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

NHS Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

(held in public)

26 September, 10:30am – 13:45pm,
The Wrights Lounge, The Mornflake Stadium, Gresty Road, Crewe, Cheshire, CW2 6EB

Public Speaking Time: 10:30am

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

Agenda

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
11:00am	**Preliminary Business**				
ICB/09/24/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain *ICB Chair*	For information	-
ICB/09/24/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the **ICB website**)*	Verbal		For assurance	-
ICB/09/24/03	Report of the ICB Chair	Paper		For information	P5
ICB/09/24/04	Experience and achievement story	Film		-	
11:10am	**Leadership Reports**				
ICB/09/24/05	Report of the ICB Chief Executive	Paper	Graham Urwin *Chief Executive*	For assurance	P7
ICB/09/24/06 **11:25am**	Report of the ICB Director of Nursing and Care	Paper	Chris Douglas *Director of Nursing & Care*	For assurance	P31
ICB/09/24/07 **11:35am**	NHS Cheshire and Merseyside Finance Report Month 4	Paper	Claire Wilson *Director of Finance*	For assurance	P39
ICB/09/24/08 **11:45am**	Highlight report of the Chair of the ICB Finance, Investment and Resources Committee	Paper	Claire Wilson *Director of Finance*	For assurance	P65
ICB/09/24/09 **11:50am**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	P70

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
ICB/09/24/10 **12:00pm**	Highlight report of the Chair of the ICB Quality and Performance Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	P98
ICB/09/24/11 **12:05pm**	Consolidated report of the ICB Directors of Place	Paper	Mark Palethorpe *Place Director (St Helens)* Alison Lee *Place Director (Knowsley)*	For assurance	P102
12:20pm	**Committee AAA Reports - matters of escalation and assurance**				
ICB/09/24/12	Highlight report of the Chair of the ICB Audit Committee	Paper	Neil Large *Non-Executive Member*	For approval	P142
ICB/09/24/13	Highlight report of the Chair of the ICB Remuneration Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	P165
ICB/09/24/14	Highlight report of the Chair of the ICB System Primary Care Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	P167
ICB/09/24/15	Highlight report of the Chair of the ICB Children and Young Peoples Committee	Paper	Chris Douglas *Director of Nursing & Care*	For assurance	P170
ICB/09/24/16	Highlight report of the Chair of the ICB Strategy and Transformation Committee	Paper	Dr Ruth Hussey *Non-Executive Member*	For assurance	P172
12:30pm	**COMFORT BREAK**				
12:40pm	**ICB Business Items and Strategic Updates**				
ICB/09/24/17	Cheshire and Merseyside Urgent Emergency Care Improvement Programme Update	Paper	Anthony Middleton *Director of Performance & Planning*	tbc	P176
ICB/09/24/18 **12:50pm**	Cheshire and Merseyside Health Infrastructure Strategy	Paper	Claire Wilson *Director of Finance*	For approval	P195
ICB/09/24/19 **13:05pm**	Cheshire and Merseyside children and young people's elective wait recovery: accelerated delivery proposal	Paper	Anthony Middleton *Director of Performance & Planning*	For approval	P293

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
ICB/09/24/20 **13:15pm**	NHS Cheshire and Merseyside Annual Business Plan	Paper	Clare Watson, *Assistant Chief Executive*	For approval	P301
ICB/09/24/21 **13:25pm**	Cheshire and Merseyside Population Health Update	Paper & Presentation	Prof. Ian Ashworth *Director of Population Health*	tbc	P343
13:35pm	**Meeting Governance**				
ICB/09/24/22	Minutes of the previous meeting: • 25 July 2024.	Paper	Raj Jain *ICB Chair*	For approval	P361
ICB/09/24/23	Board Action Log	Paper	Raj Jain *ICB Chair*	To consider	P380
13:40pm	**Any Other Business**				
ICB/05/24/24	Closing remarks and review of the meeting	Verbal	Chair / All	For information	-
13:45pm	**CLOSE OF MEETING**				

Consent items

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

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/09/24/25	Board Decision Log - CLICK HERE TO VIEW	For information	-

Consent items			
ICB/09/24/26	Confirmed Minutes of ICB Committees: • *Audit Committee – 17 June 2024* • *Audit Committee – 25 June 2024* • *Finance, Investment and Our Resources Committee – July 2024* • *Quality and Performance Committee – July 2024* • *Strategy and Transformation Committee – May 2024*	For assurance	P382

Date and start time of future meetings

28 November 2024, 09:00am, Churchill Building, Queen's Park, Queen's Park Road, Chester, CH4 7AD
30 January 2025, 09:00am, Ballroom, Bootle Town Hall, Oriel Road, Bootle, L20 7AE

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

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

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Report of the Chair of NHS Cheshire and Merseyside

Agenda Item No: ICB/09/24/03

Responsible Director: Raj Jain, Chair

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

1. Introduction

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

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

3. Key updates of note

3.1 **Appointment to Partner Member positions on the Board**
As I reported at the July 2024 Board meeting, work has progressed to appoint to the vacant or newly agreed Partner Member positions on the Board. I would now like to formally welcome Andrew Lewis, as our second Partner Member (Local Authority) on the Board, and Warren Escadale as our Partner Member (VCFSE) on the Board.

3.2 Additionally, I would like to welcome Trish Bennett to today's meeting. Trish will become our second Partner Member (NHS Trusts) on the Board upon the retirement of Professor Joe Rafferty at the end of October 2024.

4. Contact details for more information

Raj Jain
ICB Chair

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Report of the Chief Executive

Agenda Item No: ICB/09/24/05

Responsible Director: Graham Urwin, Chief Executive

Report of the Chief Executive (September 2024)

1. Introduction

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

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **consider** the updates to Board and seek any further clarification or details
- **approve** the minor amendments to the ICBs Standing Financial Instructions.

3. Response to the Southport tragedy

3.1 Throughout August and September 2024 people continued to pay their respects to the victims of the tragic events in Southport on 29 July. Our thoughts remain with Alice, Bebe and Elsie Dot's families and friends at this incredibly difficult time.

3.2 As part of the response to this tragedy, multi-agency psychological support has been stood up to ensure that all those who were directly affected – including witnesses and first responders - have access to trauma support.

3.3 In the face of such an atrocity, I would however like to pay tribute to a truly extraordinary response from the local NHS. Specifically, to acknowledge colleagues from North West Ambulance Service, Southport Hospital, Ormskirk District General Hospital, Aintree Hospital, Alder Hey Children's Hospital and Manchester Children's Hospital who cared for those who were injured under the most challenging of circumstances.

3.4 Following the standdown of the major incident, local resilience forum partners confirmed that Sefton Council would lead the recovery co-ordination process which will address a range of issues for the ongoing need for psychological support and co-ordination, support to families, children and schools, community resilience and cohesion, and support to businesses who may have been impacted in the area. It is therefore appropriate that I commend the work undertaken by Deborah Butcher, Place Director for Sefton, and Executive Director of Adult Social Care and Health and Wellbeing for Sefton Council, who led both the immediate incidence response with her colleague

Andrea Watts Executive Director for Operations and Partnerships. Deborah continues to hold a pivotal road in recovery co-ordination.

3.5 Sadly, following 29 July, the grief and trauma felt by loved ones and the community in Southport and beyond was compounded by the civil unrest we witnessed in the days following the tragedy.

3.6 As an anti-racist organisation which prides itself on a zero-tolerance approach to racism, we condemn - in the strongest terms - the criminal actions that were witnessed in our communities, the abhorrent racism and Islamophobia and the derogatory comments which appeared on social media.

3.7 Sefton Council and partner organisations including NHS Cheshire and Merseyside will be contributing to the community and health impact assessments which will be tailored separately to these individual events in order to ensure longer term support is co-designed with people directly affected. Further plans will be shared over the next few weeks .

3.8 Despite these ugly scenes, it has been heartening to see our communities come together to pay their respects to those who lost their lives and were injured and to show solidarity against deplorable acts of racism and intimidation.

4. Thirlwall Update

4.1 Tuesday, 10 September 2024 marked the first day of substantive hearings of the Thirlwall Inquiry at Liverpool Town Hall.

4.2 Chaired by Lady Justice Thirlwall, the inquiry - set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby - is examining:

- the experiences of the Countess of Chester Hospital and other relevant NHS services of all the parents of the babies named in the indictment

- the conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently

- the effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened.

4.3 More information about the inquiry is available here: https://thirlwall.public-inquiry.uk/

5. Regional Updates

5.1 Board members will be aware that Richard Barker retired in June 2024 as Regional Director for the North West, and the North East and Yorkshire Regions. I can now confirm that NHS England has appointed Louise Shepherd to the Regional Director role for the North West Region, starting in November 2024. Louise is currently the Chief Executive of Alder Hey Children's Hospital Foundation Trust. We both congratulate Louise on her appointment and look forward to working with her and her regional team.

6. Executive Team Departure

6.1 Director of Finance, Claire Wilson, has confirmed that she will be leaving NHS Cheshire and Merseyside at the end of this year to take up the position of Group Chief Finance Officer for Manchester University NHS Foundation Trust. Claire joined the ICB in 2022 and has been instrumental in leading both the organisation's financial strategy, and the Cheshire and Merseyside system recovery plan. There will be a number of opportunities between now and then for us to mark her departure and to record our thanks for her leadership and commitment.

7. Darzi investigation of the NHS in England

7.1 On the 12 September 2024, Lord Darzi's report on the state of the NHS in England was published.[1] Lord Darzi's report provides an expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system. The report explored the challenges the NHS faces and has outlined some major themes that will influence the forthcoming 10-year plan for the NHS by the Government. I would draw the Boards attention to the useful summary of Lord Darzi's report which was produced by the NHS Confederation[2] and which helpfully identified how the key challenges facing the NHS are interlinked as well as the four main interrelated drivers that contribute to these challenges. I have summarised these in Table One for ease.

Table One

Challenges	Themes
Waiting time targets have been missed consistently for nearly a decade and satisfaction is at an all-time low	It has been the most austere period for funding in NHS history, with chronic underinvestment into capital
Too many people end up in hospital, in part due to underinvestment in the community	
Both community and mental health services waiting lists have soared	The COVID-19 pandemics legacy has been long-lasting on

[1] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england
[2] https://www.nhsconfed.org/publications/darzi-investigation#:~:text=It%20points%20to%20four%20heavily,and%20management%20structures%20and%20systems.

Challenges	Themes
A&E departments are under unprecedented pressures	the productivity of the NHS and the health of the population
People receive high quality care if they access the right service at the right time, without health deteriorating, but there are areas of concern such as maternity care	The lack of and poor staff and patient engagement and empowerment is contributing to the failure in the performance and public satisfaction of the NHS
Too great a share of funding is on hospitals, with hospital expenditure and staffing haven grown faster than the other parts of the NHS	
The number of hospital staff has increased sharply but the number of appointments, operations and procedures has not increased at the same pace and so productivity has fallen.	Changes in management structures and systems has caused confusion in accountability, has caused over administration, and has caused destabilisation
Patients no longer flow through hospitals properly, linked to underinvestment in capital and social care	

7.2 The report acknowledges that the state of the NHS should not be seen as due entirely to what has happened within the service, but as linked to the severe deterioration in the health of the nation. This includes the increase in the absolute and relative proportion of citizens' lives spent in ill-health and decline in many of the social determinants of health such as poor-quality housing, which has resulted in increasing health inequalities and rising demand for healthcare.

7.3 It is also of note that the report is supportive of the Health and Care Act 2022, which put integrated care systems on a statutory basis, and the change in improvement philosophy from competition to collaboration. It concludes that any top-down reorganisation of NHS England and ICBs would be neither necessary nor desirable. However, it also points to further considerations around the variation in the understanding of ICBs' roles and responsibilities, and the need to refresh the effectiveness of the framework of national standards, financial incentives and earned autonomy.

7.4 The report also highlighted the following areas that need to be considered for inclusion within the 10-year Health plan, namely:

- **Re-engage staff and re-empower patients** to harness staff talent and passion and enable patients to take as much control of their care as possible.
- **Lock in the shift of care closer to home** by hardwiring financial flows to expand general practice, mental health and community services.
- **Simplify and innovate care delivery** for a neighbourhood NHS to embrace new multidisciplinary models of care.
- **Drive productivity in hospitals** by fixing flow through better operational management, capital investment, and re-engaging and empowering staff.
- **Tilt towards technology** to unlock productivity, particularly outside hospitals, as the workforce urgently needs the benefits of digital systems, use of automation and AI and for life sciences breakthroughs to create new treatments.

- **Contribute to the nation's prosperity** by supporting more people off waiting lists and back into work.
- **Reform to make the structure deliver** by clarifying roles and accountabilities, ensuring the right balance of management resources at the right levels and strengthening key processes such as capital approvals

7.5 The Government has said in response to the review that it will take time to improve the NHS and that they will consult patients on a ten-year plan to help make care better. The Government also confirmed that any social care changes will be looked at separately as part of the work to introduce a National Care Service.

7.6 Following the announcement by the Department of Health and Social Care that the new 10-year plan for health will be published in Spring 2025, all ICBs are working with NHS England to support the delivery of a wide-ranging programme of engagement over the next few months. The ICB Communication team are working with Regional colleagues as part of a Regional working group on the co-design of a half day deliberative engagement event for the Region, alongside a programme of system led engagement, coordinated through NHS Cheshire and Merseyside.

7.7 Further information, including the timetable for delivery of both the regional and system engagement will be available in the coming months and will be published on the ICB website.

7.8 As the NHS further develops its ten-year plan, and as more information on this emerges, I will continue to keep the Board updated.

8. 2023 - 2024 ICB Assessment

8.1 As reported to Board at its July 2024 meeting, NHS England has a statutory duty to conduct a performance assessment of each Integrated Care Board each financial year. This assessment takes into account the ICBs role in providing leadership and good governance within the Cheshire and Merseyside Integrated Care System, as well as how the ICB has contributed to each of the four fundamental purposes of an ICS. The assessment is informed by a variety of sources including:

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

8.2 The assessment is delivered in the form of a letter which seeks to provide a balanced picture of system achievements and challenges, and does not come with a specific rating. We received this letter (Appendix One) at the end of July 2024 confirming that our segmentation under the NHS Oversight Framework

remains unchanged. This letter (Appendix A) is structured around five key themes and provided the following feedback:

- **System leadership and management:** NHSE recognised that the ICB has been developing at pace, with purposeful and cohesive leadership, and evidence of a collaborative approach across places and partners. It was acknowledged that the ICB has faced significant challenges during the year in terms of a disproportionate level of industrial action, and winter pressures, but has evidenced systems and process in place to manage the performance of the ICB and its provider organisations.
- **Improving population health and healthcare:** Set against a challenging context, the ICB was commended for progress in the recovery of elective care, diagnostics and cancer services and for delivering on its Emergency Preparedness, Resilience and Response (EPRR) duties. Set against this, Urgent and Emergency Care was identified as the greatest challenge for the ICB, and one that needs to remain a focus in 2024/25.
- **Tackling unequal outcomes, access and experience:** NHS England commented that the system's commitment to reducing health inequalities and strong partnership working was evident, and welcomed the approach taken to the Health and Care Partnership Plan 2024-2029 'All Together Fairer'. Cheshire and Merseyside was commended on the improvement in cancer diagnosis at stage 1 and 2, with Cheshire and Merseyside ranking 4th nationally, and on the Lung Health Check Programme.
- **Enhancing productivity and value for money:** NHS England noted our 2023/24 accounts, which delivered a surplus of £3m against it spending allocation of £6.7 billion, whilst also drawing attention to the underlying financial challenge. As we work towards our 2024/25 control total, there needs to be a focus on improving productivity and delivery of recurring efficiencies in order to improve the underlying financial position.
- **Supporting broader social and economic development:** NHS England recognised that the ICB is leveraging its position as a large anchor institution to drive wider economic, social and environmental benefits, and commended the ICB on being the first in the country to be awarded 'The Social Value Quality Mark: Health Award'

8.3 Despite the known challenges to the system, it is a positive reflection on the work that the ICB and its partners have undertaken over the last year, and I would like to express my gratitude for the continued hard work and professional attitude that our staff and partners undertake on a daily basis to ensure that we continue to deliver the best possible care for our population.

9. Approval of the ICBs Standing Financial Instructions

9.1 At its meeting on 29 August 2024 the Executive Committee considered a report outlining minor changes to the ICBs Standing Financial Instructions (SFI).[3] The proposed changes reflected necessary amendments in recognition of the new procurement regulations for Health Care Services (Provider Selection Regime) Regulations 2023 ('PSR') for Health Contracts and the Procurement Act 2023

[3] Standing Financial Instructions https://www.cheshireandmerseyside.nhs.uk/media/wfqbkhk5/cm-sfi-updated-address.pdf

('PA23') for Non-Health Contracts which replaces the Public Contract Regulations 2015. The Executive Committee supported the proposed changes, and endorsed the intent to submit to the ICB Board for approval, as outlined within the ICBs Scheme of Reservation and Delegation.

9.2 The proposed amendments relates to Section 6: Procurement and Purchasing of the ICB SFIs and the required changes are highlighted in blue below:

6. Procurement and purchasing
6.1 Principles

The ICB will ensure that any procurement activity is performed in accordance with the ~~Public Contracts Regulations 2015 (PCR)~~ Health Care Services (Provider Selection Regime) Regulations 2023 ('PSR') for Health Contracts and the Procurement Act 2023 ('PA23') for Non-Health Contracts together with any associated statutory requirements whilst securing value for money and sustainability.

Undertake any contract variations or extensions in accordance with ~~PCR 2015~~ PSR and PA23 and the ICB procurement policy.

Recommendation:
The Executive Committee recommends that the ICB Board approves the amendments to the ICBs Scheme of Reservation and Delegation

9.2 Following approval, the SFI document will be updated with the amendments and will be published on the ICB website and on the Staff Hub.

10. Devolution

10.1 The Deputy Prime Minister and Secretary of State for Housing, Communities and Local Government has written to the leaders of Local Authorities outlining plans to extend devolution arrangements with a new devolution framework in England. This will include the arrangements with existing devolved authorities such as Liverpool City Region Combined Authority and also extending devolution with new agreements with areas presently not covered by a devolution. This includes between the three Local Authorities of Cheshire East, Cheshire West and Chester, and Warrington. Over the coming weeks and months further details, and then a white paper, will come forward from the Government outlining further detail on what is included in the framework.

10.2 I have written to the Chief Executives of Cheshire East, Cheshire West and Chester, and Warrington to outline the ICB support for their plans to work at a combined devolution footprint including outlining specific examples of how we can work with them in relation to the expected areas of focus in the devolution framework and building on some of the existing programmes of work we have underway:

- supporting people into/staying in employment and business investment
- skills development across health and social care
- housing and regeneration
- transport and Net Zero.

10.3 We have received a positive response from the Councils which welcomed the ICBs commitment to support their plans and to work together to get the best possible agreement from Government for the residents, communities and businesses across Cheshire and Merseyside.

10.4 As further information becomes available in relation to the plans of the two devolution footprints in Cheshire and Merseyside, I will provide further information to the Board on the plans and how the ICB and NHS is contributing to delivery of the ambitions and opportunities devolution presents.

11. Cheshire and Merseyside – Staying on Target

11.1 As of end June 2024, Cheshire and Merseyside ranks 2nd out of 42 ICSs for Diagnostic Waiting Time Performance. The sub-region remains one of only two ICSs to be delivering waiting time performance of 90% of patients receiving a diagnostic test within six weeks. The ranking includes waiting times for a number of diagnostic tests that are offered across Cheshire and Merseyside at various hospitals and community diagnostic centres, including computed tomography (CT) and magnetic resonance imaging (MRI) scans, sleep studies, colonoscopies, hearing assessments and echocardiography tests to name only a few. In comparison to 12 months ago, the number of people waiting has been reduced by over 9,000 patients

12. Endoscopy Hub opens at Warrington and Halton NHS Foundation Trust

12.1 A new £5million Endoscopy Hub has officially opened (09 September 2024) in the Nightingale Building at Halton Hospital. The hub, which is part of a wider endoscopy transformation programme, provides a modern space for diagnostics, surveillance and bowel cancer screening for patients across Cheshire and Merseyside. The space has four new endoscopy rooms, each equipped with state-of-the-art technology and equipment, along with a new recovery area to provide five additional beds.

12.2 The dedicated Endoscopy Hub will improve access for patients not only in Warrington and Halton but across the region, with a greater choice of appointments to reduce waiting lists and provide a better patient experience. It is anticipated the hub will be able to provide at least 200 additional appointment slots per month. Since it has opened, 193 patients have attended from across the region for upper or lower GI endoscopy, and 36 patients have attended for bowel screening.

13. Digital Workforce Initiative

13.1 The National Frontline Digitisation Programme (FD) is supporting Trusts to reach a core level of digitisation and for most organisations that includes the deployment of a new or replacement Electronic Patient Record (EPR) solution. These represent significant change programmes which are resource intensive and require a range of specialist skills to ensure successful implementation , adoption and optimisation. IN C&M we have Trusts at various stages through from business case approval to live deployment and post go-live optimisation.

13.2 These projects draw heavily on existing Trust staff (digital, operational and clinical) but also require external significant recruitment. Typically, Trusts have approached this recruitment challenge individually and often struggled to get appropriate resources deployed. With so many similar initiatives happening in the region, there are significant resourcing and financial risks as scare resources mean premium prices and project timelines are impacted by resource gaps.

13.3 To mitigate these risks and support our provider organisations the ICB is leading a piece of work to agree a shared resourcing and deployment support model a series of workshops are being held with Digital, Operational , Finance and HR staff to consider a range of shred support models. Supported by NHSE (through PwC) the workshops will agree and propose a share workforce model for EPR support across C&M. this use case is looking initially at EPR s but will subsequently consider other large digitally enabled change initiatives such as the Diagnostic programme to consider if a large model at scale would be suitable for adoption. Options under consideration include single external contracts for key services such as data migration through to a pooled expert team to support EPR work across all providers.

14. Data into Action Patient and Public Advisory Group

14.1 NHS Cheshire and Merseyside is inviting people to join a new Patient and Public Advisory Group (PPAG) for its Data into Action (DiA) programme. The aim of the PPAG is to make sure that the views and experiences of patients and the public are listened to and taken on board when decisions are made with regards how personal health data is used in health and care, and how it's shared for research.

14.2 Recruitment is underway, with the first meeting taking place later this year. To apply, you must live in Cheshire or Merseyside, and be aged 18 or over. To find out more and apply to join, please visit the Data into Action website.[4] Applications close at 5pm on Monday 14 October 2024.

14.3 Two engagement events have also been planned, with a focus on sharing data for health research with commercial organisations and industry. The events,

[4] https://dataintoaction.cheshireandmerseyside.nhs.uk/involving-the-public/

being held in partnership with the Liverpool City Region Civic Data Cooperative,[5] and take place on:

- Friday 4 October 2024, 10am to 12.30pm at Civic Health Innovation Labs, Liverpool Science Park, 131 Mount Pleasant, Liverpool, L3 5TF
- Wednesday 9 October 2024, 10am to 12.30pm, Crewe YMCA, 189 Gresty Rd, Crewe, CW2 6EL.

14.4 Participants will only need to attend one of the two above events. Places are limited and must be booked in advance. To register your interest, please email mlcsu.dia@nhs.net or call 07341 792998 by 5pm on 23 September 2024. Find out more on the Data into Action website.

15. Liverpool Women's Hospital Site Developments

15.1 A £5.7million investment has been agreed for the Crown Street site at Liverpool Women's Hospital to establish it as a centre for gynaecological procedures, ensuring patients from across all of Cheshire and Merseyside are seen in the most appropriate treatment setting. Four state of the art procedure rooms are being developed, which will help free up capacity in theatres and create additional clinic space. It is anticipated that this development will be operational by Spring 2025 and will be able to accommodate an additional 4,200 patients per year. With the current gynaecological procedures waiting list being at 37,422 patients[6] (with 60% of this waiting list being patients from the North Mersey area) this investment and increased capacity will be key towards the systems elective recovery programme work.

16. Roll out of RSV Vaccine

16.1 The NHS in Cheshire and Merseyside has started vaccinating people against Respiratory Syncytial Virus (RSV), for the first time in its history. As part of winter preparations, NHS in Cheshire and Merseyside has started vaccinating pregnant women and older adults, including those turning 75 on or after 01 September 2024. There will also be a one-off 'catch-up' offer for everyone aged 75 to 79 years old to ensure the older age group are protected as the winter months approach.

16.2 RSV, a leading cause of infant mortality around the world, is a common cause of coughs and colds but can lead to severe lung infections like pneumonia and infant bronchiolitis, which are highly dangerous to older people and young children. The RSV virus is also the main cause of winter pressures in children's hospitals every year, leading to increased pressure on paediatric intensive care units. RSV cases in children have been increasing in the past couple of years, with an average of 146 young children in hospital each day at the peak in winter last year (w/e 03 December 2023), up 11% on the peak observed during the previous winter (132) from the same time in late November.

[5] https://civicdatacooperative.com/
[6] As of 08 September 2024

16.3 Research from the thousands of women across the world who have been vaccinated against RSV shows that it reduces the risk of severe lung infection by around 70% in the first six months of life. Having the vaccine during pregnancy is the best way to protect a baby from getting seriously ill with RSV, as the vaccine boosts the mother's immune system to produce more antibodies against the virus to help protect the baby from the day they are born.

16.4 Staff from vaccination and maternity teams across the region have worked hard to offer vaccination services so that it is as easy as possible for pregnant women to get the life-saving jab at any point from 28 weeks into their pregnancy, alongside their maternity care. Women should speak to their maternity service about receiving their vaccine from 28 weeks to at any point up to birth. Alternatively, pregnant women can get vaccinated by request at their local GP practice, while older adults will be invited by their local GP practice

17. Best for Baby Too

17.1 A moving film which captured maternity experiences of six women in the asylum system was showcased in Liverpool at an event organised by Best for Baby Too. The premiere of the hour-long film 'When you know...childbirth in the asylum system' was held at Liverpool Lighthouse in Anfield on 12 September 2024.

17.2 Attended by dignitaries including Lord Mayor of Liverpool Richard Kemp CBE and Vice Lord Lieutenant of Merseyside Ruth Hussey OBE, the film was also endorsed by Dame Lesley Regan – England's first ever Women's Health Ambassador.

17.3 Attended by more than 100 people, the event – co-organised by Dr Bryony Kendall, a Liverpool GP and safeguarding lead for NHS Cheshire and Merseyside – opened with a supportive video message from Dame Lesley Regan and was followed by a lively panel discussion chaired by NHS Cheshire and Merseyside's Deputy Medical Director Dr Fiona Lemmens.

17.4 Both Liverpool John Moores University and Edge Hill University have already committed to using the film as a training resource for undergraduate midwives in the city, with an ambition to utilise the film beyond midwifery education – including among doctors and health visitors.

18. Good news and Congratulations

18.1 **Navajo Chartermark.** I am pleased to inform Board that we have received notification that our application for the Navajo Chartermark has been successful and that we will be invited to formally receive the award at the Navajo Award Ceremony that will be taking place on 03 October 2024. The Navajo Merseyside and Cheshire LGBTIQA+ Charter Mark is an equality mark sponsored by In-Trust Merseyside and supported by the LGBTIQA+ Community networks across Merseyside – and is a signifier of good practice, commitment and knowledge of

the specific needs, issues and barriers facing LGBTIQA+ people. I would like to thank out teams and staff for all of their contributions that have helped our application achieve a successful and welcomed outcome.

18.2 **Specialist Perinatal Service.** Congratulations to the Cheshire and Merseyside Specialist Perinatal Service has been awarded the prestigious Perinatal Quality Network Accreditation (PQN) from the Royal College of Psychiatrists (RCP).The service provides important mental health assessment and support for local women and birthing people, who are experiencing moderate to severe mental health issues during this time. The RCP award is testament to the continued commitment to delivering high quality perfect care for mums and families across Cheshire and Merseyside.

18.3 **Succes at HSJ Awards.** NHS organisations across Cheshire and Merseyside have gained national recognition after winning at the HSJ Patient Safety Awards 2024. Eight trusts across the region were shortlisted for awards with three winners being announced at the event held in Manchester on 16 September 2024. The awards showcase key initiatives and innovations in patient safety from the past year, while recognising the hard-working teams within the NHS who strive to deliver the best patient care. Details of those recognised are:

- **Community Care Initiative of the Year** – awarded to **Cheshire and Merseyside Cancer Alliance** for their work around community ownership of cancer information to increase timely presentation.

- **Early-Stage Patient Safety Innovation of the Year** - awarded to **Cheshire and Wirral Partnership NHS Foundation Trust** for optimising safety and innovating through the digitisation of Mental Health Act (MHA) administration.

- **Seni Lewis Award** – awarded to **Mersey Care NHS Foundation Trust and their Mental Health Triage and Response Team**.

18.4 Meanwhile, Mersey Care also received High Commendation in the Learning Disabilities Initiative of the Year Category for their development of the HOPE(S) model in collaboration with NHS England. The HOPE(S) model is a human rights-based approach to working with individuals in segregation developed from research and clinical practice.

18.5 For further details of all the winners and a full list of finalists, please visit: awards.patientsafetycongress.co.uk.

19. Decisions taken at the Executive Committee

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

- **Staff Suggestion Scheme.** The Executive Committee considered and supported recommendations, which had been informed and shaped by the Staff Engagement Forum, regarding the implementation of a new Staff Suggestion Scheme. The scheme is to encourage all staff to submit helpful ideas, suggestions and identify potential improvements in relation to any

aspect of our work at NHS Cheshire and Merseyside. An ICB Suggestion Panel will be established to consider any suggestions made, with membership drawn from across the organisation.

- **Staff Recognition Proposal.** The Executive Committee considered and supported recommendations regarding initiatives to recognise staff achievements, which included:
  - Employee and Team of the quarter
  - Annual ICB Celebration event
  - Long Service Awards
  - Retirement celebrations.

19.2 At its meetings throughout August and September 2024, the Executive Committee has also considered papers on the following areas:

- Cheshire and Merseyside Health Estates Infrastructure
- ICB Operational Model
- Section 117
- Southport Incident and recovery
- Recovery Committee escalation reports
- NHS Staff Survey 2024
- Standing Financial Instructions Update
- Intensive and Assertive Mental Health Treatment – NHSE review request.
- Inpatient Quality Transformation Programme – 3 year Plan.

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

20. Officer contact details for more information

Graham Urwin
Chief Executive

Jennie Williams, Senior Executive Assistant,
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21. Appendices

Appendix One: NHS England Letter to the ICB regarding 2023-24 Performance Assessment

Ref: MG HH 2024-07-30

To: Graham Urwin, Chief Executive Officer
Raj Jain, Chair
NHS Cheshire and Merseyside Integrated Care Board

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By email

30 July 2024

Dear Graham and Raj

Annual assessment of Cheshire and Merseyside Integrated Care Board's performance in 2023-24

I am writing to you pursuant to Section 14Z59 of the NHS Act 2006 (Hereafter referred to as *"The Act"*), as amended by the Health and Care Act 2022. Under the Act NHS England is required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making my assessment I have considered evidence from your annual report and accounts; available data; feedback from stakeholders and the discussions that my team and I have had with you and your colleagues throughout the year.

This letter sets out my assessment of your organisation's performance against those specific objectives set for it by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and its wider role within your Integrated Care System across the 2023/24 financial year.

I have structured my assessment to consider your role in providing leadership and good governance within your Integrated Care System as well as how you have contributed to each of the four fundamental purposes of an ICS. For each section of my assessment I have summarised those areas in which I believe your ICB is displaying good or outstanding practice and could act as a peer or an exemplar to others. I have also included any areas in which I feel further progress is required and any support or assistance being supplied by NHS England to facilitate improvement.

In making my assessment I have also sought to take into account how you have delivered against your local strategic ambitions as detailed in your Joint Forward Plan which you have reviewed and rebaselined. A key element of the success of

Integrated Care Systems will be the ability to balance national and local priorities together and I have aimed to highlight where I feel you have achieved this.

I thank you and your team for all of your work over this financial year in what remain challenging times for the health and care sector and I look forward to working with you in the year ahead.

Yours Sincerely,

Dr Michael Gregory
Interim Regional Director (North West)

Annual assessment of Cheshire and Merseyside Integrated Care Board's performance in 2023-24

Section 1: System leadership and management

Throughout 2023/24, we have witnessed the Integrated Care Board (ICB) developing at pace, with demonstration of purposeful and cohesive executive and place teams under the ICB leadership. The collaborative approach across places and partners is highlighted by partnership working with local authorities, health and wellbeing boards (HWBs), government agencies, academic organisations and community organisations, plus investment and development with the voluntary sector, to help improve health outcomes and reduce inequalities and unwarranted variation across the Cheshire and Merseyside footprint.

The ICB has evidenced monitoring systems and process in place to manage performance of the ICB and its provider organisations. It is acknowledged that the ICB has faced significant challenges during the year, such as a disproportionate level of industrial action, and winter pressures. The ICB's transparency and honesty in dealing with these challenges has been welcomed and the ongoing work across the system is recognised.

The ICB provided a good example of partnership working, describing the System's detailed work on elective recovery. Oversight is provided by the ICB across the system to understand where support is required. Positive relationships have been built with providers, allowing for open, transparent, and dynamic conversations. The ICB/Elective Programme tracks waiting times on a weekly basis offering system level support, facilitation of mutual aid and good practice.

At our year end assessment meeting the ICB offered several further examples of where they were leading the system in developing system wide solutions, including the commitment to move towards single EPR solution for the Liverpool trusts and the ongoing work around the system wide pathology business case.

The ICB described the development and engagement of a broad range of strategies and plans in the annual report, which have been implemented across the ICB and the wider system. With an overarching strategic vision through the Health Care Partnership (HCP) Strategy, supported by specific multi-year plans, such as the Joint Forward Plan (JFP), whilst also creating complementary plans focusing on key areas like mental health, digital transformation, and sustainability.

The ICB has demonstrated robust executive led system governance, with oversight of providers and places and accountability for the effective management of healthcare risks by joining up quality intelligence and engagement, supporting responses to system risks and escalating where required. The ICB provided detailed

sections in the annual report on: Adherence to Good Governance principles; Standards of Business Conduct; Accountability Measures; Risk Management and Internal Control; and Information Governance. Further assurance around how the ICB ensured it received appropriate clinical advice was provided at the annual assurance meeting. The Head of Internal Audit Opinion provides 'substantial assurance' in terms of the ICB's system of internal control. The ICB also referenced throughout the annual report in terms of how it ensured consideration of the effects of decisions made in line with the triple aim.

It is positive to hear of the ICB's ambition to lead the way in health and care improvement and be recognised as a beacon of excellence locally, regionally and nationally.

It is evident that choice and personalisation are integral to the ICB's commissioning approach and is a fundamental element of recovery planning. The ICB has taken a multi-pronged approach to involving local people and communities in decisions and has established a Citizens' Panel where residents can share views via online surveys on various healthcare topics which inform strategies and plans. The ICB utilises various communication channels to share information and solicit feedback. Working in partnership with Healthwatch and voluntary/community groups to tap into existing networks and ensure voices across communities are heard.

Section 2: Improving population health and healthcare

Over the past year the ICB has provided consistent evidence of a desire to improve both performance and quality of services for patients. Demand for services has been extremely high over the last year, with the residual impact of Covid-19, alongside the objective of delivering recovery against quality and performance standards. We are also aware that other delivery constraints, including discharge being further contributors to pressure and challenge in the system and have discussed the impact of this on patient flow through urgent and emergency care at a number of our meetings.

We note the important work that the ICB has done in supporting Liverpool University NHS Foundation Trust in its improvement journey, with the trust moving from a NOF 4 rating to a NOF 3 rating. In addition the ICB has supported the Countess of Chester NHS Foundation Trust through a difficult period, including the integral part the ICB has played in the establishment of an effective System Improvement Board.

The ICB is commended on the work undertaken to reduce Mental Health Out of Area Placements (OAPs), which has been noted nationally and the impact of the reduction on the experience of patients and their families. Mersey Care NHS Foundation Trust has consistently delivered on zero OAPs, while actions taken to reduce OAPs at Cheshire Wirral Partnership NHS FT included establishing an OAP focused

dedicated team, which has enabled a significant reduction in patients, either via repatriation or discharge.

Through the year the system has made considerable progress in recovering elective care following the COVID pandemic. The provider collaborative has led efforts to reduce long waits, and while delivery is not in line with the original planning requirements you have delivered a substantial reduction, improving the patient experience for many patients. This is particularly notable against the backdrop of lost episodes of care due to industrial action. It was positive to hear about the deployment of the C2-Ai Observatory System across all Cheshire and Merseyside Acute Trusts to track risk-adjusted surgical, and ward based clinical outcomes based on patient case mix complexity, with comparisons to expected outcomes.

Meanwhile the Cheshire and Merseyside Cancer Alliance has led on the restoration of cancer services, with your cancer recovery now ranking the ICB as 2nd best out of the 42 ICB's.

Diagnostic recovery has made similarly impressive progress, with the system being the first to deliver 90% against the 6 week wait target. For community diagnostics the ICB has delivered around 15% of the countries new capacity, whereas it only covers around 5% of the population.

The ICB remains in Tier 1 for urgent emergency care (UEC) with support from NHSE being deployed at Warrington and Halton Teaching Hospitals NHS Foundation Trust and Liverpool University Hospitals NHS Foundation Trust during the year. We note improvements in many of the UEC indicators compared to 12 months previously, but performance remains a concern, with C&M ranking in the lowest quartile nationally for A&E 4-Hour Performance. From a performance perspective this is the greatest challenge for the ICB and you must ensure that this remains a focus in the year ahead.

In October 2023 the ICB completed the centralisation of stroke services in North Mersey and subsequent opening of the Stroke Emergency Assessment Centre at the Aintree Hospital site. The system has also established a co-located 24/7 stroke thrombectomy service. As a result, the C&M system is ranked 3rd in the country for Sentinel Stroke National Audit Programme (SSNAP) performance.

Not Meeting Criteria To Reside (NMCTR) remains one of the key challenges to the ICB on delivery of both elective and urgent care, again with C&M ranking nationally in the lowest quartile for the percentage of beds occupied by patients who NMCTR. We agreed in Quarter 3 that there is a need to work with the local authorities to address this. We look forward to seeing the impact of the actions outlined in the Newton Group Report on NMCTR numbers.

We note that within Mental Health there is a similar issue with the need to reduce the number of inpatients who are clinically ready for discharge (CRFD). You have shared how the ICB can now monitor CRFD data via the daily situation report to the System Control Centre. We look forward to seeing the impact of this improved visibility of data in allow the ICB to look across the system for solutions.

The ICB has delivered on its Emergency Preparedness, Resilience and Response (EPRR) duties, including taking an active leadership role in the management of industrial action, ensuring that the direct patient impact was minimised where possible.

Section 3: Tackling unequal outcomes, access and experience

We look forward to the pending publication of the refreshed Health and Care Partnership Plan 2024-2029, 'All Together Fairer', for which NHS Cheshire and Merseyside has led the development of this collaborative approach to reducing health inequalities across the nine Places.

The ICB has provided concise detail, which shows clarity and understanding in developing its approach to population health management, with a clear plan for integration and data dashboard development to enable delivery. We look forward to progress being made in this area in the coming 12 months.

The ICB has progressed significantly in the prevention and inequalities space, with the Annual Report clearly outlining the work underway to engage across the whole system, developing wider partnerships and community engagement. The JFP outlines the ICB's commitment to improving the health of the Cheshire and Merseyside population, with the focus being on early intervention, tackling inequalities, addressing wider determinants and promoting good health. The health inequalities section of the ICB's Annual Report outlines the work undertaken to address the priority actions within the CORE20PLUS5 Programme, for adults and children. In terms of how successfully the ICB has restored priority services in an inclusive way, evidence has been provided to assure that the ICB has robust systems in place to analyse Waiting List data, it is noted that the ICB has implemented specific programmes of work, where data has raised issues of concern. 'All Together Fairer' contains clear actions regarding how the ICB has accelerated preventative programmes, aimed at those at increased risk of poor health outcomes.

The system's commitment to reducing health inequalities and strong partnership working was evident throughout the Place Directors' informative presentations and the valuable discussions generated during Quarters 1 and 2. With clear demonstrations of partnership working across Places, particularly with Local Authority, Primary Care Network and Third Sector colleagues and a strong focus on the Population Health Agenda, social care and Partnership Boards. With a

commitment to improving the health and wellbeing of deprived populations using innovation, risk stratification and targeted engagement. Keeping populations well and out of hospital is evidently a key focus for the Cheshire and Merseyside Places.

An area of notable achievement for 2023/24 was the improvement for cancer diagnosis at stages 1 and 2, with Cheshire and Merseyside ranking fourth nationally. This success was attributed to the Lung Health Check Programme, evidencing partnership working with the voluntary sector and targeting deprivation across the patch, with dedication and commitment from all involved.

The ICB has 7 Primary Care Network (PCN) based Women's Health hubs open in Liverpool Place offering increased access to LARC and other services. This is exceeding the national requirement for one hub in each ICB by 2025 and has delivered an increase in long acting reversible contraception (LARC) uptake to higher than pre pandemic levels with a resulting reduction in termination of pregnancy rates. This has been achieved through the establishment of a co-commissioning model with the local authority.

The appointment of a Director of Population health, and also 2 further consultants, shows the ICB's commitment to this agenda, and is a fantastic opportunity to strengthen the functions on prevention and inequalities. At the same time, we know you have started to deliver on the key prevention programmes on tobacco and alcohol. The work on oral health inequalities is another great example of a strategic prevention programme and I know there is ongoing focus on cardiovascular vascular disease (CVD) prevention.

Section 4: Enhancing productivity and value for money

The financial position remained challenging during 23/24 and the ICB reported a £3m surplus on its £6.7bn allocation. The system overall reported a £100m deficit against a plan of breakeven, with nine providers delivering deficit positions and one at breakeven offset by surpluses in the remaining seven. However, the £100m deficit included an agreed technical adjustment of £49m and therefore performance against agreed plan represents adverse variance of £51m We note that these figures are subject to audit.

In 23/24 systems were in receipt of funding for industrial action costs and elective recovery fund targets were also adjusted for the impact.

The system capital expenditure for the year was an underspend of £1m against a £268.7m allocation across both the ICB and providers.

The ICB met the requirements of the Mental Health Investment Standard, reporting £545m spend against a target of £537m for 2023/24. The ICB also underspent against their running cost allowance of £53.4m by £1.9m.

As part of Better Care Fund (BCF) integration of health and care services with Local Authorities, the ICB contributed c£300m into the joint BCF pool. Including Local Authority funding, the combined BCF pool was c£550m

Cheshire and Merseyside providers overspent on their £127.3m agency spend threshold by £0.8m (0.6%). This was in the context of a significant volume of industrial action during the year.

The ICB delivered its £388m planned efficiencies. 63% of these were delivered recurrently compared to a plan of 78%. Providers delivered £327.7m of their £330.8m of planned efficiencies of which 62% was recurrent against a plan of 73%.

Among the drivers of the deficit position were higher than planned expenditure on Continuing Healthcare and primary care prescribing.

The system has agreed a control total of £150m for 2024/25 and there needs to be a focus on improving productivity and delivery of recurring efficiencies across the system with a clear aim to improve the underlying financial position.

A strong focus on research, technology and innovation is apparent throughout the Annual Report and Accounts and the ICB clearly articulates its duties in recognition of the population it serves. It is noted that the Board approved the Integrated Research and Innovation System (IRIS) during 2023/24. Key activity within IRIS and some good examples of collaboration across the system include the Wirral Research Collaborative, with the focus being on promoting optimal outcomes through evaluation and research and the work with the Civic Health Innovation Labs, Northwest Coast Clinical Research Network and Applied Research Collaboration and the Integrated Care System Research Engagement Network Development Programme, which is a programme led by the ICB.

Section 5: Helping the NHS support broader social and economic development

The contributions of the ICB to the wider strategic priorities of the system are clearly defined, with the ICB detailing the work being undertaken across the system in terms of leading and working with system partners to tackle the strategic priorities of its system. The ICB has supported seven objectives as system-level areas for action related to addressing social determinants of health and inequalities, such as increasing funding for prevention, strengthening partnerships, co-creating interventions with communities, and developing policies focused on social determinants. The ICB launched an Anchor Framework to embed social value across the region by taking actions like paying living wages, purchasing locally, and reducing environmental impact. The ICB's initiatives have focused on reducing health inequities for children/youth, supporting employment for disabled individuals,

scaling up prevention priorities through the Prevention Pledge, promoting sustainability to tackle climate change, collaborating to prevent serious violence, tackling discrimination, and addressing housing/health connections. The ICB is working to fulfil its statutory duties around improving service quality, reducing inequalities, involving patients, promoting innovation/research/education, and promoting integration across health and social care.

The ICB is leveraging its position as a large anchor institution to drive wider economic, social and environmental benefits across its system through initiatives, frameworks, measurement and cross-sector collaboration. I would like to commend the ICB as being the first ICB in the country to be awarded "The Social Value Quality Mark: Health Award" through a partnership with the Social Value Quality Mark CIC and NHS Arden and GEM Commissioning Support Unit. This has included expansion of the Anchor Programme with local authority and community partners. Examples of how the ICB has acted as anchor institution include development of a Social Value Charter and becoming the first signatory to the Anchor Institution Framework. It was positive to see the implementation of a system-wide social value framework by the ICB, in conjunction with the Social Value Portal, to consistently measure social value delivered through procurement and activities across the system. It was described that governance for the anchor institution work is provided by the ICB's Sustainability Board with representation across health, care and wider partners.

Feedback was requested during Quarter 4 from the Cheshire and Merseyside Health and Wellbeing Boards (HWBs) in relation to how HWBs rated the effectiveness of their working relationships with the ICB and responses ranged from 'fairly good' to 'very good'. In terms of how effectively the ICB has worked with its NHS and wider system partners to implement the Joint Local Health and Wellbeing Strategy, five HWBs rated this as 'fairly effective', two as 'very effective' and one HWB rated this as 'not at all effective'. Although many positive responses were received, more work is needed to improve the effectiveness of this important working relationship. HWBs requested greater sharing of information and updates going forward, development of ICB Corporate level relationships with some HWBs, more democratic oversight of the system rather than being predominantly NHS focused and greater delegation of elements to Places, and you may wish to consider this feedback in future plans.

Conclusions

This has been challenging year in many respects and in making my assessment of your performance I have sought to fairly balance my evaluation of how successfully you have delivered against the complex operating landscape in which we are working. This is the first full year in which you have been operating as well as the first year of your Joint Forward Plan and I am keen to continue to see progress towards a maturing system of integrated care structured around placing health and care decisions as close as possible to those people impacted by them. The regional

team will continue to work alongside you in the year ahead and we look forward to working with you to support improvement throughout your system.

I ask that you share my assessment with your leadership team and consider publishing this alongside your annual report at a public meeting. NHS England will also publish a summary of the outcomes of all ICB performance assessments in line with our statutory obligations.

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Director of Nursing Report

Agenda Item No: ICB/09/24/06

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

Director of Nursing Report

1. Purpose of the Report

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

2. Executive Summary

2.1 A position update is provided in relation to the All Age Continuing Care programme, that includes operational performance and management of change processes. The report also includes an update on maternity and neonatal service delivery, including operational performance, risks and issues affecting services in Cheshire and Merseyside.

3. Ask of the Integrated Care Board & Recommendations

3.1 The Board is asked to note the contents of the report for information purposes.

4. Reasons for Recommendations

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

5. Background

5.1 **All Age Continuing Care.** The ICB is accountable for the needs-led process of assessment and provision of all-age continuing care (AACC) which is a statutory function. AACC is a major area of expenditure which is being scrutinised due to the increasing costs. There is a recovery programme focusing on AACC lead by Alison Lee (Place Director Knowsley). The recovery programmme team meets each Monday and are looking at ways to streamline the workstreams, focus on QIPP and cost efficiencies.

5.2 Challenges continue in meeting the statutory targets of 28-day assessment, and no long waiters over 12 weeks in addition to the increasing cost of care. Warrington, Halton, Wirral, St Helens and Knowsley met the Key performance indicators in Q1 2024/25.

5.3 Commissioning has continued in the predecessor CCG team configurations with different models of delivery. The ICB commissioned a review which was

initiated in January 2023 to identify an appropriate model of delivery, quantify opportunities for quality and financial improvement, fully contestable and equitable. This Management of change is in progress, and it is anticipated the new structure will be in place by October 2024. The management of change consultation process closed on Monday 02 September 2024 and is moving towards the implementation process.

5.4 The national ambition is to provide a consistent AACC end-to-end service to ensure seamless service delivery which meets statutory requirements inclusive of:

- NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended)
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (revised 2022)
- The National Framework for Children and Young People's Continuing Care (revised 2016)
- National Guidance and regulations regarding the implementation of Personal Health Budgets including the NHS Direct Payments Regulations (Amended 2013)
- The Children and Families Act 2014
- The SEND Code of Practice January 2015
- Section 117 Mental Health Act 1983
- Building the Right Support and subsequent policy documents and specifications.

5.5 In C&M ICB, All Age Continuing Care (AACC) delivery, including assessment, review, and commissioning, is the responsibility of place placed teams. This includes following areas some of which may be paid via Personal Health Budgets:

- Continuing Healthcare
- Funded Nursing Care
- Mental Health (including S117 aftercare)
- Learning Disability
- Children and Young People's Continuing Care
- Joint Packages of Care.

5.6 Table 1 below details the key performance indicators for Quarter 1 2024/25. Headline figures for Cheshire and Merseyside include:

- there were **2319** people eligible for CHC in NHSCM in Q1 24/25, which is a referral rate of **51.7 per 50k** population, compared to 34 per 50k for England and 46.8 per 50k for the North West.
- the overall conversion rate to eligibility for Cheshire and Merseyside was **24.3%**, compared to 20% for England and 27.4% at North West level.
- Cheshire and Merseyside compared favorably (**0.2%**) to the North West (0.2%) and England (0.3%) for the numbers of people assessed within the acute setting
- Cheshire and Merseyside performed below (**71.7%**) the England (72.5%) and North West (79.9%) rate for eligibility decisions within 28 days, with variation ranging from **38.7%** in Liverpool Place to **100%** in St Helens Place.

- There were **197** referrals waiting beyond 28 days, with **115** (58%) of those referrals relating to Cheshire East Place and Cheshire West Place.
- Cheshire and Merseyside had **zero** people waiting beyond 12 weeks for assessment, which is an improved position compared to previous quarters.
- Cheshire and Merseyside performed positively for fast-track conversion rates at **98.6%**.

5.7 As previously highlighted to the Board, delivery model changes following the in-housing of personnel from Midlands & Lancashire Commissioning Support Unit in Liverpool, Southport and Sefton have impacted figures and these areas are unlikely to meet the NHS England targets in Quarter 2 of 2024/25. This has been discussed in Performance, Issues, and Risk Group with NHS England assurance leads.

% Standard Referrals Completed within 28 days, Incomplete Referrals Exceeding 28 days, Referrals Exceeding by more than 2wks up to 4wks, R...
BY ORGANISATION

	England	C&M ICB	Northwest	Cheshire	Halton	Knowsley	Liverpool	Southport &Formby	South Sefton	St Helens	Warrington	Wirral
DSTs												
% DSTs completed (Acute)	0.3%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%	0.0%	0.0%	0.5%
Referrals												
% Standard Referrals Completed within 28 days	72.5%	71.7%	79.9%	65.8%	81.3%	89.5%	38.7%	42.2%	48.3%	100.0%	94.4%	83.7%
Incomplete Referrals Exceeding 28 days	1,567	197	225	115	0	2	28	24	20	1	0	7
Referrals Exceeding by up to 2wks	499	59	75	33	0	0	9	7	6	1	0	3
Referrals Exceeding by more than 2wks up to 4wks	323	48	50	22	0	0	10	8	7	0	0	1
Referrals Exceeding by more than 4wks up to 12wks	555	90	99	60	0	2	9	9	7	0	0	3
Referrals Exceeding by more than 12wks up to 26wks	146	0	1	0	0	0	0	0	0	0	0	0
Referrals Exceeding by more than 26wks	44	0	0	0	0	0	0	0	0	0	0	0
Activity												
Number Eligible for Standard CHC (Snapshot)	34,533	2,319	5,885	768	94	86	402	171	139	118	146	394
Rate per 50K population	34.0	51.7	46.8	58.2	43.3	31.8	41.9	80.5	54.1	36.2	39.7	71.0
Conversion rates												
Fast track referral conversion rate	93.7%	98.6%	98.6%	97.6%	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	97.0%	98.1%
Standard CHC assessment conversion rate	20.0%	24.3%	27.4%	27.7%	20.0%	38.9%	15.1%	22.2%	10.3%	9.1%	18.4%	28.8%

Table 1.

5.8 The review of the AACC policies and procedures from predecessor organisations into draft C&M ICB policies and procedures is making good progress. The draft Section 117 After Care Policy, Interagency Dispute and Shared Care/Joint Funding Procedures have now been shared with the NHS Cheshire and Merseyside Executive, as well as the nine Cheshire and Merseyside Local Authority Directors of Adult Social Care before moving to formal sign off through the ICB Quality and Performance Committee.

5.9 AACC is a major area of expenditure with a total budget for 2024/25 more than £412m. Due to this, AACC is one of the main areas of focus for QIPP. AACC has a dedicated recovery program, and recent recommendations include a weekly Care Assurance Panel to scrutinise any package costing more than £5k per week. The intent is that this will give more information to allow open discussion with providers around commissioning at a scale which could assist with a spending reduction.

5.10 Each ICB place team has been given a list of high impact interventions that will support cost reductions, with progress monitored via the ICB Recovery Programme.

5.11 **Local Maternity & Neonatal Services (LMNS).** In line with the perinatal safety and surveillance framework, the LMNS will be undertaking visits with all Trusts in Cheshire and Merseyside during October and November 2024. The focus of the visits will be to gain assurance against the delivery of the 3-year plan priorities and the implementation of the essential actions from Ockenden. Representation has been requested from the Neonatal Operational Delivery Network, MNVPs and Place quality leads. Trusts will also have an opportunity to showcase good practice and nominate any areas of outstanding practice.

5.12 Through the North West Region Maternity Performance Oversight Panel (MPOP) Support Tool, the LMNS were required to seek assurance from providers on Quarter 1 of 2024/25 progress against each of the 12 objectives within the three-year delivery plan. This follows on from the baseline assessment undertaken by providers during Quarter 4 of 2023/24.

5.13 Following LMNS review of the evidence submitted by providers, the LMNS met with the Regional Team 20 August 2024, with the Regional Team assured that providers are on track for delivery. Several areas of excellence were noted including:

- WHH Preceptorship Pack
- WHH Student Listening Event
- MCHT Digital Strategy and BadgerNet Roadmap
- WUTH SOP Mentorship for new B7 and B8 staff
- WUTH PSIRF Policy- Learning timeframes
- LWH Student Feedback Report
- LWH Preceptorship Pack
- COCH Leadership Succession Plan
- MWL Ormskirk- FTSU Induction Training Presentations
- MWL Whiston- PMRT Action Log.

5.14 The outcome of the provider evidence review will be fed back to individual providers, for discussion at the annual LMNS Provider Visits.

5.15 The Cheshire and Merseyside Joint Oversight and Support (JOS) Framework was agreed at the July 2024 LMNS Assurance Board and is in place for Providers with a CQC rating of 'Requires Improvement' or 'Inadequate' for maternity and/or safety, and for Providers emerging from MSSP.

5.16 The following providers are in receipt of the JOS framework:

- **Liverpool Women's Hospital** - meetings commenced in June 2024 and are ongoing, with good progress made against agreed actions.
- **Mid-Cheshire Trust** - first meeting held June 2024, with focus on progress against the CQC action / improvement plan.
- **Countess of Chester (COCH) -** Regional Chief Midwife, Lead Obstetrician, Maternity Improvement Advisors and LMNS agreed in July 2024 to stand

down the MSSP programme, in view of significant progress made. COCH will commence JOS meetings in September 2024 for additional support.

- **Mersey & West Lancashire Trust (MWL) (Southport and Ormskirk site)** – although MWL obtained CQC 'Good' overall, Ormskirk site received 'Good' for well-led but 'Requires Improvement' for Safe. Therefore, the LMNS will commence JOS meetings with the MWL team with a particular emphasis on improvements at the Ormskirk site.

5.17 In response to delays in the Induction of Labour (IOL) pathway across C&M and associated risks, the LMNS has established an IOL Taskforce in collaboration with the Innovation Agency. There is potential to align this work with the Maternity and Neonatal Safety Improvement Programme (led by the Innovation Agency) Deterioration[1] and Cultural Change workstreams.

5.18 The LMNS have introduced stretch thresholds for 24/25 in relation to the Saving Babies Lives Care Bundle version 3, to drive improvement in elements where there was high compliance with last year's thresholds. Quarter 2 24/25 review is scheduled for September 2024.

5.19 The LMNS is performing well against several metrics included in the Regional Dashboard, supporting delivery of the three-year delivery plan for maternity and neonatal services as detailed in Table Two:

Metric	Unit of Measurement	Latest Period	England	C&M
Stillbirth Rate (MSDS)	Rate per 1,000	Year to May 2024	3.2	2.6
Neonatal Mortality Rate	Rate per 1,000	2022		1.3*
3rd/4th Degree Tears	Rate per 1,000	3 months to May 2024	29.0	24.0
Preterm Birth Rate	Percentage	May 2024	6.0%	5.6%
Placement on Continuity – Black/Asian women	Percentage	May 2024	17.9%	38.6%
Placement on Continuity – Women in most deprived areas	Percentage	May 2024	13.7%	40.4%
Placement on Continuity of Carer Pathway	Percentage	May 2024	16.8%	39.1%
Baby Friendly Accreditation – Maternity	Percentage	June 2024	17.2%	25.0%

Table 2. Data Source: Regional Maternity Dashboard
**C&M is reporting the lowest neonatal mortality rate across the three LMNS (no England average is given)*

[1] The Deterioration workstream aims to improve the prevention, identification, escalation, and response (PIER) to maternal and neonatal deterioration through designing and testing the following tools, for frontline maternity staff to improve safety for service users:

- The Maternity Early Warning Score (MEWS) tool
- The Newborn Early Warning Trigger and Track (NEWTT2).

5.20 In addition:

- The access rate for the Cheshire and Merseyside combined Perinatal Mental Health & Maternal Mental Health Service was reported as 2,970, against a 23/24 target of 2,729, equating to 10% of birth rate.
- The most recent data on smoking at time of delivery (SATOD), shows that 8.2% of women in Cheshire and Merseyside were known to be smokers at the end of their pregnancy in 2023-24, against an England average of 7.4%, significantly closing the gap.

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

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

- how we work as partners for the benefit of our population
- population health
- Women's Health & Maternity
- Personalised Care.

7. Link to meeting CQC ICS Themes and Quality Statements

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

8. Risks

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

9. Next Steps and Responsible Person to take forward.

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

10. Officer contact details for more information

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Cheshire and Merseyside Integrated Care System Finance Report Month 4 (2024/25)

Agenda Item No: ICB/09/24/07

Responsible Director: Claire Wilson, Executive Director of Finance

Cheshire and Merseyside System

Finance Report Month 4

1. Purpose of the Report

1.1 This report provides an update to the Board of NHS Cheshire and Merseyside on the financial performance of the Cheshire and Merseyside ICS ("the ICS") at Month 4 2024/25.

1.2 The Board is asked to:

- Note the contents of this report in respect of the Month 4 ICS financial position for both revenue and capital allocations within the 2024/25 financial year.

- Note the estimated £63m risk to delivery of our system financial plan which will require urgent corrective action from both providers and the ICB.

2. Executive Summary

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

2.2 The System 'ICS' financial plan agreed with NHSE is a combined £150m deficit (£62.3m surplus for the ICB and £212.3m for providers).

2.3 As of 31st July 2024 (Month 4), the ICS system is reporting a YTD deficit of £138.0m against a planned YTD deficit of £99.4m resulting in an adverse YTD variance of £38.6m (1.6% of allocation). The ICS financial position as reported to NHS England at Month 4 is set out in **Table 1** below.

Table 1 – Financial Performance: Month 4

	M4 YTD			
	Plan	Actual	Variance	
	£m	£m	£m	%
ICB	20.8	(0.4)	(21.1)	-0.9%
Total Providers	(120.2)	(137.6)	(17.4)	-0.8%
Total System	**(99.5)**	**(138.0)**	**(38.6)**	**-1.6%**

2.4 As set out in the table above, the £38.6m adverse variance to plan at month 4 is made up of £21.1m relating to the ICBs own budgets and £17.4m relating to the provider sector.

2.5 The system is still formally forecasting delivery of its plan in line with NHS England requirements. A national protocol process is required before any system is able

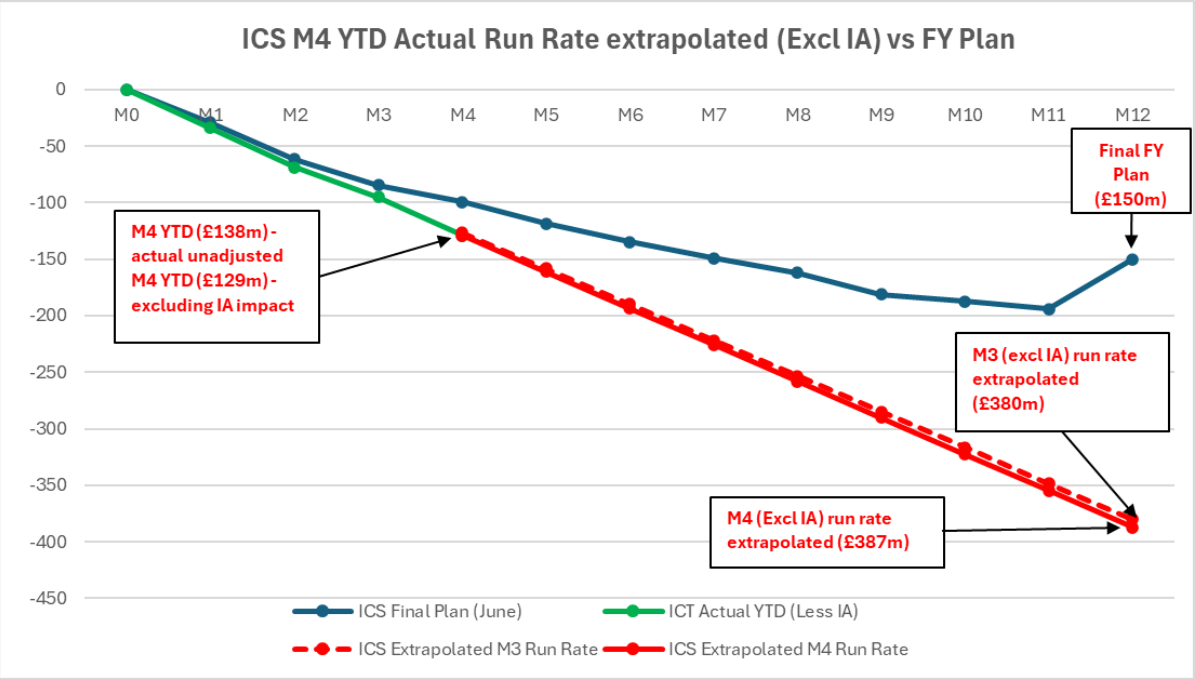
to deteriorate its forecast and at this point of the year our system is required to take further urgent corrective action in order to remain within what is already a significant deficit plan of £150m.

2.6 Delivery of this plan is still high risk in some organisations. The current risk adjusted forecast position for the system is a deficit of £213m, which is **£63m** worse than the agreed plan**.** This risk adjusted forecast is explored further in section 3.31 – 3.38 and reflects a concerning position which needs urgent corrective action from both providers and the ICB.

2.7 **Chart 1** below shows the profile of the ICS I&E plan submitted to NHSE on 12th June against the actual M4 YTD run rate.

2.8 It should be noted that at £138m YTD deficit, the system has incurred 92.3% of its £150m deficit plan in the first 3 months of the year. This reflects the challenging profile of the plan where CIPs have been assumed to deliver towards the end of the year. The current run rate will need to improve significantly in order for the system plan to be achieved and so focus and acceleration of CIP plans and expenditure run rate reductions will be critical over the next few weeks. Further analysis and review of the forecast is set out in section 3.31 - 3.38.

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



2.9 As part of the Month 4 local data collection a range of financial and operational metrics were collected covering financial performance and recent run rate trends across provider pay expenditure, workforce, efficiency, productivity and cash. A summary is set out in **Table 2** below.

Table 2 – M4 System level financial and operational indicators

Area	Aggregate System level indicators	unit	Month 2 YTD		Month 3 YTD		Month 4 YTD	
			£m / WTE	%	£m / WTE	%	£m / WTE	%
System I&E	ICB - I&E Surplus / (Deficit) - YTD	£m	1.7		6.9		(0.4)	
	Provider - I&E Surplus / (Deficit) - YTD	£m	(70.5)		(107.9)		(137.6)	
	ICS - I&E Surplus / (Deficit) - YTD	£m	(68.8)		(101.0)		(138.0)	
Provider Pay Expenditure	Average Pay Increase / (Decrease) vs 23/24 Run Rate	£m	6.5	2.2%	11.2	3.1%	7.6	2.1%
	Pay Variance to plan - favourable / (adverse)	£m	(13.5)	-1.9%	(12.7)	-1.2%	(21.3)	-1.5%
	Agency Variance to plan - favourable / (adverse)	£m	(1.4)	-7.8%	(4.4)	-18.1%	(6.1)	-18.8%
WTE Workforce	M12 23/24 actual WTEs to in month 24/25 Actual - *decrease / (increase)*	WTE	1,104	1.4%	1,616	2.0%	1,113	1.4%
	In month 24/25 Actual vs 24/25 Plan - *favourable / (adverse)*	WTE	(891)	-1.1%	(486)	-0.6%	(1,110)	-1.4%
CIP Efficiency	TOTAL CIP Variance from YTD plan (provider & ICB)	£m	(10.6)	-23.5%	(13.1)	-16.8%	(20.2)	-17.9%
	YTD Recurrent CIP delivery	£m		46.0%		59.7%		57.3%
	% of CIP schemes deemed High Risk - full year	£m		54.0%		31.2%		20.0%
Productivity - Acute Providers	*Implied Productivity Growth M12 23/24 vs 19/20	£m		-18.6%		-15.8%		-15.8%
	*Implied Productivity Growth M12 23/24 vs 22/23	£m		0.8%		2.9%		2.9%
	acute providers only	£m						
Cash	Provider Aggregate Cash Balance - March 2024	£m	N/A		521		521	
	Provider Aggregate Cash Balance - In month actual	£m	N/A		405		377	
	Reduction in cash in one month	£m	N/A	N/A	(58)	-12.5%	(27)	-6.8%

2.10 The key issues driving the Month 4 financial position are:

- Unachieved efficiencies of £20m
- £9m cost of Industrial action
- Pressures on CHC and Mental Health Packages of care of £14.4m
- Prescribing of £7m.

2.11 Whilst good progress has been made to reduce headcount from M12, this has fallen short of provider plans both in terms of WTEs and financial value. Levels of recurrent efficiency reported at month 4 are only 57.3% of planned efficiencies.

2.12 The target full-year system efficiencies (provider and ICB) amount to c6.5% of ICB allocations and currently, 54% of this is medium or high risk. The plan also assumed no further industrial action impact, managing inflation to funded levels, and delivery of 'Elective Recovery Fund' (ERF) plans.

3. Financial Performance Month 4

ICS financial performance – M4

3.1 As of 31st July 2024 (Month 4), the ICS is reporting a YTD deficit of £138.0m against a planned YTD deficit of £99.4m, resulting in an adverse YTD variance of £38.6m. The YTD deficit of £138m represents 92% of the revised full year plan of £150m deficit and is an adverse movement of £37m in-month compared to the plan.

3.2 The YTD variance against plan is due to a deterioration of both the ICB position and pressures within a small number of providers. ICB pressures continue to relate to the cost of Continuing Health Care (CHC) and Mental Health packages. In addition, there are emerging pressures on prescribing following the receipt of May-24 prescribing data. Provider pressures relate primarily to the impact of

industrial action in June and July, under-delivery of efficiency savings and ERF targets in some providers.

3.3 **Table 3** sets out the financial performance surplus/(deficit) at Month 4 at organisation level.

Table 3 – ICS Financial Performance M4 YTD by organisation

Financial performance surplus/(deficit) for the purposes of system achievement	M4 YTD Plan	M4 YTD Actual	M4 YTD Variance	M4 YTD Variance	M4 Actual Surplus / (Deficit) as a % of YTD income	Full Year Annual Plan	Month 4 YTD as a % of FY plan
	£m	£m	£m	%	%	£m	%
C&M ICB	20.8	(0.4)	(21.1)	-0.9%	-0.0%	62.3	-1%
Alder Hey Children's NHS Foundation Trust	(2.6)	(3.1)	(0.4)	-0.3%	-2.2%	3.4	-91%
Bridgewater Community Healthcare NHS Foundation Trust	(0.2)	(0.5)	(0.3)	-1.0%	-1.6%	2.1	-25%
Cheshire and Wirral Partnership NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1%	1.5	5%
Countess of Chester Hospital NHS Foundation Trust	(10.5)	(14.3)	(3.8)	-3.4%	-12.4%	(23.6)	61%
East Cheshire NHS Trust	(6.5)	(6.9)	(0.4)	-0.6%	-10.3%	(14.4)	48%
Liverpool Heart and Chest Hospital NHS Foundation Trust	3.8	2.9	(0.8)	-1.1%	3.6%	14.1	21%
Liverpool University Hospitals NHS Foundation Trust	(48.5)	(52.9)	(4.4)	-1.2%	-13.3%	(80.5)	66%
Liverpool Women's NHS Foundation Trust	(10.2)	(10.2)	0.0	0.0%	-20.8%	(28.5)	36%
Mersey Care NHS Foundation Trust (inc NWB)	1.9	1.9	0.0	0.0%	0.8%	7.1	26%
Mid Cheshire Hospitals NHS Foundation Trust	(11.5)	(12.7)	(1.2)	-1.0%	-9.7%	(35.6)	36%
Mersey & West Lancashire Teaching Hospitals NHS Trust	(14.9)	(16.9)	(1.9)	-0.6%	-5.7%	(26.7)	63%
The Clatterbridge Cancer Centre NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1%	0.9	8%
The Walton Centre NHS Foundation Trust	1.7	1.7	0.0	0.0%	2.7%	5.3	32%
Warrington and Halton Teaching Hospitals NHS Foundation Tr	(13.6)	(14.6)	(1.0)	-0.9%	-12.8%	(27.8)	53%
Wirral Community Health and Care NHS Foundation Trust	0.0	0.0	0.0	0.0%	0.0%	6.5	0%
Wirral University Teaching Hospital NHS Foundation Trust	(8.9)	(12.1)	(3.2)	-2.0%	-7.6%	(16.3)	74%
Total C&M ICS	**(99.5)**	**(138.0)**	**(38.6)**	**-1.6%**	**-5.6%**	**(150.0)**	**92%**

ICB Financial Performance – M4

3.4 The ICB has reported a YTD deficit of £0.4m on its own budgets compared to a planned surplus of £20.7m, resulting in an adverse variance to plan of £21.1m as per **Table 4** below.

Table 4 – ICB Financial Performance M4 YTD

	M4 YTD			
	Plan	Actual	Variance	Variance
	£m	£m	£m	%
ICB Net Expenditure:				
Acute Services	1,137.5	1,137.4	0.2	0.0%
Mental Health Services	229.9	238.2	(8.4)	-3.6%
Community Health Services	223.9	223.6	0.3	0.1%
Continuing Care Services	129.2	135.2	(6.0)	-4.6%
Primary Care Services	209.5	217.3	(7.8)	-3.7%
Other Commissioned Services	5.1	4.8	0.2	4.9%
Other Programme Services	20.4	20.1	0.4	0.0%
Reserves / Contingencies	(2.4)	0.0	(2.4)	100.0%
Delegated Specialised Commissioning	198.9	196.4	2.6	1.3%
Delegated Primary Care Commissioning	283.6	283.8	(0.2)	-0.1%
Primary Medical Services	182.9	183.2	(0.3)	-0.1%
Dental Services	65.8	65.8	(0.0)	0.0%
Ophthalmic Services	8.9	8.9	0.0	0.4%
Pharmacy Services	26.0	26.0	(0.0)	0.0%
Delegated Dental, Opthalmic and Pharmacy Ser	100.6	100.6	0.0	0.0%
ICB Running Costs	14.5	14.5	0.0	0.0%
Total ICB Net Expenditure	**2,450**	**2,471**	**(21.1)**	**-0.9%**
Allocation adjustment for reimbursable items	0.0	0.0	0.0	0.0%
TOTAL ICB Surplus/(Deficit)	**20.8**	**(0.4)**	**(21.1)**	**-0.9%**

3.5 This year to date overspend is driven by the following issues:

a) Mental Health Services – £8.4m overspend relating to activity on packages of care outstripping planned levels and limited impact of efficiency plans to date.
b) Continuing Care – £6m overspend relating to increasing activity and costs of packages of care (inflation and complexity) exceeding the levels budgeted and a shortfall in the delivery of efficiencies.
c) A pressure of £7.7m is reported on the prescribing budget for the first time this year based on May-24 prescribing data.
d) £2.6m of the variance shown on reserves is offsetting the £2.6m surplus reported on the delegated specialised commissioning budget – as planned.
e) Efficiency – The ICB reports a £5.9m shortfall against the efficiency savings plans for M4. Slippage on efficiency savings is a contributory factor to the overall adverse variance to plan.
f) Running costs - Costs remain within the running cost allowance following the reduction in allocation this year.

3.6 Prescribing cost per day approximately 2% lower than the equivalent period last year. However, there has been an increase in No Cheaper Stock Obtained (NCSO) costs from April which have been reflected in the current forecast outturn.

3.7 The current forecast adverse variance to plan for Continuing Care is £26.3m and £24.6m for Mental Health Complex Care packages. **Appendix 1** contains details of the forecast variance by place.

3.8 ICB financial performance by place is shown in Table 5a below

Table 5a – Month 4 Financial Performance by Place

	M4 YTD Plan £000's	M4 YTD Actual £000's	M4 YTD Variance £000's
Cheshire - East	(17,344)	(20,028)	(2,684)
Cheshire - West	(14,214)	(13,790)	424
Halton	(3,126)	(4,431)	(1,305)
Knowsley	3,954	1,859	(2,096)
Liverpool	3,537	(2,609)	(6,146)
Sefton	(3,505)	(8,244)	(4,739)
St Helens	(3,713)	(5,428)	(1,715)
Warrington	(1,537)	(3,502)	(1,965)
Wirral	(6,907)	(11,236)	(4,329)
ICB	63,619	67,038	3,419
Total ICB	**20,763**	**(372)**	(21,135)

A significant element of the overspend relates to CHC and MH Packages budgets which are reported in detail by place below (**Table 5b**)

Table 5B: Month 4 CHC and MH packages budgets by place.

Continuing Healthcare	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast £000's	Forecast Variance £000's
ICB CENTRAL	(7,338)	(10,335)	2,997	(7,338)	(7,338)	(0)
CHESHIRE EAST	26,079	27,494	(1,415)	78,709	84,522	(5,813)
CHESHIRE WEST	21,510	20,046	1,464	65,726	62,823	2,902
HALTON	5,998	6,412	(415)	18,148	19,440	(1,292)
KNOWSLEY	5,480	5,790	(310)	16,404	17,121	(717)
LIVERPOOL	22,654	24,063	(1,409)	67,782	69,717	(1,934)
SEFTON	13,647	16,680	(3,033)	43,765	51,976	(8,211)
ST HELENS	8,820	9,940	(1,120)	26,390	27,971	(1,581)
WARRINGTON	10,395	11,289	(895)	31,425	33,857	(2,432)
WIRRAL	21,939	23,790	(1,851)	67,824	75,074	(7,250)
TOTAL CHC - Month 4	**129,183**	**135,170**	**(5,986)**	**408,835**	**435,163**	**(26,328)**

Mental Health - Packages of Care	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Annual Budget £000's	Forecast £000's	Forecast Variance £000's
CHESHIRE EAST	7,040	7,750	(710)	23,062	24,936	(1,874)
CHESHIRE WEST	7,434	8,299	(865)	23,393	26,185	(2,792)
HALTON	2,871	3,480	(609)	9,214	11,086	(1,872)
KNOWSLEY	2,440	2,853	(412)	7,308	8,205	(897)
LIVERPOOL	10,719	13,650	(2,930)	32,076	39,304	(7,228)
SEFTON	6,115	7,547	(1,432)	20,814	25,172	(4,358)
ST HELENS	7,229	7,120	110	21,633	22,930	(1,297)
WARRINGTON	4,298	4,290	9	13,428	13,653	(224)
WIRRAL	8,082	9,090	(1,009)	26,581	30,607	(4,026)
TOTAL MH Packages of Care - Month 4	**56,229**	**64,078**	**(7,849)**	**177,510**	**202,078**	**(24,568)**

3.9 **Table 6** below sets out the individual provider Month 4 YTD financial positions.

