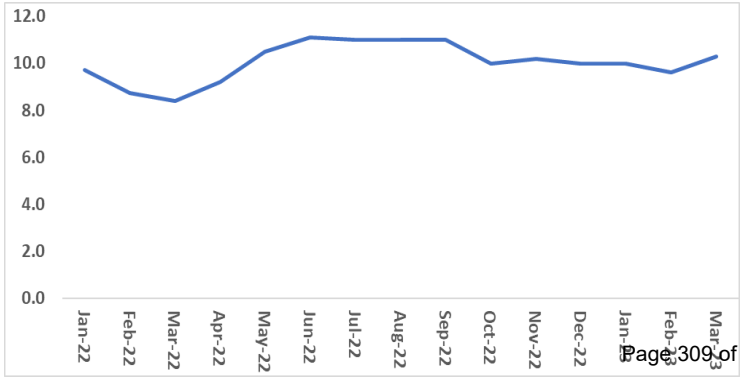
## Total number of inappropriate adult acute mental health out of area placements bed days : rolling 3 month periods




| Organisation | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|
| Cheshire and Merseyside | 1,095 | 1,195 | 1,885 |
| North West | 7,100 | 7,695 | 9,270 |
| England | 55,450 | 54,015 | 58,515 |
| *source: NHS futures core data pack* | | | |

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

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




| Organisation | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|
| Cheshire and Merseyside | 4,845 | 4,185 | 5,115 |
| North West | 14,575 | 13,225 | 14,725 |
| England | 109,806 | 99,169 | 11,279 |
| *source: NHS futures core data pack* | | | |

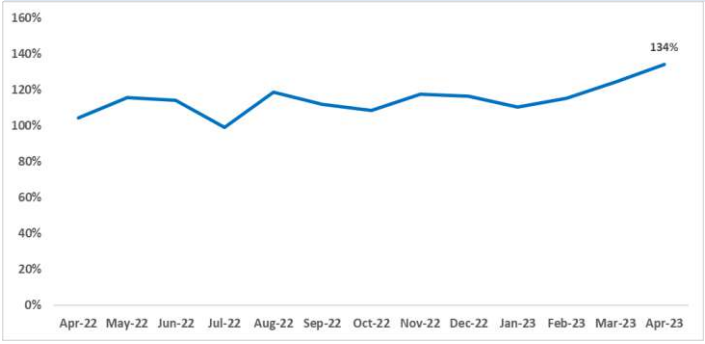
Note:

- Data used is for a Rolling Qtr
- Dec 22 performance impacted by the Mersey Care data issue. This is to be updated in the end of year refresh on NHS futures

# Section V: Primary Care

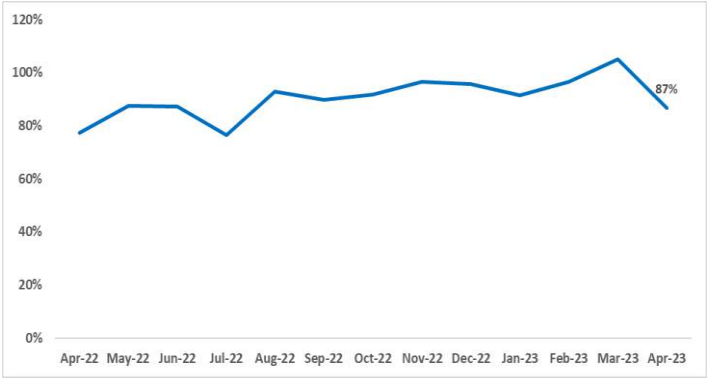
NHS Cheshire and Merseyside

## Total appointments delivered against pre-covid baseline



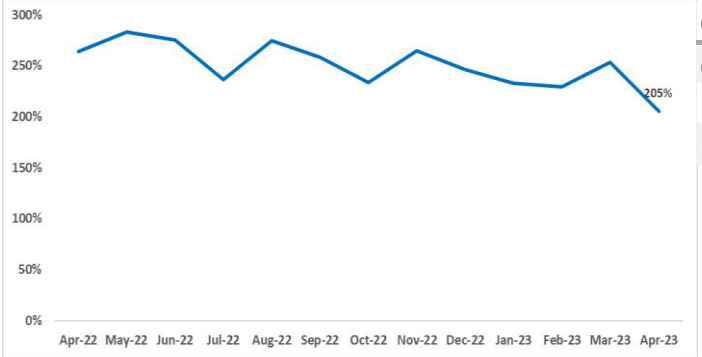

| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 117.2% | 126.7% | 133.8% |
| North West | 118.2% | 134.9% | 109.7% |
| England | 114.5% | 129.6% | 105.8% |

## Face to Face appointments delivered against pre covid baseline



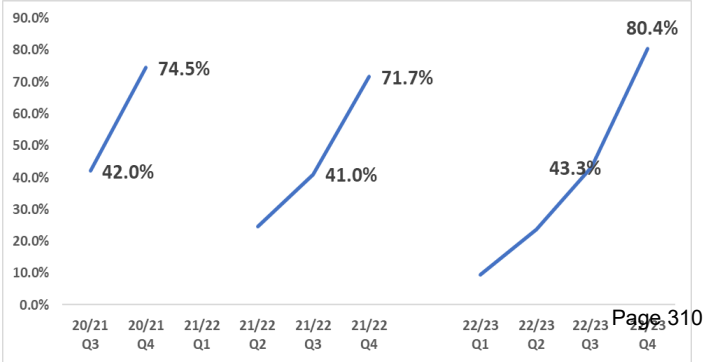

| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 96.6% | 105.2% | 86.6% |
| North West | 101.5% | 110.8% | 90.0% |
| England | 99.0% | 109.6% | 89.7% |

## Telephone appointments delivered against pre-covid baseline




| Organisation | Feb-23 | Mar-23 | Apr-23 |
|---|---|---|---|
| Cheshire and Merseyside | 229.6% | 253.2% | 205.3% |
| North West | 261.7% | 303.4% | 241.4% |
| England | 218.2% | 246.8% | 195.5% |

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

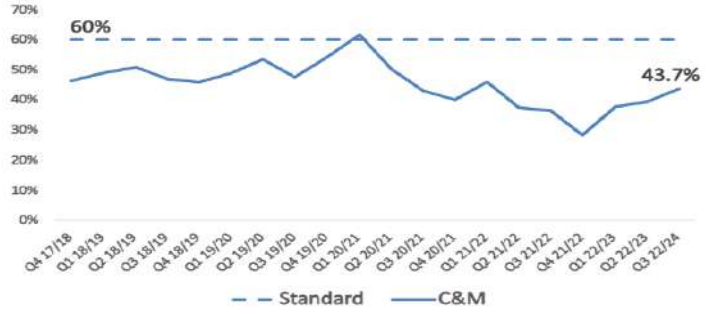



| Organisation | Q2 22/23 | Q3 22/23 | Q4 22/23 |
|---|---|---|---|
| Cheshire & Merseyside | 23.6% | 43.3% | 80.4% |
| North West | 24.1% | 44.8% | 80.4% |
| England | 26.0% | 46.0% | 80.6% |

# Section VI: Quality Care

NHS Cheshire and Merseyside

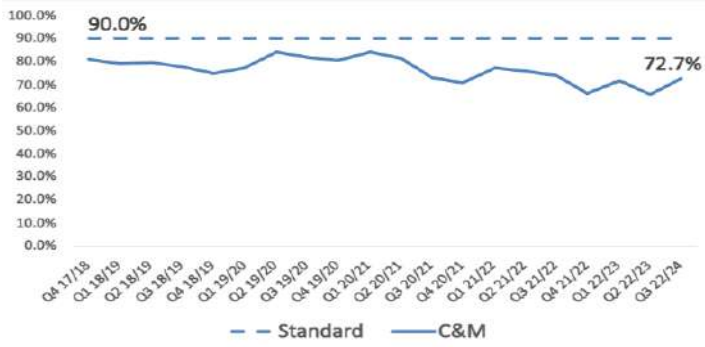
## Admitted to stroke unit <4 hours




| Organisation | Q1 22/23 | Q2 22/23 | Q3 22/23 |
|---|---|---|---|
| Cheshire & Merseyside | 37.9% | 39.6% | 43.7% |
| North West | 40.6% | 39.9% | 43.7% |
| England | 38.6% | 37.9% | 36.9% |

Note: Q3 is still the most recent published data as at 13/06/23

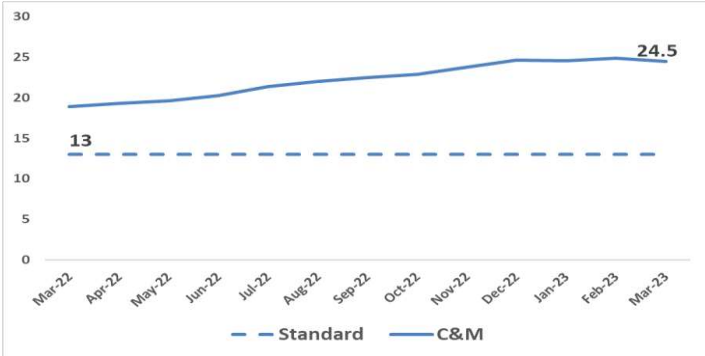
## Spent >90% of time on stroke unit




| Organisation | Q1 22/23 | Q2 22/23 | Q3 22/23 |
|---|---|---|---|
| Cheshire & Merseyside | 71.9% | 66.0% | 72.7% |
| North West | 75.0% | 72.5% | 77.2% |
| England | 74.2% | 75.8% | 75.1% |

Note: Q3 is still the most recent published data as at 13/06/23

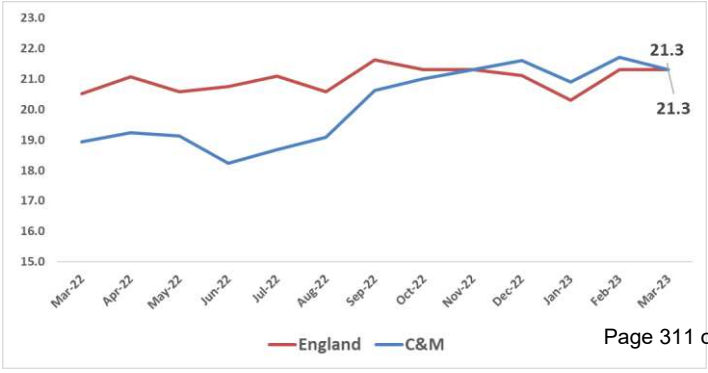
## C.Difficile (Hospital Onset)




| Organisation | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|
| Cheshire & Merseyside | 24.6 | 24.5 | 24.8 |
| North West | 27.0 | 26.7 | 25.7 |
| England | 18.9 | 19.1 | 19.5 |

Note: March 23 is the most recent published data as at 13/06/23

## E.Coli (Hospital Onset)



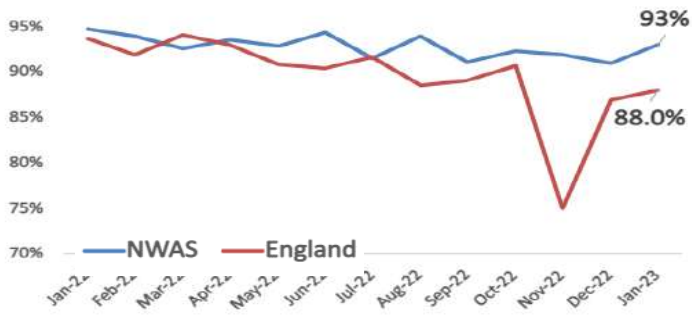

| Organisation | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|
| Cheshire & Merseyside | 20.9 | 21.7 | 21.3 |
| North West | 22.2 | 21.9 | 22.5 |
| England | 20.3 | 21.3 | 21.3 |

Note: March 23 is the most recent published data as at 13/06/23

# Section VI: Quality Care

NHS Cheshire and Merseyside

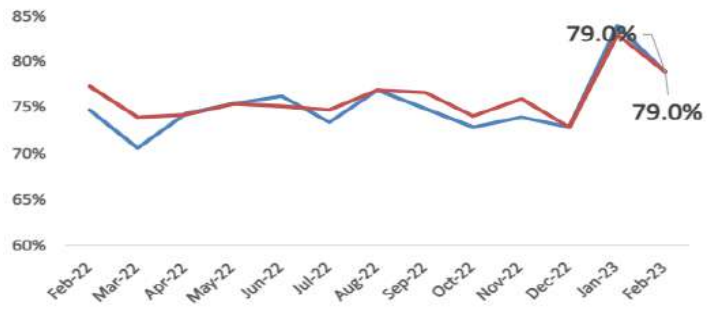
## Friends & Family – Ambulance Service




| Organisation | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|
| NWAS | 91.00% | 93.00% | 91.00% |
| England | 87.00% | 88.00% | 86.00% |

Note: February 23 is the most recent published data as at 26/05/23

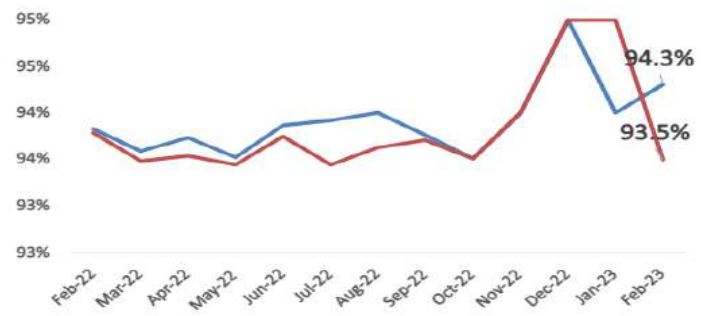
## Friends & Family score – A&E




| Organisation | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|
| Cheshire & Merseyside | 73.0% | 84.0% | 79.0% |
| North West | 73.4% | 83.2% | 81.0% |
| England | 73.0% | 83.0% | 79.0% |

Note: February 23 is the most recent published data as at 26/05/23

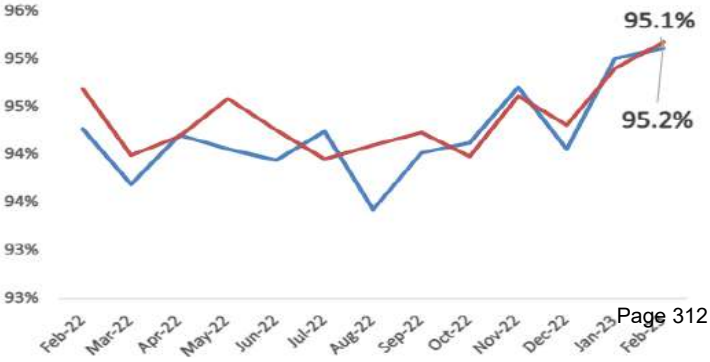
## Friends & Family score – Outpatient




| Organisation | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|
| Cheshire & Merseyside | 95.0% | 94.0% | 94.3% |
| North West | 94.1% | 94.2% | 94.2% |
| England | 95.0% | 95.0% | 93.5% |

Note: February 23 is the most recent published data as at 26/05/23

## Friends & Family score – Inpatient

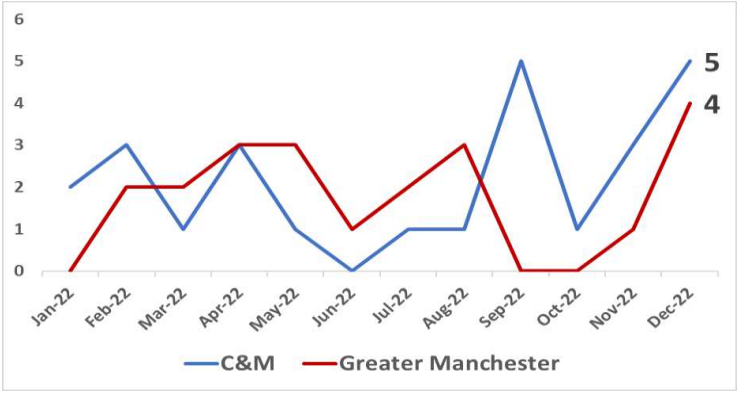


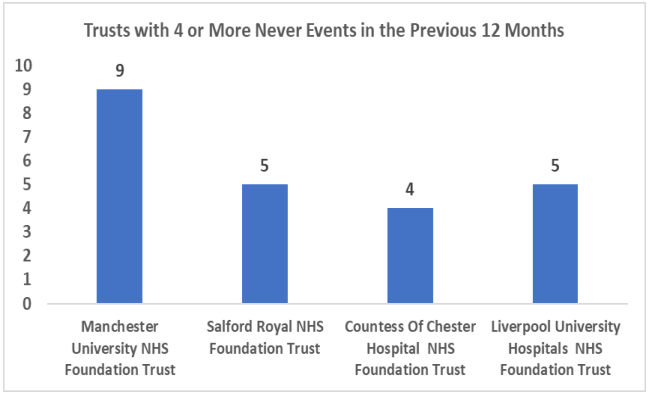

| Organisation | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|
| Cheshire & Merseyside | 94.1% | 95.0% | 95.1% |
| North West | 93.8% | 94.2% | 94.2% |
| England | 94.3% | 94.9% | 95.2% |

Note: February 23 is the most recent published data as at 26/05/23

NHS Cheshire and Merseyside

## Never Events




Note: December 23 is still the most recent we have managed to get of due to difficulty in getting the data pack as at 13/06/23