Table 6 – Provider Month 4 Financial Performance

Financial performance surplus/(deficit) for the purposes of system achievement	M4 YTD Plan	M4 YTD Actual	M4 YTD Variance	M4 YTD Variance	M4 Actual Surplus / (Deficit) as a % of YTD income	Full Year Annual Plan	Month 4 YTD as a % of FY plan
	£m	£m	£m	%	%	£m	%
C&M ICB	20.8	(0.4)	(21.1)	-0.9%	-0.0%	62.3	-1%
Alder Hey Children's NHS Foundation Trust	(2.6)	(3.1)	(0.4)	-0.3%	-2.2%	3.4	-91%
Bridgewater Community Healthcare NHS Foundation Trus	(0.2)	(0.5)	(0.3)	-1.0%	-1.6%	2.1	-25%
Cheshire and Wirral Partnership NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1%	1.5	5%
Countess of Chester Hospital NHS Foundation Trust	(10.5)	(14.3)	(3.8)	-3.4%	-12.4%	(23.6)	61%
East Cheshire NHS Trust	(6.5)	(6.9)	(0.4)	-0.6%	-10.3%	(14.4)	48%
Liverpool Heart and Chest Hospital NHS Foundation Trust	3.8	2.9	(0.8)	-1.1%	3.6%	14.1	21%
Liverpool University Hospitals NHS Foundation Trust	(48.5)	(52.9)	(4.4)	-1.2%	-13.3%	(80.5)	66%
Liverpool Women's NHS Foundation Trust	(10.2)	(10.2)	0.0	0.0%	-20.8%	(28.5)	36%
Mersey Care NHS Foundation Trust (inc NWB)	1.9	1.9	0.0	0.0%	0.8%	7.1	26%
Mid Cheshire Hospitals NHS Foundation Trust	(11.5)	(12.7)	(1.2)	-1.0%	-9.7%	(35.6)	36%
Mersey & West Lancashire Teaching Hospitals NHS Trust	(14.9)	(16.9)	(1.9)	-0.6%	-5.7%	(26.7)	63%
The Clatterbridge Cancer Centre NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1%	0.9	8%
The Walton Centre NHS Foundation Trust	1.7	1.7	0.0	0.0%	2.7%	5.3	32%
Warrington and Halton Teaching Hospitals NHS Foundatio	(13.6)	(14.6)	(1.0)	-0.9%	-12.8%	(27.8)	53%
Wirral Community Health and Care NHS Foundation Trust	0.0	0.0	0.0	0.0%	0.0%	6.5	0%
Wirral University Teaching Hospital NHS Foundation Trust	(8.9)	(12.1)	(3.2)	-2.0%	-7.6%	(16.3)	74%
Total C&M ICS	**(99.5)**	**(138.0)**	**(38.6)**	**-1.6%**	**-5.6%**	**(150.0)**	**92%**

3.10 It is anticipated that there will be some funding provided for the impact of Industrial action in year, the value of this is not confirmed and therefore this is not yet reflected in provider figures.

3.11 There are 3 trusts reporting a year-to date adverse variance to plan relating entirely to the impact of industrial action over June and July 2024 (5 days):

- Alder Hey Children's NHS Foundation Trust - £0.4m
- Mersey and West Lancashire Teaching Hospitals NHS Trust - £1.9m
- Warrington and Halton Teaching Hospitals NHS Foundation Trust - £1.0m

3.12 There are 7 Trusts reporting a year-to-date adverse variance to plan which is greater than the impact of Industrial action, In June 2024, along with other operational issues as set out below:

- **Bridgewater Community NHS Foundation Trust**
  £0.3m adverse variance YTD, forecast to plan.
  Operational issues linked with premium paediatric locum spend partially offset by vacancies, attributing to £0.2m of the YTD variance. There is also under delivery of £0.2m against the Trust's recurrent YTD CIP plan, offset by some smaller non-recurrent technical items.

- **Countess of Chester NHS Foundation Trust**
  £3.8m adverse variance YTD, forecast to plan
  £1.0m of the YTD variance is attributable to industrial action. Key drivers of the remaining £2.8m YTD variance are largely attributable to the YTD costs in relation to the public enquiry. The trust is reporting an adverse CIP YTD variance from £2.0m against the plan, offset by budgetary underspends. Schemes requiring a QIA are currently going through the trust's internal process and it is anticipated that further recurrent savings can be transacted from Month 5 (August).

- **East Cheshire NHS Trust**
  £0.4m adverse variance YTD, forecast to plan
  £0.3m of the YTD variance is attributable to industrial action. Key drivers of the remaining £0.1m YTD variance relate to unfunded costs relating to support for medically fit mental health patients.

- **Liverpool Heart & Chest Hospital NHS Foundation Trust**
  £0.8m adverse variance YTD, forecast to plan
  Key drivers of the £0.8m YTD variance are: £1.2m undelivered recurrent CIP; £0.6m from a delay in the expansion of targeted lung programme which the trust host across the ICS, the trust is expecting to see a significant increase in the scanning of patients from August across Wirral, Warrington and North Sefton that will attract associated income as planned; and £0.6m from inflation above planning assumptions across licensed drugs and cath lab consumables. These pressures have been partially offset by £1.6m non-recurrent technical items over the first three months.

- **Liverpool University Hospitals NHS Foundation Trust**
  £4.4m adverse variance YTD, forecast to plan
  £3.1m of the YTD variance is attributable to industrial action. Key drivers of the remaining £1.3m YTD variance are: £5.6m undelivered CIP; offset by £2.5m expected ERF overperformance and £2m of non-recurrent technical items and balance sheet release.

- **Mid Cheshire Hospitals NHS Foundation Trust**
  £1.2m adverse variance YTD, forecast to plan
  £0.5m of the YTD variance is attributable to industrial action. Key drivers of the remaining £0.7m YTD variance are: £3.1m under delivery on recurrent CIP plan YTD, which has been partially offset by £0.2m vacancies, non-pay controls and reduced outsourcing, and £2.0m of additional income associated with ERF and commercial activities. The trust had profiled its CIP in 12ths and is continuing to progress schemes to close its YTD variance and derisk existing schemes currently in the pipeline.

- **Wirral University Teaching Hospitals NHS Foundation Trust**
  £3.2m adverse variance YTD, forecast to plan
  £0.4m of the YTD variance is attributable to industrial action. Key drivers of the remaining £2.8m YTD variance are; £4.0m elective underperformance across surgical specialties T&O and Urology driven by under-utilisation of C&M Surgical Centre by system partners, consultant vacancies and CSSD downtime; £1.3m acute pay overspend within ED medical and ED nursing driven primarily by corridor care, with work on-going to review rotas and how to reduce shifts subject to escalated rates of pay; £1.9m shortfall on CIP delivery YTD. The above has been mitigated to an extent by £4.5m of underspends and vacancies elsewhere across the Trust.

3.13 **Table 7** sets out the provider year-to-date position compared to the Month 4 YTD plans by income, pay, non-pay and non-operating items. This shows that the aggregate YTD pay position is £21.3m (1.5%) adverse to plan, which is explained by; the net cost of medical cover during the industrial action in June and July of

c£5.5m (0.4%); undelivered pay efficiencies YTD of £13.5m (0.8%); and selected operational pay pressures and underspends across several providers as set out in section 3.11 above.

3.14 NHS Providers are also reporting additional non pay inflation across drugs and consumables above those assumed in the plan and is a key contributor to the 5.6% YTD adverse variance on non-pay expenditure. The remaining driver impacting non pay is a shortfall on YTD efficiency delivery of £6.9m (0.9%). A full breakdown of the expenditure variance by provider can be found in **Appendix 2.**

Table 7 – Provider Income and Expenditure vs YTD Plan

	M4 YTD			
	Plan	Actual	Variance	
	£m	£m	£m	%
Total Income	**2,080.9**	**2,119.8**	**38.9**	**1.9%**
Pay	**(1,449.0)**	**(1,470.2)**	**(21.3)**	**-1.5%**
Non Pay	**(719.7)**	**(759.9)**	**(40.1)**	**-5.6%**
Non Operating Items (excl gains on disposal)	**(32.4)**	**(27.3)**	**5.1**	**15.7%**
Total Provider Surplus/(Deficit)	**(120.2)**	**(137.6)**	**(17.4)**	**-0.8%**

3.15 A review of Month 4 actual provider expenditure against actual 23/24 expenditure (average run rate from M9-M11) is set out in **Table 8** below. This indicates an aggregate £7.6m (2.1%) increase in the M4 pay run rate compared to M9-11 23/24 average pay expenditure. 0.9% of the increase is explained by the element of the 24/25 pay award increase funded by the Cost Uplift Factor (CUF) through national tariff. 0.8% of the increase is explained by the impact of industrial action over June. The remainder is a combination of technical balance sheet items in M9-12 23/24 therefore deflating the 23/24 reference period; increases to pay expenditure through ringfenced allocations (MHIS/SDF) and unachieved efficiencies in M4 compared to YTD plan. Table 8 sets out the pay run rate movements per provider and this continues to be scrutinised with targeted providers.

Table 8 – Provider Pay Expenditure M4 vs 23/24 M9-11 Run Rate

	23/24 M9-11 Average Pay Run Rate	2024/25 Actual Pay Run Rate			Pay Expenditure Run Rate - Trend		Previous months	
		24/25 M2 Pay Expend	24/25 M3 Pay Expend	24/25 M4 Pay Expend	M4 Pay Increase / (Decrease) vs 23/24 Av. Run Rate	% change M4 24/25 vs M9-11 average	% change M2 24/25 vs M9-11 average	% change M3 24/25 vs M9-11 average
	£,000	£,000	£,000	£,000	£,000	%	%	%
Alder Hey Children's NHS Foundation Trust	20,514	21,708	21,895	**21,786**	1,272	6.2%	5.8%	6.7%
Bridgewater Community Healthcare NHS Foundation Tr	5,859	5,809	5,721	**5,836**	(23)	-0.4%	-0.9%	-2.4%
Cheshire and Wirral Partnership NHS Foundation Trust	17,390	17,860	18,036	**18,885**	1,495	8.6%	2.7%	3.7%
Countess of Chester Hospital NHS Foundation Trust	21,547	21,684	22,424	**20,321**	(1,226)	-5.7%	0.6%	4.1%
East Cheshire NHS Trust	12,612	12,098	12,644	**12,379**	(233)	-1.8%	-4.1%	0.3%
Liverpool Heart and Chest Hospital NHS Foundation Tru	9,028	9,350	9,595	**9,554**	526	5.8%	3.6%	6.3%
Liverpool University Hospitals NHS Foundation Trust	70,728	73,501	73,006	**72,461**	1,733	2.5%	3.9%	3.2%
Liverpool Women's NHS Foundation Trust	8,633	9,003	8,637	**8,629**	(4)	-0.0%	4.3%	0.0%
Mersey Care NHS Foundation Trust (inc NWB)	46,249	47,060	45,065	**45,845**	(404)	-0.9%	1.8%	-2.6%
Mid Cheshire Hospitals NHS Foundation Trust	24,837	24,413	24,409	**24,457**	(380)	-1.5%	-1.7%	-1.7%
Mersey & West Lancashire Teaching Hospitals NHS Tr	47,874	50,791	52,477	**51,413**	3,539	7.4%	6.1%	9.6%
The Clatterbridge Cancer Centre NHS Foundation Trust	8,801	9,161	9,122	**9,197**	396	4.5%	4.1%	3.6%
The Walton Centre NHS Foundation Trust	7,690	7,976	8,143	**8,073**	383	5.0%	3.7%	5.9%
Warrington and Halton Teaching Hospitals NHS Founda	22,626	22,541	22,561	**22,339**	(287)	-1.3%	-0.4%	-0.3%
Wirral Community Health and Care NHS Foundation Tru	6,023	6,446	5,943	**6,440**	417	6.9%	7.0%	-1.3%
Wirral University Teaching Hospital NHS Foundation Tru	29,215	28,271	31,107	**29,656**	441	1.5%	-3.2%	6.5%
C&M Total	**359,626**	**367,672**	**370,784**	**367,271**	**7,645**	**2.1%**	**2.2%**	**3.1%**

NHS Provider Agency Expenditure

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

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

3.18 At Month 4, year to date agency spend is £38.3m (£6.1m above plan), equating to 2.6% of total pay. 11 Trusts are reporting a year-to-date adverse variance to plan. Trust level information on agency spend can be found in **Appendix 3**.

3.19 Table 9 below sets out the aggregate agency performance as a system. This indicates that if the M4 YTD position was extrapolated for the year based on the current run rate this would equate to a £23m adverse variance to plan however remain within the national agency gap by £5.7m. Further work is ongoing in this area within providers and forms a key part of provider CIP plans.

Table 9 – Provider Agency Expenditure

Organisation	2023/24		2024/25 PLAN		2024/25 YTD ACTUAL				2024/25 EXTRAPOLATED		2024/25 FOT	
	23/24 Actual	23/24 Actual as a % of total 23/24 Pay	24/25 FY Plan	24/25 FY Plan as a % of Pay Plan	24/25 M4 YTD Plan	24/25 M4 YTD Actual	24/25 M4 YTD Variance	24/25 M4 Actual as a % of M4 Pay Actual	M4 YTD Extrapolated for year	Variance M4 Extraplorated vs FY Plan	Agency FOT	Agency FOT vs FY plan
	£,000	%	£,000	%	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
TOTAL C&M Providers	**(128,456)**	**2.9%**	**(91,787)**	**2.1%**	**(32,252)**	**(38,318)**	**(6,066)**	**2.6%**	**(114,953)**	**(23,166)**	**(99,770)**	**(7,983)**
Agency Cap set by NHSE	(127,322)		(120,662)			(40,221)			(120,662)		(120,662)	
Variance to Cap - favourable / (adverse)	(1,134)		28,875			1,903			5,709		20,892	

Workforce

3.20 Workforce and its triangulation with finance, performance and productivity will continue to be key focus across the system. **Table 10** below sets out the movement in provider WTEs between M12 23/24 to M4 24/25 and the position against the WTE Month 3 plan. **Appendix 4** sets out in more detail the movements at provider level.

Table 10 – M4 Workforce movements vs M12 23/24 and M4 24/25 Plan

	2023/24	2024/25	2024/25	2024/25	2024/25	M4 Variance		M3 to M4	Movement vs M12		2024/25
Workforce (WTEs) - source PWRs / June plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M4 Variance from plan favourable / (adverse)		Change in month M4 vs M3 (increase) / decrease	M12 23/24 to M4 24/25 Actuals decrease / (increase)		M12 Plan (March 25)
	WTE	WTE	WTE	WTE	WTE	WTE	%	WTE	WTE	% move	WTE
C&M Providers Total	80,465	79,607	79,361	78,849	79,352	(1,110)	-1.4%	(502)	1,113	1.4%	77,963

3.21 The Month 4 provider workforce data indicates that whilst WTE have reduced by 1,113 (1.4%) compared to Month 12 (23/24) they have not fallen to the levels planned, with an adverse 1,110 WTE position vs plan (-1.4%). This also triangulates the CIP position being behind plan. Also of concern is a c500 WTE increase in Month 4 compared to Month 3. This is being investigated with each provider and a number of data quality issues in some provider returns are being reported which artificially suppressed the month 3 position.

System Efficiencies

3.22 For 2024/25 providers and ICB are planning delivery of £368m and £72m efficiencies respectively. The aggregate system efficiency plan of £440m (6.1% of ICB Allocations / Provider Expenditure) submitted as part of the June plan re-submission is set out by organisation in **Appendix 5A and 5B**.

3.23 **Table 11** shows at Month 4 there is currently a shortfall on planned CIP delivery of £20.1m against the ICS YTD plan, with £14.3m attributable against providers and £5.9m against the ICB. The £92.3m efficiencies delivered YTD represent 3.7% of provider and ICS expenditure/allocation against the annual plan of 6.1%, indicating a larger proportion of the savings required in the remaining months.

3.24 Furthermore only 57% of the system efficiencies YTD plan have been delivered recurrently as at Month 4. This increases the risk in the underlying financial position of the ICS and is subject to ongoing work by providers to both recover the YTD shortfall and address the recurrent position.

Table 11 – ICS M4 YTD Efficiency Delivery

	CIP Efficiency - YTD Delivery						CIP Recurrent / Non Recurrent YTD			YTD CIP as a % of FY CIP Plan	
	M4 YTD Plan	M4 YTD Actual	M4 YTD Variance	M4 YTD % Variance	M4 CIP actual as a % of Op Ex	FY CIP Plan % of Op Ex	Actual Recurrent	Actual Non Recurrent	Actual Recurrent as a % of YTD plan	full year CIP (new plan)	YTD CIP as a % of FY CIP plan
	£,000	£,000	£,000	%	%	%	£,000	£,000	%	£,000	%
Alder Hey Children's	4,064	4,064	(0)	0%	2.8%	4.8%	4,004	60	99%	19,950	20%
Bridgewater Community	892	579	(313)	-35%	1.7%	6.9%	179	400	20%	6,939	8%
Cheshire & Wirral Partnership	4,168	2,938	(1,230)	-30%	3.1%	5.0%	1,410	1,528	34%	13,913	21%
Countess of Chester Hospitals	3,899	1,851	(2,048)	-53%	1.4%	5.3%	1,851	0	47%	19,822	9%
East Cheshire Trust	1,925	1,905	(20)	-1%	2.5%	5.0%	758	1,146	39%	11,225	17%
Liverpool Heart & Chest	3,238	1,998	(1,240)	-38%	2.5%	4.6%	1,561	438	48%	10,644	19%
Liverpool University Hospitals	27,223	21,576	(5,647)	-21%	4.6%	8.5%	7,944	13,632	29%	114,600	19%
Liverpool Women's	1,350	1,533	183	14%	2.5%	3.3%	630	903	47%	5,904	26%
Mersey Care	8,655	8,655	0	0%	3.4%	3.5%	8,049	606	93%	25,967	33%
Mid Cheshire Hospitals	7,006	3,964	(3,042)	-43%	2.7%	5.2%	1,752	2,212	25%	22,437	18%
Mersey & West Lancs	10,357	11,290	934	9%	3.6%	4.8%	7,357	3,933	71%	45,165	25%
The Clatterbridge Centre	3,333	3,333	0	0%	3.3%	3.4%	2,354	979	71%	10,000	33%
The Walton Centre	2,776	2,776	0	0%	4.3%	4.5%	2,199	577	79%	8,558	32%
Warrington & Halton Hospitals	3,071	3,239	168	5%	2.5%	5.1%	2,956	283	96%	19,433	17%
Wirral Community	1,583	1,458	(125)	-8%	4.1%	5.4%	237	1,221	15%	6,275	23%
Wirral University Hospitals	6,570	4,670	(1,900)	-29%	2.7%	5.2%	4,670	0	71%	26,878	17%
TOTAL Providers	**90,111**	**75,830**	**(14,281)**	**-16%**	**3.1%**	**5.5%**	**47,912**	**27,918**	**53%**	**367,710**	**21%**
C&M ICB	22,423	16,514	(5,909)	-26%	0.7%	1.0%	16,514	0	74%	72,236	23%
TOTAL ICS	**112,534**	**92,344**	**(20,190)**	**-18%**	**3.7%**	**6.1%**	**64,426**	**27,918**	**57%**	**439,946**	**21%**

3.25 **Table 12** sets out the current risk and development status of efficiency schemes. As at Month 4 20% of the CIP schemes are currently deemed high risk meaning there is still considerable work to be undertaken the derisk CIP delivery to support financial plan delivery. Further detail at organisational level is included in **Appendix 5B.**

Table 12 – Efficiency Development and Risk status – Month 4

	Month 4								
	CIP RISK				CIP DEVELOPMENT				
	Low £m	Medium £m	High £m	Total £m	Fully £m	In Progress £m	Opportunity £m	Unidentified £m	Total £m
C&M ICB	29.0	31.3	12.0	72.2	40.9	11.2	16.8	3.4	72.2
C&M Providers	175.3	118.0	76.7	369.9	216.4	83.0	59.4	11.2	369.9
TOTAL C&M ICS	**204.3**	**149.2**	**88.6**	**442.2**	**257.2**	**94.1**	**76.2**	**14.6**	**442.2**
% of risk / development status - M4	**46%**	**34%**	**20%**	**100%**	**58%**	**21%**	**17%**	**3%**	**100%**
% of risk / development status - M3	38%	31%	31%	100%	55%	22%	23%	0%	100%
% of risk / development status - plan (june)	13%	33%	54%	100%	20%	28%	52%	0%	100%
movement in risk status - M3 to M4	9%	3%	-11%	0%	3%	0%	-6%	3%	0%

Financial Recovery

3.26 The ICB has established a Recovery programme to oversea the delivery against its efficiency programme and other transformation programmes across the system. Progress is managed via the ICB Recovery Sub-Committee which reports to the Executive Committee.

Fig 2 presents the M4 position for the combined recovery and efficiency plan.

Table 13: Month 4 combined recovery and efficiency plan

Programme Name	YTD (M4)			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
All Age Continuing Health Care/Complex Care	6,902	4,925	(1,978)	59,465	49,974	(9,491)
Cheshire Urgent Care Improvement	1,654	283	(1,371)	4,965	4,965	0
Medicines Management	8,148	6,034	(2,114)	30,700	28,974	(1,726)
Mental Health - A&E/Out of Area Placements	0	0	0	10,953	1,624	(9,330)
Optimising Patient Choice Independent Sector Value	0	0	0	0	0	0
Unwarranted Variation	172	172	0	864	864	0
Workforce Optimisation	3,308	3,308	0	10,924	9,924	(1,000)
Other	2,419	1,965	(454)	8,750	8,697	(53)
TOTAL	**22,603**	**16,686**	**(5,917)**	**126,621**	**105,021**	**(21,600)**

3.27 **AACC** - The AACC Recovery Programme Target is £53.3m (excluding S117), which is the overall reduction in expenditure required for Cheshire and Merseyside ICB to meet the England average expenditure for AACC. A comprehensive set of plans are in progress to drive improvement but the impact on run rate is not yet being seen to provide confidence that expenditure will be managed within budget this year. This is a key risk to the in-year financial position of the ICB.

3.28 **Medicines Management** – £9.8m has now been identified as the annual opportunity related to high-cost drugs and devices, the forecast for 24/25 is still to be determined with efficiencies unlikely to be realised until Q3 (work on drug switch has commenced). With regards to primary care prescribing, place level QIPP data for M5 shows Cheshire East and Knowsley forecasted to be significantly behind plan. With regards to primary care prescribing, place level QIPP data for M5 shows Cheshire East and Knowsley forecasted to be significantly behind plan. Mitigations are underway to reduce the gap in both Places which are directly related to capacity challenges.

3.29 **Mental Health** – A&E/Out of Area Placements – as shown there is currently a forecasted under-achievement of £9.3m, plans are not yet sufficiently developed to provide confidence that this target will be delivered. Non recurrent slippage opportunities on investments are being identified to mitigate the underachievement in year whilst recurrent plans are developed.

3.30 **Workforce** – work has taken place to understand achievement against the 30% running cost target reduction and we are confident that the 20% required savings for 2024/25 will be delivered. There has been a further review of agency use and fixed terms contracts and these are being terminated where appropriate. Further work has been undertaken on off-payroll appointments and a plan will be developed to end these. Preparation is underway to get permission to run a further MARS scheme should that be needed. Total vacancy freeze for all non-clinical posts remains in place until at least January 2025, as which time it will be reviewed.

Risk Adjusted Forecast

3.31 An exercise was undertaken July and early August to identify the current risks and gaps in organisational plans. This was not a changing of organisations' plans, but an in year estimate of the scale of any additional mitigation required to deliver the overall system plan.

3.32 Most organisations provided analysis which set out how the risks to in year delivery of plan would be mitigated and reflected a risk adjusted forecast in line with plan. However, 5 organisations indicated that there was still work to do to fully mitigate the risks being reported. They are:

Unmitigated risk as assessed in August 2024:

- Mid Cheshire £5m
- Warrington & Halton £8.4m
- Wirral University Teaching Hospital £7m
- Liverpool University Teaching Hospitals £15.9m
- Bridgewater £1.9m
- ICB £25m
- **Total unmitigated risk = £63.3m**

3.33 The ICB itself will need significant further mitigations actions in order to deliver its plan. Table 15 below provides a summary of the ICB financial forecast for 2024/25 and represents the most likely scenario given the status of current plans.

Table 15 - ICB Forecast Risks and Mitigations

ICB Forecast Risk and Mitigation - Cheshire & Merseyside	
	£m
ICB Planned Position +/-	62.3
In year pressures	
CHC	-28.5
MH Packages	-24.6
Prescribing	-14.1
Efficiency Delivery	-6.7
MH Recovery Programme	-10.9
Complex Care Recovery Programme	-3.3
Other Place Risks	-8.6
Total	**-96.7**
Mitigations	**£m**
Place Mitigations (Green and Amber schemes)	46.8
ERF	4.0
CHC/MH Package Uplifts	10.7
Total	**61.5**
Further investment slippage still subject to agreement	**10.2**
Total mitigations	**71.7**
MITIGATED FORECAST	**37.3**
MITIGATED VARIANCE TO PLAN	**-25.0**

3.34 The CEO and CFO have met with each Place Director during September to review forecast against plans and the mitigations being pursued by each place team. Green and amber mitigations have been included above with further work being done to firm up red rated schemes which are not yet reflected (total £3m).

3.35 It should be noted that £10m of this forecast assumes slippage on investments which are still subject to internal agreement and will need national approval. There is also still considerable risk in prescribing and CHC positions given the levels of efficiency which are expected in the last half of the year. At this stage in the year, prescribing forecasts are also based on only 3 months of data.

3.36 As can be seen from the analysis above, even with the level of mitigations currently identified, the most likely scenario at this stage is that the ICB will be £25m away from its board approved plan and therefore further urgent work is needed to address this gap.

3.37 Given the profile of our cost base, the only areas where we will be able to reasonably reduce in year spend are:-

- further management of the costs of CHC and MH packages.
- further reductions in prescribing spend, including pass through high cost drugs.

3.38 Until this gap is fully mitigated, the ICB will need to review every item of expenditure which is not currently committed. Work is ongoing to identify the actions required to improve this position and an updated risk adjusted forecast will be reported to the next meeting.

Provider and Primary Care Capital

3.39 The 'Charge against Capital Allocation' represents the System's performance against its operational capital allocation, which is wholly managed at the System's discretion. For 2024/25 the System's Secondary Care allocation in 2023/24 is £258.4m, and a Primary Care allocation of £4.7m. The plan submitted in May sets out an overprogramming position against allocation of c£12m with plans to spend £270.5m. It is expected that the overprogramming position will be managed in year.

3.40 **Tables 16 & 17** sets out the YTD Month 4 position capital expenditure against plan at a system level but also the ICB's primary care capital position. At Month 4 there is a £11.2m underspend against YTD plan, with a £24.2m forecast variance against full year plan in relation to additional spend forecast at the Mid-Cheshire Leighton site to address the ongoing RAAC programme. The ICS has been provided with additional allocation by the national team to continue with the RAAC works. The £11.4m adverse forecast variance to allocation remains as per the planning position and work is ongoing with providers to manage this position.

Table 16 - System (Provider & ICB) - Charge against Capital Allocation M4

Provider - Charge against allocation	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	Forecast Year Ending £'000	Variance Year Ending £'000	%
Total Provider charge against allocation	**76,813**	**65,553**	**11,261**	**310,328**	**334,536**	**(24,208)**	**(7.8%)**
Capital allocation					323,101		
Variance to allocation					(11,435)		
Allocation met					No		

Table 17 – ICB - Charge against allocation

ICB - Charge against allocation							
	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	Forecast Year Ending £'000	Variance Year Ending £'000	%
Cheshire And Merseyside ICB	-	-	-	4,698	4,698	-	0.0%
Capital allocation					4,698		
Variance to allocation					-		
Allocation met					Yes		

4. Ask of the Committee and Recommendations

4.1 The Board is asked to

- Note the contents of this report in respect of the Month 4 ICS financial position for both revenue and capital allocations within the 2024/25 financial year.

- Note the risk adjusted forecast of £63m adverse variance to our £150m system deficit plan which required urgent corrective action from both providers and the ICB.

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5. Officer contact details for more information

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6. Appendices

Appendix 1: **Continuing Care and Complex Care Forecast Outturn by Place M4**
Appendix 2: **Provider Income and Expenditure vs YTD Plan**
Appendix 3: **Agency Expenditure M4 YTD by provider**
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Appendix 1

Continuing Care and Complex Care Forecast Outturn by Place as at 31st July 2024

Continuing Care M4 Forecast Variance (£'000)	Total	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
FYE of Packages 23/24	-3,868	1,329	5,810	-697	1,985	550	-6,379	-1,779	-234	-4,453
Prior Year Impact (relating to 23/24)	2,585	331	669	100	0	0	232	0	159	1,094
Volume above 4.3% (24/25)	4,438	-694	559	1,297	-875	2,176	5	2,249	515	-795
Price/Inflation above 1.9% (24/25)	-17,484	-5,712	-2,998	-899	-895	-3,190	-236	-1,256	-1,951	-346
QIPP Delivered YTD (inherent in Price/Volume)	-7,716	-926	-442	-788	-977	-1,537	-431	-615	-323	-1,676
Non Package Driven	-357	-117	-61	-125	38	-234	61	-208	160	129
Other Planning Adjustments	-3,293	-357	-708	-87	0	299	-1,421	17	88	-1,125
QIPP Underdelivery	-928	0	0	-109	0	0	0	0	-818	0
In Year Budget Changes	195	228	-33	0	0	0	0	0	0	0
Other	101	104	106	17	7	2	-42	10	-26	-77
Grand Total	**-26,328**	**-5,813**	**2,902**	**-1,292**	**-717**	**-1,934**	**-8,211**	**-1,581**	**-2,432**	**-7,250**

Complex Care (Packages) M4 Forecast Variance (£'000)	Total	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
FYE of Packages 23/24	-9,558	-1,332	367	-427	15	-5,255	-1,714	-1,427	268	-54
Prior Year Impact (relating to 23/24)	3,282	1,000	571	313	0	0	-51	-23	270	1,203
Volume above 4.3% (24/25)	-4,585	-886	-1,638	-309	-170	2,180	-2,376	-1,372	379	-392
Price/Inflation above 1.9% (24/25)	-6,381	210	-1,573	-640	-841	-2,331	1,070	1,493	-855	-2,912
QIPP Delivered YTD (inherent in Price/Volume)	-3,235	21	-7	-326	0	-2,006	-0	0	-352	-565
Non Package Driven	549	361	31	-24	13	207	-23	-2	-28	14
Other Planning Adjustments	-4,066	-1,000	-571	-313	0	-2	-1,264	0	379	-1,295
QIPP Underdelivery	-370	0	0	-145	0	0	0	0	-225	0
In Year Budget Changes	-260	-250	-10	0	0	0	0	0	0	0
Other	56	2	38	0	86	-20	-0	34	-59	-25
Grand Total	**-24,568**	**-1,874**	**-2,792**	**-1,872**	**-897**	**-7,228**	**-4,358**	**-1,297**	**-224**	**-4,026**

Appendix 2: Provider Income and Expenditure vs YTD Plan

	Income - Month 4 YTD			Total Pay - Month 4 YTD			Non Pay - Month 4 YTD			Other Operating Items			Income YTD Variance	Pay YTD Variance	Non Pay YTD Variance	Other Operating YTD Var
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance				
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%	%	%	%
Alder Hey Children's	134,446	139,686	**5,241**	(87,114)	(87,042)	**72**	(47,526)	(53,124)	**(5,597)**	(2,452)	(2,586)	**(134)**	3.9%	0.1%	-10.5%	-5.2%
Bridgewater Community	32,079	32,666	**587**	(22,438)	(23,193)	**(755)**	(9,922)	(10,074)	**(152)**	59	67	**8**	1.8%	-3.3%	-1.5%	-12.6%
Cheshire & Wirral Partnership	89,271	92,700	**3,429**	(70,327)	(72,653)	**(2,326)**	(18,272)	(19,581)	**(1,309)**	(603)	(395)	**208**	3.8%	-3.2%	-6.7%	52.6%
Countess of Chester Hospitals	111,810	114,900	**3,090**	(86,901)	(86,746)	**155**	(34,665)	(41,810)	**(7,145)**	(780)	(631)	**149**	2.8%	0.2%	-17.1%	23.6%
East Cheshire Trust	66,555	67,551	**996**	(48,069)	(49,713)	**(1,644)**	(24,356)	(24,207)	**149**	(672)	(559)	**113**	1.5%	-3.3%	0.6%	20.2%
Liverpool Heart & Chest	79,229	82,543	**3,314**	(36,610)	(37,846)	**(1,236)**	(38,555)	(41,608)	**(3,053)**	(292)	(153)	**139**	4.2%	-3.3%	-7.3%	91.3%
Liverpool University Hospitals	383,409	397,880	**14,471**	(278,798)	(290,173)	**(11,375)**	(145,059)	(153,383)	**(8,324)**	(8,076)	(7,257)	**819**	3.8%	-3.9%	-5.4%	11.3%
Liverpool Women's	49,460	49,251	**(209)**	(35,694)	(35,028)	**666**	(23,222)	(23,759)	**(537)**	(780)	(691)	**89**	-0.4%	1.9%	-2.3%	12.9%
Mersey Care	243,129	246,244	**3,115**	(187,760)	(183,354)	**4,406**	(51,775)	(59,632)	**(7,857)**	(1,718)	(1,382)	**336**	1.3%	2.4%	-13.2%	24.3%
Mid Cheshire Hospitals	129,161	131,426	**2,265**	(96,602)	(97,524)	**(922)**	(41,805)	(44,679)	**(2,874)**	(2,259)	(1,966)	**293**	1.8%	-0.9%	-6.4%	14.9%
Mersey & West Lancs	296,344	294,218	**(2,126)**	(201,850)	(204,149)	**(2,299)**	(99,232)	(98,320)	**912**	(10,212)	(8,599)	**1,613**	-0.7%	-1.1%	0.9%	18.8%
The Clatterbridge Centre	95,064	98,649	**3,585**	(35,380)	(36,297)	**(917)**	(58,665)	(61,916)	**(3,251)**	(956)	(368)	**588**	3.8%	-2.5%	-5.3%	159.7%
The Walton Centre	61,988	63,501	**1,513**	(31,176)	(32,219)	**(1,043)**	(28,982)	(29,636)	**(654)**	(126)	79	**205**	2.4%	-3.2%	-2.2%	-259.3%
Warrington & Halton Hospitals	112,276	114,180	**1,904**	(88,313)	(90,031)	**(1,718)**	(36,107)	(37,572)	**(1,465)**	(1,461)	(1,197)	**264**	1.7%	-1.9%	-3.9%	22.1%
Wirral Community	33,851	34,286	**435**	(25,241)	(25,375)	**(134)**	(8,335)	(8,657)	**(322)**	(266)	(240)	**25**	1.3%	-0.5%	-3.7%	10.6%
Wirral University Hospitals	162,850	160,126	**(2,724)**	(116,695)	(118,885)	**(2,190)**	(53,262)	(51,926)	**1,336**	(1,835)	(1,456)	**380**	-1.7%	-1.8%	2.6%	26.1%
TOTAL Providers	**2,080,922**	**2,119,807**	**38,885**	**(1,448,968)**	**(1,470,228)**	**(21,260)**	**(719,740)**	**(759,883)**	**(40,143)**	**(32,429)**	**(27,333)**	**5,096**	**1.9%**	**-1.4%**	**-5.6%**	**15.7%**

Appendix 3 – Agency Expenditure M4 YTD by provider

Organisation	2023/24		2024/25 PLAN		2024/25 YTD ACTUAL				2024/25 EXTRAPOLATED		2024/25 FOT	
	23/24 Actual	23/24 Actual as a % of total 23/24 Pay	24/25 FY Plan	24/25 FY Plan as a % of Pay Plan	24/25 M4 YTD Plan	24/25 M4 YTD Actual	24/25 M4 YTD Variance	24/25 M4 Actual as a % of M4 Pay Actual	M4 YTD Extrapolated for year	Variance M4 Extraplorated vs FY Plan	Agency FOT	Agency FOT vs FY plan
	£,000	%	£,000	%	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Alder Hey Children's NHS Foundation Trust	(2,070)		(599)	0.2%	(200)	(557)	(357)	0.6%	(1,671)	(1,072)	(1,878)	(1,279)
Bridgewater Community Healthcare NHS Foun	(4,824)		(1,456)	2.3%	(722)	(838)	(116)	3.6%	(2,514)	(1,058)	(1,659)	(203)
Cheshire and Wirral Partnership NHS Foundati	(9,649)		(8,161)	3.9%	(3,250)	(3,278)	(28)	4.5%	(9,834)	(1,673)	(10,486)	(2,325)
Countess of Chester Hospital NHS Foundation	(6,026)		(4,948)	1.9%	(1,681)	(1,839)	(158)	2.1%	(5,517)	(569)	(4,948)	0
East Cheshire NHS Trust	(8,392)		(7,280)	5.2%	(2,267)	(2,242)	25	4.5%	(6,726)	554	(7,280)	0
Liverpool Heart and Chest Hospital NHS Founc	(922)		(900)	0.8%	(300)	(226)	74	0.6%	(678)	222	(900)	0
Liverpool University Hospitals NHS Foundation	(18,136)		(10,013)	1.2%	(4,516)	(4,558)	(42)	1.6%	(13,675)	(3,662)	(10,013)	0
Liverpool Women's NHS Foundation Trust	(686)		(1,354)	1.3%	(451)	(214)	237	0.6%	(642)	712	(516)	838
Mersey Care NHS Foundation Trust (inc NWB)	(19,010)		(18,019)	3.2%	(6,003)	(5,583)	420	3.0%	(16,749)	1,270	(15,458)	2,561
Mid Cheshire Hospitals NHS Foundation Trust	(13,238)		(8,511)	3.0%	(2,812)	(4,164)	(1,352)	4.3%	(12,492)	(3,981)	(8,811)	(300)
Mersey & West Lancashire Teaching Hospitals	(22,657)		(17,916)	3.0%	(5,972)	(8,563)	(2,591)	4.2%	(25,689)	(7,773)	(17,916)	0
The Clatterbridge Cancer Centre NHS Founda	(1,809)		(726)	0.7%	(260)	(511)	(251)	1.4%	(1,533)	(807)	(980)	(254)
The Walton Centre NHS Foundation Trust	(670)		0	0.0%	0	(280)	(280)	0.9%	(840)	(840)	(841)	(841)
Warrington and Halton Teaching Hospitals NHS	(8,900)		(7,313)	2.9%	(2,252)	(1,284)	968	1.4%	(3,852)	3,461	(7,313)	0
Wirral Community Health and Care NHS Founc	(1,170)		(362)	0.4%	(121)	(291)	(170)	1.1%	(872)	(510)	(474)	(112)
Wirral University Teaching Hospital NHS Founc	(10,298)		(4,229)	1.3%	(1,446)	(3,890)	(2,444)	3.3%	(11,669)	(7,440)	(10,297)	(6,068)
TOTAL C&M Providers	**(128,456)**	**2.9%**	**(91,787)**	**2.1%**	**(32,252)**	**(38,318)**	**(6,066)**	**2.6%**	**(114,953)**	**(23,166)**	**(99,770)**	**(7,983)**
Agency Cap set by NHSE	(127,322)		(120,662)			(40,221)			(120,662)		(120,662)	
Variance to Cap - favourable / (adverse)	(1,134)		28,875			1,903			5,709		20,892	

Appendix 4 – Workforce Analysis M4 vs M12 trend and M4 Plan by Provider

	2023/24	2024/25	2024/25	2024/25	2024/25	M4 Variance		M3 to M4	Movement vs M12		2024/25
Workforce (WTEs) - source PWRs / June plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M4 Variance from plan favourable / (adverse)		Change in month M4 vs M3 (increase) / decrease	M12 23/24 to M4 24/25 Actuals decrease / (increase)		M12 Plan (March 25)
	WTE	WTE	WTE	WTE	WTE	WTE	%	WTE	WTE	% move	WTE
Alder Hey Children's NHS Fou	4,368	4,333	4,347	4,326	4,334	6	0.1%	(8)	34	0.8%	4,298
Bridgewater Community Healt	1,434	1,453	1,462	1,447	1,454	0	0.0%	(7)	(20)	-1.4%	1,472
Cheshire and Wirral Partnersl	4,072	4,061	4,024	4,017	4,000	(27)	-0.7%	17	71	1.8%	4,015
Countess of Chester Hospital	4,886	4,849	4,783	4,809	4,829	79	1.6%	(19)	57	1.2%	4,657
East Cheshire NHS Trust	2,675	2,691	2,633	2,633	2,656	11	0.4%	(23)	19	0.7%	2,633
Liverpool Heart and Chest Ho	1,912	1,874	1,880	1,898	1,886	14	0.8%	12	26	1.4%	1,880
Liverpool University Hospitals	15,448	15,261	15,163	15,041	15,228	(1,138)	-7.5%	(187)	220	1.4%	13,915
Liverpool Women's NHS Four	1,687	1,703	1,718	1,717	1,715	58	3.4%	2	(28)	-1.7%	1,774
Mersey Care NHS Foundatior	11,623	11,344	11,224	11,091	11,244	140	1.2%	(153)	379	3.3%	11,316
Mid Cheshire Hospitals NHS F	5,687	5,445	5,425	5,398	5,429	(65)	-1.2%	(31)	258	4.5%	5,339
Mersey & West Lancashire T	10,614	10,458	10,538	10,478	10,556	78	0.7%	(79)	58	0.5%	10,566
The Clatterbridge Cancer Cer	1,893	1,890	1,919	1,920	1,896	(155)	-8.2%	24	(3)	-0.1%	1,746
The Walton Centre NHS Four	1,562	1,554	1,522	1,570	1,552	6	0.4%	18	10	0.7%	1,558
Warrington and Halton Teach	4,786	4,626	4,646	4,637	4,657	(51)	-1.1%	(19)	129	2.7%	4,544
Wirral Community Health and	1,560	1,587	1,579	1,567	1,566	(30)	-1.9%	1	(6)	-0.4%	1,952
Wirral University Teaching Ho	6,258	6,389	6,499	6,300	6,350	(35)	-0.6%	(50)	(92)	-1.5%	6,297
C&M Providers Total	**80,465**	**79,607**	**79,361**	**78,849**	**79,352**	**(1,110)**	**-1.4%**	**(502)**	**1,113**	**1.4%**	**77,963**

Appendix 5A - System Efficiencies: Current Performance M4

	CIP Efficiency - YTD Delivery						CIP Recurrent / Non Recurrent YTD			YTD CIP as a % of FY CIP Plan	
	M4 YTD Plan	M4 YTD Actual	M4 YTD Variance	M4 YTD % Variance	M4 CIP actual as a % of Op Ex	FY CIP Plan % of Op Ex	Actual Recurrent	Actual Non Recurrent	Actual Recurrent as a % of YTD plan	full year CIP (new plan)	YTD CIP as a % of FY CIP plan
	£,000	£,000	£,000	%	%	%	£,000	£,000	%	£,000	%
Alder Hey Children's	4,064	4,064	(0)	0%	2.8%	4.8%	4,004	60	99%	19,950	20%
Bridgewater Community	892	579	(313)	-35%	1.7%	6.9%	179	400	20%	6,939	8%
Cheshire & Wirral Partnership	4,168	2,938	(1,230)	-30%	3.1%	5.0%	1,410	1,528	34%	13,913	21%
Countess of Chester Hospitals	3,899	1,851	(2,048)	-53%	1.4%	5.3%	1,851	0	47%	19,822	9%
East Cheshire Trust	1,925	1,905	(20)	-1%	2.5%	5.0%	758	1,146	39%	11,225	17%
Liverpool Heart & Chest	3,238	1,998	(1,240)	-38%	2.5%	4.6%	1,561	438	48%	10,644	19%
Liverpool University Hospitals	27,223	21,576	(5,647)	-21%	4.6%	8.5%	7,944	13,632	29%	114,600	19%
Liverpool Women's	1,350	1,533	183	14%	2.5%	3.3%	630	903	47%	5,904	26%
Mersey Care	8,655	8,655	0	0%	3.4%	3.5%	8,049	606	93%	25,967	33%
Mid Cheshire Hospitals	7,006	3,964	(3,042)	-43%	2.7%	5.2%	1,752	2,212	25%	22,437	18%
Mersey & West Lancs	10,357	11,290	934	9%	3.6%	4.8%	7,357	3,933	71%	45,165	25%
The Clatterbridge Centre	3,333	3,333	0	0%	3.3%	3.4%	2,354	979	71%	10,000	33%
The Walton Centre	2,776	2,776	0	0%	4.3%	4.5%	2,199	577	79%	8,558	32%
Warrington & Halton Hospitals	3,071	3,239	168	5%	2.5%	5.1%	2,956	283	96%	19,433	17%
Wirral Community	1,583	1,458	(125)	-8%	4.1%	5.4%	237	1,221	15%	6,275	23%
Wirral University Hospitals	6,570	4,670	(1,900)	-29%	2.7%	5.2%	4,670	0	71%	26,878	17%
TOTAL Providers	**90,111**	**75,830**	**(14,281)**	**-16%**	**3.1%**	**5.5%**	**47,912**	**27,918**	**53%**	**367,710**	**21%**
C&M ICB	22,423	16,514	(5,909)	-26%	0.7%	1.0%	16,514	0	74%	72,236	23%
TOTAL ICS	**112,534**	**92,344**	**(20,190)**	**-18%**	**3.7%**	**6.1%**	**64,426**	**27,918**	**57%**	**439,946**	**21%**

Appendix 5B - System Efficiencies: M4 Risk and Development of CIP Plan

	Month 4 (end of July 24) assessment									% of CIP High Risk	% of CIP Opportunity
	CIP RISK				CIP DEVELOPMENT						
	Low £m	Medium £m	High £m	Total £m	Fully £m	In Progress £m	Opportunity £m	Unidentified £m	Total £m	%	%
Alder Hey Children's NHS Foundation Trust	5.0	10.5	4.4	**20.0**	5.0	8.4	6.6	0.0	**20.0**	22%	33%
Bridgewater Community Healthcare NHS Foundation Tru	1.70	0.92	4.33	**6.94**	2.61	0.00	0.00	4.33	**6.94**	62%	62%
Cheshire and Wirral Partnership NHS Foundation Trust	6.5	2.6	4.8	**13.9**	6.5	2.6	0.5	4.3	**13.9**	34%	34%
Countess of Chester Hospital NHS Foundation Trust	5.3	2.7	11.8	**19.8**	5.7	2.9	9.7	1.5	**19.8**	60%	56%
East Cheshire NHS Trust	3.8	2.5	4.9	**11.2**	3.8	2.5	4.9	0.0	**11.2**	44%	44%
Liverpool Heart and Chest Hospital NHS Foundation Trus	5.0	3.4	2.3	**10.6**	2.6	5.4	2.6	0.0	**10.6**	22%	24%
Liverpool University Hospitals NHS Foundation Trust	59.6	33.4	21.0	**114.0**	93.6	0.3	20.1	0.0	**114.0**	18%	18%
Liverpool Women's NHS Foundation Trust	2.2	3.7	0.0	**5.9**	3.6	2.3	0.0	0.0	**5.9**	0%	0%
Mersey Care NHS Foundation Trust	12.2	13.8	0.0	**26.0**	10.4	15.6	0.0	0.0	**26.0**	0%	0%
Mid Cheshire Hospitals NHS Foundation Trust	8.8	7.2	6.5	**22.4**	13.4	2.9	6.2	0.0	**22.4**	29%	28%
Mersey & West Lancashire Teaching Hospitals NHS Trus	29.3	14.9	3.8	**48.0**	30.7	13.2	4.0	0.0	**48.0**	8%	8%
The Clatterbridge Cancer Centre NHS Foundation Trust	6.1	1.5	2.4	**10.0**	6.1	1.5	2.4	0.0	**10.0**	24%	24%
The Walton Centre NHS Foundation Trust	4.4	4.0	0.1	**8.6**	1.7	6.9	0.0	0.0	**8.6**	2%	0%
Warrington and Halton Teaching Hospitals NHS Foundat	11.5	4.0	3.9	**19.4**	11.4	7.2	0.8	0.0	**19.4**	20%	4%
Wirral Community Health and Care NHS Foundation Trus	1.4	3.3	1.6	**6.3**	2.8	0.8	1.6	1.1	**6.3**	25%	43%
Wirral University Teaching Hospital NHS Foundation Trus	12.6	9.5	4.8	**26.9**	16.4	10.5	0.0	0.0	**26.9**	18%	0%
C&M ICB	29.0	31.3	12.0	**72.2**	40.9	11.2	16.8	3.4	**72.2**	17%	28%
Total	**204.3**	**149.2**	**88.6**	**442.2**	**257.2**	**94.1**	**76.2**	**14.6**	**442.2**	**20%**	**21%**
% of risk / development status - M4	**46%**	**34%**	**20%**	**100%**	**58%**	**21%**	**17%**	**3%**	**100%**		
% of risk / development status - M3	38%	31%	31%	100%	55%	22%	23%	0%	100%		
% of risk / development status - Plan	13%	33%	54%	100%	20%	28%	52%	0%	100%		

Appendix 6: Provider Capital Expenditure YTD and FOT vs ICS Allocation at Month 4

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	Forecast Year Ending £'000	Variance Year Ending £'000	%
Alder Hey Children'S NHS Foundation Trust	948	1,181	(233)	16,923	16,923	-	0.0%
Bridgewater Community Healthcare NHS Foundation Trust	2,633	1,325	1,308	4,467	3,994	473	10.6%
Cheshire And Wirral Partnership NHS Foundation Trust	2,412	1,962	450	7,866	7,866	-	0.0%
Countess Of Chester Hospital NHS Foundation Trust	24,100	18,416	5,684	77,750	77,750	-	0.0%
East Cheshire NHS Trust	1,870	1,443	427	6,222	6,222	-	0.0%
Liverpool Heart And Chest Hospital NHS Foundation Trust	2,343	1,974	369	7,811	7,811	-	0.0%
Liverpool University Hospitals NHS Foundation Trust	9,592	7,731	1,861	59,398	59,398	-	0.0%
Liverpool Women'S NHS Foundation Trust	2,041	958	1,083	5,035	5,035	-	0.0%
Mersey Care NHS Foundation Trust	4,492	3,726	766	36,254	36,254	-	0.0%
Mid Cheshire Hospitals NHS Foundation Trust	5,609	10,634	(5,025)	13,553	38,234	(24,681)	(182.1%)
Mersey and West Lancashire Teaching Hospitals NHS Trust	9,351	5,541	3,810	28,256	28,256	-	0.0%
The Clatterbridge Cancer Centre NHS Foundation Trust	2,404	2,958	(554)	11,110	11,110	(0)	(0.0%)
The Walton Centre NHS Foundation Trust	584	745	(161)	6,890	6,890	-	0.0%
Warrington And Halton Teaching Hospitals NHS Foundation Trust	3,429	2,837	592	9,470	9,470	-	0.0%
Wirral Community Health And Care NHS Foundation Trust	2,144	1,489	655	6,453	6,453	-	0.0%
Wirral University Teaching Hospital NHS Foundation Trust	2,862	2,633	229	12,870	12,870	-	0.0%
Total Provider charge against allocation	**76,813**	**65,553**	**11,261**	**310,328**	**334,536**	**(24,208)**	**(7.8%)**
Capital allocation					323,101		
Variance to allocation					(11,435)		
Allocation met					No		

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

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

Agenda Item No: ICB/09/24/08

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

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

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	20 August 2024 & 17 September 2024

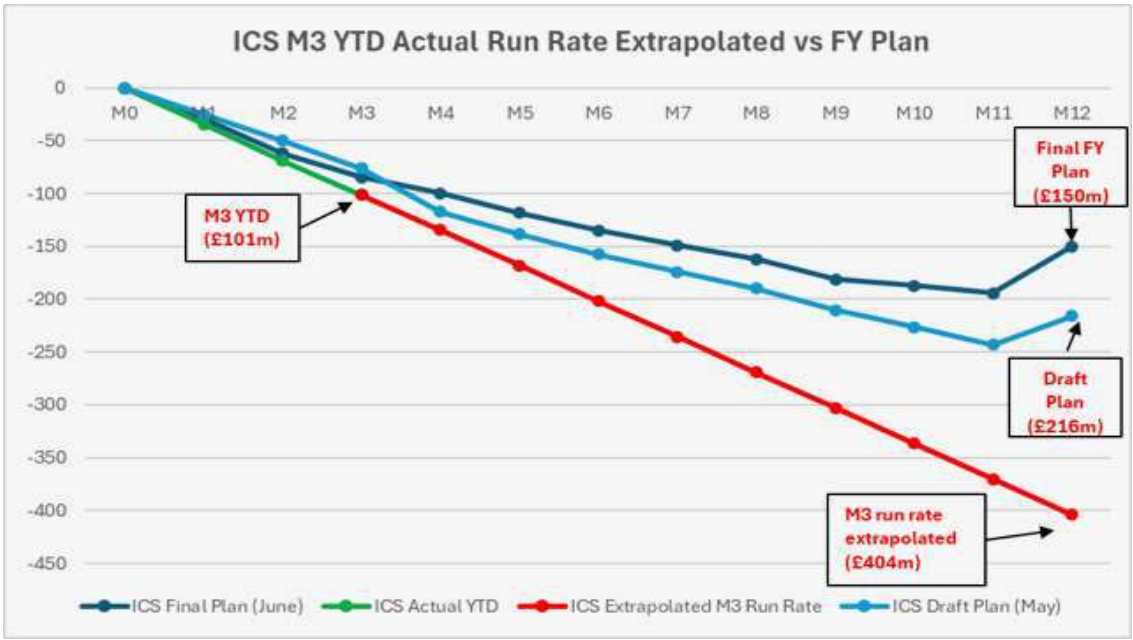
Key escalation and discussion points from the Committee meeting

Alert

From the Committee meeting on 20 August 2024

- **Month 3 position**
  As of 30th June 2024 (Month 3) the ICS is reporting aYTD deficit of £101.0m against a planned YTD deficit of £84.5m resulting in an adverse YTD variance of £16.4m (0.9%).
- **Month 4 tabled position**
  as of the 31st July (Month 4) the ICS is reporting a YTD deficit of £138.0m against a planned YTD deficit of £99.5m, resulting in an adverse YTD variance of £38.6m). This is 92% of the overall FY planned deficit of £150m.

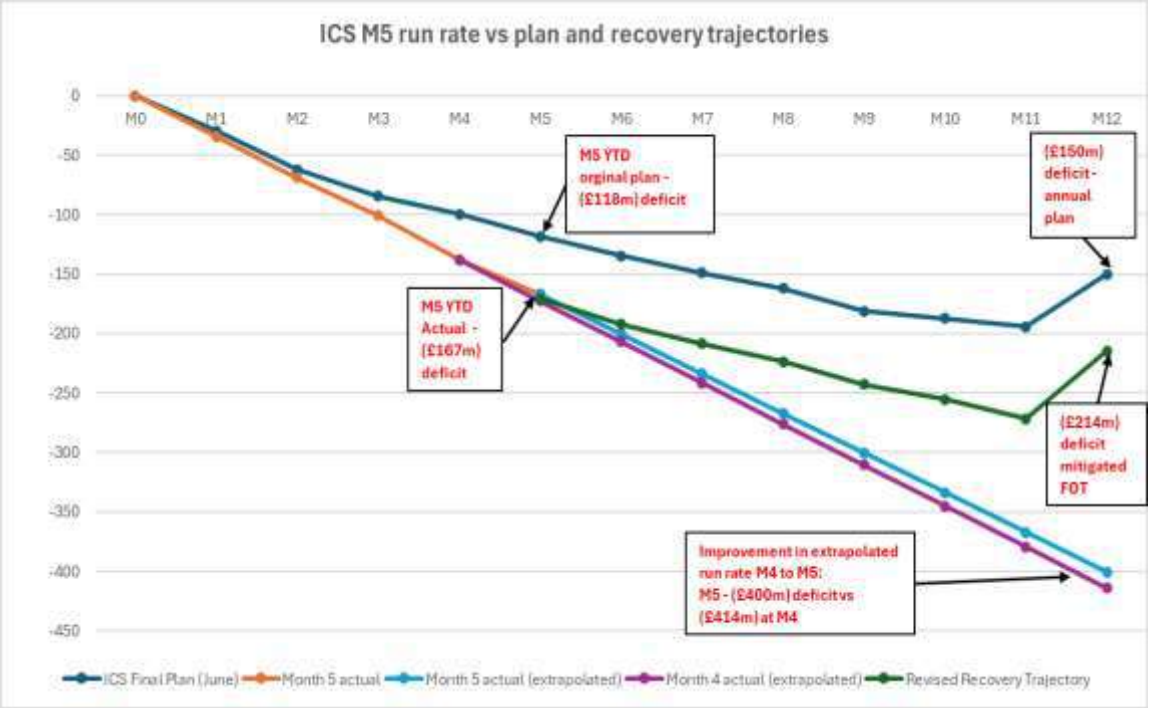
- There is considerable risk in the delivery of both provider and ICB financial positions, with early corrective action required to accelerate implementation of efficiency plans to support deliver of the overall system financial plan. Key challenges remain:
  - Poor CIP trajectory (recurrent = 57% of total plan)
  - Workforce/variable pay pressures above plan
  - Package costs of CHC and Mental Health above plan
  - Prescribing costs above plan



From the Committee meeting on 17 September 2024

- **Month 4 position**
  As of the 31st July (Month 4) the ICS is reporting a YTD deficit of £138.0m against a planned YTD deficit of £99.5m, resulting in an adverse YTD variance of £38.6m). This is 92% of the overall FY planned deficit of £150m.
  Detailed report shared, with analysis of provider and ICB financial position covering revenue, WTEs, efficiencies and capital.

- **Month 5 tabled position**
  As of the 31st August (Month 5) the ICS is reporting a YTD deficit of £166.9m against a planned YTD deficit of £118.4m, resulting in an adverse YTD variance of £48.5m.This is 112% of the overall FY planned deficit of £150m.
  Key drivers are undelivered efficiencies, overspends on CHC and Prescribing, Industrial Action and Thirlwell enquiry costs.



- **Recovery position**
  At Month 4 the recovery plan is £6m behind plan. Forecast variance, with no further action is a variance of £21.6m.

- **PwC External Review**
  The first phase of the external review is drawing to an end, with the report – covering recommendation s for individual providers, the ICB and the ICS as a whole – due to be published shortly. Recommendations include weekly review of KPIS that drive financial improvement, individual support for 4 providers and additional support for the ICB in the areas of Prescribing and CHC.

Advise

From the Committee meeting on 20 August 2024

- **FIRC Membership for short-form meetings to include:**
  Provider collaborative representation, Workforce Executive, Quality & Safety Executive, Non-executive Director, Finance Executive and Assistant CEO.

- **Feedback from External Review work**
  - Individual Provider/ICB reports from PwC almost complete, with circa 20+ immediate actions. These actions will need to be monitored to ensure delivery.
  - NHS nominated lead: Simon Worthington – appointed to provide increased focus on in-year delivery of financial position.
  - Resubmission of workforce plan is being undertaken to address errors relating to hosted WTEs. Increased focus required on what we can control.

- **Update on 24/25 Recovery programme**
  Recovery committee update on UEC and further deep dives to follow on CHC/MH including trajectories/Risk assessments/escalation

From the Committee meeting on 17 September 2024

- **Revised Workplan**
  Updated to take into account additional monthly monitoring of the financial position.

- **Procurement update**
  Health and Non-Health procurement decision plan updates presented with information on the implementation of the new Procurement Act 2023.
  Position on accreditation requests for new providers under PSR Direct award route B presented.
  Procurement route decisions approved by the Procurement Decision Review Group noted.
  Requirement for continuity of contracts for NEPTS noted due to delays in the recent pan North West procurement.

- **MLCSU update**
  six- month report setting out the financial and non-financial benefits

- **System Infrastructure Strategy**
  Strategy approved and submitted to Board for Approval.
  Creation of strategic Estates Board approved.
  Link to key risks around backlog maintenance noted.

Assure

N/a

Committee risk management

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

From the Committee meeting on 17th September 2024

Discussed further consideration of Risk/BAF for system infrastructure and will be considered by Executive, following ratification of Infrastructure Strategy at Board.

Discussed workforce challenges post transfer of services from CSU. Paper to be provided at future FIRC with detail.

Risk of in-year financial delivery currently 20 and retained.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Development and delivery of a Cheshire and Merseyside system-wide financial strategy for 2024/5	24/25 Financial Plan report for both ICB and Specialised Commissioning
Delivery of the Finance Efficiency & Value Programme	Month 3, 4 and 5 finance report
Development and delivery of the Capital Plans.	Month 3 & 4 finance report
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	System Infrastructure Strategy

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Integrated Performance Report

Agenda Item No: ICB/09/24/09

Responsible Director: Anthony Middleton: Director of Performance and Planning

Integrated Performance Report

1. Purpose of the Report

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

2. Executive Summary

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

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

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

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

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

Reviewing the quality and performance of services, providers and place enables the ICB to set system plans that support improvement against health inequalities.

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

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

9. Risks

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

9.2 Additionally, waits for cancer and elective treatment, particularly due to industrial action and winter pressures within the urgent care system could result in reduced capacity and activity leading to poor outcomes, which maps to Board Assurance Framework Risk P3.

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report.

NHS
Cheshire and Merseyside

Integrated Performance Report

26th September 2024

Index

Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

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

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

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

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

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

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

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Aug-24	73.2%	71.0%	69.7%	68.9%	69.4%	68.9%	68.1%	71.9%	72.1%	71.1%	72.7%	74.4%	74.3%	75.2%	78% by Year end	73.8%	76.3%	30/42
	Ambulance category 2 mean response time	Aug-24	00:35:13	00:39:13	00:39:41	00:43:45	01:04:31	00:49:45	00:43:30	00:29:31	00:24:49	00:33:02	00:34:47	00:37:59	00:24:58	-	00:30:00	00:21:03	00:27:25	-
	A&E 12 hour waits from arrival	Aug-24	14.6%	16.5%	17.0%	16.6%	16.1%	18.5%	16.7%	15.7%	15.8%	16.8%	15.8%	15.6%	15.5%	-	-	12.8%	8.6%	39/42
	Adult G&A bed occupancy	Aug-24	95.0%	96.0%	96.5%	96.9%	95.3%	96.6%	95.9%	96.0%	95.3%	95.8%	95.9%	95.5%	94.9%	93.4%	92.0%	94.3%	95.4%	30/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Aug-24	19.2%	20.8%	20.1%	20.6%	20.8%	21.0%	19.8%	20.1%	21.6%	21.8%	21.3%	21.5%	19.9%	12.8%	*	16.3%	13.9%	42/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jul-24	4,888	5,078	5,393	4,842	5,227	4,732	3,736	2,195	2,324	2,331	2,285	2,098		753	-	6,089	50,860	-
	Number of 52+ week RTT waits, of which children under 18 years.	Aug-24							1,497	1,446	1,471	1,505	1,542	1,493	1,295	1,534	-	n/a	n/a	-
	Total incomplete Referral to Treatment (RTT) pathways	Jul-24	375,312	372,005	376,230	369,440	372,974	369,750	371,542	365,756	367,759	369,179	368,967	370,607		373,388	-	1,071,993	7,624,600	-
	Patients waiting more than 6 weeks for a diagnostic test	Jul-24	23.3%	23.0%	20.0%	16.0%	17.2%	16.2%	10.7%	10.0%	10.2%	10.0%	10.1%	9.0%		10.0%	10.0%	17.9%	22.4%	3/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Jun-24	70.3%	71.3%	70.1%	70.9%	71.8%	67.2%	69.0%	75.4%	70.9%	71.8%	72.1%			70.7%	85.0%	70.6%	67.4%	8/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Jun-24	94.7%	94.1%	93.4%	94.0%	95.0%	91.9%	93.2%	92.4%	91.8%	95.4%	94.5%			96.0%	96.0%	94.0%	90.9%	6/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Jun-24	69.5%	68.6%	70.0%	68.9%	70.2%	67.2%	74.8%	76.0%	71.3%	71.4%	73.8%			72.0%	77% by Year end	76.2%	76.3%	33/42
Mental Health	Access rate to community mental health services for adults with severe mental illness	Mar-24	98.0%	101.0%	103.0%	105.0%	107.0%	110.0%	117.0%	121.0%						100.0%	100.0%	105.3%	98.9%	4/42
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Mar-24	65.0%	68.0%	70.0%	72%	75%	75%	76%	78%						60.0%	60.0%	72.0%	69.8%	15/42
	Access rate for Talking Therapies services	Mar-24	63.0%	60.0%	72.0%	67.0%	47.0%	66.0%	66.0%	59.0%						100.0%	100.0%	62.3%	61.8%	25/42
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	Q4 23/24	45.3%			45.0%			57.8%							-	75.0%	63.9%	68.5%	-
	Dementia Diagnosis Rate	Jul-24	66.0%	66.2%	66.5%	66.9%	66.4%	66.3%	66.8%	67.0%	67.0%	67.2%	67.4%	67.7%		66.7%	66.7%	70.3%	65.2%	14/42
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Jul-24	110	110	110	110	110	100	100	100	95	95	95	95		≤ 60	-	285	1,835	31/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Jun 24 YTD	21.3%	26.9%	34.8%	40.1%	45.4%	61.1%	76.0%	91.4%	3.1%	7.3%	12.0%			10.2%	75% by Year end	12.6%	12.7%	23/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Jun-24	86.0%	84.0%	85.0%	80%	83%	80.0%	82.9%	80.0%	84%	87%	84%			70.0%	70.0%	88.0%	84.0%	24/42
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Apr-24	87.3%	71.2%	80.9%	94.9%	68.2%	82.8%	85.8%	92.8%	81.3%					100.0%	100.0%	90.7%	87.0%	28/42
	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Jul-24	105.9%	106.9%	102.7%	98.6%	94.3%	106.8%	109.2%	92.8%	122.2%	106.9%	94.0%	109.0%		-	-	112.7%	113.6%	-
	Percentage of appointments made with General Practice seen within two weeks	Jun-24	89.3%	88.7%	89.3%	89.8%	90.8%	91.0%	90.6%	90.1%	88.9%	89.7%	89.5%			85.0%	85.0%	88.5%	88.0%	14/42
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Mar-24	7.31%	7.29%	7.27%	7.24%	7.36%	7.33%	7.27%	7.19%						10.0%	10.0%	7.24%	7.76%	10/42
	Total volume of antibiotic prescribing in primary care	Mar-24	1.082	1.081	1.081	1.077	1.040	1.036	1.040	1.033						0.871	0.871	1.053	0.938	34/42
Note/s	* no national target for 2024/25																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Local Trajectory	National Target	Region value	National value	Latest Rank
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)	Q4 23/24	250.1		262.5			262.8								-	-	248.0	215.0	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Jun-24	92.7%	92.5%	92.4%	92.5%	92.4%	92.8%	92.8%	93.3%	93.0%	95.3%	95.1%			-	-	92.5%	92.8%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)	Q4 23/24	510.9		607.0			531.5								-	-	462.8	438.9	-
Health Inequalities & Improvement	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028**. (rolling 12 months)	May-24	59.2%	59.0%	59.4%	59.4%	59.0%	59.0%	59.1%	59.1%	59.0%	59.0%				70.0%	75% by 2028	57.3%	58.6%	20/42
	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q4 23/24	65.84%		65.89%			69.58%								77.0%	80.0%	70.64%	70.9%	30/42
	Children and young people accessing mental health services as % of LTP trajectory (planned number)	Mar-24	87.4%	89.0%	90.0%	88.0%	89.0%	89.0%	91.0%	90.0%						100.0%	100.0%	107.0%	94.00%	25/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Aug-24				14.3%	14.2%	14.2%	14.1%	13.9%	13.9%	13.8%	13.7%	13.6%	13.7%	12.0%	12.0%	-	12.7%^	-
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Jun-24	3.14	3.16	3.02	3.51	3.12	3.14	2.69	2.95	2.78	2.60	2.63			-	-	-	-	-
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	12 months to Jul 24	581	572	583	576	575	578	582	608	636	655	655	681		439	439	n/a	n/a	23/42~
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Jul 24	793	779	769	768	778	797	788	812	816	823	810	813		518	518	n/a	n/a	38/42~
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Mar-24	1.028	1.039	1.034	1.034	1.017	1.004	1.006	1.001						0.887 to 1.127 *		-	1.000	-
	Never Events	Aug-24	0	5	3	3	3	1	1	3	4	2	2	1	1	0	0	-	-	-
	21+ day Length of Stay	Jul-24	1,295	1,227	1,273	1,187	1,368	1,386	1,396	1,413	1,303	1,379	1,364	1,321		1,298	-	-	-	-
Workforce / HR (ICS total)	Staff in post	Jul-24	71,531	71,902	72,324	72,903	72,993	73,069	73,344	73,267	73,078	73,011	72,945	72,909		71,994	-	198,623	-	-
	Bank	Jul-24	5,372	5,386	5,425	5,662	5,246	5,739	5,881	6,086	5,230	5,262	4,833	5,339		3,246	-	16,424	-	-
	Agency	Jul-24	1,363	1,274	1,260	1,286	1,245	1,257	1,187	1,279	1,209	1,088	1,072	1,104		980.8	-	4,206	-	-
	Turnover	Jun-24	12.1%	12.0%	11.7%	11.5%	11.4%	11.2%	11.1%	11.2%	11.3%	11.2%	11.3%			13.0%	-	12.3%	-	-
	Sickness	Jun-24	5.6%	5.6%	5.6%	5.6%	5.5%	5.5%	5.6%	5.6%	5.6%	5.6%	5.6%			6.2%	-	5.9%	5.04%	37/42
Note/s	* National average upper and lower control limits (UCL and LCL) for SHMI across all non-specialist trusts. This gives an indication of whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, for C&M was as expected when compared to the national baseline. This "rate" is different to the SHMI "banding" used for trusts on slide 8, therefore a comparison cannot be drawn between the two. ^ National figure is the latest ONS figure from 2022. local data is directly from GP systems. this has been reviewed against historic ONS data for LA's and the variation ranges from -0.9% to +5.9% # Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected ~Banding based on SOF % against target not number of cases ** -From December 2023 this metric is now available at ICB level, previously this was only reported at Cancer Alliance level. historical data has been updated																			

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Jul-24	-103	-123.65	-128.2	-143.9	-80.8	-72.2	-79.8	-61.5	-98.7	-	-68.8	-101.0	-138.0	-99.5		-150.0	-150.0	0.0
	Financial position £ms (ICS) VARIANCE	Jul-24	-38.1	-49.9	-56.7	-70.0	-42.2	-40.8	-57.8	-50.5	-98.7	-	-19.1	-16.5	-38.5					
	Efficiencies £ms (ICS) ACTUAL	Jul-24	97.9	132.7	158.0	192.9	227.0	246.4	302.7	334.4	388.6	-	41.9	64.7	92.3	112.5		439.9	442.2	2.3
	Efficiencies £ms (ICS) VARIANCE	Jul-24	-7.7	-4.6	-11.0	-12.2	-14.0	-30.7	56.3	-16.8	-0.1	-	-15.2	-13.1	-20.2					
	Capital £ms (ICS) ACTUAL	Jul-24	38.8	42.8	53.9	77.3	110.8	133.7	115.3	153.6	267.3	-	N/A	39.5	65.6	76.8134		275.2	299.8	-24.6
	Capital £ms (ICS) VARIANCE	Jul-24	6.0	16.8	41.2	17.8	2.8	7.1	49.7	51.8	1.1	-	N/A	3.9	11.3					

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

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

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Urgent care	4-hour A&E waiting time % waiting less than 4 hours)	Aug-24	59.7%	53.1%	61.5%	73.2%	69.4%	75.3%	81.1%	96.0%	-	88.7%		-	-	-	-	-	-	74.3%
	A&E 12 hour waits from arrival	Aug-24	27.2%	9.8%	14.9%	20.5%	19.1%	13.4%	16.4%	0.0%	-	**	-	-	-	-	-	-	-	15.6%
	Adult G&A bed occupancy	Aug-24	98.6%	94.1%	93.4%	94.3%	96.9%	92.2%	97.7%	-	74.4%	63.4%	87.1%	90.3%					-	94.9%
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Aug-24	20.3%	no data	17.6%	18.3%	25.5%	21.0%	23.2%										-	19.9%
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jul-24	265	25	224	310	397	176	468	67	25	68	0	0			0	-	73	2,098
	Number of 52+ week RTT waits, of which children under 18 years.	Aug-24	158	26	153	100	98	124	110	521	-	2	-	3						1,295
	Total incomplete Referral to Treatment (RTT) pathways	Jul-24	32,168	12,455	38,155	45,909	36,377	75,123	82,229	23,653	5,509	16,675	1,171	16,489			64	-	-	370,607
	Patients waiting more than 6 weeks for a diagnostic test	Jul-24	14.7%	15.5%	5.3%	3.9%	18.3%	1.6%	2.7%	14.4%	19.3%	3.8%	0.0%	1.0%	56.5%	0.0%	-	-	-	9.0%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for	Jun-24	78.9%	70.5%	60.9%	74.9%	78.1%	72.5%	75.4%	100.0%	81.6%	28.6%	87.0%	100.0%	90.9%				-	72.1%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Jun-24	95.5%	100.0%	90.6%	90.6%	98.4%	88.7%	88.2%	100.0%	100.0%	68.2%	99.8%	100.0%	93.8%				-	94.5%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Jun-24	74.9%	75.6%	73.8%	79.4%	58.5%	77.0%	70.8%	100.0%	44.4%	57.4%	60.0%	100.0%	87.5%				-	73.8%
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Mar-24	Mental Health service providers only														78.0%	78.0%	-	78.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Jun-24	88.0%	88.0%	83%	Community Service Providers only									89.0%	94.0%	81.0%	100%	78%	84.0%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Health Inequalities & Improvement	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Q3 2023	65.6%	60.0%	64.8%	68.6%	47.8%	68.9%	70.4%	66.7%	70.6%	60.0%	37.9%	25.0%	100.0%					59.1%
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Jun-24	0.61	3.20	4.38	3.35	3.46	-	1.47	-	-	2.64	-	-						2.63
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	12 months to July 24	(82 vs 56)	(16 vs 6)	(62 vs 31)	(123 vs 71)	(85 vs 36)	(184 vs 133)	(106 vs 85)	(2 vs 0)	(1 vs 2)	-	(9 vs 13)	(11 vs 6)						681
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to June 24	(60 vs 35)	(46 vs 27)	(52 vs 24)	(92 vs 53)	(86 vs 54)	(262 vs 165)	(165 vs 121)	(7 vs 8)	(6 vs 6)	(6 vs 5)	(19 vs 10)	(12 vs 10)						813
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Mar-24	0.9550	1.2166	0.9085	1.0295	0.9519	0.9709	1.0579											1.001
	Never Events (rolling 12 month total)	12 Months to Aug 24	1	2	1	2	5	2	2	2	0	4	0	2	0	0	0	0	6***	29
	21+ day Length of Stay (ave per day)	Jul-24	98.9	55.4	124.1	157.3	116.3	449.0	264.4	2.4	18.2	0.2	28.9	30.4						1,321
Workforce / HR (Trust Figures)	Staff in post	Jul-24	4,434	2,383	4,889	5,884	4,194	13,989	9,479	4,152	1,801	1,631	1,856	1,468	1,395	1,507	10,147	3,701	-	72,909
	Bank	Jul-24	364	212	446	405	432	1,096	798	166	78	72	25	76	21	50	879	219	-	5,339
	Agency	Jul-24	31	61	94	61	31	142	280	16	7	12	15	8	38	9	218	80	-	1,104
	Turnover	May-24	11.6%	10.7%	9.7%	9.6%	10.2%	10.5%	10.1%	9.3%	12.7%	12.9%	13.1%	12.5%	10.0%	18.4%	13.8%	12.9%	-	11.3%
	Sickness (via Ops Plan Monitoring Dashboard)	May-24	5.8%	5.6%	5.0%	5.9%	5.7%	6.3%	3.9%	5.6%	5.0%	6.0%	4.6%	5.5%	5.9%	6.3%	7.8%	6.6%	-	5.6%
Finance	Overall Financial position **Variance** (£m)	Jul-24	-3.75	-0.39	-1.24	-3.20	-1.02	-4.41	-1.90	-0.42	-0.84	0.01	0.00	0.02	-0.31	0.00	0.00	0.00	-21.14	-38.56
	Efficiencies (Variance)	Jul-24	-2.05	-0.02	-3.04	-1.90	0.17	-5.65	0.93	-0.00	-1.24	0.18	0.00	0.00	-0.31	-0.13	0.00	-1.23	-5.91	-20.19
	Capital (Variance)	Jul-24	5.68	0.43	-5.03	0.23	0.59	1.86	3.81	-0.23	0.37	1.08	-0.55	-0.16	1.31	0.66	0.77	0.45	0.00	11.26
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. *** Independent Providers / Other providers 1 at Spire Hospital Liverpool, 1 at Spire Murrayfield,1 at Fairfield Independent Hospital and 2 at Isight Clinic – Southport, 1 at Spa Medica Wirral # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																			

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours)	Aug-24	58.3%	60.4%	45.9%	54.9%	76.9%	56.0%	75.2%	66.0%	65.9%		74.3%	75.2%	78% by Year end
	Ambulance category 2 mean response time	Aug-24	00:27:00		00:23:35	00:24:29	00:22:44	00:25:26	00:24:47	00:25:59	00:25:37		00:24:58		00:30:00
	A&E 12 hour waits from arrival	Aug-24	12.7%	21.9%	18.9%	17.1%	10.1%	14.5%	10.7%	17.4%	13.3%		15.5%	-	-
Planned Care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jul-24	692		313	281	222	162	119	224	85		2,098	753	-
	Total incomplete Referral to Treatment (RTT) pathways	Jul-24	104,197		50,855	31,176	63,721	31,801	25,661	22,968	40,228		370,607	373,388	-
	Patients waiting more than 6 weeks for a diagnostic test	Jul-24	12.6%		4.2%	14.7%	2.8%	7.6%	3.9%	21.4%	4.9%		9.0%	10.0%	10%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Jun-24	64.4%	71.8%	76.6%	83.7%	74.4%	78.6%	74.3%	77.1%	62.4%		72.1%	70.7%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Jun-24	94.3%	93.9%	94.5%	96.4%	95.1%	97.9%	94.2%	94.9%	93.5%		94.5%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Jun-24	74.6%	74.5%	78.5%	66.9%	74.5%	72.9%	73.4%	68.1%	73.3%		73.8%	72.0%	77% by Year end
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Mar-24	79.0%		71.0%	100.0%	75.0%	75.0%	81.0%	79.0%	-	-	78.0%	60.0%	60.0%
	Access rate for Talking Therapies services	Mar-24	66.0%		72.0%	55.0%	45.0%	91.0%	51.0%	38.0%	58.3%		59.0%	100.0%	100.0%
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	Q4 23/24	66.3%		64.7%	77.0%	65.9%	58.8%	36.4%	56.4%	20.7%		57.8%	-	75.0%
	Dementia Diagnosis Rate	Jul-24	67.4%		67.1%	72.8%	66.2%	69.3%	61.9%	69.5%	67.8%		67.7%	66.7%	66.7%
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Jul-24	25		10	5	20	5	10	5	10		95	-	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Jun 24 YTD	11.4%		9.4%	12.2%	13.0%	11.2%	12.7%	13.9%	14.1%		12.0%	10.2%	75% by Year end
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Jun-24	84.3%		94.3%	88.3%	67.4%	79.7%	84.8%	100.0%	87.1%		84.0%	70.0%	70.0%
Primary Care	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Jul-24	109.9%	107.4%	107.5%	110.5%	110.7%	111.2%	115.0%	106.1%	104.1%		109.0%	-	-
	Percentage of appointments made with General Practice seen within two weeks	Jun-24	89.0%		88.7%	86.0%	91.7%	90.9%	88.2%	84.2%	92.1%		89.5%	85.0%	85.0%
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Mar-24	6.92%		8.80%	6.05%	7.48%	5.62%	6.66%	6.30%	8.09%		7.19%	10.0%	10.0%
	Total volume of antibiotic prescribing in primary care	Mar-24	0.928		1.112	0.937	1.042	1.152	1.192	1.077	1.102		1.033	0.871	0.871
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.														

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q4 23/24	199.9	245.0	244.3	178.7	391.8	270.4	332.0	281.3	221.3		262.8	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence ***	May-24	85.3%	90.8%	95.3%	95.2%	95.4%	93.9%	95.4%	94.2%	92.6%		93.0%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q4 23/24	499.1	509.2	474.6	438.9	669.0	516.5	668.7	559.6	447.9		531.5	-	-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q4 23/24	71.8%		68.2%	66.2%	71.0%	69.4%	64.0%	71.0%	67.7%		69.6%	77.0%	80.0%
	Children and young people accessing mental health services as % of LTP trajectory	Mar-24	82.6%		88.5%	92.3%	99.4%	123.6%	N/A	63.7%	81.1%		90.0%	-	-
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Aug-24	11.4%	12.2%	14.2%	9.4%	16.4%	13.4%	16.9%	17.4%	13.4%		13.7%	12%	12%
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place totals	12 months to July 24	(287 Vs 156)		(190 Vs 131)	(97 Vs 45)	(186 Vs 172)	(69 Vs 47)	(68 Vs 47)	(55 Vs 33)	(106 vs 100)		681	439	439
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to July 24	(667 Vs 498)		(281 Vs 178)	(192 Vs 130)	(450 Vs 346)	(161 Vs 137)	(144 Vs 110)	(115 Vs 89)	(270 Vs 212)		813	518	518
Finance	Overall Financial position Variance (£m)	Jul-24	-2.7	0.4	-4.3	-1.9	-6.1	-1.7	-2.1	-1.4	-4.7		3.4	0.0	0.0
	Efficiencies (Variance)	Jul-24	-1.3	-1.0	-1.0	-0.9	0.0	-0.6	-0.7	-0.4	0.0		0.0	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	Jul-24	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Jul-24	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	9/9	9/9
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories **** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is different to the NHS Oversight Framework indicator used in the ICB table														

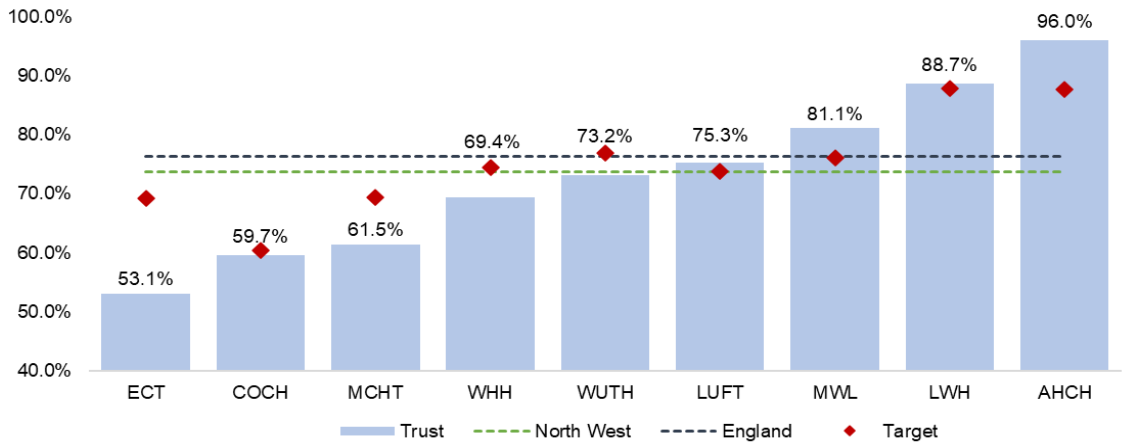
5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

A&E 4 hour waits from arrival

Latest ICB Performance (Aug-24)	74.3%	National Ranking	30/42

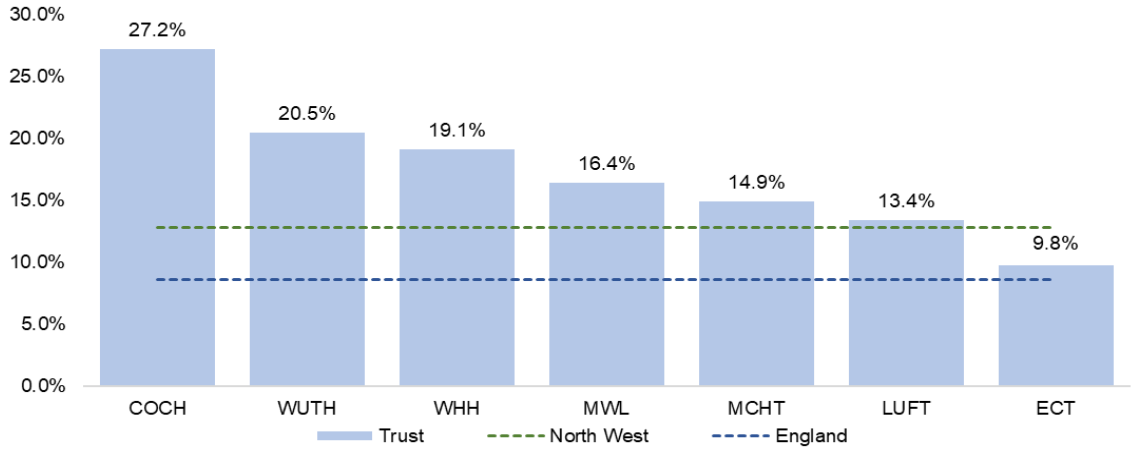
Provider Breakdown (Aug-24) — Deteriorated



A&E 12 hour waits from arrival

Latest ICB Performance (Aug-24)	15.5%	National Ranking	39/42

Provider Breakdown (Aug-24) — Improved



Issue

- Cheshire and Merseyside performance is 0.9% below the in-year trajectory that has been set to achieve the 78% March 2025 ambition.
- 15.5% of Cheshire & Merseyside A&E patients were delayed over 12 hours compared to the England average of 8.6%.

Action

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

Delivery

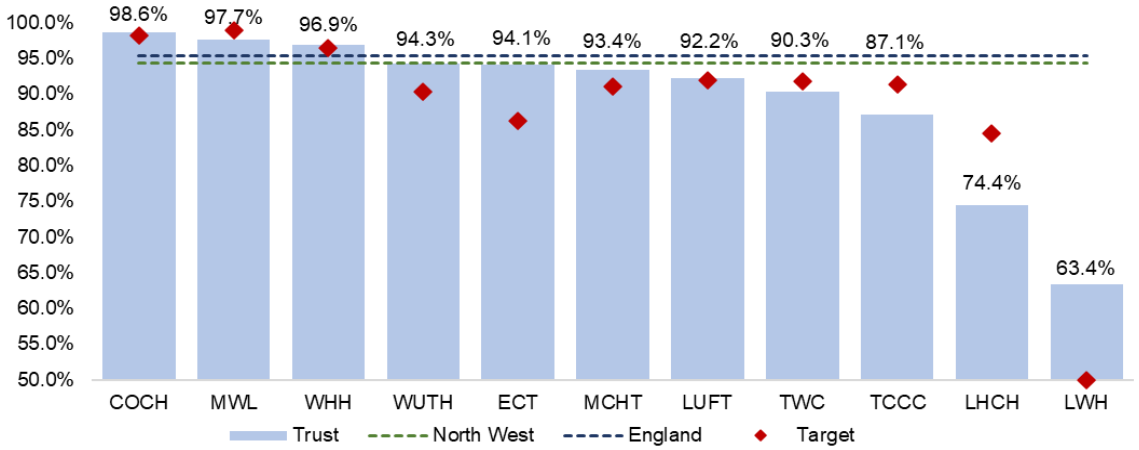
- C&M is adopting a recovery approach to UEC in 2024/25 and is committed to achieving 78% by the end of 2024/25 and a reduction in 12 hour waits

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (Aug-24)	94.9%	National Ranking	30/42
Provider Breakdown (Aug-24)			Improved



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

Action
- The Cheshire and Merseyside UEC Recovery Programme will focus on in hospital flow within the acute Length of stay workstream.
- The August Super MADE event spanned the bank holiday (7-day event) which included a focus on reducing the number of long LOS patients

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

No Criteria To Reside (NCTR)

Latest ICB Performance (Aug-24)	19.9%	National Ranking	42/42
Provider Breakdown (Aug-24)			Improved

Issue
- NCTR is at 19.9%, higher than England (13.9%) and North West (16.3%).
- Note no data for ECT due to the trust's change freeze in place whilst rolling out a new Electronic Patient Record (EPR) system. This has an impact on the data we receive.

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

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

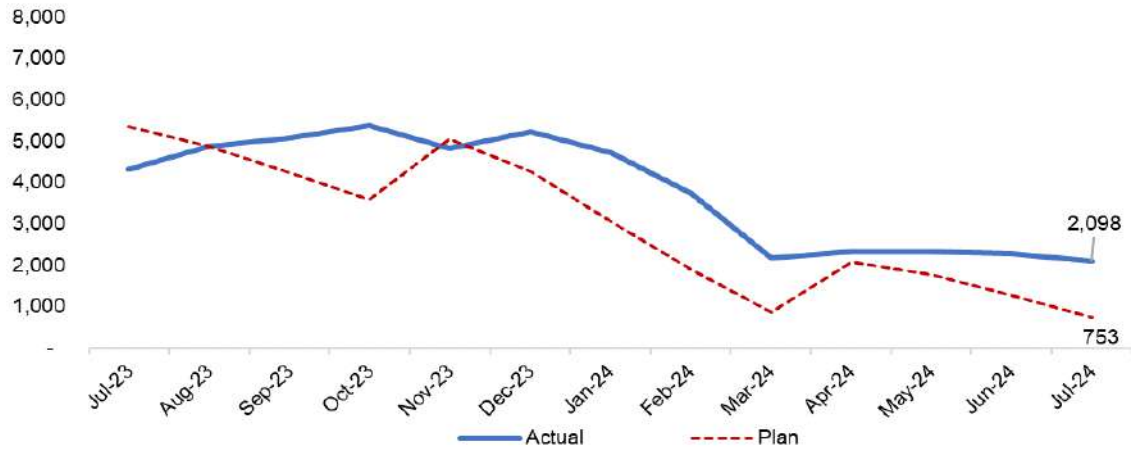
5. Exception Report – Planned Care

NHS Cheshire and Merseyside

ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Jul-24)	2,098	National Ranking	n/a

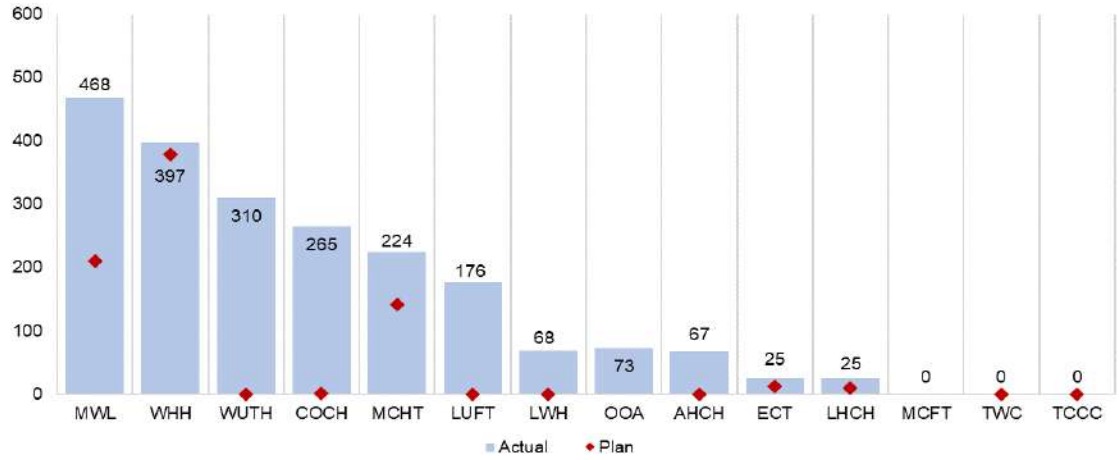
ICB Trend (Jul-24) — Improved



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Jul-24)	2,098	National Ranking	n/a

Provider Breakdown (Jul-24) — Improved



Issue
- There remains challenges for several trusts to clear 65 week wait patients by end of September, given patient choice and complexity issues.
- In addition to those already breached, there are also 3,332 patients that could breach if not treated by the end of September.

Action
- C&M currently have 8 active mutual aid requests within, T&O, Gynae, Cardiology, Mini Mitral and Plastics.
- At COCH, ENT has the largest number of 65+ week patients. This is being supported through the insourcing model and the trust are ahead of trajectory in clearing these waits.
- At MCHT, the trust continues to experience pressures within Cardiology and T&O due to operational pressures. Outsourcing approval has been received for Vascular patients.
- At LUFT, ENT and T&O are the most challenged specialties. An action plan is in place internally to reduce numbers, and the T&O Clatterbridge hub is being utilised where possible.
- At WUTH, Gynae is the area of concern with the trust reporting a potential breach of around 100 patients. In depth work is ongoing around Gynae capacity and demand for theatres which has been broken down further into surgeon availability and theatre sessions.
- Provider action plans have been received for the continued reduction of long waits. These are reviewed during regular trust PTL meetings
- A 65 week glide path submission will continue weekly to review plans. Complex patients are being identified so that additional support can be provided.

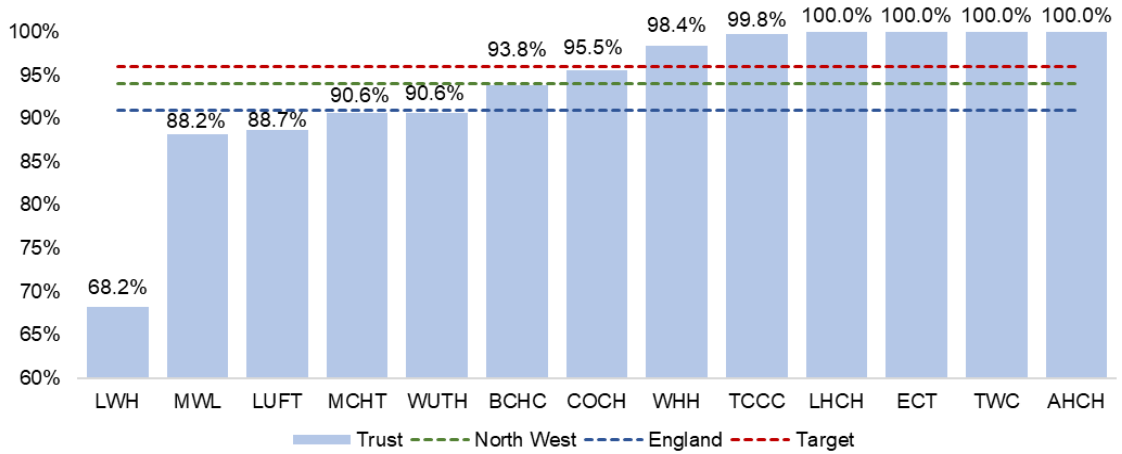
Delivery
- There is a continued focus on clearance of all 65 week waits by September. Major focus on 78-week clearance to eradicate these long waits.

5. Exception Report – Cancer Care

NHS Cheshire and Merseyside

Patients commencing first definitive treatment within 31 days of a decision treat

Latest ICB Performance (Jun-24)	94.5%	National Ranking	6/42
Provider Breakdown (Jun-24)			Improved



Issue

- C&M is not yet achieving the 96% 31-day combined standard required however, the figure of 94.5% is 4th amongst Cancer Alliances and 6th amongst ICBs.

Action

- A performance management forum has been agreed at CMCA Steering group with 28, 62, and 31-day standards as the sole focus. Pathway analyser tools will be utilised in line with planning guidance to understand any blockers to surgical treatments in C&M.
- The C&M performance forum has identified specific areas of work to improve 31-day performance.
- A short-term SBAR is being developed with the providers holding 90% of surgical breaches for additional capacity funding and a longer-term plan requested.

Delivery

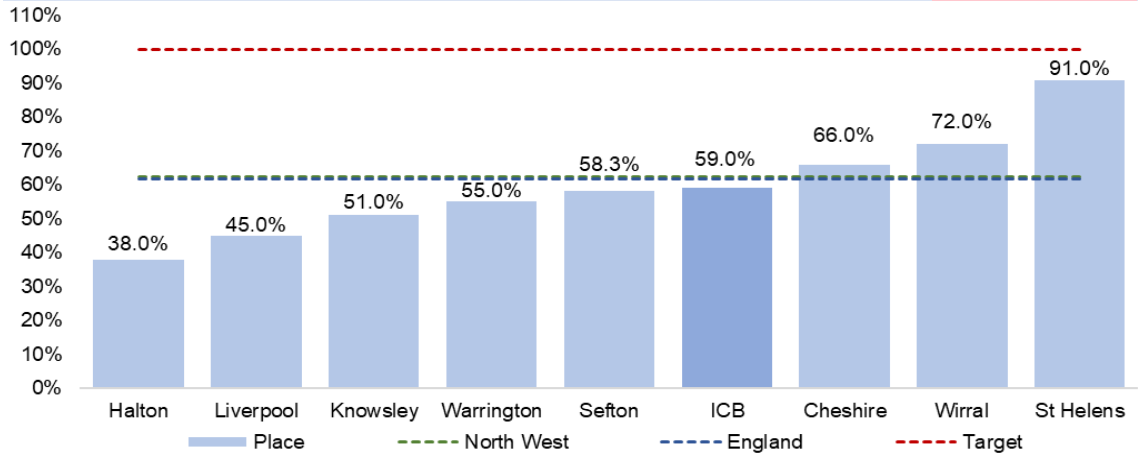
- C&M expects to meet the 96% performance standard by the end of Q4 24/25 because the specific areas of 31-day breaches are identified and are targeted with improvement plans.

5. Exception Report – Mental Health

Cheshire and Merseyside

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

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



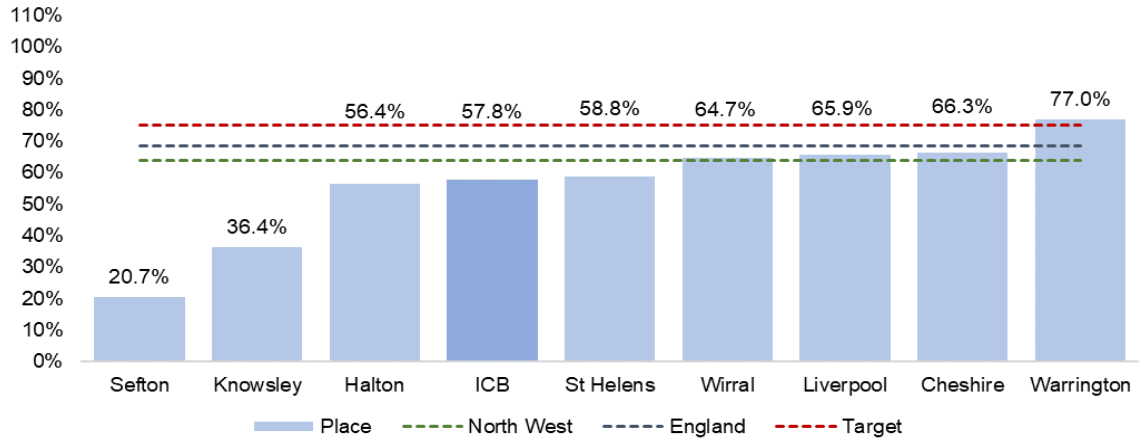
Issue
- Talking Therapies (TT) is not achieving the access ambition set out in the Long-Term Plan.
- Performance in March has deteriorated from 66% to 59% of the LTP trajectory, which is lower than the national achievement of 62%. St Helens is the only place to have met their LTP trajectory in some months,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

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

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

People with SMI receiving a full annual physical health check

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



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

Action
- C&M workshop held 11 July with Place leads and MH Primary Care Leads. New BIP report presented which allows drill down to PCN and practice level. Place leads to identify lowest performing practices and liaise to identify issues and develop actions to support increase in uptake.
- New dashboard for SMI checks under development to support streamlined and more focussed access to local data.
- Place leads are holding local meetings to support delivery and improvement.
- ICB Board has requested a deep dive into PH in SMI at their November 2024 Board meeting.

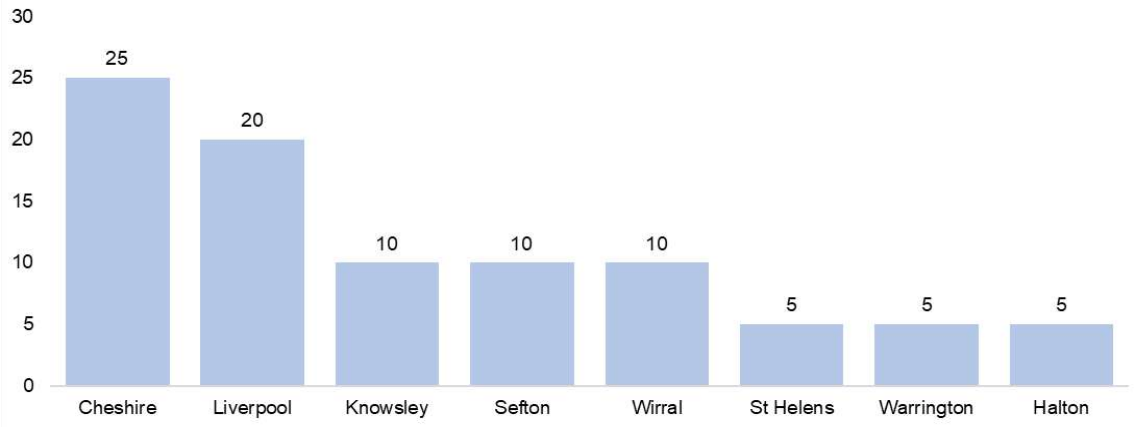
Delivery
- Four of the nine places are not meeting the minimum 60% national target for SMI Health checks. Focus on these areas is underway with the development of improvement plans.

5. Exception Report – Learning Disabilities

NHS Cheshire and Merseyside

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Jul-24)	95 *	National Ranking	31/42
Place Breakdown (Jul-24)			Improved



Issue

- There are currently 93 adult inpatients, of which 49 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 44 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 88 or fewer by the end of Q4 2025.

Action

- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge and there have been 11 adult discharges in Q1 to date. Of those 93 adults there are there are currently 20 individuals currently on Section 17 Leave. We expect that a number of these will be discharged in Q2 pending MOJ Clearance for some.
- Data quality checks to be completed on Assuring Transformation to ensure accuracy.
- Weekly C&M system calls ongoing to address Delayed Discharges.
- Housing Lead continues to work to find voids which can accommodate delayed discharges, and is meeting with North West Housing Lead and analysts to map those individuals clinically ready for discharge with housing difficulties, with the C&M Housing Strategy in development.

Delivery

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

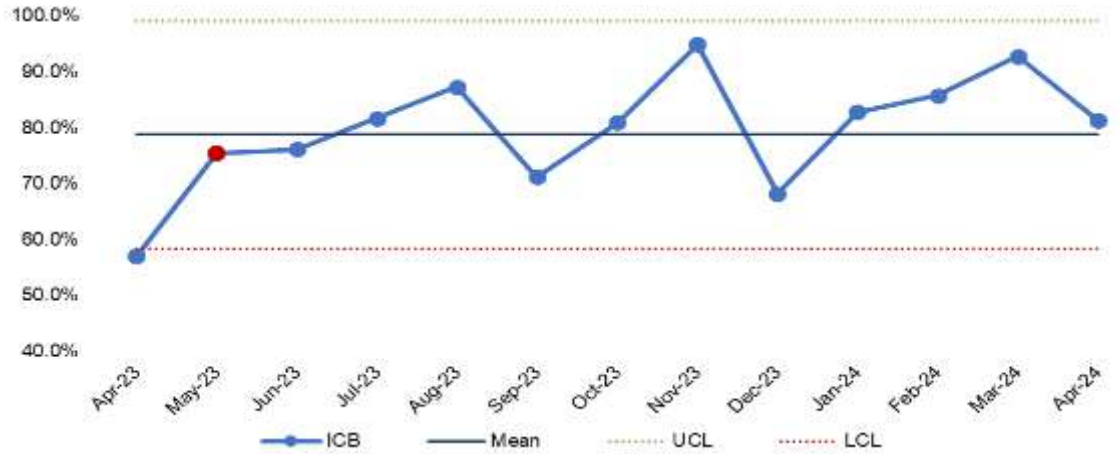
***** *Data rounded up/down to nearest 5: therefore Place subtotals may not add up to the ICB total*

5. Exception Report – Primary Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (Apr-24)	81.3%	National Ranking	28/42
ICB Trend (Apr-24)	Deteriorated		



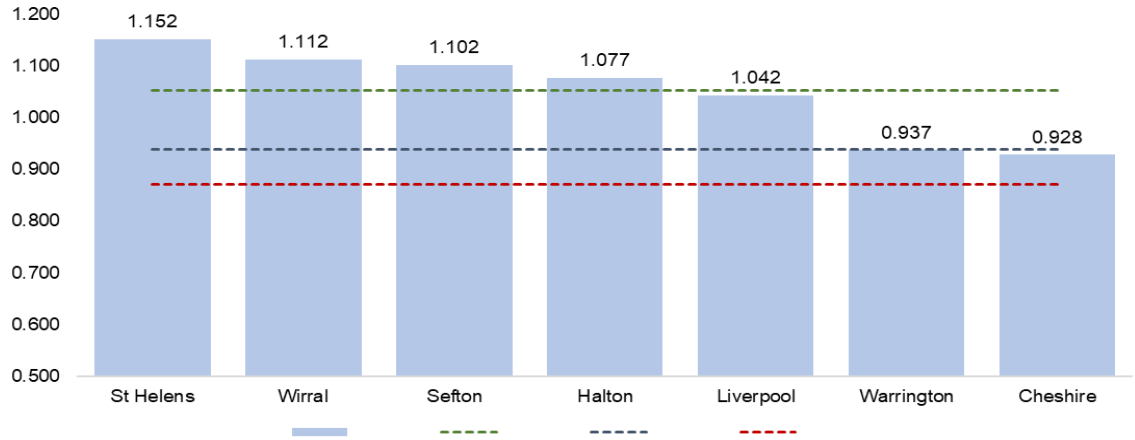
Issue
- C&M does not currently meet the 100% target

Action
- About to commence 24/25 mid-year contract review process with contractors in line with NHSE policy.
- Provers underperforming will be issued with action plans for assurance regarding year end.
- Commissioners will identify where additional activity can be undertaken and where appropriate reallocate UDA's subject to executive approval
- Implementation of local ICB Dental Improvement Plan Pathways 1+2 and 3 continues

Delivery
- Fluctuations in delivery of target are expected throughout the year and based on previous year's performance.
- 143 practices signed up as of 2/9/24 to the New Patient Premium payment scheme as part of national dental recovery plan.
- 52 practices have signed up to the ICB additional routine access scheme as of 2/9/24

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Mar-24)	1.033	National Ranking	34/42
Place Breakdown (Mar-24)	Improved		



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

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

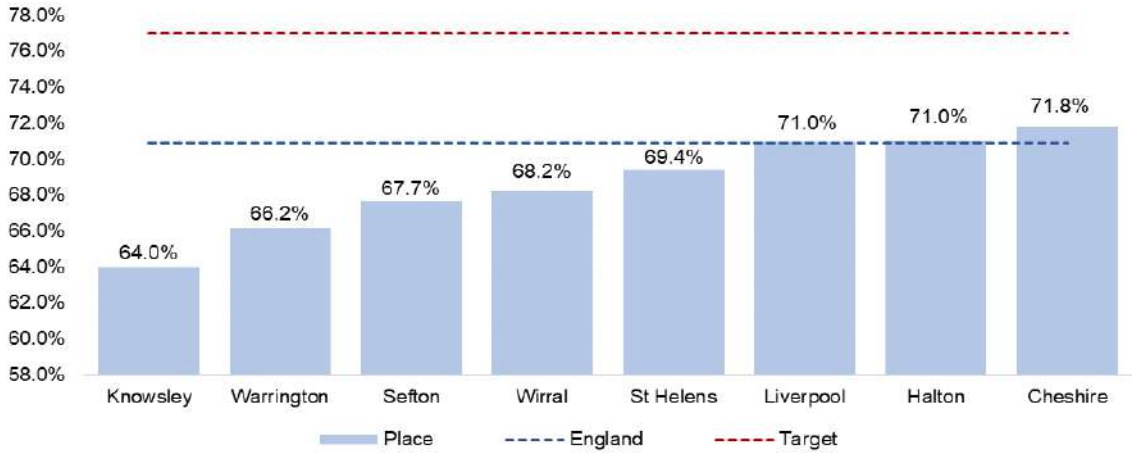
Delivery
- Improvement in Q1 of 2024/25 is expected, assuming the current levels of infection remain static. Further analysis will be undertaken on Q1 2024/25 data to identify if there are areas to focus on additional to the planned work happening across C&M.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

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

Latest ICB Performance (Q4-23/24)	69.6%	National Ranking	30/42
Place Breakdown (Q4-23/24)			Improved



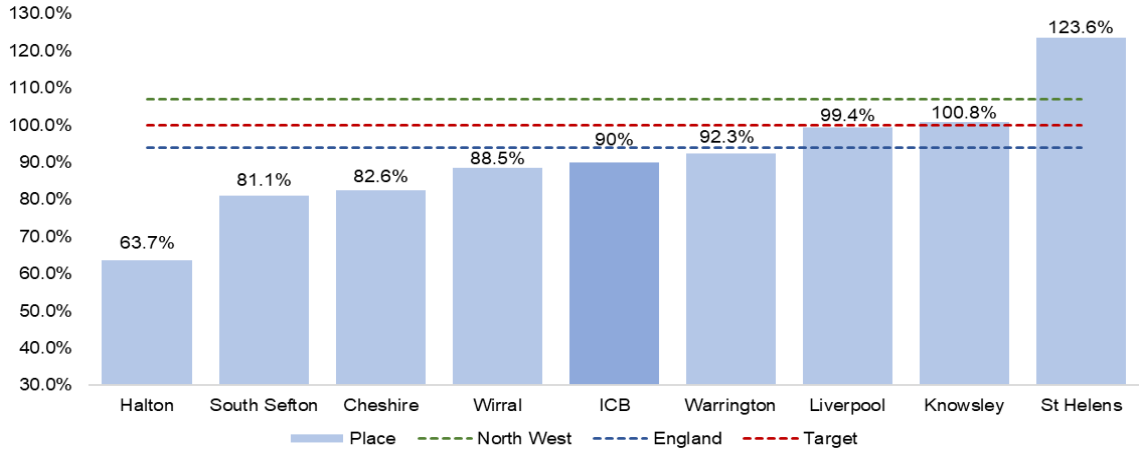
Issue
- Considerable variation in C&M, reductions in capacity & funding continue to affect performance; C&M currently does not meet the national target ambition.

Action
- ICB SRO for CVD Prevention (CVD-P) in post, C&M CVD-P Programme Manager starting end of Q2 and C&M CVD-P Board re-established
- A renewed and co-ordinated focus on CVD-P providing an opportunity to review and refresh the C&M CVD-P strategy with efforts focussing on the ABC of CVD-P: detection and management of atrial fibrillation (A), hypertension/ blood pressure (B) and cholesterol (C)
- Strategic conversations continue re: non recurrent transformation funded work e.g. Familial Hypercholesteremia services.
- Planning underway re: C&M level hypertension case finding pilots in optometry settings
- Activities across C&M during Know Your Numbers! week 2nd – 8th September raising awareness of high blood pressure and encouraging all adults to get a blood pressure check
- NHS Health Checks SLI work and discussions with OHID re: variations in local Places

Delivery
- CVD-P leadership and re-established CVD-P Board will be the vehicle to coordinate C&M wide and local Place CVD Prevention plans and drive improvements

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

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



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

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

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

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

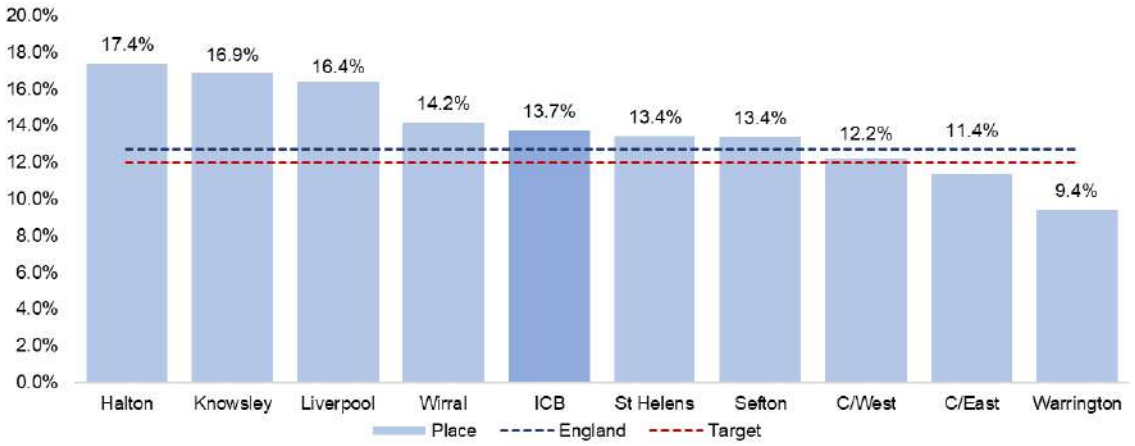
5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

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

Latest ICB Performance (Aug-24)	13.7%	National Ranking	n/a

Place Breakdown (Aug-24)



Issue

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

Action

- Mobilisation of the All Together Smokefree programme has commenced with an implementation plan approved by Directors of Public and Population Health Executive Board
- Recruitment of the All Together Smokefree team has commenced via Champs
- A commissioning plan has been developed for implementation in quarter 3
- Directors of Public and Population Health wrote again to all Cheshire and Merseyside MPs to highlight support for the Tobacco and Vapes Bill ahead of Party Conference season

Delivery

- All Acute and Maternity services are now delivering NHS Treating Tobacco Dependency Services, and a pilot service has been establishing in one of the Mental Health NHS Trusts.

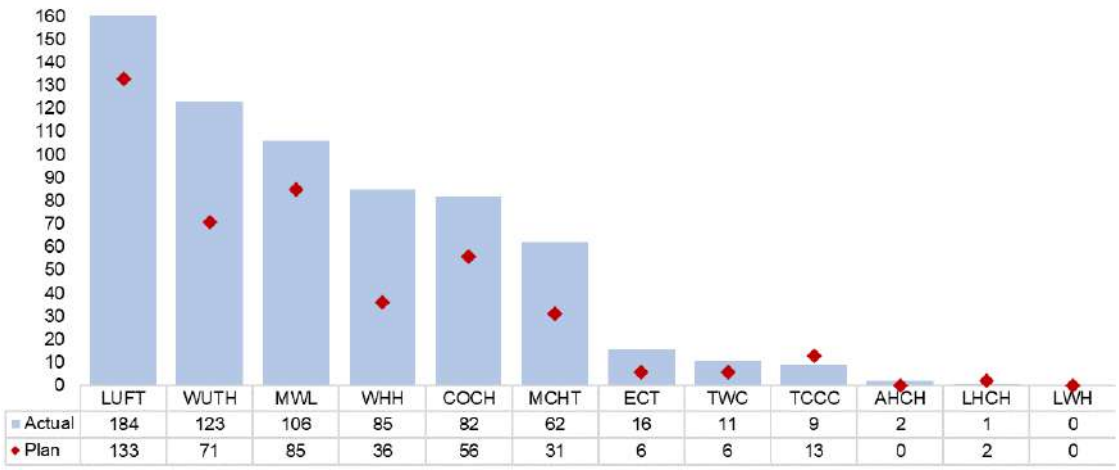
5. Exception Report – Quality

NHS Cheshire and Merseyside

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (12 months to Jul-24)	681	National Ranking	23/42

Provider Breakdown (rolling 12 months to Jul-24)

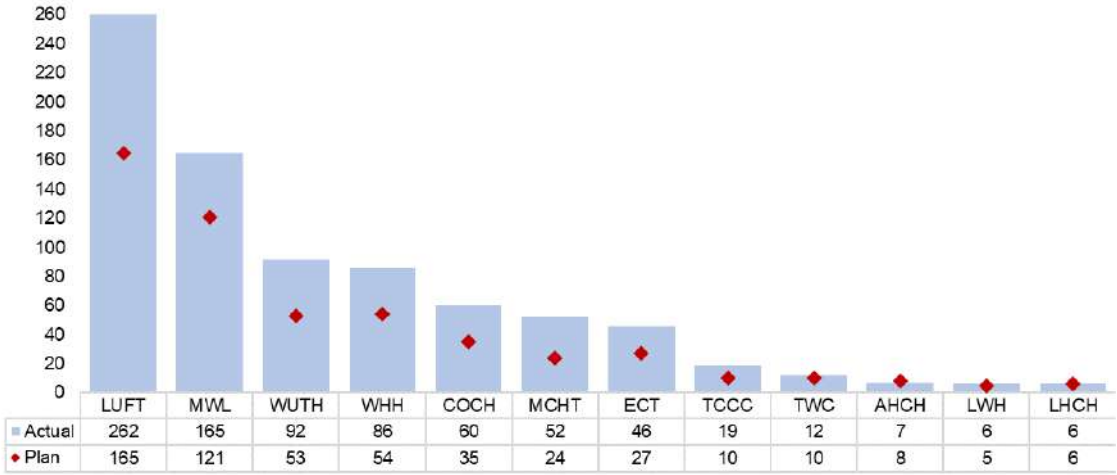


	LUFT	WUTH	MWL	WHH	COCH	MCHT	ECT	TWC	TCCC	AHCH	LHCH	LWH
Actual	184	123	106	85	82	62	16	11	9	2	1	0
Plan	133	71	85	36	56	31	6	6	13	0	2	0

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

Latest ICB Performance (12 months to Jul-24)	813	National Ranking	38/42

Provider Breakdown (rolling 12 months to Jul-24)



	LUFT	MWL	WUTH	WHH	COCH	MCHT	ECT	TCCC	TWC	AHCH	LWH	LHCH
Actual	262	165	92	86	60	52	46	19	12	7	6	6
Plan	165	121	53	54	35	24	27	10	10	8	5	6

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

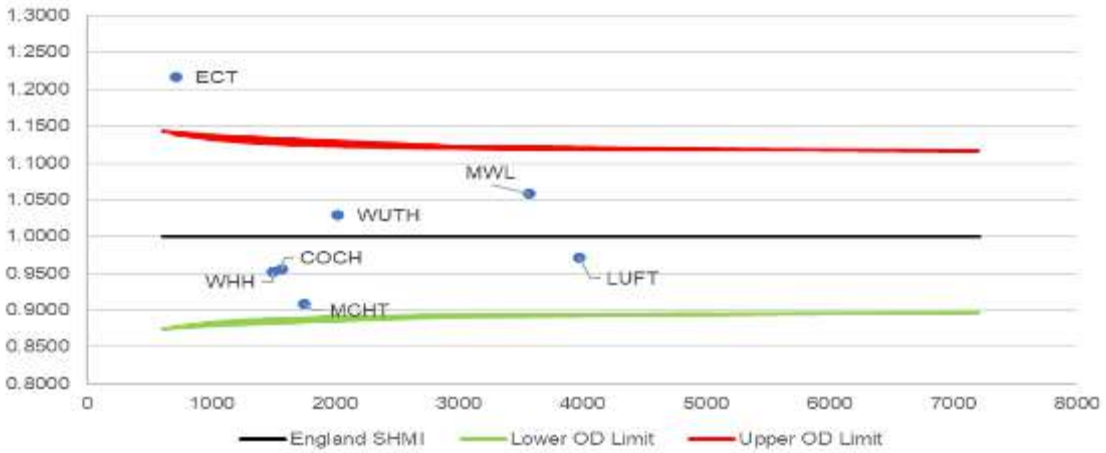
Action
- All place-based teams are receiving assurance from those Trusts identified as outliers on actions being taken to improve.
- Performance in relation to HCAI is a feature of provider oversight where appropriate.
- Post infection reviews are undertaken on each case to identify themes and trends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

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

5. Exception Report – Quality

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Mar-24)	1.001	National Ranking	n/a
Provider Breakdown (Mar-24)*			Improved



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

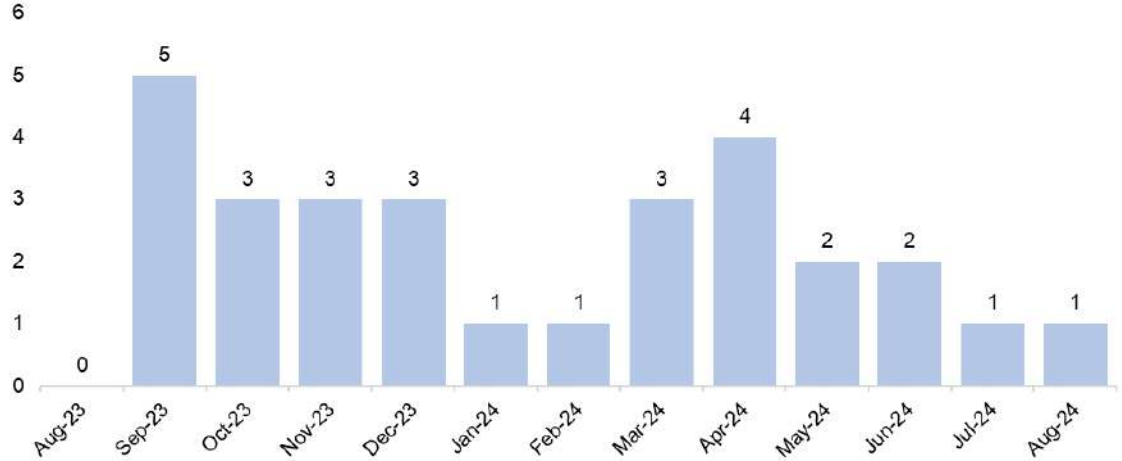
Action (ECT only)
- The trust has moved to quality improvement phase of quality governance/escalation.
- The ICB continues to work closely with the Trust to review positive progress and ensure the optimal support is in place to bring about best patient outcomes.
- Following the meeting of ICB and trust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

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

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

Never Events

Latest ICB Performance (Aug-24)	1	National Ranking	n/a
ICB Trend (Aug-24)			No change



Issue
- C&M have had 29 Never Events over the last 12 month rolling period, which is a slight reduction from 31 during the previous 12 month period. Whilst a reduction this remains within natural variation.

Action/s
- Following a Never Event summit held in May 2024 that brought together all trusts across the system and observed human factors development lead by Aqua, plans are being developed for an ongoing network focused on surgical safety and seeking to share learning and improvement post Never Events and other surgical safety incidents.

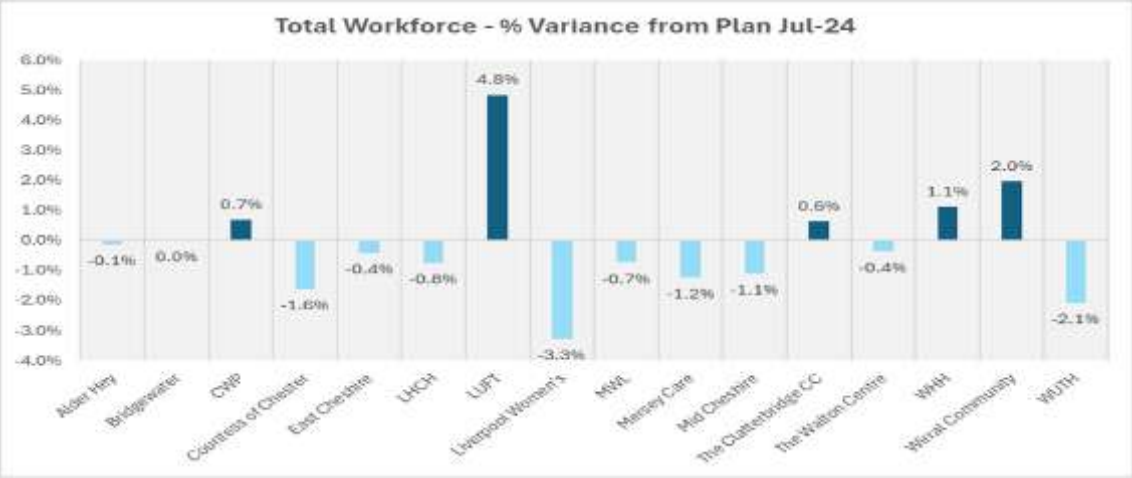
Delivery
- There have been 8 Never Events during Q1 showing a slight increase from Q4 but within natural variation, impact of action not yet observed.

5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

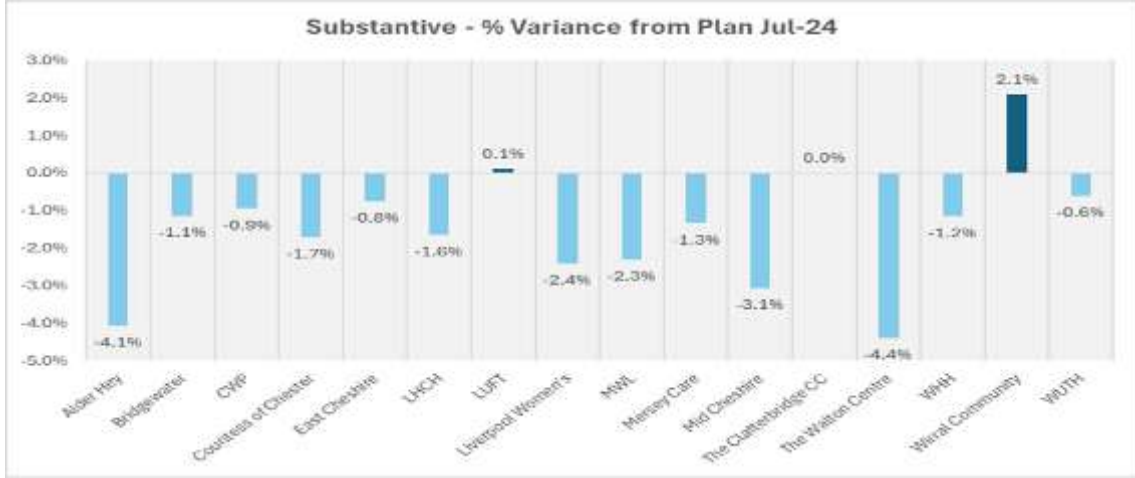
Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PWRs	
C&M ICB Performance (Jul-24)	**0.3%**

Provider Breakdown (Jul-24)



Substantive Variance from Plan % - via PWRs	
C&M ICB Performance (Jul-24)	**-1.4%**

Provider Breakdown (Jul-24)



Issue
- In June, ten of sixteen C&M Trusts reported substantive staff in post numbers below that forecast in their operational workforce plans. The total system performance was a variance from plan of +0.3%
- At system level, substantive staffing increased by 277.3 WTE / 0.4% from the previous month

Action
- The Trusts have in place robust vacancy authorisation processes. Greater scrutiny of workforce and productivity data at organisational and system level is now taking place. A workforce dashboard has been developed and shared with Trusts on a monthly basis – for review and feedback. (This is where individual Trust performance can be interrogated in terms of WTE numbers)

Delivery
- Proactive monitoring of workforce data now takes place with Chief People Officers as part of monthly assurance meetings

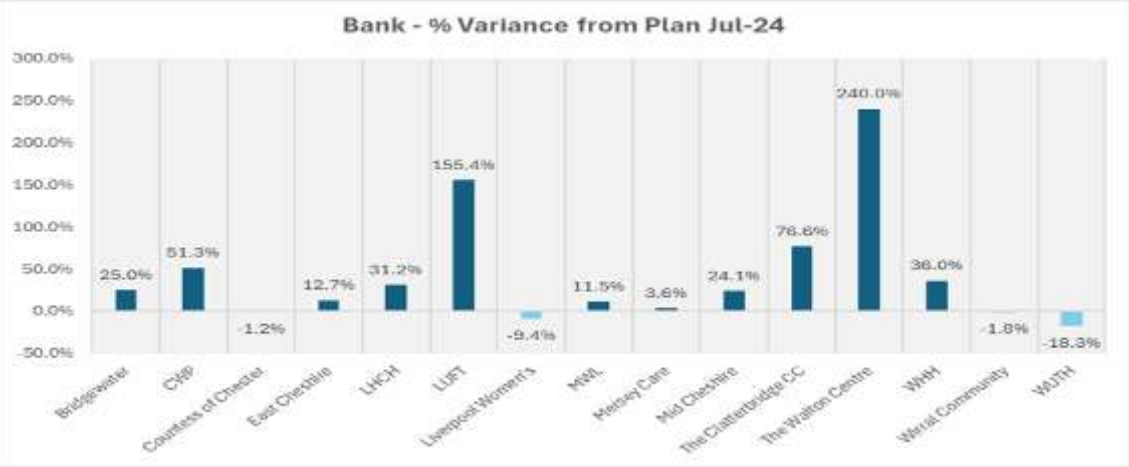
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Bank Variance from Plan % - via PWRs

C&M ICB Performance (Jul-24)	29.9%

Provider Breakdown (Jul-24)



Issue
- Twelve of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of July. The total system performance was a variance from plan of +29.9%
- At system level, the total bank usage increased by 294.7 WTE / 5.8% from the previous month
- *Please note that Walton Centre figure above equates to a +55.3 WTE variance from plan (and therefore may look skewed due a low planned forecast)*

Action
- The Trusts have in place robust vacancy authorisation processes. Greater scrutiny of workforce and productivity data at organisational and system level is now taking place. A workforce dashboard has been developed and shared with Trusts on a monthly basis – for review and feedback. (This is where individual Trust performance can be interrogated in terms of WTE numbers)

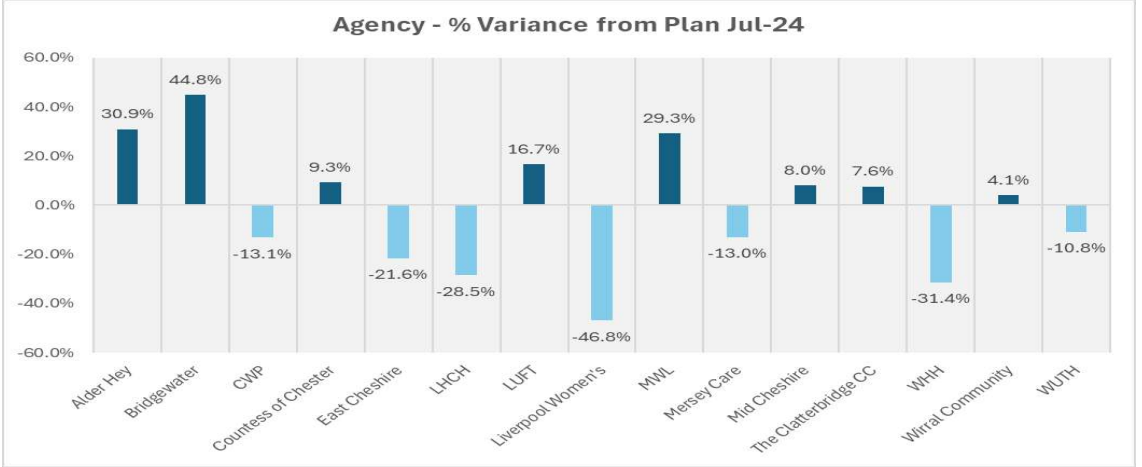
Delivery
- Proactive monitoring of workforce data now takes place with Chief People Officers as part of monthly assurance meetings

** Alder Hey not included in chart above due to planned Bank usage of zero*

Agency Variance from Plan % - via PWRs

C&M ICB Performance (Jul-24)	-2.6%

Provider Breakdown (Jul-24)



Issue
- Nine of sixteen C&M Trusts had Agency usage higher than that forecast in their operational workforce plans for the month of July. The total system performance was a variance from plan of -2.6%
- At system level, Agency usage decreased by 15.4 WTE / 1.4% from the previous month

Action
- The Trusts have in place robust vacancy authorisation processes. Greater scrutiny of workforce and productivity data at organisational and system level is now taking place. A workforce dashboard has been developed and shared with Trusts on a monthly basis – for review and feedback. (This is where individual Trust performance can be interrogated in terms of WTE numbers)

Delivery
- Proactive monitoring of workforce data now takes place with Chief People Officers as part of monthly assurance meetings

** The Walton Centre not included in chart above due to planned Agency usage of zero*

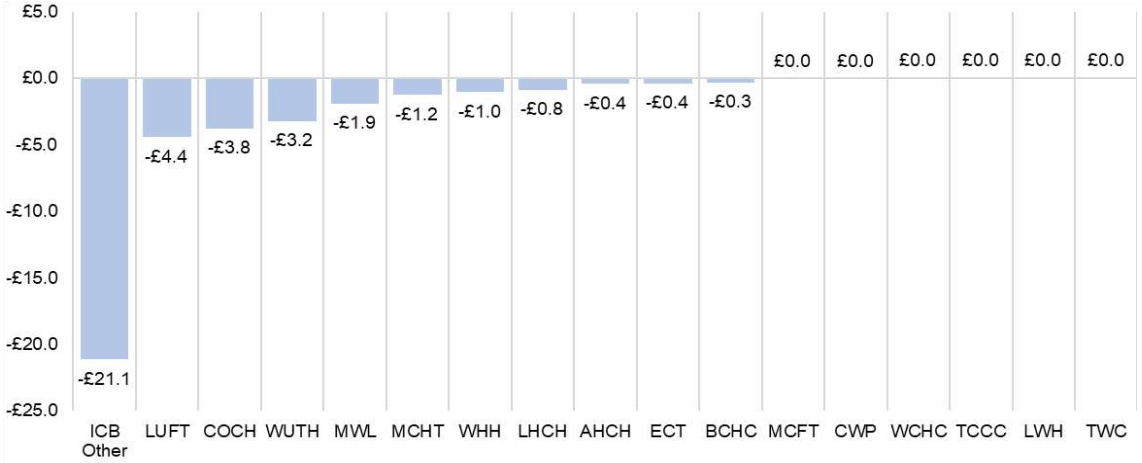
5. Exception Report – Finance

Cheshire and Merseyside

Overall Financial position Variance (£m)

Latest ICB Performance (Jul-24)	-38.5	National Ranking	n/a

Provider Breakdown (Jul-24)



Issue

- The ICS reports a YTD deficit of £138m as at Jul-24 which represents a £38.6m adverse variance to plan.
- The ICB adverse variance YTD (£21.1m) primarily relates to continued challenges around CHC and MH packages of care and the emergence of pressures within prescribing budgets.
- The adverse variance on provider positions (£17.4m) is driven primarily by £8.6m industrial action pressure within June and July. In addition, there are costs associated with the enquiry at Countess of Chester (£2.5m) and undelivered CIP and ERF underperformance.

Action

- PWC review ongoing.
- Place directors working on mitigation plans to bring the position back into balance.

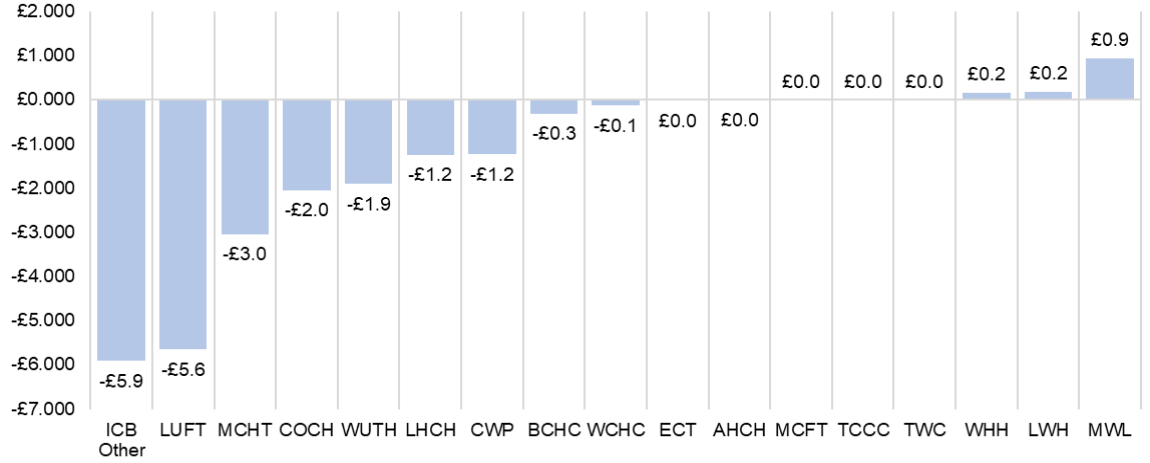
Delivery

- System reported a forecast in-line with plan to NHSE for M4. However, the level of unidentified risk reported to NHSE was £121.8m across the system.
- Mitigations being worked through as part of I&I work and with NHSE Nominated Lead. Full mitigation plans to be submitted 20th Aug.

Efficiencies Variance (£m)

Latest ICB Performance (Jul-24)	-20.2	National Ranking	n/a

Provider Breakdown (Jul-24)



Issue

- ICS efficiencies - £92.3m achieved as at M4 – a £20.2m shortfall against the plan and a contributory factor to the YTD adverse variance reported.
- Currently the system is forecasting full achievement of the efficiency plans – as part of the overall forecast to deliver the financial plan for 2024/25.
- Continued concern over the level of recurrent QIPP delivery. Recurrent plans are forecast to slip by £75m, which are forecast to be delivered through non-recurrent measures.
- £60.3m of the ICB's £72.2m efficiency plan classed as medium or high risk.

Action

- Expenditure controls in place including additional vacancy controls.
- ICB taken decision not to record non-recurrent savings as efficiency – to focus on recurrent savings
- ICB on track to remain within running cost allowance following 20% reduction in allocation in 2024/25.

Delivery

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

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

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

Agenda Item No: ICB/09/24/10

Committee Chair: Tony Foy, Non-executive Member

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

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
meeting date:	12 September 2024

Key escalation and discussion points from the Committee meeting

Alert

Hospice Sustainability & Oversight

The committee received updates in relation to two hospices within the Cheshire & Merseyside area. The Hospice of the Good Shepherd (HOGS) in Cheshire West and Marie Curie in Liverpool.

HOGS had received a Section 31 notice following a CQC inspection relating to medical / clinical cover and indemnity arrangements, resulting in the hospice being closed to admissions whilst assurance was received. There were 3 patients being cared for at the hospice and all were safely managed whilst remedial action was undertaken.

Marie Curie Liverpool's inpatient unit has been closed to admissions since July 2024, due to vacancies and absences within nursing team. This is being managed by Liverpool place with Marie Curie national team providing in reach support. The service is due to reopen at the end of September 2024.

The committee has requested detailed assurance to be brought back to outline contractual oversight arrangements for hospice provision in C&M.

Cheshire & Wirral Partnership (CWP)

As previously reported, the ICB has been seeking further assurance into governance and performance oversight at CWP, due to several emerging and ongoing risks to quality and safety. The Trust has engaged positively with the Emerging Concerns Group process throughout and has evidenced some insight into the need to further improve arrangements.

However, following an assessment of the information available to date, overall, there remains limited assurance that the Trust has sufficiently developed plans in place across the range of areas needing improvement and that delivery is taking place at the required pace. The committee approved a recommendation that due to the limited / partial assurance received to date, that the Trust should be moved from a NOF rating of 2 to 3. The decision to increase NOF ratings is undertaken by NHSE at regional level.

Advise

Infection Prevention & Control (IPC)

The committee received a gap analysis of alignment with NQB guidance on quality functions within the ICS. The committee was advised that there were gaps in relation

to IPC capacity and capability and this was further corroborated following the commissioning of an external review. Steps have been taken to secure a secondment opportunity from Provider Trusts and to seek regional support.

Learning Disability Mortality Reviews (LeDeR)
The committee received its quarterly (Q1 24/25) assurance report regarding the undertaking and outcomes of reviews. The committee requested further assurance regarding outcomes of the Focused Reviews and potential unwarranted variation in quality of care and responsiveness of services within each of the place-based footprints.

Urgent & Emergency Care
NHS England completed a focused review of all acute provider sites to identify areas of safety concern, national and regional themes of opportunity for further improvement. The review identified 19 (out of 169) acute sites across England to receive additional support, 5 of the 19 are in Cheshire & Merseyside:

- Countess of Chester Hospital
- Macclesfield DG
- Whiston Hospital
- Arrowe Park Hospital
- Leighton Hospital.

The ICB has had a focus on briefing the Trusts and ICB UEC SROs, requesting that they consider which improvement journeys they would find most beneficial. An initial meeting was held with National Programme Director for UEC, with the intention to rapidly engage with Trusts to support implementation from week commencing 16 September 2024. Clarity has been sought on the relationship between this targeted support and current support offers in place, as well as the link between this intervention and the wider UEC Tiering process and governance.

Assure

Women's Health
The committee received assurance that the ICB is making positive progress in the introduction of women's health hubs. The committee received positive information about the work to ensure that resources were predicated on need and equity. Further reporting will be presented that will provide assurance that the hubs are achieving equity of outcomes.

Patient Safety
The committee asked for further information in relation to the role and function of Patient Safety Partners, in line with the requirements of the Patient Safety Incident Response Framework and Safety Strategy, an update will be provided to a future meeting.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
QU04 – Safeguarding Recruitment QU05 – ASD.ADHD Assessments QU08 – Standards of Care QU09 – East Cheshire SHMI G8 – Non-compliance to the Involvement Framework QU10 (new) – Safeguarding Initial Health Assessments QU11 (new) – AACHC Performance QU12 (new) – AACHC Variation in Quality Assessment QU13 (new) – SEND Delays in Needs Assessments QU14 (new) – SEND Data Dashboard	**System Oversight Board report –** Risks were revised and realigned in accordance with ICB Risk Management Strategy.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
Board Assurance Framework Risk Urgent and Emergency Care P5.	The Committee received information in relation to Tier 1 UEC approach involving 5 Trusts within C&M.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Review of standard performance data – update on Tier 1 programme
Maternity Service Quality and Safety	LMNS report - Women's Health Hubs
Infection Prevention & Control	NQB Standards Gap Analysis

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Report of the ICB Directors of Place

Agenda Item No: ICB/09/24/11

Responsible Director: Mark Palethorpe, St Helens Place Director
Alison Lee, Knowsley Place Director

ICB Place Director Update Report

1. Purpose of the Report

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

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

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

2. Executive Summary

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

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

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

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

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

4. Place Partnership Development

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

4.1 Cheshire East

Our most recent Place Partnership Board was held in early September 2024. This was attended by Dr Ruth Hussey. Our agenda included – as always – celebrating the work of one of our excellent care communities. This time it was Congleton and Holmes Chapel.

We have a highly developed performance dashboard with key metrics for urgent and emergency care. We recognise the need to strengthen the use of this information, and also to develop stronger accountability for performance.

Key items on the agenda included Special Education Needs and Disabilities (SEND) (where we are preparing for an imminent inspection), a briefing on the progress being made towards a new Leighton hospital, and finally sharing emerging thinking on the Cheshire health and care sustainability review.

4.2 Cheshire West

Place Partnership development has continued with a reset of our local Integrated Transformation Programme, taking into account the work of the recovery programme and the more streamlined resource available to progress these priorities. The four current priorities have been summarised into a one page visual and, where possible, key linkages to recovery have been made.

In addition, the Place Health and Care Committee within September has been prioritised to focus on ensuring this approach is meeting key areas of population need, and how population health data and case finding can help us to develop our plans for the next two years. A summary of the successes to date, including the reduction in length-of-stay for patients utilising our Community Response Hub, has been included. In short:

- Community Response Hubs have been rolled-out in Winsford and are due to be rolled-out across the West Cheshire within the Autumn – Bed Days within the pilot have reduced from 53 to 11 days and the teams are giving extremely positive feedback of this work.
- Community Partnerships are now being led by the third sector, making significant savings within the Place Transformation Budget, and meaning the third sector are more able to influence the Place agenda. This is leading to greater ownership and the development of a tool to demonstrate the impact this work has made.
- In addition, a joint strategy and delivery Plan has been agreed between Place Partners for our Mental Health and Learning Disability Complex Models and Accommodation Strategy, with delivery metrics and timescales agreed.

Due to this more streamlined approach, Place Partnership Governance is also in the process of being clarified, so that meetings have a key purpose and feed into our wider system appropriately.

4.3 **Halton**

One Halton Delivery Group met in July to take forward the series of recommendations which had been made at June's Partnership Board. As part of this, the Delivery Group is reviewing each key theme within the One Halton life course approach and the various under-pinning projects such as Family Hubs, Same Day Access to Primary Care, Long Term Conditions, Mental Health, Cancer, Falls, End of Life Care etc to clarify progress, delivery, metrics, and outcomes. The Delivery Group also spent some time discussing the ICB-wide Recovery Programme approach and immediate focus and potential impact this year on local work not aligned to the Recovery Programme priorities.

4.4 **Knowsley**

Knowsley Healthier Together Board met in early September with a focus on Children and Young People. Partners including colleagues from Beyond programme updated on the Healthier Weight Programme, mental health services and neurodiversity pathway recovery work. Local Authority partners updated on the Children and Families plan which will be a key driver to deliver the strategic outcomes set out in Knowsley 2030. The oversight provided by partners will provide a framework to support the delivery of the actions from Knowsley strategic documents and plans across the partnership – including the new Council Plan and Joint Health and Wellbeing Strategy. The plan will be partnership led and driven with clear, tangible outcomes to demonstrate and measure progress.

4.5 **Liverpool**

The most recent meeting of the One Liverpool Partnership Board (OLPB) was held on 14 August 2024. The focus of the meeting was a 'single agenda item' in relation to the case for change for Liverpool Women's Hospital and women's services in the city. The next two meetings of the OLPB (September and October 2024) will have a similar focus on 'single agenda' items linked to the Children & Young People Partnership and Liverpool City Council's 'Family Hubs'. The imminent Local Government Association (LGA) assisted review of the Liverpool Health & Wellbeing Board will be used as an opportunity to also look at the roles of the One Liverpool Partnership Board, Liverpool Strategic Partnership (LSP) and the Health Care Partnership (HCP) to ensure there is clarity of purpose between partners in terms of decision-making, governance, and future planning.

4.6 **St Helens**

A recent development in terms of Partnerships is the maturity of the Mid Mersey Mental Health Relationship meeting, along with Knowsley, Halton and Warrington plus partners from the four Local Authorities and Mersey Care NHS Foundation Trust. The quarterly meeting looks at Mid Mersey matters in a depth that the larger contract and quality meetings don't allow.

The meeting covers adult mental health with a part B focus specifically on older persons mental health. Recent meetings have looked at housing & accommodation, winter funding bids and patient flow. The last meeting supported the proposal of developing into a Mid Mersey Mental Health Partnership Board / Forum. This would bring additional partners to the table including Primary Care, Public Health and Voluntary, Community & Social Enterprise Sector Organisations (VCSE). Draft terms of reference are being developed and the Board / Forum will be piloted across the remainder of 24/25.

The Place Better Care Fund (BCF) plan has been signed off nationally. St Helens have a BCF Board, and all system partners attend this. This group prioritises the limited funds to ensure that they support the development of the key BCF priority areas, i.e. hospital flow (admissions avoidance and discharge schemes) and falls.

4.7 **Sefton**

Mental Health Capacity & Flow Meetings - as a system we meet on a weekly basis with Mersey Care NHS Foundation Trust (MCFT), North and Mid Mersey Place representatives, Local Authority (LA) representatives and North West Ambulance Service NHS Trust (NWAS) to review sitrep data and support the Trust in accelerating patient discharges where possible. This forum also enables us to identify any issues/trends that need to be addressed strategically from a place/pan-place perspective with housing/accommodation availability being a key issue. There are also multi-agency discharge event (MaDE) meetings that take place on a weekly basis with operational staff that supports patient flow. The ICB has recently taken over chairing responsibility for these meetings, and we are starting to evidence an increase in discharge arrangements due to the meetings being more solution focused.

In respect of the above we have an established Strategic Housing Commissioning Group which is led by Sefton Council's Housing Department, which meets monthly to address our specific housing/accommodation needs across health and social care, which informs our strategy locally and the work that is currently being undertaken across Cheshire & Merseyside, as part of the Transitional Care Plan (TCP)/Mental Health Programme to develop provision that facilitates timely discharge and prevents hospital admission at Place.

We have commissioned an integrated mental health recovery service at place (Woodlands) which provides 11 beds and 2 emergency respite beds to support timely discharge and prevent hospital admission and we are working in partnership with Sefton's Housing Department and their Housing Options Team to further develop pathways that will support capacity and flow.

We are also working in partnership with the Council's Adult Social Care Department to develop a joint reviewing/commissioning strategy for both Mental Health and Learning Disabilities that will enable us to review current commissioned activity, ensuring we have appropriate services at place that will support assessed need and address any gaps in current service provision.

We are currently reviewing the Mental Health Recovery Team to understand if we need to expand this resource. The Team provides 12-week short-term intensive reablement support to accelerate hospital discharge or promote recovery from mental illness and improve quality of life. The team consists of 4.5 support workers who work across both North and South Sefton and sit within Community Mental Health Teams (CMHT) and are managed by Adult Social Care Team Managers. The team achieve really positive outcomes with 66% of individuals accessing the service no longer requiring long term support.

4.8 **Warrington**

Warrington Together Partnership Boards recent meetings have focused on a number of key partnership priorities, which include:

Development of the BCF end of year position and endorsement of the BCF plan for 2024/25 prior to approval at the Warrington Health and Wellbeing Board and submission to the national BCF team.

The Board also received an update on the Poverty work across Warrington that is ongoing across the town, particularly in relation to the development of a Poverty Truth Commission, which will include transformation targeted on health inequalities with a focus on Core 20 PLUS 5.

The Board has supported the work underway on the ICB's key local priorities aimed at improving flow of patients through the local Urgent and Emergency Care (UEC) and the ongoing work to strengthen Integration across Warrington and Halton Hospital Foundation Trust and Bridgewater Community Foundation Trust

In addition, the Board has commissioned deep dives into opportunities across the Public sector estate in Warrington, the financial position across partners and the Warrington Place Development Assurance Framework.

The August meeting of the Board also received an overview of the Healthwatch Hospital Discharge review, the findings of which will support the Warrington and Halton UEC Recovery Programme.

It is also worth noting that Warrington Borough Council were notified in June that they will be subject to the newly established CQC inspection regime for local authorities. The self-assessment was completed and submitted on 11th June which includes assessing the development of partnerships across systems and the extent to which integration has been achieved across key areas.

The next meeting will take place on 11th September.

4.9 **Wirral**

No significant update to provide.

5. Place Risks and actions to address

5.1 The top four risks common across places and key actions being taken to address them are set out in Table One. The finance risks in relation to potential cost pressures and inability to deliver efficiencies have been combined into a single risk.

Table One

Rank	Risk	Key Actions
1	**Finance:** Cost pressures driving overspends and / or inability to deliver efficiency improvements	Current controls include delegated budgets, budgetary control and expenditure approvals process, financial recovery plans and efficiency schemes, programme and project management, monitoring, and reporting. Key further action is being taken to address cost pressures in relation to CHC and prescribing, and to develop longer-term financial plans delivering recurrent efficiencies.
2	**Quality:** Neurodevelopmental assessment delays	Current controls include the assessment framework, performance monitoring of commissioned providers, clinical networks, SEND improvement plans, and quality and performance reporting. Key further action underway to develop joint and strategic approach to commissioning for Autism and ADHD.
3	**Quality:** Reduced standards of care	Current controls include key policies and standards, incident reporting and harm review process, standard contracts, System Quality Group, and quality dashboard reporting. Key further actions planned include development of UEC patient safety principles, development of primary care quality forum and strengthening of host commissioner arrangements.
4	**Quality:** Inadequate compliance with CHC National Framework	Current controls include the System Oversight Group (SOG) which has responsibility for All Age Continuing Healthcare (AACC) and onward reporting from the SOG to the System Oversight Board (SOB). Key further action underway to implement the target operating model, with the aim of standardising the service delivery model.

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

5.3 There is a further significant risk in common in the pipeline in relation to the decommissioning and restricted funding for tier 3 weight management services potentially impacting Liverpool, Halton, and St Helens places. This is currently being assessed and will be escalated to the Strategy and Transformation Committee in September.