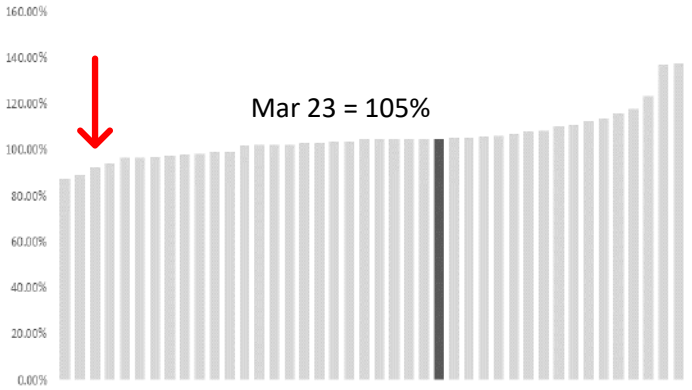
# National Performance Ambition Metrics

NHS Cheshire and Merseyside

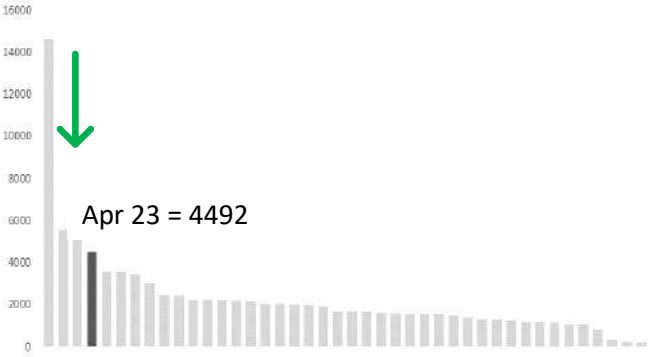
↑ Deterioration since July 2022

↑ Improvement since July 2022

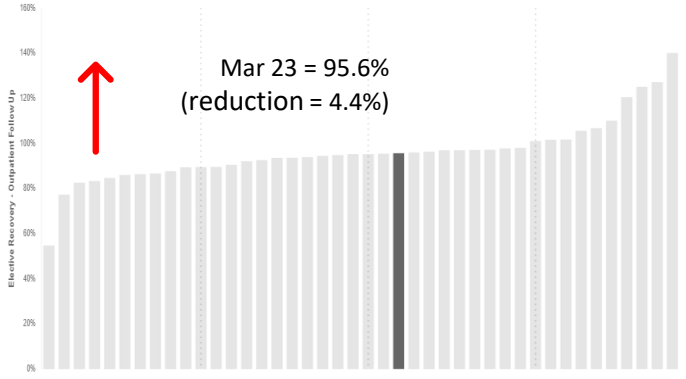
Increase diagnostic activity to 120% pre-pandemic levels *(see note on following slide)



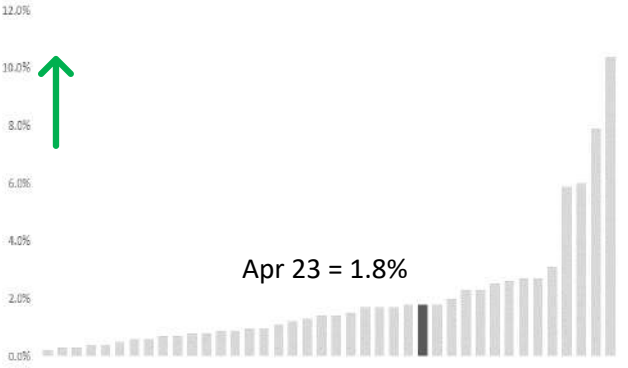

65-week waiters



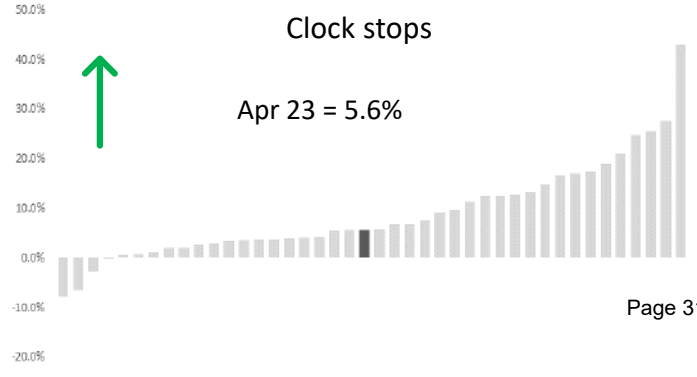

-25% reduction in outpatient follow up attendances

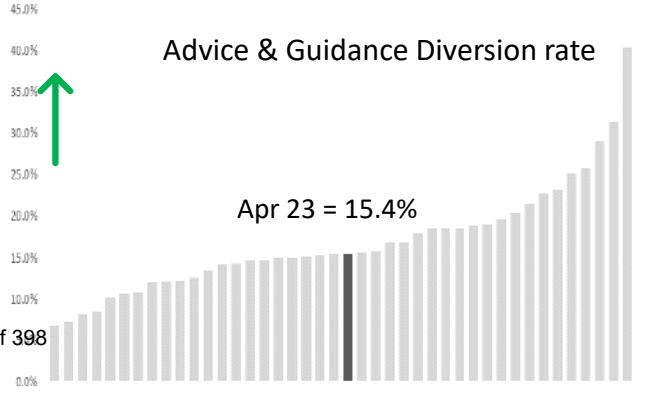



5% of outpatient attendances to convert to PIFU




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



# National Performance Ambition Metrics

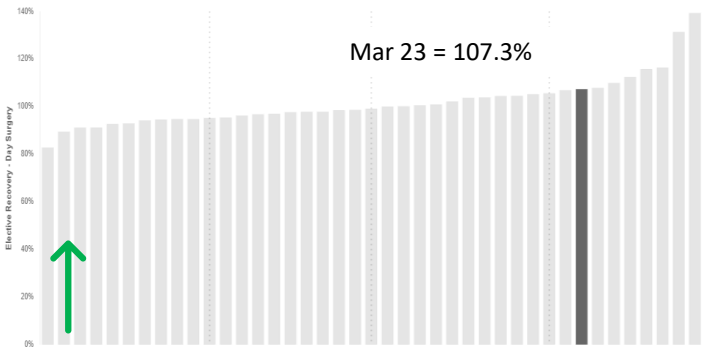
NHS Cheshire and Merseyside

↑ Deterioration since July 2022

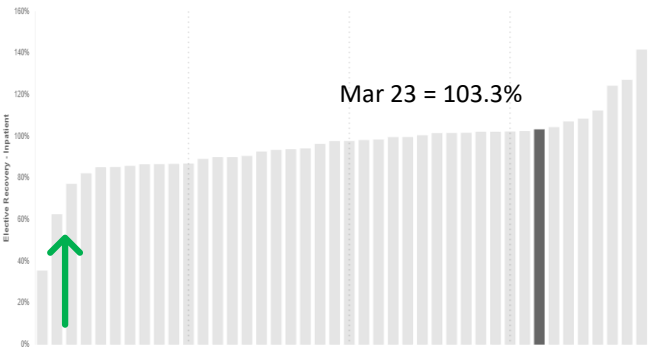
↑ Improvement since July 2022

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

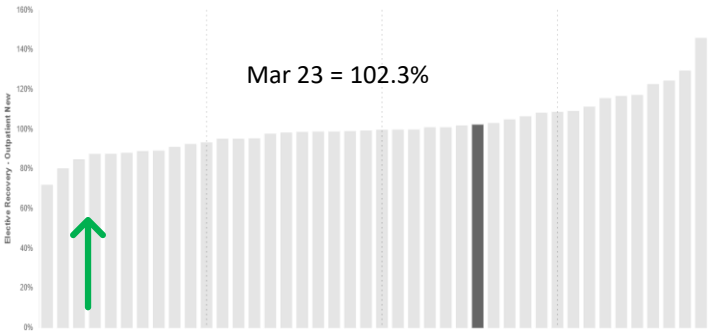
Day case




Ordinary admissions




Outpatient new




Note:

- Diagnostic activity reported here differs slightly to the YTD position due to this measure reported on an ICS provider footprint by NHS Futures and the YTD reported on a Sub ICB place footprint by NHS Digital
- A provisional local figure of 58 has been reported for March 2023, this is in line with the downward trajectory seen in the last two months, however this figure has not yet been confirmed in the national published figures and as such no comparison data is available.

# National Performance Ambition Metrics

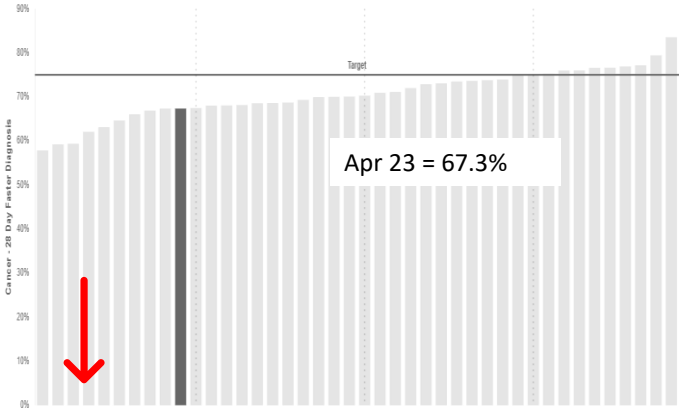
NHS Cheshire and Merseyside

↑ Deterioration since July 2022

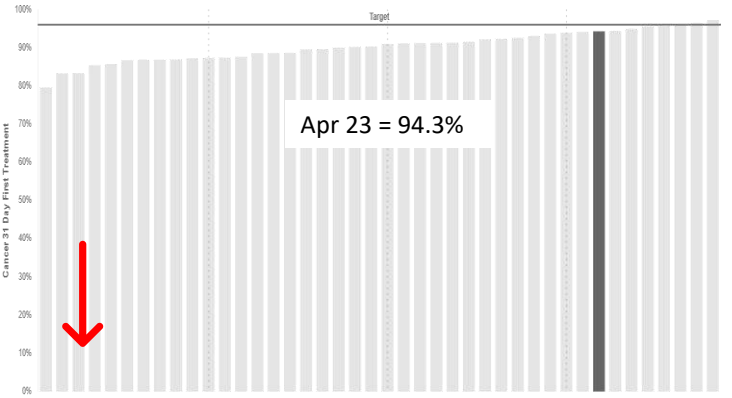
↑ Improvement since July 2022

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

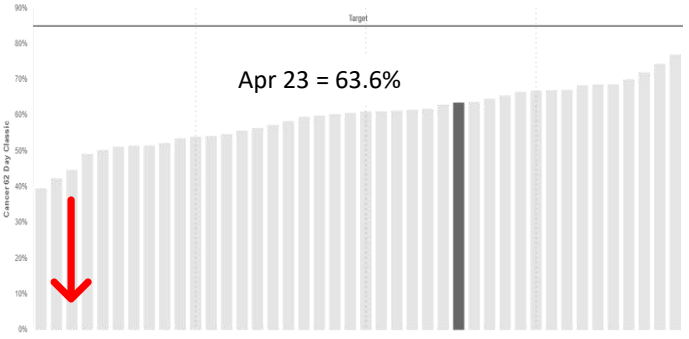
28 day faster diagnosis (75% standard)




31 day decision to treat (96% standard)




62 day referral to treat (85% standard)



NHS
Cheshire and Merseyside

# Appendix 2 – Provider Summaries

# Warrington & Halton Hospital

NHS
Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | **71.0%** |
| A&E Attendances All | May 23 | - | 11,049 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **22.5** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **68.8%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **62.9%** |
| Cancer 2 Week Wait Breast Symptomatic | Apr 23 | 93.0% | **22.0%** |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | **94.9%** |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **48.2%** |
| Day Surgery Activity | Mar 23 | - | 2,325 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **25.5%** |
| E.coli (All Cases) | Mar 23 | - | 115.2 |
| Elective Inpatient Activity | Mar 23 | - | 270 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | **8** |
| MRSA (All Cases) | Mar 23 | - | 2.0 |
| Outpatient Follow Up Activity | Mar 23 | - | 30,640 |
| Outpatient New Activity | Mar 23 | - | 7,955 |
| RTT 104 Week Breach | Apr 23 | 0 | **1** |
| RTT 52 Week Breach | Apr 23 | 0 | **1,894** |
| RTT 78 Week Breach | Apr 23 | 0 | **39** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **54.3%** |
| RTT Total Incompletes | Apr 23 | - | 31,385 |
| Sickness Absence Rate | Jan 23 | 4.00% | **6.1%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **55.8%** |
| Summary Hospital Mortality Indicator | Dec 22 | 100.00 | 99.0 |

# Wirral University Teaching Hospital

NHS Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | **63.6%** |
| A&E Attendances All | May 23 | - | 11,352 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **44.7** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | 75.3% |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **77.4%** |
| Cancer 2 Week Wait Breast Symptomatic | Apr 23 | 93.0% | **-** |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | **95.9%** |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **69.2%** |
| Day Surgery Activity | Mar 23 | - | 4,510 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **8.4%** |
| E.coli (All Cases) | Mar 23 | - | 94.3 |
| Elective Inpatient Activity | Mar 23 | - | 585 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | **2** |
| MRSA (All Cases) | Mar 23 | - | 1.1 |
| Outpatient Follow Up Activity | Mar 23 | - | 34,225 |
| Outpatient New Activity | Mar 23 | - | 12,575 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **1,388** |
| RTT 78 Week Breach | Apr 23 | 0 | **15** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **58.5%** |
| RTT Total Incompletes | Apr 23 | - | 41,720 |
| Sickness Absence Rate | Jan 23 | 4.00% | **6.6%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **62.1%** |
| Summary Hospital Mortality Indicator | Dec 22 | 100.00 | **105.8** |

# St Helens & Knowsley Hospital

NHS Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | **64.1%** |
| A&E Attendances All | May 23 | - | 14,786 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **16.6** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **69.0%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **75.9%** |
| Cancer 2 Week Wait Breast Symptomatic | Apr 23 | 93.0% | 96.0% |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | 97.2% |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **82.3%** |
| Day Surgery Activity | Mar 23 | - | 4,610 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **35.0%** |
| E.coli (All Cases) | Mar 23 | - | 88.4 |
| Elective Inpatient Activity | Mar 23 | - | 465 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 0.7 |
| Outpatient Follow Up Activity | Mar 23 | - | 33,320 |
| Outpatient New Activity | Mar 23 | - | 16,545 |
| RTT 104 Week Breach | Apr 23 | 0 | **1** |
| RTT 52 Week Breach | Apr 23 | 0 | **1,775** |
| RTT 78 Week Breach | Apr 23 | 0 | **49** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **62.4%** |
| RTT Total Incompletes | Apr 23 | - | 48,268 |
| Sickness Absence Rate | Jan 23 | 4.00% | 3.8% |
| Staff Recommend Care | Q3 22/23 | 80.00% | **77.6%** |
| Summary Hospital Mortality Indicator | Dec 22 | 100.00 | **101.2** |

# Mid Cheshire Hospitals

NHS
Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | **65.9%** |
| A&E Attendances All | May 23 | - | 10,160 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **16.5** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **66.0%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **89.9%** |
| Cancer 2 Week Wait Breast Symptomatic | Apr 23 | 93.0% | 93.3% |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | 96.3% |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **65.8%** |
| Day Surgery Activity | Mar 23 | - | 2,505 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **27.3%** |
| E.coli (All Cases) | Mar 23 | - | 103.6 |
| Elective Inpatient Activity | Mar 23 | - | 260 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 2.6 |
| Outpatient Follow Up Activity | Mar 23 | - | 19,280 |
| Outpatient New Activity | Mar 23 | - | 8,940 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **2,000** |
| RTT 78 Week Breach | Apr 23 | 0 | **40** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **57.4%** |
| RTT Total Incompletes | Apr 23 | - | 39,685 |
| Sickness Absence Rate | Jan 23 | 4.00% | **5.9%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **67.1%** |
| Summary Hospital Mortality Indicator | Dec 22 | 100.00 | 97.2 |

# Liverpool University Hospitals

NHS Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | **70.7%** |
| A&E Attendances All | May 23 | - | 25,152 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **25.0** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **66.4%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **76.1%** |
| Cancer 2 Week Wait Breast Symptomatic | Apr 23 | 93.0% | **86.7%** |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | **86.0%** |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **48.2%** |
| Day Surgery Activity | Mar 23 | - | 8,065 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **17.9%** |
| E.coli (All Cases) | Mar 23 | - | 117.6 |
| Elective Inpatient Activity | Mar 23 | - | 1,430 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | **1** |
| MRSA (All Cases) | Mar 23 | - | 1.9 |
| Outpatient Follow Up Activity | Mar 23 | - | 62,390 |
| Outpatient New Activity | Mar 23 | - | 29,390 |
| RTT 104 Week Breach | Apr 23 | 0 | **3** |
| RTT 52 Week Breach | Apr 23 | 0 | **6,175** |
| RTT 78 Week Breach | Apr 23 | 0 | **34** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **51.4%** |
| RTT Total Incompletes | Apr 23 | - | 78,006 |
| Sickness Absence Rate | Jan 23 | 4.00% | **7.1%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **56.0%** |
| Summary Hospital Mortality Indicator | Dec 22 | 100.00 | **104.1** |

# East Cheshire Hospitals

NHS Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | **55.2%** |
| A&E Attendances All | May 23 | - | 4,226 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **15.2** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **60.2%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **63.1%** |
| Cancer 2 Week Wait Breast Symptomatic | Apr 23 | 93.0% | **31.8%** |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | 100% |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **59.0%** |
| Day Surgery Activity | Mar 23 | - | 885 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **18.1%** |
| E.coli (All Cases) | Mar 23 | - | 120.8 |
| Elective Inpatient Activity | Mar 23 | - | 85 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 2.5 |
| Outpatient Follow Up Activity | Mar 23 | - | 6,060 |
| Outpatient New Activity | Mar 23 | - | 4,555 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **302** |
| RTT 78 Week Breach | Apr 23 | 0 | **2** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **59.1%** |
| RTT Total Incompletes | Apr 23 | - | 12,238 |
| Sickness Absence Rate | Jan 23 | 4.00% | **6.5%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **62.6%** |
| Summary Hospital Mortality Indicator | Dec 22 | 100.00 | **117.2** |

# Countess of Chester Hospital

NHS
Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | **60.2%** |
| A&E Attendances All | May 23 | - | 7,386 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **41.4** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **66.1%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **73.5%** |
| Cancer 2 Week Wait Breast Symptomatic | Apr 23 | 93.0% | **-** |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | 96.6% |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **72.3%** |
| Day Surgery Activity | Mar 23 | - | 2,580 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **22.1%** |
| E.coli (All Cases) | Mar 23 | - | 106.4 |
| Elective Inpatient Activity | Mar 23 | - | 300 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 2.6 |
| Outpatient Follow Up Activity | Mar 23 | - | 26,550 |
| Outpatient New Activity | Mar 23 | - | 9,740 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **2,932** |
| RTT 78 Week Breach | Apr 23 | 0 | **22** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **46.7%** |
| RTT Total Incompletes | Apr 23 | - | 35,373 |
| Sickness Absence Rate | Jan 23 | 4.00% | **5.8%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **46.7%** |
| Summary Hospital Mortality Indicator | Dec 22 | 100.00 | **100.2** |