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

NHS Cheshire and Merseyside

Figure One

Risk ID	Risk Title	Current Risk Score									
		ICB Wide	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
F8/9*	As a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties.	20	20	20	8↓	12	10	12↓	12	8↑	16↑
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	20	16	12↓	12↑	8	16	12↓	16↑	16↓	20↑
QU07	Continuing Healthcare delivery is impacted due to inadequate compliance with the CHC National Framework which leads to delays in assessment and unmet need.	16↑	N/A	N/A	N/A	8	16	12	12	N/A	12
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	20	8↓	8↓	12	15↓	16	20	6↓	9↓	16↑
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm	20	20	N/A							

*Associate Directors of Finance in each place have reviewed the scoring of the common finance risks following the challenges raised at the last Board meeting. This has confirmed that the risk has been assessed consistently in each place, based on the forecast outturn compared to place budget, and does not include the budgets of system partners at place. It did highlight that some places have assessed as a single combined risk rather than separate risks, and it has been agreed that this will be adopted by all places. The changes to the risk matrix in March, which created a single combined impact score criteria for place and ICB wide has also had the effect of lowering place impact scores i.e. for smaller places with lower budgets, a relatively high percentage overspend would have only a minor impact on the ICB wide budget. Further discussion is required to review the scoring criteria to determine whether changes are required to more effectively represent the level of risk at place and to agree a consistent risk description/s.

6. Action on Health Inequalities at Place

6.1 Cheshire East

No significant update to provide.

6.2 Cheshire West

As part of the Cheshire and Merseyside Health Inequalities Programme opportunity, Cheshire West has pulled together a proposal to support Children, Young People and Families in need of Mental Health Support. This proposal was presented jointly by the Local Authority and ICB at our Integrated Transformation Steering Group and approved. In addition, a joint venture between NHS Partners resulted in a Cardio-Vascular Disease Symposium in July focussing on the health inequalities surround this disease area. This will be backed by our Acute Care Sensitive Conditions Programme working with Primary Care over the Autumn, again focusing on health inequalities for those patients within the community at risk of admission and preventing these to support the reduction in Corridor Care. This will be further supported by a Respiratory Symposium, due to take place within November 2024.

6.3 Halton

Halton has continued to maximise the use of the roving Health and Wellbeing Bus, working with Halton Borough Council's Health Improvement Team, to ensure it is located in areas of highest need or footfall. Delivered by Cheshire and Wirral Partnership NHS Foundation Trust (CWP), the drop-in service provides routine UK immunisations (including Flu and Covid-19 when in season), health checks, and mental wellbeing support at the heart of communities. The service uses health diagnostics software interoperable with GP clinical systems to ensure all interactions with residents are fed directly back to the patients practice including any necessary follow-up requirements.

One Halton partners are currently in the process of developing a Poverty Truth Commission (PTC). The work is being supported by the Health Creation Alliance via funding from the Lloyds Bank Foundation. The Commission will act as a platform for system leaders to gain insight into the 'lived experience' of local people who are challenged by poverty. A number of Voluntary, Community, Faith & Social Enterprise Sector (VCFSE) organisations are assisting with the project including Citizens' Advice, Halton Voluntary & Community Action (VCA) and Halton Veterans' Legion.

The National Institute of Health Research (NIHR) is supporting work across Halton's Core20 neighbourhoods. Utilising 'Kitty,' the research bus, NIHR colleagues are working alongside NHS and Halton Borough Council Public Health Team to offer research opportunities and health checks.

The bus has visited a number of community venues in Runcorn, offering blood pressure checks, BMI, and advice on early cancer detection. Participants are also offered the opportunity to take part in a research study on 'attitudes to bowel cancer screening.' The NIHR bus is a welcome addition to our wider Core20 Connector Project, which aims to find new ways to engage in under-served neighbourhoods. Approximately 800 people have had their blood pressure taken via the Core20 Connector and NIHR work streams.

Halton perinatal service provided by MCFT has considered how they can address health inequalities for two groups: women from ethnic minority backgrounds and young mums aged 25 or younger.

In Halton, Jan-Dec 23 data showed lower numbers of women from minority ethnic groups accessing the service and that proportionally higher numbers of Asian women are discharged after one contact than white/white British women. 37% of referrals to the service were for young mums, 11% of which were aged 19 or younger. During 2024/25 the service is working to increase access for ethnic minority families and build links with specific community groups and organisations. The service aims to increase engagement with young mums.

6.4 **Knowsley**

The Mental Health Long Term Plan requires that people with Severe Mental Illness (SMI) receive an annual physical health check. This is because people with SMI are dying up to 20 years earlier than those without SMI due to a combination of factors including the effects of psychotropic medication, poor lifestyle choices etc. The health check comprises of six elements including blood pressure, cholesterol, use of alcohol, smoking etc. The NHS England target is that 60% of people on the primary care "SMI Register", receive all six elements of the health check. Performance across most of Cheshire & Merseyside is below target. Places are being supported by the Cheshire and Merseyside Mental Health Programme Board; the Clinical Lead has recently held a workshop to consider innovations, which are now being reviewed locally.

St Helens and Knowsley are working with Primary Care and Mersey Care NHS Foundation Trust (MCFT) to improve performance and have established steering groups, supported by Place Clinical Leads.

Business Intelligence leads are part of the meetings, supporting as trajectories are set to deliver improved performance by the end of Quarter4.

<u>Northwood – Health Inequalities Programme</u>

Within Knowsley we have a targeted Health Inequalities programme which is aimed at supporting one of our most deprived wards within Knowsley. This innovative programme is undertaking a targeted population health programme which has been led by Knowsley NHS in conjunction with Public Health using asset-based community development principles. The programme looks at the whole population but uses proportionate universalism to target efforts within Northwood.

The programme aims to reduce unjust health inequalities which are evident across the life course and improve health outcomes by working with a range of organisations including the voluntary and community sector to tackle poverty.

A group of residents, named Your Northwood, was formed, and shaped the approach so far. Alongside is a task group of key stakeholders – VCFSE, NHS Trusts, various Local Authority services, leisure provider, housing provider, local GPs, local businesses, and youth services. Both groups work together to respond to the community's needs and improve services and the environment to reduce health inequalities. There have been some significant achievements on both a community and individual basis already. The focus on working closely with the local community as the solution to some of the challenges faced is being positively received in the area and has been key to the continued development of the Programme.

6.5 **Liverpool**

Primary Care Network (PCN) Plans in relation to population health have been reviewed for baseline / target performance on cancer; long term conditions (LTC) management; health inequalities and proactive care. New priorities agreed include phlebotomy services and high intensity users of acute services.

The alignment of community-based Integrated Care Teams (ICTs) and Liverpool City Council Neighbourhood models also continues to advance, whilst the rollout of a case finding tool (using Data into Action) is also progressing, with the aim of increasing the number of individuals accessing 'proactive care,' including the use of Telehealth.

Liverpool will test the impact of a data-led, Liverpool City Region multi-agency intervention approach – the North Liverpool Prototype - to support residents in North Liverpool who experience multiple complex needs. Persistent school absence (PSA) has been chosen as an entry point as it is likely a symptom of wider household needs such as housing, domestic abuse, or poverty. A diagnostic exercise is currently underway to understand the root causes of PSA. It is expected that once this phase has been completed, system discussions will commence around the potential interventions which can then be mobilised cross-sector.

6.6 **St Helens**

The Mental Health Long Term Plan requires that people with Severe Mental Illness (SMI) receive an annual physical health check. This is because people with SMI are dying up to 20 years earlier than those without SMI due to a combination of factors including the effects of psychotropic medication, poor lifestyle choices etc. The health check comprises of 6 elements including Blood Pressure, cholesterol, use of alcohol, smoking etc.

The NHS England target is that 60% of people on the primary care "SMI Register", receive all 6 elements of the health check. Performance across most of Cheshire & Merseyside is below target. Places are being supported by the Cheshire & Merseyside Mental Health Programme Board; the Clinical Lead has recently held a workshop to consider innovations, which are now being reviewed locally. St Helens is working with Primary Care and Mersey Care NHS Foundation Trust (MCFT) to improve performance and have established a steering group, supported by Place Clinical Leads.

Across the world, approximately one-third of global greenhouse gas emissions are attributed to food systems, which includes emissions generated by land use, agricultural production, the food supply chain, food waste, and more. By recovering food that might have otherwise been lost or wasted and by using local supplies where possible, food pantries are preventing billions of kilograms of greenhouse gases (GHG) from entering the atmosphere.

The first and most action identified by the Inequalities Commission, and reinforced by feedback from community leaders, was access to healthy food. A task group was formed with representation from the VCFSE, Local Government, NHS and our biggest local social housing provider, Torus. Through this network, an additional £30,000 was committed to set up community food pantries using the 'Your Local Pantries' model to increase the number of pantries. Mission in the Economy, with support from the Council, was also successful in securing funding for a 'mobile pantry.'

Since its inception, the work on food poverty has progressed rapidly throughout the Borough, with the number of pantries increased from 3 to 12 as of August 2024, with four of these sites serviced by the 'mobile pantry' van. In line with the ongoing cost-of-living crisis, these eleven sites continue to see high demand, with some opening for two days a week in order to increase available food provision to residents in need. There has also been an expansion of community allotment growing schemes, enhancing the provision of fresh, locally grown fruit and vegetables available to local food pantries.

Healthy Air for Healthy Lungs is a Public Health and Environmental Health led partnership between St Helens Borough Council and Warrington Borough Council, funded by a successful grant application the Department for Environment, Food & Rural Affairs (DEFRA). A total of 250 households in or close to the four Air Quality Monitoring Areas (AQMA) in St Helens and two in Warrington, will be identified to take part and offered a health promotion intervention and receive homes visits from the St Helens Wellbeing Service. Indoor air quality monitors will be issued to around 150 households in St Helens and around 110 in Warrington. The monitors collect data on particulate matter (PM1, PM2.5) NO2, CO2, Volatile Organic Compounds (VOCs), temperature and humidity. Households taking part will also receive additional funding for energy costs and support from the affordable warmth team. The data from the monitors will be used to give advice and support to improve indoor air quality.

The hope is that as a result, respiratory health will improve (as monitored by prescriptions issued and GP and hospital attendances). The project has now started to recruit families to take part and seems to be well received with families responding well to the use of the monitor. Some of the families targeted have been found to be living in properties with high levels of damp and we are working with them to reduce this. The project is being evaluated by Edge Hill University.

6.7 **Sefton**

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

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

6.8 **Warrington**

There are a number of key projects that are targeting health inequalities in Warrington, these include:

Targeted Lung Health Checks are now being rolled out across Warrington, with the first PCN to go live being Central and West Warrington (CWW), which includes the highest areas of deprivation within the town. CWW also continue to work with CLEAR (Clinically Led workforce and Activity Redesign) on a CVD (cardiovascular disease) project which is also linked to the obesity pilot that is being undertaken. Positive impacts of this project that are being realised include:

- NHS Health Checks (NHSHC) have doubled since 2023.
- There has been an increase in engagement in the NHSHC from the most deprived patients and from a South Asian ethnic background.
- The obesity register has increased by 56%.
- The PCN is on track to exceed the ambition of completing the health check with 75% of the eligible population.
- Nearly 3 weeks of time has been redistributed from GPs annually.

One of the five conditions of Core 20 PLUS 5 is hypertension and we know there are excess CVD (Cardio Vascular Disease) deaths in Warrington as such Warrington Innovation Network (WIN) PCN are continuing to implement their Hypertension project across the town. Positive patient feedback is being received, examples of which include:

> *"The service I have received is exceptional due to the dedication of all involved in caring for the patient."*
>
> *"Easy to use as I'm not local a lot of the time so using the app with the blood pressure machine to relay results was very convenient."*

"This type of service should be used more. It feels like I am more connected to my GP practice."

Both PCN projects outlined above have been nominated for HSJ awards.

Additionally, a number of projects relating to Core 20 PLUS 5 are detailed in the Children's and Young People section of the report.

6.9 **Wirral**
No significant update to provide.

7. Patient Discharge and Flow

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

7.2 **Halton**
As previously reported, Halton is part of two Urgent and Emergency Care (UEC) recovery programmes reflecting Halton's patient flows. Work is being undertaken across the range of partners to address "No Right to Reside" system challenges. During the summer period there were some discharge challenges due to workforce issues within social worker teams, but the local authority sought to mitigate the challenges through the recruitment of additional agency staff to support recovery.

Halton Borough Council has recently completed a procurement for domiciliary care services, with two main providers for each town which will come into effect over the next few months.

As part of the UEC improvement program Halton is working with the transfer of care hub in Warrington & Halton Hospital to match the quality of discharge information provided to Warrington Place to reduce further requests for information needing to be made.

By matching the same level and quality of information it is expected that the social work assessment phase can be shortened which will have a positive impact on Halton patients.

The new e-DIS as Whiston is operational and final issues are being resolved to allow greater access and control of the discharge information. Direct referrals for pathways 1 and 2 are being trialed with intermediate care services and reablement staff are attending wards to identify suitable patients that can be discharged more quickly.

Work continues to implement a more robust discharge to assess process for the majority of patients with only the complex and new care home placements requiring on site social worker assessment.

7.3 **Knowsley**

Workstream plans under the Mid Mersey and Lancs (MWL) Urgent & Emergency Care (UEC) Recovery Programme are progressing well in relation to flow and discharge indicators such as Length of Stay (LoS), Non-Criteria to Reside / pathways and discharges.

Knowsley continue to support the Capacity & Flow meetings including MaDE / SuperMaDE meetings.

Knowsley are also part of the Mental Health Recovery workstream which is majoring on patient flow. Part of the work is to review the high impact discharge initiatives which we are working with mental health providers on.

'Navigator' role implemented in February as a pilot to reduce ambulance conveyance and support care at home via Urgent Community Response (UCR). This has been inhibited by the Triage model within NWAS in Q1. The pilot is due to recommence in September for a period of 6 weeks to assess if this is a valuable way to increase appropriate referrals to the UCR teams.

Additional discharge capacity to support achieving a target of 10% non-criteria to reside (NCTR). The Knowsley figures continue to show an improving trend within our local Acute providers and whilst there remain data quality issues the indications are the Knowsley NCTR rate is 11-12%.

UCR links to support Care Homes and referrals from Out of Hours (OOH). Care Homes are able to refer directly into the UCR service and there is a pilot running within North Mersey where a member of UCR staff are present in PC24 to accept patients over the weekend period and it is expected that the 111 Directory of Service will allow referrals via 111 and Out of Hours to begin in September.

Virtual wards have been set up by Mersey and West Lancashire Teaching Hospital (MWL) for Respiratory and Frailty and a Heart Failure virtual ward is provided by Liverpool Heart and Chest Hospital. The Frailty service is supported by Mersey Care and links into the UCR service.

7.4 **Liverpool**

Workstream plans under the North Mersey Urgent & Emergency Care (UEC) Recovery Programme are progressing well in relation to flow and discharge indicators such as Length of Stay (LoS), Non-Criteria to Reside / pathways and discharges.

Length of Stay – Liverpool University Hospitals (LUHFT) level LoS information shows reductions across 14 and 21 day + metrics.

Discharge - Collaborative work to improve discharge processes has continued, with a system launch planned for 4th September 2024. Engagement sessions have taken place between nursing home managers and senior nursing leads from LUHFT and Mersey Care with plans progressing re: additional support for 'complex' patient placements.

Admission Avoidance – The mapping of all falls and frailty service provision is now complete for Liverpool Place, with work continuing to extend across the North Mersey footprint. A steering group has also been established to improve clinical escalation decision making and reduce conveyancing from Care Homes. Work is also underway to map Urgent Care Referrals (UCR) 'rejection criteria' with a view to eliminating inappropriate rejections and increasing referrals from NWAS. Additionally, the development of a direct social care pathway to eliminate rejections due to capacity (and aligning UCR across the North Mersey footprint) is also progressing well.

7.5 **St Helens**

St Helens continues to support the Capacity & Flow, RADAR and MaDE / SuperMaDE meetings. St Helens is also part of the Mental Health Recovery workstream which is majoring on patient flow. Part of the work is review of the high impact discharge initiatives which we are working with mental health providers on. At this point, (23.8.24) St Helens have two patients who are Clinically Ready for Discharge.

The SuperMaDE event in the run up to the bank holiday was well supported by all system partners in St Helens. The event supported system flow over the bank holiday and the Whiston site remained at OPEL 3 following the bank holiday, without the need to escalate to OPEL 4, the highest level of escalation.

Work is ongoing to collectively look at and improve the data and discharge process led by NHS place and Local Authorities when this work is complete it will support a standard approach across all three pathways. Presently data is being cleansed so we have a collected agreement on NCTR numbers and work can be focused on the right patients to be discharged in a timely manner.

The introduction of Homefirst which includes AI and assistive technology within the St Helen patient cohort is resulting in an increase in the number of pathway 1 patients, this will be extended to pathway 2/3 as we further recruit into reablement. An analysis will be completed in March to see if this new approach is making a difference.

The BCF Delivery Group is focusing on ensuring schemes are in place to support ambulatory care admission avoidance as well as reduce LoS. Recent Q1 data shows a reduction in the ambulatory care conditions resulting in MWL meeting its BCF national target. Work is still ongoing to improve the falls and LoS metrics. Both the long-term care from hospital and reablement targets are also being met.

Daily multi organisational meetings take place to support and agree discharge targets and flow management.

7.6 **Sefton**

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

Programme Objectives include:

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

To achieve the programme objectives the B@H programme is focusing on 5 areas:- 1. Market management and commissioning the right quality services , 2. Urgent and hospital to home transformation including increase use of admission avoidance services, establishing a Care transfer Hub to co-ordinate and prescribe appropriate care on discharge , mobilising a Home first model with additional reablement capacity, reviewing the community bed base, redesigning the health & social care front and working with trust colleagues on internal acute processes preparing patients for discharge. The scope of Sefton's programme 2 (Urgent and Hospital to Home are aligned to the ICB priorities will be delivered working with MWL, LUHT and other place Leads. Other Enablers Sefton will look to develop will focus on 3. Workforce, 4.Quality assurance and 5. Digital enablement

Challenges to delivery include:-

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

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

7.7 **Warrington**

Progress continues to be made in all workstreams towards delivering the opportunities identified from the Newton Europe diagnostic work, with some of the indicators already on track. Most notably:

- A significant improvement in Corridor Care where the mean number of morning corridor care patients in August this year compared to last has reduced, combined with an overall reduction of time spent on the corridor per person.
- Achieving trajectory set for A&E (Accident and Emergency) 4-hour performance alongside improvement in 12-hour performance and a reduction in A&E attendances.
- A reduction in Length of stay of Intermediate Care Beds for the Warrington population.
- Consistent and maintained reduction in the number of Children and Young People attending A&E and being admitted to paediatric wards for mental health reasons over the last 2-3 years.

All workstreams are intended to improve urgent and emergency care outcomes for the whole population however there is a particular focus throughout for our most vulnerable population with frailty syndromes of falls, immobility, delirium, incontinence, and side effects of medication.

Activities and interventions that have driven these improvements in:

- Ensuring flow through the Frailty Assessment Unit (FAU) is improved as a new GP is now working in the unit and developing pathways to support flow and discharge.
- Ensuring Comprehensive Geriatric Assessments are completed in a timely manner.
- Developing the One Front Door Model and improving access to capacity in the rapid response services (including Urgent Community Response) to ensure where possible this cohort are cared for and treated in the community to avoid the need for hospital all together.
- Increasing communication of expectations on discharge by introducing an improved booklet for patients, families, and carers
- Increasing capacity in the Frailty Virtual Ward.
- Decreasing the length of stay in Intermediate Care beds to increase capacity available.

7.8 **Wirral**

No significant update to provide.

8. Primary Care Network Development

8.1 **Cheshire East**

General practice in Cheshire East has in some ways led the way on collective action owing to many of our practices being larger and more cohesive.

Although at the time of writing there are few apparent significant implications from the taking of collective action, the situation is being kept under close review.

What has been seen is at least one senior GP stepping back from the kind of leadership roles that GPs have historically occupied.

8.2 **Cheshire West**

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

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

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

Finally, a proposal has been drawn up by the Primary Care Team to work collaboratively with PCNs to utilise System Development Funding towards recovery priorities. The proposal focuses on the stepping up of Acute Hubs to deal with on the day demand and free-up clinicians to focus on chronic conditions. This will be backed by Targeted Interventions within frailty, cardio-vascular disease, respiratory and diabetes. Once this funding is confirmed, the PCNs are ready to roll-out these initiatives.

8.3 **Halton**

The Same Day Primary Care Integrated Neighbourhood Model Programme is progressing with cross organisational booking between Practices and the Urgent Treatment Centre's (UTC) to commence shortly.

The model aims to improve access, by aligning the Practices and UTCs within each PCN. Through collaborative working a Standard Operating Procedure has been agreed defining where patients should best access same day care for a range of clinical conditions, including Community Pharmacy.

To support a consistent access model, Practices continue to review and improve their access models, working towards implementation of the Modern General Practice Access Model. This includes local access surveys, sharing best practice and sharing the lessons learned whilst implementing change. The Support Level Framework continues to be offered as a supportive development tool, alongside access to Transition and Transformation funding which has been used by seven Practices to implement access improvements.

Whilst Widnes PCN appointed a new Clinical Director on the 01 April 2024, Runcorn PCN are currently also appointing a new Clinical Director to commence late September 2024. Despite this change in clinical leadership, both PCNs are committed to continuing the development work already in place, and in working collaboratively with the Place team and local partners.

The Place Primary Care Workforce Group, which includes PCN Clinical representation, has reviewed the results of the local GP Retention Survey, undertaken with the Training Hub. The survey highlights the clinical areas for development, many of which align to PCN and Place priorities. Discussions continue on how best to support development and expand clinical leadership. A similar survey is planned for the nursing workforce to inform the development of general practice nursing leadership, essential for the implementation of the local LTC Integrated Neighbourhood Model.

8.4 **Knowsley**

Knowsley's three PCNs continue to mature following a reconfiguration in April 2024 which resulted in two GP practices changing their core network membership. All three have engaged Mersey Internal Audit Agency (MIAA) to undertake a review of PCN systems, processes, and governance arrangements to support further development. Reports and recommendations are expected in October. PCNs are also progressing in their engagement with wider system partners and stakeholders, a dedicated protected time event with Mersey Care was held in July to identify opportunities for improved collaboration and development of integrated delivery in both physical and mental health and PCNs are fully engaged in development of Women's Health Hub arrangements for Knowsley.

Place and 'at scale' Primary Care Service Development Plans for 2024/25 have been developed with PCNs, locally endorsed submitted for formal approval to ICB, at scale plans seek to provide additional capacity to support UEC pressures throughout winter period which will be accessible to partner organisations.

Numbers of GP practice appointments continue to increase, 73,516 appointments were available in June 2024 compared to 71,109 in June 2023. GP practices are seeing significantly more patients each month than before the pandemic. 70% of appointments are provided 'face-to-face'. To support initial access all practices now have cloud-based telephony in place with 'call back' functionality and all GP practices reception teams have received care navigation training to help patients access services across health and care systems. All three PCNs have implemented 'EMIS hub' to support shared clinic arrangements with full access to patient records and diagnostic requests.

All practices in Knowsley are participating in the Local Quality Incentive Scheme, this two-year scheme expires in March 2025 providing an opportunity for review and potential harmonisation with neighbouring ICB place based GP quality schemes.

Strong local links with practices and LMC colleagues are in place which have been helpful in supporting an open dialogue in relation to Collective Action (CA), at time of writing no formal notification of CA has been received from any Knowsley practice.

8.5 **Liverpool**

Liverpool's 9 PCNs continue to collaborate and engage with wider system partners and stakeholders. System Development Funding (SDF) funding has enabled 6 of the 9 Liverpool PCNs to work together on a collective plan for adult ADHD transformation, whilst good progress continues to be made with the Women's Health Hubs programme. A number of emerging funding opportunities have supported the initiation of projects aimed at tackling health inequalities – including obesity and vaccines health inequalities pilots in collaboration with Liverpool School of Tropical Medicine.

8.6 **St Helens**

PCNs are progressing well with developing their Care Communities. Whilst these are much wider than PCNs, and include community, mental health, VCFSE, social care etc, the PCNs are at the heart of the care community and are taking a lead role in their development. North PCN is starting to work with partners to support children who are unable to attend school as a result of health issues, either personally or family issues. This programme will start when schools re start in September.

Newton and Haydock PCN are at advanced planning stage of their care community and have identified patients who will benefit from a wide multi-disciplinary approach to their health and care. These include people known to multiple services from our most deprived communities. Newton and Haydock also have a specialist frailty team and they will also focus on this cohort where they believe they can benefit from wider support.

South and Central PCN are in the earliest stages of planning and will be identifying the cohort with the highest need using data available to them.

The ability to share data in advance of the meetings in currently causing some difficulties as data agreements now need to be reviewed where PCN employed staff are sharing data e.g. care coordinators. This has been reviewed and a process to overcome this is well underway.

PCNs continue to mature and are developing plans to support the system over winter. The plans consist of additional appointment availability for key cohorts of patients e.g. additional children's clinics. North PCN pilot of an urgent care hub is currently running and will be evaluated in terms of effectiveness at the end of the pilot period (quarter 3 24/25).

8.7 **Sefton**

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

Challenges we experience include suitable estates to maximise roll out of PCN services and embed additional roles. The ongoing demand in general practice means many practices are concerned about viability.

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

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

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

Lincoln House Surgery, Southport

The former contract holder for Lincoln House Surgery retired in December 2023. NHS Cheshire and Merseyside, which is responsible for planning GP services in Sefton, took the decision to appoint an interim provider for the practice, to provide continuity for patients while a longer-term plan was agreed. Southport and Formby Health Ltd was awarded an interim contract for the period 1 January 2024 to 31 March 2025. However, they have recently served notice on the contract, with a termination date of 31 October 2024.

NHS Cheshire and Merseyside have looked at different options to identify a new provider to continue to manage the practice but have concluded that unfortunately this has not been successful. Lincoln House is a small practice, with 1,921 registered patients as of April 2024, making it less attractive to potential providers. When the ICB tested the market during the process to recruit an interim provider, the current provider was the only one to submit an interest. When they gave notice, Southport and Formby Health cited the small list size as the reason they felt the contract was not sustainable.

NHS Cheshire and Merseyside wants to ensure that people in Sefton receive good quality, sustainable GP services, which provide continuity of care. The ICB believe that the best way to do this is to transfer Lincoln House patients to other local GP practices, meaning that the practice would close.

Next steps
Sefton place has written to everyone registered with Lincoln House Surgery to explain the situation and give them the opportunity to provide any comments. Sefton are also holding two drop-in session for anyone who would like to share feedback or ask questions face to face.

They are currently working with other local GP practices to plan for the transfer of patients by the end of October 2024.

People will be allocated to another practice close to where they live – their medical records will be securely moved, and they will not need to take any further action. The plan is to write to patients again during October to let them know which practice they will be transferred to.

The practice is in a building managed by NHS Property Services. There is ongoing work with partners to explore the potential for other local services to utilise the space.

Staff at Lincoln House Surgery are employed by the current interim contract holder, who is responsible for keeping them updated and informed about the process and next steps for them.

8.8 **Warrington**
Warrington has 26 practices which make up five PCNs. The PCNs and their Clinical Directors are well embedded within the Warrington Together system and are working collaboratively with each other and with partners.

The East PCN Complex Pain programme continues to progress well. Work is ongoing with partner agencies to establish the second cohort of clients, now extending eligibility beyond the original criteria to include a wider group of GP Practices to encourage enrolment. Collaboration with our High Intensity Users team has also supported a targeted offer to those more complex clients who are presenting regularly at our Urgent & Emergency Care department.

WIN PCN are utilising a variety of funding sources e.g., System Development Funding, transitional funding, Capacity, and access funding to implement to further improve efficiencies within the PCN and support resilience for practices to manage the increased demand brought about by improving access. WIN will be utilising their PCN online access tool (Anima) and dedicated SystemOne unit to implement PCN level signposting and triage. Their ARRS team will be an essential component as a first line of contact and support, making sure their patients get access to the right clinician and right care, first time. With varied skill mix, WIN PCN estimates that up to 50% of patient presenting conditions can

be dealt with at PCN level via PCN ARRS roles without the need to reach individual practice level.

The model aims to support practices with acute on the day access but also to improve the way planned care is delivered. This will increase access and the timeliness of our acute illness response offer for patients. For practices, this will improve resilience, continuity of care and access to proactive and routine care at practice level.

8.9 **Wirral**

New PCN: Implementation from 01 August 2024 continues and is going well to date.

Collective Action is being monitored where possible. Open dialogue with practices, PCNs and LMC where appropriate.

Additional Role Reimbursement Scheme (ARRS) roles: Progress as planned as per recruitment plans. Challenges and use of Mental Health practitioner role continues with a further PCN serving notice to Cheshire and Wirral Partnership NHS Foundation Trust (CWP).

Service Development Fund: At Scale – Acute Respiratory Infection (ARI) Hub being explored for Winter period. Transformation – PCN plans in development for ICB approval.

Alternative Providers of Medical Services (APMS) procurement process for 2 practices underway.

Neighbourhoods: 9 Neighbourhood areas have been set out in Wirral. To date, two trail blazer neighbourhoods progressed, with one Neighbourhood being established. Due to changing stakeholder commitments, both neighbourhoods are currently without a Chair and as such are not able to move forward. Proposal to pause any further work to support financial recovery.

Moreton Group Practice: Branch site in Chadwick Street, Moreton to close from 30th September. Engagement with patients and staff has taken place with minimal feedback from patients received.

COVID-19 Vaccination Programme: Onboarding process for 7 PCN groupings being progressed in readiness for the start of the programme on 3rd October 2024. Community pharmacy providers have increased from 6 to 20 for this campaign.

9. Provider Market Development / Strategic Initiatives

9.1 **Cheshire East**

Sustainable Hospital Services is the name of the programme that describes East Cheshire Trust's work with principally Stockport Foundation Trust to address some of their challenges around service sustainability.

Since the case for change was supported by a wide range of partners, progress has been made in some areas (for example maternity); less progress made in others. One example where less progress has been made is in general surgery where a plan to transfer higher risk patients to Stepping Hill in exchange for elective orthopaedic work being delivered in Macclesfield has foundered because of capital and revenue constraints.

The original case for change is being refreshed, at which point it is planned to be able to agree a sustainable way forward.

Healthier Futures is the name of the programme that will deliver a new Leighton Hospital. The strategic outline case has been presented to the national decision-making panel, and meanwhile work proceeds towards an outline business case in Summer 25. This is a very significant programme for us, with potentially wide-ranging implications. It is important that the hospital is 'right sized', and that any assumptions about wider place transformation are aligned to the resources necessary to deliver them.

9.2 **Cheshire West**

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

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

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

9.3 **Halton**

In addition to the development of the Runcorn Health and Education Hub located in the Runcorn town centre library, exploratory meetings have been held amongst One Halton partner organisations to consider the feasibility of establishing a Widnes Health Hub. The proposal is that the Health Hub will be based within the Widnes Healthcare Resource Centre, adjacent to the new Council leisure complex within Widnes town centre which will expected to provide a renewed concentration of footfall to the area.
The Health Hub will seek to amalgamate under a ‘single roof’ a range of primary and (public health) preventative healthcare services, including re-located sexual health clinics and heart failure services alongside existing primary care practices and other community services.

Additionally, the One Halton Strategic Estates Group has been re-focused to support better appreciation and understanding of the interface and interdependencies between Halton’s respective strategies for economic

regeneration and healthcare, by ensuring earlier and more extensive consideration of potential impact of proposed housing development (Section 106) applications. The Strategic Estates Group will also strengthen oversight of Place estates planning processes and will see to ensure that optimisation within any existing estates constraints.

Work is progressing on the Halton care homes provider market development with a project commissioned through Capacity, a Liverpool based social enterprise working across the Northwest. The project vision is to achieve outstanding delivery of care to residents in care homes in Halton. This 5 stage project will engage with residents, families and staff through focus groups, to establish their views on what ideal care looks like. The ambition is to ensure families and residents receive a good experience of living in a care home in Halton and that staff delivering care within these homes, feel supported, have access to good training and have opportunities for career development.

9.4 **Knowsley**

Helping to shape and support a strong and stable local care market within Knowsley is a priority for both NHS Knowsley and our Local Authority. As an organisation we actively encourage new providers to enter the market, particularly small, local providers who know the area and can deliver truly personalised outcomes for people. By working with providers across a whole range of sectors and residents/patients themselves we aim to enable innovation and creativity within the market locally.

As a system we continue to support this by designing new models of care which reflect the “Knowsley Better Together” way of working. One of the key challenges that we, as a local system have prioritised are the significant challenges in relation to recruitment for social care jobs. To support this further we have pooled existing budgets within our Section 75 agreements and also utilised growth monies within our BCF (Better Care Fund) to support the ongoing recruitment of roles, which cut across both Health and Social Care.

9.5 **Liverpool**

Liverpool Clinical Services Review (LCSR): Liverpool Place is responsible for ensuring that the recommendations from the LCSR are delivered, which will enable an acute and specialist hospital system that is clinically and financially sustainable and able to achieve improved outcomes, patient experience, and efficiency.

The first phase of the LCSR programme has initially focused on the recommendations relating to population health, cancer outcomes, CMAST-led (Cheshire and Merseyside Acute and Specialist Trust Alliance) programmes and digital improvements. The programme has defined workstreams and performance metrics which are being managed through an Oversight Delivery Group, with partner representation.

Phase two of the LCSR programme was initiated in August, focusing on actions to be taken by Liverpool's acute and specialist trusts to realise further opportunities to enable more streamlined decision making and to build upon existing collaboration.

9.6 **St Helens**

The Market position statement (MPS) is now live, following this we have been approached by several developers who are willing to work collectively with us to build and provide the right type of accommodation and support around Mental Health, Learning Disabilities, Dementia and Autism.

The new domiciliary care contract and redesign opportunities will enable all partners to work together to bring about an integrated approach that includes health and social care particularly those in receipt of continuing health care to enable a seamless approach to the consistencies of care.

The All Age MPS covers young people, and we will continue to work with children and young people services and health colleagues around SEND, Personal Health Budgets and young people's mental health.

Provider Forums have been redesigned to support the delivery of the MPS and bring about strategic change with willing providers.

9.7 **Sefton**

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

Our Shaping Care Together programme (a partnership between MWL Teaching Hospitals, NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria) has developed a Case For Change which has now been approved and engagement is underway with local residents to inform the development of a pre-consultation business case. Discussions are also underway regarding the establishment of a Joint Committee of the partners to ensure full oversight of the process and any proposed changes.

Sefton place is working with Sefton Local Authority on an integrated contracting and brokerage function for home care and care home provision.

9.8 **Warrington**

The Place team are working collaboratively with Warrington Borough Council Commissioning and Public Health teams to identify increased co-commissioning arrangements, focussing particularly on integrating contracts with the same providers to realise economies of scale.

The Warrington and Halton Integration programme between Warrington and Halton Hospital Foundation Trust (WHHFT) and Bridgewater Community Healthcare Foundation Trust is progressing well with the following clinical priorities being identified as a high priority:

- Urgent and Emergency Care
- Intermediate Care
- Dermatology
- Paediatric audiology
- Child protection medicals.

9.9 **Wirral**

Mental Health Recovery Programme - patient flow, Wirral MaDE has expanded its membership to include housing colleagues and discharge facilitation. As a result, all relevant organisations and teams are represented to ensure patients who are clinically ready for discharge (CRFD) will be discussed and facilitate their discharge in a timely manner. The same forum has also included out of area patients who are delayed, along with patients delayed in non-contracted beds with a view in understanding that regardless of the type of bed, a delay is a delay to the system.

The ten property Independent Living Pilot with Magenta Living is now in a position to identify properties for a patient list including both in and out of area patients in either inpatient beds or supported living placements.

This will significantly reduce the cost involved with these individuals and provide a greater independence and community rehabilitation. Expected timelines are for the first patient to enter their property around October-November 2024.

There is now a small working group established between Wirral, Cheshire East, and Cheshire West places, alongside CWP to progress the engagement work and modelling to redesign the current crisis step down mental health beds we have across the footprint. Engagement is planned with housing providers on the 29 September and the 01 October 2024, along with discussions around potential procurement timelines

Children and Young People (CYP), the Emotional Wellbeing Alliance contract launched in April 2024 and service delivery commenced from this date with the 5 providers. Branch, the new website with built in referral access to these services and up to twenty other Wirral services supporting CYP is currently in a soft launch phase.

The matching function which provides a service or resource to CYP, parent/carers or professionals using the website will fully launch in early October 2024. Wirral CYP Mental Health services provided by CWP are associate members of the contract and will provide multidisciplinary team (MDT) support for any referrals.

Wirral Place in conjunction with Wirral Council launched The Drop In, an equivalent Crisis Cafe offer for children on the Wirral. A joint venture, jointly funded and building on the success and learning of the pilot, this provision now provides open access support to children alongside the Response Counselling service, and is fully integrated within the new Branch platform.

Dementia, is part of the mental health programme chaired by Suzanne Edwards, the strategy has leads for each of the 5 sections who will be reporting back through the implementation group.

#The nurse practitioners for older people (NPOP) are now supporting with the referrals and diagnosis process through undertaking ECGs, and the Alzheimer's Society have recruited another full time dementia adviser to support with post diagnostic care following diagnosis of dementia.

Adult ADHD – LEAP model, this service is going well and is a much better patient journey, we have had approval in Place for a pilot to move the risk stratification of patients into primary care and there is another cohort of Wirral GPs being training as assessors in Sept/October. Wirral colleagues are supporting Places across C&M with their own implementation of LEAP.

10. Children and Young People (CYP)

10.1 **Cheshire East**
No significant update to provide.

10.2 **Cheshire West**
We are progressing an in-depth review of Children in Care service with provider and Local Authority to consolidate efficiencies to deliver better outcomes for Children and Young People placed in care within Cheshire West. Further work will also take place with the Local Authority around their recent Inspection of Local Authority Children's Services (ILACs) inspection of Social Services.

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

A joint approach with Local Authority and Voluntary Sector is being developed to invest in Early Help and support to build emotional resilience in Children and Young People in an effort to reduce the levels of demand for mental health services. This should be supported by the Health Inequalities Programme opportunity as detailed above.

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

10.3 **Halton**

Halton Borough Council has received an Improvement Notice following the outcome of their ILACS rated as inadequate. A Children's Improvement Board development session has been held and a multi-agency Improvement Board will address the outcome findings and recommendations.

Mid Mersey places have secured recurrent Transforming Care funding for a CYP Intensive Support Team (IST). The IST will have specialist skills and capacity for CYP on Dynamic Support Registers that present with behaviours that challenge to achieve change that reduces or prevents the need for: the use of restrictive practices, inpatient services, and residential placements. Commissioners will work with the provider Mersey Care NHS Foundation Trust, to mobilise the service.

Halton also continues to progress work around early support for CYP and their families. The digital Family Hub was officially launched on the 3rd August 2024 and partners are working together to increase the amount and quality of information that families can access about local services. Within the CYP Neuro-Development programme, Halton will be piloting the Portsmouth profiling tool which aims to help identify a child's needs and what may help to meet the need. The tool does not replace the need for a neurodevelopment assessment if this is required, but will help CYP and their families to access support at an earlier stage.

There has been one notifiable children's safeguarding case within the Quarter. A review has been undertaken and the report was shared with the National Safeguarding Panel. Learning from the case will be managed through the Halton Safeguarding Children's Partnership Improvement Tracker as the case did not meet the threshold for a Statutory Review.

NHS Cheshire and Merseyside Halton Place and the commissioned providers continue to discharge their Safeguarding Duty effectively and meet statutory requirements.
Halton Place continues to support the Safeguarding Children's Partnership at all levels. Work is ongoing to embed the new partnership arrangements mandated within the Working Together to Safeguard Children Statutory Guidance 2023.

10.4 **Knowsley**

Mid Mersey places have secured recurrent Transforming Care funding for a CYP Intensive Support Team (IST). The IST will have specialist skills and capacity for CYP on Dynamic Support Registers that present with behaviours that challenge to achieve change that reduces or prevents the need for: the use of restrictive practices, inpatient services, and residential placements. Commissioners will work with the provider Mersey Care NHS Foundation Trust, to mobilise the service.

There has been one notifiable children's safeguarding case within the Quarter – Child G. A rapid review was undertaken, and the report was shared with the National Safeguarding Panel. It was agreed that a single agency review would be undertaken by Warrington CSC. The case did not meet the threshold for a Statutory Review. Awaiting a decision to the consideration from the National Panel.

There is an ongoing Child safeguarding practice review being undertaken in joint partnership with Liverpool, - Child A, the independent reviewer is finalising the report. Once completed it will be shared.

Work is progressing to improve the current Adoption medical process within Knowsley. The completion of prospective adopter and foster carer medicals are not in the national GP contract and therefore they are completed at the discretion of the GP, multifaceted pressures across primary care have impacted in the completion of the assessments, which has an impact on prospective adopter and foster carers being approved, delaying the Adoption Orders being granted, thus leaving children in the care of the local authority for longer than necessary.

Knowsley Place will propose a local enhanced service for completion of adult medicals for adoption and fostering purposes, improving the timeliness and quality of the medical assessment reports completed for adults.

10.5 **Liverpool**

In response to the ICB Recovery Plan, a programme of work focusing on admissions avoidance at Alder Hey has been designed in conjunction with the development of primary care diagnostics. The focus for this work is the presentation of asthma and other respiratory symptoms in C&YP; this is a group of patients who would benefit most from a better developed local offer from community-based services. The primary care diagnostics offer is being tested in North Liverpool, and it is anticipated that this will contribute to a reduction in Accident & Emergency Department (AED) attendances, as well as enabling patients to better manage their symptoms.

A wider piece of work around lung health for our local population will take account of additional environmental and social determinants, and will take a partnership approach (health, social care, housing, education etc.) to improving experiences and outcomes.

The Liverpool Early Help & Prevention Partnership Strategy 2024-27 is due to be re-launched imminently. Although the LA is the lead commissioner, Liverpool Place is a key commissioning partner, and the revised strategy will therefore reflect an integrated approach.

The network of Family Hubs continues to be rolled out across the city, with the ultimate aim of having thirteen Hubs co-located in Neighbourhoods. A city-wide partnership is in place to oversee the 'local offer' for each of these Hubs and it is expected that this will result in need-led services for each neighbourhood.

Mental Health, Neurodevelopmental and Transforming Care, a steering group has been established for CYP with 'complex situations' and multiple needs with Liverpool City Council and wider health partners. Programmes include data/information sharing, workforce development and the roll out of the 'Growing Stronger' campaign (an Adverse Childhood Experience programme) in partnership with LCC and School Improvement Liverpool.

SEND, Liverpool Place continues to work with Liverpool City Council to implement a revised 'graduated' approach. Additional funding has been made available via Transforming Care to extend the current Neuro Diversity support offer and development of a system for joint funding complex cases that do not meet continuing care eligibility.

10.6 **St Helens**

Mid Mersey places have secured recurrent Transforming Care funding for a CYP Intensive Support Team (IST). The IST will have specialist skills and capacity for CYP on Dynamic Support Registers that present with behaviours that challenge to achieve change that reduces or prevents the need for: the use of restrictive practices, inpatient services, and residential placements. Commissioners will work with the provider Mersey Care NHS Foundation Trust, to mobilise the service.

10.7 **Sefton**

Performance and waiting times for: specialist children and adolescent mental health services (CAMHS), Speech & Language therapy, ASD/ADHD assessment and diagnostic services remain challenged, although positively waiting times have seem some improvement and/or stabilised in Q1 2024/25.

Sefton Place and Alder Hey continue to lead on further development of the Occupational Therapy sensory model (0 – 18) and graduated approach. A business case for the joint funding of specialist Occupational Therapy (OT) sensory assessments is being progressed and SEND partners recently completed a mapping of current provision to inform pathway development and joint commissioning plans.

Sefton Place submitted a successful bid for C&M ICB Transforming Care funding to provide an enhanced offer of support to those waiting on the ASD and ADHD assessment and diagnostic pathway to be delivered in partnership by Alder Hey and Advanced Solutions Community Network. The enhanced offer is in the process of being mobilised.

Sefton's Parent Carer Forum have been selected to give a presentation on work in Sefton on a national co-production forum.

Neuro Diversity (ND) demand continues to be challenging. National ADHD medications shortage requires the clinical team to prioritise follow up appointments and support associated with supply of medication which is impacting assessment capacity. Trust to source additional ADHD assessment capacity from external provider. Place engaged with all C&M wide ND discussions and workstreams.

The current recruitment freeze means Sefton's key working team is under capacity and will not be able to meet plans to expand its offer to the 18-25 cohort. This will limit caseload capacity and ability to engage fully in transition.

Sefton Place Team and Alder Hey have prepared a cost neutral business case to provide resilience and bolster CYP community continence to meet national standards and provide opportunities for pathway improvements and efficiencies.

Sefton Place Team leading on development of Sefton's Respiratory improvement Plan which is being supported and implemented by local system partners. With a focus on better management of respiratory conditions/asthma in primary care/community this will support a reduction in A&E attendances and hospital admissions. This includes input from public health and housing to address the wider determinants of health, particularly in areas of deprivation.

First phase of providing a local model to support the emotional health and wellbeing needs of care experienced young people is being developed, via spot purchasing of counselling support from established local VCF providers.

10.8 **Warrington**

There are a number of projects that are being delivered against the Core 20 PLUS 5 clinical priorities which are having a positive impact and improved outcomes, these are detailed below:

Respiratory, Model Hospital data shows that Warrington and Halton Hospital Foundation Trust now have the lowest rate of acute lower respiratory infection admissions in their peer group and are around the national average for children's acute lower respiratory infection admissions.

The ongoing work in this area shows that hospital attendance and admissions are proportionately higher from our wards in the town with the higher indices of deprivation. Local Transformation funding has been utilised to establish a Paediatric Respiratory programme targeted at our most deprived wards. Working with GP's, the acute Trust and Housing we are looking to improve respiratory function, outcomes and reduce unplanned hospital attendances/admissions for this vulnerable cohort of children and young people. Baseline data shows an increase in A&E attendances over the last 2023/24 period compared to the previous year, however, owing to the ongoing project, we are now seeing a 6% reduction in overall admissions.

Epilepsy, Model Hospital data shows that WHHFT are the second lowest in their peer group and in the lowest quartile nationally for 0-17 Non-Elective Epilepsy admissions. Warrington also has fewer admissions than the national average.

Diabetes, the National Paediatric Diabetes Audit (NDPA) (July 2023) shows that in comparison to the Northwest and England & Wales average the unit at WHHFT has lower emergency admissions for Type 1 diabetes.

Children & Young Peoples Mental Health (CYP MH), partners continue to work in collaboration across all sectors in Warrington to deliver CYP MH services. These services include the Core CAMHS service, which achieved 119% against the National Access Target in 2023/24. Other key areas of collaboration include CAMHS 24/7 Crisis offer including Home Treatment offer, the development of the Youth Zone Drop In 7 days/week service, and the development of a bespoke offer in Youth Justice teams all of which can support children in care.

Like other Places, we are continuing to face the challenge in relation to the increasing demand for Neuro Developmental (ND) assessments. This is being progressed as part of the CYP Neuro-Diversity Pathway Group, one of the ICB Recovery programmes.

Children's Safeguarding, since the last report, an outcome report has been published following the Inspection of the Local Authority services for children in need of help and protection. (ILACS). The Local Authority was judged as Good overall with 2 categories identified as Outstanding, Leadership and positive experiences of Children in Care. The report has been reviewed and references to health have been incorporated into an improvement plan which will be monitored.

There are two children's safeguarding cases that are ongoing. The Child Safeguarding Practice Learning Review was published on the 12th August 2024 which garnered significant media interest. There is a multiagency action plan in place as a response to the recommendations, however the health elements have been incorporated into a local plan for monitoring and oversight.

The second case has been subject to a Rapid Review and is awaiting sign off by the Warrington Safeguarding Partnership. A thematic review is being completed.

The ICB Warrington Place and the commissioned providers continue to discharge their Safeguarding Duty effectively and meet Statutory requirements. Warrington Place continues to support the Safeguarding Children's Partnership at all levels. Work is ongoing to embed the new partnership arrangements mandated within the Working Together to Safeguard Children Statutory Guidance 2023.

10.9 **Wirral**

No significant update to provide.

11. Use of Resources

11.1 **Cheshire East**

At the end of Month 4, Cheshire East Place reported a deficit of £20m, which is a £2.6m adverse variance than the planned deficit of £17.3m.

The predicted deficit at the end of the financial year is £61.5m, which is a £9.4m adverse variance to the planned deficit of £52m. A review of potential risks and mitigations has identified a potential further net deterioration of £7.6m.

In terms of spending that can potentially be influenced, continuing healthcare is our principal focus. We have identified cost improvement opportunities by reducing the number of one-to-one packages of care, and also by a more robust approach to price negotiation. These are being actively pursued in conjunction with the broader recovery program in this area. At the same time, demographic pressures remain, and it is important that budgets are set at a realistic place appropriate level.

Cheshire East Place has delivered £1.4m worth of savings compared to the £2.7m that was included as part of the financial plan. However, it should be noted that Cheshire East Place is currently forecasting that £13.1m of the £13.2m planned savings target will be delivered by the end of the financial year. Additional recovery plans are also being developed to mitigate the known risks but there are still emerging pressures in respect of continuing healthcare and therefore these may not be fully mitigated.

11.2 **Cheshire West**

At the end of Month 4, Cheshire West Place reported a deficit of £13.8m, which is a £0.4m lower the planned deficit of £14.2m.

The predicted deficit at the end of the financial year is £44.3m, which is £1.7m adverse variance to the planned deficit of £42.6m. A review of potential risks and mitigations has identified a potential further net deterioration of £1.5m, and therefore the risk adjusted forecast outturn is a projected deficit of £45.8m which is a £3.2m adverse variance to plan.

Cheshire West place has delivered £1.6m worth of savings compared to the £2.6m that was included as part of the financial plan. However, it should be noted that Cheshire Wests Place is indicating that the full £8.2m savings target will be delivered by the end of the financial year. Additional recovery plans are also being developed to mitigate the known risks but there remains a risk that these may not be fully mitigated.

11.3 **Halton**

At the end of Month 4, Halton Place reported deficit was £4.4m, which is a £1.3m adverse position to the planned deficit of £3.1m.

The predicted deficit at the end of the financial year is £12.9m, which is £3.5m above the planned deficit of £9.4m. A review of potential risks and mitigations has identified a potential further net deterioration of £1.1m to that position, and therefore the risk adjusted deficit is currently projected to be £14.0m.

The Financial Recovery target at Month 4, to deliver the financial plan, is £4.7m and mitigations are being actively pursued and progressed to deliver against this as a priority, but this remains a risk as for other Places across Cheshire and Merseyside.

With no scope for discretionary investment, Halton is also committed to contributing to the improvement action plan arising from the recent CQC review

of SEND. In addition, the challenging outlook of the local authority potentially reduces the scope for new joint investment opportunities and increases risk on current arrangements.

11.4 **Knowsley**

At the end of Month 4, Knowsley Place reported surplus was £1.9m, which is a £2.1m adverse position to the planned surplus of £4.0m.

The predicted surplus at the end of the financial year is £10.0m, which is £1.9m below the planned surplus of £11.9m. A review of potential risks and mitigations has identified a potential further net deterioration of £1.1m to that position, and therefore the risk adjusted surplus is projected to be £8.9m. The Financial Recovery target at month 4, to deliver the financial plan, is £3.0m and mitigations have been identified to deliver against this.

Knowsley Place has delivered £0.4m worth of savings compared to a plan of £1.1m, which is an adverse variance of £0.7m. However, Knowsley Place is indicating that the full efficiency plan of £3.4m will be delivered by the end of the financial year.

11.5 **Liverpool**

At the end of Month 4, Liverpool Place deficit was £2.6m which is £6.1m above the planned surplus of £3.5m and reflects an adverse position.

The predicted deficit at the end of the financial year is £1.6m which is £12.2m above the planned surplus of £10.6m. A review of potential risks and mitigations has identified a shortfall in our QIPP delivery and additional risks which together total £5.1m to give a risk adjusted deficit of £17.4m.

Liverpool Place has delivered £3.2m worth of savings compared to a plan of £3.2m. Liverpool Place is indicating that the full efficiency plan of £11.9m will be delivered by the end of the financial year. Additional Recovery plans of £13.2m are being developed, which leaves a remaining risk of £4m against which further actions are being considered to achieve financial balance by the end of the year.

11.6 **St Helens**

At the end of Month 4, St Helens Place reported deficit was £5.4m, which is a £1.7m adverse position to the planned deficit of £3.7m.

The predicted deficit at the end of the financial year is £15.3m, which is £4.2m adverse to the planned deficit of £11.1m. A review of potential risks and mitigations has identified a potential further net deterioration of £0.6m to that position, and therefore the risk adjusted deficit is projected to be £15.9m. The Financial Recovery target at month 4, to deliver the financial plan, is £4.8m and mitigations have been identified towards delivering against this.

For the 5% planned cost reductions, St Helens Place has delivered £1.0m worth of savings compared to a plan of £1.6m, which is an adverse variance of £0.6m. However, St Helens Place is indicating that the full cost reduction plan of £4.9m will be delivered by the end of the financial year.

11.7 **Sefton**

At the end of Month 4, the Sefton Place financial position was a deficit of £8.2m which is £4.7m above the planned deficit of £3.5m and reflects an adverse position.

The predicted deficit at the end of the financial year is £23.8m which is £13.3m above the planned deficit of £10.5m. A recovery plan which identifies cost reductions of £12m has been agreed and implemented and there is further work in progress to address the remaining £1.3m required to deliver the agreed financial plan.

In respect of the agreed efficiency target included in the financial plan for 2024/25, Sefton Place has reported £2.588m worth of savings within the Month 4 position and is indicating that the full efficiency plan of £7.795m will be delivered by the end of the financial year.

11.8 **Warrington**

At the end of Month 4, Warrington Place reported deficit was £3.5m, which is £2.0m adverse to the planned deficit of £1.5m.

The predicted deficit at the end of the financial year is £8.0m, which is £3.4m above the planned deficit of £4.6m. A review of potential risks and mitigations has identified a potential further net risk of £0.9m, therefore the risk adjusted deficit is projected to be a £8.9m.

Warrington Place has delivered £0.6m worth of efficiency savings year to date, compared to a plan of £1.1m (i.e., £0.5m adverse). With anticipated annual savings of £2.1m against a plan of £4.5m (i.e., £2.4m adverse).

To mitigate all the current risks, the month 4 financial savings recovery target is £4.3m, mitigations have been identified to deliver this in full bringing Warrington back in line with the initial 24/25 financial plan.

11.9 **Wirral**

At the end of Month 4, Wirral Place deficit was £11.2m which is £4.3m above the planned deficit of £6.9m and reflects an adverse position.

The predicted deficit at the end of the financial year is £35.9m which is £15.2m above the planned deficit of £20.7m.

A review of potential risks and mitigations has identified a net improvement of £1m and the risk adjusted deficit is therefore £14.2m.

Wirral Place has delivered £1.7m worth of savings compared to a plan of £2.7m which is an adverse variance of £1m. Wirral Place is indicating that the full efficiency plan of £11.2m will be delivered by the end of the financial year.

12. Southport Major Incident

A significant amount of work has been taking place to support the victims, their families and the wider community following the tragic incident that occurred last month. This support also extends to the emergency responders that were involved with the incident.

The recovery planning architecture is now in place in Sefton and the Sefton Place Director is leading on this work for Sefton Council and Sefton Place, fully supported by Sefton's Assistant Director of Quality and Safety improvement.

This includes key cells being set up to focus on psychological support, business and economy, communications and engagement, safeguarding children's and families, Community resilience and the Community and Voluntary sector - meetings are also being held with key government departments.

There has been a significant focus on the psychological support that will be required for all those affected by this incident in the immediate and longer term.

Learning has been taken from other major incidents, for example the Manchester Arena attack and Grenfell. This is in line with NHS England's standard guidance on responding to the stress caused by major incidents.

The role of the Psychological Care Co-ordination Group is to ensure psychological and trauma support offer is pulled together to provide a coordinated response and effective messaging.

13. Officer contact details for more information

- Mark Wilkinson, Cheshire East Place Director
  Mark.Wilkinson@cheshireandmerseyside.nhs.uk
- Laura Marsh, Cheshire West Place Director (Interim)
  Laura.Marsh@cheshireandmerseyside.nhs.uk
- Anthony Leo, Halton Place Director
  Anthony.Leo@cheshireandmerseyside.nhs.uk
- Alison Lee, Knowsley Place Director
  Alison.Lee@cheshireandmerseyside.nhs.uk
- Mark Bakewell, Liverpool Place Director:
  mark.bakewell@cheshireandmerseyside.nhs.uk
- Deborah Butcher, Sefton Place Director
  Deborah.butcher@cheshireandmerseyside.nhs.uk
- Mark Palethorpe, St Helens Place Director
  Mark.Palethorpe@sthelens.gov.uk
- Carl Marsh, Warrington Place Director
  Carl.Marsh@cheshireandmerseyside.nhs.uk
- Simon Banks, Wirral Place Director
  Simon.Banks@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/09/24/12

Report approved by: Neil Large, Non-Executive Member, Audit Committee Chair

Highlight report of the Chair of the ICB Audit Committee

Committee Chair	Neil Large
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	03 September 2024

Key escalation and discussion points from the Committee meeting

Alert

The Audit Committee at its 26 September 2024 meeting:

- received and considered proposed changes (highlighted in **RED**) to the ICBs Operational Scheme of Reservation and Delegation (OSORD) (Appendix A). Changes included amendments to thresholds reflecting the new procurement regulations, and the inclusion of the ICBs Care Assurance Panel and its authority to make decisions to approve AACC individual care packages that have an annual cost of over £260k. This authority was previously under that of each ICB Place Director. Committee members requested a tightening up of the wording in the OSORD to reflect the governance of the Assurance Panel being able to make these decisions, as well as sought clarity about responsiveness to make decisions on urgent cases. Following commitment to update the OSORD prior to Board consideration, and having received assurance regarding how urgent decisions would be addressed, the Committee supported the changes to the OSORD.

Recommendation:

- **the Audit Committee recommends that the ICB Board approves the amendments to the ICBs Operational Scheme of Reservation and Delegation (Appendix A).**

- received its Committee Annual Report for 2023-24 (Appendix B), which provided summary detail of the key items covered and decisions made by the Committee during the 2023-24 period. The Committee approved its Annual Report and agreed to submit to the ICB Board at its meeting in September 2024.

Recommendation:

- **the Board is asked to note the 2023-24 Annual Report of the Audit Committee (Appendix B).**

Advise

The Audit Committee at its 26 September 2024 meeting:

- received an update report on the Procurement Act 2023 and which provided Committee members with an overview of the implementation of the regulations, an outline of some of the key changes associated and the actions that the ICB intends to take to manage compliance. The Committee provided feedback regarding how sustainability/social value is measured and influences procurement decisions, how can be used as an opportunity for local economic growth as well our meaningful

measures regarding outcomes/outputs. The Committee also highlighted the need for greater identification of any risks within the report. The Committee noted the update report.

- received the latest draft of the ICBs Procurement Policy which contained proposed inclusions in respect of the Modern Slavery Act and the ICBs commitments to this in respect of Procurement, as well as minor changes to reflect the new Procurement Regulations 2023. **The Committee approved the updated ICB Procurement Policy.**

- received an update report on the work of the Risk Committee, including recommendations around the oversight of the ICBs risk management processes following 12 months of operation of the Risk Committee. **The Audit Committee approved the recommendation to step down the Risk Committee**

- received a quarterly update report on the ICBs IG service which highlighted the work of the ICBs information Governance Management Group and its workplan, provided on update on the progress of the commissioned service following its transition from Midlands and Lancashire CSU to Mersey Internal Audit Agency. The Committee noted the report.

- received the 2023-24 Annual Report of the ICBs IG service, outlining the achievements and outputs of the service during that period. The Committee noted the report.

- received the ICBs Quarter One Freedom of Information (FOI) report outlining the number and type of requests that the ICB had received from 01 April to the end of July 2024. The Committee were informed that the ICB had received 187 FOIs during this period, that the ICB was 100% compliant in responding to FOIs within the statutory timescale and that the main themes with respect to FOIs centred around Continuing Healthcare/packages of Care, weight management services and request for contact details of ICB lead officers. The Committee noted the report.

- received a report providing an update on the ICBs controls and processes around managing declarations of interest. The Committee discussed progress in capturing all declarations from staff, training and noted the progress being made. The Committee requested that at its next meeting that there was further information regarding gifts and hospitality received by the ICB. The Committee noted the report.

- received a report from the providers of the ICBs Subject Access Requests (SARs) providing information regarding the numbers of SARs received (23) and completed between 01 April 2024 and the end of June 2024.Committee members were informed of some of the challenges with regards meeting timescales to complete the SARs due to complexity of requests and process issues, as well as hearing how service improvements are being prioritised. Committee members requested future reports have more details re lessons learned and actions to address, as well as seeking assurance around the development of a more comprehensive patient facing leaflet outlining the SARs process and what can be expected of the service. The Committee noted the report.

- received a report outlining the results of the Committees annual self-assessment survey. Key areas highlighted within the survey responses centred on length of papers to the Committee, need for concise summaries, clear identification of risks, management of the Committees action log and the role of the committee in relation to the ICBs responsibilities around Cyber-Security. Overall survey responses indicated the Committee was well Chaired, supported and acted fully within its Terms of Reference.

- received a report from the ICBs Internal Auditors outlining progress against the Annual workplan for 2024-25. The Committee noted the progress report and supported the inclusion of a summary follow up report that highlighted progress against completion of the recommendations provided by Internal Auditors following each audit.

- received and noted the progress report from the ICBs Anti-Fraud specialist in accordance with the ICBs agreed anti-fraud workplan.

- received and noted and update paper from the ICBs External Auditors which outlined emerging national issues and developments that may impact ICBs, NHS sector updates and progress against the 2024/25 deliverables. The Committee noted the update report.

- received the Committees risk register, reviewed the 5 risks assigned to the Committee, discussed where risks associated with Cyber security are considered and how there in a connection with the role of Audit Committee. The Committee noted the report.

Assure
n/a

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions / discussion undertaken**
Commissioning support or other data processors acting on ICB's behalf breach statutory or regulatory requirements resulting in financial loss and / or reputational damage	No risks were changed
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	

Corporate Risk Register risks	
Internal controls are insufficient to prevent fraudulent activity by ICB staff, contractors, patients or other third parties resulting in financial loss and / or reputational damage	
Re-procurement of information governance services de-stabilises existing arrangements resulting in adverse financial and reputational impacts	
NHS Patients - This risk area covers any fraud and corruption risks that are carried out by patients	

The next meeting of the Committee is scheduled for 03 December 2024.

1. Operational Delegated Limits

Section	Description	Reserved By:																				
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	Care Assurance Panel	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
A	**ACCEPTANCE OF GIFTS, HOSPITALITY & SPONSORSHIP** (Governance Lead to maintain a register of declared gifts and hospitality received)															Gifts over £50	Gifts over £50		Gifts up to £50	Gifts up to £50	Gifts up to £50	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
B	**LITIGATION CLAIM PAYMENTS** Medical negligence and other litigation payments made on the advice of NHS Resolution	Over £1,000,000														Up to £1,000,000	Up to £500,000					
C	**LOSSES & SPECIAL PAYMENTS** (CFO to maintain a register of losses and special payments (including bad debts to be written off). All payments to be reported to the Audit Committee.	Over £500,000			Up to £500,000											Up to £100,000	Up to £50,000	Up to £5,000				
D	**PETTY CASH FLOAT**																					
D1	Authorisation to set up float															Over £300	Over £300	Up to £300				
D2	Replenish petty cash float																					Head of Financial Services (or equivalent role)
D3	Issue petty cash																Up to £50	Up to £50				Associate Director of Finance (Place)
E	**CREDIT CARD**																					
E1	Account signatories (who can make changes to the account, authorise additional card holders, amend card limit)															x	x	x				
E2	Authorise single transaction (single transaction limit £2,500)															x	x	x	x	x	x	x
F	**REQUISITIONING GOODS & SERVICES: NON-HEALTHCARE**																					
F1	Utilisation of External Agency Staff (based on total expected cost as per below notes) Supporting Notes: a) Prior approval from the ICB Vacancy Panel must be sought for all consultancy requests regardless of value. b) Prior approval from NHSE must be sought for: - Any appointments over £600 per day; or - any appointments for over a 6 month period, or - any appointment with significant influence (e.g. ICB roles). c) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and in line with agreed ICB IR35 policy	Over £500,000			Up to £500,000											Up to £150,000	Up to £150,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000

Section	Description	Reserved By: Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	Care Assurance Panel	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
F2	Utilisation of Consultancy (based on total expected cost as per below notes). Supporting Notes a) Prior approval from the ICB Vacancy Panel must be sought for all consultancy requests regardless of value. a) Prior approval from NHSE must be sought for: Any expenditure above £50,000; or Any appointments over £600 per day; or - Any appointments for over a 6 month period, or - Any appointment with significant influence (e.g. ICB roles) b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and in line with agreed ICB IR35 policy	Over £500,000			Up to £500,000											Up to £150,000	Up to £150,000		Up to £25,000	Up to £25,000	Up to £25,000	
F3	Services including IT, maintenance, and support services (over lifetime of contract) where not included within agreed annual budgets	Over £2,000,000			Up to £2,000,000											Up to £1,000,000	Up to £500,000		Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F4	Approval of non-healthcare payments within agreed budget *With appropriate consideration of procurement requirements															Over £2,000,000	Up to £2,000,000	Up to £500,000	Up to £500,000	Up to £500,000	Up to £500,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
G	**RELOCATION EXPENSES** In line with Policy approved by ICB Remuneration Committee															Over £8,500	Up to £8,500					
H	**DECISION TO APPROVE 'NEW' INVESTMENT BUSINESS CASES**																					
H1	Where funding is: a) available and identified within agreed financial plan or b) from additional notified resource allocations (e.g. new in-year) c) other identified income streams (e.g. other agencies / recharges)	Over £10,000,000			Up to £10,000,000	Up to £1,000,000		Up to £1,000,000 *Primary Care Related								Up to £5,000,000	Up to £3,000,000	Up to £1,000,000	Up to £1,000,000	Up to £1,000,000	Up to £1,000,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H2	Where not included in approved financial plan (but still subject to ICB Executive / Place Leadership Team Approval) N.B any material underspend / variation from plan at individual budget holder level cannot be reinvested / redirected (see Virement Policy - Section L) without Executive team approval due to overall financial management requirements of the ICB.	Over £5,000,000			Up to £5,000,000	Up to £500,000 *Specialised services related		Up to £500,000 *Primary Care Related								Up to £500,000	Up to £500,000		Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H3	Primary Care Capital Expenditure Approval (within ICB allocation) NB - Capital Plan to be approved by the ICB for each financial year	Over £1,000,000						Up to £1,000,000 *Primary Care Related								Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)					
I	**CONTRACTING**																					
I1	Signing of Healthcare Contracts including S75 agreements. S75 approval via place governance processes in line with S75 agreements operational policy. (Annual Contract Value)															Over £500,000,000	Up to £500,000,000	Up to £75,000,000			Up to £100,000,000	
I2	Approval of Healthcare Contract Payments All healthcare contract payments must be supported by signed contract (see I1).															As per agreed plan / budget value	As per agreed plan / budget value)	As per agreed plan / budget value)		As per agreed plan / budget value	As per agreed plan / budget value	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Sianatory List
I3	Signing of Non-Healthcare Contracts (Annual Contract Value)															Over £3,000,000	Up to £3,000,000	Up to £1,000,000		Up to £1,000,000	Up to £1,000,000	Up to £100,000

Section	Description	Reserved By: Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	Care Assurance Panel	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
J	**APPROVAL OF OTHER HEALTHCARE PAYMENTS WITHIN BUDGET** See authorised signatory list for approval limits for other officers.															Over £1,000,000	Up to £1,000,000	Up to £100,000	Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
K	**QUOTATIONS AND TENDERS HEALTHCARE / NON-HEALTHCARE**																					
K1	Approval of ICB Procurement Plan				X																	
K2	Procurement route decision - in line with the options contained within the Healthcare Provider Selection Regime (2023) Regulations (Annual Contract Value)	X (For Novel or Contentious issues escalated by FIR Committee)			X From £5,000,000 with Novel or Contentious Procurement route decisions to be escalated to the Board	Up to £3,000,000		Up to £3,000,000								Up to £5,000,000	Up to £3,000,000	Up to £1,000,000	Up to £663,000	Up to £663,000	Up to £663,000	
NEW	Decision to put Non-Healthcare goods and services out to competive procurement (Total contract value)	X (For Novel or Contentious issues escalated by FIR Committee)			X From £5,000,000 with Novel or Contentious Procurement route decisions to be escalated to the Board											From threshold up to Up to £5,000,000	From threshold up to Up to £3,000,000	From threshold up to £1,000,000				
K3	Approval of Quotations for Non-Healthcare expenditure (total value)		£20,000 to procurement thresholds specified in the Procurement Act 2023 (PA23) (currently £215k including VAT) in line with delegated limits for expenditure type. Minimum of three written quotes required																			
K4	Quotation Waiver Approval for Non-Healthcare goods and services (Total Contract Value) – see detailed financial policy on tendering when permissible)		£20,000 to procurement thresholds (currently Non Healthcare £214k) in line with delegated limits for expenditure type																			
K5	Procurement for Non-Healthcare goods and services through approved national / local framework agreement (in line with call off rules) (Total Contract Value)		From £20k to delegated budgeted limit for expenditure type (with approval from procurement team) Above delegated budgeted limits, subject to Finance, Investment & Resources Committee Approval																			
K6	Tender Waiver Approval for Non-Healtcare goods and services	In line with limits for procurement route decisions N.B. Reporting of all Tender Waiver Approval to Audit Committee																				
K7	Opening of Tender Documentation (where not received electronically) (at least 2 people from list)															x	x	x	x			
L	**VIREMENT**	Relating to a transfer of funds from an unspent or underspent budget to another; within virement rules to allow greater financial flexibility in using available resources All Transfers must be: • affordable within budget; and • agreed by both budget holders Virements may not be used to create new budgets																				
L1	Within Existing Approved Pay or Non-Pay Budgets															Over £1,000,000	Up to £1,000,000	Up to £500,000		Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
L2	With regards to transfers from reserves (including distribution of new in-year resource / capital allocations)																Up to £70,000,000	Up to £25,000,000				As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
M	**DISPOSALS AND CONDEMNATION** All assets disposed at market value.	Over £50,000														Up to £50,000	Up to £10,000	Up to £5,000				
N	**CHARITABLE FUNDS** (Not applicable to ICB)																					
O	**HUMAN RESOURCES**																					
O1	Approve HR Decisions Not Covered By ICB HR Policies or Is Exceptional To Policies (e.g. additional compassionate leave or exceptional carry forward of leave days)															x	x	x	x	x	x	

Section	Description	Reserved By: Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	Care Assurance Panel	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
O2	Decisions As Set Out Within HR Policies (where there is some management discretion e.g. study leave authorisation)															x	x		x	x	x	
O3	Approval of Operational Structure (re staffing and departments), and in accordance with organisation change policy															x						
O4	Approval of Appointment to Posts Below Executive Directors (following approval at Vacancy Panel)																x	x	x	x	x	x
O5	Approval of the below arrangements as required by the ICB: · Approval of the arrangements for discharging the ICB statutory duties as an employer · Approve human resources policies for ICB employees and for other persons working on behalf of the ICB · Approve any other terms and conditions of services for ICB AFC employees · Approve disciplinary arrangements for ICB employees · Approve arrangements for staff appointments (excluding matters detailed within the Constitution) · Approve the ICBs organisational development plans				x (following endorsement of the People Committee)																	
P	**EXTERNAL COMMUNICATIONS & REPORTING**																					
P1	Approve Complaints Responses and Letters to Politicians and Media Responses															x				x (Assistant Chief Executive)		x (Associate Director of Corporate Affairs & Governance)
P2	Approve Public Consultation Material															x				x (Assistant Chief Executive)		
P3	Approve Public & Staff Engagement Material inc Website															x				x (Assistant Chief Executive)		
P4	Approve FOI Responses and Subject Access Requests																			x (Assistant Chief Executive)		x (Associate Director of Corporate Affairs & Governance)
P5	Approve Annual Engagement & Communication Plan	x																				
Q	**FINANCE** Approval of Operational Policies as required by the organisation				x																	
R	**INDIVIDUAL PACKAGES OF CARE** Approval of Individual AACC Packages of Care (Annual Value)														Annual value cost of over £260,000						Annual value cost of up to £260,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
S	**INFORMATION GOVERNANCE**																					
S1	Approve Digital and Data programmes Data Protection Impact Assessments (DPIA), Information / Data Sharing agreements and Data Processing Agreements																		x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, SIRO and Caldicott Guardian, or their deputies)
S2	Approve Confidentiality Advisory Group (CAG) Applications																		x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, Deputy SIRO and Deputy Caldicott Guardian)
S3	Approve NHS Digital Data Access Requests (DARs) – Data Sharing Agreements, Data Sharing Framework Contracts																		x (SIRO)			
S4	Data Security and Protection Toolkit submissions approval																		x (SIRO)			x (Deputy SIRO)
S5	Privacy Notices																		x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, Deputy SIRO or Deputy Caldicott Guardian)

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NHS
Cheshire and Merseyside

Audit Committee

Annual Report 2023-2024

Contents

1. Introduction

The Audit Committee (the Committee) has been established by NHS Cheshire and Merseyside Integrated Care Board ('ICB') as a Committee of the ICB in accordance with its Constitution.

The Committee is a non-executive committee of the ICB and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

This report sets out the work undertaken by the Audit Committee during the 2023-24 year (01 August 2023 – 31 July 2024). This demonstrates how the committee has met the responsibilities set out for it by the ICB within its constitution, its compliance with the committees Terms of Reference (TOR), its effectiveness and the impact of the Committee.

In addition to it being a formal report to the Committee, the evidence contained in this report will be shared with the Board of the ICB.

The committee's membership requirements are set out in its TOR, which was last reviewed and approved by the Board of the ICB in September 2023.

2. Membership

The membership of the Committee between 01 August 2023 and 31 July 2024 was:

- Neil Large, Non-Executive Member (Chair)
- Tony Foy, Non-Executive Member (Deputy Chair)
- Erica Morris, Non-Executive Member
- Prof. Hilary Garratt, Non-Executive Member
- Dr Ruth Hussey, Non-Executive Member.

3. Meetings

From 01 August 2023 to 31 July 2024, the Committee met on seven occasions and was quorate at each meeting. The Committee met on the following dates:

05 September 2023
05 December 2023
05 March 2024
09 April 2024
21 May 2024
17 June 2024
25 June 2024.

Details of the attendance of Committee members at all of these meetings are enclosed at **Appendix One** for information.

4. Committee Responsibilities and Duties

The Committee's main purpose 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.

In summary, the Committee's duties for and on behalf of the ICB and its functions can be categorised as follows:

- Integrated governance, risk management and internal control
- Internal Audit
- External Audit
- Counter Fraud
- Conflicts of Interest
- Information Governance
- Freedom to Speak Up
- Financial Reporting
- Other assurance functions to the Board.

The Audit Committee is authorised by the Board to:

- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- commission any reports it deems necessary to help fulfil its obligations
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.
- commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

The Audit Committee is authorised to:

- approve the ICBs counter-fraud and security management arrangements
- appoints the ICBs Internal Auditors and approves the Internal Audit Plan
- appoints the ICBs External Auditors and approves the External Audit Plan
- review, approve and monitor counter fraud work plans
- seek assurance on the financial reporting arrangements of the ICB
- approve the arrangements for managing conflicts of interest and declarations of Gifts and Hospitality

- approve the policies and arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.

5. Review of Committee Activities

Between 01 August 2023 and 31 July 2024, the Committee reviewed the following areas: -

- Committee Terms of Reference
- Committee end of year (2022-23) effectiveness self-assessment survey results
- ICB Conflicts of Interest – Management Framework and Policy and updates against delivery
- ICB Risk Management Framework, ICB Risk Policy and Board Assurance Framework Development
- ICB Annual Report and Accounts 2023-2024 incorporating Internal and External Auditor Opinions
- Internal and External Auditor Update Reports, including updates and recommendations against areas audited as within plan
- Internal Audit Annual Plan 2024/25
- External Audit Annual Plan 2024/25
- Mental Health Investment Standard compliance Statement
- MIAA TIAN Insight Reports
- Appointment of ICB External Auditors
- Appointment of ICB Internal Auditors
- ICB Anti-Fraud Annual Plan and Updates to Counter-Fraud and Anti-Bribery Policy
- ICB Financial Policies
- ICB Procurement waivers
- Updates and revisions to the ICB SORD, and Operational SORD
- HFMA Financial Control and Sustainability Reports
- ICB Information Governance Updates, ICB Information Governance Policies and Privacy Notices
- ICB DSPT Submission Updates
- ICB FOI and SARs Annual Report and updates
- SMART Dental Updates
- ICB Freedom to Speak Up arrangements update
- Committee Risk Register Updates
- Risk Committee Chair Reports
- ICB Procurement Policy
- ICB Consent Policy

Decisions undertaken by the Committee during 01 August 2023 – 31 July 2024 included:

05 September 2023

Committee Annual Report 2022-23. The Committee approved the Committees Annual Report for the period 2022 20223.