# Southport & Ormskirk Hospital

NHS
Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | **75.5%** |
| A&E Attendances All | May 23 | - | 10,797 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **28.1** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **65.8%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **77.2%** |
| Cancer 2 Week Wait Breast Symptomatic | Apr 23 | 93.0% | **-** |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | **85.2%** |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **44.1%** |
| Day Surgery Activity | Mar 23 | - | 1,790 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **19.4%** |
| E.coli (All Cases) | Mar 23 | - | 133.6 |
| Elective Inpatient Activity | Mar 23 | - | 215 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | **5** |
| MRSA (All Cases) | Mar 23 | - | 0.7 |
| Outpatient Follow Up Activity | Mar 23 | - | 15,725 |
| Outpatient New Activity | Mar 23 | - | 6,205 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **183** |
| RTT 78 Week Breach | Apr 23 | 0 | 0 |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **62.0%** |
| RTT Total Incompletes | Apr 23 | - | 19,701 |
| Sickness Absence Rate | Jan 23 | 4.00% | **7.0%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **51.2%** |
| Summary Hospital Mortality Indicator | Dec 22 | 100.00 | **101.7** |

# Liverpool Women's Hospital

NHS
Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | 93.3% |
| A&E Attendances All | May 23 | - | 1,324 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | 0.0 |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **38.7%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | **47.4%** |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | **94.7%** |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **33.3%** |
| Day Surgery Activity | Mar 23 | - | 505 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **7.6%** |
| E.coli (All Cases) | Mar 23 | - | 46.0 |
| Elective Inpatient Activity | Mar 23 | - | 160 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 0.0 |
| Outpatient Follow Up Activity | Mar 23 | - | 7,985 |
| Outpatient New Activity | Mar 23 | - | 5,220 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **1,586** |
| RTT 78 Week Breach | Apr 23 | 0 | **22** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **43.9%** |
| RTT Total Incompletes | Apr 23 | - | 17,444 |
| Sickness Absence Rate | Jan 23 | 4.00% | **7.4%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **71.6%** |

# Liverpool Heart & Chest Hospital

NHS Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | 3.9 |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **50.0%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | 100% |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | **89.4%** |
| Cancer 62 Day Classic | Apr 23 | 85.00% | 85.7% |
| Day Surgery Activity | Mar 23 | - | 455 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **1.2%** |
| E.coli (All Cases) | Mar 23 | - | 11.6 |
| Elective Inpatient Activity | Mar 23 | - | 445 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 0.0 |
| Outpatient Follow Up Activity | Mar 23 | - | 4,890 |
| Outpatient New Activity | Mar 23 | - | 2,870 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **56** |
| RTT 78 Week Breach | Apr 23 | 0 | **2** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **71.8%** |
| RTT Total Incompletes | Apr 23 | - | 5,092 |
| Sickness Absence Rate | Jan 23 | 4.00% | **4.9%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | 90.6% |

# Alder Hey Hospital

NHS Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | 84.8% |
| A&E Attendances All | May 23 | - | 5,772 |
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | 0.0 |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | 100% |
| Cancer 2 Week Wait | Apr 23 | 93.00% | 100% |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | - |
| Cancer 62 Day Classic | Apr 23 | 85.00% | - |
| Day Surgery Activity | Mar 23 | - | 1,990 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **13.7%** |
| E.coli (All Cases) | Mar 23 | - | 46.2 |
| Elective Inpatient Activity | Mar 23 | - | 390 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 0.0 |
| Outpatient Follow Up Activity | Mar 23 | - | 18,810 |
| Outpatient New Activity | Mar 23 | - | 6,980 |
| RTT 104 Week Breach | Apr 23 | 0 | **1** |
| RTT 52 Week Breach | Apr 23 | 0 | **761** |
| RTT 78 Week Breach | Apr 23 | 0 | **7** |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **52.4%** |
| RTT Total Incompletes | Apr 23 | - | 25,056 |
| Sickness Absence Rate | Jan 23 | 4.00% | **6.7%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | 86.4% |

# The Walton Centre

NHS Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **15.5** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | 100% |
| Cancer 2 Week Wait | Apr 23 | 93.00% | 100% |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | 100% |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **0.0%** |
| Day Surgery Activity | Mar 23 | - | 1,035 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | 0.7% |
| E.coli (All Cases) | Mar 23 | - | 28.8 |
| Elective Inpatient Activity | Mar 23 | - | 255 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 0.0 |
| Outpatient Follow Up Activity | Mar 23 | - | 9,215 |
| Outpatient New Activity | Mar 23 | - | 4,430 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **53** |
| RTT 78 Week Breach | Apr 23 | 0 | 0 |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **73.4%** |
| RTT Total Incompletes | Apr 23 | - | 13,381 |
| Sickness Absence Rate | Jan 23 | 4.00% | **7.1%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | 86.5% |

# The Clatterbridge Cancer Centre

NHS
Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| C.difficile (Hospital Onset) | Mar 23 | 13.00 | **33.6** |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | **73.7%** |
| Cancer 2 Week Wait | Apr 23 | 93.00% | 93.8% |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | 97.9% |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **77.5%** |
| Day Surgery Activity | Mar 23 | - | 345 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | 0.0% |
| E.coli (All Cases) | Mar 23 | - | 140.9 |
| Elective Inpatient Activity | Mar 23 | - | 100 |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| MRSA (All Cases) | Mar 23 | - | 0.0 |
| Outpatient Follow Up Activity | Mar 23 | - | 43,875 |
| Outpatient New Activity | Mar 23 | - | 1,820 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | **1** |
| RTT 78 Week Breach | Apr 23 | 0 | 0 |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | 96.3% |
| RTT Total Incompletes | Apr 23 | - | 977 |
| Sickness Absence Rate | Jan 23 | 4.00% | **4.9%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | 85.4% |

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| Day Surgery Activity | Mar 23 | - | - |
| **EIP Open Referrals Waited < 2 Weeks** | **Apr 23** | **60.00%** | **-** |
| Elective Inpatient Activity | Mar 23 | - | - |
| IAPT Face to Face | Jan 23 | - | 13% |
| IAPT Recovery Rate | Jan 23 | 50.0% | 52.8% |
| IAPT Referrals Entered Treatment | Jan 23 | - | 825 |
| IAPT Waited Less Than 18 Weeks | Jan 23 | 95.0% | 98.9% |
| IAPT Waited Less Than 6 Weeks | Jan 23 | 75.0% | 94.5% |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| Outpatient Follow Up Activity | Mar 23 | - | - |
| Outpatient New Activity | Mar 23 | - | - |
| Sickness Absence Rate | Jan 23 | 4.00% | **6.6%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **70.6%** |

# Mersey Care

NHS
Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | 97.8% |
| A&E Attendances All | May 23 | - | 12,132 |
| Day Surgery Activity | Mar 23 | - | - |
| **EIP Open Referrals Waited < 2 Weeks** | **Apr 23** | **60.00%** | **64.0%** |
| Elective Inpatient Activity | Mar 23 | - | - |
| IAPT Face to Face | Jan 23 | - | - |
| IAPT Recovery Rate | Jan 23 | 50.0% | **49.1%** |
| IAPT Referrals Entered Treatment | Jan 23 | - | 2,110 |
| IAPT Waited Less Than 18 Weeks | Jan 23 | 95.0% | 99.5% |
| IAPT Waited Less Than 6 Weeks | Jan 23 | 75.0% | 96.8% |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | 0 |
| Outpatient Follow Up Activity | Mar 23 | - | - |
| Outpatient New Activity | Mar 23 | - | - |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | 0 |
| RTT 78 Week Breach | Apr 23 | 0 | 0 |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | 97.2% |
| RTT Total Incompletes | Apr 23 | - | 36 |
| Sickness Absence Rate | Jan 23 | 4.00% | **8.5%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **66.8%** |

# Wirral Community

NHS
Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | 94.4% |
| A&E Attendances All | May 23 | - | 4,541 |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | - |
| Cancer 62 Day Classic | Apr 23 | 85.00% | - |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | 0.0% |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | 0 |
| RTT 78 Week Breach | Apr 23 | 0 | 0 |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | 99.1% |
| RTT Total Incompletes | Apr 23 | - | 107 |
| Sickness Absence Rate | Jan 23 | 4.00% | **7.1%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **71.6%** |

# Bridgewater Community Healthcare

NHS Cheshire and Merseyside

| Key Performance Indicator | Period | Target | |
|---|---|---|---|
| A&E - 4 Hour Standard | May 23 | 76.00% | 97.4% |
| A&E Attendances All | May 23 | - | 3,483 |
| Cancer - 28 Day Faster Diagnosis | Apr 23 | 75.0% | 83.3% |
| Cancer 2 Week Wait | Apr 23 | 93.00% | 97.8% |
| Cancer 31 Day First Treatment | Apr 23 | 96.00% | 100% |
| Cancer 62 Day Classic | Apr 23 | 85.00% | **77.8%** |
| Day Surgery Activity | Mar 23 | - | 0 |
| Diagnostics - 6 Week Standard | Apr 23 | 1.00% | **13.6%** |
| Elective Inpatient Activity | Mar 23 | - | 0 |
| IAPT Recovery Rate | Jan 23 | 50.0% | - |
| IAPT Referrals Entered Treatment | Jan 23 | - | - |
| IAPT Waited Less Than 18 Weeks | Jan 23 | 95.0% | - |
| IAPT Waited Less Than 6 Weeks | Jan 23 | 75.0% | - |
| Mixed Sex Accommodation Breaches | Apr 23 | 0 | - |
| Outpatient Follow Up Activity | Mar 23 | - | 8,040 |
| Outpatient New Activity | Mar 23 | - | 2,010 |
| RTT 104 Week Breach | Apr 23 | 0 | 0 |
| RTT 52 Week Breach | Apr 23 | 0 | 0 |
| RTT 78 Week Breach | Apr 23 | 0 | 0 |
| RTT Incomplete 18 Week Standard | Apr 23 | 92.00% | **58.7%** |
| RTT Total Incompletes | Apr 23 | - | 2,485 |
| Sickness Absence Rate | Jan 23 | 4.00% | **6.3%** |
| Staff Recommend Care | Q3 22/23 | 80.00% | **79.3%** |

# C&M Place Summary:

*April 23 System Oversight Framework publication*

NHS Cheshire and Merseyside

| NHS OF Metric Name Full | Aggregation Source | Period | NHS CHESHIRE (SUB ICB LOCATION) (27D) | NHS HALTON (SUB ICB LOCATION) (01F) | NHS KNOWSLEY (SUB ICB LOCATION) (01J) | NHS LIVERPOOL (SUB ICB LOCATION) (99A) | NHS SOUTH SEFTON (SUB ICB LOCATION) (01T) | NHS SOUTHPORT AND FORMBY (SUB ICB LOCATION) (01V) | NHS ST HELENS (SUB ICB LOCATION) (01X) | NHS WARRINGTON (SUB ICB LOCATION) (02E) | NHS WIRRAL (SUB ICB LOCATION) (12F) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| S009a: Total patients waiting more than 52 weeks to start consultant led treatment | SubICB | 2023 03 | 6,287 | 869 | 1,234 | 4,624 | 1,440 | 408 | 764 | 1,263 | 1,466 |
| S009b: Total patients waiting more than 78 weeks to start consultant led treatment | SubICB | 2023 03 | 154 | 27 | 11 | 49 | 16 | 11 | 26 | 36 | 19 |
| S009c: Total patients waiting more than 104 weeks to start consultant led treatment | SubICB | 2023 03 | 6 | 0 | 0 | 6 | 1 | 1 | 0 | 2 | 0 |
| S010a: Total patients treated for cancer compared with the same point in 2019/20 | SubICB | 2023 03 | | 122% | 128% | 102% | 95% | 111% | 81% | 93% | 99% |
| S012a: Proportion of patients meeting the faster cancer diagnosis standard | SubICB | 2023 03 | 66.8% | 72.7% | 70.7% | 67% | 67.4% | 72.9% | 70.3% | 75.1% | 77% |
| S013a: Diagnostic activity levels: Imaging | SubICB | 2023 03 | 117.1% | 103.4% | 102.8% | 109% | 104.3% | 102.3% | 102.7% | 97.8% | 102.2% |
| S013b: Diagnostic activity levels: Physiological measurement | SubICB | 2023 03 | 72.1% | 81.4% | 91.2% | 93.8% | 67.1% | 93.9% | 88.6% | 71.3% | 94.7% |
| S013c: Diagnostic activity levels: Endoscopy | SubICB | 2023 03 | 64.3% | 121.5% | 143.1% | 103.9% | 109% | 128.6% | 119.3% | 132.7% | 93.4% |
| S013d: Diagnostic activity levels: Total | SubICB | 2023 03 | 108% | 102.6% | 104% | 107.1% | 101.3% | 103.4% | 102.2% | 97.2% | 100.4% |
| S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate | SubICB | 2023 03 | 16 | 2 | 1 | 7 | 2 | 0 | 1 | 2 | 3 |
| S041a: Clostridium difficile infection rate | SubICB | 2023 03 | 142% | 141.2% | 85.7% | 109.8% | 98.3% | 108.3% | 74.3% | 166.5% | 144.7% |
| S042a: E. coli bloodstream infection rate | SubICB | 2023 03 | 110.5% | 107.4% | 126.7% | 129.6% | 116.2% | 114% | 87.6% | 125.5% | 130.9% |
| S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care | SubICB | Mar 2022 - Feb 2023 | 97.3% | 117.6% | 118.6% | 112.7% | 122.9% | 105% | 119.1% | 98.6% | 116.2% |
| S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care | SubICB | Mar 2022 - Feb 2023 | 6.95% | 6.16% | 6.93% | 7.69% | 8.17% | 8.31% | 5.79% | 6.27% | 9.58% |
| S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio | SubICB | 2023 02 | 84.3% | 80.3% | 73.1% | 73.8% | 76.2% | 82.7% | 77.7% | 80.9% | 81.1% |
| S050a: Cervical screening coverage : % females aged 25 : 64 attending screening within the target period | SubICB | 22-23 Q2 | 74.4% | 69.8% | 71.1% | 63% | 68% | 71.9% | 70.5% | 72.8% | 71.3% |
| S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy | SubICB | 2021-22 | 88.4% | 90.7% | 91.6% | 89% | 88.9% | 89.5% | 90.7% | 90.9% | 90.6% |
| S053b: % of hypertension patients who are treated to target as per NICE guidance | SubICB | 2021-22 | 60.7% | 57.1% | 53.6% | 57.3% | 52.3% | 62.8% | 58.1% | 58% | 57.7% |
| S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins | SubICB | 22-23 Q3 | 58.1% | 59.6% | 60.8% | 62.5% | 59.2% | 53.2% | 58.1% | 56.7% | 60.7% |
| S055a: Number GP referrals to NHS Digital weight management services per 100k population | SubICB | 22-23 Q4 | 74 per 100,000 | 77.1 per 100,000 | 90.3 per 100,000 | 73.7 per 100,000 | 16.5 per 100,000 | 115.7 per 100,000 | 36.5 per 100,000 | 12.7 per 100,000 | 21.8 per 100,000 |
| S081a: Access rate for IAPT services | SubICB | 2022 12 | 59.4% | 58.5% | 62.6% | 48.8% | 42.8% | 44.7% | 80.5% | 53.2% | 69.3% |
| S086a: Inappropriate adult acute mental health placement out of area placement bed days | SubICB | Dec2022 - Feb 2023 | 890 | 0 | 0 | 0 | 0 | 0 | 0 | 25 | 285 |
| S105a: Proportion of patients discharged from hospital to their usual place of residence | SubICB | 2023 03 | 89.4% | 94.8% | 95% | 93.4% | 92.9% | 91.3% | 93.1% | 94.7% | 92.7% |
| S115a: Proportion of diabetes patients that have received all eight diabetes care processes | SubICB | 21-22 Q4 | 42.9% | 28.5% | 31.8% | 42.9% | 32.4% | 47.2% | 26.9% | 27.3% | 30.9% |

# ICB – Provider SOF Segments

NHS Cheshire and Merseyside

## Updated 25th May 2023

| Trust | Segment | Change from October 22 |
|---|---|---|
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 1 | ↔ |
| The Walton Centre NHS Foundation Trust | 1 | ↔ |
| Alder Hey Children's NHS Foundation Trust | 2 | ↔ |
| Bridgewater Community Healthcare NHS Foundation Trust | 2 | ↔ |
| Cheshire and Wirral Partnership NHS Foundation Trust | 2 | ↑ |
| Mersey Care NHS Foundation Trust | 2 | ↔ |
| Mid-Cheshire Hospital NHS Foundation Trust | 2 | ↔ |
| North West Ambulance Service NHS Trust | 2 | ↔ |
| Southport and Ormskirk Hospital NHS Trust | 2 | ↔ |
| St Helens and Knowsley Teaching Hospitals NHS Trust | 2 | ↔ |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 2 | ↔ |
| Wirral Community Health and Care NHS Foundation Trust | 2 | ↔ |
| Clatterbridge Cancer Centre NHS Foundation Trust | 2 | ↔ |
| Countess of Chester NHS Foundation Trust | 3 | ↔ |
| East Cheshire NHS Trust | 3 | ↔ |
| Liverpool Women's Hospital NHS Foundation Trust | 3 | ↔ |
| Wirral University Teaching Hospital NHS Foundation Trust | 3 | ↔ |
| Liverpool University Hospitals NHS Foundation Trust | 4 | ↔ |

https://www.england.nhs.uk/publication/nhs-oversight-framework-segmentation/

Key

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

# ICB SOF Segments

NHS Cheshire and Merseyside

**NHS ICB Segmentation**

| ICB | Segment |
|---|---|
| Frimley | 1 |
| Bath and North East Somerset, Swindon and Wiltshire | 2 |
| Bedfordshire, Luton and Milton Keynes | 2 |
| Dorset | 2 |
| Gloucestershire | 2 |
| Humber and North Yorkshire | 2 |
| North Central London | 2 |
| North East & North Cumbria | 2 |
| North West London | 2 |
| Nottingham and Nottinghamshire | 2 |
| Somerset | 2 |
| South West London | 2 |
| South Yorkshire | 2 |
| Suffolk and North East Essex | 2 |
| Surrey Heartlands | 2 |
| Sussex | 2 |
| West Yorkshire | 2 |
| Birmingham and Solihull | 3 |
| Black Country | 3 |
| Bristol, North Somerset and South Gloucestershire | 3 |
| Buckinghamshire, Oxfordshire and Berkshire West (BOB) | 3 |
| Cambridgeshire and Peterborough | 3 |
| Cheshire and Merseyside | 3 |
| Cornwall and The Isles of Scilly | 3 |
| Coventry and Warwickshire | 3 |
| Derby and Derbyshire | 3 |
| Greater Manchester | 3 |
| Hampshire and the Isle of Wight | 3 |
| Herefordshire and Worcestershire | 3 |
| Hertfordshire and West Essex | 3 |
| Kent and Medway | 3 |
| Lancashire and South Cumbria | 3 |
| Leicester, Leicestershire and Rutland | 3 |
| Mid and South Essesx | 3 |
| North East London | 3 |
| Northamptonshire | 3 |
| South East London | 3 |
| Staffordshire and Stoke on Trent | 3 |
| Devon | 4 |
| Lincolnshire | 4 |
| Norfolk and Waveney | 4 |
| Shropshire, Telford & Wrekin | 4 |