05 December 2023
Supplier Set Up Policy. The Committee approved the ICBs Supplier Set Up Policy.
Managing Conflicts of Interest Policy. The Committee approved the ICBs Managing Conflicts of Interest Policy

05 March 2024
Accounting Policies. The Committee approved the ICBs Accounting Policies.

Procurement Policy. The Committee approved the ICBs Procurement Policy.

Data Protection and Security Policy. The Committee approved the ICBs Data Protection and Security Policy.

Information Governance Handbook. The Committee approved the ICBs Information Governance Handbook.

Privacy Notice. The Committee approved the ICBs Privacy Notice: C&M ICS Digital and Data Programme - Secure Data Environment (SDE) Data into Action.

09 April 2024
Anti-Fraud, Bribery and Corruption Work Plan Workplan 2023-2024. The Audit Committee reviewed and approved the Anti-Fraud, Bribery and Corruption Work Plan Workplan 2024-2025.

Internal Audit Provider Procurement. The Committee endorsed the decision to direct award via the NHS SBS framework.

16 May 2024
Annual Report and Accounts 2023-24. The Committee approved the narrative to be used for the Governance statement in the ICBs 2023-24 Annual Report.

External Audit Representation letter. The Committee approved the letter of representation.

Anti-Fraud Services Annual Report 2023 - 2024. The Committee reviewed and approved the Anti-Fraud Services Annual Report for the 2023-24 period.

17 June 2024
Annual Report and Accounts 2023-24. The Committee endorsed the final draft of the Annual Report and accounts 2023-24 and agreed to recommend their approval to the Board at its meeting on 20 June 2024.

25 June 2024
Atamis eCommerce System. The Committee approved the changes to the approval sign off.

Internal Audit Plan 2024-25. The Committee reviewed and approved the Internal Audit Plan for 2024-25.

7. Conduct of the Committee

In year, the Committee has reviewed its membership and TOR, with changes being approved by the Board. The Committee administrative support minuted the proceedings of all meetings of the Committee, including recording the names of those present and in attendance. Where any declarations where made these were recorded within the minutes of the meeting. The Committee reported to the Board after each Committee meeting via a Committee Chairs report.

Committee members have also been asked to undertake an Annual Committee effectiveness self-assessment survey so as to help inform where improvements may need to be made to the Committee as well as if there are any gaps. The results of this survey (Appendix Two) indicate that Committee members and regular attendees who completed the survey believe that the Committee is well Chaired and supported, members have the opportunity to contribute to the issues on the agenda, and it acts in accordance to its Terms of reference. Comments for improvements included:

- shorter papers
- more timely distribution of papers
- more proactive management of the action log and holding action owners to account
- more opportunity for members to shape the agenda of meetings
- confirmation of / clarity around its role around cyber security arrangements for the ICB.

8. Conclusions from the Audit Chair

The second year of the ICB saw significant developments in the risk management and governance arrangements of the ICB, which was recognised by the ICB receiving a Head of Internal Audit Substantial Assurance rating, which was a considerable improvement from the previous year. The Committee was in a position to recommend to the Board at its meeting in June 2024 that the Annual Report and accounts 2023-24 should be approved, and recognised the considerable work that had been achieved by the ICB over that year in delivering against its statutory responsibilities,

The committee has met its regularity obligations, as well as performing those other functions delegated to it by the Board. The committee has met when required to discharge these functions.

The Committee has applied best practice in its deliberations and decision making processes, and it has conducted its business in accordance with national guidance and relevant codes of conduct and good governance practice.

The Committee will continue to seek improvements in how it operates and will seek to address the areas for improvements as identified within the Committees annual effectiveness survey.

Appendix One - 01 August 2023 – 31 July 2024 Meeting attendance details

		Meeting dates 2023-2024						
Name	**Position**	**05.09.23**	**05.12.23**	**05.03.24**	**09.04.24**	**21.05.24**	**17.06.24**	**25.06.24**
Neil Large	Non-Exec (Chair)	☑	☑	☑	☑	☑	☑	☑
Erica Morriss	Non-Exec	☑	☑	☑	☑	☑	☑	☑
Tony Foy	Non-Exec (Deputy Chair)	☒	☑	☒	☑	☑	☑	☒
Hilary Garratt	Non-Exec	☒	☒	☑	☒	☒	☑	☑
Ruth Hussey	Non-Exec	Not in post	☒	☑	☑	☑	☑	☑

☑ Present
☒ Apologies received

Appendix Two Annual Committee Effectiveness Self-assessment 2023-24 Survey Results

Terms of Reference

2. The Committee Terms of Reference are clear in outlining the remit and authority of the Committee? **If you disagree please state why in Q21**

More Details

Strongly agree	2
Agree	4
Disagree	0
Strongly disagree	0

3. Would you make any changes to the committee terms of reference? **If you answer Yes please outline what in Q21**

More Details

Yes	0
No	6

4. Do you agree that the Committee has operated within and has met the requirements of its Terms of Reference throughout the year? **If you disagree please state why in Q21**

More Details

Strongly agree	2
Agree	4
Disagree	0
Strongly disagree	0

Reporting arrangements

5. The Committee is clear about its reporting arrangements to the ICB Board? **If you disagree please state why in Q21**

More Details

Strongly agree	3
Agree	3
Disagree	0
Strongly disagree	0

6. The Committee is clear on its interactions and interrelation with other Committees of the ICB? **If you disagree please state why in Q21**

More Details

Strongly agree	2
Agree	4
Disagree	0
Strongly disagree	0

7. Do you think that there are any overlaps in ICB business and responsibilities that are covered within more than one of our Committees and which are maybe causing confusion/inefficiency? **If YES please outline what within Q21**

More Details

Yes	1
No	5

Meeting arrangements

8. Agenda for meetings are well constructed? **If you disagree please state why in Q21**

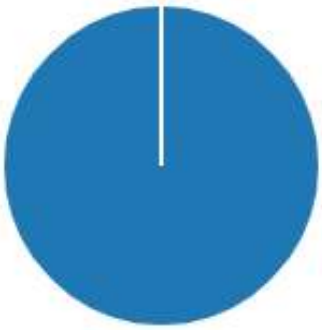
More Details

Strongly agree	1
Agree	5
Disagree	0
Strongly disagree	0

9. The Committee has an agreed workplan / forward plan?

More Details

Yes	6
No	0



10. Papers for meetings are comprehensive, clear and succinct in their recommendations? **If you disagree please state why in Q21**

More Details

Strongly agree	2
Agree	3
Disagree	1
Strongly disagree	0

11. The Committee ensures that relevant officers/topic experts attend meetings to enable full understanding of relevant issues? **If you disagree please state why in Q21**

More Details

Strongly agree	1
Agree	5
Disagree	0
Strongly disagree	0

12. Committee papers are distributed in sufficient time for members to give them due consideration ahead of Committee meetings? **If you disagree please state why in Q21**

More Details

Strongly agree	1
Agree	4
Disagree	1
Strongly disagree	0

13. The committee has met frequently enough to fulfil its duties and responsibilities? **If you disagree please state why in Q21**

More Details

Strongly agree	1
Agree	5
Disagree	0
Strongly disagree	0

14. Meetings are chaired so that members are able to contribute to the issues discussed, and express their view, concerns and opinions? **If you disagree please state why in Q21**

More Details

Strongly agree	1
Agree	5
Disagree	0
Strongly disagree	0

15. Committee decisions, recommendations or actions are clearly summarised and agreed following consideration of each agenda item? **If you disagree please state why in Q21**

More Details

Strongly agree	1
Agree	4
Disagree	1
Strongly disagree	0

16. At the end of each meeting the committee reviews and reflects on decisions and discussions?

More Details

Yes	4
No	2

17. Committee members have the opportunity to contribute to the planning of future agendas and meetings? **If you disagree please state why in Q21**

More Details

Strongly agree	1
Agree	3
Disagree	2
Strongly disagree	0

18. What would you change about the way the secretariat administers meetings?

Set dates for meetings annually to fit with reporting requirements. Shorter papers and timely distribution

19. Members of the committee appear to understand their responsibilities in relation to Declaration of Interest around any conflicts?

More Details

Yes	6
No	0

20. Do you think that there are any gaps in ICB business and responsibilities that are not covered within our Committees? **If YES please can you outline what in Q21**

More Details

Yes	2
No	4

21. Please provide any other observations or comments you would like to make about the committee, its effectiveness and any improvements that could be made?

My only observation would be - inspect what you expect. The Comm can only make decisions on what we are told/detailed but would be good to test out at times - ie SARS

None, as I have only joined the Committee recently.

Overall, the audit committee is well chaired and covers the range of issues expected of an audit committee. Other audit committees tend to cover cyber security and I am not clear where that sits in governance. I sometimes think that there may be overlaps with the Finance committee but that may just be a perception. I think the action log needs to be managed in a timely way and Directors held to account if deadlines for actions are missed

I think it is well-chaired and ran.

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/09/24/13

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

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	29 August 2024

Key escalation and discussion points from the Committee meeting

Alert

n/a

Advise

The Remuneration Committee at its meeting on 29 August 2024:

- received a report from the Chief Executive outlining the process to be undertaken for the recruitment to the ICB of a Chief People Officer and a Director of Finance to replace the current incumbents due to their planned departure from the ICB in December 2024. The report also submitted a recommendation to the Committee for its consideration regarding the steps that will need to be taken to finalise the approval of any remuneration offer to the preferred candidate for each of these posts prior to the ICB progressing any formal appointment offer.

- the report outlined and clarified the process as outlined within the ICBs Constitution, as well as that indicated within the Committees Terms of Reference and the current draft ICB Board Member appointments policy. Committee members discussed how there were variations between these documents with regards the process to be undertaken and the the role of the Committee in the establishment of an appointments panel. A commitment was given to the Committee that all documents would be reviewed and aligned, and that an updated ICB Board Member Appointments Policy would come to the Committee at its September 2024 meeting for approval.

- the Committee was also updated on the recruitment process progress as well as planned arrangements for stakeholder and interview panels

- the report also reiterated the Pay Range for both positions as outlined within the agreed ICB VSM Pay Framework, as well as providing peer benchmark data for remuneration of these roles.

- following discussion, the Committee approved the request of the Chief Executive to be able to offer a salary to the preferred candidates, with the salary offered being within the agreed pay range as outlined for each position within the ICBs VSM Pay Framework. If there was a need to consider offering a salary outside of these pay ranges then approval would need to be sought directly from the Remuneration Committee prior to offer being extended to the candidate by the Chief Executive. The Committee also noted that the Chief Executive would provide a further update to the next meeting of the Committee.

Assure

n/a

The next meeting of the Committee is scheduled for 24 September 2024.

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Highlight report of the Chair of the ICB System Primary Care Committee

Agenda Item No: ICB/09/24/14

Committee Chair: Erica Morris, Non-Executive Member

Highlight report of the Chair of the ICB System Primary Care Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	15t August 2024

Key escalation and discussion points from the Committee meeting
Alert
• GP Patient Survey – The Committee noted that full analytics not available until September and this is the first year of the newly designed survey with the actual response was low at 28%. Places already looking at high-level information. It was agreed that inconsistencies and lack of perceived progress with access all to be investigated and be discussed at future SPCC Meeting. Currently planned for December to tie in with overall Access Improvement Plan/Update going to Board in November. • Risk - Collective Action - agreed to be included as new risk for the Committee and discussions held around impact on Access/Data Sharing and Interface between primary and secondary care. • Finance – The Committee noted the 2m deficit to plan in M3 with prescribing and risks around this. • Primary Care Quality - QSAG (System Quality Group) covering all 4 contractor groups now in place with TOR and 2 meetings held. Incident reporting going to both Q & P and SPCC noting escalation/template and process for primary medical (managed at place) currently being finalised. To become a standard item for SPCC and progress in line with asks from Internal Audit report was seen as good.
Advise
• Minutes of PSRS (Pharmaceutical Committee) were noted • Agreement to recommendation of an APMS contract term prior to NHSE approval • System Pressure across all contractor groups discussed and where possible mitigating actions noted • Discussion and update on Local GP network that has now had 2 meetings as this was seen as a gap across the 4 contractors, this together with other 3 contractor networks will feed into a Primary Care Forum (yet to be formed). • Contracting, Commissioning and Policy Updates were noted for all four contractor groups. • Agreement to allocation of Digital/Estates annual capital allocation and draft Primary Care Digital Strategy currently planned for Octobers Committee
Assure

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
Workforce - Risk 16 - unchanged Dental Contractor - Risk 12 - unchanged and further update in Oct SPCC	

Corporate Risk Register risks
Collective Action (to be added) - Currently scored at 16 and will be included in future Risk reviews. Quality (to be added) - Referred to Risk Comm and will be reviewed at SPCC in December

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Finance Update	SPCC reviewed all the budgets.
Recovering Access to Primary Care	Progress/plans in relation to the access recovery were given noting updated plan in December.

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Highlight report of the Chair of the ICB Children and Young Persons Committee

Agenda Item No: ICB/09/24/15

Report approved by: Raj Jain, ICB Chair, CYP Committee Chair

Highlight report of the Chair of the ICB Children and Young Persons Committee

Committee Chair	Raj Jain
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	14 August 2024

Key escalation and discussion points from the Committee meeting

Alert

- received further information on inequalities faced by care leavers and a presentation regarding the Care Leavers Covenant and the work underway in supporting care experienced young people across Cheshire and Merseyside. The Committee determined that all member organisations should treat experience of care as a "Protected Characteristic" and accordingly implement actions that enable people with this characteristic to benefit from this support. Each organisation was asked to explore how this recommendation could be implemented to deliver the desired outcomes.
- following a presentation regarding the impact on Children and families experiencing poverty in Cheshire and Merseyside (produced by CHAMPs) Committee members resolved that there should be a system level dashboard that provides a 'single version of truth' that enables the ICS to better align and better measure the impact of approved and proposed actions and investments aimed at mitigating the impact of poverty and reducing the number of children and young people living in poverty (c100k in Cheshire and Merseyside). This is very likely to inform strategic plans of the ICB and Partner Organisations.
- received a further report on Appropriate Places of Care. This evidenced the significant failings and poor experience of CYP and poor value for money (£ms) that the ICS is incurring. Urgent solutions are required which will be facilitated by strong partnership working across the ICS. Local Authorities lead this programme, needing the ICB to co-ordinate and align Place strategies. Work is underway to produce a business case, which will be received before December 2024.

Advise

At its August 2024 meeting the Committee:

- received a presentation providing Committee members with an update on the work underway in developing a Cheshire and Merseyside Children and Young Peoples (CYP) campaign, with a focus of putting children first in appointments and how to ensure children and young people herd, felt seen and are actively listened to. Committee members heard directly from C&YP in attendance regarding their experiences of using health services, how CYP are being involved in the design of the campaign and outcomes of the workshops that have been run so far to help inform the campaign
- received an update from Louise Shepherd, Chair of the NHS England National CYP Board, which provided Committee members with an insight in national developments around CYP as well as any insight into priorities to be set by the new Government and any early intelligence coming from the Darzi Report. Committee members were also informed about national work on a refreshed approach to supporting children with disabilities and complex needs, as well as those with long term conditions, and the national intelligence indicating the increase in time that CYP are on waiting lists. The Chair of the Committee committed to have a discussion at the next ICB Board regarding waiting times for CYP and to set an ambition/target for Cheshire and Merseyside above that of the national targets
- discussed ways to get CYP involvement and membership of the Committee. Committee members agreed to receive a proposal at its next meeting

Assure

n/a

The next meeting of the Committee is scheduled for 20 November 2024.

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Highlight report of the Chair of the ICB Strategy & Transformation Committee

Agenda Item No: ICB/09/24/16

Committee Chair: Dr Ruth Hussey, Non-Executive Member

Highlight report of the Chair of the Strategy and Transformation Committee

Committee Chair	Dr Ruth Hussey
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	19 September 2024

Key escalation and discussion points from the Committee meeting

Alert

- Committee received the Transformation Programmes Mid-Year Position report. This detailed the progress of the 2024/25 projects. An overview of wider programme accountability and reporting routes in line with the ICB NHS Delivery Plan was also presented within the report. Committee noted the progress of the funded programmes to date and the request to support the recommendation on the commitment to fund both the Familial Hypercholesterolaemia and CVD Prevention services to a maximum of their combined current annual value for 2025/26. **Committee could not make a decision on supporting the recommendation due to the delegated authority within its Terms of Reference and escalates to Board and Exec. Team the need for clarity around decision making.**

- Committee approved an updated Population Health Partnership Board Terms of Reference.

Advise

- Committee conducted a workshop session on strategy as part of the Five Year Joint Forward Plan refresh for the 2025-30. Neil Evans (Associate Director of Strategy and Collaboration) provided a background pack to inform discussion. Committee was asked to discuss the current situation, the top priorities and how to develop a deliverable plan. The presentation outlined the key challenges, areas of opportunity identified as significant in our C&M data, C&M's long term financial model and the emerging national policy position. Views of the Committee were captured to help identify the work needed to develop a clear and implementable strategy including to identify affordable models of care, system levers for change, priorities underpinned by strong collaboration, integration and public involvement.

- a paper on the Decommissioning Policy which addresses the requirement for a robust process to appropriately make significant changes to contracted services and covers all contractual agreements including NHS Standard Contracts, Model Contracts, Grant, section and Partnership Agreements was presented for approval. The policy describes the process to manage significant changes to the commissioning of services, in a safe, fair and transparent manner and provides advice and guidance on the process and best practice to follow when considering changes to the commissioning of a service. Committee noted the contents of the report and suggested further clarity around roles and responsibilities to be included within the policy, further clarity on quality and equality considerations and the application of the policy in terms of the cost threshold and the time it takes to go through the process. Committee agreed to support the recommendation that the approach is further tested before finalising to ensure it works in practice.

- a paper on Gluten Free Prescribing was presented as part of the Unwarranted Variation Recovery Programme. Committee noted that there is currently variation in prescribing gluten free products across C&M (bread and bread mix). Noting the general rise in availability of both products, the Committee was asked to support a recommendation to withdraw prescribing before being presented to Board for a decision. Committee noted that this paper was also discussed at Recovery Sub-Committee on 16th September which supported the proposed option (Option 3) to stop prescribing. The committee endorsed the preferred option (to withdraw prescribing and realise a financial benefit of c.£525k cash releasing and c.£130k cost avoidance), noting the preferred option is subject to public consultation ahead of any decision made, with the public consultation plan to be approved by Board – 28th November 2024.

- Committee was presented with a paper relating to the Individual Funding Request (IFR) Service Review which commenced in November 2022 as part of a wider review of the commissioned support services delivered by Midlands and Lancashire Commissioning Support Unit (MLCSU). The original proposal was to bring the service in-house encompassing the IFR service also delivered by the CSU for Lancs. & South Cumbria ICB and was also supported through LSC ICB governance. Committee noted that in February 2024, LSC ICB withdrew their support for this which then triggered a further review of C&M internal processes. Committee was requested to support the recommendation that provision of the IFR service remain with MLCSU with a programme of work to be delivered to improve consistency and efficiency which can be done within the existing contract. This was subsequently agreed by Committee, but it was noted that this should be reconciled with other decisions taken by the Finance Investments and Resources Committee. It was also agreed that Audit Committee has a role in assurance of the system.

Assure

- Committee was presented with the regular risk report. This detailed the principal risks within the remit of the Strategy and Transformation committee and the corporate and Place risks that have been escalated to the committee. Committee noted the seven risks detailed in the report (three principal risks, three corporate risks and one escalated place risk). The report also updated Committee on the Board Assurance Framework refresh for 2024-25 and also described the Specialised Commissioning Risk Register. Committee noted the current position in relation to the risks escalated to this committee, including Specialised Commissioning risks and also noted the committee's emerging risks and the recommended action for these. It was agreed that further work was needed to ensure the scope of Committee's responsibility was fully covered in the risks being reported.

- There was an opportunity for updates from relevant boards/groups, including DTCI, CMAST, Population Health Board and ADs of Transformation & Partnerships.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
T1 - Unable to achieve NHS directives on emissions as mandated and targeted in the Green Plan which will impact on the ICB's reputation and opportunity to deliver financial savings	Committee noted the risks and existing controls in place for mitigation.
14DR - There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P1 - the ICB is unable to progress meeting its statutory duties to address health inequalities.	Committee noted the risk was mitigated from critical (20) to extreme (15) through strategy and plans to implement Marmot principles and focus on Core 20+5 supported by Population Health Partnership Group and Place Based Partnership Boards.
P8 - The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services	Committee noted the risk was mitigated from extreme (16) to high (12) through the continuous improvement approach and transformation programmes in Liverpool, East Cheshire, and Sefton and for women's services and clinical pathways in Liverpool. progress and development of pre-consultation business cases.
P11 - The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside	Committee noted the risk was mitigated from critical (20) to extreme (16) through cyber security systems and processes, local and national oversight. Key further actions include C&M wide baseline analysis and benchmarking, identifying and progressing opportunities for collaboration and standardisation, and identifying and addressing supply chain risks.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Urgent and Emergency Care (UEC) Recovery Update

Agenda Item No:

Responsible Director: Anthony Middleton, Director of Performance and Planning

Urgent and Emergency Care (UEC) Recovery Update

1. Purpose of the Report

1.1 This report is intended to provide an update to the Cheshire and Merseyside Integrated Care Board on the development of the urgent and emergency care improvement plan, governance, and progress achieved to date by the Cheshire & Merseyside UEC Recovery Group as demonstrated by the UEC sentinel metrics.

2. Executive Summary

2.1 In September 2023, NHS England launched the UEC tiering programme to support the delivery of the UEC recovery plan.

2.2 NHS Cheshire and Merseyside ICB was allocated to Tier 1 (the highest level of oversight) with a specific focus on UEC performance in the systems containing Liverpool University Hospitals and Warrington and Halton Hospitals.

2.3 In September 2024, in the latest iteration of the national tiering allocations, Whiston Hospital, Arrowe Park Hospital, Countess of Chester Hospital, Leighton Hospital and Macclesfield Hospital were also identified as sites requiring additional ‘targeted support’ ahead of winter.

2.4 Cheshire and Merseyside ICB has established an Urgent and Emergency Care Recovery Programme the design of which was borne out of the intelligence provided by the Newton diagnostic previously reported on at Board and system partner engagement on effective governance.

2.5 The programme focusses on improvement across five locality areas (North Mersey, Mersey & West Lancashire, Wirral, Cheshire and Warrington and Halton). These locality programmes are supported by five ‘at-scale’ improvement programmes focussing on thematic aspects of the UEC pathway that were identified through system diagnostics that have been undertaken as offering opportunity to improve overall system performance. The ‘at-scale’ programmes are:

- Ambulance improvement
- Admissions avoidance
- Acute Length of Stay (LOS)
- Discharge Pathways
- System Oversight and Resilience.

2.6 The five locality programmes have consistent governance and sentinel metrics complemented by the at scale programmes. Each programme has tailored interventions, impact assessment and trajectories to judge delivery.

2.7 As we head into what is anticipated to be a challenging winter period for the NHS and social care it is imperative that we see positive performance improvement and an increased focus on the targeted improvement interventions that are planned within localities and 'at-scale' and how these interventions will start to drive performance improvement.

2.8 There are currently no known plans for any additional funding to be allocated ahead of winter to support additional capacity and the expectation is that maintaining system flow through winter will need to be achieved through the delivery of these improvement plans.

3. Ask of the Board and Recommendations

3.1 The Board is asked to **note** the contents of this report for information and to continue to oversee the impact of the UEC Recovery Programme in delivering performance improvement across the UEC pathway across Cheshire & Merseyside.

4. UEC Recovery Programme Update

Locality UEC Improvement

4.1 Each locality area has in place a locally owned UEC recovery and improvement programme, focused on driving improvements across the end-to-end UEC pathway aligned to recommendations identified through the recent UEC diagnostic reviews undertaken across the Warrington and Halton and North Mersey localities supported by Newton Europe.

4.2 Robust and detailed improvement plans are in place within each locality. Five Place Directors are designated Senior Responsible Officer for the locality improvement plans with executive and senior management representatives from across all health and social care partners who are responsible for delivery of their respective workstreams (Appendix 3).

4.3 As we head into the anticipated challenging operational context of the coming winter it will be important that locality teams sustain a consistent focus on delivery of their improvement plans and the impact that they are having on performance at local level.

At-Scale Programmes

4.4 The UEC Recovery 'At-Scale' improvement workstreams have been established to support local delivery efforts and to ensure consistency of focus across the ICB footprint.

4.5 The five 'At-Scale' workstreams are focused on specific aspects of the UEC pathway that are common in each of the locality delivery plans. These are:

- Ambulance Handovers
- Admissions avoidance

- Reducing Acute Length of Stay (LOS)
- Improving Discharge Pathways
- System Oversight and Resilience.

4.6 The five ‘at-scale’ workstreams share a set of common improvement objectives which are:

- to spread and scale best practice and focus on understanding unwarranted variation between localities.
- to identify opportunities to develop standard operating models where it is agreed these would be beneficial.
- to promote the use of evidence based continuous improvement approaches aligned to NHS IMPACT recommendations.
- to coordinate input from national subject matter experts and ensure alignment with the national delivery plan for recovering urgent and emergency care.
- to support evaluation and share toolkits to support implementation.

4.7 The ‘at-scale’ workstreams now have identified Senior Responsible Officers in place and are in the process of working with the Programme Management Office to develop their Project Initiation Documents and establish their own governance and assurance arrangements to support the delivery of improvements in locality performance and performance in aggregate at ICS level.

H2 and Winter Priorities

4.8 NHSE have now set out the priorities for H2 and Winter and confirmed that systems will be expected to work to their agreed 2024/5 financial plan (Appendix 4).

4.9 The guidance emphasises the need for a consistent focus on ensuring quality and safety of care is maintained even during periods of full capacity. The ICB has developed and implemented its UEC Red Lines Toolkit in order to maintain quality and safety during periods of heightened pressure.

4.10 The UEC Recovery Programme is the primary vehicle for the delivery of winter resilience through a focus on admissions avoidance, improving discharge, system oversight and delivery of the ten high impact interventions for improving UEC.

4.11 The guidance identifies that pro-active identification and management of people with complex needs and delivery of a robust vaccination programme are critical preventative measures, which the ICB oversees through established programmes and collaboratives.

4.12 A series of winter assurance meetings, led by the ICB CEO will be held during the first two weeks in October. These sessions will focus on assurance of delivery improvement expectations ahead of the peak of winter pressures.

Sentinel Metrics

4.13 The 'North Star' aim of the programme is to eliminate corridor care across all Cheshire and Merseyside sites by March 2025.

4.14 Corridor care is a symptom of system dysfunction across the UEC pathway and so this aim will be achieved by focusing on achieving improvements in the conditions that lead to corridor care and restrict patient flow (Appendix 2).

4.15 These conditions, which align to the UEC Recovery Programme workstreams, are aimed at:

- reducing demand for A&E and hospital admission through optimising use of Urgent Community Response, Primary Care, NHS 111, Urgent Treatment Centres and Walk-In Centres.
- improving the conditions for flow in hospital by increasing Same Day Emergency Care activity, reducing bed occupancy, and reducing in hospital length of stay through focusing on in-hospital efficiencies.
- improving discharge pathways to reduce the numbers of patients in hospital who no longer have criteria to reside, minimising days delayed once a patient is identified as being ready for discharge and a focus on increasing the number of patients discharged home from hospital (P0 and P1) as opposed to into bed-based discharge pathways (P2 and P3).

4.16 The 'at-scale' programmes will monitor both variation in performance between locality areas to identify opportunities to share best practice and the impact of locality improvements on aggregate performance at ICS level.

Summary of Current Performance

4.17 The majority of the plans anticipate tangible change from September onwards against each of the sentinel metrics.

4.18 Whilst some improvements can be seen against individual workstream it is clear that demand can quickly negate the overall benefit, endorsing the view that improvements need to be delivered in a sustained and holistic manner across the UEC pathway.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Enable all children, young people and adults to maximise their capabilities and have control over their lives

Objective Two: **Improving Population Health and Healthcare**
Provide high quality, accessible and safe services

Objective Three: **Enhancing Productivity and Value for Money**
Poor UEC flow represents poor productivity and value for money

Objective Four: **Helping to support broader social and economic development**
Not a direct focus of this report/proposal.

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

6.1 This workstream links to the following element of the Annual Delivery Plan: 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.*

7. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
- QS4 Equity in access
- QS5 Equity in Experience and Outcomes

Theme Two: **Integration**
- QS7 Safe Systems, Pathways and Transitions
- QS8 Care Provision, Integration and Continuity
- QS9 How staff, teams and services work together

Theme Three: **Leadership**
- QS10 Shared Direction and Culture
- QS14 Partnerships and communities
- QS15 Learning, improvement and innovation.

7. Risks

7.1 This report has a direct read across to:
- Board Assurance Risk 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*

7.2 There is a secondary link with risks P7, P8 and P9 in terms of enhancing productivity and value for money.

7.3 No change in risk ratings is proposed at this time.

8. Finance

8.1 The primary focus of the UEC Recovery Programme is on performance and quality, however it is recognised that addressing UEC challenge will also be instrumental in improving productivity and value for money in the context of the ICB wide recovery programme.

9. Communication and Engagement

9.1 Communication and engagement support is included within the Recovery Programme approach.

10. Equality, Diversity and Inclusion

10.1 Tackling UEC challenges including variation in performance between locality areas has a direct impact on equality, diversity, and inclusion.

11. Climate Change / Sustainability

11.1 There are no direct climate change or sustainability implications associated with the recommendations within this report.

12. Next Steps and Responsible Person to take forward

12.1 The Director of Performance and Planning will continue to be the responsible Director for the UEC Recovery Programme and will report through the C&M Recovery Sub-Committee on a monthly basis with highlight updates to the Cheshire and Merseyside Integrated Care Board on a quarterly basis unless requested otherwise by the Board.

13. Officer contact details for more information

15.1 Authorising Director: Anthony Middleton, Director of Performance and Planning

14. Appendices

Appendix One: UEC Recovery Programme Governance
Appendix Two: UEC Recovery Sentinel Metrics Driver Diagram (C&M) (Sept 2024)
Appendix Three: Responsible Officers – UEC Recovery Programme
Appendix 4: Winter Planning and H2 Priorities Letter

Appendix One: UEC Recovery Programme Governance

Fig 1.

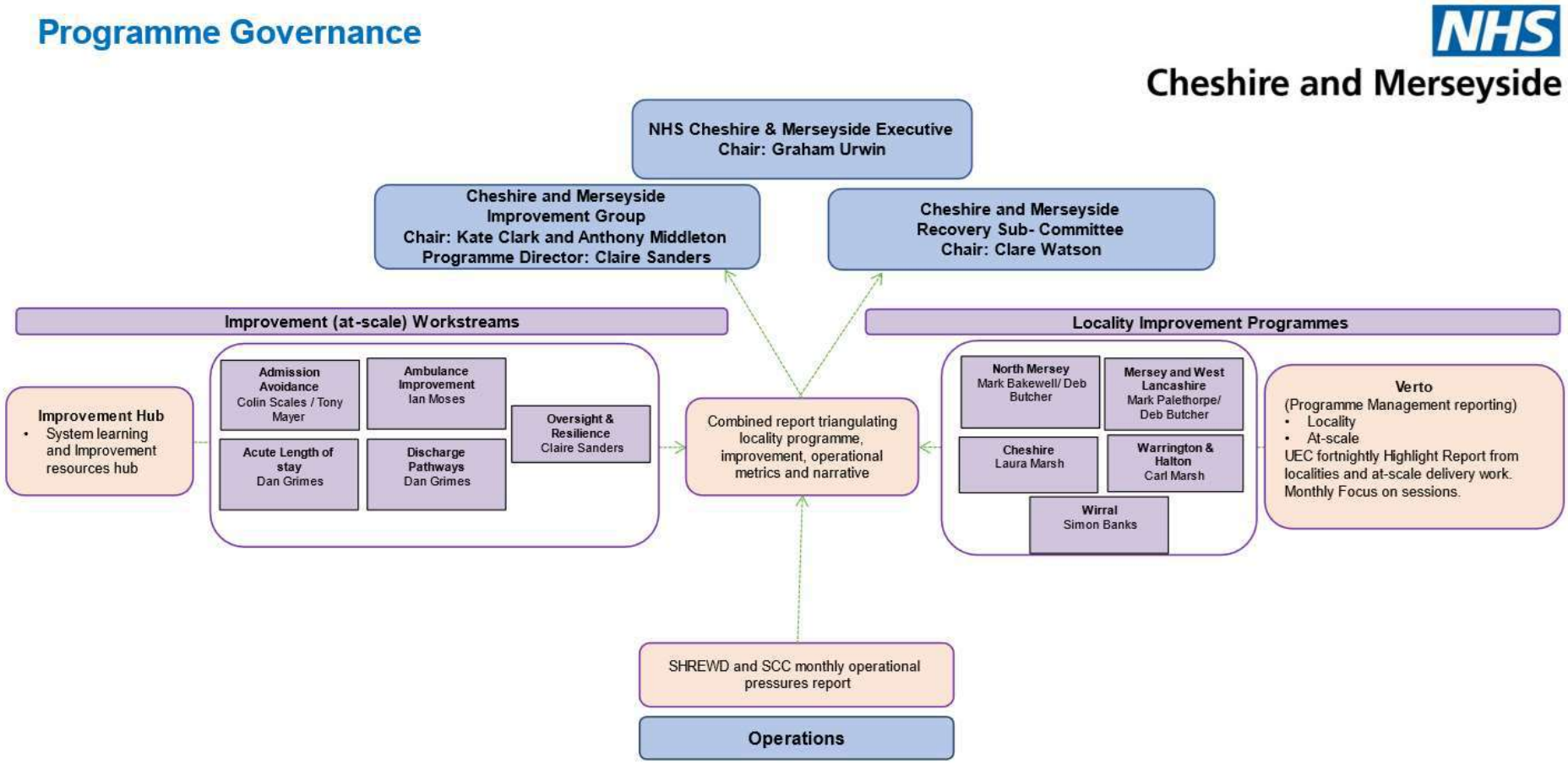
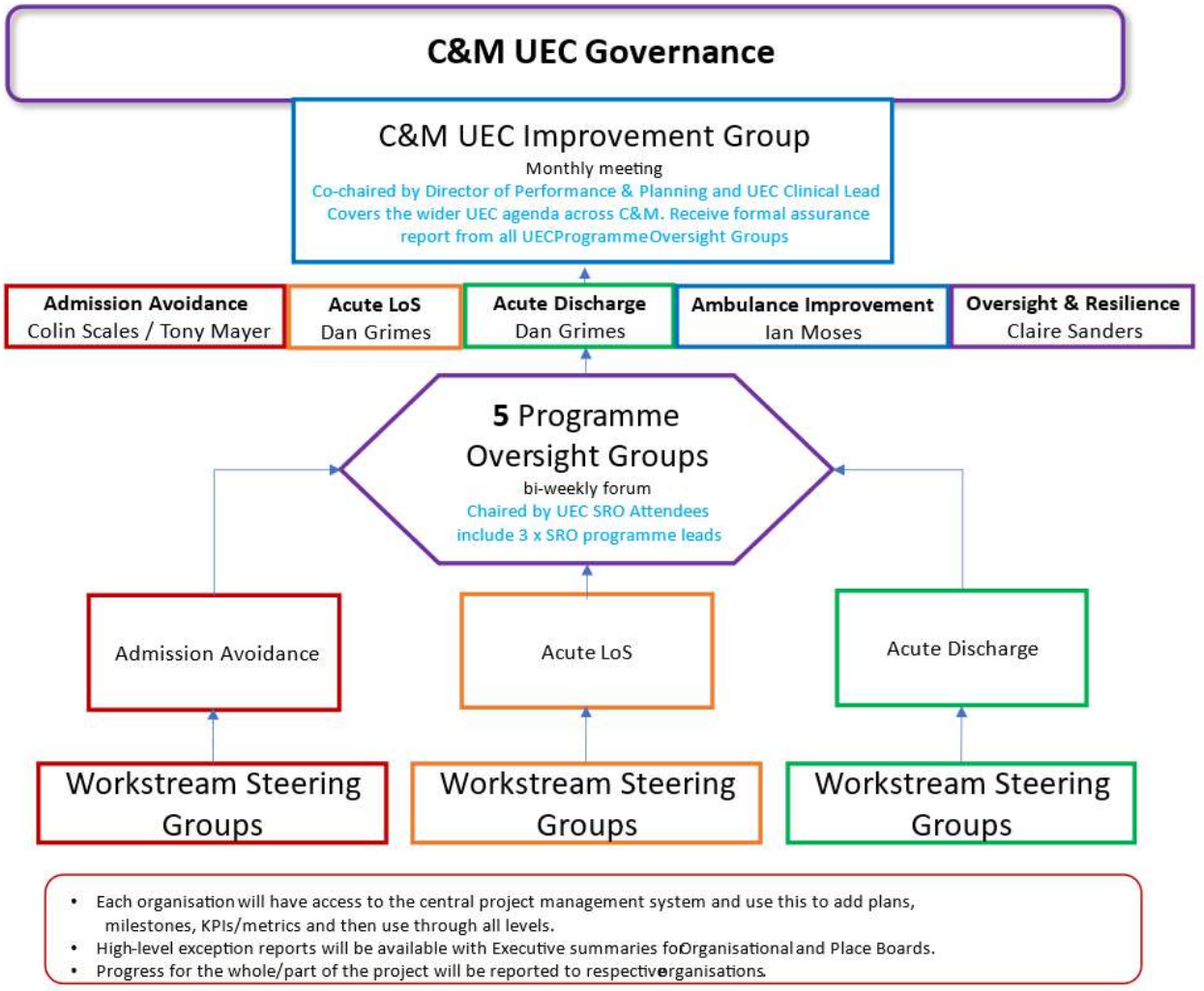
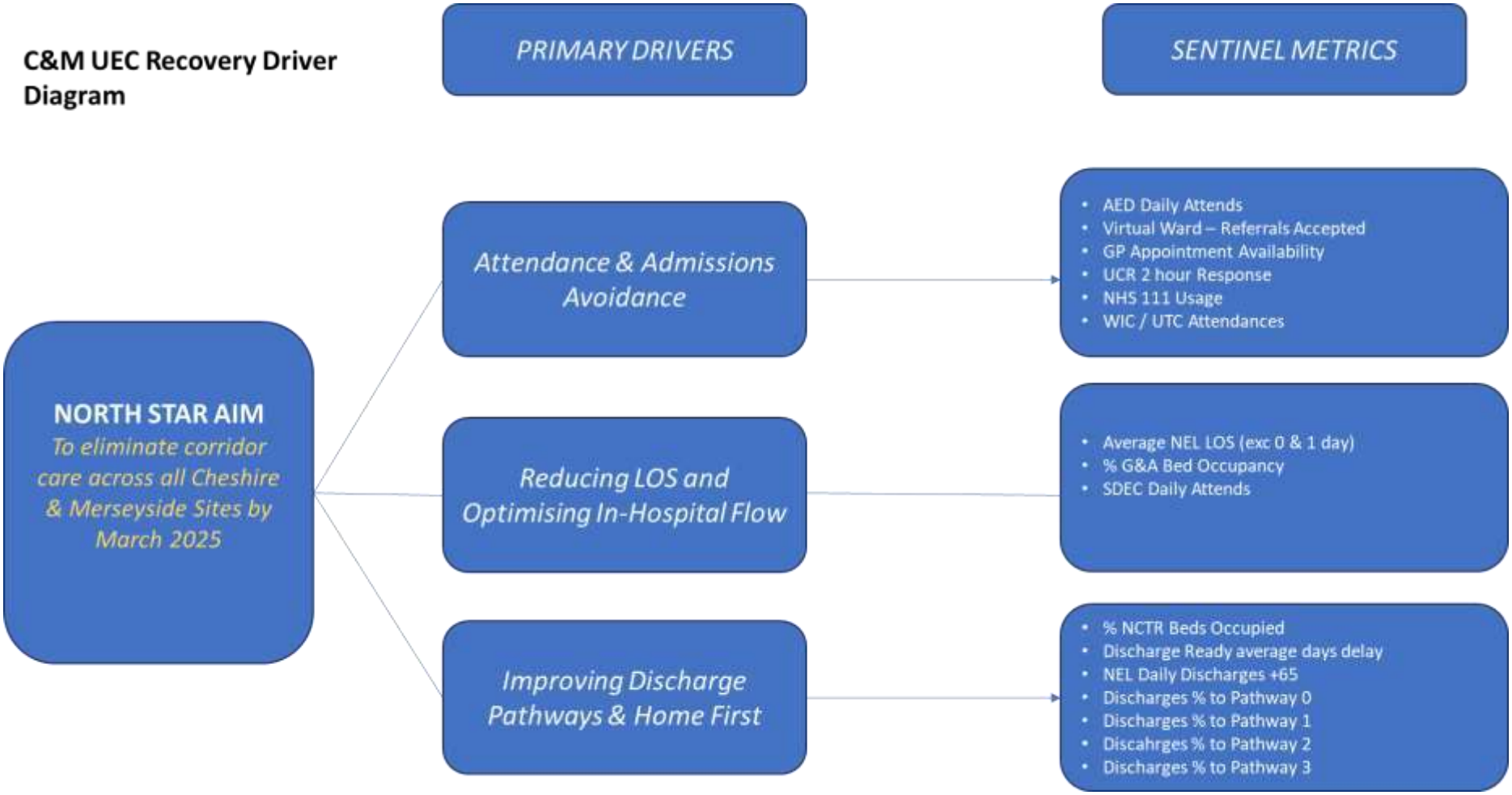


Fig 2.


C&M UEC Governance
C&M UEC Improvement Group
Monthly meeting
Co-chaired by Director of Performance & Planning and UEC Clinical Lead
Covers the wider UEC agenda across C&M. Receive formal assurance report from all UECProgrammeOversight Groups
Admission Avoidance
Colin Scales / Tony Mayer
Acute LoS
Dan Grimes
Acute Discharge
Dan Grimes
Ambulance Improvement
Ian Moses
Oversight & Resilience
Claire Sanders
5 Programme Oversight Groups
bi-weekly forum
Chaired by UEC SRO Attendees
include 3 x SRO programme leads
Admission Avoidance
Acute LoS
Acute Discharge
Workstream Steering Groups
Workstream Steering Groups
Workstream Steering Groups
• Each organisation will have access to the central project management system and use this to add plans, milestones, KPIs/metrics and then use through all levels.
• High-level exception reports will be available with Executive summaries forOrganisationaland Place Boards.
• Progress for the whole/part of the project will be reported to respectiveorganisations.

Appendix Two: UEC Recovery Sentinel Metrics Driver Diagram (C&M) (Sept 2024)



Appendix Three: Responsible Officers – UEC Recovery Programme

Locality	Programme / Workstream	Responsible Officer	Organisation
Cheshire	**Locality Programme**	Laura Marsh	**ICB**
Cheshire	Admissions Avoidance	Dr Andy McAlavey	ICB
Cheshire	In Hospital Flow (CoCH) In Hospital Flow (MCFT) In Hospital Flow (ECT)	Cathy Chadwick Nicola Costin Davies Simon Goff	CoCH MCFT ECT
Cheshire	Discharge (West) Discharge (East)	Alison Swanton Jo Young / Dan McCabe	CoCH ECT / Cheshire East Council
Mersey & West Lancashire (MWL)	**Locality Programme (St Helens)** **Locality Programme (Sefton)**	**Mark Palethorpe** **Deb Butcher**	**ICB** **ICB**
MWL	Admissions Avoidance	Lee McMenamy	Mersey Care
	In Hospital Flow	Lesley Neary	MWL
	Discharge (Knowsley) Discharge (MWL)	Sarah Smith Wayne Longshaw	Knowsley Council MWL
North Mersey	**Locality Programme (Liverpool)** **Locality Programme (Sefton)**	**Mark Bakewell** **Deb Butcher**	**ICB** **ICB**
North Mersey	Admissions Avoidance	Leigh Thompson	Mersey Care
North Mersey	Acute Length of Stay (LOS) (RLH) Acute Length of Stay (LOS) (AUH)	Jo Eccles Neil Holland	LUHFT LUHFT
North Mersey	Discharge Discharge (ToCH)	Jason Oxley Lee Taylor	Liverpool CC Mersey Care
Warrington & Halton	**Locality Programme**	**Carl Marsh**	**ICB**
Warrington & Halton	Admissions Avoidance	Sarah Brennan	Bridgewater

Warrington & Halton	Acute LOS (Post NCTR – Halton) Acute LOS (Post NCTR – W'ton) Acute LOS (Pre-NCTR)	Stephanie Haddock Sarah Haworth Dan Moore	HBC WBC WHH
Warrington & Halton	Optimising Intermediate Care (H) Optimising Intermediate Care (W)	Damian Nolan Caroline Williams	HBC WBC
Wirral	**Locality Programme**	**Simon Banks**	**ICB**
Wirral	Admission Avoidance (Pre-Hosp)	Bradley Palin	WCH&C
Wirral	Acute LOS (In Hospital)	Stephen Baily	WUHT
Wirral	Discharge (Post Hospital)	Jayne Marshall	Wirral Council
At Scale	**UEC Recovery Programme**	**Anthony Middleton**	**ICB**
At Scale	Ambulance Improvement	Ian Moses	NWAS
At Scale	Admissions Avoidance	Tony Mayer	C&M MHLDC Collaborative
At Scale	Acute LOS	Dan Grimes	ICB
At Scale	Discharge	Dan Grimes	ICB
At Scale	Oversight & Resilience	Claire Sanders	ICB

To:
- Integrated care board:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- Integrated care partnership chairs
- All NHS trust and foundation trust:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- Regional directors

cc.
- Local authority:
  - chief executive officers

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

16 September 2024

Dear colleagues

Winter and H2 priorities

Further to the meeting with ICB and provider chief executives on 3 September, we are now confirming operating assumptions for the remainder of this financial year.

This letter outlines the steps NHS England is going to take, as well as those ICBs and providers are asked to take, to support the delivery of safe, dignified and high-quality care for patients this winter.

Planning and financial framework

You are all aware of the tight financial environment both across the NHS and for the government more widely; it remains essential in H2 that systems continue their work to return to their agreed 2024/25 plans.

Providing safe care over winter

As set out in our letter of 16 May, we are in the second year of the delivery plan for recovering urgent and emergency care (UECRP).

Colleagues across the country have worked incredibly hard to implement the priority interventions identified in the UECRP. This has delivered improvements in performance on the 4-hour emergency department (ED) and Category 2 ambulance response time ambitions, against an extremely challenging backdrop.

The delivery priorities for this winter remain unchanged from those agreed in system plans.

We all recognise, however, that despite these improvements, far too many patients will face longer waits at certain points in the pathway than are acceptable.

Given demand is running above expected levels across the UEC pathway, ahead of winter we collectively need to ensure all systems are re-confirming that the demand and capacity plans are appropriate and, importantly, are taking all possible steps to maintain and improve patient safety and experience as an overriding priority.

Supporting people to stay well

As a vital part of preventing illness and improving system resilience, it will be important to maximise the winter vaccination campaign.

As well as eligible population groups, it is imperative that employers make every possible effort to maximise uptake in patient-facing staff – for their own health and wellbeing, for the resilience of services, and crucially for the safety of the patients they are caring for.

More detail on eligible flu cohorts is on gov.uk:

- National flu immunisation programme 2024 to 2025
- COVID-19 autumn/winter eligible groups

We confirmed campaign timings for both vaccines in our system letter on 15 August.

This year for the first time, the NHS is offering the RSV vaccine to those aged 75 to 79 and pregnant women. This is a year-round offer but its promotion ahead of winter by health professionals is vital, particularly to those at highest risk.

To support vaccination efforts, NHS England will:

- ensure all relevant organisations receive information as quickly as possible for flu, COVID-19 and RSV
- maintain the National Booking Service, online and through the NHS 119 service for COVID and flu (in community pharmacy settings)
- continue to share communication materials to support local campaigns

ICBs are asked to work with:

- local partners to promote population uptake with a focus on underserved communities and pregnant women
- primary care providers to ensure good levels of access to vaccinations, ensuring that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised
- primary care and other providers, including social care, to maximise uptake in eligible health and care staff

NHS trusts are asked to:

- ensure their eligible staff groups have easy access to relevant vaccinations from Thursday 3 October, and are actively encouraged to take them up, particularly by local clinical leaders
- record vaccination events in a timely and accurate way, as in previous campaigns
- monitor staff uptake rates and take action accordingly to improve access and confidence
- ensure staff likely to have contact with eligible members of the public are promoting vaccination uptake routinely

Maintaining patient safety and experience

We recognise this winter is likely to see UEC services come under significant strain, and many patients will face longer waits at certain points in the pathway than acceptable.

It is vital in this context to ensure basic standards are in place in all care settings and patients are treated with kindness, dignity and respect.

This means focusing on ensuring patients are cared for in the safest possible place for them, as quickly as possible, which requires a whole-system approach to managing winter demand and a shared understanding of risk across different health and care settings.

Evidence and experience shows the measures set out in the UECRP are the right ones, and systems and providers should continue to make progress on them in line with their local plans, with assurance by regional teams.

In addition, NHS England will continue to support patient safety and quality of care by:

- standing-up the winter operating function from 1 November:
  - providing capabilities 7 days a week, including situational reporting to respond to pressures in live time
  - this will be supported by a senior national clinical on-call rota to support local escalations
- completing a Getting It Right First Time (GIRFT) data-led review of support needs of all acute sites:
  - across all systems, and deploying improvement resources as appropriate, to support implementation of key actions within the UECRP, with a dedicated focus on ensuring patient safety
- convening risk-focused meetings with systems:
  - to bring together all system partners to share and discuss key risks and work together to agree how these can be mitigated
- expanding the Operational Pressures Escalation Levels (OPEL) framework:
  - to mental health, community and 111, and providing a more comprehensive, system-level understanding of pressures

NHS England will continue to support operational excellence by:

- co-ordinating an exercise to re-confirm capacity plans for this winter, which will be regularly monitored
- running an exercise in September to test the preparedness of system co-ordination centres (SCCs) and clinical oversight for winter, including issuing a new specification to support systems to assess and develop the maturity of SCCs

NHS England will continue to support transformation and improvement by:

- continuing the UEC tiering programme to support those systems struggling most to help them to enact their plans
- reviewing updated maturity scores for UEC high-impact interventions with regions and ICBs, to identify further areas for improvement
- as part of NHS IMPACT, launching a clinical and operational productivity improvement programme in September:
  - this will include materials and data for organisations to use, as well as a set of provider-led learning and improvement networks, to implement and embed a focused set of actions

ICBs are asked to:

- ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter:
  - primary care and community services should be working with these patients to actively avoid hospital admissions
- provide alternatives to hospital attendance and admission:
  - especially for people with complex needs, frail older people, children and young people and patients with mental health issues, who are better served with a community response outside of a hospital setting
  - this should include ensuring all mental health response vehicles available for use are staffed and on the road ahead of winter
- work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow
- assure at board level that a robust winter plan is in place:
  - the plan should include surge plans, and co-ordinate action across all system partners in real time, both in and out of hours
  - it should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers
- make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
- review the 10 high-impact interventions for UEC published last year to ensure progress has been made:
  - systems have been asked to repeat the self-assessment exercise undertaken last year, review the output, consider any further actions required, and report these back through regions

NHS trusts are asked to:

- review general and acute core and escalation bed capacity plans:
  - with board assurance on delivery by the peak winter period
- review and test full capacity plans:
  - this should be in advance of winter
  - in line with our letter of 24 June 2024, this should include ensuring care outside of a normal cubical or ward environment is not normalised; it is only used in periods of elevated pressure; it is always escalated to an appropriate member

of the executive and at system level; and it is used for the minimum amount of time possible

- ensure the fundamental standards of care are in place in all settings at all times:
  - particularly in periods of full capacity when patients might be in the wrong place for their care
  - if caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces
- ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow:
  - including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way
- ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week:
  - with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility

Next steps

In addition to existing guidance in the UECRP Year 2 letter and elsewhere, we have recently published further evidence-based guidance in the following areas to support further optimisation of winter plans:

- Same day emergency care service specification
- Single Point of Access hubs
- Virtual wards operational framework

As set out above, system risk discussions will follow during September.

We want to thank you and everyone across the NHS for your continued hard work this year.

Together, we are committed to doing everything we can to support the provision of safe and effective care for patients this winter, as well as continuing to improve services for the longer term.

Yours sincerely,

Sarah-Jane Marsh

National Director for Urgent and Emergency Care and Deputy Chief Operating Officer

Dr Emily Lawson DBE

Chief Operating Officer

Professor Sir Stephen Powis

National Medical Director

Duncan Burton

Chief Nursing Officer for England

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 September 2024

Draft Cheshire & Merseyside health Infrastructure Strategy

Agenda Item No: ICB/09/24/17

Responsible Director: Claire Wilson, Director of Finance

Draft Cheshire & Merseyside Health Infrastructure Strategy

1. Purpose of the Report

1.1 In March 2024, NHS England required all 42 Integrated Care Systems (ICS's) to develop a 10-year Infrastructure Strategy that will inform a set of national priorities. This strategy is a key enabler of the ICS's future clinical model, supporting the delivery of the NHS Long Term Plan and setting out how the local estate will be used.

1.2 These plans ensure the most efficient and productive use of NHS resources in helping to address necessary backlog maintenance, support the recovery of our core services, and produce flexible solutions to meet the future needs of patients and staff.

1.3 These plans incorporate requirements from the NHS Trusts and Primary Care network estates within a system and support national strategic plans and priorities such as those for the New Hospital Programme.

1.4 The draft Cheshire and Merseyside Health Infrastructure Strategy is now complete for review, having previously being endorsed by the ICBs Finance Investment and Resources Committee (FIRC).

2. Executive Summary

2.1 With the government's pledge to launch a new 10-year plan for the NHS, and the findings within the recently published Darzi Report, it is more important than ever that the NHS in Cheshire and Merseyside has a robust Infrastructure Strategy that provides a road map to the future.

2.2 Our 2024-2034 Cheshire and Merseyside health Infrastructure Strategy has been aligned with our Joint Forward Plan and will support the Cheshire and Merseyside ICS by providing a system wide roadmap to improve sustainability, collaboration and efficiencies across our health infrastructure. The strategy structured into four key sections:

1. **Who we are**
   Section 1 of the strategy provides an overview of our system structure, our partnerships, the area in which we provide our services, what we do and our vision.

2. **Where are we now?**
   Section 2 details our current infrastructure, covering the health estate, where we have already leveraged the power of digital, and progress against our workforce objectives.

3. **Where do we want to be?**
   Section 3 considers where we need to be as a collaborative system by 2034, our aims against each infrastructure pillar and our capital pipeline, detailing the investment required to achieve our objectives.

4. **How do we get there?**
   Section 4 looks at the approaches and actions required to achieve our vision, including a high-level implementation plan.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **note** the content of the report
- **approve** the publication of the strategy and its submission to NHS England, considering this as an initial draft with an updated document to follow in 2025.

4. Reasons for Recommendations

4.1 The Health Infrastructure Strategy provides the high-level recommendations to be implemented by our Central Estates Team, including a relaunch of governance and business as usual processes, development of our asset management plan to include a focus on cost improvement and value for money, development of our estates workforce plan and increased collaboration and working with wider public sector colleagues.

4.2 It is critical this work programme begins with support from the Board regarding key next steps.

5. Background

5.1 The strategy has been through extensive engagement including with:
- Directors of Estates (Acute, Community and Specialist Trusts)
- Directors of Strategy
- Place Directors
- Strategic Estates Groups (9 Places)
- Central Estates Team
- Directors & Associate Directors of Finance.

5.2 The strategy has been endorsed by the ICBs Finance Investment and Resources Committee (FIRC) and recommended for Board approval.

6. Next Steps and Responsible Person to take forward

6.1 Following approval by the Board, the high-level implementation plan will need to continue to be developed by the ICBs central estates team with a relaunch of associated governance to support delivery, including the establishment of a Strategic Estates Board. All BAU processes will be reviewed, including a review of the existing risk management framework and how this connects with ICB governance.

6.2 The next iteration of the strategy will include:

- a refresh of the planning footprints;
- further engagement and inclusion of wider public sector; and
- additional transformational estates schemes such as Shaping Care Together.

7. Officer contact details for more information

Claire Wilson, Director of Finance
claire.wilson@cheshireandmerseyside.nhs.uk

8. Appendices

Appendix One: CM ICS Health Infrastructure Strategy summary Update Slides

Appendix Two: Cheshire and Merseyside Health Infrastructure Strategy

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside: Infrastructure Strategy Update

Our Approach

NHS Cheshire and Merseyside

Our 2024-2034 Cheshire and Merseyside Infrastructure Strategy has been structured into four key sections as shown below. The strategy aligns with our Joint Forward Plan and will support Cheshire and Merseyside ICS provide a system wide roadmap to unlock improved sustainability, collaboration and efficiencies across our health infrastructure.

1. Who we are

Section 1 of the strategy will give an overview of our system structure and partnerships, the area in which we provide our services, what we do and our vision

2. Where are we now?

Section 2 will outline our current infrastructure, covering the health estate, where we have leveraged the power of digital already and progress against our workforce objectives

3. Where do we want to be?

Section 3 will consider where we need to be as a collaborative system by 2034, our aims against each infrastructure pillar and our capital pipeline, detailing the investment required to achieve our objectives

4. How do we get there?

Section 4 will look at the approaches and actions required to achieve our vision, including a high-level implementation plan for further development

Our Infrastructure Principles

NHS
Cheshire and Merseyside

The infrastructure addressed in this strategy and our infrastructure principles are centred around three pillars; Our Estate, Our People, and Our Systems and Processes, supported by key enablers; investment, environmental sustainability and collaboration.

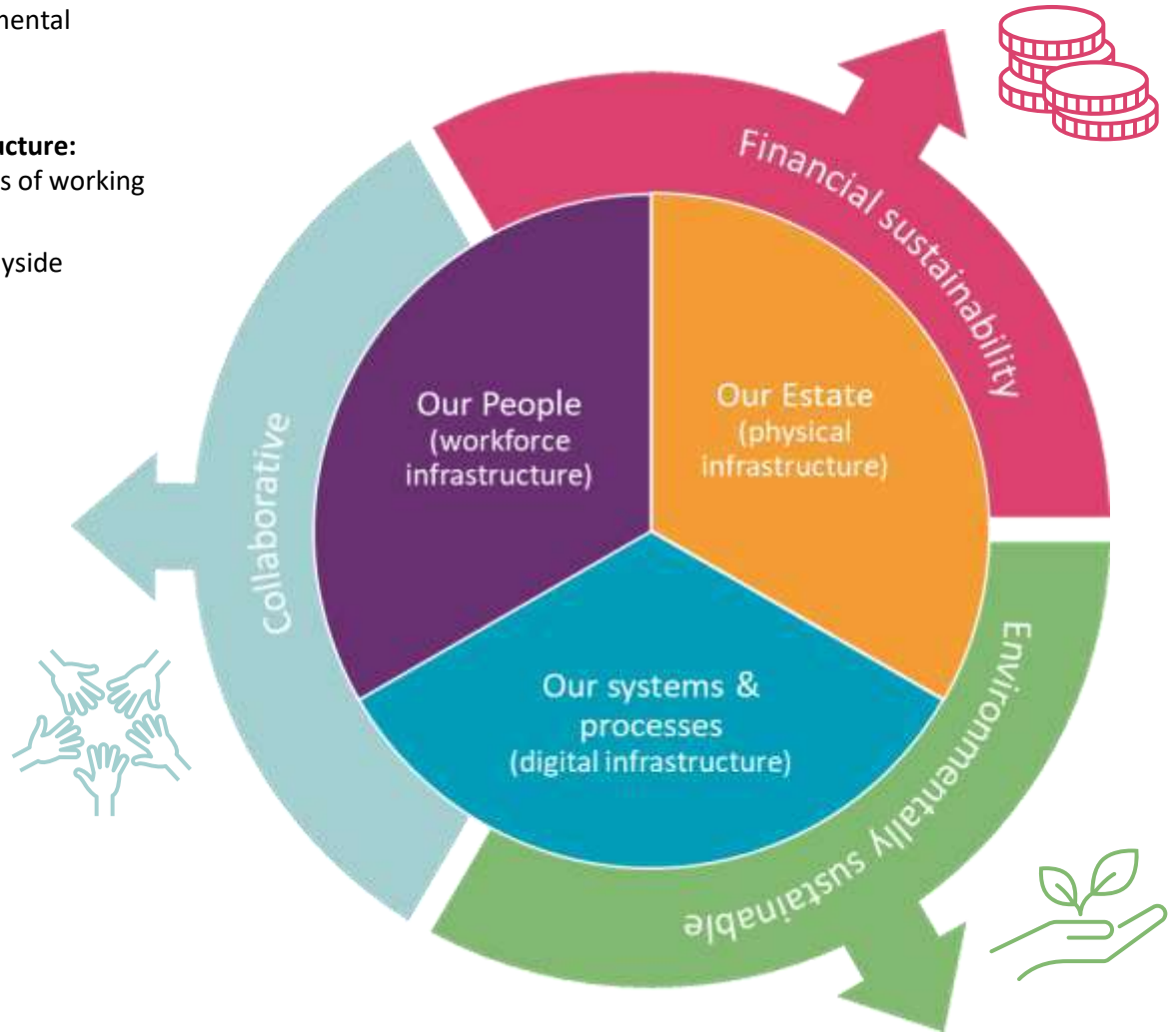
Physical infrastructure: Our Estate

Workforce infrastructure: Our People

Digital Infrastructure: Our Systems and ways of working

Through partnership discussions and involvement from many stakeholders within the Cheshire and Merseyside health system, our Infrastructure Principles have been established to guide our Infrastructure journey and enable us to measure our progress and success.

- Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population
- Our future is digital, smart and intelligent to deliver better care and empower people to manage their own health
- Our workforce is integrated and adaptive to new ways of working
- Our future is green and environmentally sustainable
- Our infrastructure is collaborative and shapes healthier places
- Our future infrastructure is affordable and financially sustainable



Strategy Overview

NHS
Cheshire and Merseyside

WHERE ARE WE NOW?

We have made significant progress across our infrastructure;

- 10 Community Diagnostic Centres opened
- New Hospitals Programme developments progressing at Mossley Hill and Leighton Hospital
- Significant NHSE capital awarded to providers, such as Wirral University Teaching Hospital
- Sustainability initiatives benefits being progressed such as LED Lighting Replacement at Mersey Care NHS Foundation Trust
- Improved digital maturity and digital strategy for the ICS
- System wide Efficiencies at Scale programme commenced and evidencing benefits

However, our system still faces challenges

- Deprivation across every place in Cheshire and Merseyside with significant socio-economic challenges across Liverpool and Knowsley, impacting health outcomes
- Ageing estate not conducive to new ways of working
- Limited capital funding for our physical estate infrastructure exacerbated by the significant increases in building costs adding additional pressure and complexities to the already limited resources
- 23% of our whole estate comprises of general practice services, which creates difficulties in providing services at scale and support for patients in the community
- 12% of the population receive GP care from tail estate
- **£654,176,660** Total backlog costs, including Primary and Secondary Care

WHERE DO WE WANT TO BE?

- Population health to be at the centre of our decision making, including infrastructure planning, with a data driven approach
- Investment in our infrastructure to enable integrated services across our system as outlined by the Fuller Stocktake Report
- Reduce our carbon emissions and achieve the ambitions of our Green Plan
- Optimise, consolidate and improve our estate
- Work as a system to develop an integrated digital infrastructure enabling collaborative and integrated care between partners, supporting our patients to stay well and manage their health
- Maximise the use of our estate through digital efficiencies and innovation
- Build our estates workforce for the future

HOW WILL WE GET THERE?

- Through strong leadership and a clear system wide governance structure linking our pillars of infrastructure (estates, workforce and digital)
- Investment through a prioritised, systematic capital pipeline of projects, ensuring our highest priority areas are supported
- System wide collaboration and partnership working, developing our Asset Management Plan with partners to create the roadmap to optimise and consolidate our estate
- Continued development in our digital tools, systems and processes, enabling us to have the tools and capability to ensure a data driven approach in everything we do
- Based on local strategies, prioritise delivering caring closer to home and preventative care

How do we get there: Recommendations

Throughout this strategy we have considered how our transformation programme can impact our physical infrastructure and also present opportunities to think and work differently. For us to continue planning and designing the estate of the future, which will enable new ways of working, the following key next steps are recommended:

GOVERNANCE: **A full system governance review should be undertaken** to ensure discussions impacting our infrastructure have estates representation or are reported back via existing estates forums, such as the Strategic Estates Groups. In addition, we must ensure our estates forums ultimately report back into the ICB via the Strategic Estates Board, ensuring effective comms, lines of accountability and transparency.

PRIORTISATION: We are ambitious as a system, driven by providing the best possible services and experience for our patients. It is critical that we effectively prioritise our schemes to ensure we are taking forward those which drive the most benefit and enable us to work towards our aim and objectives**. A consistent methodology for capital prioritisation will be signed off by the ICB** and shared via our Strategic Estates Groups along with guidance on approvals and governance process.

DEVELOPMENT OF OUR ESTATES ASSET MANAGEMENT PLAN: Our Strategic Estates Groups need to continue developing an accurate estates baseline across Place and partners, a process for tracking our vacant estate and leases, categorise the full estate into core, flex and Tail, and develop a Place Asset Management Plan. This should build on the Core, Flex and Tail categorisation and include plans for any potential disposals (reuse, recycle, receipt).

DIGITAL: Our work in the digital space is changing the way we deliver care, and with that driving benefits for patients and staff. We must now begin to consider where we can utilise these tools, such as CIPHA, in other parts of the system to support decision making, ensuring the data we use is consistent. Digital will be a key enabler in the development of our Estates Asset Management Plan.

DEVELOPMENT OF OUR SYSTEM WIDE ESTATES WORKFORCE PLAN: Our Estates workforce Plan and ambitions are articulated on pages 71-73. We must bring our Estates leaders together to develop this plan and focus on succession planning to ensure a workforce fit for the future.

COLLABORATION: We must continue to collaborate across our system, learning from our provider collaboratives and adopting their approach in the identification of opportunity and efficiencies. Our implementation and delivery plan must include partners across Local Authority, VCSE and the wider public sector.

High Level Estates Implementation Plan- Key Actions

NHS Cheshire and Merseyside

The key next steps and actions described throughout this document are captured below and will be developed into a full implementation and delivery plan to support NHS Cheshire and Merseyside ICS to work towards our vision.

Governance	• System wide estates governance to be launched with clarity around roles, function, link into Place, reporting & accountability – to include the relaunch of the Strategic Estates Board (SEB). We must understand how workstreams across estates, digital and workforce are connected so opportunities and co-dependencies are identified and discussed • The vision and objectives for estates needs to be agreed in the SEB and shared with SEGs, agreeing short-, medium- and long-term priorities to ensure the accountability and delivery of objectives at both Place and system level
Operational Estates	• Improved baseline data of our community estate to be gathered and understanding of the estate utilisation through digital technologies such as the installation of room sensors • Design and implementation of BAU processes to drive proactive asset management including lease management, grant and funding applications (e.g. s106/CIL) • Develop system wide principles for the management of void / bookable space to ensure our buildings are utilised and provide value for money • Identify opportunities for Digital / touchdown space for staff
Strategic Estates	• Core, flex and tail categorisation to be completed at Place level across all provider and local authority estate • Tail estate categorisation and disposal opportunities to be signed off at Place and SEB • Building on the estate classification work, develop our Estate Asset Management Plan with place and wider system colleagues: to include a clear strategic direction and level of priority for each asset (reuse, repurpose, receipt) ensuring optimisation and integration of the right estate across each place • Develop system wide plan for the NHSE sustainability indicators to achieve the carbon net zero targets • Review where existing digital tools can be used to complement and enhance estates processes, for example using CIPHA to support decision making
Estates Workforce	• Estates workforce strategy and succession plan to be developed looking at how the role of apprenticeships can be further developed across C&M estates • Identify opportunities for pooling of resource across Providers to reduced bank and agency spend • Review of recruitment and retention policy • Estates workforce marketing campaign to be discussed as part of SEB
Finance	• Consistent methodology for capital prioritisation to be developed and agreed • Prioritisation of full system capital pipeline to be reviewed using agreed methodology • Delivery of prioritised projects • Estates Cost Improvement Programme to launch via the SEB and Strategic Estates Groups
Collaboration	• Whilst this strategy is primarily focussed on our health estate, work with Local Authority, VCSE and system partners must continue to identify opportunities for integration and collaboration – this will drive benefits not only for our patients, communities and staff, but also ensure we are working as efficiently as possible, operating only across the footprint we need, delivering services where they are required for our communities and supporting our work to reduce running costs where possible by taking a proactive approach

NHS
Cheshire and Merseyside

NHS Cheshire & Merseyside ICS Infrastructure Strategy 2024-2034

September 24

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With Thanks to Our Partners

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Wirral

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Knowsley Council

Sefton Council

Cheshire East Council

Cheshire West and Chester

Warrington Borough Council

Foreword

Inadequate and inefficient infrastructure and buildings not only incur costs for the NHS but also significantly contribute to poor health outcomes and experience for our patients and staff. High-quality environments, backed by the right workforce, excellent digital systems, and medical equipment, are essential to deliver the level of care our patients and population deserve.

Cheshire and Merseyside face substantial infrastructure challenges, exacerbated by years of underinvestment and a lack of integration. As one of the largest Integrated Care Systems in the country, we serve a diverse population, including some of the most deprived areas nationally. To achieve the necessary scale and speed of infrastructure transformation, increased system **collaboration is essential**; we must work together as a network of partners to create a sustainable, efficient, smart, and integrated **infrastructure ecosystem**.

Our Infrastructure **must enable new models of service delivery and a 'digital first' approach**, whilst also providing an alternative for those who can't access care in this way. It is critically important our transformation programme reduces health inequalities across Cheshire and Merseyside, and our Infrastructure Strategy and planning must support this. Our inaugural Infrastructure Strategy builds on our existing strategies, linking estates with other enablers such as digital and workforce, to outline how our infrastructure will support our ambition for everyone in Cheshire and Merseyside to have **a great start in life and receive the support needed to stay healthy and live healthier for longer**.

This strategy covers where we are now, where we want to be and a high-level overview of the key enablers which will support us to get there. From this we will need to work collaboratively across place, neighbourhoods and providers, taking forward the recommendations to begin realising the **benefits of greater integration for our patients, staff and local communities.**

Claire Wilson
Director of Finance,
Cheshire & Merseyside
Integrated Care System

Introduction

Infrastructure goes beyond just 'bricks and mortar' from encompassing well-designed facilities to having adequately trained staff equipped with the necessary technology and equipment that must seamlessly integrate to ensure efficient service delivery. Good infrastructure is essential to the long-term sustainability for our system and plays a critical role in preserving the health and well-being of the community. It is also fundamental to high-quality patient care, from well-designed facilities that promote patient flow and quicker recovery, to staff being better able to care for patients using the equipment that they need.

Similar to systems across the country, our current infrastructure across **Cheshire & Merseyside Integrated Care System (ICS)** is not without complexities and challenges. Some of our significant system wide challenges include:

Increasing Demand: The demand for healthcare services continues to rise for a variety of reasons, such as an ageing population, increasing prevalence of chronic diseases, and advancements in medical technology and treatments. This increased demand puts pressure on existing resources.

Budget Constraints: Budget allocations cannot keep up with the increasing demand for services, leading to funding shortfalls. Available funding for estates and infrastructure have suffered as a result, evidenced by the level of backlog maintenance and estates risk within the system.

Workforce Challenges: Staffing costs, including salaries, training, and recruitment, constitute a significant portion of the NHS budget (c46%). Addressing workforce shortages and meeting increasing demand for healthcare services require additional investment in recruitment, retention, and training – including our estates workforce.

Digital interoperability, skills and training: Integrating care requires seamless sharing of patient information across different healthcare organisations and systems. However, interoperability issues, incompatible systems and not having access to the technology required can impact our efforts.

Estate and Maintenance: Maintaining and upgrading physical healthcare infrastructure, including hospitals, clinics, and equipment, requires substantial funding. Neglecting infrastructure maintenance leads to inefficiencies, decreased capacity, and compromised patient care. Some of our physical infrastructure is not digitally adaptable or flexible, meaning our estate will not be fit for the future.
We also have upcoming infrastructure deadlines; with end of lease terms immanent for some of our LIFT/3PD and PFI estate, and the need to source additional investment to meet targets such as the national sustainability agenda.

Larger and complex organisations: Different healthcare organisations often have distinct workflows and priorities. Aligning these and fostering collaboration among stakeholders can be challenging and may require significant time investment and leadership support.

Addressing the social determinants of health and caring for patients with more complex needs: Integrated care systems must address the social determinants of health, such as housing instability, food insecurity, fuel poverty and access to transportation, which significantly impact health outcomes. Coordinating healthcare with social services and community resources is essential but can be challenging due to funding constraints, resource limitations and cross boundary working.

As a system we have invested significant time and resource to support a more integrated and collaborative infrastructure delivery model; looking at opportunities to streamline and transform the way we work. This strategy will outline our journey so far, how we are working collaboratively as a system to tackle these challenges and what we need to do next to ensure our estate can support our vision for the future.

"We must take action to improve the long-term sustainability of the Cheshire and Merseyside health system by managing demand and transforming the way we use services, staff, and buildings"
Cheshire and Merseyside Joint Forward Plan 2023-28

Our Approach

Our 2024-2034 Cheshire and Merseyside Infrastructure Strategy is our inaugural health infrastructure strategy and has been structured into four key sections as shown below. The strategy aligns with our Joint Forward Plan and will support Cheshire and Merseyside ICS provide a system wide roadmap to unlocking improved sustainability, collaboration and efficiencies across our health infrastructure.

1. Who we are

Section 1 of the strategy will give an overview of our system structure and partnerships, the area in which we provide our services, what we do and our vision

2. Where are we now?

Section 2 will outline our current infrastructure, covering the health estate, where we have leveraged the power of digital already and progress against our workforce objectives

3. Where do we want to be?

Section 3 will consider where we need to be as a collaborative system by 2034, our aims against each infrastructure pillar and our capital pipeline, detailing the investment required to achieve our objectives

4. How do we get there?

Section 4 will look at the approaches and actions required to achieve our vision, including a high-level implementation plan for further development

Strategy Overview

WHERE ARE WE NOW?

We have made significant progress across our infrastructure;

- 10 Community Diagnostic Centres opened
- New Hospitals Programme developments progressing at Mossley Hill and Leighton Hospital
- Significant NHSE capital awarded to providers, such as Wirral University Teaching Hospital
- Sustainability initiatives benefits being progressed across all trusts such as LED Lighting Replacement at Mersey Care NHS Foundation Trust
- Improved digital maturity and digital strategy for the ICS
- System wide Efficiencies at Scale programme commenced and evidencing benefits

However, our system still faces challenges

- Deprivation across every place in Cheshire and Merseyside with significant socio-economic challenges across Liverpool and Knowsley, impacting health outcomes
- Ageing estate not conducive to new ways of working
- Limited capital funding for our physical estate infrastructure exacerbated by the significant increases in building costs adding additional pressure and complexities to the already limited resources
- 23% of our whole estate comprises of general practice services, which creates difficulties in providing services at scale and support for patients in the community
- 12% of the population receive GP care from tail estate
- **£654,176,660** Total backlog costs, including Primary and Secondary Care

WHERE DO WE WANT TO BE?

- Population health to be at the centre of our decision making, including infrastructure planning, with a data driven approach
- Investment in our infrastructure to enable integrated services across our system as outlined by the Fuller Stocktake Report
- Reduce our carbon emissions and achieve the ambitions of our Green Plan
- Optimise, consolidate and improve our estate
- Work as a system to develop an integrated digital infrastructure enabling collaborative and integrated care between partners, supporting our patients to stay well and manage their health
- Maximise the use of our estate through digital efficiencies and innovation
- Build our estates workforce for the future

HOW WILL WE GET THERE?

- Through strong leadership and a clear system wide governance structure linking our pillars of infrastructure (estates, workforce and digital)
- Investment through a prioritised, systematic capital pipeline of projects, ensuring our highest priority areas are supported
- System wide collaboration and partnership working, developing our Asset Management Plan with partners to create the roadmap to optimise and consolidate our estate
- Continued development in our digital tools, systems and processes, enabling us to have the tools and capability to ensure a data driven approach in everything we do
- Based on local strategies, prioritise delivering caring closer to home and preventative care

Our Infrastructure Principles

The infrastructure addressed in this strategy and our infrastructure principles are centred around three pillars; Our Estate, Our People, and Our Systems and Processes, supported by key enablers; investment, environmental sustainability and collaboration.

Physical infrastructure: Our Estate

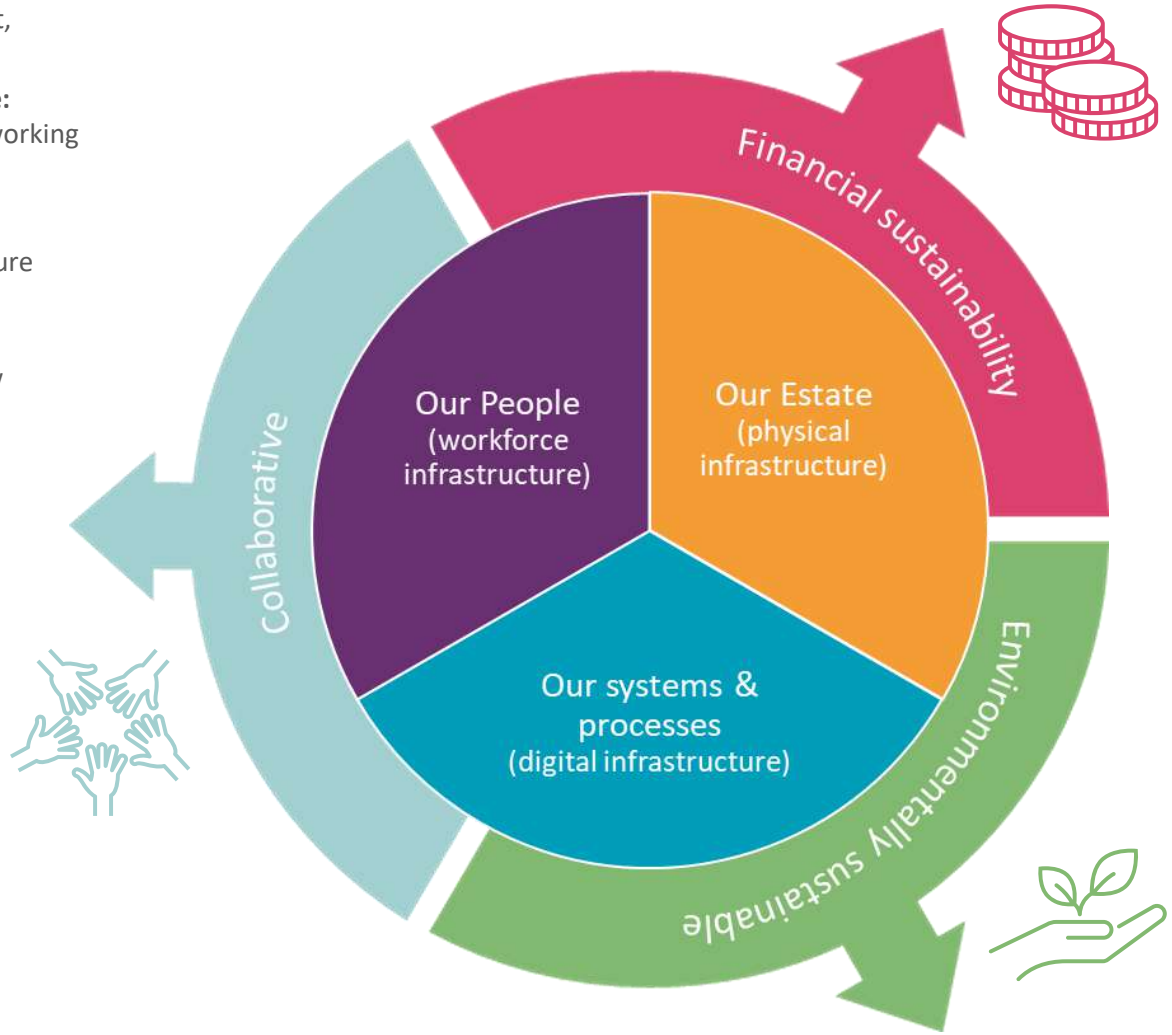
Workforce infrastructure: Our People

Digital Infrastructure: Our Systems and ways of working

Through partnership discussions and involvement from many stakeholders within the Cheshire and Merseyside health system, our Infrastructure Principles have been established to guide our Infrastructure journey and enable us to measure our progress and success.

Our principles underpin every decision we will make from now until 2034 at which point we will review and refresh our strategy. Our principles are fundamental to our future; ensuring that as an integrated system we are working towards a shared vision and in doing so follow consistent processes.

- Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population
- Our future is digital, smart and intelligent to deliver better care and empower people to manage their own health
- Our workforce is integrated and adaptive to new ways of working
- Our future is green and environmentally sustainable
- Our infrastructure is collaborative and shapes healthier places
- Our future infrastructure is affordable and financially sustainable



SECTION 1: WHO WE ARE

Our Current Infrastructure

Located in the North West of England, NHS Cheshire and Merseyside ICS is a partnership that brings together health and care organisations in Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral.

Across our communities, we have a unique set of challenges with a mixture of rural, coastal and urban deprivation. Therefore, demand for health and care services in each region is variable – yet a challenge across all.

Without a different approach to our health infrastructure; including collaboration, a shift in focus to population health led models of care and fit for future physical infrastructure, we recognise our services are not sustainable for the future.

Our Strategy will look at our nine places in three areas from an estate's perspective due to provider footprints. When this strategy is refreshed the planning footprints will be updated:

North Mersey
Sefton
Liverpool
Knowsley

Mid Mersey
Warrington
St Helens
Halton

Cheshire and Wirral
Cheshire East
Cheshire West
Wirral

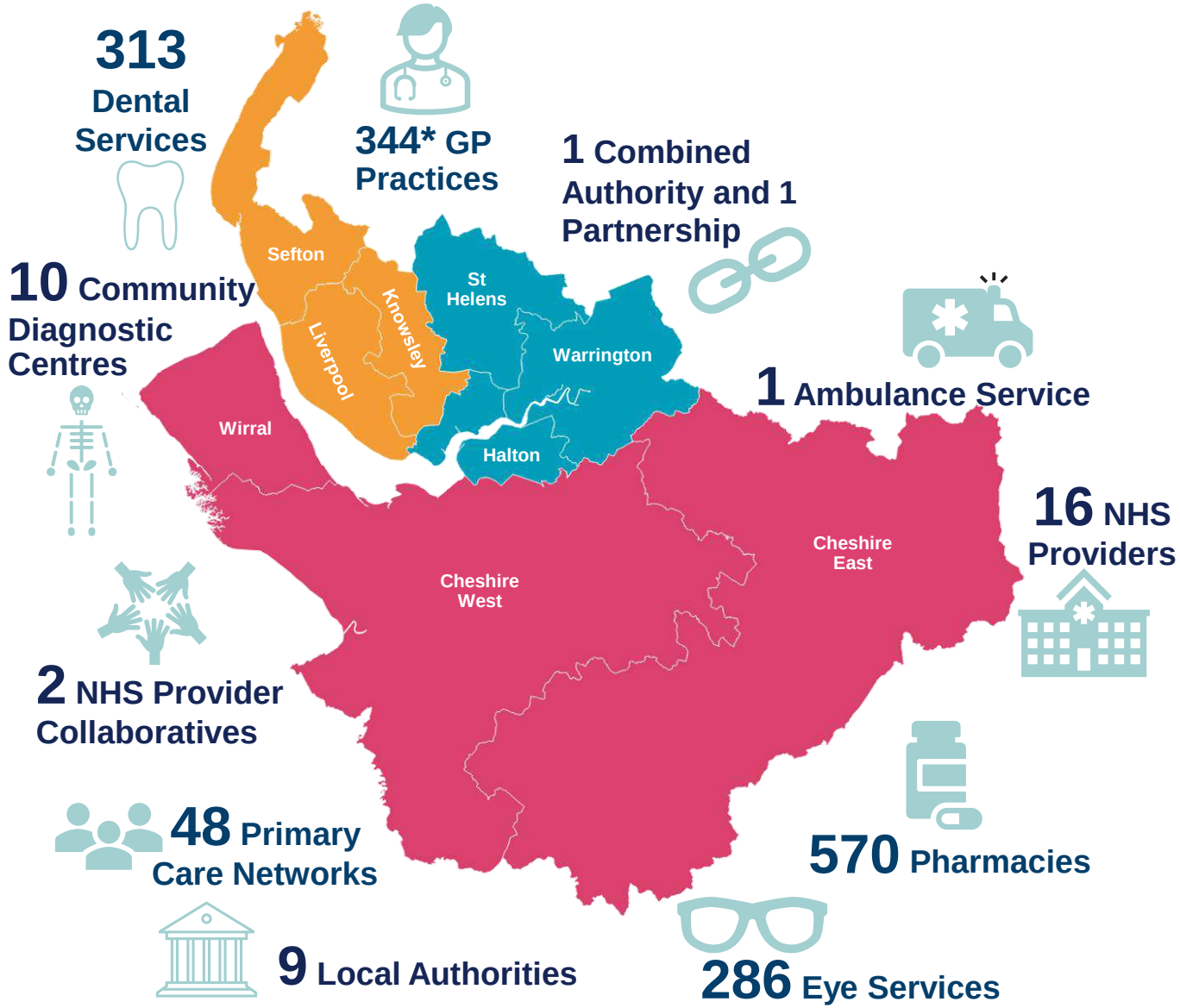


Image: Cheshire and Merseyside Infrastructure

*Source: NHS Cheshire and Merseyside Joint Forward Plan 2024-2029

Our ICS vision, mission and objectives

Our vision is focused around three collective areas; tackling poverty, equity in all places and transformation. Our infrastructure pillars and enablers are fundamental to support us to achieve our mission and vision which we will describe throughout this strategy.

We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.

We Will:

- ✓ Provide safe, effective and timely care
- ✓ Improve Outcomes in Population Health and Healthcare and reduce inequalities in all we do
- ✓ Make decisions based on evidence and have a culture of innovation and continuous improvement
- ✓ Increasingly focus on prevention reducing the need to treat ill health
- ✓ Find the optimum way to provide services, working to integrate and simplify how we work
- ✓ Provide services within the funding available to us Deliver our Anchor principles to have a positive impact on our communities socially, economically and environmentally

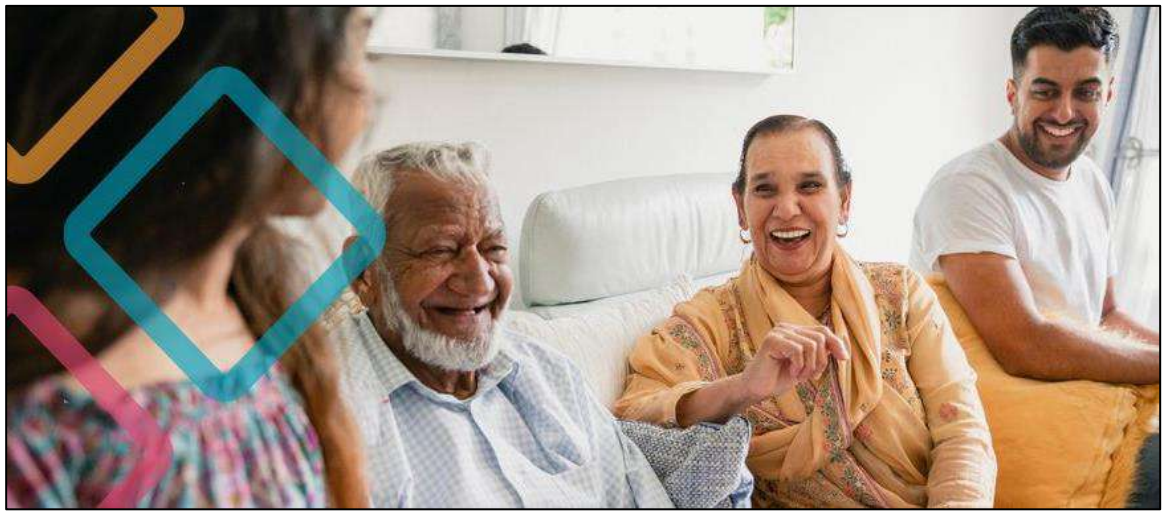
Mission:

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

We will do this by working together, as equal partners, to support seamless, person-centred care and tackle health inequalities by improving the lives of the poorest fastest.

We will deliver this by:

- ✓ Balancing funding to support prevention
- ✓ Developing our workforce
- ✓ Investing in technology and data
- ✓ Creating estate fit for the future
- ✓ Focusing on environmental sustainability
- ✓ Supporting research and innovation
- ✓ Effective communications and engagements
- ✓ Ensuring equality and diversity



Key System Challenges

Our system faces a complex set of challenges which range from;

- **Growing Population Health Challenges:** Polarised Boroughs with areas of high deprivation
- **Challenges associated with fast growth**: Planned housing growth across our nine localities, whilst creating great opportunity also present the challenge of ensuring we have adequate infrastructure which goes beyond health
- **Current Infrastructure is not fit for purpose**: Our estate is characterised by a vast and ageing infrastructure that needs maintenance and improvement to meet our current and future requirements

DEMOGRAPHICS

33%
of our population live in the most deprived 20% of neighbourhoods in England

Knowsley and Liverpool
are the 2nd & 3rd most deprived boroughs in England

North Mersey and Mid Mersey
have a lower life expectancy than the average for England

Six of our local authorities
have alcohol-related and drug misuse mortality rates above the England average

POPULATION

2.7m
population across our nine places

Liverpool
is our most densely populated place with 4475 people per sqm

↑28%
increase of people aged 90+ in Cheshire and Merseyside (between 2011 to 2021)

↑10%
increase in our population (between 2024 to 2041)

GROWTH

Over 28
planned regeneration schemes in Cheshire and Merseyside

156,000+
new homes and dwellings to be built by 2040 per local plans

c. £130M
of Towns plans secured for the Government's Towns Fund

£98M
of Levelling Up Funding secured for regeneration schemes

ESTATE

1.7M m²
of health and social care estate in Cheshire and Merseyside

1 in 4
of our provider estate predates the NHS

70%
of our estate is below Condition B

£654,176,660
Is our total backlog maintenance costs for our estate

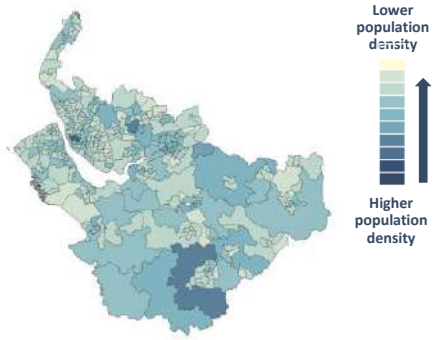
Population Health Management: Summary

Our area comprises of a diverse landscape encompassing rural areas, towns and cities; all with different population health challenges and needs. There are long standing social, economic and health inequalities across our places, with levels of deprivation and health outcomes in many communities worse than the national average. Cheshire and Merseyside ICS is recognised as a Marmot Community working to be an exemplar for system-level work on inequalities, including a coordinated, consistent approach to building healthy and inclusive economies, tackling the wider determinants of health and reducing health inequalities.

Population

Cheshire and Merseyside has a population of 2.7 million. This is set to rise to 3 million by 2041.

The map on the right highlights the population density at MSOA (Middle Super Output Area) level, with Liverpool having the highest density at 4,474.51 people/km2 and overcrowded houses, higher than the national average - compared to Cheshire having the lowest population density at 350.68 people.



Children & Young People

The percentage of Children in Mid Mersey (19.4%) and North Mersey (26.7%) that live in poverty is significantly higher than the national average (17.1%). The number of Looked After Children is 47% higher than the England average. The rate of emergency hospital admissions for children under 5 is higher than the national average in all areas. Analysis shows each 10 percent spending cut for early years services was associated with a 0.34% relative increase in child obesity prevalence the following year.

Ethnic Minorities

Ethnic minority groups often experience worse outcomes in the social determinants of health. Ethnic minority populations are more likely to report being in poor health and have poor experiences using health services than the white British population. Additionally, one-fifth of our ethnic minority groups encounter challenges in accessing services due to language barriers. Liverpool witnesses a notable concentration of asylum-seeking and refugee families, who bear a disproportionate burden of poverty.

Life Expectancy

Across our three place areas life expectancy significantly varies. In the most deprived areas, women experience a life expectancy that is 9.5 years lower than those residing in the least deprived areas.

Obesity

Overall prevalence of obesity is increasing. Around **26.9%** of adults are physically inactive, significantly higher than England (**23.4%**). Halton's rate of overweight or obesity at 78% is the highest in the region.

Drug & Alcohol Misuse

Six of our local authorities have alcohol-related mortality rates above the England average and above average deaths related to drug misuse. Over a quarter of the adult population consume alcohol at levels above the UK Chief Medical Officers guidelines, increasing their risk of alcohol-related ill health.
Hospital admissions for alcohol-specific conditions are higher than average for North and Mid Mersey areas.

Causes of premature death

Compared to national SMR average of 100 for deaths from cancer North Mersey and Mid Mersey are higher than the National Average.
In relation to Deaths considered preventable as an average all three places are higher than the National Average, North Mersey 145.7, Mid Mersey 118.4 and Cheshire – 101.6. Individually Cheshire and Warrington are lower than the average.

Mental Health

Emergency admissions for intentional self-harm are significantly worse than the national average, with highest being in Mid Mersey

Long Term Conditions

All of our place areas have a higher percentage of the population with limiting long term condition or disability, significantly higher than the national average.

Population Health Management: Deprivation

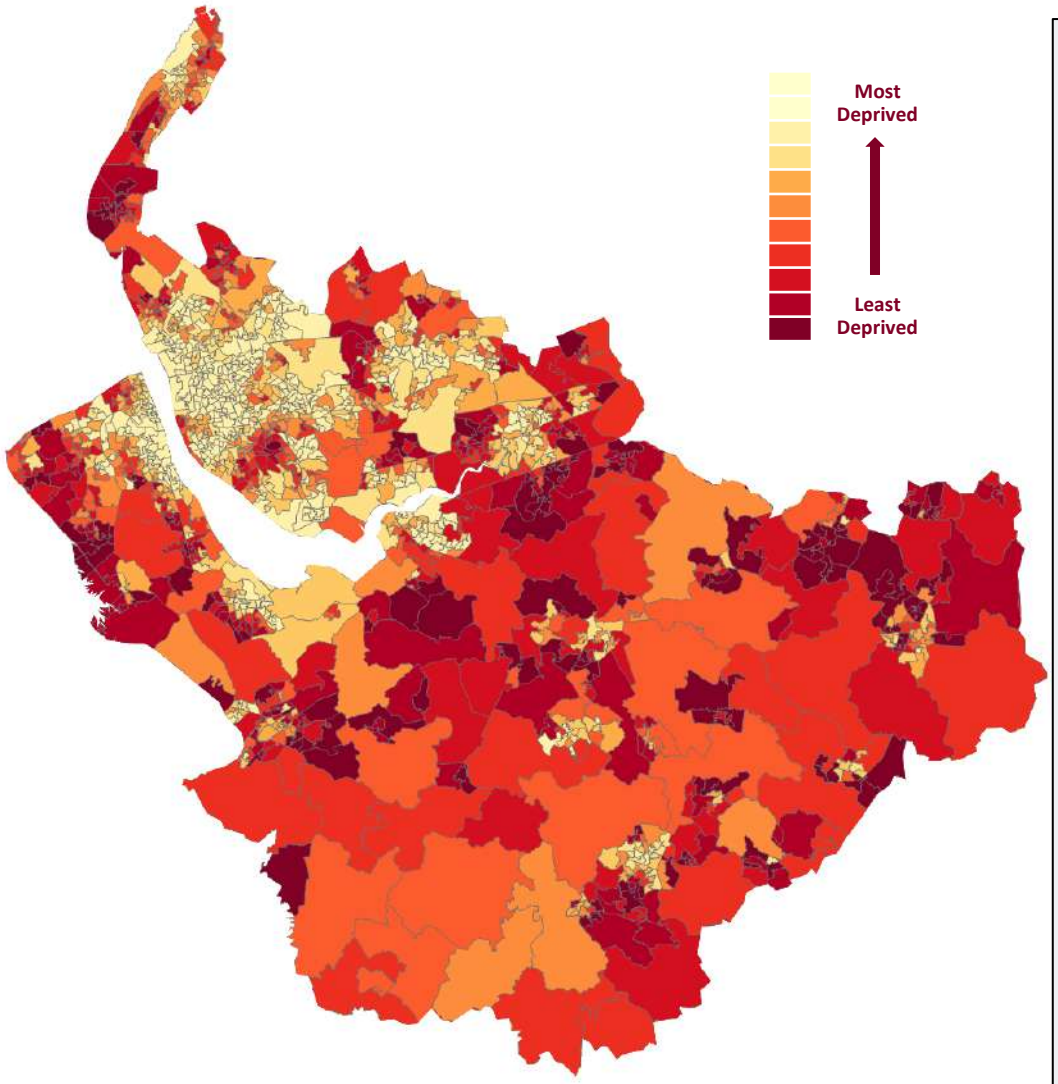


Image: Map of IMD in Cheshire and Merseyside

The Cheshire and Merseyside region is home to more than two and a half million people across nine boroughs. The region has areas of substantial wealth and substantial deprivation. Overall, a third (33%) of Cheshire and Merseyside population live in the most deprived 20% of neighbourhoods in England, with significant negative implications for health. The average Index of Multiple Deprivation score in Cheshire and Merseyside is 28.6 compared to 19.6 in England.

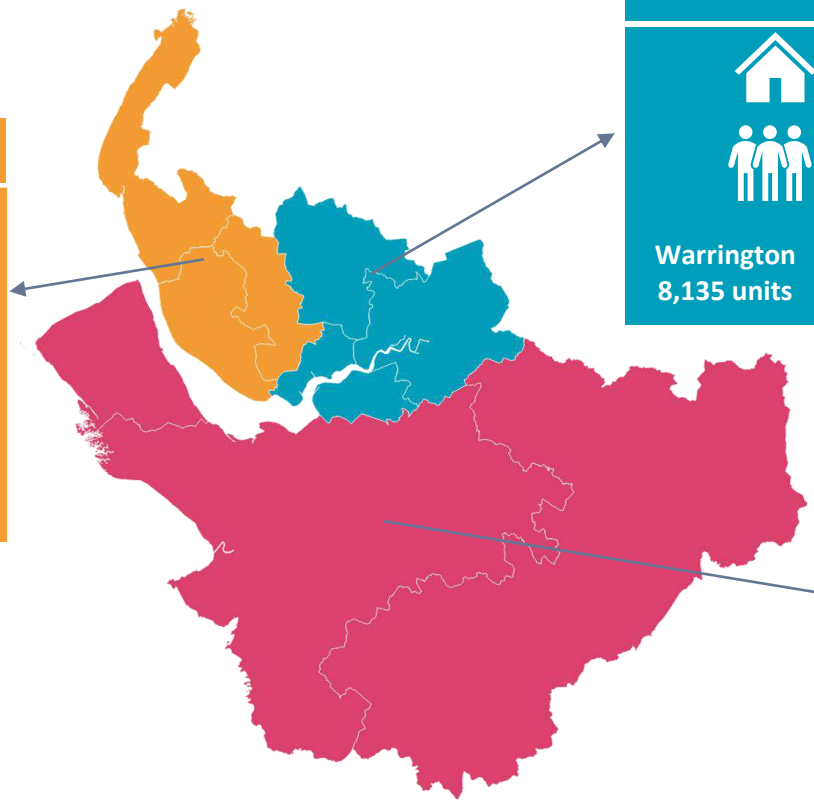
The Index of Multiple Deprivation shows that Knowsley is the second most deprived borough in England, Liverpool the third. Knowsley has the highest proportion of its population living in income deprived households in England (tied with Middlesborough), equating to one in four of all households. Liverpool has the fourth highest proportion, with 24% living in income deprived households.

Area	Index of Multiple Deprivation Score
North Mersey	**37.48**
Knowsley	43.01
Liverpool	42.41
Sefton	27.04
Mid Mersey	**27.59**
Halton	32.32
Warrington	18.94
St Helens	31.52
Cheshire	**20.71**
Cheshire East	14.48
Cheshire West	18.08
Wirral	29.59

Even within the more affluent areas in the region, there is substantial deprivation and associated poor health – while 31% of neighbourhoods in Cheshire West and Chester are in the top two income deciles, 16% of neighbourhoods in Cheshire West and Chester are in the lowest income deciles. Extensive cuts to local authority budgets and increasing inflation has resulted in many of the social determinants of health – housing, education, early years, youth services, legal aid and police, the services offered by the voluntary, community, faith and social enterprise sector – to suffer real cuts for many years. Knowsley, the most deprived local authority in the HCP, had the highest spending cuts in the region at £725 per head of population.

Housing Developments: A growing Population

Many large regeneration schemes are planned across Cheshire and Merseyside, which will lead to significant population growth. The map below highlights the large housing developments (Over 200 dwellings) for each area in the next 10 years.



North Mersey

29,858 units

71,650 people

Sefton	Liverpool	Knowsley
1,670 units	25,400 units	2,788 units

Mid Mersey

11.923 units

25,615 people

Warrington	Halton	St Helens
8,135 units	1,502 units	2,286 units

Cheshire & Wirral

23,360 units

56,064people

Wirral	Cheshire East	Cheshire West
3,760 units	1,800 units	17,800 units

What impact will this have on our infrastructure?

New housing developments and increased population will inevitably lead to higher demand for services; including primary, secondary and community care, as well as the sider public sector. Older assets have generally not been designed and built to accommodate the size of the communities they now serve, and often lack flexibility. Collaboration between housing developers, local councils and the NHS is crucial to ensure that healthcare infrastructure keeps pace with housing growth. S106/CIL agreements provide a mechanism to manage this impact positively. Through careful planning, targeted financial contributions, and collaborative efforts, S106/CIL agreements can help ensure that healthcare services are adequately expanded and improved to meet the needs of growing communities.

*Based on 2.4 people / unit, ONS

Cheshire and Merseyside Key Strategies

In Cheshire & Merseyside we have articulated our vision and strategy across all pillars of infrastructure.

Green Plan

Our Green plan outlines our commitment to deliver sustainable and high-quality services for the people of Cheshire and Merseyside and highlights the ways in which we are working with our partners to positively impact the wider determinants of health to address health inequalities and to embed social value into everything that we do.

Joint Forward Plan (2024-2029)

The 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 8 Marmot principles); improving population health and healthcare; enhancing productivity and value for money and helping to support broader social and economic development.

Cheshire & Merseyside HCP Estate Strategy (2022)

Our estates strategy details how we will transform the way that care is delivered in our area, increasing operational efficiency and capability for both national priorities as well local needs.

Digital & Data Strategy (2022-2025)

Our Digital and Data Strategy sets out the goals to make Cheshire and Merseyside ICS the most digitally advanced and data driven ICS in England by 2025 through strong digital and data foundations, 'at scale' digital and data platforms and system wide digital and data tools and services.

All Together Fairer: Health Equity and the Social Determinants of Health in Cheshire& Merseyside (2022)

As a result of this work and the development of the indicators and recommendations, a five-year Cheshire and Merseyside Marmot strategy has been created to drive at-scale actions. It includes:

- Supporting NHS and local authority leaders and partners, to deliver a coordinated and collaborative social determinants of health approach.
- Working with ICS leaders and systems to deliver leadership commitments and increase investments to transform the role of the NHS in addressing the social determinants of health.
- Assessing place-based plans to decrease health inequalities including analysis of social value practices.
- Continuing to support the Cheshire and Merseyside Marmot Leads Group and Marmot Advisory Board.

Clinical Strategy

In development.

Core 20PLUS 5: Our commitment to reducing health inequalities

Core20PLUS5 is a national approach to drive action to reduce healthcare inequalities. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Core20
The most deprived 20% of the national population. For Cheshire and Merseyside this is more than 900,000 of our 2.7m population.

PLUS
PLUS population groups are groups who may be excluded in society and in Cheshire and Merseyside include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and wider socially excluded groups.

There are **5** clinical areas which we are actively working on and they are:

- **Maternity:** The Core20Plus5 approach will ensure continuity of care is the default model of care for all women most at risk in pregnancy including those from ethnic minority population groups and from the most deprived groups
- **Severe Mental Illness:** The approach will ensure annual health checks for 60% of those living with severe mental illness
- **Chronic Respiratory disease:** Aims to implement four key pathways to improve the speed and asthma and chronic obstructive pulmonary disease (COPD)
- **Early Cancer Diagnosis:** Working collaboratively across Cheshire and Merseyside, the Core20Puls5 approach will focus to build on best practice and implement new initiatives to prevent cancer and reduce inequalities • Support Primary Care with the implementation of the early cancer diagnosis agenda, including initiatives to increase cancer screening • Reduce waiting times for diagnosis and treatment • Work with healthcare professionals to provide improved, personalised, and faster treatments and care • Invest in the skills and education of cancer professionals and support workers • Reduce unwarranted variation in care, access, experience, and outcomes • Reduce health inequalities for vulnerable communities, who have been affected by cancer.
- **Cardiovascular Disease (CVD):** By 2029 it aims to: • Have detected at least 85% of those with Atrial Fibrillation & anticoagulated 90% of those at high risk of stroke • Have diagnosed at least 80% of those with high blood pressure & be treating 80% of them to target • Have provided at least 75% of the people aged 40 to 74 with a validated CVD risk assessment and cholesterol reading and 45% of those at highest risk of CVD will be treated with statins • Have reduced the numbers of strokes and heart attacks

How can effective Infrastructure planning support our ambitions around Core20PLUS5 and reducing health inequalities?

Whilst the target populations are different with different needs, there are common themes and enablers across each.

Diagnostics, interventions, care or services need to be **accessible** to the groups identified, delivering care in the community which requires our infrastructure to be in the right locations

This infrastructure needs to be equipped with the **right technology and workforce** to be able to support the services required, for example, imaging equipment or dental facilities

We need to **better utilise our community assets to focus on preventative services,** such as increasing uptake of COVID, flu and pneumonia vaccines to reduce infective COPD exacerbations and emergency hospital admissions due to those exacerbations.
Not all interventions require a clinical setting services like social prescribing, mental health counselling IAPT, health promotion and prevention can be carried out in existing facilities such as community centres and libraries etc.

SECTION 2: WHERE ARE WE NOW

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

Our NHS Physical Infrastructure Overview

Our ICS
c. 1200 properties across Cheshire and Merseyside

344* General Practices

13 Acute Hospitals

467** Properties delivering Community services

2 Mental Health Providers

133 NHSPS Buildings

31 LIFT Buildings

10 Place Head Quarters

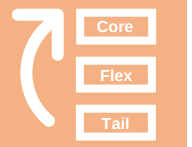
c. 1.7m m^2 GIA
Total size of the Cheshire and Merseyside care Estate

48 NWAS Properties

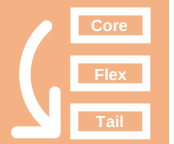
25% Trust provider estate predates the NHS (pre-1948)

£654m Total backlog maintenance costs (£384/m^2)

37% Of our GP Estate is Core



20% Of our GP Estate is Tail



£63m Investment to reduce backlog maintenance –High/ Critical infrastructure

As of 2024, our existing built infrastructure is over 1 million m^2 of health space across Cheshire and Merseyside. Our portfolio is of mixed quality, ranging from 'Core' assets - described as being that which is flexible, fit-for-purpose, and integral for the delivery of the ICS medium-to-long-term clinical strategy, with room sizes that are in accordance with adopted HBN standards; to 'Tail' assets – described as having little or no opportunity to bring the standard of this accommodation up-to a level that can deliver the service models and the direction of travel heralded by the Long-Term Plan, including the PCN and MDT workforce agendas. Room sizes and circulation spaces are not in accordance with adopted standards, and there is no site-flexibility to achieve this. Most converted residential properties, for example, are likely to fall into this category.

Whilst recent investment to reduce backlog maintenance within providers has been significant, action is required to ensure that our estate is fit for purpose and future proofed.

The following section will look at our current estate in further detail.

*Source: NHS Cheshire and Merseyside Joint Forward Plan 2024-2029
**Data Collected from Shape, may be duplicates within properties, April 2024

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

Our Estate Principles: Where we are in 2024

As part of our Cheshire & Merseyside ICS Estates Strategy published in 22/23, eight estate commitments were co-developed, ensuring our estate continues to be a key enabler across the system. The commitments and examples of our progress to date are summarised below.

Principles	Our progress
Our Estate will be **fit for purpose**. It will accommodate the needs of patients and staff alike and provide the best possible care for those who need it the most.	Aspen Wood is a new 40 bed specialist learning disability unit which opened to service users in March 2024. The site provides care for those who need the lowest level of security appropriate for them. The unit sits on Maghull Health Park, Mersey Care, which holds some of the largest concentration of expertise in forensic psychiatry and psychology within Europe. Mersey Care have continually invested in new infrastructure and innovative ways of delivering complex clinical care.
Our Estates will be more environmentally sustainable. We are willing to invest in making our buildings more energy efficient to make this happen. We will reduce our carbon footprint and play an active role in tackling climate change.	Clatterbridge Cancer Centre Liverpool opened in 2020. The centre is highly efficient due to the BMS system and has been built to provide the best possible patient experience. Located centrally for the population, the hospital has also reduced the travel time for many patients. Being positioned near to the Royal Liverpool University Hospital and the University of Liverpool, means there is onsite access to medical specialties, the ability provide specialist treatment and carry out pioneering research.
We will strive to ensure **maximum value for money and economic benefit for society**. We will continuously look for ways to improve social value and make a positive impact on society.	NHS Cheshire and Merseyside has become the first organisation in the UK to receive an award for social value in health. In 2022, NHS Cheshire and Merseyside launched its Anchor Framework to bring NHS, Local Authorities and Voluntary, Community, Faith and Social Enterprise sector (VCFSE) organisations together to explore how social value can be practically and effectively embedded across the region; working together to reduce health inequalities and improve health and wellbeing.
We are committed to **maximising the utilisation** of clinical space – We will be efficient in our design and operation of services.	Our partners have deployed utilisation sensors within several of their buildings to digitally monitor what is booked and used by services, this has provided digitally enabled, real time utilisation data which can be continually monitored and enable changes to made to ensure maximum utilisation.

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

Our Estate Principles: Where we are in 2024

Principles	Examples of our progress
We want to ensure that everyone has access to the care they need when they need it - Providing care in the right buildings with the right staff and resources.	The Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) diagnostics programme has been successful in securing £52m for Community Diagnostic Centres (CDCs), establishing 10 CDCs across the system. Due to these efforts and success of the diagnostics programme, Cheshire and Merseyside has the largest concentration of CDCs in the country, with all 10 sites selected based on viability and population need.
Flexibility is built into Estate - We will adapt our buildings and facilities to meet the changing needs of the service and constantly review and make changes where necessary.	The new Royal Liverpool University Hospital, Liverpool University Hospitals NHS Foundation Trust (LUHFT) opened in October 2022. The new facility is the largest hospital in the country to provide inpatients with 100% single ensuite bedrooms. It has 18 state-of-the-art operating theatres for inpatient and day-case surgery, 640 beds, including 40 critical care beds.
We will optimise the use of technology for our Estate, making sure our buildings are “Digitally Ready”	There has been significant change in the use of digital solutions since 2018, accelerated due to the COVID-19 pandemic. Rapid adoption of tools such as team collaboration software, video consultations and remote monitoring have changed the way health and care staff work now and into the future. Public Wi-Fi is now available in all our general practices.
We are committed to working in partnership with Local Authorities to allow for more efficient use of resources and create opportunities for better health outcomes.	Local Authority partners are part of the core team across all 9 Place Estates Groups. Since April 2023 a total of £6.7m S106/CIL healthcare contributions have been requested to mitigate the impact of new housing on primary care services for significant developments across Cheshire, Halton, Knowsley, St Helens and Wirral.

Our System Wide Achievements: Community Diagnostic Centres

Community Diagnostic Centres (CDCs) provide increased access to planned diagnostics including imaging, physiological measurements, pathology and endoscopy, closer to home and without the need to attend the main acute sites.

Accessibility

In Cheshire and Merseyside, we had 2 early adopter sites at St Helens and Knowsley Teaching Hospitals NHS Trust and Clatterbridge in Wirral.

Following the success of these sites we have now opened a further 8 sites totalling **10 operational CDCs** across our places, noting that they are predominately in the north of the patch due to the rurality of the area.

Benefits

Since our first CDC was established over 400,000 diagnostic tests, the fourth-highest number of diagnostic tests in the country, have been performed and we have reduced our waiting lists. As of March 2024, we have reduced the number of patients waiting over 65 weeks for treatment by over 180,00.

Images: Clatterbridge Diagnostics and Paddington CDCs

Our Local Care Achievements: The Living Well Hub Warrington

The Living Well Hub is a new health and wellbeing facility created in retail space in Warrington town centre, with a focus on promoting ill health prevention, early intervention, self-care and community-led support. The Hub brings together a wide range of physical and mental health providers, Local Authority teams and services from other public sector and Voluntary, Charity, Faith and Social Enterprise (VCFSE) partners. The services on offer blend booked appointments with drop-in availability to create a unique service offer targeting specific cohorts of the local population.

Operating Model

The Hub is unique in that we are trying to create a far-reaching offer to benefit as many people as possible. To do this, a weekly timetable has been developed that brings together connected services from multiple providers on the same day. On different days of the week, we target services at different groups of the local population. For example, every Monday we offer services designed to support the local "staying well" place agenda. There is a focus on healthy living and healthy lifestyles in the morning and a shift towards women's health in the afternoon and evening. On Thursday, working in partnership with the Local Authority, we run a targeted offer for children in care and care leavers. They provide bespoke and targeted support and intervention around life skills, education and training and relationship management.

Benefits

In the first 7 weeks of opening the Hub saw over 1,100 attendees. One of the key design principles of the Hub is to ensure voluntary sector partners have an equal platform alongside larger statutory partners to use the space to provide support services to the public. The value added through linking Hub visitors into early support and local community services is significant in terms of the longer-term impact on health outcomes and inequalities.

Images: The Living Well Hub

Collaboration

The 'Collaboration and Contribution agreement' (CCA) that underpins the longer-term partnership for the Hub is also reflective of a pioneering and innovative approach. Beyond the initial grant for the first 18 months, the CCA secures ongoing investment to ensure the project runs for a minimum period of 5 years. Under the terms of the CCA, the four core partners (Warrington and Halton Teaching Hospitals NHS FT, Mersey Care NHS FT, Bridgewater Community Healthcare NHS FT and Warrington Borough Council) as the larger statutory organisations have agreed to split the running costs equally ensuring spaces and rooms are allocated to partners based upon their ability to add value to the local population as part of a collaborative model.

Future Scope

We will be expanding our Hub model over the next 24 months, with the Runcorn Health and Education Hub expected to go-live in Summer 2025. This is designed to work on a similar principle to the Warrington Living Well Hub, although services are tailored slightly differently to reflect Runcorn's population health needs. This will include an offer to young people, families, and those living with a long-term condition, and will include Riverside College, a local education provider, as a core partner, which will enhance the local health and care training offer and contribute to addressing local challenges around recruitment across the health and care sector.

Our System Wide Achievements: Modular Theatres

Cheshire and Merseyside Surgical Centre at Clatterbridge Hospital, Wirral. The site opened in 2022 and has treated over 3,000 patients a year. The centre, which has two brand new theatres, has started treating patients from across the region. It has been developed to solely treat patients waiting elective or planned surgery. In 2023 we opened phase 2 of the project to build two additional modular theatres.

Design

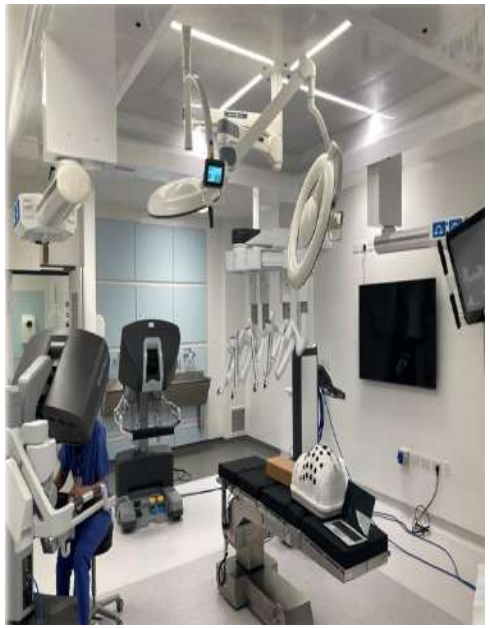
This £25 million innovative development, created through national NHS funding, saw the theatres created as modular buildings, meaning they were largely pre-built before arriving on site, and constructed alongside the current theatres at Clatterbridge Hospital. This reduced time for completion allowing for the theatres to be operational at pace.

Capacity

The additional theatres will create capacity to treat 6,000 extra patients a year across the region for elective surgery helping to reduce the backlog of patients with less urgent needs.

Accreditation

The centre has been accredited as a national elective surgical hub.



Images: Theatre Suite at Clatterbridge Hospital

System wide estate challenges

DRAFT FOR REVIEW

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

To recover services there is a need for more activity to be delivered in primary and community settings. Currently the majority of capital infrastructure investment is focused on the acute sector. Similarly to the national picture, as a system we face many challenges within our physical estate including;

Ageing Estate & Complex Tenure Arrangements

- We have services operating from ageing estate, coupled with complex tenure arrangements limiting flexibility and integration efforts.
- There are significant backlog maintenance issues, including properties with Reinforced Autoclaved Aerated Concrete (RAAC) roofing which pose substantial risks across the system.

Digitally Enabled

- As we move towards a 'digital first' clinical model, our estate must be equipped to support our teams to be able to work in this way. Different providers must be able to work from different assets and have access to clinical systems – in many areas this presents a challenge. Our estate must be able to support this shift as we look to optimise and consolidate our estate.

Funding & Investment

- General Practice faces significant challenges from an infrastructure perspective, primarily due to limited capital funding and the restriction to reimburse for PCN and Additional Roles Reimbursement Scheme (ARRS) positions.
- Compounding these issues are the demands for asset replacement and adherence to net carbon zero requirements, both of which require significant investment. Despite these national targets, there is currently no ring-fenced funding to ensure the sustainability of general practice. This presented significant risk in maintaining and modernising healthcare infrastructure.
- As a system we are under pressure to identify and deliver efficiency savings and cost reduction. From an estate's perspective, there is a significant risk due to the amount of backlog maintenance across the system and estate deemed not fit for purpose (tail estate) which makes identification of efficiencies more challenging.

Governance & Leadership

- We do not currently have a system-wide Cheshire and Merseyside Strategic Estates Board, leading to limited direction for individual places and a lack of governance regarding the usage of buildings and long-term strategic planning.
- A system-wide view of planning and Capital Departmental Expenditure Limits (CDEL) responsibilities is required, as well as a coordinated and sustainable approach to healthcare estate management.

Demand Vs Capacity

- 23% of the Gross Internal Area (GIA) is dedicated to General Practice. If the system is to drive a 'left shift' out of secondary care into General Practice and community this capacity needs to be addressed.

Some departments within our provider estate are unable to accommodate increased demand or new service models. Redevelopment, as outlined in the Liverpool Clinical Services Strategy, is therefore required.

- Whilst some estate is at capacity, we recognise that we have substantial void, vacant and under-utilised space in some of our community buildings, leading to financial inefficiencies as millions are spent on empty areas that could be repurposed to increase capacity or relocate services.

Workforce

- A high proportion of our estate and facilities workforce is nearing retirement age. Proactive workforce planning and development initiatives to maintain operational continuity and expertise are required across the system.
- PCNs, which are not legal entities, face uncertainties concerning contractual arrangements post-Directed Enhanced Services (DES). The lack of clarity around these arrangements poses risks for estate management, as the future responsibilities and resource allocations remain uncertain. This uncertainty complicates strategic planning making it difficult to effectively manage and optimise our estate.

Backlog Maintenance in our estate

Backlog maintenance is the cost to bring estate assets that are below acceptable standards in terms of their physical condition or compliance with mandatory fire safety requirements and statutory safety legislation up to an acceptable condition. In essence, backlog maintenance relates to assets that need some investment at the date of assessment. Inadequate maintenance of infrastructure poses a significant risk to patient safety and increases the chances of a clinical incident.

Trust Estate Backlog Maintenance

Our total backlog maintenance cost for our Trust estate is **£637,684,797** with high-risk provider backlog maintenance cost forming 9% of our provider backlog.

Of our 16 providers, Mid Cheshire Hospitals NHS Foundation Trust has the highest total backlog maintenance cost. This is driven by the fact that Leighton Hospital is made up of 60% RAAC which will be mitigated in the development of the new hospital as part of the New Hospitals Programme.

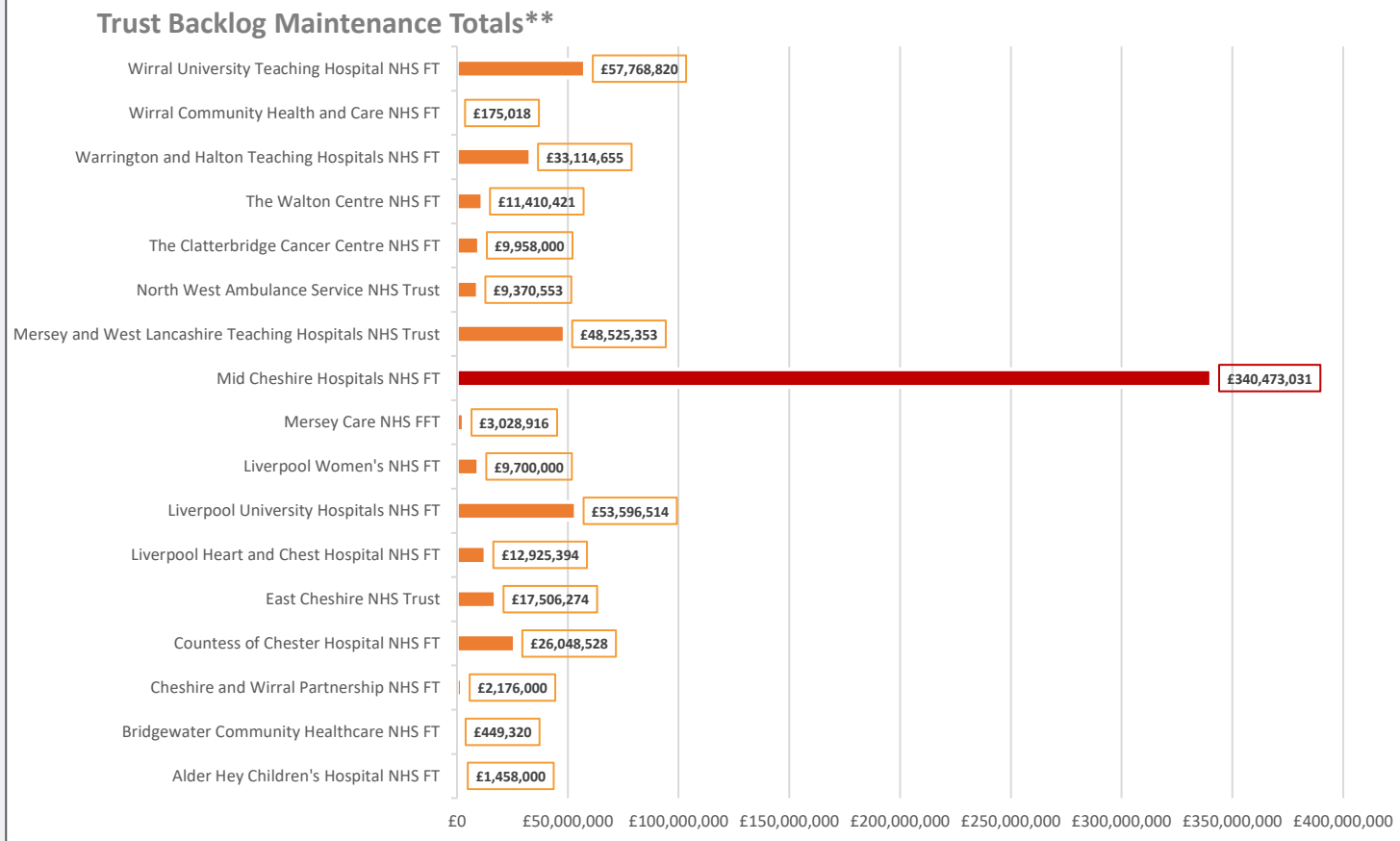
General Practice Backlog Maintenance*

Within **General Practice** the split of backlog maintenance across our regions is;

North Mersey: £6,362,053

Mid Mersey: £5,526,435

Cheshire and Wirral : £4,603,375



£63,152,370 **High risk provider backlog** + £132,351,672 **Significant risk provider backlog** + £382,730,092 **Moderate risk provider backlog** + £59,450,663 **Low risk provider backlog** + £16,491,863* **Across General Practice** = £654,176,660 **Total backlog costs**

*SHAPE ATLAS Primary Care Data Gathering Exercise undertaken in 2021 & excludes NHSPS Property Company buildings

** 2022/2023 ERIC Return; through engagement some individual trusts have provided updated data.

General Practice: National ambitions for estate

Estate is a key enabler for General Practice transformation and the way we can deliver services locally to support our specific and complex population needs. There have been a number of nationally produced reports on General Practice recently with particular focus on the infrastructure requirements of the future such as;

NHS Five Year Forward View

The Five Year Forward View stated that our general practice estate should;

- Serve more than 10,000 patients per practice
- Be built within the last 40 years
- Larger than 1,000 m2
- Have more than 5 clinical rooms per practice
- Capable of operating for 7 day working

The Fuller Stocktake Report

The Fuller Stocktake sets out a new vision for integrating primary care, improving access, experience and outcomes for communities centred around three essential elements:

- Streamlining access to care and advice
- Providing more proactive, personalised care from a multidisciplinary team of professionals
- Helping people stay well for longer

Delivery Plan for recovering access to Primary Care

The Primary Care Recovery Plan has two main ambitions;

- To tackle the 8am rush and reduce the number of people struggling to contact their practice
- For patients to know on the day they contact their practice how their request will be managed

Image: Marine Lake Health and Wellbeing Centre

To realise these ambitions, we require modern and efficient buildings, equipped with the latest technology to support the development and expansion of services.

In Cheshire and Merseyside, we have 344 GP practices (hub and branch sites included as one practice), 48 PCNs delivering services in over 340 properties and provide over 1 million appointments on average each month. We have significantly increased our access and capacity within general practice through the DES and ARRS however, as noted in our Primary Care Strategic Framework, with demand at an all-time high and falling workforce numbers with high levels of reported stress and burnout, we still have much more to do to resolve these challenges. We will only achieve the ambitions within the Framework through collaborative, whole-system working including primary and secondary care, commissioners, Local Authority and other key partners.

Our Cheshire and Merseyside Estates Strategy (Published in 2022) provides a clear direction of travel for our general practice estate to ensure we maximise the use of available sites, our estate is fit for the future, and it supports general practice to provide effective services that patients can easily access.

Our General Practice Estate

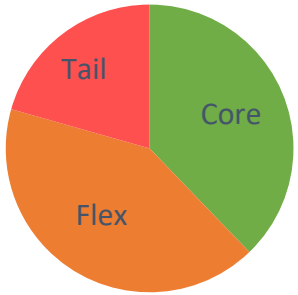
DRAFT FOR REVIEW

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

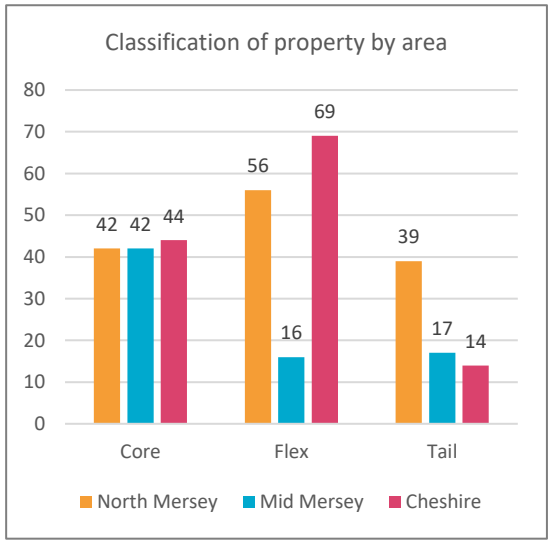
In 2023 we developed our PCN Clinical and Estate Strategies through the National PCN Service and Estate Toolkit delivery programme*. This programme has provided us with a robust primary care baseline and investment plan across our PCNs that align to our wider ICS strategies. As part of the programme, the toolkit categorises three types of building

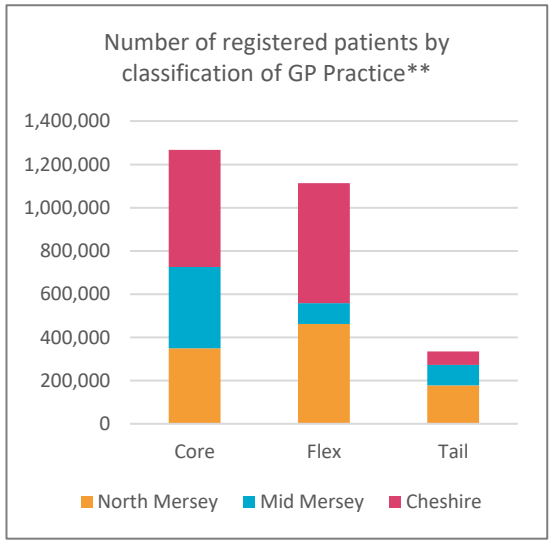
Core (fit for purpose for at least the next 10 years):
Flex (fit for purpose for the next 5 years but may not be long term):
Tail (likely to be disposed of within the next five years)

The split for across the properties reviewed within the programme is show in the chart to the right;



The graphs below give an analysis of the distribution of properties within each estate classification as described above and the number of registered patients accessing each type of property.
This data highlights the disparity of our estate condition across our places.





Across our places we have a mix of estate tenure; from GP owned, leasehold through NHS Property Companies and Third-Party leases; each with their own complexities when managing our physical infrastructure as a system.

A significant proportion of our GP owned buildings are converted ex-residential buildings and therefore the quality and overall functionality are mixed. Over half of our GP owned estate is deemed to be either not sufficiently functional or fit for the future delivery models of general practice when reviewed as part of the National Toolkit Programme.

Within the Programme, clinical and estates capacity planning was completed for each PCN and 60% utilisation of clinical rooms during operational hours for patient consultation was considered to be satisfactory. When looking at all PCNs combined across place, demand in Cheshire outweighs capacity with both Mid and North Mersey nearing capacity. **All places are forecast to not have enough estate capacity by 2032**. The lack of capacity within general practice in many areas creates challenges across our system to accommodate the new ARRS roles across PCNs causing challenges both operationally and with recruitment and retention.

12% of our registered patient population is served from tail estate property. For North Mersey alone this increases to 18%, however for Cheshire reduces to just 5%, showing variation amongst our places.

41% of the registered patient population is served from flex estate property. In Cheshire this increases to 48%, whilst in Mid Mersey this reduces to 17% - with 66% of patients in Mid Mersey served from core estate.

**Figures based on National Toolkit Programme & exclude South and East Knowsley PCN who did not partake in the toolkit programme*
***NHS Digital, Registered Patients at a GP Practice (March 2024)*

DRAFT FOR REVIEW

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

Acute Hospital Estate

Acute estate plays a vital role in providing patients a wide range of specialist acute in-patient and out-patient specialist services which cannot be provided in community hospitals. Our acute estate spans the Cheshire and Merseyside geography, comprising of the 14 key acute sites illustrated below.

1) Southport and Formby District General Hospital
Tenure: Freehold
GIA: 37,669sqm
Total Backlog Maintenance Cost: £31,877,397

2) Broadgreen Hospital
Tenure: Freehold
GIA: 45,737sqm
Total Backlog Maintenance Cost: £9,139,840

3) Aintree University Hospital
Tenure: Freehold
GIA: 149,615sqm
Total Backlog Maintenance Cost: £29,445,569

4) Royal Liverpool Hospital
Tenure: Freehold
GIA: 147,375sqm
Total Backlog Maintenance Cost: £242,000

5) Whiston Hospital
Tenure: PFI
GIA: 109,368sqm
Total Backlog Maintenance Cost: £0

***Ormskirk District General Hospital**
Tenure: Freehold
GIA: 35,295sqm
Total Backlog Maintenance Cost: £16,510,456

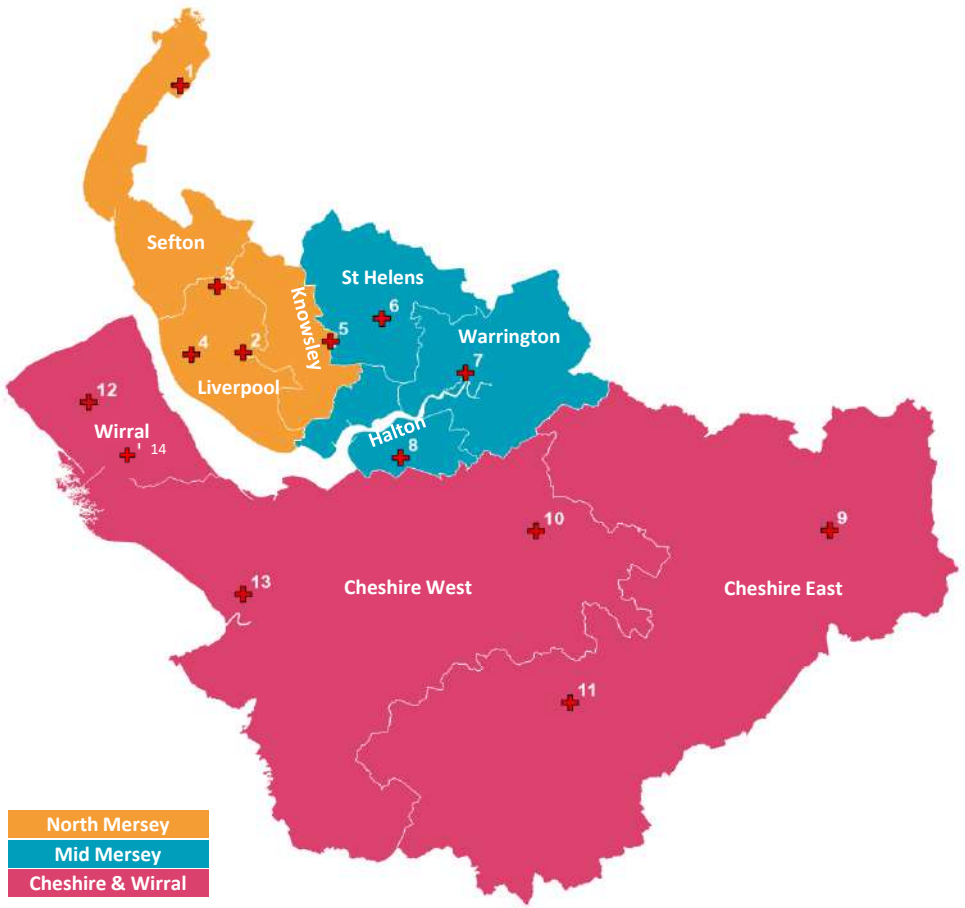


Image: Map of general acute estate in Cheshire and Merseyside ICS

*Ormskirk District General Hospital not included on map as out of the area but is commissioned by Cheshire and Merseyside ICS.

6) St Helens Hospital
Tenure: PFI
GIA: 2,000sqm
Total Backlog Maintenance Cost: £0

7) Warrington Hospital
Tenure: Freehold
GIA: 65,579sqm
Total Backlog Maintenance Cost: £22,669,350

8) Nightingale Building (formerly Halton General Hospital)
Tenure: Freehold
GIA: 29,115sqm
Total Backlog Maintenance Cost: £10,445,305

9) Macclesfield District General Hospital
Tenure: Freehold
GIA: 35,615sqm
Total Backlog Maintenance Cost: £13,138,772

10) Victoria Infirmary
Tenure: Freehold
GIA: 5,387sqm
Total Backlog Maintenance Cost: £3,300,217

11) Leighton Hospital
Tenure: Freehold
GIA: 81,082sqm
Total Backlog Maintenance Cost: £337,172,814

12) Arrowe Park Hospital
Tenure: Freehold
GIA: 74,111sqm
Total Backlog Maintenance Cost: £43,518,570

13) Countess of Chester Hospital
Tenure: Freehold
GIA: 65,210sqm
Total Backlog Maintenance Cost: £26,048,528

14) Clatterbridge General Hospital
Tenure: Freehold
GIA: 36466.78sqm
Total Backlog Maintenance Cost: £8,547,529

Specialist Trust Estate

DRAFT FOR REVIEW

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

Alongside our general acute estate, our specialist estate plays an important role in serving our patients ranging from our children's specialist hospital to our heart and chest specialist hospital. Our specialist estate is concentrated predominantly in North Mersey, comprising of the 7 key specialist sites illustrated below.

1) Liverpool Heart and Chest Hospital
Tenure: Freehold
GIA: 31,062sqm
Total Backlog Maintenance Cost: £12,925,934

2) Alder Hey Children's Hospital
Tenure: Part Site - PFI
GIA: 104,000sqm
Total Backlog Maintenance Cost: £729,000

3) Liverpool Women's Hospital
Tenure: Freehold
GIA: 32,135sqm
Total Backlog Maintenance Cost: £9,700,000

4) Clatterbridge Cancer Centre (Liverpool)
Tenure: Freehold
GIA: 27,875sqm
Total Backlog Maintenance Cost: £0

5) Clatterbridge Cancer Centre (Aintree)
Tenure: **Tenure**: Freehold
GIA: 2,460sqm
Total Backlog Maintenance Cost: £ 258,000

6) The Walton Centre
Tenure: **Tenure**: Freehold
GIA: 28,595sqm
Total Backlog Maintenance Cost: £ 11,410,421

7) Clatterbridge Cancer Centre (Wirral)
Tenure: Freehold
GIA: 11,278sqm
Total Backlog Maintenance Cost: £9,700,000

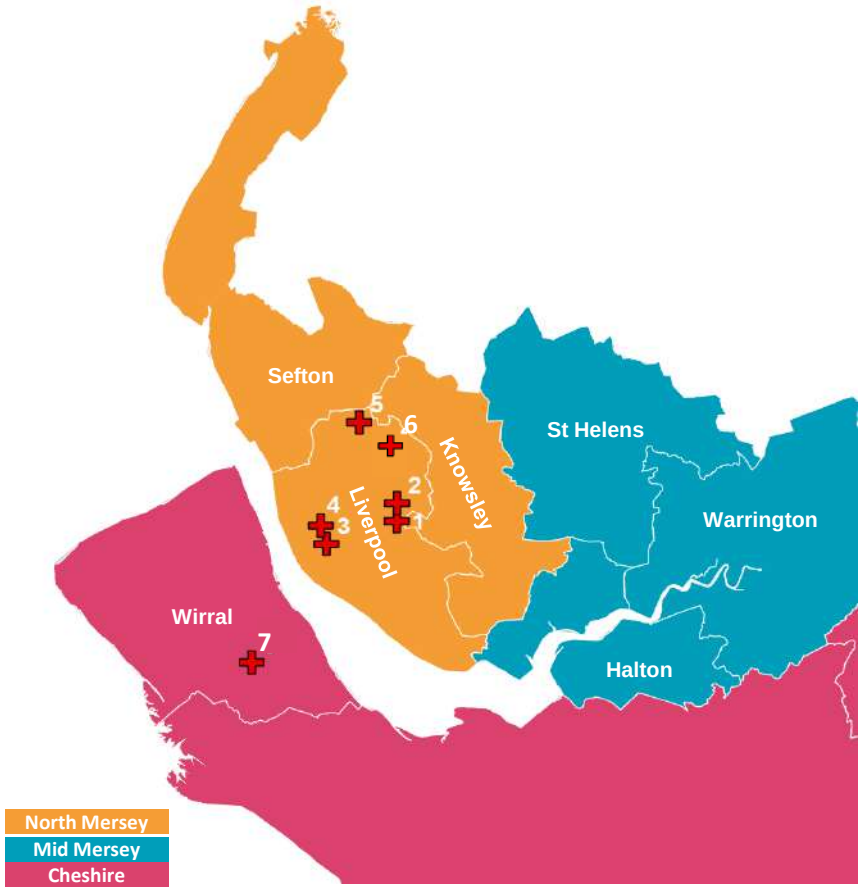


Image: Map of specialist acute estate in Cheshire and Merseyside ICS

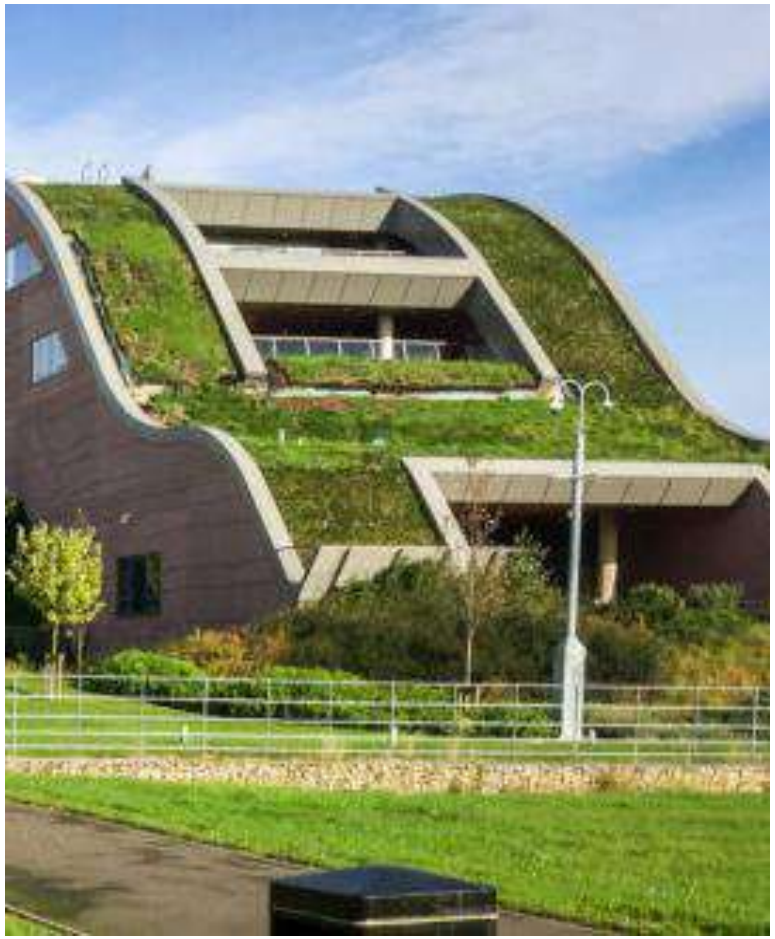


Image: Alder Hey Children's Hospital

Eradication of Reinforced Autoclaved Aerated Concrete (RAAC)

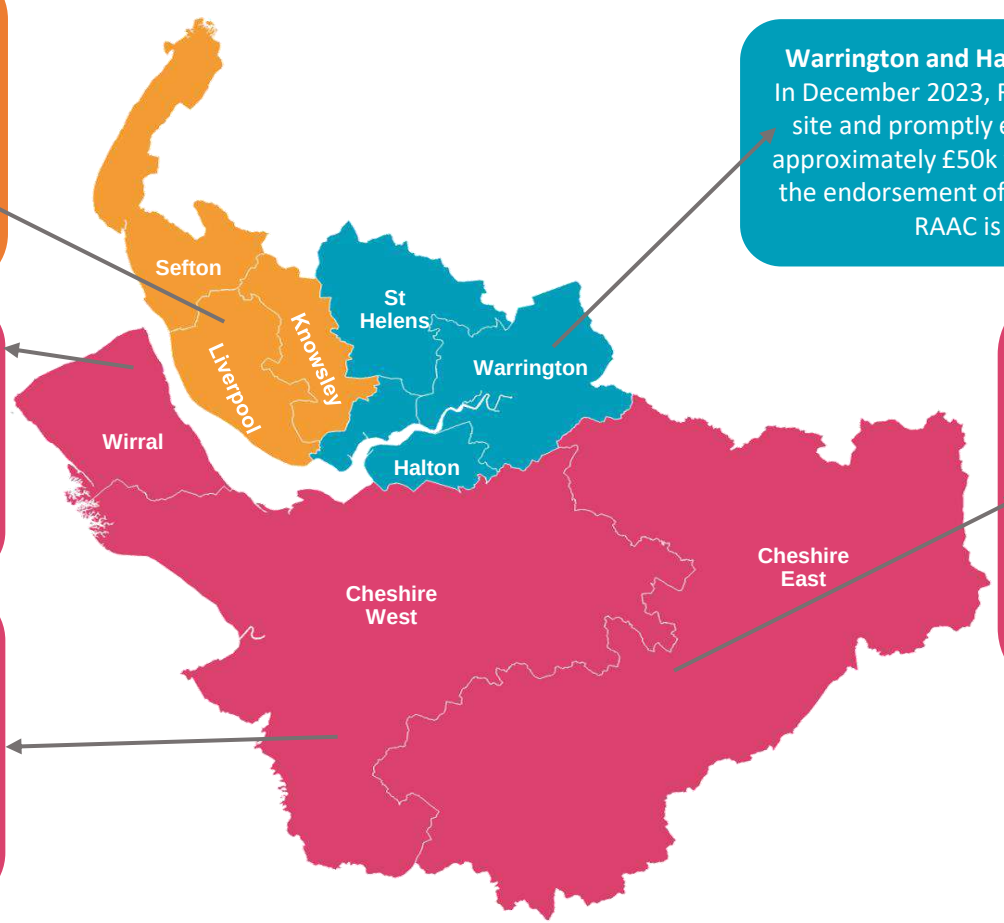
In response to growing concerns regarding the risks associated with Reinforced autoclaved aerated concrete (RAAC), guidance and clear directives have been issued towards its eradication. RAAC is a reinforced lightweight concrete used in construction between the 1950s and mid-1990s and is predominantly found as precast panels in roofs (commonly flat roofs, sometimes pitched) and occasionally in floors and walls. There are currently 5 trusts within Cheshire and Merseyside with RAAC which are illustrated below:

Liverpool University Hospital NHS Foundation Trust: Aintree Hospital Site
This site has a significant amount of RAAC, prompting the Trust to develop a comprehensive programme of works and costing for its removal. RAAC removal efforts have successfully targeted the critical care area and plant rooms on the roof of the main block, with ongoing work to eliminate RAAC in other affected areas. The programme extends well into 2028/2029 and is subject to obtaining funding.

Wirral University Teaching Hospital NHS Foundation Trust: Clatterbridge Site
RAAC has been identified in a single-storey office building known as Birch House at the Clatterbridge Hospital site.

Surveys have been completed, risks have been mitigated and a bid for investment to replace the roof is underway.

The Countess of Chester Hospital NHS Foundation Trust, Cheshire: Women and Children's Unit
This site is operational while failsafe works, and surveys are being carried out worth £250,000. Recent site surveys revealed additional RAAC in a substation, prompting the Trust to accelerate the failsafe program and request £530,000 in additional funding. This will address the newly identified RAAC and support further decanting and failsafe measures in the Women and Children's Unit.



Warrington and Halton Hospitals NHS Trust: Warrington Hospital Site
In December 2023, RAAC was detected on the roof of a post room at this site and promptly escalated to the National team. A capital request of approximately £50k was submitted and subsequently approved following the endorsement of the business case. The scheduled elimination of the RAAC is scheduled for completion by April 2024.

Mid Cheshire Hospitals NHS Foundation Trust: Leighton Hospital
Most of this hospital is constructed with RAAC and has now been included on the New Hospital Programme for a total rebuild. In the interim, the Trust are carrying out substantial failsafe works to keep patients and staff safe, and they have a robust programme of works to do this. Funding has been allocated on an annual basis to enable surveys, failsafe, procure decant accommodation to facilitate these works.

Source: DfE Reinforced Autoclaved Aerated Concrete (RAAC):Identification guidance (2023)

Community Estate

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

Across our system we have five Community service providers delivering a comprehensive range of health and care services for the whole population across multiple settings;

- Cheshire and Wirral Partnership NHS Foundation Trust
- Wirral Community Health and Care NHS Foundation Trust
- Bridgewater NHS Foundation Trust
- Central Cheshire Integrated Care Partnership (CCICP)
- Mersey Care NHS Foundation Trust

Community health estate is pivotal to providing integrated services in the heart of our local communities, however due to the history of provider organisations, the commissioning of community services and the number of buildings our community providers deliver services from, we currently have a lack of baseline data for each service at ICS level. We do know that the age profile of the estate significantly ranges with the oldest buildings - over 100 years old - to the most recent developments in 2023. It is important to gain an accurate understanding of the community buildings within Cheshire and Merseyside, and how much of this is suitable to meet the needs of the current and growing population

Utilisation

Community health estate is variably utilised across Cheshire and Merseyside, and we know the assets can be utilised more efficiently.

There is also an opportunity to shift activity from the acute hospital setting into the community and closer to patients, releasing capacity on the acute sites and reducing costs spent on void and underutilised space within the community, as we have done as part of our Community Diagnostic Centre programme.

We must continue working with our partners and providers to look at “One Public Estate” related opportunities that may exist, increasing collaboration and integration as well as opportunities to optimise and consolidate our wider public sector estate. This work is underway as part of the Core, Flex and Tail categorisation at Place level.

The following pages highlight recent investment into our community health estate.

Wirral Community Health and Care NHS Foundation Trust

St Catherines Health Centre

Cheshire and Wirral Partnership NHS Foundation Trust

Ancora House

Bridgewater NHS Foundation Trust

Woolston Clinic

Central Cheshire Integrated Care Partnership (CCICP)

Ashfields Primary Care Centre

Mersey Care NHS Foundation Trust

Rowan View

Community Estate Completed Projects

Our providers have taken forward capital improvement works utilising both their allocated and central budgets accessed by NHS England. The following boxes set out examples of improvements to estate since 2020, improving the quality of services for our patients.

LUHFT Royal Redevelopment
The redevelopment of the new Royal Liverpool University Hospital and the decision to maintain the hospital within its current location has supported the development of Liverpool's Knowledge Quarter and its successful Paddington Village development. The demolition of the current Royal will enable the Trust to further enhance the life sciences offer for the Liverpool City Region.

Electronic patient records (EPR) systems enable organisations to change the way they operate and are the foundation for the use of more advanced technology systems for patient care. There has been investment in Liverpool **(£19m),** Mid and East Cheshire **(£15m)** and Warrington **(£7m).**

Liverpool Heart and Chest Catheter Lab
A £10 million project to build and refurbish the catheter laboratories at Liverpool Heart & Chest Hospital (LHCH).The work was delivered in three stages in a live environment over a three-year programme. The project was heavily serviced, with all works undertaken while keeping existing systems operational.

Marine Lake Health Centre
The multi-million pound 2,037sqm bespoke, state of the art centre brings together community and primary care in one place, as well as access to specialist health and care services. It is a partnership project between Wirral Community Health and Care NHS Foundation Trust (WCHC), Marine Lake and Estuary Medical Practice and Age UK Wirral.

Broadgreen Therapies Garden
At Broadgreen hospital, funding was secured for a Therapies garden which is used by the Complex Rehabilitation ward and Macmillan Cancer Support. Patients use the garden as an outdoor therapy area, undertaking planting and light gardening activities. Further funding has been secured to develop food growing areas and an outdoor gym at Broadgreen.

Alder Hey Children's Hospital: Sunflower House and Catkin Centre
The Catkin Centre is situated on the Children's Health Campus and is next to Sunflower House. It is a community, mental health and outpatients building and is home to several outpatient clinics. The Sunflower House is a new tier four mental health inpatient unit. It is for children and young people aged 5 to 13 years old. The new building has 12 specially designed bedrooms and a family bedroom. Also provided on the site is a therapy garden, a calming sensory room that can be used to prepare young people for outside life, an immersive room, a destimulation room, a safe kitchen environment to learn cooking and other life skills, group therapy rooms and classrooms.