## Published 27th March 2023

Key

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

https://www.england.nhs.uk/publication/nhs-oversight-framework-segmentation/

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## 29 June 2023

## Report of the Quality & Performance Committee Chair (May 2023)

| | |
|---|---|
| **Agenda No** | ICB/23/06/18 |
| **Report author & contact details** | Kerry Lloyd, Deputy Director of Nursing & Care<br>kerry.lloyd@cheshireandmerseyside.nhs.uk |
| **Report approved by (sponsoring Director/ Chair)** | Tony Foy, Chair |
| **Responsible Officer to take actions forward** | Kerry Lloyd, Deputy Director of Nursing & Care |

# Report of the Quality & Performance Committee Chair (May 2023)

| | | | | | |
|---|---|---|---|---|---|
| **Executive Summary** | The purpose of this report is to provide assurance to the C&M Integrated Care Board in regard to key issues, considerations, approvals and matters of escalation considered by the C&M ICB Quality & Performance Committee in securing continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centered, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance. | | | | |
| **Purpose (x)** | **For information / note** | **For decision / approval** | **For assurance** | **For ratification** | **For endorsement** |
| | x | x | x | | |
| **Recommendation** | **The Board is asked to:**<br>• Section 2 note the content<br>• Section 4 note and consider the content of issues agreed as requiring escalation to the Board | | | | |

| **Impact (x)** (further detail to be provided in body of paper) | **Financial** | **IM &T** | **Workforce** | **Estate** |
|---|---|---|---|---|
| | x | x | x | x |
| | **Legal** | **Health Inequalities** | **EDI** | **Sustainability** |
| | x | x | x | x |

| | |
|---|---|
| ***Management of Conflicts of Interest*** | No conflicts of interest declared at the Committee. |
| ***Next Steps*** | Noted in the body of report. |
| **Appendices** | None |

| **Glossary of Terms** | **Explanation or clarification of abbreviations used in this paper** |
|---|---|
| | |

# Report of the Quality & Performance Committee Chair (May 2023)

## 1. Summary of the principal role of the Committee

| Committee | Principal role of the committee | Chair |
|---|---|---|
| Quality & Performance Committee | The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable, and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance.<br>The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues.<br><br>In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties:<br>• Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); and<br>• Adult safeguarding and carers (the Care Act 2014). | Tony Foy |

## 2. Meetings held and Summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| 23/05/05 | 18/05/23 | **LMNS Maternity Report**<br><br>The committee received its monthly report in relation to maternity and neonatal services.<br><br>The committee was updated in relation to the publication of the national three year maternity 'single delivery plan' and was appraised as to how the detail of this plan aligns with work already being undertaken, colleagues from the LMNS will be conducting a gap analysis which will identify any risks to delivery, the committee requested to receive an update on this work when available.<br><br>The committee was informed that Wirral University Trust had received an inspection of its maternity services by the CQC in April 2023 and a full report is awaited, and to which the committee will be informed of outcome, once available, there were no immediate concerns raised.<br><br>The committee was informed of ongoing work in relation to the Liverpool Women's Hospital and the intensive scrutiny and support the Trust is currently receiving following the CQC inspection in February 2023. The committee was assured by the involvement and input of the Executive Director of Nursing & Care.<br><br>The committee was informed that due to an increase in numbers of maternity related incidents being reported in certain NHS providers, the committee will receive a thematic analysis report at the July 2023 committee meeting, via the Chair of the C&M Maternity Serious Incident Panel. |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| 23/05/06 | 18/05/23 | **Patient Safety Report**<br><br>The committee received its quarterly report that examines learning from patient safety incidents and the performance of the C&M system in closing of investigations and system readiness for transition to Patient Safety Incident Response Framework (PSIRF). The committee requested further assurance as to provider readiness for PSIRF adoption.<br><br>The committee noted the Standard Operating Procedure in relation to those safety incidents involving the cancer pathways, following collaborative work with the cancer alliance.<br>The committee was given assurance by the Associate Director of Quality at Liverpool place as to the ongoing work within Liverpool University Trust as to improving the quality of investigations and the closure of a significant number of investigations by the end of July 2023.<br><br>The committee received assurance as to the commissioning of MLCSU to support in closing of legacy investigations aligned to the Serious Incident Framework across C&M. |
| 23/05/08 | 18/05/23 | **Performance Report**<br><br>The committee received its monthly report that described the levels of performance in key areas across the C&M system.<br><br>It was reported there have been two key events focussed on urgent care system since the last update and how C&M would be in a tier 1 status for urgent and emergency care.<br><br>The committee was informed that the approach that has been taken on urgent care is to look at 4 key metrics:<br>1) Ambulance response times,<br>2) A&E performance times, |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | 3) 12-hour timing department,<br>4) Percentage of beds occupied by patient for over 14 days.<br><br>The tiering system established by NHS England would look at the aggregate position in C&M, but also the individual Places.<br><br>The committee discussed the national visit in April 2023 to agree a coordinated support offer and tackle inconsistencies in delivery of improved patient flow across the system.<br><br>The committee also agreed that it would require further assurance in relation to pperformance against associated General Practice targets outlined within the performance May 2023 performance report and would receive a paper in July 2023. |
| 23/05/09 | 18/05/23 | **Place Based Quality Report**<br><br>The committee received its monthly report that outlines and aggregates the strategic risks to quality in C&M across each of the nine places.<br><br>The committee received assurance as to the work needed to expedite progress against the SEND Written Statement of Action in Wirral place.<br><br>The committee received details of the findings of the SEND inspection that was undertaken in Warrington Place in March 2023 and was assured by the work by the Place team to respond to the inspection findings.<br><br>The committee discussed the ongoing challenges in delivery of the AACHC pathway. The committee received assurance as to the work to mitigate and align to the organisational AACHC review being concluded currently. |

## 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 |
|---|---|---|
| | | |

## 4. Issues for 4. 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 |
|---|---|---|
| 23/05/07 | 18/05/23 | **Never Events at The Countess of Chester Hospital**<br><br>The committee received an ad hoc report following an increase in Never Event reporting at the Countess of Chester Trust.<br><br>The committee discussed the report and its associated findings, and was not fully assured and therefore requested that this was escalated via the Executive Director of Nursing to the Trust / System Improvement Board and feedback as to next steps be reported back to Committee. |
| 23/05/10 | 18/05/23 | **Mortality Reporting**<br><br>The committee received a report from the Medical Director for the ICB in relation to mortality for Acute providers in C&M.<br><br>The committee had detailed discussion in relation to the overall figures and in particular the outlier status of East Cheshire Trust. Via the ongoing work of the ICB Medical Director with East Cheshire Trust, the committee asked to be updated as to the level of assurance by the Trust in relation to the necessary and remedial work to improve. |

## 5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

| Decision Log Ref No. | Meeting Date | | Recommendation from the Committee |
|---|---|---|---|

## 6. Recommendations

6.1 **The ICB Board is asked to:**

1. Section 2 note the content
2. Section 4 note and consider the content of issues agreed as requiring escalation to the Board

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## 29 June 2023

# Cheshire and Merseyside System Finance Report Month 2

| | |
|---|---|
| **Agenda Item No** | **ICB/06/23/19** |
| **Report author & contact details** | Frankie Morris – Associate Director of Finance (Provider Assurance, Capital & Financial Strategy)<br>Rebecca Tunstall – Associate Director of Finance (Planning & Reporting) |
| **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 2

<table>
<tr><td>Executive Summary</td><td colspan="5">This report updates the Committee on the financial performance of Cheshire and Merseyside ICS (“the System”) for 2023/24, in terms of relative position against its financial plan as submitted to NHS England in May 2023, 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.<br><br>As at 30th May 2023 (Month 2), the ICS ‘System’ is reporting a deficit of £48.2m against a planned deficit of £40.4m resulting in an adverse year to date variance of £7.8m.<br><br>The system is forecasting a position in line with its plan by year end of £51.2m deficit.</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 Committee is asked to:<br>• Note the contents of this report in respect of the Month 2 ICB / ICS financial position for both revenue and capital allocations within the 2023/24 financial year.</td></tr>
<tr><td>Key issues</td><td colspan="5">The financial plan is expected to be delivered in year; but continued focus on the achievement of recurrent efficiencies is required.</td></tr>
<tr><td>Key risks</td><td colspan="5">Outlined within the main paper.</td></tr>
<tr><td rowspan="4">Impact (x)<br>(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">X</td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td colspan="2">Sustainability</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">X</td></tr>
<tr><td>Route to this meeting</td><td colspan="5">Financial plan previously discussed at ICB Finance, Investment and Resources Committee.<br><br>Provider position will be presented to Cheshire and Merseyside Acute and Specialist Provider Collaborative in line with agreed reporting timetable.</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">No specific issues raised</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="5">Financial performance at both place and provider level will be subject to local public communications and engagement arrangements.</td></tr>
<tr><td>Equality, Diversity and Inclusion</td><td colspan="5">Efficiency Plans and Investment decisions will need to be subject to organisation level Equality Impact Assessments (EIA). This will be subject to internal audit review in line with locally agreed audit plans.</td></tr>
</table>

| | |
|---|---|
| **Health inequalities** | Healthcare resource and investment decisions impact on health inequalities and so future place-based allocation decisions will be subject to EIA processes. Strong budget management and control is important to minimise areas of overspend which lead to an unplanned redistribution of resources. |
| **Next Steps** | 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. |
| **Appendices** | Appendices 1-6 gives details of the narrative in the main body of the report. |

# Cheshire and Merseyside System Finance Report – Month 2

**Executive Summary**
This report updates the Board on the financial performance of Cheshire and Merseyside ICS ("the System") for 2023/24, 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.

**Financial performance for the period ending 30th May 2023**

- The system is reporting a deficit of £48.2m against a planned deficit of £40.4m resulting in an adverse year to date variance of £7.8m.
- Cost Improvement Plans have delivered £43.2m YTD, £7.3m behind plan, with just £30m achieved recurrently.
- The system is forecasting achievement of plan, but a number of significant risks have been identified namely, ERF/activity achievement, excess inflation, delivery of recurrent efficiencies, addition pay costs arising from industrial action and cost of delayed transfers of care across the system.

The financial position for the year is set out in the table below:

| | M2 YTD | | |
|---|---|---|---|
| | Plan £m | Actual £m | Variance £m |
| ICB | 11.5 | 10.8 | (0.7) |
| Total Providers | (51.9) | (59.0) | (7.1) |
| Total System | (40.4) | (48.2) | (7.8) |

**Capital**
At the end of May 2023, Provider capital spend was £15.4m, £2.5m behind the plan of £17.9m. Primary Care Capital is not reported at month 2.

# System Finance Report to 30th May 2023 (Month 2)

## Background

1) This report updates the ICB on the financial performance of Cheshire and Merseyside ICS ("the System") for 2023/24, in terms of relative position against its financial plan as submitted to NHS England in May 2023, and utilisation of available Capital resources for the financial year.

2) The revised system plan for 2023/24 submitted on 4th May 2023 as a combined £51.2m deficit consisted of a £68.9m 'surplus' on the commissioning side (ICB) partially offsetting an aggregate NHS provider deficit position of £120.1m. The plan position reflected a variety of surplus / deficit positions across each C&M place and NHS Provider organisations as can be seen in Appendix 1.

3) It should be noted that ICBs 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.

## Month 2 (May) Performance

### ICB performance

4) The ICB has reported a surplus of £10.8m compared to an original planned surplus of £11.5 m resulting in an adverse variance to plan of £0.7m as per the table below:

| | M2 YTD Plan £m | Actual £m | Variance £m | Variance % |
|---|---|---|---|---|
| **System Revenue Resource Limit** | **(1,071.1)** | **0.0** | **0.0** | |
| **ICB Net Expenditure:** | | | | |
| Acute Services | 551.4 | 550.0 | 1.4 | 0.3% |
| Mental Health Services | 97.1 | 96.9 | 0.1 | 0.2% |
| Community Health Services | 105.0 | 105.1 | (0.1) | (0.1%) |
| Continuing Care Services | 58.3 | 61.2 | (2.9) | (5.0%) |
| Primary Care Services | 100.1 | 102.0 | (1.9) | (1.9%) |
| Other Commissioned Services | 2.4 | 2.2 | 0.1 | 5.7% |
| Other Programme Services | 7.0 | 6.9 | 0.1 | 1.0% |
| Reserves / Contingencies | 2.6 | 0.0 | 2.6 | 100.0% |
| Delegated Primary Care Commissioning | 127.7 | 127.8 | (0.2) | (0.1%) |
| *Primary Medical Services* | 82.6 | 82.8 | (0.2) | (0.2%) |
| *Dental Services* | 28.9 | 28.9 | 0.0 | 0.0% |
| *Ophthalmic Services* | 4.5 | 4.5 | 0.0 | 0.0% |
| *Pharmacy Services* | 11.6 | 11.6 | (0.0) | (0.0%) |
| ICB Running Costs | 8.0 | 8.0 | 0.0 | 0.0% |
| **Total ICB Net Expenditure** | 1,059.6 | 1,060.3 | (0.7) | (0.1%) |
| Allocation adjustment for reimbursable items | | 0.0 | | |
| **TOTAL ICB Surplus/(Deficit)** | **11.5** | **10.8** | **(0.7)** | (0.1%) |

5) 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. Acute – Underperformance against elective activity for NHS providers. The month 2 ICB financial position assumes no clawback of Elective Recovery Funding (ERF) from the system, however, under the current payment mechanisms, any underperformance for the year will be removed from our allocation. It is anticipated that the underspend will disappear over coming months as the national ERF payments process is clarified further.
   b. Continuing care - overspend relating to increases to volume and price for continuing care packages and funded nursing care including the impact of inflation above national planning assumptions. This is an area of significant focus and by each place team.
   c. Prescribing – estimated overspend based on March 2023 prescribing data (latest available) and reflecting inflationary pressure above national planning assumptions.
   d. Efficiency savings are built into the position and are forecasting to achieve the planned position. Further work is required to fully identify saving schemes in year and recurrently.

## Place Performance

6) Details of ICB performance split by place is shown below and more detail is provided in appendix 1. ICB central budges are currently showing a positive variance to plan due to slippage on centrally funded programmes. Places with

adverse variances to plan at month 2 will be required to identify actions to mitigate the position by year end in order for the ICB plan to be achieved.

**ICB Financial Position: Combined Year-to-date Financial Position by Place as at Month 2 (31st May 2023)**

| | M2 YTD Plan £m | M2 YTD Actual £m | M2 YTD Variance £m | Annual Plan £m | M2 Forecast ACTUAL £m | M2 Forecast VARIANCE £m |
|---|---|---|---|---|---|---|
| Cheshire - East | (6.1) | (6.9) | (0.8) | (36.4) | (36.4) | 0.0 |
| Cheshire - West | (4.6) | (6.5) | (2.0) | (27.3) | (27.3) | 0.0 |
| Halton | (1.4) | (1.6) | (0.2) | (8.6) | (8.6) | 0.0 |
| Knowsley | 1.9 | 1.7 | (0.2) | 11.2 | 11.2 | 0.0 |
| Liverpool | 1.2 | 0.2 | (1.0) | 7.2 | 7.2 | 0.0 |
| Sefton | (0.9) | (1.2) | (0.2) | (5.7) | (5.7) | 0.0 |
| St Helens | (1.4) | (1.6) | (0.2) | (8.6) | (8.6) | 0.0 |
| Warrington | (1.3) | (1.9) | (0.6) | (7.8) | (7.8) | 0.0 |
| Wirral | (1.2) | (1.8) | (0.6) | (7.2) | (7.2) | 0.0 |
| ICB | 25.4 | 30.4 | 5.1 | 152.1 | 152.1 | 0.0 |
| **Total ICB** | **11.5** | **10.8** | **(0.7)** | **69.0** | **69.0** | **0.0** |

## NHS Provider Performance

7) The table below summarises the combined NHS provider position to the end of May 2023 reflecting a year-to-date cumulative deficit position of £59.0m compared to a deficit plan of £51.9m, giving an adverse variance of £7.1m. Further detail is provided in Appendix 2.

8) All Providers are forecasting achievement of plan, but there is a significant amount of risk in this position

| | M2 YTD | | | 2324 Forecast | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance |
| | £m | £m | £m | £m | £m | £m |
| Alder Hey Children's NHS Foundation Trust | (1.0) | (1.0) | (0.0) | 12.3 | 12.3 | (0.0) |
| Bridgewater Community Healthcare NHS Foundation Trust | 0.0 | (0.6) | (0.6) | (0.0) | (0.0) | (0.0) |
| Cheshire and Wirral Partnership NHS Foundation Trust | (0.1) | (1.1) | (1.0) | 0.0 | 0.0 | (0.0) |
| Countess of Chester Hospital NHS Foundation Trust | (4.2) | (6.6) | (2.5) | (25.2) | (25.2) | (0.0) |
| East Cheshire NHS Trust | (2.8) | (3.1) | (0.3) | (4.4) | (4.4) | 0.0 |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 1.6 | 1.3 | (0.4) | 9.8 | 9.8 | 0.0 |
| Liverpool University Hospitals NHS Foundation Trust | (29.3) | (29.1) | 0.2 | (60.7) | (60.7) | 0.0 |
| Liverpool Women's NHS Foundation Trust | (3.1) | (3.1) | 0.0 | (15.4) | (15.4) | 0.0 |
| Mersey Care NHS Foundation Trust | 1.3 | 1.3 | 0.0 | 6.4 | 6.4 | 0.0 |
| Mid Cheshire Hospitals NHS Foundation Trust | (5.2) | (5.9) | (0.7) | (18.9) | (18.9) | 0.0 |
| Southport And Ormskirk Hospital NHS Trust | (1.3) | (1.3) | (0.0) | 0.0 | 0.0 | 0.0 |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 0.9 | 0.9 | (0.0) | 5.6 | 5.6 | 0.0 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 0.1 | 0.1 | (0.0) | 0.4 | 0.4 | (0.0) |
| The Walton Centre NHS Foundation Trust | 0.9 | 0.9 | 0.0 | 4.1 | 4.1 | 0.0 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | (4.1) | (5.6) | (1.5) | (15.7) | (15.7) | 0.0 |
| Wirral Community Health and Care NHS Foundation Trust | 0.1 | (0.2) | (0.4) | 0.2 | 0.2 | 0.0 |
| Wirral University Teaching Hospital NHS Foundation Trust | (5.7) | (5.7) | 0.0 | (18.6) | (18.6) | (0.0) |
| **Total Providers** | **(51.9)** | **(59.0)** | **(7.1)** | **(120.2)** | **(120.2)** | **(0.0)** |

9) 8 provider trusts are reporting a year-to-date position adverse to plan.

10) Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£21.9m) and non-pay costs (£16.1m) partially offset set by favourable movements in Income (£27.1m) and non-operating items (£3.8m) as per the table below. The variance on pay compared to plan reflects the additional costs of the pay award agreed shortly after the planning submission but this is funded by NHSE and as reflected on the overperformance in income reported.

| | M2 YTD | | | |
|---|---|---|---|---|
| | Plan | Actual | Variance | |
| | £m | £m | £m | % |
| **Total Income** | **(977.5)** | **(1,004.6)** | **(27.1)** | **(2.8%)** |
| Pay | 673.4 | 695.3 | 21.9 | (3.2%) |
| Non Pay | 339.5 | 355.6 | 16.1 | (4.7%) |
| Non Operating Items ( excl gains on disposal) | 16.5 | 12.7 | (3.8) | 22.9% |
| **Total Expenditure** | **1,029.4** | **1,063.6** | **34.2** | **(3.3%)** |
| **Total Provider Surplus/(Deficit)** | **(51.9)** | **(59.0)** | **(7.1)** | **(13.6%)** |

11) The following Trusts are currently reporting forecast adverse variances to plan.

- **Bridgewater Community Healthcare Trust**
  **£0.6m adverse variance ytd, forecast to plan**
  Experiencing increased locum rates for Dermatologists, alongside inflation on continence products. Trust expects to mitigate these challenges over the remaining months of the year.

- **Cheshire and Wirral Partnership NHS Trust**
  **£1.0m adverse variance YTD, forecast to plan**
  A high level of out of area placements has driven increased costs year to date. A number of patients are clinically fit for discharges to the community, resulting in delays to admissions and placements in the independent sector.

- **Countess of Chester NHS Foundation Trust**
  **£2.5m adverse variance YTD, forecast to plan**
  Key driver is undelivered CIP of £2.7m as the Trust has not been able to step down the winter escalation ward as planned.

- **East Cheshire NHS Trust**
  **£0.3m adverse variance YTD, forecast to plan**
  The variance is driven by £112k lost elective income arising from industrial action and non-achievement of CIP.

- **Liverpool Heart and Chest Hospital NHS Foundation Trust**
  **£0.4m adverse variance YTD, forecast to plan**
  Key driver is non-achievement of CIP, which the Trust expects to recover as the year progresses.

- **Mid Cheshire Hospitals NHS Foundation Trust**
  **£0.7m adverse variance YTD, forecast to plan**
  Key drivers are CIP slippage of £0.3m, cost of industrial action £0.2m, and anticipated pay pressure of £0.2m

- **Warrington and Halton Teaching Hospital NHS Trust**
  **£1.5m adverse variance YTD, forecast to plan**
  Key driver of variance is the lost elective income arising from industrial action and compared to improvement trajectory.

- **Wirral Community Health and Care NHS Trust**
  **£0.4m adverse variance YTD, forecast to plan**
  Underachievement of CIP is the key driver of this position, the Trust is anticipating this to recover as the year progresses.

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

## Provider Agency Costs

13) ICB Providers set a plan for agency spend of £117.6m, compared to actual spend in 2022/23 of £155.9m. The system is required to manage agency costs within budget and to demonstrate reduced reliance on agency staffing year on year.

14) Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency above £50k. In Month 2, agency spend is £23.2m (£0.6m below plan), equating to 3.33% of total pay. 8 Trusts are reporting an adverse variance to plan.

15) Trusts are forecasting agency spend to be £119.4m, a £1.8m variance to a plan of £117.6m, but still below the overall ICS agency ceiling of £127.3m. 5 Trusts: Countess of Chester, Southport and Ormskirk, Walton Centre, Wirral Community and Wirral Acute all forecasting a forecast adverse variance to plan for agency spend.

## Efficiencies

## ICB Efficiencies

16) The ICB has is reporting an adverse position against plan of £1.1m YTD for unidentified efficiencies but is forecast to achieve the full £57.9m for the year.

17) Key schemes are focussed on Continuing Health Care and Prescribing costs in each of the 9 places. Enhanced reporting of place level plans is being developed and will be reported in more detail in future Committee papers.

## Provider Efficiencies

18) Provider efficiency schemes have delivered efficiencies of £35.5m YTD, an adverse variance of £6.1m. However only £23.4m of this has been delivered recurrently, which raises concerns over the underlying financial position. The detail by provider is included in Appendix 4.

19) An in-depth review of providers' scheme level CIP programmes is underway to support assurance, benchmarking and sharing of best practice amongst partners.

## System Risks & Mitigations

20) The system is currently forecasting that the financial plan will be delivered by year-end. However, several risks have been highlighted namely:
    a. **Non-achievement of ERF/activity requirements** – progress in April and May was impacted by industrial action but otherwise remained strong.
    b. **Identification and delivery of recurrent CIPs** – this is subject to focussed system wide review to identify areas for acceleration and improvement
    c. Inflation, specifically food and energy inflation
    d. **Industrial action disruption** – costs are being monitored by each provider so that the impact can be accurately quantified.
    e. **Maintenance of escalation beds year-round** – targeted improvement plan in development across system in response to recommendations identified by National team
    f. **Cost of out of area placements** arising from delayed transfers of care
    g. **Pay claims** – situation being monitored closely by HR directors

## Provider Capital

21) The 'Charge against Capital Allocation' represents the System's performance against its operational capital allocation, which is wholly managed at the System's discretion. The Secondary Care allocation in 23/24 is £238.1m

22) Spend in relation to IFRS16 changes (movement of Operating leases from revenue to capital recognition) were administered by the national team, on behalf of systems, but there are indications that this may come into the remit of the ICS, but this has not yet been confirmed.

23) 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.

24) At month 2, providers have spent £15.4m against a system allocation of £17.9m. Detail by provider is set out in Appendix 5.

25) Capital spend is behind plan at Mid Cheshire £1m, East Cheshire, £1m and Wirral Acute £0.8m. All Trusts are reporting achievement of forecast.

26) The IFRS16 plan, actual and forecast are set out in Appendix 5b. This is for information only as the ICS is not yet held responsible for this performance.

27) The Total CDEL position is set out appendix 5c. This is also for information only as it includes national schemes, such as CDCs, diagnostics, digital diagnostics, Frontline Digitisation, New Hospital Programmes and Elective Recovery.

**Primary Care Capital**

28) The ICB has been allocated £4.7m in 23/24 and £4.7m in 24/25, for Primary Care Capital to cover GP Improvement Grants and GP BAU digital.

29) The process for distribution of this allocation is ongoing, with approval given via the Primary Care Committee.

30) The ICB was not required to report Primary Care Capital in Month 2. This will be reported in month 3.

**Cash**

31) Provider Cash position at Month 2 is £693.8m, with the detail set out in Appendix 6. This is £30.2m higher than at the end of 22/23 and £306.3m higher than at the end of 2019/20.

32) 3 Trusts have requested cash support from the ICS: LWH, Southport and Ormskirk and Mid Cheshire.

33) ICB Cash position at Month 2 is -£0.4m, this is a technical overdraft due to two unpresented bacs runs at the end of the month.

## Recommendations

**The Board is asked to:**

- Note the contents of this report in respect of the month 2 financial position for both revenue and capital allocations within the 2023/24 financial year.

## Officer contact details for more information

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# Appendix 1

## ICB Place Performance split by Programme Area as at 31st May 2023

| ICB "Default" - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 108,119 | 106,467 | 1,652 |
| Mental Health Services | 169 | 169 | (0) |
| Community Health Services | 5,184 | 5,184 | (0) |
| Continuing Care Services | 0 | 0 | (0) |
| Primary Care Services | 0 | 0 | 0 |
| Other Commissioned Services | 0 | (0) | 0 |
| Other Programme Services | 0 | (0) | 0 |
| Reserves / Contingencies | 3,300 | 0 | 3,300 |
| Delegated Primary Care Commissioning | 45,537 | 45,420 | 117 |
| a) Primary Medical Services | 260 | 144 | 117 |
| b) Other Services | 45,277 | 45,277 | 0 |
| ICB Running Costs | 8,023 | 8,023 | 0 |
| **Total Net Expenditure** | **170,332** | **165,263** | **5,069** |
| Surplus / (Deficit) plan | 25,354 | 0 | 25,354 |
| **Surplus / (Deficit) Reported** | **195,686** | **165,263** | **30,423** |

| Cheshire East Place - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 59,049 | 59,122 | (72) |
| Mental Health Services | 11,113 | 10,902 | 210 |
| Community Health Services | 12,967 | 12,888 | 80 |
| Continuing Care Services | 10,583 | 10,941 | (358) |
| Primary Care Services | 14,135 | 14,743 | (609) |
| Other Commissioned Services | 318 | 354 | (36) |
| Other Programme Services | 531 | 512 | 19 |
| Reserves / Contingencies | (81) | 0 | (81) |
| Delegated Primary Care Commissioning | 11,999 | 11,999 | 0 |
| a) Primary Medical Services | 11,999 | 11,999 | 0 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **120,615** | **121,461** | **(846)** |
| Surplus / (Deficit) plan | (6,063) | 0 | (6,063) |
| **Surplus / (Deficit) Reported** | **114,552** | **121,461** | **(6,909)** |

| Cheshire West Place - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 60,523 | 60,616 | (93) |
| Mental Health Services | 11,777 | 11,578 | 199 |
| Community Health Services | 10,571 | 10,763 | (192) |
| Continuing Care Services | 8,011 | 9,220 | (1,209) |
| Primary Care Services | 13,839 | 14,424 | (586) |
| Other Commissioned Services | 284 | 329 | (45) |
| Other Programme Services | 340 | 304 | 37 |
| Reserves / Contingencies | (88) | 0 | (88) |
| Delegated Primary Care Commissioning | 11,261 | 11,261 | 0 |
| a) Primary Medical Services | 11,261 | 11,261 | 0 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **116,516** | **118,494** | **(1,978)** |
| Surplus / (Deficit) plan | (4,550) | 0 | (4,550) |
| **Surplus / (Deficit) Reported** | **111,966** | **118,494** | **(6,528)** |

| Halton Place - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 24,288 | 24,289 | (0) |
| Mental Health Services | 5,221 | 5,221 | (0) |
| Community Health Services | 5,811 | 5,769 | 42 |
| Continuing Care Services | 2,942 | 3,146 | (204) |
| Primary Care Services | 5,111 | 5,118 | (8) |
| Other Commissioned Services | 81 | 63 | 18 |
| Other Programme Services | 267 | 267 | 0 |
| Reserves / Contingencies | 0 | 0 | 0 |
| Delegated Primary Care Commissioning | 4,103 | 4,103 | 0 |
| a) Primary Medical Services | 4,103 | 4,103 | 0 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **47,825** | **47,976** | **(151)** |
| Surplus / (Deficit) plan | (1,429) | 0 | (1,429) |
| **Surplus / (Deficit) Reported** | **46,396** | **47,976** | **(1,580)** |

| Knowsley Place - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Knowsley Net Expenditure** | | | |
| Acute | 29,732 | 29,732 | 0 |
| Mental Health Services | 6,493 | 6,493 | (0) |
| Community Health Services | 9,656 | 9,656 | 0 |
| Continuing Care Services | 2,099 | 2,214 | (115) |
| Primary Care Services | 6,305 | 6,356 | (52) |
| Other Commissioned Services | 166 | 166 | 0 |
| Other Programme Services | 637 | 637 | 0 |
| Reserves / Contingencies | 0 | 0 | 0 |
| Delegated Primary Care Commissioning | 6,629 | 6,629 | 0 |
| a) Primary Medical Services | 6,629 | 6,629 | 0 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **61,718** | **61,884** | **(166)** |
| Surplus / (Deficit) plan | 1,868 | 0 | 1,868 |
| **Surplus / (Deficit) Reported** | **63,585** | **61,884** | **1,701** |

| Liverpool Place - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 90,382 | 90,382 | (0) |
| Mental Health Services | 22,576 | 22,834 | (258) |
| Community Health Services | 20,742 | 20,742 | (0) |
| Continuing Care Services | 9,956 | 10,334 | (378) |
| Primary Care Services | 20,615 | 20,952 | (337) |
| Other Commissioned Services | 700 | 700 | 0 |
| Other Programme Services | 1,418 | 1,418 | 0 |
| Reserves / Contingencies | 0 | 0 | 0 |
| Delegated Primary Care Commissioning | 16,984 | 16,984 | 0 |
| a) Primary Medical Services | 16,984 | 16,984 | 0 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **183,373** | **184,347** | **(974)** |
| Surplus / (Deficit) plan | 1,193 | 0 | 1,193 |
| **Surplus / (Deficit) Reported** | **184,566** | **184,347** | **219** |

| Sefton - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 49,326 | 49,392 | (66) |
| Mental Health Services | 10,699 | 10,699 | 0 |
| Community Health Services | 11,848 | 11,867 | (19) |
| Continuing Care Services | 6,736 | 6,891 | (156) |
| Primary Care Services | 11,793 | 11,901 | (108) |
| Other Commissioned Services | 312 | 220 | 91 |
| Other Programme Services | 2,469 | 2,455 | 13 |
| Reserves / Contingencies | 0 | 0 | 0 |
| Delegated Primary Care Commissioning | 7,991 | 7,991 | 0 |
| a) Primary Medical Services | 7,991 | 7,991 | 0 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **101,173** | **101,417** | **(244)** |
| Surplus / (Deficit) plan | (947) | 0 | (947) |
| **Surplus / (Deficit) Reported** | **100,226** | **101,417** | **(1,191)** |

| St Helens - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 35,440 | 35,440 | 0 |
| Mental Health Services | 8,168 | 8,169 | (2) |
| Community Health Services | 8,338 | 8,338 | (0) |
| Continuing Care Services | 3,941 | 3,941 | 0 |
| Primary Care Services | 7,818 | 7,957 | (138) |
| Other Commissioned Services | 177 | 177 | (0) |
| Other Programme Services | 623 | 624 | (0) |
| Reserves / Contingencies | (55) | 0 | (55) |
| Delegated Primary Care Commissioning | 6,421 | 6,421 | 0 |
| a) Primary Medical Services | 6,421 | 6,421 | 0 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **70,873** | **71,067** | **(195)** |
| Surplus / (Deficit) plan | (1,430) | 0 | (1,430) |
| **Surplus / (Deficit) Reported** | **69,442** | **71,067** | **(1,625)** |

| Warrington - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 34,824 | 34,825 | (0) |
| Mental Health Services | 7,652 | 7,652 | (0) |
| Community Health Services | 6,335 | 6,330 | 5 |
| Continuing Care Services | 4,731 | 5,240 | (509) |
| Primary Care Services | 6,883 | 6,998 | (115) |
| Other Commissioned Services | 181 | 115 | 67 |
| Other Programme Services | 722 | 722 | 0 |
| Reserves / Contingencies | (42) | 0 | (42) |
| Delegated Primary Care Commissioning | 6,168 | 6,168 | 0 |
| a) Primary Medical Services | 6,168 | 6,168 | 0 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **67,455** | **68,049** | **(594)** |
| Surplus / (Deficit) plan | (1,307) | 0 | (1,307) |
| **Surplus / (Deficit) Reported** | **66,148** | **68,049** | **(1,901)** |

| Wirral - Month 2 Financial Position | 2023/24 YTD Plan £000's | 2023/24 YTD Actual £000's | 2023/24 YTD Variance Favourable / (Adverse) £000's |
|---|---|---|---|
| **Net Expenditure** | | | |
| Acute | 59,725 | 59,725 | 0 |
| Mental Health Services | 13,233 | 13,233 | (0) |
| Community Health Services | 13,519 | 13,519 | 0 |
| Continuing Care Services | 9,327 | 9,319 | 8 |
| Primary Care Services | 13,646 | 13,566 | 80 |
| Other Commissioned Services | 132 | 93 | 39 |
| Other Programme Services | 0 | (0) | 0 |
| Reserves / Contingencies | (460) | 0 | (460) |
| Delegated Primary Care Commissioning | 10,578 | 10,857 | 279 |
| a) Primary Medical Services | 10,578 | 10,857 | 279 |
| b) Other Services | 0 | 0 | 0 |
| ICB Running Costs | 0 | 0 | 0 |
| **Total Net Expenditure** | **119,701** | **120,313** | **(54)** |
| Surplus / (Deficit) plan | (1,195) | 0 | (1,195) |
| **Surplus / (Deficit) Reported** | **118,506** | **120,313** | **(1,250)** |

# Appendix 2

## System Financial Position: Combined Year-to-date Financial Position by Organisation as at Month 2 (31st May 2023)

| | M2 YTD | | | 2324 Forecast | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Current | Variance |
| | £m | £m | £m | £m | £m | £m |
| **ICB** | **11.5** | **10.8** | **(0.7)** | **69.0** | **69.0** | **0.0** |
| Alder Hey Children's NHS Foundation Trust | (1.0) | (1.0) | (0.0) | 12.3 | 12.3 | (0.0) |
| Bridgewater Community Healthcare NHS Foundation Trust | 0.0 | (0.6) | (0.6) | (0.0) | (0.0) | (0.0) |
| Cheshire and Wirral Partnership NHS Foundation Trust | (0.1) | (1.1) | (1.0) | 0.0 | 0.0 | (0.0) |
| Countess of Chester Hospital NHS Foundation Trust | (4.2) | (6.6) | (2.5) | (25.2) | (25.2) | (0.0) |
| East Cheshire NHS Trust | (2.8) | (3.1) | (0.3) | (4.4) | (4.4) | 0.0 |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 1.6 | 1.3 | (0.4) | 9.8 | 9.8 | 0.0 |
| Liverpool University Hospitals NHS Foundation Trust | (29.3) | (29.1) | 0.2 | (60.7) | (60.7) | 0.0 |
| Liverpool Women's NHS Foundation Trust | (3.1) | (3.1) | 0.0 | (15.4) | (15.4) | 0.0 |
| Mersey Care NHS Foundation Trust | 1.3 | 1.3 | 0.0 | 6.4 | 6.4 | 0.0 |
| Mid Cheshire Hospitals NHS Foundation Trust | (5.2) | (5.9) | (0.7) | (18.9) | (18.9) | 0.0 |
| Southport And Ormskirk Hospital NHS Trust | (1.3) | (1.3) | (0.0) | 0.0 | 0.0 | 0.0 |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 0.9 | 0.9 | (0.0) | 5.6 | 5.6 | 0.0 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 0.1 | 0.1 | (0.0) | 0.4 | 0.4 | (0.0) |
| The Walton Centre NHS Foundation Trust | 0.9 | 0.9 | 0.0 | 4.1 | 4.1 | 0.0 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | (4.1) | (5.6) | (1.5) | (15.7) | (15.7) | 0.0 |
| Wirral Community Health and Care NHS Foundation Trust | 0.1 | (0.2) | (0.4) | 0.2 | 0.2 | 0.0 |
| Wirral University Teaching Hospital NHS Foundation Trust | (5.7) | (5.7) | 0.0 | (18.6) | (18.6) | (0.0) |
| **Total Providers** | **(51.9)** | **(59.0)** | **(7.1)** | **(120.2)** | **(120.2)** | **(0.0)** |
| **Total System** | **(40.4)** | **(48.2)** | **(7.8)** | **(51.2)** | **(51.2)** | **(0.0)** |

*Note: brackets denote deficit/overspend.*

# Appendix 3

## Agency spend: Current Performance and Forecast Outturn as at Month 2 (31st May 2023)

| | M2 YTD | | | 2324 Forecast | | | 2223 |
|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Forecast £m | Variance £m | Actual £m |
| Alder Hey Children's NHS Foundation Trust | (0.2) | (0.2) | 0.0 | (1.1) | (0.9) | 0.2 | (1.5) |
| Bridgewater Community Healthcare NHS Foundation Trust | (0.7) | (0.9) | (0.2) | (4.2) | (4.2) | 0.0 | (5.8) |
| Cheshire and Wirral Partnership NHS Foundation Trust | (1.1) | (1.5) | (0.3) | (6.7) | (6.7) | (0.0) | (8.0) |
| Countess of Chester Hospital NHS Foundation Trust | (1.2) | (1.4) | (0.2) | (6.9) | (7.4) | (0.4) | (18.0) |
| East Cheshire NHS Trust | (1.9) | (1.8) | 0.1 | (9.5) | (9.5) | 0.0 | (12.3) |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | (0.2) | (0.1) | 0.0 | (1.1) | (0.9) | 0.2 | (1.2) |
| Liverpool University Hospitals NHS Foundation Trust | (5.1) | (3.4) | 1.7 | (15.7) | (15.7) | 0.0 | (16.3) |
| Liverpool Women's NHS Foundation Trust | (0.4) | (0.2) | 0.2 | (2.3) | (2.3) | 0.0 | (2.2) |
| Mersey Care NHS Foundation Trust | (3.2) | (3.1) | 0.1 | (19.3) | (19.3) | 0.0 | (20.7) |
| Mid Cheshire Hospitals NHS Foundation Trust | (2.8) | (2.0) | 0.8 | (12.6) | (12.6) | 0.0 | (20.6) |
| Southport And Ormskirk Hospital NHS Trust | (1.1) | (1.3) | (0.2) | (6.5) | (7.5) | (1.0) | (7.2) |
| St Helens And Knowsley Teaching Hospitals NHS Trust | (1.8) | (2.5) | (0.7) | (10.8) | (10.8) | 0.0 | (12.6) |
| The Clatterbridge Cancer Centre NHS Foundation Trust | (0.3) | (0.2) | 0.1 | (1.8) | (1.8) | 0.0 | (1.8) |
| The Walton Centre NHS Foundation Trust | 0.0 | (0.1) | (0.1) | 0.0 | (0.4) | (0.4) | (0.3) |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | (2.5) | (2.3) | 0.2 | (11.6) | (11.6) | 0.0 | (14.8) |
| Wirral Community Health and Care NHS Foundation Trust | (0.3) | (0.4) | (0.1) | (1.5) | (1.7) | (0.2) | (2.7) |
| Wirral University Teaching Hospital NHS Foundation Trust | (1.0) | (1.8) | (0.8) | (5.7) | (6.0) | (0.3) | (9.9) |
| **Total Providers** | **(23.8)** | **(23.2)** | **0.6** | **(117.6)** | **(119.4)** | **(1.8)** | **(155.9)** |
| **as a proportion of Total Pay** | 3.5% | 3.33% | | 3.00% | 3.02% | | |

System agency ceiling is £127.3m

# Appendix 4

## System Efficiencies: Current Performance and Forecast Outturn as at Month 2 (31st May 2023)

| | M2 YTD | | | 23/24 | | |
|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Forecast £m | Variance £m |
| **ICB** | 8.7 | 7.6 | (1.1) | 57.9 | 57.9 | 0.0 |
| | **8.7** | **7.6** | **(1.1)** | **57.9** | **57.9** | **0.0** |
| **Providers:** | | | | | | |
| Alder Hey Children's NHS Foundation Trust | 2.4 | 0.6 | (1.7) | 17.7 | 17.7 | 0.0 |
| Bridgewater Community Healthcare NHS Foundation Trust | 0.9 | 0.3 | (0.6) | 5.1 | 5.1 | 0.0 |
| Cheshire and Wirral Partnership NHS Foundation Trust | 2.0 | 1.5 | (0.6) | 12.8 | 12.8 | 0.0 |
| Countess of Chester Hospital NHS Foundation Trust | 3.5 | 0.8 | (2.7) | 20.8 | 20.8 | 0.0 |
| East Cheshire NHS Trust | 0.7 | 0.5 | (0.2) | 10.3 | 10.3 | 0.0 |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 1.5 | 0.8 | (0.7) | 9.0 | 9.0 | 0.0 |
| Liverpool University Hospitals NHS Foundation Trust | 7.0 | 9.5 | 2.5 | 81.7 | 81.7 | 0.0 |
| Liverpool Women's NHS Foundation Trust | 0.7 | 0.4 | (0.3) | 8.3 | 8.3 | 0.0 |
| Mersey Care NHS Foundation Trust | 6.2 | 6.2 | 0.0 | 37.2 | 37.2 | 0.0 |
| Mid Cheshire Hospitals NHS Foundation Trust | 1.9 | 1.5 | (0.4) | 21.2 | 21.2 | 0.0 |
| Southport And Ormskirk Hospital NHS Trust | 1.9 | 1.9 | 0.0 | 13.2 | 13.2 | 0.0 |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 4.7 | 4.7 | 0.0 | 28.4 | 28.4 | 0.0 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 1.4 | 0.6 | (0.8) | 8.2 | 8.2 | 0.0 |
| The Walton Centre NHS Foundation Trust | 1.5 | 1.5 | 0.0 | 7.5 | 7.5 | 0.0 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 1.2 | 1.1 | (0.0) | 17.9 | 17.9 | 0.0 |
| Wirral Community Health and Care NHS Foundation Trust | 0.9 | 0.3 | (0.6) | 5.3 | 5.3 | 0.0 |
| Wirral University Teaching Hospital NHS Foundation Trust | 3.4 | 3.4 | 0.0 | 26.2 | 26.2 | 0.0 |
| **Total Providers** | **41.7** | **35.5** | **(6.1)** | **330.8** | **330.8** | **0.0** |
| **Total System** | **50.4** | **43.2** | **(7.3)** | **388.7** | **388.7** | **0.0** |

## Recurrent/Non-recurrent split of Provider YTD CIP delivery as at Month 2 (31st May 2023)

| | YTD Recurrent | | | YTD Non Recurrent | | | YTD Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m |
| Alder Hey Children's NHS Foundation Trust | 2.4 | 0.5 | (1.9) | 0.0 | 0.1 | 0.1 | 2.4 | 0.6 | (1.7) |
| Bridgewater Community Healthcare NHS Foundation Trust | 0.9 | 0.1 | (0.8) | 0.0 | 0.2 | 0.2 | 0.9 | 0.3 | (0.6) |
| Cheshire and Wirral Partnership NHS Foundation Trust | 1.0 | 0.5 | (0.5) | 1.0 | 0.9 | (0.1) | 2.0 | 1.5 | (0.6) |
| Countess of Chester Hospital NHS Foundation Trust | 1.7 | 0.6 | (1.1) | 1.7 | 0.2 | (1.5) | 3.5 | 0.8 | (2.7) |
| East Cheshire NHS Trust | 0.7 | 0.3 | (0.4) | 0.0 | 0.2 | 0.2 | 0.7 | 0.5 | (0.2) |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 1.5 | 0.3 | (1.2) | 0.0 | 0.5 | 0.5 | 1.5 | 0.8 | (0.7) |
| Liverpool University Hospitals NHS Foundation Trust | 7.0 | 6.0 | (1.1) | 0.0 | 3.6 | 3.6 | 7.0 | 9.5 | 2.5 |
| Liverpool Women's NHS Foundation Trust | 0.7 | 0.4 | (0.3) | 0.0 | 0.0 | 0.0 | 0.7 | 0.4 | (0.3) |
| Mersey Care NHS Foundation Trust | 2.8 | 2.8 | 0.0 | 3.4 | 3.4 | 0.0 | 6.2 | 6.2 | 0.0 |
| Mid Cheshire Hospitals NHS Foundation Trust | 1.9 | 1.5 | (0.4) | 0.0 | 0.0 | 0.0 | 1.9 | 1.5 | (0.4) |
| Southport And Ormskirk Hospital NHS Trust | 1.9 | 1.9 | 0.0 | 0.0 | 0.0 | 0.0 | 1.9 | 1.9 | 0.0 |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 3.6 | 3.6 | 0.0 | 1.2 | 1.2 | 0.0 | 4.7 | 4.7 | 0.0 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 1.4 | 0.6 | (0.8) | 0.0 | 0.0 | 0.0 | 1.4 | 0.6 | (0.8) |
| The Walton Centre NHS Foundation Trust | 1.5 | 0.9 | (0.6) | 0.0 | 0.6 | 0.6 | 1.5 | 1.5 | 0.0 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 1.2 | 0.3 | (0.9) | 0.0 | 0.8 | 0.8 | 1.2 | 1.1 | (0.0) |
| Wirral Community Health and Care NHS Foundation Trust | 0.8 | 0.1 | (0.7) | 0.0 | 0.2 | 0.1 | 0.9 | 0.3 | (0.6) |
| Wirral University Teaching Hospital NHS Foundation Trust | 3.4 | 3.4 | 0.0 | 0.0 | 0.0 | 0.0 | 3.4 | 3.4 | 0.0 |
| **Total Providers** | **34.3** | **23.7** | **(10.6)** | **7.4** | **11.9** | **4.5** | **41.7** | **35.5** | **(6.1)** |

## Recurrent/Non-recurrent split of Provider 23/24 Forecast CIP delivery as at Month 2 ( 31st May 2023)

| | 2324 Recurrent | | | 2324 Non Recurrent | | | 2324 Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m |
| Alder Hey Children's NHS Foundation Trust | 17.7 | 17.4 | (0.3) | 0.0 | 0.3 | 0.3 | 17.7 | 17.7 | 0.0 |
| Bridgewater Community Healthcare NHS Foundation Trust | 5.1 | 4.0 | (1.2) | 0.0 | 1.2 | 1.2 | 5.1 | 5.1 | 0.0 |
| Cheshire and Wirral Partnership NHS Foundation Trust | 6.6 | 6.5 | (0.0) | 6.2 | 6.2 | 0.0 | 12.8 | 12.8 | 0.0 |
| Countess of Chester Hospital NHS Foundation Trust | 10.4 | 10.4 | 0.0 | 10.4 | 10.4 | 0.0 | 20.8 | 20.8 | 0.0 |
| East Cheshire NHS Trust | 10.3 | 9.8 | (0.5) | 0.0 | 0.5 | 0.5 | 10.3 | 10.3 | 0.0 |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 9.0 | 5.7 | (3.3) | 0.0 | 3.3 | 3.3 | 9.0 | 9.0 | 0.0 |
| Liverpool University Hospitals NHS Foundation Trust | 58.8 | 58.8 | 0.0 | 22.9 | 22.9 | 0.0 | 81.7 | 81.7 | 0.0 |
| Liverpool Women's NHS Foundation Trust | 8.3 | 8.3 | 0.0 | 0.0 | 0.0 | 0.0 | 8.3 | 8.3 | 0.0 |
| Mersey Care NHS Foundation Trust | 16.8 | 16.8 | 0.0 | 20.4 | 20.4 | 0.0 | 37.2 | 37.2 | 0.0 |
| Mid Cheshire Hospitals NHS Foundation Trust | 21.2 | 21.2 | 0.0 | 0.0 | 0.0 | 0.0 | 21.2 | 21.2 | 0.0 |
| Southport And Ormskirk Hospital NHS Trust | 13.2 | 13.2 | 0.0 | 0.0 | 0.0 | 0.0 | 13.2 | 13.2 | 0.0 |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 21.4 | 21.4 | 0.0 | 7.0 | 7.0 | 0.0 | 28.4 | 28.4 | 0.0 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 8.2 | 8.2 | 0.0 | 0.0 | 0.0 | 0.0 | 8.2 | 8.2 | 0.0 |
| The Walton Centre NHS Foundation Trust | 7.5 | 5.2 | (2.4) | 0.0 | 2.4 | 2.4 | 7.5 | 7.5 | 0.0 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 17.9 | 3.8 | (14.1) | 0.0 | 14.1 | 14.1 | 17.9 | 17.9 | 0.0 |
| Wirral Community Health and Care NHS Foundation Trust | 5.0 | 4.3 | (0.7) | 0.3 | 1.0 | 0.7 | 5.3 | 5.3 | 0.0 |
| Wirral University Teaching Hospital NHS Foundation Trust | 26.2 | 26.2 | 0.0 | 0.0 | 0.0 | 0.0 | 26.2 | 26.2 | 0.0 |
| **Total Providers** | **263.7** | **241.3** | **(22.3)** | **67.2** | **89.5** | **22.4** | **330.8** | **330.8** | **0.0** |

*Note: brackets denote underdelivery*

# Appendix 5

## A) Provider Capital: Current & Forecast Performance (excluding IFRS16 impact) as at Month 2 (31st May 2023)

| | YTD Charge against Capital Allocation (excluding IFRS 16 impact) | | | 23/24 Charge against Capital Allocation (excluding IFRS 16 impact) | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | ACTUAL | Variance |
| | £m | £m | £m | £m | £m | £m |
| Alder Hey Children's NHS Foundation Trust | 1.5 | 1.3 | 0.2 | 14.6 | 14.6 | 0.0 |
| Bridgewater Community Healthcare NHS Foundation Trust | 0.0 | 0.5 | (0.5) | 2.1 | 2.1 | 0.0 |
| Cheshire and Wirral Partnership NHS Foundation Trust | 0.4 | 0.1 | 0.2 | 4.5 | 4.5 | 0.0 |
| Countess of Chester Hospital NHS Foundation Trust | 4.2 | 4.4 | (0.2) | 45.3 | 45.3 | 0.0 |
| East Cheshire NHS Trust | 1.0 | 0.0 | 1.0 | 3.5 | 3.5 | 0.0 |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 1.3 | 0.9 | 0.4 | 6.1 | 6.1 | (0.0) |
| Liverpool University Hospitals NHS Foundation Trust | 1.2 | 0.6 | 0.6 | 39.4 | 39.4 | 0.0 |
| Liverpool Women's NHS Foundation Trust | 0.7 | 0.7 | (0.0) | 5.0 | 5.0 | 0.0 |
| Mersey Care NHS Foundation Trust | 1.0 | 1.3 | (0.2) | 16.0 | 16.0 | 0.0 |
| Mid Cheshire Hospitals NHS Foundation Trust | 4.2 | 3.1 | 1.1 | 31.0 | 31.0 | 0.0 |
| Southport And Ormskirk Hospital NHS Trust | 0.1 | 0.2 | (0.1) | 19.5 | 19.5 | 0.0 |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 0.0 | 0.6 | (0.6) | 5.0 | 5.0 | 0.0 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 0.0 | 0.1 | (0.1) | 7.3 | 7.3 | 0.0 |
| The Walton Centre NHS Foundation Trust | 0.2 | 0.3 | (0.1) | 4.8 | 4.8 | 0.0 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 0.6 | 0.7 | (0.1) | 8.9 | 8.9 | 0.0 |
| Wirral Community Health and Care NHS Foundation Trust | 0.5 | 0.4 | 0.1 | 4.4 | 4.4 | 0.0 |
| Wirral University Teaching Hospital NHS Foundation Trust | 0.9 | 0.0 | 0.9 | 12.6 | 12.7 | (0.1) |
| **Total Charge against System Operational Capital Plan** | **17.9** | **15.3** | **2.6** | **230.0** | **230.0** | **(0.1)** |

| | |
|---|---|
| System Operational Capital Allocation | 238.1 |

## B) Provider Capital: Current & Forecast Impact of IFRS16 as at Month 2 (31st May 2023)

| | YTD Impact of IFRS16 | | | 23/24 Impact of IFRS16 | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance |
| | £m | £m | £m | £m | £m | £m |
| Alder Hey Children's NHS Foundation Trust | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Bridgewater Community Healthcare NHS Foundation Trust | (0.7) | 0.0 | (0.7) | (0.7) | (0.7) | 0.0 |
| Cheshire and Wirral Partnership NHS Foundation Trust | 0.4 | 0.4 | 0.0 | 0.4 | 0.4 | 0.0 |
| Countess of Chester Hospital NHS Foundation Trust | 2.0 | 0.0 | 2.0 | 2.0 | 2.0 | 0.0 |
| East Cheshire NHS Trust | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 0.0 |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Liverpool University Hospitals NHS Foundation Trust | 0.0 | 0.0 | 0.0 | 2.0 | 2.0 | 0.0 |
| Liverpool Women's NHS Foundation Trust | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 |
| Mersey Care NHS Foundation Trust | 2.7 | 2.8 | (0.0) | 6.0 | 6.0 | 0.0 |
| Mid Cheshire Hospitals NHS Foundation Trust | 0.6 | 0.1 | 0.5 | 3.4 | 3.4 | 0.0 |
| Southport And Ormskirk Hospital NHS Trust | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 0.0 | 0.0 | 0.0 | 0.7 | 0.7 | 0.0 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 |
| The Walton Centre NHS Foundation Trust | 0.0 | 0.0 | 0.0 | 1.4 | 1.4 | 0.0 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 4.6 | 0.0 | 4.6 | 5.0 | 5.0 | 0.0 |
| Wirral Community Health and Care NHS Foundation Trust | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Wirral University Teaching Hospital NHS Foundation Trust | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total Charge against System Operational Capital Plan** | **9.6** | **3.3** | **6.4** | **20.5** | **20.5** | **0.0** |