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Community Estate Projects in Progress

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

There has been significant capital investment happening in 2023/2024 and planned for 2024/2025

£35m, of which £18m has been secured through the national HIP programme, has been secured for the new Arrowe Park Hospital A&E which will encompass urgent and emergency care working with both Wirral University Teaching Hospital and Wirral Community Health Care Trust.

£40m for the modernisation of **Mossley Hill** Hospital Mental Health 80 bedded facility which will include an urgent care hub, critical decisions units, triage cars, The Life Rooms, crisis resolution home treatment, community mental health team and many more services.

Further elective recovery investment at **both Mid Cheshire (£9.5m) and Alder Hey (£4.5m)** (Raised by Alder Hey Children's Charity) for a new surgical NICU and a new Same Day Emergency Care Centre.

£110m for a new three-storey **Women and Children's facility at the Countess of Chester** which will replace the existing site and **£7.5m** for the refurbishment of a single-storey building working with CWP for a perinatal unit, which is the first of its kind across Cheshire, Merseyside, and North Wales.

Halton Health Hub Work has commenced on the construction of a new, £7.5m purpose-built diagnostics centre next to the existing Captain Sir Tom Moore Building. It is scheduled to open in February 2025 offering new MRI and CT services, this is running in parallel with the CDC within Runcorn Shopping Village.

Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

NHS Property Companies

The two NHS property companies; NHS Property Services (NHSPS) and Community Health Partnerships (CHP} manage and/or own 164 properties of our community and out of hospital infrastructure. Our NHS Property estate is split across our areas as follows:

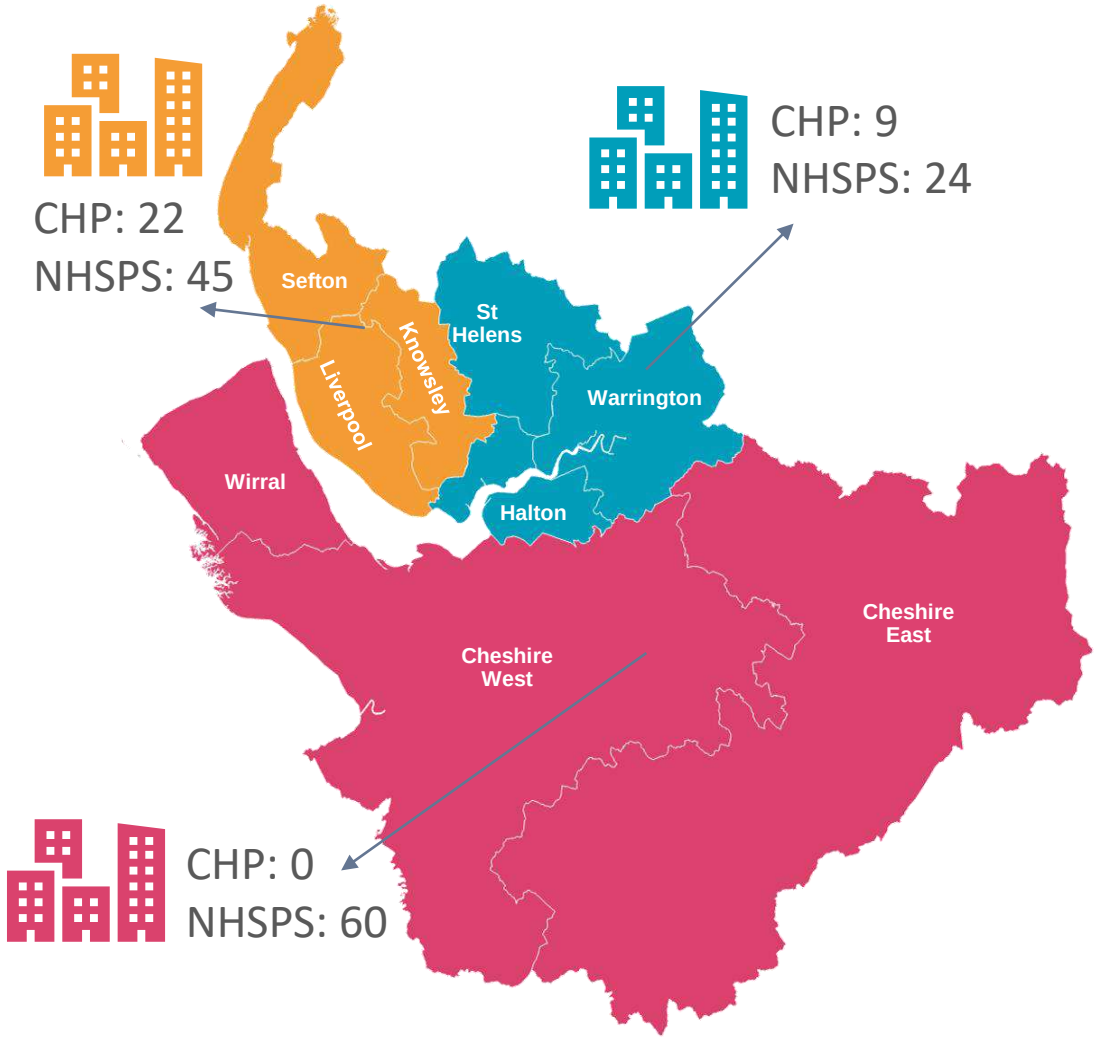

Image: Number of NHS Property company estate across Cheshire and Merseyside

164 PROPERTIES

114 LOCATIONS

176,606 sqm GIA

£54.645m OCCUPANCY COSTS /ANNUM

There are two LIFT companies across Cheshire & Merseyside; Liverpool and Sefton Health Partnership Ltd (LSHP) and Renova Developments Ltd. Community Health Partnerships are the public sector shareholder with 40% share. CHP provide building management and Soft FM to the assets owned by LIFTCo who act as the landlord for the buildings and are responsible for long-term repairs and maintenance ensuring high quality spaces for health and social care services delivered in local communities, especially in areas of high need.

The LIFTCo also oversees building improvement works (or 'variations') to allow new space and facilities to be added as needed. Work on these core assets focusses on improving utilisation and maximising the use of quality assets and improved service integration. Across both LIFT companies the estate comprises of over 80,000 sqm GIA across 31 properties.

Work on these assets focusses on optimisation to maximise the use of our core infrastructure and improve service integration.

NHSPS estate in Cheshire and Merseyside comprises of over 96,606 sqm GIA across 133 properties including clinical, non-clinical, nursing homes and support space across hospital and community sites. These properties transferred to NHSPS on its formation with a significant level of backlog maintenance created from decades of under investment and we still feel the impact of this across our system today. In collaboration with our partners, we will undertake an asset classification of the estate (Core, Flex and Tail) to identify our strategic priorities for the future.

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Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

Investing with our NHS Property Companies

Below is an overview of some of the recent investment within our NHS property company estate.

Sustainability

- ✓ New Boilers fitted within **CHP estate**, providing a minimum of 30% reduction in energy consumption.
- ✓ Rolling Programme for all LED lighting across all **CHP estate.** commenced and to be replaced by March 2025, providing a 30-50% reduction in energy consumption.

New Developments

- ✓ **NHSPS** supported Connect North West (CNW) Team with an end-to-end service to move to a single site base to combine the current arrangements at Manchester University NHS Foundation Trust (MFT) and Liverpool Women's Hospital (LWH). MFT holds the CNW Neonatal Transport Service contract on behalf of specialised commissioning (NHSE) and the North West Neonatal Operational Delivery Network (NWNODN). The services new facility at Unit 19, Gemini 8, Warrington provides space for training, a call centre, administration teams, storage, cot servicing facility and ambulance base along with new state of the art equipment, all leading to improving both the patient and staff experience.

Minor Alteration Works

- ✓ 70k minor alterations works at **Sheil Park (NHSPS)** to create two Health Visitor rooms.
- ✓ Alternations for a new breast screening service at **Bath Street Health and Wellbeing Centre (CHP)** significantly improving the utilisation.

National Programmes

- ✓ **CHP** delivered the National Primary Care Data Gathering Programme on behalf of NHS England. The programme established a consistent baseline of data for every NHS reimbursed GP practice across England with outputs covering many areas from patient list size, GP workforce, backlog maintenance data, age of the premises and EPC/DEC ratings.
- ✓ **CHP** worked with the National Association of Primary Care (NAPC) on behalf of NHS England, to produce a Primary Care Network (PCN) Estates Toolkit to provide PCNs with a flexible framework and support process for producing robust primary care investment plans with clear priorities that align to wider ICS strategies.

Optimisation & Utilisation

- ✓ **CHP** commissioned Utilisation and Optimisation Studies at Ainsdale Centre for Health and Wellbeing and Southport Centre for Health and Wellbeing, leading to Ainsdale Centre for Health and Wellbeing being 80% demised space.
- ✓ Estate optimisation feasibility studies across 5 **NHSPS properties** for major refurbishments and extensions.

Image: NHS Property Company Estate

PFI Handback and LIFTCo Expiry

Across Cheshire and Merseyside there are **39** buildings, currently providing millions of appointments and inpatient stays, whose Project Agreements/Leases expire during the period 2030 to 2047. **7** buildings are PFI facilities, and **31** buildings are 'LIFT' facilities, developed via the NHS Local Improvement Finance Trust programme established in the early 2000's and managed by Community Health Partnerships (CHP). **1** building is a LIFT facility not managed by CHP.

Project Agreement/Lease expiry dates vary for each facility, however a typical LIFT Lease Plus Agreement (LPA) is for a 25-year term. The timeline on the next page shows the 36 of 39 properties whose Project Agreements/ Leases expire in the next 10 years.

The Infrastructure and Projects Authority (IPA) provides guidance to contracting authorities on managing PFI expiry and service transitions. The guidance describes the preparation and process required that is vital for ensuring value for money and continuity of public services. The IPA recommends preparation starts 7 years prior to the expiry date, which means for the buildings whose Project Agreements/Leases expire before 2031 , planning needs to start now. **As can be seen on the next page, 4 LSHP LIFTCo and 3 Renova LIFTCo buildings expire prior to 2031.**

CHP has established a "Securing the Future" programme to work collaboratively with systems and identifies an asset transition roadmap which includes the need for business cases to demonstrate value for money and make the case for either capital or revenue funding.

If the system does not dedicate resource, expertise and leadership to prepare, plan and implement a programme of work, there is a risk that current leases will expire and there will be no provisions in place for health services to continue to operate from the buildings.

With each property considerable assessment and planning needs to be undertaken to identify and then deliver the best value way forward and understand if the best value option is to extend the lease, purchase or vacate the facility. Decisions are dependent on several complex issues including government policy, funding, CDEL limits, organisational capability, national and local support.

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Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

End of Term Key Dates up to 2034

The timeline below shows both the LIFT and PFI Estate properties whose Head Lease will expire over the next 10 years, there are additional properties as part of Cheshire and Merseyside Estates with lease expiry dates post 2034.

2027-2032

2027
- Firdale Medical Centre

2028
- Rope Green Medial Centre

2029
- Nantwich Health Centre
- The Kiltearn Medical Centre
- Tudor Surgery
- Cedars Medical Centre
- Mere Park Medical Centre

2030
- Tower Hill Primary Care and Community Centre
- Ainsdale Centre for Health and Wellbeing
- Everton Road Health Centre
- Litherland Town Hall Health Centre

2031
- Cavendish Medical Centre
- Miriam Primary Care Group
- Waters Green Medical Centre
- Widnes Health Care Resource Centre
- Picton Neighbourhood Health and Childrens Centre

2032
- Garswood Health Centre
- Sunlight Group Practice
- Commonfield Road Surgery

2024-2032

2025
- Ashfields Primary Care Centre

2026
- Moreton Health Clinic

2027
- Oakwood Medical Centre

2028
- High Street Practice Winsford
- Swanlow Medical Centre
- The Weaver Vale Surgery

2030
- Earnswood Medical Centre
- Millcroft Medical Centre
- Tower Hill Primary Care and Community Centre

2031
- Widnes Health Care Resource Centre

2032
- Garswood Health Centre

2033-2034

2033
- North Huyton Primary Care Resource Centre
- Beaconsfield Primary Care Centre
- Newton Community Hospital
- The Halewood Centre
- Warrington Child Development Centre
- Chelford Surgery

2034
- Witton Street Surgery

Key

North Mersey
Mid Mersey
Cheshire and Wirral

Void and Vacant Space

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Our estate is fit for purpose; supports our service strategies and our core estate is located in the most appropriate place to benefit our population

A significant proportion of our community lettable space are demised to services; however, we know that this does not always mean our buildings are utilised as efficiently as possible.

Currently, there is 878sqm (51 rooms) of clinical and non-clinical void and vacant space across our CHP estate, costing our system c.£900,000/annum. This incorporates spaces such as café and previous reception area that are being used by other services. In addition, there is 9,000 sqm (405 rooms) of bookable space with a variable level of use across the properties.

Similarly,within our NHSPS properties we have over 3,400sqm of clinical and non-clinical void and vacant space, for both Primary and Community Care as well as corporate Head Quarters costing c.£1.26million per annum. This also includes some buildings within Cheshire West that have been declared surplus from the ICS and are in the process of becoming a disposal.
Included in Appendix 3 is an NHSPS action plan summary for each place

CHP		
Place	**Cost**	**SQM2**
Liverpool	£346k	284sqm2
Sefton	£282k	330sqm2
Knowsley	£175k	166sqm2
Halton	**No Void or Vacant space**	
St Helens	£10k	9sqm2
Warrington	£89k	90qm2
Cheshire East	**NO LIFTCO BUILDINGS WITHIN CHESHIRE AND WIRRAL**	
Cheshire West		
Wirral		

NHSPS		
Place	**Cost**	**SQM2**
Liverpool	£52k	473sqm2
Sefton	£21k	205sqm2
Knowsley	**No Void or Vacant space**	
Halton	**No Void or Vacant space**	
St Helens	£13k	52sqm2
Warrington	**No Void or Vacant space**	
Cheshire East	£127k	433sqm2
Cheshire West	£133k	1364sqm2
Wirral	£116k	867sqm2

Costs and SQM2 provided as of April 2024 ***Service and FM charges not included***
Appendix 3 to review action plan summary for each place

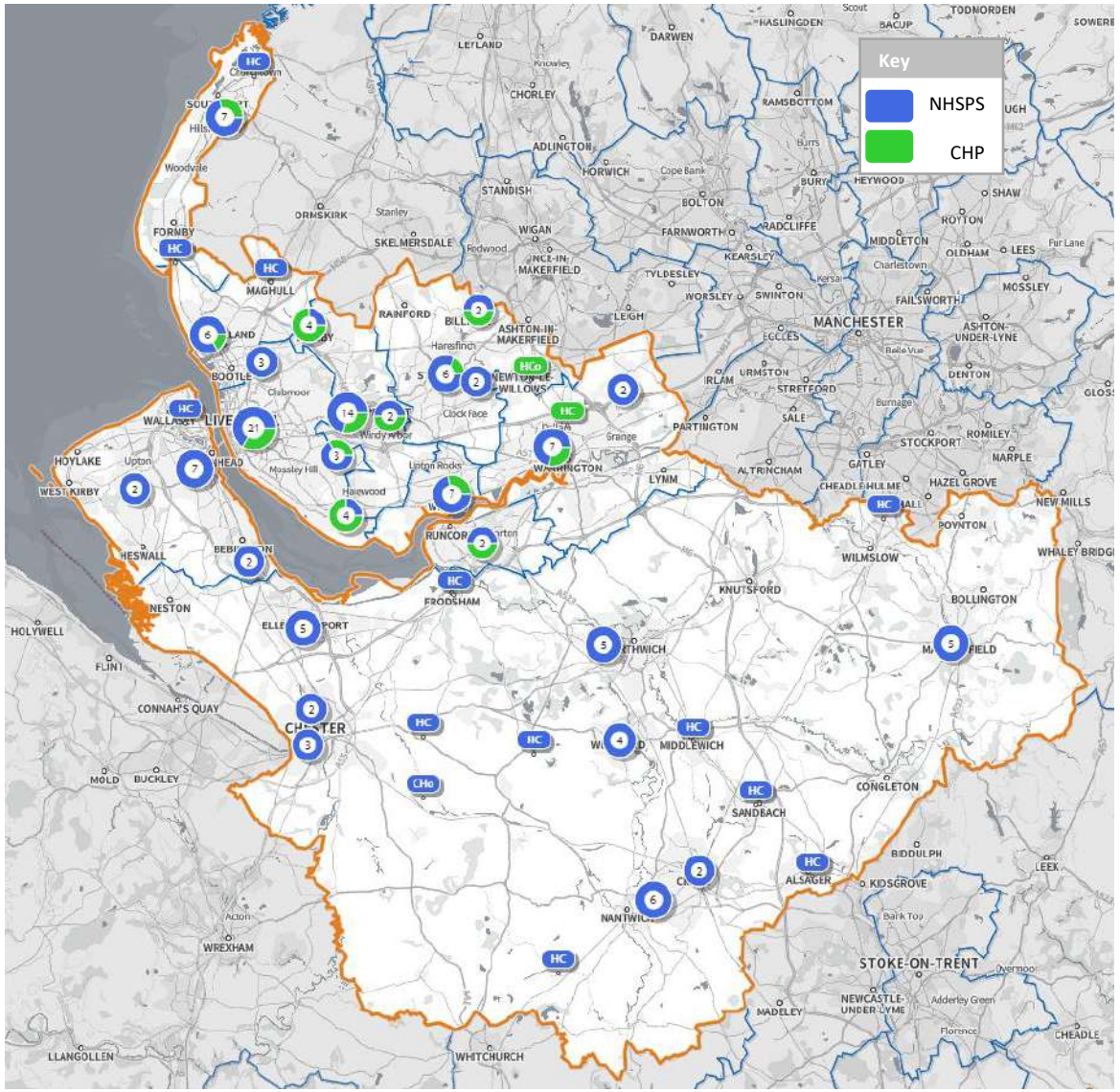


Image: Map of NHS Property Company Estate

Improving our utilisation: Bath Street Health & Well-being Centre

Image: Bath Street Health and Wellbeing Centre (Renova Developments LiftCo)

Background:

Bath Street Health and Wellbeing Centre is a 3,500m2 five-storey modern Health Centre in the heart of Warrington town centre which opened in 2012. Other services at Bath Street include Sexual Health services and community clinic rooms. Bath Street is also home to a GP surgery and a Dental clinic. The Health Centre is owned by Renova Developments (LIFTco) with CHP as the head tenant. CHP LIFT buildings, such as Bath Street, provide place-based care closer to home for patients in core NHS assets.

Approach:

A new expanded breast screening service and additional clinical rooms opened for patients at Bath Street Health and Wellbeing Centre (HWC) in Warrington town centre in May 2023. £930k CHP capital funding provided two new screening rooms, four new clinic rooms and extra interview space to enable additional services and capacity for screening has increased by over 100% at Bath Street. This means patients will have reduced waits as they can visit the accessible town centre location with car parking and good transport links.

Services are now delivered in a central location in Warrington and help decrease the current NHS backlog. This change was supported by a public consultation exercise in 2022. CHP worked with the Warrington and Halton Hospital (WHH) team on consultation exercises, and to obtain WHH Board approval.

It has been a team effort working alongside Renova colleagues, and closely with the Trust, to provide much-needed clinical space in the community. Partnership working, delivery, capability and flexibility of CHP's existing high-quality, modern estate has been critical factors in overcoming challenges and successfully delivering the additional breast screening services at Bath Street with two breast screening machines.

Benefits:

Locating breast screening services into a modern, purpose-built clinical environment, and a building that is fully accessible with better public transport and parking options, will also significantly improve patient experience.

Patients from the Warrington and Halton Teaching Hospitals Trust's Experts by Experience programme contributed to the design at different points in the project to ensure it met the varied needs of all patients.

Sustainable Estate

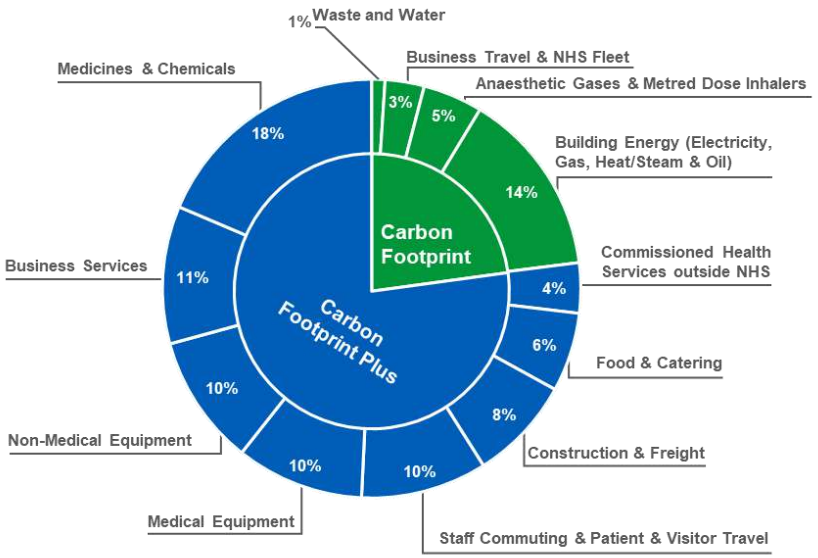
Sustainability planning and management are paramount for tackling climate change and ensuring the long-term resilience of our system's current and future infrastructure needs. Cheshire and Merseyside ICS are committed to meeting national sustainability targets outlined in the NHS Net Zero Building Standard (2023), Delivering a 'Net Zero' National Health Service (2022) and Estates 'Net Zero' Carbon Delivery Plan (2021) recognising climate change as the most significant health and human rights issue facing us today.

Green Plans

As per the Green Plan mandate, all systems and providers are required to produce a Green Plan. A 'Green Plan' combines carbon reduction and social value analyses to produce a comprehensive improvement strategy and delivery plan that meets the targets set out in national guidance. All of our health and care partners as well NHS Property Services and CHP have produced Green Plans which outlines our collective commitment as well as our partner organisations to deliver sustainable and high-quality services.

Carbon Footprint

Our carbon footprint is 289,050 tC02e which amounts to 23% of our carbon emissions with Building Energy (Electricity, Gas, Heat/Steam & Oil) being the largest contributor. Our carbon footprint plus is 967,220 tC02e which amounts to 77% of our carbon emissions with Medicines & Chemicals being the largest contributor.



Cheshire and Merseyside ICS Carbon Footprint *(2022)*

Climate Adaption and Mitigation

Climate impacts have serious consequences for public health and the delivery of healthcare services, ranging from risks to hospitals, supply chains and transport, as well as new pressures on the health system as a result of heatwaves, pests and diseases, and extreme weather events. Understanding, anticipating, and adapting to these new challenges is essential to developing a more climate-resilient NHS.

What we have achieved

Currently, we proactively collaborate with organisations from across the health and care system and wider system partners to positively influence wider health determinants in a sustainable and innovative way. Below are some examples:

Solar Installation: Wirral Community Health and Care Foundation Trust

306 solar panels have been installed at St Catherine's Health Centre, generating an estimated 84,607kWh p/a – enough to power 21 houses for a year! This clean energy generation will help avoid 27.9 tonnes of CO2e emissions each year, which is the equivalent of planting over 130 trees.

Virtual Fracture Clinic: Mid Cheshire Hospitals NHS Foundation Trust

Mid Cheshire Hospitals NHS Foundation Trust have implemented the award-winning and innovative Virtual Fracture Clinic in 2017 which assesses patients with fractures remotely minimising unnecessary hospital visits and carbon emissions.

LED Lighting Replacement: Mersey Care NHS Foundation Trust

Mersey Care undertook a lighting replacement project in 2019/20 that saw over 1,500 light fittings across 4 hospital sites replaced with LEDs. In less than 3 years the savings from energy (5.5% reduction) and maintenance total more than the cost of the project.

ICB Wide

Nearly all of our trusts have moved to Crown Commercial Services as a procurement tool for Energy which has allowed us to pool energy contracts together to ensure value for money and economies of scale.

Collaboration in our estate

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Provider Collaboratives

Provider collaboratives are partnerships that bring together multiple NHS trusts (providers of NHS services including hospitals and mental health services) to work together at scale. Within Cheshire and Merseyside, there are two provider Collaboratives:

- **Cheshire and Merseyside Acute and Specialist Trust (CMAST)**
  CMAST is one of only nine Provider Collaboratives in the country to secure Provider Collaborative Innovator status. This is an NHSE scheme that offers access to national expertise for collaboratives; to accelerate the benefits they can deliver for their populations and to provide a strong platform and community of practice to help spread the benefits to every area. It should also enable CMAST to play a greater role in leading service transformation and shaping national policy.
- **Mental Health, Community and Learning Disability Collaborative (MHLDSC)**
  The MHLDC Provider Collaborative is a joint working arrangement between the 9 providers of community, mental health and learning disabilities services in Cheshire and Merseyside. The collaboration is based on a principle of "collaboration at scale to deliver better care at Place" and on the understanding that there are service areas that can benefit from sharing best practice and by mutual aid between organisations.

The Hewitt Review in 2023, identified the need for collaboration within and between systems and national bodies via cross governmental collaboration to embed a national mission for health improvements.

What we have achieved

Network of Community Diagnostic Centres

Ten CDCs are currently in operation around the region thanks to the collaboration of the Cheshire and Merseyside Cancer Alliance, hospital trusts, and NHS Cheshire and Merseyside ICS. The CDCs possess the capacity to do essential NHS tests and scans in locations away from the pressures of a busy acute hospital providing emergency care but close to where patients live.

Following the NHS's acquisition of the formerly privately operated Rutherford Cancer Centre North West, one CDC has opened in Paddington Village, close to The Clatterbridge Cancer Hospital in central Liverpool. The Clatterbridge Cancer Centre NHS Foundation Trust is the owner and operator of this CDC. The other CDC, Warrington and Halton Diagnostics Centre, is operated by Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH). The initial stage of this facility has included redevelopment of part of Halton Hospital, with services now fully operational there, and there will also be an extension to services provided at Halton Health Hub, in Runcorn Shopping City. In addition, this CDC scheme includes the construction of a new, £6m purpose-built diagnostics centre next to the existing Captain Sir Tom Moore building at Halton General Hospital, which is scheduled to open February 2025

The Halton Health Hub

The Halton Health Hub was developed in partnership with Warrington and Halton Hospitals NHS Foundation, Halton Borough Council, Liverpool City Region Combined Authority and One Halton Partnership. Runcorn Shopping City's vacant retail spaces were transformed into The Halton Health Hub which offers a range of clinical services. Further funding of NHS England's Community Diagnostic Centre programme has been secured by the Trust to offer additional services, including sleep studies, phlebotomy and ultrasound later in the year. The Hub aims to offer 72 appointments each week from five consultation rooms and two diagnostic imaging rooms.

Collaboration & Integrated Service Delivery – Children's & Family Hub

Lowe House Primary Care Resource Centre (Renova)

> *"The Children's and Families Community Hub at Lowe House Health Centre will be a huge asset for families in St Helens. The birthing suite will allow Mums who are low risk to birth on a site in St Helens and receive all their care including scans at Lowe House, meaning that they don't have to travel to a hospital site. Women will be able to access support for smoking cessation, perinatal mental health and infant feeding all from the same site."*
>
> **Ann-Marie Barrow, Senior Commissioning and Transformation Manager who had been leading the project for NHS St Helens CCG (now NHS Cheshire and Merseyside ICS)**

Background:

Lowe House, constructed in 2010 under the NHS LIFT Programme by Renova, an investor in community healthcare facilities serves the St Helens community. In 2021, it underwent a £736k internal variation, funded in part by Cheshire & Merseyside Women's and Children's Services Partnership, to include a Children's and Families Community Hub with a midwifery unit and birthing facilities.

Approach:

Internally, adjustments were made for a dedicated entrance and exit for service users and their families, changes to internal access doors as well as work on the existing clinical treatment rooms to provide a wet and a dry birthing suite, with extra provisions for changing and showering.. Additionally, work was carried out on water, wastewater and sluice facilities as well as external modifications made for a dedicated ambulance bay next to the new public entrance. This work was done as a result of a collaborative effort between Renova, CHP and local healthcare stakeholders to ensure patient-centred solutions for the local community.

Solution & Benefits:

The building expanded birthing options for local women and reduced the reliance on hospital visits. The birthing suite provided low-risk mothers with comprehensive care, including scans and access support services for smoking cessation, perinatal mental health, and infant feeding, without the need to travel to a hospital.

Our future is digital, smart and intelligent to deliver better care and empower people to manage their own health

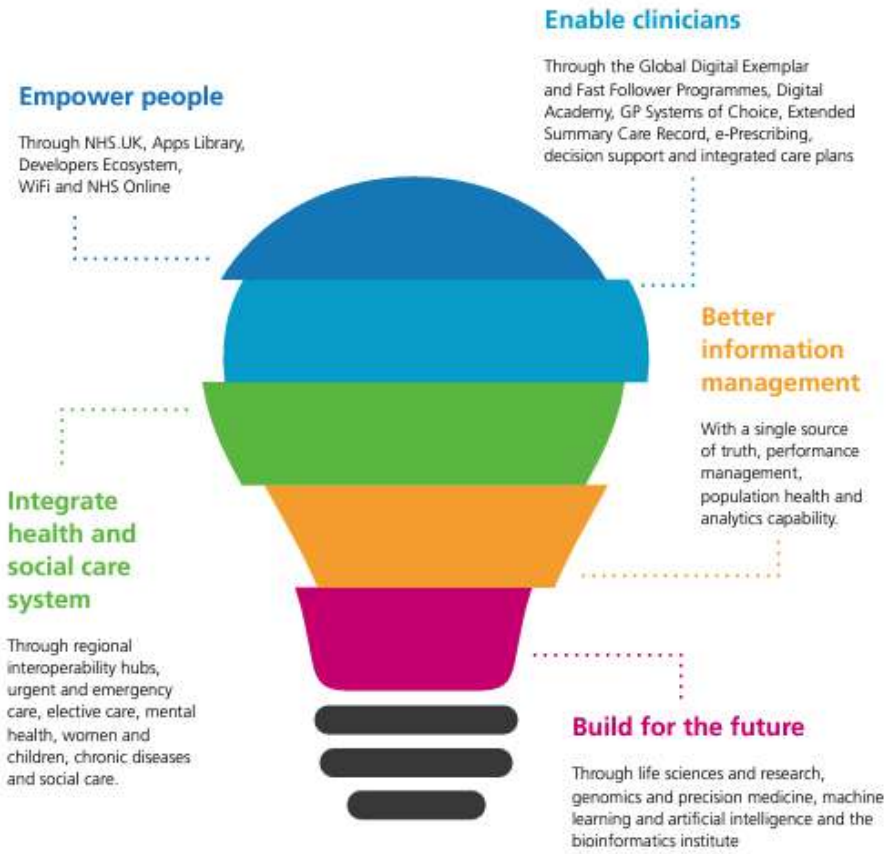
Harnessing the power of digital to ensure the most efficient use of our physical assets

Just as our physical infrastructure is critical in supporting the delivery of our services, digital infrastructure also plays a hugely important and complementary role. By harnessing new ways of working, we can ensure utilisation and patient flow through our physical assets is optimised. This includes integrating the use of digital into our patient pathways where possible.
Our aim is to use technology to identify those at risk of acute illness and those who would benefit from early intervention to help reduce morbidity, mortality and cost. When our population are ill, and require health and care services, they should be able to receive integrated care. No one should have to tell their story more than once, unless there is a clinical need to do so, and our population should be able to access their health and care services in the way in which they access other services in their day-to-day lives. By ensuring our digital infrastructure is fit for purpose, we can work differently to reduce pressure on both our estate, workforce and improve patient outcomes.

For our staff, this will enable our workforce to do their jobs differently. Coming to work in Cheshire and Merseyside will feel different as we reduce the amount of paper involved in care delivery and increase the level of digital maturity and connectivity between our local organisations and places. With a focus on digitally enabled outcomes, care will be delivered through innovative technologies and processes – again, reducing the pressure on the estate associated with previous models of care.

Our system published the **Digital and Data Strategy (2022)** which set out the goals to make Cheshire and Merseyside ICS the most digitally advanced and data driven ICS in England by 2025:

- **Strong digital and data foundations**, delivering reliable, seamless and secure digital and data infrastructure and associated support services, fundamental care records solutions and integrated data sets across our ICS.
- **'At scale' digital and data platforms**, providing core solutions which are mainstreamed and embedded in health and care service delivery and planning at all levels. This includes platforms for shared care records, remote care, intelligence delivery and patient empowerment.
- **System wide digital and data tools and services**, which build on those core platforms and directly support the delivery of the ICS health and care objectives. This includes the use of solutions for population health management and business intelligence and solutions and apps that meet the specific needs of one or more specific groups of the population.



"Place-based care isn't defined by existing structures and organisations but by citizens and their health concerns who can access high quality care for any health concern anywhere in the geography of our Care Partnership."
Cheshire & Merseyside ICB Joint Forward View

Progress towards digitally enabled models of care

We are building our digital future based on some great building blocks. Over the past 5 years through the previous local systems and legacy Local Digital Roadmaps, we have an excellent track record of digital achievements, which are summarised opposite. We have a wealth of digital expertise and clinical leadership to draw upon. At a local level, our clinical leadership is strong. Our clinicians are engaged and lead our digital initiatives both strategically and operationally. Our digital leaders work in partnership with clinical teams to ensure that everything we do is focussed around improving quality, safety and the experience our patients and their families have.

What are we doing in the Digital space to support Infrastructure pressures and service delivery

DIGITAL DIAGNOSTICS

The digital diagnostics programme is using technologies such as Artificial Intelligence (AI) and machine learning, clinical decision support, robotic process automation and intelligent scheduling to support clinical pathway re-design, increased efficiency and productivity through end-to-end connected digital diagnostics provision, that ensures safety, reduces variation and increases productivity. Pathology and Imaging networks are submitting digital maturity self-assessments 6 monthly and are working towards being thriving networks by March 2025. Our NHS Cheshire and Merseyside's Radiology Imaging Network (CAMRIN) has secured funding from the NHS Transformation Directorate's AI Diagnostic Fund to accelerate the deployment of AI to help diagnose lung cancer patients quicker. The tool, will be rolled out to nine acute and specialist NHS trusts to identify nodules and masses on chest X-rays ensuring those patients can be prioritised and reduce the administrative burden on clinical staff.

PTL RISK STRATIFICATION TOOL, OBSERVATORY (C2-AI) AND SURGERY HERO

We are introducing technology to support the assessment and prioritisation of patients on elective waiting lists. Benefits of embedding this technology include increased safety for patients on waiting lists and streamlined "business as usual" processes across the region. Our Surgery Hero programme supports self-care for patients awaiting surgery both before, during and after their operations through individualised risk stratification, prehabilitation and prevention and reduction in avoidable clinical harm. This can also reduce face to face appointments where appropriate, reducing pressure on our physical assets.

Key achievements supporting our Infrastructure

- Developing increased provision of access to ICS wide person level health and care linked datasets through the CIPHA platform, and further embedding this in the System P transformation programme of work
- Procurement and early-stage roll-out of a common online/video consultation platform for use in primary care (PATCHS)
- Implementation of a single Picture Archiving and Communications Systems (PACS) solution and associated infrastructure to support developments in system wide radiology working
- Work to scale up and roll out Robotic Process Automation (RPA) to improve the efficiency of repetitive administrative processes
- Scaling up of the ICS wide remote monitoring platform to support an increased number of virtual ward beds as well as more widespread telehealth support for long term condition management
- Implementation of Patient Empowerment Portals (PEPs) in all of our acute trusts to deliver both patient and clinical benefits for secondary care and across Place and commencement of a pilot to roll out in other care settings, including Mental Health
- Continued rollout across care settings and increased availability of care information through the C&M Shared Care Record platforms. Deployment of an accredited Digital Social Care Record in care providers
- Development and early-stage adoption of the Digital Inclusion Impact Assessment toolkit for all existing and new digital and data initiatives
- Decision to procure a single Laboratory Information Management System (LIMS) to support development of the system wide pathology network

Our Provider Collaboratives have reduced outpatient demand by 200,000 appointments in the last year using digital tools, reducing pressure on our physical estate

Cheshire and Merseyside's provider collaborative gained national recognition after winning **Provider Collaborative of the Year** in the 2023 HSJ Awards.

Judges praised **Cheshire and Merseyside Acute and Specialist Trust Alliance (CMAST)** for its "strong and effective collaboration" and its potential for further growth and co-production.

The Elective Recovery and Transformation Programme is integral to this and focuses on reducing waiting times, increasing capacity and enhancing how trusts work together to improve patient outcomes - making best use of resources. By working together, the provider collaborative eliminated the 104-week wait and reduced the 78-week wait for nearly 40,000 people, enabling our patients to receive the care they need. A number of initiatives have contributed to this, including The Diagnostics Programme, which encompasses more than 70 tests and drives improvements for the population of Cheshire and Merseyside, across 355 GP practices and 16 NHS trusts. The programme has delivered over 117% more CT scans and 115% more colonoscopies than pre-pandemic levels and ensured patient waiting times have reduced. As this work progresses and we continue to reduce variation and eliminate waste, we must consider the Implications for our estate and possible efficiencies and opportunity.

CMAST Commitment	What we have delivered
Increase to 9 CDCs (Community Diagnostic Centres)	From March 2024 C&M ICS have 10 operational CDCs
Deliver Increased activity	8% above plan
No patients waiting more than 52 weeks for first definitive treatment	Achieved
Reduce DNA rates to less than 5% in Endoscopy & Imaging	Big improvements made with only endoscopy slightly above 5%: Endoscopy 5.35% CT 1.07% MRI 2.53% Ultrasound 2.03% Dexa 2.03%
Deliver 10% productivity gains	Imaging: Acceleration Technology Installed on 19 MRI Scanners Pathology: Single Laboratory Information System implementation on track & secured £9.2m of capital for C&M

The **Robotic Process Automation (RPA) project** was also shortlisted for '**Integrated Care Initiative of the Year**' at the 2023 HSJ Awards, recognising an outstanding contribution to healthcare. The aim of the project was to streamline and automate processes, such as those that support large scale data migration activities, referrals, repeat bloods, and patient-initiated follow-up, to optimise staff time and enable our workforce to focus on more complex, patient-centred activities. Whilst RPA software also helped with enhancing process accuracy and reliability, minimising errors, and improving patient safety. This has enabled ten Trusts to automate high-volume, manual, repetitive, and rule-based tasks, which has freed up time for clinical and/or non-clinical workforces to utilise more efficiently elsewhere.

What we must now begin to understand and quantify as a system, is how this impacts our physical estate and how we currently work – **creating opportunities to optimise and consolidate estate, whilst also ensuring services are accessible for those who need them**

Digital Infrastructure challenges

Whilst we have made significant progress across our digital and data infrastructure, we still have challenges across our system as outlined in the themes below;

INTEGRATION & INTEROPERABILITY

A lack of interoperability, meaning that different systems for storing data cannot "speak to" each other.
Data that is collected is often not readily available or amendable outside of the setting that collected it, making delivering joined-up care challenging.

HEALTH INEQUALITIES & ACCESS

For a large proportion of our population, accessing information and services online is the norm and as a result, expectation is now greater than they have ever been for health and social care services to be digital by default.
However, whilst there are many people who can and do embrace the use of digital, there are others within our region who find themselves digitally excluded and unable to use online services for a variety of reasons including lack of kit, skill, confidence or support. For these individuals, the growing trend towards online services creates a digital barrier risking inequalities in health and care.

Ensuring digital and non-digital options are available, will help us to retain equity of provision, improve access, understanding, and will help us meet the needs of the population we serve.

CONNECTING DIGITAL & ESTATES

It is difficult quantifying the impact of our digital work and its alignment to the estate priorities and therefore estates and digital programmes are delivered in silo.
Our governance structures currently do not join all parts of infrastructure as a system.

VARIABILITY IN OUR SYSTEM

Unwarranted variation in any system leads to avoidable cost and differences in quality of care for our patients. Digitising care records has been variable across Providers. We have previous successes in Cheshire and Merseyside through national programme investment, and our system has one of the most digitally advanced hospitals in the UK (Alder Hey NHS FT). However, we still have hospitals which do not meet the minimum Electronic Patient Record (EPR) standard, which are predominantly paper based in their processes, and although Adult Social Care providers have electronic case management systems, Digital Social Care Records (DSCRs) generally do not exist in other providers of adult social care. Addressing this variability will be one of our key challenges moving forward.

FUNDING & RESOURCING

Resources across the system are constrained, and this is no different for our digital team which limits our ability to progress our ambitions as quickly as we would like. Investment in digital and data during a financially constrained period is challenging but it is key we focus on the programmes that have the greatest improved outcomes for our population.
The ICS will make future investment decisions and an approach to prioritisation that will create most impact in the 'levelling up' and 'intelligence into action' agendas, whilst also addressing the backlog of care.

Our People: A snapshot across our system

Our workforce

c82,000
Headcount of all Staff across Cheshire and Merseyside

42,320
Professionally qualified clinical staff

7,483
Headcount of HCHS Doctors

22,696
Nurses & health visitors

15,559
NHS infrastructure support staff

5,435
Property & estates staff

NHS Workforce Statistics - November 2023

> *The ICB executive team recognises the value of **clinical and care professional leaders** supporting the objectives of the ICS and we are committed to ensuring our clinical and care leaders, and wider workforce, are directly influencing decision making across all parts of our system. We will support them with the **time** and **infrastructure** to be effective in these roles.*
>
> **Graham Urwin, CEO Cheshire and Merseyside ICS**
> **Cheshire and Merseyside Joint Forward Plan 2023-28**

Across our system we have a large workforce of over 80,000 members of staff, spanning five generations and working across all services.

The 2023 NHS Long Term Workforce Plan set out the case for taking a more strategic, long-term approach to NHS workforce planning. It outlines how the NHS will address existing vacancies, meet the challenges of a growing and aging population by recruiting and retaining hundreds of thousands more staff over the next 15 years and reforming the way we work through three priority areas; **Train, Retain and Reform**.

The Cheshire and Merseyside workforce is no exception to these pressures. As part of our workforce priorities and response to the Long-Term Workforce Plan, we know we need to change the way we work by;

- Collaborative working across organisations, including pooling of clinical staff and back-office functions
- Having population health at the heart of our strategic planning
- Reviewing our corporate estate and the opportunities to rationalise, supporting our people to work differently

In addition, we are recovering from the COVID-19 pandemic and facing emerging pressures, such as the increasing cost of living, which has impacted recruitment and the number of people commencing formal training, the impact of which will be seen over the next 2-3 years.

Equality & Diversity

Our equality objectives focus on key priorities, including the development of an Equality, Diversity and Inclusion framework and operating model that matches the full ambitions of the ICB. The purpose is to shape the future of health and care, to help improve the access, experiences and health outcomes for all patients and communities, and to support NHS Cheshire and Merseyside to become a more inclusive employer by making full use of the talents of its diverse staff and the communities it serves.

Estates Workforce

The Estates and Facilities Management (EFM) team, comprising around 100,000 members across England and representing 8% of the NHS workforce, is essential to the delivery of all NHS services. Daily, our EFM teams, including cleaners, porters, catering staff, security personnel, engineers, capital delivery, and maintenance staff, collaborate with clinicians to ensure patients receive the care they need. During the pandemic, the EFM workforce rose to the extraordinary challenge, often going beyond their regular duties to ensure the estate continued to support world-class clinical services. They also designed and rapidly constructed new facilities, such as the Nightingale Hospitals. The pandemic underscored the importance of a well-maintained and resilient estate as the foundation for clinical service delivery.

Significant capital investment has been committed to support the Government's plan to deliver 48 new healthcare buildings by 2030 through the New Hospital Programme. This investment will also modernise existing hospitals and address backlog maintenance issues. This presents a once-in-a-generation opportunity to innovate and redefine our estate, service delivery, and industry best practices while working towards decarbonising our estate in line with the NHS's and the Government's net zero carbon strategies. The successful execution of this ambitious hospital development program requires us to address our most urgent issue: building a diverse, high-performing workforce, filling skill gaps, and providing people with the necessary tools, support, and development opportunities to ensure we have a strong and resilient team for our future needs.

The various Skilled Trade appointments within EFM are critical to delivery of our service levels to maintain the infrastructure and assets throughout the Trust. We do have an aging demographic and replenishment of these key trade skills is very difficult. As a system we regularly have skilled trade vacancies from leavers and retirees in all areas, and our recruitment can take up to 4 rounds of advertisement, shortlisting and interview to recruit any staff. There is competition across the patch and variability in the Recruitment & Retention Payment (RRP), used as an annual payment to help bridge the pay differentials between the NHS and other external organisations, ranging from £3,000 up to £6,500 for skilled trades.

Our EFM Workforce Priorities

- Boost wellbeing and improve the work environment
- Make NHS EFM an inclusive place to work
- Create new career pathways
- Future proof our skills
- Embed data-driven decision-making
- Develop our managers
- Recruit the best talent
- Be the EFM employer of choice
- Invest in what matters to our people

Estates Workforce Challenges

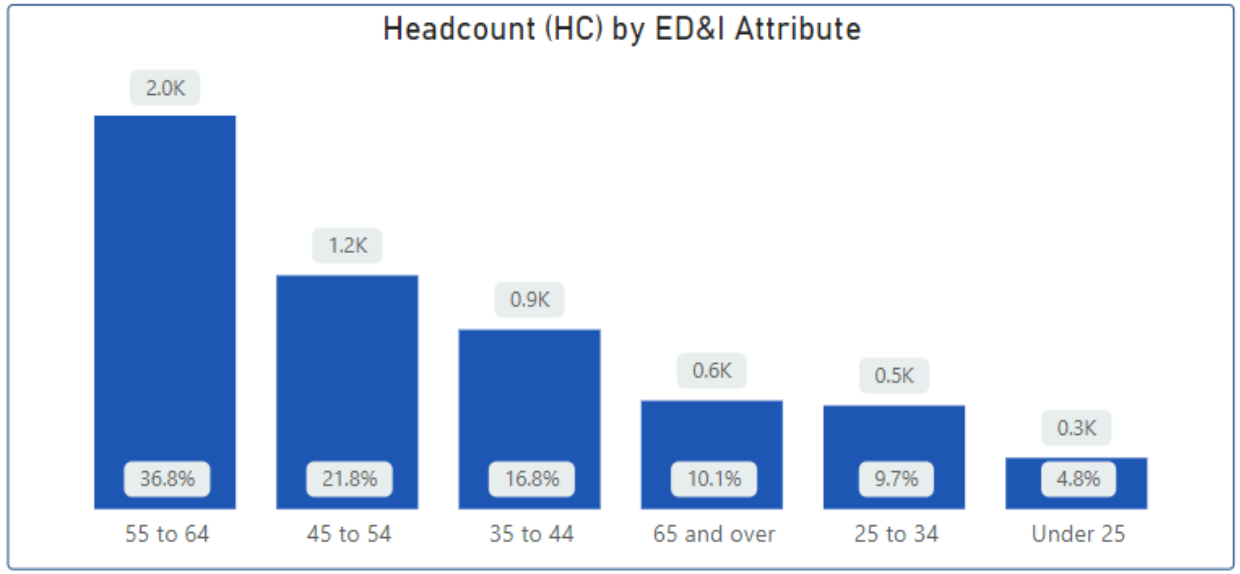
Our **key challenges** from an estate's workforce perspective are:

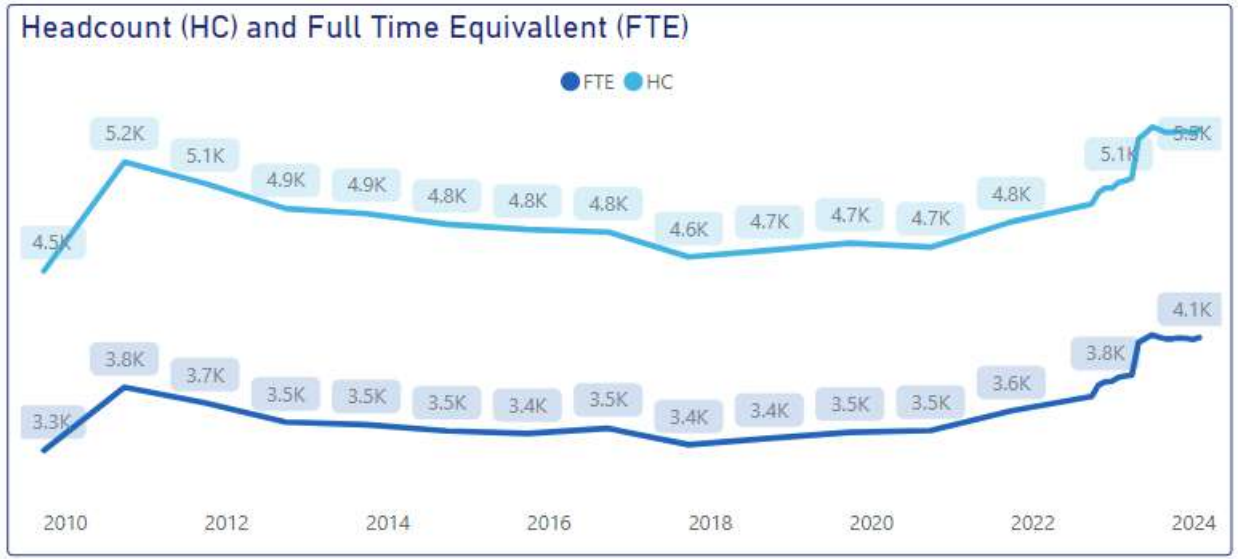
- **Recruitment difficulties driven by national shortage and availability** of skilled trade labour (Electricians, Plumbers, Joiners, multi trade)
- Competing with industry for candidates, including around pay (within the NHS for skilled trade appointments this is band 4)
- Almost 50% of our workforce over 55: As the workforce ages, **there is an imminent risk of a significant number of retirements, leading to a loss of experienced staff**
- **Skills & knowledge for a specialist environment:** Knowledge of the very wide scope of assets and infrastructure within a hospital environment, plus availability of key HTM asset knowledge in ventilation, Decontamination, Medical gases and general healthcare premises
- Awareness of skilled trade appointments within the NHS
- **Financial Pressure**: The need to rely on contractors to fill gaps in staffing adds to the financial burden on the system

Cheshire & Merseyside face the challenge of a high proportion of our Estates and Facilities Management (EFM) workforce reaching retirement age in the next 10 years. Whilst this is a national challenge, Cheshire & Merseyside as an ICS has one of the highest proportions of EFM staff aged 55 and over, at 47% - almost half of our workforce.

With ongoing challenges including high staff turnover, an aging workforce and regular recruitment challenges, Cheshire & Merseyside face being under resourced with skilled trade staff which will directly impact our ability to deliver safe and effective patient care. The impact of not having fully trained, qualified and experienced in-house staff adds risk throughout the system.

Shortfalls in suitably trained, qualified and experienced staff are addressed by backfilling posts with additional contractor support, which adds financial pressure to our already challenged system which we must address as a priority.

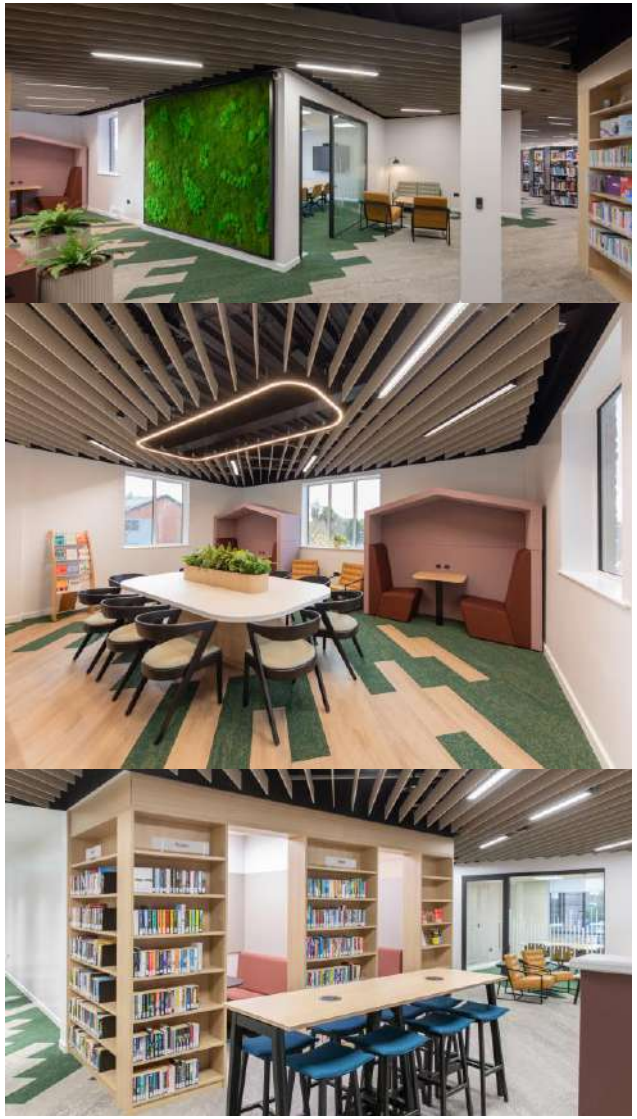




Using our estate to support Learning & Development

As we begin to work differently, opportunities with regards how we best use our assets are emerging. At **East Cheshire NHS Trust**, the team had an opportunity to reconfigure space previously used by the CCG and more recently as a PPE storage facility during the pandemic.
The vision was to create a shared learning, education and development hub, supporting the Trusts ambitions in the education space, supporting both existing members of staff and students, as well as attracting prospective
The initial brief presented challenges due to different requirements. Originally the floor plan was office space for the CCG and then later Secretaries and Consultants. The brief listed very different spaces which needed to fit within the 450m2 floor plan:

- 5 Teaching Rooms including a 40-person large teaching space
- Library
- Quiet Learning Area
- Break Out Space
- Reception
- Simulation Zone
- Computer Training Suite
- Store
- Staff Office



The restriction on floor area meant that the teaching rooms had to be flexible. The designers introduced a movable partition in the large teaching room which splits the room in to two medium sized teaching spaces. Pop up IT desks were installed in the digital lab so this space could easily be turned into a teaching room.
The brief required the Library and Individual learning area had to be quiet. The designers achieved this by incorporating acoustic finishes into the ceilings and walls. An Autex slatted ceiling can be seen in the central core of the Hub, the design of the ceiling slats and finish absorbs and deflects the soundwaves from general background noise and voices. The walls have been covered in an acoustic board which absorbs sounds much like soft furnishings in a home. The plant pots are also covered in sound absorbent material.
In addition to the key requirements of the brief the design team wanted to create a **calming and peaceful environment to enhance the learning experience**. The team have achieved this by the choice of colours and materials.
The LE&D Hub is packed full of technology, each teaching room has its own dedicated ECNT PC, so any member of staff can login and use presentation of teaching material from their own personal files. The rooms have laptop connectivity trough USB and HDMI. All the AV Screens have touchscreen and MS Teams capability with speakers and camera. Projectors and cameras to support new ways of working are also available across the facility.

Funding Overview

Funding availability remains constrained, any capital opportunities must be prioritised to ensure alignment with our key priorities. In 2024/25, £4.7 million ICS capital allocation has been ringfenced across Digital and Primary Care, which will be prioritised based on driving a reduction in health inequalities, with capital allocated to both estate and digital improvements. From the National Toolkit Programme, our forecast pipeline suggests we need total capital of **£135,851,017*,** significantly more than our allocated budget. These projects need to be prioritised at place level.

S106/Central Infrastructure Levy Funding (CIL)

Since December 2022 NHSPS have worked on behalf of Cheshire and Merseyside ICS providing support in obtaining s106/CIL, across the 9 places andand have requested in excess of **£4.5m.**

We now have a standardised approach in 8 of our places to accessing funding with local councils and developers enabling early engagement and insight on planning policy development.

Due to the significant population growth projected within Liverpool City Council, all partners are working in collaboration to develop a tailored approach for securing developer contributions and improving processes to ensure consistency across the Liverpool City Region.

The total S106/CIL currently available across the system is **£3,184,486** , allocation of this funding is subject to s106 conditions and ICS approvals.

The ICB needs to secure other funding sources, including but not limited to Local Authority funding, landlord funding (including NHS Property companies) and GP investment.

Premises Cost Directions

In May 2024 the Department of Health and Social Care published '**The National Health Service (General Medical Services Premises Costs) Directions 2024'**. The new directions are based on the 2013 directions with some key changes:

- Changes to grant funding including an increase in the value of grant which may be paid
- Requirement of Project Initiation Documents in accordance with NHS England Standard operating procedures
- A more detailed process for determining rent reviews together with a statement prohibiting NHS England or the ICB from negotiating directly with landlords or their representatives during the rent review process

Image: Kelsall Medical Centre and Wellbeing Hub

*Source: PCN Toolkit Programme Outputs

**Source: NHSPS Town Planning Team- excludes requests ICB may have submitted that fall below the 200+ unit threshold *and where further s106/CIL is allocated as part of a phased allocation*

Financial Inefficiency driven by Estates Inefficiency

A critical dependency of productivity improvement is modernisation of our health and care facilities. This means addressing the maintenance backlog to reduce disruption. Failing to invest in our ageing estate will mean increasing instances of incidents that result in lost clinical time, such as electrical faults and leaks – there have been 12,000 reported estate failures that have stopped clinical services over the past two years'. Across all of our organisations in Cheshire & Merseyside are reports of clinical service incidents linked to estates and Infrastructure failures.

In 2022/23 our system reported 69 incidents linked to critical infrastructure failures. A further 92 incidents linked to non-critical estates and infrastructure failures were also reported.

Such incidents include:

- Age profile of buildings
- Quality of buildings
- Facilities management
- FM services
- Heating and energy
- Water services
- Waste
- Car parking
- Laundry and linen
- Portering services

As part of our implementation and delivery plan, in partnership with our provider and system colleagues, a plan to minimise backlog maintenance must be developed. Issues which contribute the largest risk in terms of patient safety and our ability to run effective services must be prioritised.

Capital Requirements

Within NHS Cheshire and Merseyside ICS, regular financial performance reports are provided to the Finance, Investment and Resources Committee who undertake detailed review and challenge on behalf of the Board.

The NHS Cheshire and Merseyside ICS draft financial plan was submitted to NHSE England which was reviewed and ratified by the Board in March 2024.

In relation to Infrastructure a high-level overview of our capital allocation and requirements is below:

Capital Requirements

For Capital in 2024/25 the secondary care allocation is the same as 2023/24 **, £258.4m**, and the primary care and digital allocation is **£4.7m**.

Our current planned expenditure on our estate is **£5,606.78m** over the next ten years, of which the ask for further new national capital is £**633.56 m.**

The **£633.56m** represents the current identified funding need and does not include a fully costed solution to net zero, taking into consideration future depreciation in terms of funding not being made available.

SECTION 3:
WHERE DO WE WANT TO BE

DRAFT FOR REVIEW

Connecting our pillars of infrastructure

In order to meet the ICS vision for ***everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer*** our joint forward plan identifies that we need to work differently to delivery quality, timely patient care and **our infrastructure is the key enabler**. Our estate must be smarter, more efficient and support new models of working in order to provide a truly integrated service for our population. This can only be achieved by working in collaboration; we know we can no longer separate our strategic view of physical and digital infrastructure. Our progress in one area will directly impact the other.

Our overarching aims are;

Investing in our estate

Our estate must support effective and integrated service delivery. There has been significant progress on key programmes within Cheshire and Merseyside, including, completion of the National PCN estates Toolkit, investment via The New Hospital Programme, and completion of the One Public Estate: Liverpool City Region Place Plans to create one baseline across the system.

General Practice Estate

The PCN Estates Toolkit programme has provided PCNs with a framework and process for producing General Practice investment plans, with clear priorities that align to wider ICS strategies. We want to provide integrated provision in modern, efficient buildings equipped with the latest technology to support the development and expansion of services. As part of the estates review, we have categorised our estate into core, flex and tail. The classification of 'core' is defined as estate which is flexible, fit for purpose and is integral for service delivery. The accommodation is likely to have level access for all patient facing areas and room sizes that are in accordance with HBN 11 standards, which allows the asset to be capable of supporting modern service delivery. Across Cheshire and Merseyside there is still a reliance on 'tail' estate with 12% of our registered patient population being served by practices which operate out of these properties.

We now have a development pipeline consisting over 300 General Practice projects, seeking approximately £136 million. **Next steps** are to prioritise and start delivery of our pipeline which **should focus on supporting** recovery efforts and minimise service delivery from tail assets where possible without impacting access to services. We will focus **o**n areas **to address health inequalities and where we have significant housing growth, which will result in additional demand for services.**

Moving forward we will incorporate a **bi-annual review of our estate plans,** including developments, investment and disposals, as part of ICS "business as usual" with Place leads and ICS executive team oversight, which should **focus on minimising reliance on "tail" estate and measuring the impact of delivered projects.**

Provider Estate

In addition to our general practice estate, it is critical that we continue to invest in our provider estate, particularly given the current levels of backlog maintenance required to ensure assets are safe and fit for purpose. **Categorisation of all ICS Estate**, including Acute Trusts and community assets, needs to be completed to include a quantified investment pipeline to base wider strategic decisions on.

For our provider infrastructure we will need to consider the number of significant projects and reconfigurations for investment and disinvestment. This will need to be aligned to the core, flex and tail categorisation.

Cheshire and Merseyside ICS has successfully secured investment for two new hospitals as part of the New Hospital Programme, Leighton Hospital and Mossley Hill Hospital.
In addition, funding has been secured via the NHSE RAAC programme to address the RAAC roofing across 5 of our sites.

General Practice Estate Capital Pipeline

This is a high-level overview of the **General Practice** Capital Pipeline, which was the output from the National Toolkit Programme. These projects have not been approved or prioritised yet at place level or approved for funding. Each individual Place are working to develop both a prioritised list for the ICS and PIDs that support these schemes.

The National Toolkit Programme Principles focused on utilising and optimising existing estate before recommending new estate solutions. The costs provided are early stage estimates inclusive of build costs only and exclude land or financing unless specifically stated in the individual output.

Place	Total no of Projects	Estimated Project Costs
Liverpool	89	£30m
Sefton	29	£4m
Knowsley	15	£11m
Halton	22	£6m
St Helens	32	£20m
Warrington	19	£30m
Cheshire East	42	£24m
Cheshire West	34	£5m
Wirral	43	£6m

£136m* Estimated Capital Costs.

325 Projects identified including Digital programme, Utilisation and Optimisation Reviews, Refurbishments and Reconfiguration, Relocations and New Builds.

£7.6m Estimated costs for Digitisation Programme.

£16.3m Estimated costs for Extensions. (Revenue not included).

£85.5m Estimated costs for New Builds (Revenue not included).

£26.5m Estimated costs for Refurbishments and Reconfiguration and Relocations. (Revenue not included).

*based on costed projects only

Trust Capital Pipeline

DRAFT FOR REVIEW

INVESTMENT

NHS England (NHSE) has requested each ICS to provide a 10-year prioritised capital pipeline in a standardised template format. The submitted capital pipeline is to contain estates-related capital projects across all healthcare providers and settings, and the submission will inform the ongoing implementation of the ICS's Infrastructure Strategy. Capital Pipelines were requested from our providers through stakeholder engagement.

The capital required for each project has been profiled over a 10-year period starting from 24/25 and ending in 33/34.

The chart to the right breaks down the capital requirement by type of project as defined by the 'Finance Reporting Category' and year of need.

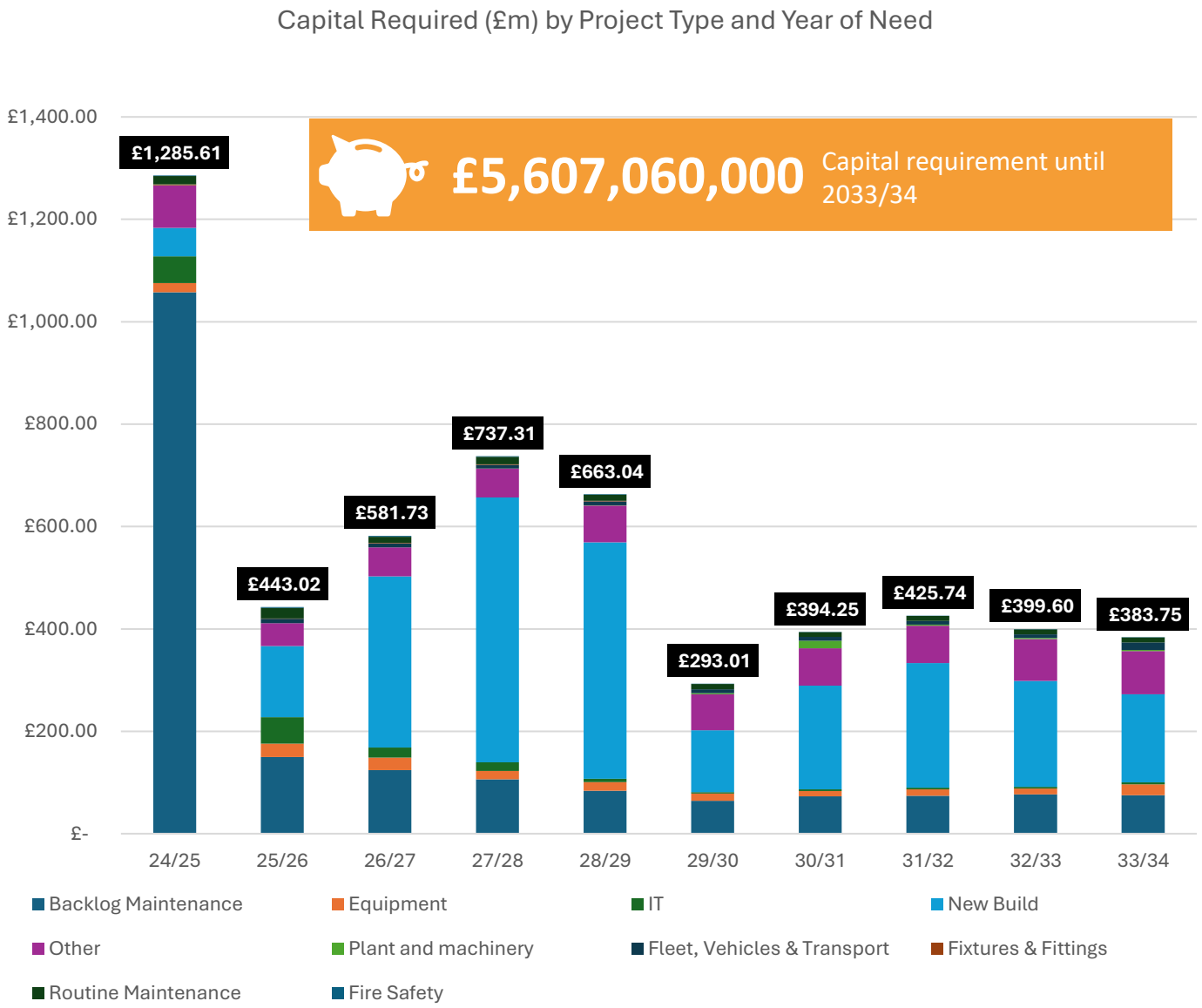
The projects types that have the largest proportions of capital requirement over each year are ''Backlog Maintenance' (Navy blue), 'New Build' (Blue) , and 'Other' (This includes fixture and fittings, routine maintenance and new builds with no funding source available yet) (Purple). Backlog maintenance has a large decrease from year 24/25 to 25/26. This is due to the new hospital programme at Mid Cheshire Hospitals being the largest cost of backlog maintenance within Cheshire and Merseyside.

Backlog Maintenance requirements £1.9b

New Builds requirements £2.5b

Other Projects requirements £0.7b

The relative size of the 24/25 capital requirement is linked to the fact that many Trusts submitted data for the first year only.



Funding Category

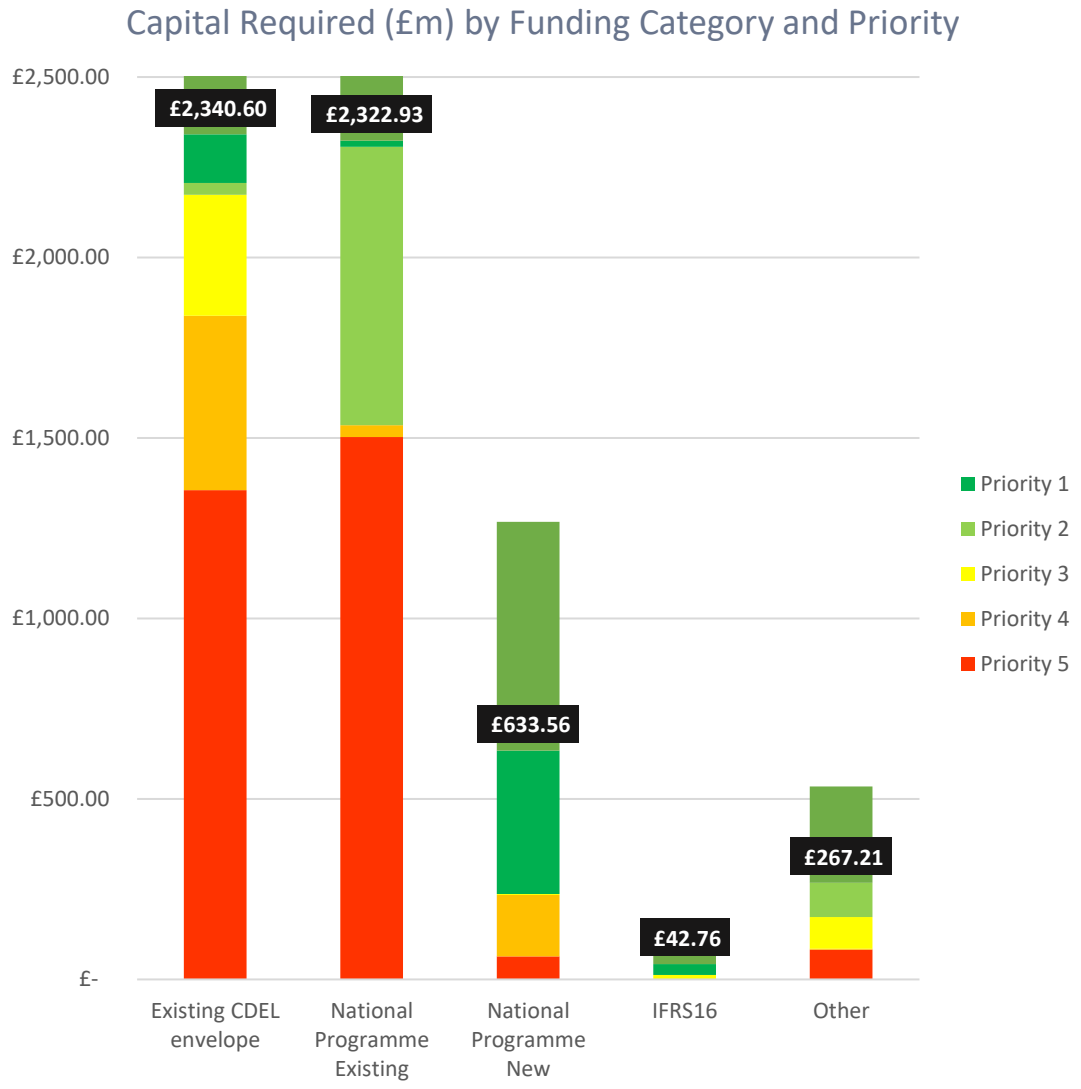
The table below and graph to the right show the breakdown of the 10-year capital required by funding category and priority level. Priority Level 5 is highest, and Priority Level 1 is lowest. A definition of the priority levels is provided in the Appendices.

The funding categories 'National Programme Existing' and 'Existing CDEL envelope' dominate the total capital request, accounting for 42% and 41% of the pipeline respectively. Priority Level 5 accounts for the majority (54%) of the total capital spend requirement. This is because priority level 5 is for critical investment required to meet ICS plan and objectives.

Funding Category	Capital Required (£m) by Priority Level					
	5	4	3	2	1	Total
Existing CDEL envelope	1,354.82	483.82	334.97	32.63	134.35	**2,340.60**
National Programme Existing	1,502.03	33.39	0.00	770.62	16.90	**2,322.93**
National Programme New	63.77	170.20	2.80	0.00	396.79	**633.56**
IFRS16	0.00	0.00	12.38	0.00	30.38	**42.76**
Other	82.16	2.82	87.58	94.65	0.00	**267.21**
Total	**3,002.78**	**690.22**	**437.73**	**897.90**	**578.43**	**5,607.06**

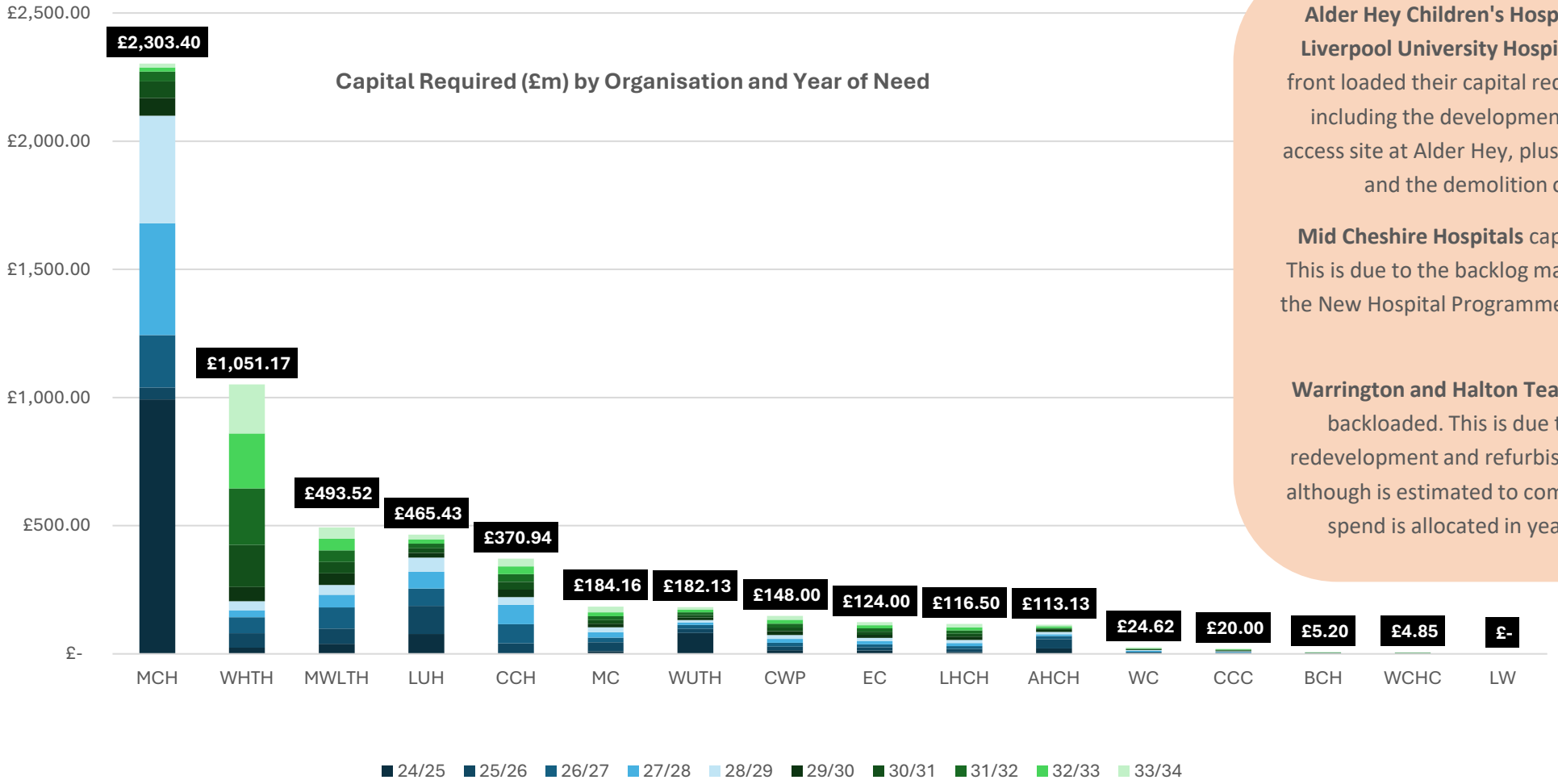
There is a total system ask of Existing CDEL equalling c **£2.3bn** until 2034, this is made up of schemes including backlog maintenance, medical equipment replacement and digital upgrades.

IFRS-16 capital requirements were not gathered during data collection. The figure of £42m reported is significantly under-represented, and only reflects the requirements of one trust who included this data in their submission.