## C) Provider Capital: Current & Forecast CDEL as at Month 2 (31st May 2023)

| | YTD NET CDEL | | | 23/24 NET CDEL | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | ACTUAL | Variance |
| | £m | £m | £m | £m | £m | £m |
| Alder Hey Children's NHS Foundation Trust | 1.5 | 1.3 | 0.2 | 21.1 | 21.1 | 0.0 |
| Bridgewater Community Healthcare NHS Foundation Trust | (0.7) | 0.5 | (1.2) | 1.6 | 1.6 | 0.0 |
| Cheshire and Wirral Partnership NHS Foundation Trust | 0.8 | 0.6 | 0.2 | 8.3 | 8.3 | 0.0 |
| Countess of Chester Hospital NHS Foundation Trust | 6.2 | 4.4 | 1.8 | 47.5 | 47.5 | 0.0 |
| East Cheshire NHS Trust | 3.0 | 0.8 | 2.2 | 12.9 | 12.9 | 0.0 |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 1.3 | 0.9 | 0.4 | 6.1 | 6.1 | (0.0) |
| Liverpool University Hospitals NHS Foundation Trust | 3.8 | 1.8 | 2.0 | 80.3 | 80.3 | 0.0 |
| Liverpool Women's NHS Foundation Trust | 0.7 | 0.7 | (0.0) | 5.2 | 5.2 | 0.0 |
| Mersey Care NHS Foundation Trust | 9.8 | 10.2 | (0.4) | 61.4 | 61.4 | 0.0 |
| Mid Cheshire Hospitals NHS Foundation Trust | 7.0 | 3.9 | 3.1 | 47.9 | 47.9 | 0.0 |
| Southport And Ormskirk Hospital NHS Trust | 0.1 | 0.2 | (0.1) | 21.0 | 21.0 | (0.0) |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 0.4 | 1.2 | (0.7) | 12.2 | 12.2 | 0.0 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 0.0 | 0.1 | (0.1) | 7.4 | 7.6 | (0.2) |
| The Walton Centre NHS Foundation Trust | 0.2 | 0.3 | (0.1) | 6.2 | 6.2 | 0.0 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 7.1 | 1.0 | 6.1 | 24.8 | 24.8 | 0.0 |
| Wirral Community Health and Care NHS Foundation Trust | 0.5 | 0.4 | 0.1 | 4.4 | 4.4 | 0.0 |
| Wirral University Teaching Hospital NHS Foundation Trust | 4.5 | 0.4 | 4.1 | 26.8 | 26.8 | (0.1) |
| **Total Charge against System Operational Capital Plan** | **46.2** | **28.7** | **17.5** | **395.1** | **395.4** | **(0.2)** |

*Note: brackets denote underspend*

# Appendix 6

**Provider Cash: Current Cash Position as at Month 2 (31st May 2023)**

| | M2 ACTUAL £m | M1 ACTUAL £m | M1 to M2 CHANGE £m | 31/03/2023 BALANCE £m | 31/03/2022 BALANCE £m | 31/03/2021 BALANCE £m | 31/03/2020 BALANCE £m |
|---|---|---|---|---|---|---|---|
| Alder Hey Children's NHS Foundation Trust | 83.1 | 83.1 | 0.0 | 83.5 | 91.5 | 92.7 | 90.0 |
| Bridgewater Community Healthcare NHS Foundation Trust | 20.7 | 20.7 | 0.0 | 24.3 | 26.2 | 17.9 | 3.6 |
| Cheshire and Wirral Partnership NHS Foundation Trust | 32.7 | 37.6 | (4.9) | 37.5 | 41.1 | 33.9 | 21.2 |
| Countess of Chester Hospital NHS Foundation Trust | 10.9 | 10.9 | 0.0 | 22.9 | 40.9 | 32.7 | 12.2 |
| East Cheshire NHS Trust | 30.6 | 31.4 | (0.8) | 30.3 | 37.3 | 27.4 | 11.4 |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 46.2 | 45.0 | 1.2 | 41.3 | 42.7 | 49.0 | 30.2 |
| Liverpool University Hospitals NHS Foundation Trust | 100.6 | 100.6 | 0.0 | 99.3 | 211.4 | 167.5 | 43.6 |
| Liverpool Women's NHS Foundation Trust | 4.8 | 8.7 | (3.9) | 9.8 | 11.2 | 4.2 | 4.6 |
| Mersey Care NHS Foundation Trust | 93.8 | 94.0 | (0.3) | 83.3 | 84.2 | 90.8 | 59.6 |
| Mid Cheshire Hospitals NHS Foundation Trust | 14.4 | 12.1 | 2.3 | 8.4 | 26.7 | 33.1 | 14.0 |
| Southport And Ormskirk Hospital NHS Trust | 1.8 | 3.6 | (1.8) | 1.0 | 18.5 | 6.4 | 1.1 |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 67.8 | 40.8 | 27.0 | 25.6 | 54.2 | 51.4 | 7.3 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 67.9 | 67.9 | 0.0 | 70.0 | 80.7 | 60.2 | 35.4 |
| The Walton Centre NHS Foundation Trust | 47.0 | 48.7 | (1.6) | 47.7 | 40.7 | 35.7 | 26.7 |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 28.8 | 0.0 | 28.8 | 34.9 | 44.7 | 47.9 | 2.2 |
| Wirral Community Health and Care NHS Foundation Trust | 13.9 | 17.4 | (3.5) | 19.5 | 23.8 | 26.2 | 18.3 |
| Wirral University Teaching Hospital NHS Foundation Trust | 29.1 | 29.1 | 0.0 | 24.3 | 36.4 | 21.3 | 5.9 |
| **Total Providers** | **693.8** | **651.3** | **42.5** | **663.6** | **912.1** | **798.2** | **387.5** |

# Appendix 7

## Provider BPPC: YTD BPPC Position as at Month 2 (31st May 2023)

| | M2 YTD | | | |
|---|---|---|---|---|
| | NHS by Value % | NHS by Number % | Non NHS by Value % | Non NHS by Number % |
| Alder Hey Children's NHS Foundation Trust | 97.1% | 78.8% | 93.6% | 95.4% |
| Bridgewater Community Healthcare NHS Foundation Trust | 99.9% | 99.0% | 99.6% | 99.5% |
| Cheshire and Wirral Partnership NHS Foundation Trust | 92.4% | 87.2% | 95.8% | 97.0% |
| Countess of Chester Hospital NHS Foundation Trust | 93.0% | 79.2% | 81.4% | 80.0% |
| East Cheshire NHS Trust | 97.2% | 93.0% | 97.0% | 95.6% |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | 99.6% | 96.3% | 99.1% | 97.7% |
| Liverpool University Hospitals NHS Foundation Trust | 96.9% | 84.3% | 92.1% | 86.4% |
| Liverpool Women's NHS Foundation Trust | 84.8% | 93.0% | 92.6% | 91.2% |
| Mersey Care NHS Foundation Trust | 92.6% | 89.1% | 92.5% | 95.4% |
| Mid Cheshire Hospitals NHS Foundation Trust | 91.8% | 57.6% | 88.3% | 88.8% |
| Southport And Ormskirk Hospital NHS Trust | 85.1% | 82.5% | 95.9% | 94.6% |
| St Helens And Knowsley Teaching Hospitals NHS Trust | 86.0% | 90.3% | 98.3% | 94.4% |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 100.0% | 100.0% | 99.7% | 99.5% |
| The Walton Centre NHS Foundation Trust | 78.4% | 63.9% | 85.6% | 87.7% |
| Warrington and Halton Teaching Hospitals NHS Foundation Trust | 86.7% | 82.9% | 92.0% | 93.4% |
| Wirral Community Health and Care NHS Foundation Trust | 95.0% | 93.6% | 94.8% | 89.0% |
| Wirral University Teaching Hospital NHS Foundation Trust | 94.6% | 91.8% | 97.5% | 94.8% |

## ICB BPPC: YTD as at Month 2 (31st May 2023)

| | This Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance |
| No. of bills paid in period | | 12,160 | | | 24,072 | |
| No. of bills paid within target | | 12,024 | | | 23,881 | |
| % of bills paid within target | **95.00%** | **98.88%** | **3.88%** | **95.00%** | **99.21%** | **4.21%** |
| | | | | | | |
| Value of bills paid in period (£000) | | £ 500,152 | | | £ 981,270 | |
| Value of bills paid within target (£000) | | £ 498,266 | | | £ 978,923 | |
| % of bills paid within target | **95.00%** | **99.62%** | **4.62%** | **95.00%** | **99.76%** | **4.76%** |

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## 29 June 2023

## Report of the Finance, Investment & Resource Committee Chair (May 2023)

| | |
|---|---|
| **Agenda Item** | ICB/06/23/20 |
| **Report author & contact details** | Claire Wilson, Executive Director of Finance<br>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<br>Frankie Morris, Associate Director of Finance |

# Report of the Finance, Investment & Resource Committee Chair (May 2023)

<table>
<tr><td>Executive Summary</td><td>The Finance, Investment and Resource committee of the NHS Cheshire and Merseyside Integrated Care Board met on 23rd May2023<br><br>The meeting was quorate and was able to undertake its business.<br>The main items considered at the meeting included:<br>• Review of annual workplan<br>• Review final Month 12 financial position<br>• High level review of Month 1<br>• Approval of 2023/24 budget and planning update<br>• Approach to financial recovery and strategy<br>• Approval of Wirral Place 22/23 S75 agreement<br>• Review of the MLCSU contract, financial consequences of the clinical policy harmonisation programme and outcomes of NICE TAs<br><br>The committee also held a private meeting considering a few procurement items relevant to the ICB Business and in accordance with the scheme of reservation and delegation<br><br>The next meeting of the Committee is scheduled to be held on 27th June 2023.</td></tr>
<tr><td>Purpose (x)</td><td><table><tr><th>For information / note</th><th>For decision / approval</th><th>For assurance</th><th>For ratification</th><th>For endorsement</th></tr><tr><td>X</td><td>X</td><td>X</td><td></td><td></td></tr></table></td></tr>
<tr><td>Recommendation</td><td>The Board is asked to:<br>• note the items covered by the Committee<br>• note that the committee considered the final 22/23 financial position of the ICB/ ICS in respect of both revenue and capital allocations<br>• note that updates were received in respect of 2023/24 planning and financial recovery, with approval given to the 23/24 ICB budget book.</td></tr>
<tr><td>Impact (x)<br>(further detail to be provided in body of paper)</td><td><table><tr><th>Financial</th><th>IM &T</th><th>Workforce</th><th>Estate</th></tr><tr><td>X</td><td>X</td><td>X</td><td></td></tr><tr><th>Legal</th><th>Health Inequalities</th><th>EDI</th><th>Sustainability</th></tr><tr><td>X</td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>Management of Conflicts of Interest</td><td>No</td></tr>
<tr><td>Next Steps</td><td>None</td></tr>
<tr><td>Appendices</td><td>None</td></tr>
</table>

# Report of the Finance, Investment & Resource Committee Chair (May 2023)

## 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<br>• 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.<br>• 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.<br>• 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 these issues required escalation to the ICB Board:

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | 23.5.23 | Committee Risk Report<br>• **Noted for assurance**<br>Committee Terms of Reference<br>• **Noted for assurance** |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | Month 1 position<br>• **Noted for assurance**<br>Business Impacts of Clinical Policy Harmonisation<br>• **Noted for assurance, further report will follow in due course**<br>MLCSU review of ICB commissioned services<br>• **Updated noted, further update to follow**<br>Workforce: Chairs report<br>• **Noted** |

## 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 |
|---|---|---|
| | 25.5.23 | Outcome of NICE TAs<br>• **Prescribing recommendations from NICE TA877 approved** |
| | 25.5.23 (Private) | The private section of the meeting considered a number of procurement items relevant to ICB Business and was in accordance with the scheme of reservation and delegation |

## 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 |
|---|---|---|
| - | 23.5.23 | **Updated Month 12 Finance Report**<br>The Committee noted |

| | | |
|---|---|---|
| | | • Verbal update on Month 12 draft position. Paper with final position will be brought to FIRC and Board following audit completion |
| | 25.5.23 | **2023/24 Planning update including approach to financial recovery and strategy**<br>• Presentation noted for information |

## 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 |
|---|---|---|
| | 23.5.23 | Wirral S75 agreement 22/23<br>• **APPROVED** |
| | 23.5.23 | 23/24 Budget Book sign-off<br>• **APPROVED** |

## 6. Recommendations

**6.1 The ICB Board is asked to:**

- **Note** the main areas of discussion at the committee meeting which were in line with workplan
- **Note** the approval of the s75 agreement for Wirral Place 22/23
- **Note** the approval of the 23/24 Budget Book
- **Note** the updated draft month 12 financial outturn position for capital and revenue
- **Note** the financial risks in the financial plan for 2023/24 as presented and the approach to financial recovery and strategy .

## 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 plan and associated risks both as the ICB but also as part of the ICS in order to deliver the required financial plan for 2023/24.

# NHS Cheshire and Merseyside Integrated Care Board Meeting

29 June 2023

## Report of the Audit Committee Chair

| | |
|---|---|
| **Agenda Item No** | **ICB/06/23/21** |
| **Report author & contact details** | Matthew Cunningham, Associate Director of Corporate Affairs & Governance |
| **Report approved by (sponsoring Director/Chair)** | Neil Large, Chair of the Audit Committee |
| **Responsible Officer(s) to take actions forward** | Claire Wilson, Executive Director of Finance<br>Matthew Cunningham, Associate Director of Corporate Affairs and Governance |

# Report of the Audit Committee Chair (June 2023)

| | |
|---|---|
| **Executive Summary** | The Audit Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 16 May 2023. The meeting was quorate and was able to undertake the business of the Committee. Declarations of interest where applicable were minuted.<br><br>Main items considered at the meeting via papers received or verbal update provided included:<br>• update on the ICBs Freedom to Speak Up arrangements<br>• a paper on IG Privacy Notices to approve<br>• a paper on Finance and Procurement Policies to approve<br>• a paper on ICB Procurement Waivers<br>• Board Assurance Framework Update<br>• a paper on the Audit Committee Risk Register for approval<br>• a paper on the ICB Risk Committee Terms of Reference for approval<br>• ICB Declarations of Interest Update, including business case for Civica Declare system<br>• an update on the development of the Annual Report and Accounts 2022-23<br>• Internal Audit progress report<br>• the draft Head of Internal Audit Opinion<br>• a paper outlining the HfMA Improving NHS Financial Sustainability Checklist - Audit Outcomes & Insights Briefing (March 2023)<br>• the Anti-Fraud Services Annual Report<br>• a paper outlining the External Audit 2023-24<br>• DSPT Update Report.<br><br>Meeting papers are available to all Board members upon request to the Associate Director of Corporate Affairs and Governance.<br><br>The next meeting of the Committee is scheduled to be held on 27 June 2023. |

| **Purpose (x)** | **For information / note** | **For decision / approval** | **For assurance** | **For ratification** | **For endorsement** |
|---|---|---|---|---|---|
| | X | | X | | |

| | |
|---|---|
| **Recommendation** | **The Board is asked to:**<br>• **note** the items covered by the Audit Committee at its meeting on the 16 May 2023. |

| **Impact (x)** (further detail to be provided in body of paper) | **Financial** | **IM &T** | **Workforce** | **Estate** |
|---|---|---|---|---|
| | X | | X | |
| | **Legal** | **Health Inequalities** | **EDI** | **Sustainability** |
| | X | | | |

| | |
|---|---|
| **Management of Conflicts of Interest** | There were no declarations of interest made by Members or attendees at the meeting that would materially or adversely impact on matters requiring discussion and decision. |
| **Next Steps** | None |
| **Appendices** | None |

# Report of the Audit Committee Chair

## 1. Summary of the principal role of the Committee

| Committee | Principal role of the committee | Chair |
|---|---|---|
| Audit Committee<br><br>(Statutory Committee) | The main purpose of the Committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB. | Neil Large, Non-Executive Director |

## 2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| - | 16.05.23 | **ICB Declaration of Interest Update**.<br>Committee members received an update on the ICBs compliance around submitted declarations from ICB staff within its main decision-making groups. Latest figures showed an 87% compliance rate.<br><br>**The Audit Committee noted the update and will receive a further update at its next meeting regarding progress in increasing the compliance rate.** |
| - | 16.05.23 | **Civica Declare System**<br>Committee members received a paper that outlined a proposal for consideration on an ICB wide implementation of software for managing declarations of interest.<br><br>The paper provided background to the current arrangements in place with an intention to enter into a 3-year contract with an existing ICB supplier.<br><br>Members were advised:<br>• that the proposal would allow for a robust management system to help the ICB meet audit |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | requirements for up-to-date records at the press of a button<br>• that there had been challenges in the way that declarations had been covered in meetings due to manual collation of information<br>• three places previously used Civica successfully so this was the starting point.<br>• the system provided alerts to out-of-date records.<br>• Other systems were also considered but functionality was questioned or deemed not suitable for requirements<br>• in respect of procurement the proposed costs sat within thresholds.<br><br>**The Audit Committee noted the content of the report and endorsed option three to enter into a 3-year contract with the named provider.** |
| - | 16.05.23 | **ICB Board Assurance Framework Development.**<br>Committee members received an update on the ICB Board Assurance Framework (BAF) which would be going to the ICB Board for its approval at the May Board meeting.<br><br>**The Committee noted the update report.** |
| - | 16.05.23 | **ICB Procurement Waivers**<br>Committee members received an update on tender waivers approved by the ICB Executives / Board and its various Place Directors / Associate Finance Directors between 1 March and 30 April 2023. The paper outlined that:<br>• there had been four tender waivers approved that have either been reviewed and approved in line with the ICB Scheme of Reservation and Delegation (SORD) limits.<br><br>• there had been 51 procurement decisions taken at ICB Board or Finance Investment and Resources Committee that would result in a tender or quotation waiver and additionally, a further 20 that had been taken in line with the Delegated Limits outlined within the SORD. |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | Members were advised that the ICB continued to review the planned procurements for 2023/24 to determine the impact.<br><br>**The Audit Committee noted the report.** |
| - | 16.05.23 | **Annual Report and Accounts 2022 - 2023**<br>Committee members received an update on the ICB's progress in developing the Annual Report and Accounts. An education session was run, with invites extended to other Board members to join, which explained the Annual Report and Accounts in further detail so as to help members understand how and why ICB Accounts and Reports are constructed.<br><br>**The Committee noted the progress being made on the Annual Report and Accounts and noted it will review a final draft at its June 2023 meeting.** |
| - | 16.05.23 | **Internal Audit Progress Report,**<br>The Progress report provided an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit Plan for 2022/23.<br><br>Committee members were informed that the following work had been completed:<br>• Key Financial Systems – moderate/substantial assurance<br>• Governance Core Controls Checklist<br>• Conflicts of Interest Core Controls Phase 2<br>• DSPT Phase 1.<br><br>Payroll / ESR, Mandatory Training, Information Governance reviews were in progress.<br><br>For the ICB, MIAA had raised six recommendations as part of the reviews undertaken during 2022/23. All of which had been accepted by management.<br><br>**Head of Internal Audit Opinion (HOIAO)** |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | The report to the Committee summarised the timescales for the submission of the HoIAO and the key considerations in forming the overall assurance opinion., based upon, and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control, and governance processes.<br><br>Committee members heard that the ICB would be given limited assurance mostly due to maturity of organisation. The internal auditors had provided wording for the ICB to use to reflect this and attendees asked for this to be amended to be clear on what had been assessed and how this had led to their findings.<br><br>Discussions moved to how could the ICB improve the score for the following financial year. LCO provided the example of an operational risk framework that could be assessed. In 12 months', time other frameworks would also be embedded that could also be assessed.<br><br>**The Committee noted the reports and requested that a report is presented to a future meeting outlining what the ambitions were for the ICB and resources that we need to get to higher Opinion rating for next year followed by an action plan.** |
| - | 16.05.23 | **External Audit Plan**<br>The Committee received a verbal update on the work in progress, and that the External Audit opinion report regarding the ICB Annual Report and Accounts would be presented at the Committees June 2023 meeting.<br><br>**The Audit Committee noted the update.** |
| - | 16.05.23 | **IG Bi-Monthly Update and DSPT**<br>Committee members received the bimonthly report updated on all aspects of the IG Service provided to the ICB and which provided assurance against annual workstreams and escalated any known issues. |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | The report included progress on the ICB's Data Security & Protection Toolkit, projects supported by the MLCSU IG Team, IG breaches and MLCSU SAR/FOI provision. Risks were highlighted in the relevant section and those key to the progress of IG workstreams were summarised.<br><br>Also provided was the final report of the NHS England Data Sharing Remote Audit which recorded the key findings of a remote data sharing audit of NHS Cheshire and Merseyside Integrated Care Board (ICB) and Graphnet Health Limited (Graphnet) between 12 and 20 September 2022.<br><br>In respect of the Data Security and Protection Toolkit (DSPT) Committee members were advised that the submission was at the end of June and the position was similar to CCGs positions in previous years. Exceptions were shown in the report and had been highlighted to the SIRO. Training was showing at 85% as of 15 May 2023 but needed to reach 95%. There was a 1% increase each per week and this rate would not be high enough to reach the target. The teams were looking at ways to increase the uptake.<br><br>There had been good progress on Board member training with just one now outstanding.<br><br>Other updated included:<br>• further exceptions to the report with 4 and 7 referred to specifically<br>• risk work programme was progressing well.<br>• training needs analysis had started and the M&L CSU IG team would work with staff to identify what other training was required<br><br>**The Audit Committee noted the report.** |

## 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 |
|---|---|---|
| - | 16.05.23 | **Annual Reports and Accounts Finance Policy**<br>Committee members received a report that provided an update on the development of the ICB's financial policies, and which included the proposed draft Annual Report and Accounts Finance Policy for approval.<br><br>**The Audit Committee approved the Annual Report and Accounts Finance Policy.** |
| - | 16.05.23 | **Audit Committee Risk Register**<br>Committee members received a report on and its risk register for review. Three risks have been assigned to the Audit Committee with two rated as high and one as moderate. The most significant were:<br>• G2: Commissioning support or other data processors acting on the ICB's behalf breach statutory or regulatory requirements, resulting in financial loss and / or reputational damage, currently rated as high (9)<br>• G5: The inconsistent adherence to core set of governance, financial and operational policies, and procedures across the ICB leads to control failures, poor audit outcomes and reputational damage, currently rated as high (9)<br><br>The report and its appendices set out the controls in place, an assessment of their effectiveness and further control actions planned in relation to each risk. Committee members were informed that fraud risks would be included in a future report as MIAA's counter fraud risk assessment, which was due to be received, would be subject to internal scoring using the ICB's own Risk Management Strategy to identify any fraud risks that need to be added to the ICB's risk register(s).<br><br>**The Audit Committee noted the current position in relation to the three risks assigned to this committee, did not identify any further risks for inclusion (beyond the planned fraud ones), and considered the level of assurance that can be** |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | **provided to the Board and any further assurances required.** |
| - | 16.05.23 | **ICB Risk Committee TOR**<br>The committee was advised that the Board had approved the establishment of a Risk Committee as a Sub-Committee of the Audit Committee on an interim basis to provide support in overseeing the successful development and embedding of risk management systems across NHS Cheshire and Merseyside.<br><br>The draft terms of reference for the Risk Committee were presented for review and approval by the Audit Committee.<br><br>Following presentation discussions included<br>• that there was lots of work ahead and interest nationally around system risks<br>• that the committee would not take over the role of the Audit Committee. It was concerned with challenge, support and developing system risks<br>• Section 2, 4th paragraph described how the committee would operate. The explanation of system working needed to be explicit.<br><br>**The Audit Committee agreed the proposed terms of reference for the Risk Committee and requested that the explanation of system working be expanded within the TOR.** |
| - | 16.05.23 | **The Anti-Fraud Annual Report 2022/23**<br>Committee members received the Annual Report, which outlined the work undertaken by the Anti-Fraud Specialist from July 2022 to March 2023. It included an assessment of the ICB's compliance against the Government Functional Standard GovS 013 for Counter Fraud (CFFSR)., with the ICB scoring an overall green rating, with only one of the 13 components showing as amber.<br><br>Committee members heard that there was high compliance in training and overall this was positive, |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | and their confirmation that there were no new fraud investigations.<br><br>**The Audit Committee reviewed and approved the Anti-Fraud Services Annual Report** |
| - | 16.05.23 | **IG Privacy Notices**<br>The committee received a report on a number of Privacy Notices. The report advised that ICB had a requirement for increased and more integrated cross-organisational working, for digital, data and intelligence.<br><br>The content of the Privacy Notices for the Cheshire & Merseyside ICS-wide Digital and Data Programmes had been approved at the Cheshire & Merseyside ICS-wide Digital and Data Information Governance Strategy Committee. The notices would also include hyperlinks to allow the public to open the Information Governance Tiered Framework documents and associated statutory Data Protection Impact Assessments.<br><br>**The Audit Committee approved the uploading of Privacy Notices to be to the ICB website and gave approval for the Information Governance Tiered Framework documents to be uploaded on to the ICB website.**<br><br>**The Committee requested that the communication and engagement team work on the production of easy read guides regarding the Privacy notices so as to make it easier for members of the public to understand.** |
| - | 16.05.23 | **Financial Policies**<br>The committee received a report requesting the approval of three new policies:<br>• Non-Pay Expenditure Finance Policy. This covered all third parties<br>• Credit Card Policy.<br>• ICB Procurement Policy. |

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | | These ICB policies replaced the inherited policies from the former nine CCGs covering Cheshire and Merseyside and there was no fundamental change from how these predecessor organisations had operated to how the ICB will operate.<br><br>**The Audit Committee approved the three policies.**<br><br>**Committee members requested that follow-up report be brought to the Audit Committee to describe the processes for using credit cards.** |



## 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 |
|---|---|---|
| - | - | None |

## 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 |
|---|---|---|
| - | - | None |

## 6. Recommendations

6.1 **The Board is asked to:**

- **note** the items covered and decisions made by the Audit Committee at its meeting on the 16 May 2023.

# NHS Cheshire and Merseyside Integrated Care Board Meeting

## 29 June 2023

## Report of the Transformation Committee Chair

| | |
|---|---|
| **Agenda Item No** | **ICB/06/23/22** |
| **Report author & contact details** | Neil Evans; Associate Director of Strategy and Collaboration neilevans@nhs.net |
| **Report approved by (sponsoring Director/ Chair)** | Clare Watson; Assistant Chief Executive |
| **Responsible Officer to take actions forward** | Neil Evans; Associate Director of Strategy and Collaboration neilevans@nhs.net |

# Report of the Transformation Committee Chair

<table>
<tr><td>Executive Summary</td><td colspan="5">The Transformation Committee has been established to support NHS Cheshire and Merseyside in the delivery of its statutory duties and provide assurance to the Board in relation to the development and delivery of our strategic plans.<br><br>The meeting considered:<br>• The update on the progress of each of the Cheshire and Merseyside Transformation Programme delivery vehicles and key achievements to date;<br>• A report providing an update on the C&M Transformation Sub Group;<br>• The mid-year status report around the Digital and Data Strategy;<br>• A report describing the approach to implementing the Prioritisation Framework for C&M;<br>• A summarised position on the approach to be taken for investment in Transformation Programme areas for 2023-25<br>• An update on Specialised Commissioning and the requirements for each ICS to develop a number of specialised commissioning priorities within its plans; and<br>• The Transformation Committee’s Risk Report</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:<br>• Note the contents of this report and the next steps</td></tr>
<tr><td>Key issues</td><td colspan="5">• The Transformation Group will look at discussing its work plan and the need for efficiencies and to ensure a whole system view is taken, given the ICBs financial challenge;<br>• There is a need to understand how the Digital and Data Strategy aligns with Place strategies as each Place has different levels of digital strategic planning going on.</td></tr>
<tr><td>Key risks</td><td colspan="5">• That we have insufficient resources to deliver the identified transformational priorities and don’t make the expected progress in improving outcomes and reducing inequalities.</td></tr>
<tr><td rowspan="4">Impact (x)<br>(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></td><td colspan="2"></td></tr>
</table>

| | |
|---|---|
| **Management of Conflicts of Interest** | Not applicable |
| **Next Steps** | The Transformation Committee has asked for further reports to be presented to their next committee in relation to:<br>• A further paper for the meeting in July which maps the ICB Digital and Data Strategy and the priorities of each Place;<br>• A paper describing the plans in relation to the Efficiency at Scale programme to be brought to a future meeting;<br>• Detailed plans in relation to the agreed Specialised Services service transformation priority areas are to be developed and overseen through the Specialised Services Transition Group. |
| **Appendices** | N/A |

| **Glossary of Terms** | **Explanation or clarification of abbreviations used in this paper** |
|---|---|
| ICB | Integrated Care Board |
| HCP | Health and Care Partnership |
| ICP | Integrated Care Partnership |
| ICS | Integrated Care System |
| FiR | Finance, Investments & Resources (Committee) |

# Report of the Transformation Committee Chair

## 1. Summary of the principal role of the Committee

| Committee | Principal role of the committee | Chair |
|---|---|---|
| Transformation | Provide a leadership forum, across the system, to consider the development and implementation of the HCP strategy and policy and plans of the ICB securing continuous improvement of the quality of services<br>Retain a focus on health inequalities and improved outcomes and ensure that the delivery of the ICP / ICB's strategic and operational plans are achieved.<br>within financial allocations. | Clare Watson |

## 2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

| Decision Log Ref No. | Meeting Date | Issues considered |
|---|---|---|
| | 11/05/23 | An update on Transformation Programme Assurance was provided with all programmes reporting as "on track". There were no additional risks, issues or escalations to report. A report on the Efficiency at Scale Programme will be brought back to a future meeting to provide more detail on the final plans.<br><br>The Committee was informed that the C&M Transformation Group is planning a workshop, which provider collaboratives will link into, to look at developing a work plan and what elements can be supported across the system. The Committee will be informed of anything that requires its attention. |
| | 11/05/23 | A report summarising the work of the C&M Transformation Group was presented. Adult ADHD was highlighted with a C&M model being looked at. The C&M Transformation Group is also looking at the risks relating to the work programme and also had discussions around the MH, Community and LD Collaborative work plan to avoid duplication across both work plans as well as Place work plans. |

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| | | There was a discussion around future work programme updates, including quantification of the efficiencies that the programmes are trying to identify and deliver on or set targets that provides granularity. |
| | 11/05/23 | A mid-year status report on the ICS Digital and Data Strategy was presented to the Committee, detailing what has been delivered to date and also providing a forward look, with most of the commitments in the strategy falling in year two and three. There is close working with the ongoing planning exercise to ensure the strategic components are woven in. The Committee was briefed on the national exercise with providers on self-assessing on a list of digital maturity criteria and the C&M position was to be submitted on 12th May and which will be used to inform regional/national investment processes. The Committee also learned that C&M has being identified as a leading ICB in relation to population health data analytics capability and is being looked at as an exemplar.<br><br>The themes of the ICS Data and Digital Strategy were summarised. Work is underway on aligning the system strategy with Place strategies as each Place has different levels of digital strategic planning going on. The Committee requested a further paper for the meeting in July which maps the ICB Digital and Data Strategy and the priorities of each Place. |
| | 11/05/23 | The Committee was given a summary of the background around the separate asks to develop priorities and a prioritisation framework by the ICB and Directors of Public Health across C&M. This included the two phases of work that took place, including identifying a set of emerging priorities looking at where C&M performed worse or significantly worse than the England average.<br><br>The second phase was also discussed which was around deploying a prioritisation framework to compare competing priorities. The Committee acknowledged that there is no intention to roll this out immediately across C&M due to the volume of work involved being unmanageable.<br><br>The Committee briefly discussed and emphasised the importance of considering finance on everything that is |

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| | | done and that the approach taken should ensure quality is still in place with the challenge to ensure delivery of efficiencies. |
| | 11/05/23 | The Committee was presented with a paper summarising the position around 2023/24 Q1 and Q2 Transformation Programme funding and future funding arrangements for Q3 onwards. The key Q1 & Q2 milestones and the updated financial information were also discussed around what was requested and what was agreed on funding.<br><br>There was a more in-depth discussion in around the Beyond Programme which requested additional funding of £132K for Q2 relating to non-pay cost for the year with only 6 months having been committed. This is in addition to the reduced Q2 allocation requested of £151K. This request was not supported or approved by the Committee, with considerable staffing resource noted as a concern and the reliance on requests for ICB funding to sustain ongoing support for staff. There was also consensus around the general principal of only committing funding for Q1 and Q2 before being eligible for the next tranche of bidding.<br>The Committee agreed the Q1 and Q2 funding detailed in the report for programmes with all work plans having been received.<br><br>The processes for Q3 and the key principles of ensuring funds are allocated in alignment with the priorities of the ICB and HCP with visibility of work plans, helping to shape the priorities, was also presented. The report detailed the £5.6M working allocation with a proposal to retain 10% in reserve as an efficiency or any in year requests submitted to the Committee with just over £2.5M being available to allocate to Transformation Programme funding after Q1 and Q2 commitments. The plan for Q3 and Q4 will see the full £5.6M being allocated and the paper detailed the bidding process. |

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|---|---|---|
| | | The Committee also discussed prioritisation for funding and was informed discussions have been held around using the weighted scorecard background documentation and the proposal for transformation funding to link to improving health inequalities. The bidding process commenced on 22nd May and two review panels will review bids and full support around the process was given by the Committee. It was also suggested the process should be reported to the Finance, Investment and Resources Committee in retrospect to provide assurance. |
| | 11/05/23 | The Committee was updated on the ongoing work around Specialised Commissioning. C&M has identified four transformational priorities for 2023-24, with the help of NHSE colleagues, and the goal is to look at full pathways and to improve the overall experience of the pathway. The Committee was also informed of the additional areas where all three NW ICSs would work together on those specialised service areas and would deliver these through new governance structures to be introduced. The priorities were identified as:<br>• Renal Service Transformation Programme<br>• Neurorehabilitation – integrated case management<br>• Optimisation of the Stroke Pathway from 999 to Thrombectomy<br>• Transition from Specialised Paediatric Services to Adult Services (local additional priority) |
| | 11/05/23 | The Transformation Committee Risk Report provided an introduction to the ICB's Risk Management Strategy, including the key components of the risk management structure and key roles and responsibilities for ICB committees. The report also provided an up to date position on risks assigned to the Committee and making sure they are managed and to help provide assurance to the ICB Board around the risks that are within the remit of the Committee.<br><br>The work around the transformation across corporate and Place teams and the legacy risks from the CCGs was outlined, with most being closed due to now sitting on other risk registers and the governance |

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|---|---|---|
| | | structure below the Committee. The Committee discussed its role in providing assurance against those risks and agreed there is a need to consider which additional areas that will be reporting into the Committee, such as Specialised Commissioning and the digital programmes. |

## 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 |
|---|---|---|
| | | N/A |

## 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 |
|---|---|---|
| | | N/A |

## 5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

| Decision Log Ref No. | Meeting Date | Issue for escalation | Recommendation from the Committee |
|---|---|---|---|
| | | | N/A |

## 6. Recommendations

6.1 **The ICB Board is asked to:**

- Note the contents of this report

## 7. Next Steps

7.1 The Transformation Committee has asked for further reports to be presented to the next committee in relation to:

- A further paper for the meeting in July which maps the ICB Digital and Data Strategy and the priorities of each Place;
- A paper describing the plans in relation to the Efficiency at Scale programme to be brought to a future meeting;
- Detailed plans in relation to the agreed Specialised Services service transformation priority areas are to be developed and overseen through the Specialised Services Transition Group.