Organisational Breakdown

The largest capital requests have been made from Mid Cheshire Hospitals (MCH) and Warrington and Halton Teaching Hospital, of £2.3bn and £1.1bn respectively. Both Trusts are part of the New Hospital Programme, and MCH has a significant Backlog Maintenance requirement of £0.9bn because of the level of RAAC across the site at Leighton Hospital. The graph shows the yearly breakdown of capital required, where blue is short-term (24/25 to 28/29), and green is long-term (29/30 to 33/34).



Alder Hey Children's Hospital NHS Foundation Trust and **Liverpool University Hospital NHS Foundation Trust** have front loaded their capital request. This is for several projects including the development of a new NICU and same day access site at Alder Hey, plus Ward Refurbishments at Aintree and the demolition of the old Royal Hospital.

Mid Cheshire Hospitals capital request is also frontloaded. This is due to the backlog maintenance capital requested and the New Hospital Programme to eradicate RAAC (priority level 5).

Warrington and Halton Teaching Hospital capital request is backloaded. This is due to the capital request for the redevelopment and refurbishment of the Halton site, which although is estimated to commence in 2026/2027 the largest spend is allocated in years 2031/32 (priority level 2).

Highest Value Capital Pipeline Projects

Our 10 highest value projects (to the value of £3.6bn) are funded via National Programmes, existing CDEL envelope and other funding sources.

The following 5 projects (inflated to 2034) are the highest value provider schemes on the Cheshire and Merseyside ICS Capital Pipeline. Two of these projects do not yet have agreement or an identified funding source (Warrington and Halton Hospitals).

Leighton Hospital	Leighton Hospital	Leighton Hospital	Warrington Hospital	Halton Hospital
Mid Cheshire Hospitals NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust	Mid Cheshire Hospitals NHS Foundation Trust	Warrington and Halton Teaching Hospitals NHS Foundation Trust	Warrington and Halton Teaching Hospitals NHS Foundation Trust
				
Development of the New Hospital Site Part of the New Hospital Programme to replace the current site with a state of the art facility which would transform services for the people of Cheshire.	**Backlog Maintenance to existing site** The majority of Leighton hospital is constructed with RAAC and has now been included on the New Hospital Programme for a total rebuild. The Trust are carrying out substantial failsafe works to keep patients and staff safe on the existing site.	**Developing the new operating model and transformation** The vision for the new Leighton Hospital is for a carbon neutral facility that will play a vital role in the heart of the community and support the delivery of a new clinical model – a blueprint for providing care both in and out of hospital.	**Development of Warrington Hospital** The vision for the redevelopment of Warrington Hospital is still being developed currently. This will focus on either redeveloping the existing site or the development of a town centre site.	**Halton Site Redevelopment** Halton Hospital and Wellbeing Campus is an aspiration of Warrington and Halton Teaching Hospitals NHS Foundation Trust, building on from the work the trust have already done around the Halton Clinical Research Unit, and includes increased Services including PACU
Value: **£1,190.83m**	**Value:** **£877,503m**	**Value:** **£173.93m**	**Value:** **£531.82m**	**Value:** **£238.80m**

Transforming care delivery through the New Hospitals Programme

Mid Cheshire Hospitals NHS Foundation Trust - Leighton Hospital

In 2023 a bid for funding was submitted to the Department of Health and Social Care for the redevelopment of Leighton Hospital in Crewe. The aim was to replace the current ageing hospital with a state-of-the-art facility that would transform the healthcare of the people of Cheshire and the North West of England. Leighton Hospital was built in the 1970s and the type of materials used has resulted in significant spending to resolve safety risks, primarily reinforced concrete planks in the roof and walls (known as RAAC planks). There is RAAC in over 60% of the hospital's site footprint. The vision for the new Leighton is for a carbon neutral facility that will play a vital role at the heart of the community and support the delivery of a new clinical model – a blueprint for providing care both in and out of hospital. A new hospital provides a unique opportunity to transform the experience of both patients and staff, working closely with our many partners. Digital innovation is at the forefront of health services designed to tackle inequalities and meet the needs of a growing and ageing population.

The Trust, which employs nearly 5,000 staff and serves a population of over 300,000, has an ongoing commitment to enhancing its clinical facilities until a new hospital is possible. Continued investment is a key component of the Trust's five-year strategy.

Mersey Care NHS Foundation Trust- Mossley Hill Hospital

The rebuilding of mental health hospitals forms part of the government's commitment to eradicate dormitory accommodation from mental health facilities across the country and put mental health on an equal footing to physical health. This new site paves the way for the end of dormitory wards in the city. The new 80 bed Mossley Hill service will eradicate traditional shared dormitory style mental healthcare wards by providing:

- Single bedrooms with ensuite bathrooms to promote privacy and dignity
- Therapeutic light and airy environments that include activity areas
- Facilities that promote recovery such as family visiting and multi faith spaces
- Access to safe garden areas

The 80 bedded facility will be at the centre of a range of inpatient and community mental health services for Liverpool. The new facility will be completed in 2025.

Optimising the use of our estate

Whilst there is variability across the system, generally our estate is not utilised optimally, with many sites either consistently or inappropriately underutilised (admin services within a clinical room and void spaces). Underutilised estate remains a financial burden on the system, incurring charges such as rent, rates and operating costs. To support better utilisation of assets across Cheshire & Merseyside, **we are working more frequently in an integrated way,** with different service providers sharing space – which is not only driving benefits from an estate's perspective, but also for our patients and staff. Moving forward, we must continue to identify opportunities for integrated service delivery, allowing us to share use of assets and identify opportunities for optimisation and rationalisation. The ICS commit to undertaking a review on the current funding mechanisms and rules around utilisation of space to ensure where this is an opportunity to utilise our assets in a better way, support service delivery and recovery efforts, teams are able to do so.

Developing our Estates Asset Management Plan

Across the ICS we need to develop and embed our processes around asset management. Key actions include:

- At Place we need to build on the **Place Estate Baselines – building on this to categorise the full system estate into Core, Flex and Tail -** ensuring these are kept live and accurate. For each asset we need to determine whether the intention is to 're-use, recycle or receipt' – meaning we either intend to continue using an asset (which may require investment), change how an asset is currently used within the system, or dispose of an asset.
- We must develop a system or **tracking our vacant estate, understand drivers for underuse and work across our SEGs to reduce.**
- Where space is available, we must develop ways of sharing this data across the system. If certain assets are no longer necessary for service delivery, it's imperative to implement a clear disposals policy to efficiently recycle capital or revenue to more beneficial assets.
- Across the ICS we must **develop a robust process for management of leases**, including expiries and breaks, and wider plans for our freehold sites to ensure there is a co-ordinated system response to need and we are not paying for estate which isn't required.
- **Further opportunities around centralising our back-office functions** need to be explored to both drive efficiency and reduce variation across our system. In addition to revenue savings, this will further reduce pressure on the estate. Where this work is carried out it is critical local teams understand the estate impact to avoid an increase in underutilised space. Where admin spaces are still required, we need to consider if the current layout and configuration is still fit for purpose. Post pandemic, where offices are not our sole workspaces**, there is a bigger requirement for 'touch down' areas, pods and meeting space for staff.**

Our Estates Asset Management Plan should be supported by our digital tools and systems, ensuring its sustainability, minimising the work required to keep live and ensuring value for value.

Developing Integrated Community Care & Supporting Regeneration: The Strand Integrated Health and Social Care Hub

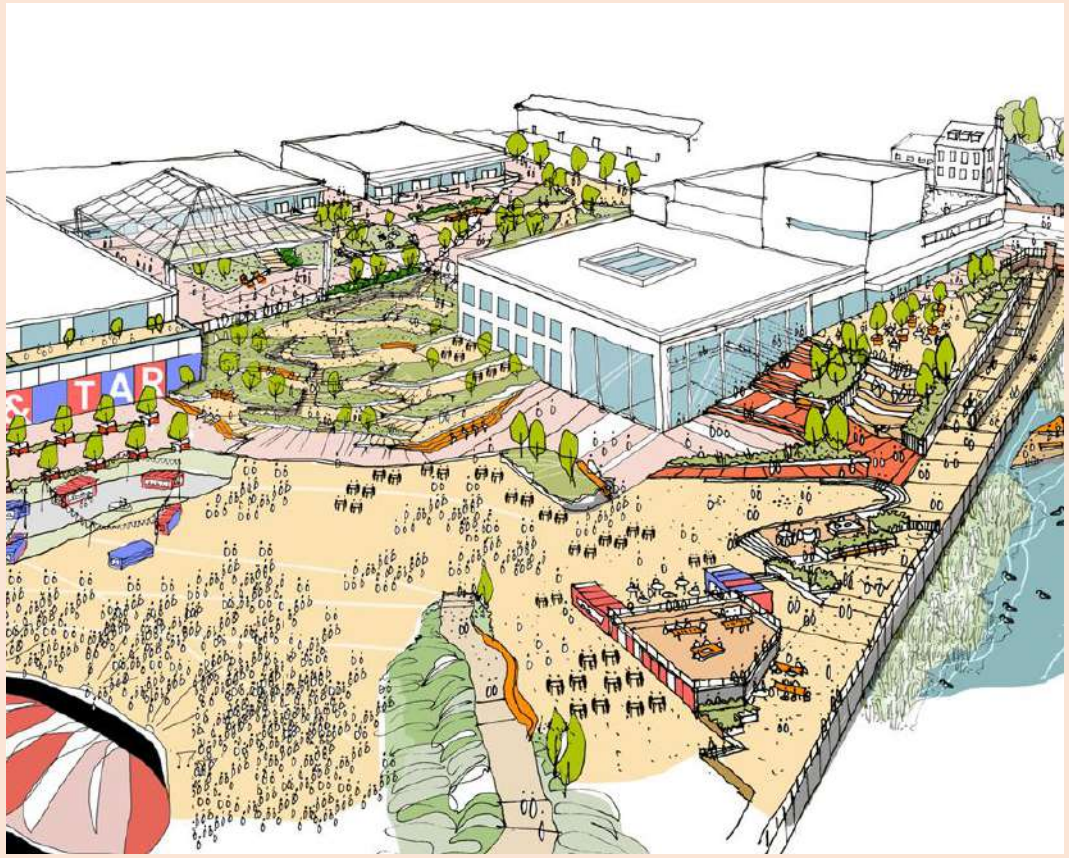


Image: The Strand Redevelopment Programme Visual, over 10 years in 4 phases

Background:

In 2017, Sefton Council purchased Bootle Strand Shopping Centre as a key part of its commitment to regenerate the town centre. The Strand Transformation Programme delivers the vision to see the area transformed over the next 10 years in 4 phases. Improving residents' wellbeing is a key outcome.

The integrated health hub brings together a wide range of health, social care, and well-being services in an integrated setting, improving accessibility for the community through a high street location, as well as increasing footfall.

Sefton Place have been working with health and social care colleagues to ensure the Health and Social care hub is collaborative and responds to the needs of residents, service users and providers, ensuring the services delivered are complimentary to those already operating in the area. The Integrated Health and Social Care Hub is currently at RIBA Stage 1 with RIBA stage 2 commencing in March 2025.

Approach:

The aims of the Health and Social Care hub are:

- To provide modern, flexible, fit for purpose accommodation to provide capacity to meet current and future demand and offer an increased range of services
- Offer flexible space to support collaboration between services, promote opportunities for education and the sharing of best practice to ensure the efficient use of assets
- Provide accessible services within an environment which will provide the best possible patient experience together with supporting digital health solutions
- Procure a cost effective and timely building solution which makes optimal use of NHS resources, Primary Care Estate and Local Authority services which in turn will complement the wider Strand repurposing programme
- Provide a safe, health and sustainable environment that will help deliver NHS and public expectations of net zero carbon targets
- Improve health and wellbeing outcomes within an area of high deprivation

Benefits:

To deliver an Integrated health and social care hub, on the high street, at the heart of Bootle's community where it is much needed. Bootle is one of our most deprived communities, impacted by health inequalities and poor outcomes. By offering primary, secondary, community, VCF and preventive services from The Strand, we could not only address health outcomes but also increase footfall, positively impact the local economy and regeneration of the area.

Driving benefits through collaboration

Our estates teams need to work collaboratively to ensure clinical priorities can be delivered within the available estate and where estate is not required, to develop cost saving opportunities. Closer collaboration between NHS and Local Authorities is needed to improve partnership working and enable us to identify further opportunity for integration.

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There is a need for a comprehensive system-wide approach to estates and capital requirements. This includes developing plans at place level and then extending to the wider system to formulate a cohesive whole-system estates strategy. We need to ensure that there is connection with estates and finances teams to shape use of available capital for strategic projects.

Developing a digital estates management system must be one of our key priorities moving, supporting collaboration between partners and systems. This would support our ambitions around maximising utilisation of assets and show value for money.

*As part of our aim to develop our **Estate Asset Management Programme** and proactive management of the estate, we must now consider opportunities for **greater collaboration from an estates perspective and how estates can further contribute to our cost improvement programme**. Priority collaboration opportunities to explore include:*

- *Pooling of estates workforce where possible to reduce premium bank & agency spend. A system wide workforce plan should be developed in collaboration with partners*
- *Categorisation of the wider public sector estate into Core, Flex and Tail, with all system partners to drive opportunities for optimisation and consolidation*
- *Identification of opportunities for shared physical space to support integration, improve utilisation and consolidate the estate*
- *Review business as usual (BAU) processes across providers to identify opportunities for completing at scale or automating to drive efficiency*

To support our efforts around collaboration we must ensure a robust governance structure is in place to enable effective and transparent reporting as well as reducing duplication of efforts and providing clear lines of accountability. There's a pressing need for greater emphasis on good governance, accompanied by clear processes, defined workstreams, and focused leadership dedicated to managing estates, providing an environment where stakeholders are well-informed, and systems are focused. This will enable well-considered, transparent decisions to be made, driving the efficiency and effectiveness of estate management initiatives.

In Cheshire and Merseyside, we have evidenced that we can work collaboratively across providers to drive benefits for our patients – our provider collaboratives have shown great success. We must now consider an Estates workstream to support our work across clinical pathways.

Accountability for our environmental impact

There is increasing pressure on the NHS to recognise and improve its environmental impact. To do this we need to focus on:

- Short Term quick wins within our current estate e.g. LED lightbulbs
- Investment at scale e.g. heat network
- Changing culture and behaviours e.g. reduction in single use consumables
- Collective Energy purchasing
- Solar Power and access to Electric Charging points
- Reduction of our carbon footprint e.g. use of electric fleet vehicles
- Enhancing sustainable food in hospitals

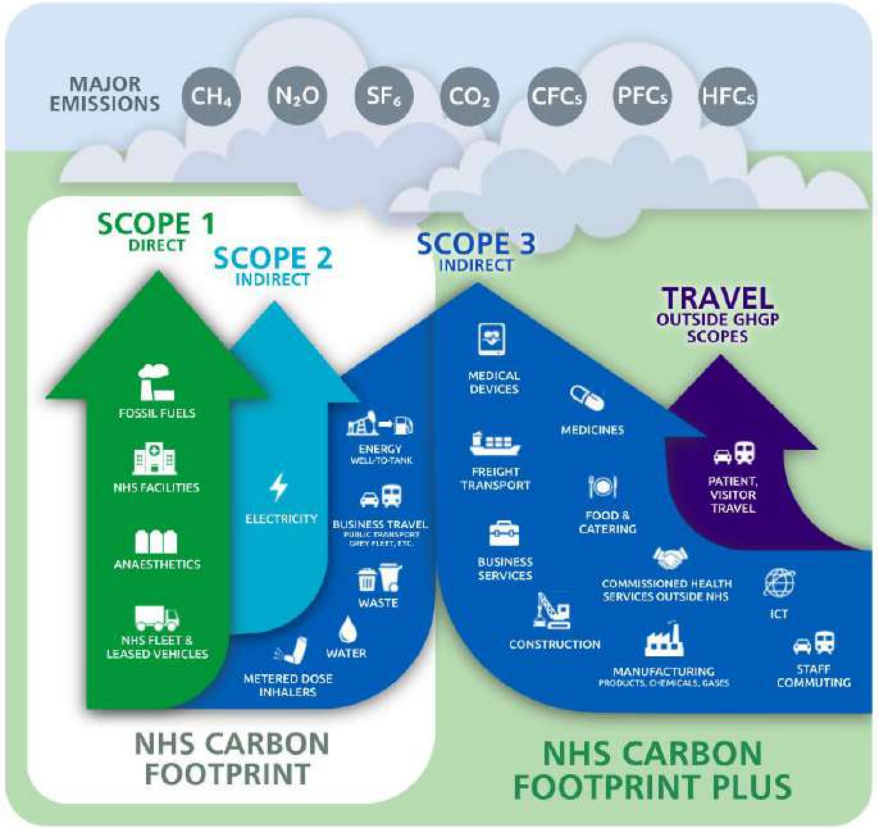
Reducing Carbon Emissions

Electricity, gas, heat/steam & oil are the largest contributor to our NHS Carbon Footprint, with medicines & chemicals being the largest contributor to our NHS Carbon Footprint Plus. It is imperative that our ICS establish system-wide priorities to modernise the current health infrastructure, shift to low-emission smart hospitals, optimise energy consumption, boost data digitisation, collaborate with suppliers to lower their carbon emissions, and achieve energy savings throughout the ICS networks. Our system and its partners must focus on interventions to support national objectives to deliver a net zero NHS.

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The NHS Estates and Facilities Net Zero Carbon Delivery Plan published in November 2021 sets out a clear, sequential four step investment approach to decarbonising NHS sites:

- Making every kWh count: investing in no-regrets energy saving measures
- Preparing buildings for electricity-led heating: upgrading building fabric
- Switching to non-fossil fuel heating: investing in innovative new energy sources
- Increasing on-site renewables: investing in on-site generation



As a system we commit to the following aims:

- Our Estate will be environmentally sustainable
- We will drive maximum value for money and economic benefit for society
- We will optimise the use of Technology for our Estate, making sure our buildings are “Digitally Ready”
- We will focus on decarbonising estates and enhancing sustainable food in hospitals

Maximising the use of our estate through technology

Ensuring adequate digital infrastructure is imperative to ensure use of our assets can be fully optimised. There is the opportunity to use digital across the estate in a number of ways from use of digital platforms to ensure availability of patient records, use of digital systems to measure utilisation to ensure estates optimisation and use of data to analyse the efficiency of the estate, supporting the ICS to achieve its Green Plan. Some examples of the use of digital are summarised below. Alongside **our Estates Asset Management Plan** we must consider the role of digital and how this will enhance our efforts.

Wi-Fi

Strong Wi-Fi is imperative to enable a smooth online operation.

This enables a host of activities to be conducted such as remote working to online consultations.

Wi-Fi also allows the connection of multiple devices to share files more efficiently than over a mobile.

Energy Metrics

Using digital tools can enable energy metrics data to be calculated and stored to provide analysis into energy consumption and the economic costs.

This includes all water, electricity, gas and heat metrics.

Digital Platforms

Digital platforms offer opportunity to digitise health records and incorporate more efficient processes into daily operations.

Digital platforms also allow for activities such as remote working and online consultations but needs to be supported by strong Wi-Fi.

Security

Digital can provide higher levels of security from physical security on site such as CCTV to Zonal Alarms.

In addition, digital security such as firewalls will protect databases or digitalised records.

Utilisation

Digital tools can be utilised to measure the utilisation of both administrative and clinical spaces. This information can support with service planning, and ultimately allow Trusts to optimise the estate, driven by data. This can support achievement of both performance and financial targets.

Waste

Digital tools can incorporate waste by providing data and analysis into how much waste is being produced in a certain area.

This information can help identify if waste can be recycled tying into the Net 2040 target.

Applications

Applications offer opportunity to revolutionise daily processes, for example booking a GP consultation can be done efficiently through a smart phone,, which would eliminate long phone queues for the surgery. Apps can also offer 'self-help' so information and solutions are provided digitally before seeing a GP.

Digital transformation and infrastructure planning

Cheshire & Merseyside ICS are radically transforming how we deliver care to our patients. We have the tools required to identify patients for early intervention and prevention - We now need to consider how we join together digital and estates programmes to ensure these tools are used in the decision-making process around our infrastructure, ensuring any decisions regarding our estate align with our clinical strategy, digital vision and ambitions to reduce health inequalities. **It is critical that we continue to make progress around digital care delivery, whilst still offering 'traditional' access and service delivery options for those who need it as per our digital inclusion strategy.**

Our clinical strategy: Digital first where appropriate and possible, whilst still providing alternative ways to access care for those who needs it

Over the last 10 years, and accelerated during the pandemic, we have been moving towards a 'Digital First' approach. This has included use of online consultation, remote monitoring for example through our virtual ward programme and for Long Term Conditions management, roll out of the C&M SCR, and patient engagement portals (PEPs) including Patient Initiated Follow-up (PIFU). These developments will not only shape the way our patients access and receive care, but they will also radically transform **how and where we deliver our services from**.

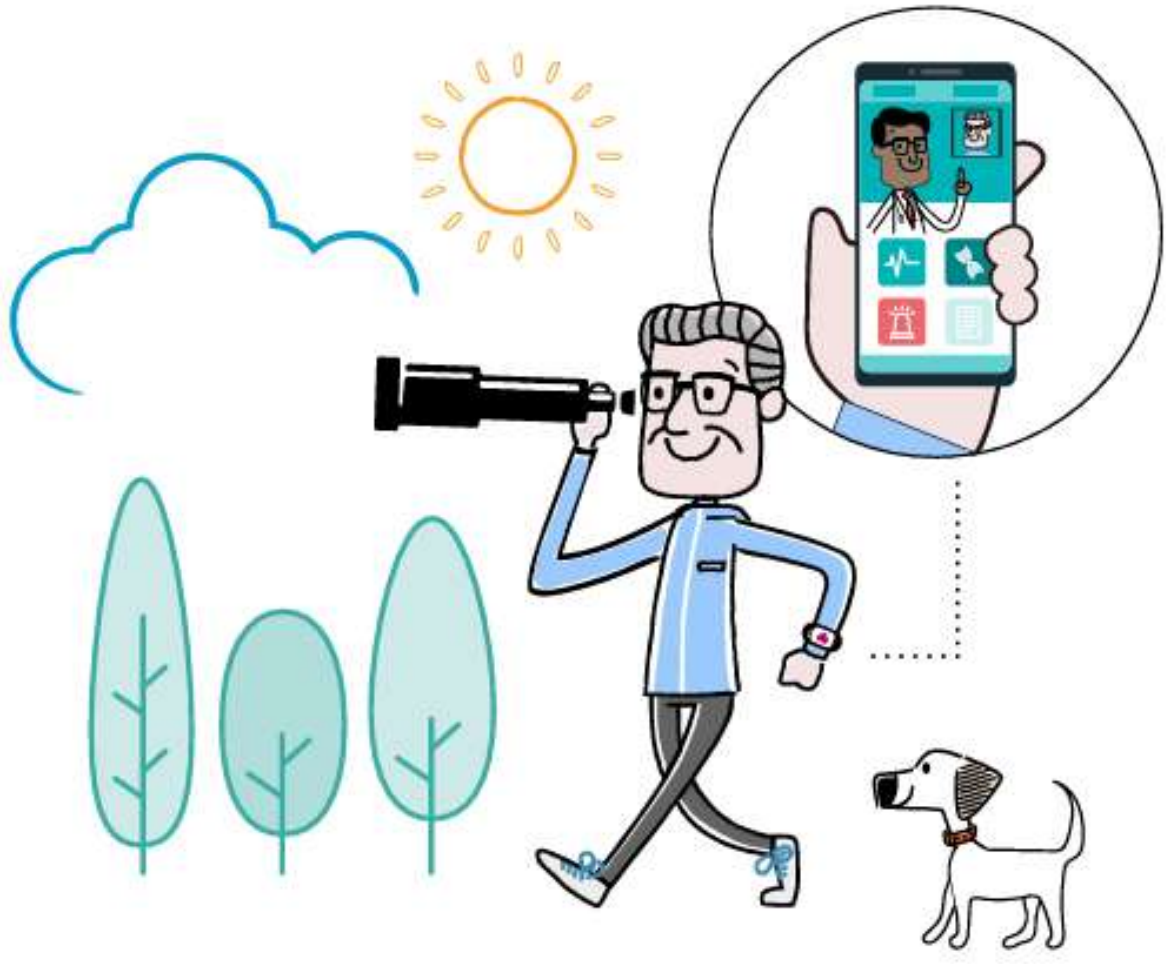
From an infrastructure perspective, we must start to consider and develop **how our estates strategy will adapt to new models of care**, whilst ensuring that those who still wish to access services how they have done previously, can still do so. It is critical that our work in this space does not increase digital exclusion and that our services are accessible and inclusive for all.

Our prevention agenda: Using digital and data to support prevention, early intervention and shape our future estate

We have the tools needed to be responsive and adaptable to the needs of our population. CIPHA and the Data into Action programme will enable us to identify emerging health trends and challenges. We plan to expand the scope of these linked datasets to encompass education, housing and emergency services further enriching the analytical capacity and offering deeper insights into the social determinants of health and how we as a system must respond.

In addition, to develop our research capabilities we are developing a Secure Data Environment to make data available securely. From an infrastructure perspective, we must consider how we can begin to integrate these tools into our decision-making process, **supporting teams to ensure population need and health inequalities are taken into consideration when optimising our estate.**

Digital tools for our patients and staff



Our tools for patients and staff: Supporting patients to stay well and manage their health and ensuring our teams have the systems and access required to their jobs successfully

We want to ensure every member of health and care staff in NHS and Local Authority providers will be equipped with reliable access devices and seamless network infrastructure to facilitate their roles across Cheshire and Merseyside; ensuring that all staff possess core digital and data skills is essential to support increased utilisation of digital tools in their daily work. PublicView has been successfully embedded across all Providers and Service Planners across the ICS. Additionally, a single performance information system has been implemented, allowing all partners to access key data. In addition to this, where staff are working on site, we are able to ensure our estate is equipped with the tools required to provide staff access to our systems.

As part of the **Estates Asset Management Plan** (page 65), we will develop and implement digital tools to support this programme including an Estates Digital Management System.

In summary, as we transform the way we work it is critical we ensure equal access to our services and care. **We must begin to consider the impact new ways of working will have on our estate** so we can begin to plan and adapt for new models of care. As our Strategic Estates Group progress, we must better connect discussions around Clinical and Operational Service Delivery, Digital, Estates and Workforce and begin to develop;

- How will new ways of working and digital care pathways impact our estate; what opportunities are there to ensure our estate is utilised and efficient whilst also ensuring access for those who need it?
- How do we ensure our teams are joined up and our governance enables integrated discussions and decision making, supporting us to quantify the impact new ways of working has across our infrastructure

Building the Estates Workforce for the future: System wide succession plan

As discussed in this strategy, we know that our current EFM workforce is not sustainable; largely due to,

- Almost half of our workforce reaching retirement age in the next 10 years
- Challenges recruiting and retaining individuals into the profession and our organisations
- A reliance on bank and/or contractors across our organisations

Due to the fully qualified trade skill set needed to perform many EFM roles, we must consider options which support recruitment and retention across all grades. Whilst some individual Trusts have apprenticeship programmes in place, it is not consistent.

This presents an opportunity for us to develop a system wide, future proofed, estates workforce plan for Cheshire & Merseyside where we can consider:

- How does our system EFM workforce need to look to support new, integrated ways of working
- How we are currently attracting, training, recruiting and retaining EFM professionals into our organisations
- Our marketing and comms strategy to ensure we are competitive with other sectors, with a focus on both industry hires and school leavers
- Reviewing our current training opportunities to ensure both new hires and colleagues already in our organisations can keep their skills up to date

Development of a system wide succession plan

Marketing & promotion of NHS Cheshire & Merseyside EFM opportunities. We will work as a system to identify opportunities to promote roles in our organisations and the benefits of working in the NHS, attracting all grades of staff

Strategically invest in development and training, developing a system wide skills action plan to ensure our workforce have the skills required for the future across social, technical and digital skills (for example Net Zero Carbon skills and management)

Streamline our recruitment processes, which can be more time consuming for candidates compared to our competitors, particularly for roles at Band 2 which is 70% of our workforce

Make better use our existing expertise and grow skills through **coordinated programmes such as apprenticeships**. Development of a C&M EFM apprenticeship programme will help us to attract talent that has historically not joined our EFM community, removing recruitment barriers and improving our engagement with people from diverse backgrounds and under the age of 25

Estates and Facilities Management Workforce Action Plan

In June 2022 NHS England published their **first Estates and Facilities Management Workforce Action Plan**. The EFM Workforce Action Plan builds upon 'The NHS People Plan' Key Themes, links them with EFM priorities and lists actions. Commitment has been made locally by providers to embed the key themes across Cheshire and Merseyside estates and facilities workforce.

People plan themes	EFM Priorities	Actions
Looking after our people	Improve the health and wellbeing of our people.	• Boost wellbeing and improve the work environment
Belonging in the NHS	Embed equality, diversity and inclusion	• Make NHS EFM an inclusive place to work • Create new career pathways
New ways of working and delivering care	Develop our people	• Future proof our skills • Embed data-driven decision making • Develop our mangers
Growing the future	Build the next generation of EFM people	• Recruit the best talent • Be the UK's EFM employer of choice • Invest in what matters to our people

Our partner workforce commitments

CWP have funding for two trade staff apprentice positions: Plumber and Electrician. This is the start of our programme of work to increase the number of apprentice positions across Cheshire & Merseyside.

In LUHFT' sustainability strategy they have committed to growing for the future and establishing an integrated approach to grow their organisation in a smart, sustainable way. This includes focusing on local recruitment, addressing gaps in their workforce and providing career development to staff.

In 'Going Greener' Countess of Chester Hospital Green Plan they have committed to ensuring all their plans allow them to develop a sustainable workforce long term.

Building the Estates Workforce for the future: Apprenticeship Scheme

By utilising the apprenticeship system, we can build a sustainable pipeline of skilled trade staff, reducing the risks associated with high turnover, an aging workforce, and recruitment challenges. This approach not only addresses staffing needs but also alleviates financial pressures by gradually reducing dependency on external contractors. Key next steps to mobilise our apprenticeship plan include:

- Skills gap analysis: Conducting a skills gap analysis to determine the specific trades and skills most at risk due to retirements and turnover, supporting us to prioritise areas for recruitment and training
- Partnership development and programme design: Our scheme should be co-developed across the system, offering apprentices the opportunity to rotate across organisations creating a well-rounded and varied learning opportunity, whilst also ensuring all providers benefit from the scheme
- Performance monitoring and impact assessment: Measuring the impact of the program on staff turnover, reliance on contractors, and overall departmental performance provides data to refine and improve future iterations, ensuring the programmes long-term success

Long Term Planning
Proactive workforce planning:
By developing a strategic workforce plan, the system can anticipate retirements and align the training of apprentices to ensure smooth transitions, minimising disruptions and maintaining a stable workforce. **By 2028, we aim to have a minimum of 5% of the estates and facilities workforce on an apprenticeship programme annually**
Future ready pipeline: Establishing a pipeline of apprentices ensures a continuous flow of trained individuals ready to step into roles as current staff retire, preventing gaps in skilled labour.

Enhanced Apprenticeship Programs
Flexible Training Programs:
Partnering with local trade schools and vocational programs to create tailored apprenticeship programs guarantees that training meets the specific technical and practical needs of our EFM teams, leading to a more competent workforce.
Exploring different entry routes: We need to explore and offer multiple entry routes into the profession, from school leavers and graduates to industry professionals. We will actively engage in widening **participation/local employment schemes** including Project Search or the supported internship scheme.

Mentorship and Knowledge Transfer
Effective Mentorship:
Pairing apprentices with experienced tradespeople who are nearing retirement facilitates mentorship and knowledge transfer, preserving critical expertise within the sector.
Incentivised Expertise Sharing:
We will develop a formal mentorship program that incentivises senior staff to share their expertise and encourages experienced employees to invest in the development of apprentices, enriching the learning experience.

Retention and Development Initiatives
Career Growth Opportunities:
Offering career development opportunities and clear progression paths helps retain apprentices within the department post-qualification, reducing turnover and fostering a loyal workforce.
Competitive Compensation:
We will review RRP across the patch to understand options around compensation and benefits which will drive down spend on contractors.
Rotational Posts: We will commit to developing an ICS-level estates and facilities apprenticeships with rotation across organisations, sharing the benefits of the programme amongst providers.

SECTION 4:
HOW WILL WE GET THERE

How will we get there: Overview

Significant opportunity exists within our physical, digital and workforce infrastructure to drive opportunities for change and support our ambitions. Cheshire and Merseyside are evidencing this through our work to create new delivery models which address the backlog of care, enhance quality and reduce pressure on physical assets. It is critical that on the next step of the journey these workstreams are connected to ensure our infrastructure supports future ways of working and drives maximum value.

Our enablers will be crucial to our success;

LEADERSHIP & GOVERNANCE

Through strong Leadership and a clear system wide governance framework we will be able to make key decisions and provide links across our infrastructure, improving collaboration and efficiencies across our infrastructure pillars – working in a more integrated way

COLLABORATION & PARTNERSHIPS

Strengthening our System wide collaboration and partnership working will provide enhanced opportunities to improve access and the quality of health and care across Cheshire and Merseyside

INVESTMENT

We must continue to invest across our system infrastructure through a prioritised, systematic capital pipeline of projects using a one-public sector collaborative approach. This will ensure our highest priority areas are supported, providing services where our communities need them and supporting our health inequality and prevention agenda

DATA AND EVIDENCE

Continued development in our digital tools, systems and processes, as well as research and innovations, enabling us to have the capability and capacity to ensure a data driven approach to everything we do

Leadership & Governance

As an ICS we need strong leadership supported by robust governance processes to be able to make key decisions and provide the links across our infrastructure.
By doing so we can ensure that:

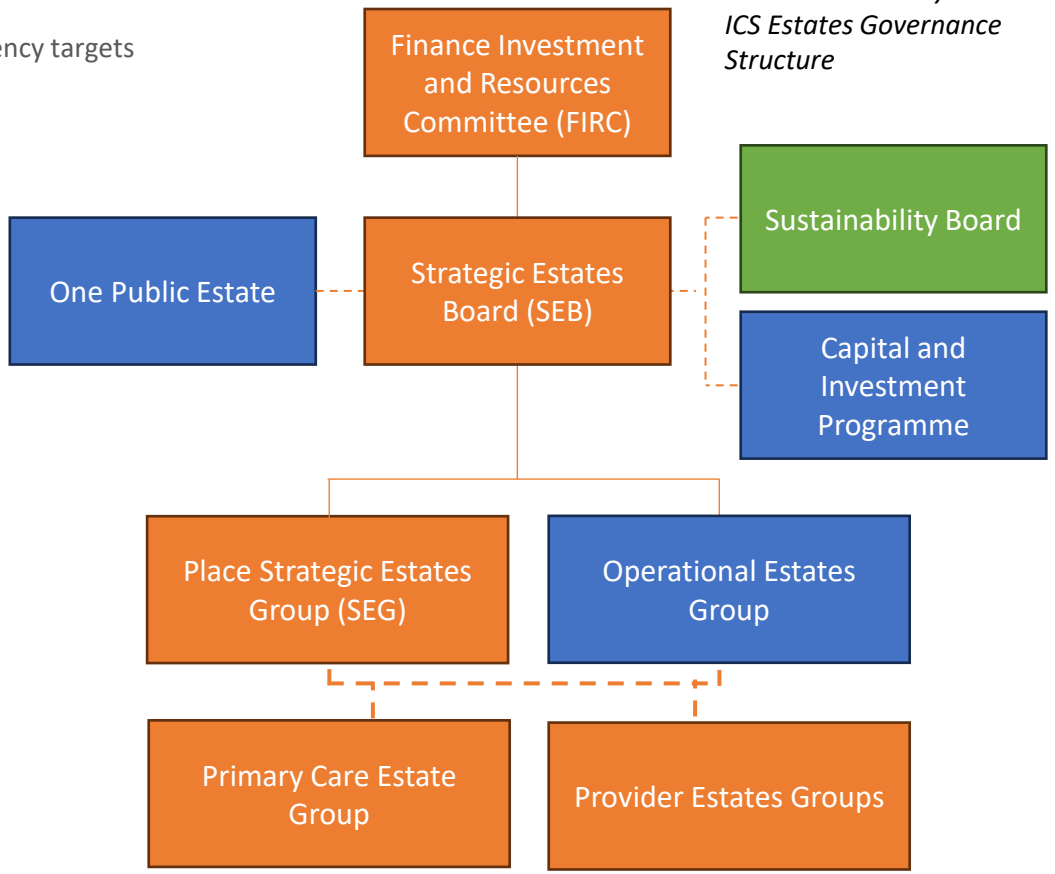
- We have a robust process for annual **capital prioritisation -** ensuring how we invest is targeted, evidence based and drives maximum benefits for our communities
- We are **proactive** in our approach to securing capital for estate investment - ensuring we are on the 'front foot' and don't miss opportunities
- We can identify **cross system opportunities for cost improvement**
- We have accountability and transparency against our key performance indicators, much as Net Zero and efficiency targets
- By having system wide collaboration, we will create a more effective, high performing estate

Our governance framework and structure will need to be centred around the issues that matter most to our population, through collective responsibility and effective partnership working with our places and providers. This approach will help us demonstrate value for money, manage risks, and ensure that any of our major developments are evidence-based and overseen effectively.

Importantly, the governance process need to avoid adding layers of complexity to our already intricate system. Having an inclusive approach ensures that diverse perspectives are integrated into our strategic planning and decision-making.

Our proposed governance structure, which sees estates reporting into our Finance Investment & Resources Committee, is shown to the right. Our teams have worked hard to re-establish the Strategic Estates Groups at Place level over the last 18 months, and many of these are now functioning with great success and collective membership across NHS, Local Authorities and other system partners. The Strategic Estates Board, which will ensure our SEGs are operating consistently and effectively is being re-established and will report directly into FIRC, providing clear accountability and ensuring delivery against our key priorities. It is critical that estates has dedicated, named support from both an SRO and delivery lead, at Place and system level.
Once this structure is established, we must broaden our focus to enable key representatives across Estates, Digital and Workforce to connect – ensuring that programmes and priorities are aligned. We can begin to understand and articulate how our developments across each pillar of infrastructure impact one another and quantify the benefits. There is significant opportunity to drive benefits for patients and staff, as well as ensuring our system is efficient.

Cheshire & Merseyside ICS Estates Governance Structure



Strengthening our collaborations and partnerships

To reduce inequalities, close the gap in disparities in access and improve the outcomes for health and care, we must collaborate, co-create and co-produce solutions for the design, development and delivery of local services. Across Cheshire & Merseyside, we have evidenced the **power of partnerships** through our provider collaboratives, from reducing waiting times for patients to driving efficiency in the way we work through automation and reducing variation. Moving forward, the Cheshire & Merseyside Acute & Specialist Trust (CMAST) Provider Collaborative will continue their programme of work, focusing on efficiencies at scale, clinical pathways and diagnostics, with objectives aligned to our ICS ambitions, shown below.

Now we have established and evidenced the benefit of our providers working in partnership, we must begin to broaden our focus to harness additional benefits for our patients, staff and communities – and as with all our transformation programmes, start to consider the impact this will have on how and where we work:

- Continue to Broaden our partnerships beyond the NHS to include Local Authority, thereby sharing learning, knowledge, and expertise - Growing the approach the SEGs are already taking across Cheshire & Merseyside
- Better integration and co-ordination of holistic services to support population need and drive our prevention agenda – this needs to go beyond collaboration with NHS teams and include Local Authority, VCSE and other partners
- Understanding and working with communities at place level, including Healthwatch and other partners, is essential - Using these groups well-established methods for engaging with people and communities. We need to build on these strengths and assets, recognising their vital role in creating and delivering solutions to local challenges
- Futureproofing the workforce and supporting local workforce development by regularly presenting to students and young people the wide variety of roles within the NHS, encouraging them to choose the NHS as an employer. We are working with the Department of Work and Pensions (DWP), Job Centre Plus, Prince's Trust, and the Westminster Foundation to offer pre-employability programs aimed at securing Kickstart roles, work placements, and internships that link into bank work opportunities
- Making best use of limited financial resources – our Efficiencies at Scale programme has made great progress. We now need to build on the identified estates opportunities to ensure we are working efficiently and reducing running costs
- Expanding and developing our current collaboration programmes (Clinical Pathways Programme, Diagnostics Programme, Efficiencies at Scale Programme) and the workstreams delivered through our provider collaboratives

Investment across our infrastructure

We recognise the need for significant capital investment in our infrastructure and the crucial role of NHS capital in achieving our goals. However, this requires a rethink of our capital and strategic investment planning. Using our capital pipeline and building on the Primary Care National Toolkit Programme, we need to adopt a system-wide prioritisation approach to plan collaboratively across the system – maximising the use of NHS capital. **This will ensure our investment requirements are targeted, supporting our areas of greatest need as well as the long-term sustainability of our healthcare infrastructure.**

There are 3 key elements to securing future investment for our infrastructure:

Strategic Planning

- To effectively manage our infrastructure and investment needs, we have established a capital pipeline for investment. **This baseline will be regularly monitored and updated through our governance processes to ensure ongoing prioritisation of initiatives extending over the next 10 years.**
- Building on the National Toolkit Programme, **we will Identify and map system-wide core, flex, and tail estate and establish agreed principles for investment.**
- In preparation for delivering our prioritised projects, **we will establish clear delivery structures and governance to ensure successful project implementation and foster collaborative partnerships with local authorities and health partners to secure alignment and maximise our efforts.**
- **We will Identify revenue opportunities through reducing property voids, Maximise the utilisation of existing assets and pursue strategic disinvestment.**

Sources of Funding

- Opportunities for securing estate funding include, Local Authority Funding, GP Investment, Landlord Funding through NHS Property Companies, Rentalised Capital Investment, Funding through Section 106 and the Community Infrastructure Levy (S106/CIL)
- Our focus must be on **enhancing our processes to effectively prepare for and secure the most appropriate funding sources**.
- This involves:
    - identifying and leveraging these diverse funding streams to support our infrastructure and strategic investment needs.
    - Ensuring we can meet our long-term objectives and deliver optimal outcomes for our population.

Skills and Resources

- Investment in our **people enables us to retain staff as well as giving us the ability to grow our workforce.**
- Our response to the EFM Workforce Plan (pages 71-73) has started to articulate how we will secure the future workforce. We now need to further develop and refine this plan to articulate resource requirements and timescales for delivery.

Data & Evidence

Across Cheshire & Merseyside we are proud of our developments in the digital space, providing us with the tools and capability to ensure a data driven approach to everything we do. It is a key priority for us to continue developing our systems and processes to support effective service planning and prioritisation. By doing this we can, where possible, target interventions at the earliest possible opportunity, work towards our prevention agenda, reduce attendance and admission, and reduce health inequalities across our communities.

To enable us to do this we will continue to work on the following key programmes:

- **Combined Intelligence for Population Health Action Platform (CIPHA)** - Focused on improving Population Health and Healthcare across our whole system through the transfer of core health and care information between providers using a single health and care data architecture to facilitate a comprehensive understanding of individuals' health needs and enables tailored interventions – we must begin to consider where we can include this in our infrastructure planning processes ensuring our patients are at the heart of decision making
- **Estates Asset Management Programme** - In addition to our system wide business intelligence tools, we will continue to develop our infrastructure tools, ensuring a proactive approach to our estate and asset management and improving our strategic intelligence function. From an infrastructure perspective, we need to articulate the role of digital in how we **track our vacant estate and understand drivers for underuse and proactively manage leases.**

Whilst we are working to bring system partners together, we must ensure our digital infrastructure is able to do the same, working across boundaries to minimise duplication and ensure the best use our assets.
We can use property data in a more connected way to develop potential opportunities for innovation across neighbourhood, system or place, exploring greater use of the Department of Health and Social Care's SHAPE tool.

Our key next steps to ensure we are using data and digital tools to support how we manage our estate include:

Supporting our annual **capital prioritisation process -** ensuring how we invest is targeted, evidence based and drives maximum benefits for our communities. We will explore opportunities for automation to make the process more time and cost effective, ensuring we can respond to opportunities.

Following on from the categorisation of our estate into Core, Flex and Tail, develop digital tools and processes to proactively manage assets, ensuring we are managing leases effectively and operating out of the footprint required from the right locations to support our communities.

Forecast what our estate needs to look like in the future – planning today for future service delivery.

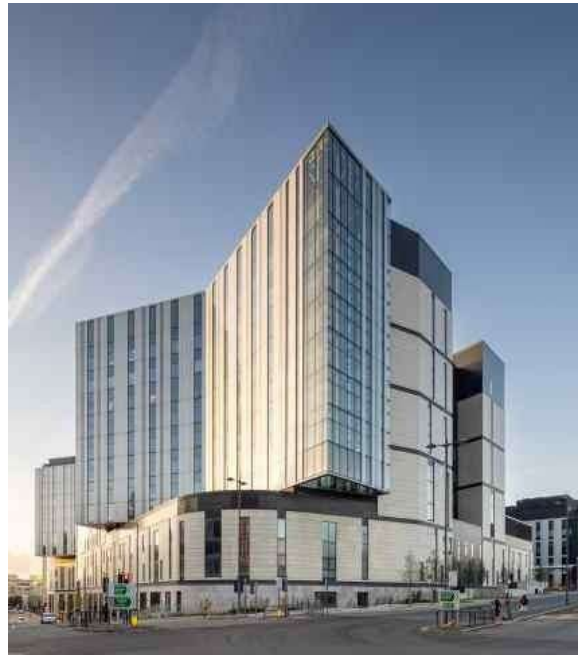
Identify potential cost improvement initiatives by reviewing opportunities for process automation as well as using digital tools to make business as usual processes more efficient.

How do we get there: Recommendations

Across Cheshire & Merseyside we are working to achieve our aim for ***everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.*** This aim underpins everything we do across our providers, and we are working across the system on an exciting programme of transformation to both drive quality and timely access to services for our patients, whilst also ensuring we deliver maximum value for money.

Throughout this strategy we have considered how our transformation programme can impact our physical infrastructure and also present opportunities to think and work differently. For us to continue planning and designing the estate of the future, which will enable new ways of working, the following key next steps are recommended:

GOVERNANCE: **A full system governance review should be undertaken** to ensure discussions impacting our infrastructure have estates representation or are reported back via existing estates forums, such as the Strategic Estates Groups. In addition, we must ensure our estates forums ultimately report back into the ICB via the Strategic Estates Board, ensuring effective comms, lines of accountability and transparency.



PRIORTISATION: We are ambitious as a system, driven by providing the best possible services and experience for our patients. It is critical that we effectively prioritise our schemes to ensure we are taking forward those which drive the most benefit and enable us to work towards our aim and objectives**. A consistent methodology for capital prioritisation will be signed off by the ICB** and shared via our Strategic Estates Groups along with guidance on approvals and governance process.

DEVELOPMENT OF OUR ESTATES ASSET MANAGEMENT PLAN: Our Strategic Estates Groups need to continue developing an accurate estates baseline across Place and partners, a process for tracking our vacant estate and leases, categorise the full estate into core, flex and Tail, and develop a Place Asset Management Plan. This should build on the Core, Flex and Tail categorisation and include plans for any potential disposals (reuse, recycle, receipt).

DIGITAL: Our work in the digital space is changing the way we deliver care, and with that driving benefits for patients and staff. We must now begin to consider where we can utilise these tools, such as CIPHA, in other parts of the system to support decision making, ensuring the data we use is consistent. Digital will be a key enabler in the development of our Estates Asset Management Plan.

DEVELOPMENT OF OUR SYSTEM WIDE ESTATES WORKFORCE PLAN: Our Estates workforce Plan and ambitions are articulated on pages 71-73. We must bring our Estates leaders together to develop this plan and focus on succession planning to ensure a workforce fit for the future.

COLLABORATION: We must continue to collaborate across our system, learning from our provider collaboratives and adopting their approach in the identification of opportunity and efficiencies. Our implementation and delivery plan must include partners across Local Authority, VCSE and the wider public sector.

High Level Estates Implementation Plan

The key next steps and actions described throughout this document are captured below and will be developed into a full implementation and delivery plan to support NHS Cheshire and Merseyside ICS to work towards our vision.

	Key actions
Governance	• System wide estates governance to be launched with clarity around roles, function, link into Place, reporting & accountability – to include the relaunch of the Strategic Estates Board (SEB). We must understand how workstreams across estates, digital and workforce are connected so opportunities and co-dependencies are identified and discussed • The vision and objectives for estates needs to be agreed in the SEB and shared with SEGs, agreeing short-, medium- and long-term priorities to ensure the accountability and delivery of objectives at both Place and system level
Operational Estates	• Improved baseline data of our community estate to be gathered and understanding of the estate utilisation through digital technologies such as the installation of room sensors • Design and implementation of BAU processes to drive proactive asset management including lease management, grant and funding applications (e.g. s106/CIL) • Develop system wide principles for the management of void / bookable space to ensure our buildings are utilised and provide value for money • Identify opportunities for Digital / touchdown space for staff
Strategic Estates	• Core, flex and tail categorisation to be completed at Place level across all provider and local authority estate • Tail estate categorisation and disposal opportunities to be signed off at Place and SEB • Building on the estate classification work, develop our Estate Asset Management Plan with place and wider system colleagues: to include a clear strategic direction and level of priority for each asset (reuse, repurpose, receipt) ensuring optimisation and integration of the right estate across each place • Develop system wide plan for the NHSE sustainability indicators to achieve the carbon net zero targets • Review where existing digital tools can be used to complement and enhance estates processes, for example using CIPHA to support decision making
Estates Workforce	• Estates workforce strategy and succession plan to be developed looking at how the role of apprenticeships can be further developed across C&M estates • Identify opportunities for pooling of resource across Providers to reduced bank and agency spend • Review of recruitment and retention policy • Estates workforce marketing campaign to be discussed as part of SEB
Finance	• Consistent methodology for capital prioritisation to be developed and agreed – with a critical plan for backlog maintenance developed • Prioritisation of full system capital pipeline to be reviewed using agreed methodology • Delivery of prioritised projects • Estates Cost Improvement Programme to launch via the SEB and Strategic Estates Groups
Collaboration	• Whilst this strategy is primarily focussed on our health estate, work with Local Authority, VCSE and system partners must continue to identify opportunities for integration and collaboration – this will drive benefits not only for our patients, communities and staff, but also ensure we are working as efficiently as possible, operating only across the footprint we need, delivering services where they are required for our communities and supporting our work to reduce running costs where possible by taking a proactive approach

Appendices

Appendix 1: Housing Development breakdown

North Mersey:

Sefton

- **Land East of Maghull:** The new **housing development in Maghull** is set to deliver 408 new homes in Maghull. This is part of a larger scale development called the Land East of Maghull which looks to create a minimum of 1,400 dwellings.
- **Brackenway, Formby:** Development at Brackenway, Formby will feature 270 new homes.
- **Kenyon's Lane, Lydiate:** Plans have been implemented for 291 homes between Liverpool Road and Kenyon's Lane in the village north of Maghull.
- **Summerhill Park, East Maghull:** The Summerhill Park development will provide 433 homes, which forms part of a wider new community being built to the east of Maghull.
- **Land North of Lydiate Lane, Thornton:** Outline Permission (June 2022) has been granted to build 268 homes to be built on greenfield land.

Knowsley

- **Cherryfield Drive Kirkby:** 730 new homes close to Kirkby town centre.
- **East Halewood Masterplan:** The council has signed off on a 'masterplan' to build 1,500 homes across 200 acres between Halewood and Everton FC's Finch Farm training ground.
- **Elowen Garden Village:** A 208-home scheme in Whiston along with a three-unit industrial development off Ormskirk Road has been approved.
- **Halsnead Garden Village:** The Halsnead Garden Village development will create 350 homes.

Liverpool

- **Stonebridge Cross, Croxteth:** A 1,200 dwellings scheme, which will be directly managed by the council once completed.
- **Knowledge Quarter, Kensington-** A residential funded scheme of over 700 dwellings.
- **Liverpool Waters, City Centre (Including Kings and Central Dock):** The development is planned to create at least 17,000 full-time jobs and 21m sq ft of new commercial and residential floor space including 23,000 apartments.
- **Festival Gardens, Otterspool: Festival Gardens,** The overall plan is to create 22-acres of remediated land with access roads and other infrastructure for residential development of up to 1,500 homes,, with an overall completion date of August 2031.

Warrington

- **Peel Hall: A** development of up to 1,200 new homes and community facilities including a local centre, a new primary school, a care home and shops.
- **Waterfront: A** development of 1,335 new homes, a primary school, a health centre, a local centre and mixed community facilities.
- **Fiddlers Ferry:** A development of 1,800 homes, including supported and extra care housing. 101ha of employment land, a primary school, local shops and community facilities. There is also a contribution of land for a potential GP branch surgery.
- **Southeast Urban Extension:** A development of 2,400 new homes and 137 hectares of employment land for distribution, logistics, industrial and ancillary offices.
- **Omega Development: A** development of 1,400 new homes. It is proposed there will be a new health facility to serve a population of circa 6,000. A S106 contribution of £250,000 on completion of housing.

Halton

- **Hale Gate Road, Widnes:** Harworth has submitted a application for permission of up to 500 homes and 100 later living homes.
- **Mill Green Farm, Widnes:** Redrow has submitted plans for two projects.
- **Lunts Heath Road, Widnes:** An application has been submitted for 317 homes off Lunts Heath Road.
- **Daresbury Garden Village:** Planning permission has been granted for 335 homes, which forms part of the Daresbury Garden Village masterplan, which will oversee a possible 1,100 homes built over a 10 year period.
- **Chapel Lane, Widnes: Early** stage proposals include the construction of 350 homes, together with open green spaces and walking/cycling routes, on land between Chapel Lane and Queensbury Way, north of Widnes.

St Helens

- **Moss Nook, St Helens:** This project will create 258 new homes that will be built on former industrial land.
- Former Pilkington Glass site - Cowley Hill Development: Plans have been submitted to build 1,250 homes.
- **Anderton Green, St Helens:** Anderton Green is a brand new community of 258 high quality homes consisting of two, three and four-bedroom homes. The new homes are part of a wider development, which will feature up to 900 new homes, open space and sports pitches, whilst ensuring connectivity is provided to the local area and into St Helens town centre.
- **Linkway Distribution Park:** Bloor Homes has had approval for 288 market homes and 6 designated as affordable.
- **Ibstock Brickworks, St Helens:** A planning application has been submitted for 232 new build homes on the ex-factory site.

Appendix 1: Housing Development breakdown cont.

Wirral

- **Seacombe River Corridor-** The Seacombe River Corridor, It will provide for approximately 340 new dwellings .
- **Scotts Quay:** The Scott's Quay Regeneration Area will provide for approximately 700 new dwellings. Birkenhead Waterfront :The Birkenhead Waterfront will be developed as a residential led mixed use will provide for approximately 630 new dwellings.
- **Central Birkenhead :**The Local Plan allocates three main housing sites within the Central Birkenhead Regeneration Area which will deliver up to 450 new dwellings. It is anticipated that an additional 1,000 new dwellings will also be delivered during the Plan period within the Regeneration Area.
- **Hind Street and St Werburgh's Regeneration Area** The Regeneration Area will provide for approximately 1,640 new dwellings.

Cheshire East

- **Garden Village-**This development will include 1,500 new high-quality design homes and extensive 'green infrastructure'.
- **Bloor Homes-**Cheshire East council approved the first phase of a 3-phase plan to create 300 homes. The development of 154 new homes will make up the first phase of development at Viking Way.

Cheshire West

- **Chester-**The Local Plan (Part One) sets out a requirement of at least 5,200 dwellings, developed through the strategic site at Wrexham Road
- **Northwich**, located east of Cheshire West and Chester, will have room for 4,300 additional homes. This will be accomplished through the development of the Winnington urban village, as well as a variety of existing planning approvals.
- **Ellesmere Port** The Local Plan calls for at least 4,800 new houses to be built.
- **Winsford-**Winsford is one of the borough's four main towns, located in the west of the district. A minimum of 3,500 additional homes are required.

Appendix 2: Capital Pipeline prioritisation matrix

Priority Matrix from NHS Cheshire and Merseyside Capital Pipeline

Priority Level

5	4	3	2	1
Critical investment required to meet ICS strategy, Plan and objectives.	Major investment required to meet ICS strategy, Plan and objectives.	Moderate investment required to meet ICS strategy, Plan and objectives.	Minor investment required to meet ICS strategy, Plan and objectives.	Minimal investment required to meet ICS strategy, Plan and objectives.

Priority Categories and Definitions

Strategic Priority: Investments that align with the long-term strategic objectives of the organisation.

Financial Priority: Investments that focus on maximising financial returns.

Risk Priority: Investments that prioritise risk mitigation and management.

Operation Priority: Investments that aim to improve operational efficiency, productivity, and effectiveness.

Environmental Priority: Investments that focus on sustainability, environmental responsibility, and social impact.

Appendix 3: NHSPS Void/Vacant Data Action Plan for Each Place

Place	Property Name	Action Plan	Unit Area (Demised)
Cheshire East	Alsager Health Centre	No changes able to be achieved - storage.	9.96
Cheshire East	Ashfields Primary Care Centre	Action Plan in progress. Expected 25/26	72.99
Cheshire East	Eagle Bridge Health & Wellbeing Centre	Action Plan to be created to review optimisation	23.72
Cheshire East	Firdale Medical Centre	Action Plan in progress. Expected end 24/25	115.25
Cheshire East	Weston Clinic	Action Plan to be created to review optimisation	12.38
Cheshire West	Fernlea (Chagford)	Disposed - awaiting completion	154.75
Cheshire West	1829 Building Countess of Chester Health Park	Action Plan to be created to review optimisation	163.47
Cheshire West	1829 Building Countess of Chester Health Park	Action Plan to be created to review optimisation	317.92
Cheshire West	Part Car Park Wharton PCC	Car Park - N/A	1
Cheshire West	Princeway Health Centre - Land	Land - N/A	1
Cheshire West	Stanney Lane Clinic	Disposal in Progress	267.78
Cheshire West	St Martin Clinic	Disposal in Progress	396.16
Cheshire West	Tarvin Health Centre	Action Plan to be created to review options	25.4
Cheshire West	Wharton Primary Healthcare Centre	Action Plan to be created to review optimisation	60.09
Cheshire West	Wharton Primary Healthcare Centre	Action Plan to be created to review optimisation	10.27
Cheshire West	St Cyrils Countess of Chester Health Park	Land - N/A	1
Knowsley	Prescot Primary Care Resource Centre	Action Plan to be created to review optimisation	81.21
Liverpool	Abercromby Health Centre	Action Plan to be created to review optimisation	6.42
Liverpool	Croxteth Family Health Clinic	Action Plan in progress. Expected 25/26	92.73
Liverpool	Netherley Health Centre	Action Plan to be created to review optimisation	12.04
Liverpool	Ropewalks	No changes able to be achieved - storage.	4.12
Liverpool	Sheil Park Family Health Clinic	Utilisation agreed with Primary Care - documentation in progress	52.53
Liverpool	Vauxhall Health Centre	Action Plan to be created to review optimisation	11.64
Liverpool	West Speke Health Centre		231.62
Liverpool	Yew Tree Centre	No changes able to be achieved - storage.	2.87
Liverpool	Yew Tree Centre		24.14
Liverpool	Kensington Neighbourhood Centre Portacabin	Utilisation agreed with Primary Care - documentation in progress	35
Sefton	Maghull Health Centre	Proposed New Build Scheme - linked asset	102.2
Sefton	Curzon Road	Action Plan to be created to review optimisation	25.32
St Helens	Ashtons Green Parr Childrens Centre	Action Plan to be created to review optimisation	21.74
St Helens	Ashtons Green Parr Childrens Centre	Action Plan to be created to review optimisation	30.54
Warrington	Guardian Medical Centre	Utilisation agreed with Provider - documentation in progress	1
Warrington	IT Suite Warrington Wolves		111.6
Warrington	Westbrook Health Centre	Utilisation agreed with Primary Care - documentation in progress	53.89
Wirral	Greenway Road Surgery	Action Plan in progress - lease end date approaching.	234.23
Wirral	Devaney Medical Centre	Action Plan to be created to review options	95.83
Wirral	Devaney Medical Centre	Action Plan to be created to review options	135.79
Wirral	Townfield Health Centre	Action Plan to be created to review options	158
Wirral	Townfield Health Centre	Action Plan to be created to review options	158
Wirral	Victoria Central Health Centre	Action Plan to be created to review optimisation	92.9
Wirral	The Warrens Health Centre - Land	Land - N/A	1

The Power of Partnerships

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Cheshire and Merseyside children and young people's elective wait recovery: accelerated delivery proposal

Agenda Item No: ICB/09/24/18

Responsible Director: Anthony Middleton, Director of Performance and Planning

Cheshire and Merseyside children and young people's elective wait recovery: accelerated delivery proposal

1. Purpose of the Report

1.1 Long waits for planned care can have significant consequences on the development of children and young people (CYP). Currently an unacceptable number of CYP patients are waiting for more than a year for treatment.

1.2 **The purpose of this report is to propose an ambitious timeline for the reduction of long waits and a return to the waiting time standards set out in the NHS Constitution for CYP in Cheshire and Merseyside (C&M).**

2. Executive Summary

2.1 Long waits before accessing planned care can have significant consequences for children and young people (CYP).

2.2 Post pandemic, there was a significant increase in the overall size of the elective waiting list, and also long waits, which has been further exacerbated by industrial action and wider operational pressures.

2.3 The NHS Constitution states that patients have a right to start consultant-led treatment within 18 weeks of referral and that no patient should wait longer than 52 weeks for treatment, other than for reasons of patient choice.

2.4 Given the particular risk of delays in treatment for CYP, and the ICBs broader objectives for CYP, it is proposed that a more ambitious timeline is set for the reduction of long waits in excess of 52 weeks for this cohort, and to build on this to bring treatment times for CYP within the referral to treatment (RTT) standards.

2.5 Whilst planning guidance for the next financial year is not due until December, the government's election manifesto set the high level intention to clear over 18 week waits within five years of taking office.

2.6 It is proposed that C&M goes further and faster for CYP waiting times given the context set out above and disproportionate impact of long waits on children and young people.

2.7 A new timeline is proposed for the rapid reduction and ultimate elimination of long waits and a return to the waiting time standards set out in the NHS Constitution for CYP across Cheshire and Merseyside.

2.8 The Cheshire & Merseyside Acute and Specialist Trust Alliance (CMAST) has undertaken a feasibility assessment with C&M Trusts to establish how zero 52ww can be achieved by the end of September 2025.

2.9 This approach is consistent with the Integrated Care Board's (ICB) strategic objectives in terms of tackling health inequalities in access, outcomes and experience, and is intended to be extended to other services for CYP such as those in the community that are not subject to the referral to treatment standards, but which are equally vital.

3. Ask of the Board and Recommendations

3.1 The Board is asked to consider this proposal for the ICB to adopt a revised, more ambitious timeline to prioritise the reduction of CYP long waits and delivery of the NHS Constitution 92% referral to treatment standard, in recognition of the specific needs of children and young people.

3.2 The proposal is that a stretch target is set for the reduction of over 52 week waits for the remainder of 2024/25, in order to eliminate over 52 week waits by the end of September 2025 and return to the 92% RTT standard for CYP.

4. Reasons for Recommendations

4.1 It is recognised that long waits have a disproportionate negative effect on the health, development and overall wellbeing of children and young people, and therefore prioritisation of CYP waits is justified.

4.2 Setting a more ambitious target is intended to signal a system wide commitment to reaffirming the tenets of the NHS Constitution as our ultimate goal in terms of access to elective care for everyone, and to continue to foster a collaborative approach to addressing this longer term challenge.

4.3 This increased ambition is consistent with the ICB's strategic objectives, in particular **Tackling Health Inequalities in access, outcomes and experience.**

5. Background

5.1 In April 2022, the NHS set out an ambition to eliminate elective waits of over one year by March 2025 for all patients, except where patients chose to wait longer.

5.2 NHS planning guidance for 2024/25 acknowledged that industrial action has had a significant impact on recovery and has delayed achievement of this ambition.

5.3 The national focus is now on the elimination of 65-week waits by 30 September 2024 (except where patients choose to wait longer or in specific specialties) and this too has slipped due to industrial action and operational pressures.

5.4 Set against this challenging picture we also know that CYP are disproportionately impacted by such delays, which can have life-long consequences on the development of children and young people.

5.5 The Royal College of Paediatrics and Child Health has highlighted that the consequences of long waiting times are particularly damaging for children. Many treatments and interventions must be administered within specific age or developmental stages, making the irrevocable effects of such delays even more pronounced. Prolonged waits not only impair children's mental and physical development but also have a detrimental impact on their education and overall wellbeing.

5.6 The NHS Constitution states that patients have a right to start consultant-led treatment within 18 weeks of referral or request an offer of alternative providers that can start their treatment sooner.

5.7 The operational standard for the NHS is that at least 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral. This tolerance is designed to account for patient choice and complexity for some patient pathways.

5.8 In addition, as a backstop, the NHS Constitution mandated that no patient should wait longer than 52 weeks for treatment, except by patient choice.

5.9 **It is proposed that the ICB should therefore focus on eliminating 52 week waits for CYP as soon as possible in line with the original intent of the NHS elective recovery plan.**

5.10 **It is also proposed that waiting times should be returned to the 92% standard as soon as possible for the children and young people of Cheshire & Merseyside, in recognition of the particular impact of delays in treatment.**

5.11 The total hospital waiting list for patients of all ages has risen from approximately 130,148 in December 2019, to 370,607 in July 2024. Within this, 42,795 are under 16, whilst a further 7,206 are aged 16-18. In all, approximately 50,000 patients aged 18 or under are on hospital waiting lists.

5.12 **52 week wait plans and performance:** The ICB worked with its providers to agree a trajectory to reduce over 52 week waits from 1604 in April 2024 to 943 in March 2025. Performance is currently within the approved plan at 1,493 in July 2024 against plan of no more than 1,604, however it is proposed that the ICB should go further and faster.

5.13 **65 week waits:** The first step remains to eliminate waits in excess of 65 weeks. As at the week ending 25 August 2024, 124 patients aged under 16, and 43 aged 16-18 had been waiting over 65 weeks.

5.14 The Cheshire & Merseyside Acute and Specialist Trust Alliance (CMAST) leads on elective recovery and transformation for C&M. Trusts are using the NHS

England CYP elective recovery toolkit to support waiting list management, and CYP waiting times are discussed regularly at Patient Tracking List (PTL) meetings between the CMAST elective recovery team and all Trusts.

5.15 CMAST is represented on the CYP board to ensure cohesion and support with the CYP agenda.

5.16 CMAST has undertaken a feasibility assessment with C&M Providers to establish whether zero 52ww can be achieved and to understand what supporting actions would be required.

5.17 Five Trusts have indicated that 52ww should be eliminated by September 2025, within existing plans/capacity – Countess of Chester, LUHFT, Liverpool Women's, Warrington & Halton and WUTH.

5.18 The remaining Trusts have all indicated that elimination of waits in excess of 52 weeks is achievable with caveats which relate mainly to workforce, demand and capacity constraints, and potential cost pressures. These are being worked through to develop mitigations.

5.19 It is also recognised that within the 2024/25 planning guidance there is an ambition to reduce the overall waiting time for community services, including reducing waits over 52 weeks for children's community services, and this remains a continuing focus alongside elective referral to treatment waiting times. Historically waits in community services have been less 'visible' as they have not been subject to the referral to treatment rules, but the ICB is committed to ensuring that these waits are also closely tracked. The plan is to reduce these waits to close to zero by the end of March 2025.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Give every child the best start in life.
Enable all children, young people and adults to maximise their capabilities and have control over their lives.

Objective Two: **Improving Population Health and Healthcare**
Provide high quality, accessible and safe services

Objective Three: **Enhancing Productivity and Value for Money**
Not a direct focus of this report/proposal.

Objective Four: **Helping to support broader social and economic development**
Not a direct focus of this report/proposal.

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

7.1 This workstream links to the following element of the Annual Delivery Plan: System development: Children & Young People (CYP) and the work of the ICB's Children and Young Peoples Committee.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
- QS4 Equity in access
- QS5 Equity in Experience and Outcomes

Theme Two: **Integration**
- QS7 Safe Systems, Pathways and Transitions
- QS8 Care Provision, Integration and Continuity

Theme Three: **Leadership**
- QS10 Shared Direction and Culture

9. Risks

9.1 This report has a direct read across to Board Assurance Risk 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.* No change in risk rating is proposed at this time.

10. Finance

10.1 Setting a revised ambition for the elimination of over 52 week waits and for a return to the NHS Constitution standards, will potentially have resource implications, which will need to be identified and quantified in line with developing plans in response to the proposed acceleration of elective recovery in this area. This may require reprioritisation of existing resources.

11. Communication and Engagement

11.1 CMAST is undertaking engagement with Cheshire & Merseyside acute and specialist providers in relation to this proposal and development of supporting plans.

12. Equality, Diversity and Inclusion

12.1 The proposed ambition levels for recovery pf long waits are intended to address the specific needs of CYP in the context of the impact of delays.

13. Climate Change / Sustainability

13.1 There are no direct climate change or sustainability implications associated with the recommendation within this report.

14. Next Steps and Responsible Person to take forward

14.1 Subject to the Board approving the recommendation within this paper, the following next steps will be undertaken:

- CMAST will work with C&M Trusts to confirm a stretch target for the elimination of 52 week waits for 0-18s by the end of September 2025, and to work towards recovery of the 92% standard.

15. Officer contact details for more information

Anthony Middleton, Director of Performance and Planning

16. Appendices

Appendix One: 2024/25 Trajectory

Appendix 1: 2024/25 Trajectory

Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of 52+ week RTT waits, of which children under 18 years.	1604	1604	1604	1604	1534	1464	1381	1302	1231	1127	1044	943
ACTUAL	1471	1505	1542	1493	Not available	Not available	-	-	-	-	-	-

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

NHS Cheshire and Merseyside Annual Business Plan

Agenda Item No: ICB/09/24/**20**

Responsible Director: Clare Watson, Assistant Chief Executive

NHS Cheshire and Merseyside Annual Business Plan

1. Purpose of the Report

1.1 This paper presents to the Board the NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan. This document describes the key priority plans for NHS Cheshire and Merseyside in 2024-25 and reflects the following NHS Cheshire and Merseyside key documents:

- 2024-2029 Joint Forward Plan, including the NHS Delivery Plan
- NHS 2024-25 Operational, Financial and Workforce Plans.

1.2 The Annual Business Plan provides details of the key programme plans contained in these documents describing what we will deliver to meet both locally determined priorities as well as the nationally determined Operational Planning priorities in relation to clinical services, performance, quality and safety, workforce, as well as our financial and capital plans.

1.3 Delivery of this plan provides assurance as to how the ICB will meet the requirements of the NHS Oversight and Assessment Framework. The Framework describes how Integrated Care Boards (ICBs), providers, and wider system partners work together to improve local health and care outcomes, maximise value for taxpayer money and deliver better services for our patients.

1.4 The paper references the development of All Together Fairer: our Health and Care Partnership (HCP) Plan, which will be considered by the HCP in October and will replace the HCP Interim Strategy as the strategic plan of the HCP.

2. Executive Summary

2.1 During 2024-25 a revised Health and Care Partnership Strategy has been developed: ***All Together Fairer: Our Health and Care Partnership Plan.*** *T*he final approval of this strategic plan has been delayed *d*ue to the General Election and a period to ensure the document remained aligned with the priorities of the new Government. This strategic plan, and a supporting delivery plan, will now be presented to the HCP at the 1st of October meeting.

2.2 The published Joint Forward Plan (2024-29) is hosted on the ICB website and comprises of four documents: a short overarching introductory document to outline the purpose of the Joint Forward Plan (JFP) and three independent but interrelated plans to ensure the prominence of both NHS and wider partners priorities:

- HCP/All Together Fairer Delivery Plan (not yet published)
- Place Partnership Delivery Plans
- NHS Cheshire and Merseyside 2024/25 Delivery Plan.

2.4 This NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan describes the key actions required to implement the NHS Delivery Plan elements of the JFP.

2.5 The Annual Business Plan covers the time period of 2024-25 whereas the Joint Forward Plan reflects a five-year period, as well as being reflective of a whole Health and Care Partnership programme of work rather than specifically the NHS.

2.6 This Annual Business Plan document is therefore focused on the role of the ICB and provides detail on the priorities we will deliver this year, covering:

- Key organisational priority work programmes to develop our organisation and system capability and fulfil our statutory duties
- Key outcomes that will be improved as a result of these programmes and the timescales for delivery
- The governance overseeing the programmes including Committee and Executive Leadership and Accountability.

2.7 The structure of the document reflects the requirements of the NHS Oversight Framework which outlines that plans should be built around the four fundamental purpose of an ICS. These same objectives have been adopted in Cheshire and Merseyside as our Strategic Objectives.

- Improve outcomes in population health and health care
- Tackle health inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS support social and economic development.

3. Ask of the Board

3.1 The Board is asked to**:**

- **Approve** the attached NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan.

- **Note** that the Cheshire and Merseyside Health and Care Partnership are due to receive the revised strategic plan ***All Together Fairer: our Health and Care Partnership Plan*** and the associated HCP/All Together Fairer Delivery Plan at the next meeting on 1st October 2024. Copies of the final documents will be shared with the ICB Board as soon as they are available.

4. Reasons for Recommendations

4.1 The 2024-29 Joint Forward Plan was approved by the ICB Board in July 2024 and reflected the Operational Plan agreed with NHS England, including workforce, financial and capital plans.

4.4 This Annual Business Plan summarises for the Board the key outcomes required in delivery of these plans in 2024-25.

5. Background

5.1 The Joint Forward Plan (JFP) reflects both local priorities as well as the nationally mandated planning priorities set by NHS England.

5.2 The NHS Delivery Plan section of our JFP outlines our Vision, Mission and Strategic Objectives alongside some key ambition ambitions. It builds on the 2023-28 JFP and the priorities outlined in the interim HCP Strategy to support this it focuses on four core themes that provide the framework for the:

- Recovery Programme (focus for 2024-25)
- Transforming our Services (additional transformational change programmes)
- Innovation and use of new technology
- Improving outcomes in Population Health and addressing Health Inequalities (which includes the priorities identified through ***All Together Fairer: our Health and Care Partnership Plan*** in relation to reducing inequalities).

5.3 This 2024-25 Annual Business Plan focuses on the approach to delivering the ICB responsibilities and priorities and ambitions set against the four strategic objectives of the ICB in line with the NHS Oversight and Assessment Framework.

5.4 Each section includes a cross reference to both the Board Assurance Framework (BAF) risks and the ICB's corporate risk log as well as identifying Executive and Board sub-committee ownership for each action.

5.5 The majority of measures are drawn from the Integrated Performance Report (IPR). To avoid inconsistency of reporting these largely reflect those measures included in the national NHS Objectives for 2024-25. It is acknowledged that for some areas further work is required to fully define and refine appropriate measures/metrics and that for some schemes the metrics will need to change in future years in reflection of the changing focus of the scheme.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience
Objective Two: Improving Population Health and Healthcare

Objective Three: Enhancing Productivity and Value for Money

Objective Four: Helping to support broader social and economic

6.1 All of the above are core elements in the Joint Forward Plan and the NHS Delivery Plan, as well as the alignment of the Health and Care Partnership

(HCP) Strategy with the All Together Fairer report – and as such are core to the presented Annual Business Plan.

6.2 Our plan reflects the revised HCP strategic plan (***All Together Fairer: Our Health and Care Partnership Plan)*** reflects the eight All Together (Marmot) Themes. All nine of our Cheshire and Merseyside Health and Wellbeing Boards have committed to the recommendations in ***All Together Fairer*** and form part of our ***Marmot Community***; our plans reflect the strong support, enthusiasm and shared ambitions of partners.We have summarised the recommendations into three principles.

- Shifting investment to Prevention and Equity
- Anti-Poverty Work
- Social Justice, Health and Equity in All We Do.

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

7.1 As outlined the drivers for this plan reflects the revised focus on the current 2024-29 Joint Forward Plan and the associated NHS Delivery Plan – the NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan has been designed to support the ICB to meet its objectives - which will include programme governance and reporting processes to ensure a robust delivery approach.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
Theme Two: **Integration**
Theme Three: **Leadership**

8.1 The key themes above are included in the Joint Forward Plan, NHS Delivery Plan and as such are integral to this NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan.

9. Risks

9.1 The NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan has been directly mapped to delivery of the Board Assurance Framework and Corporate risk register. In addition, there are a range of related additional risks that are being considered.

9.2 That current plans do not provide sufficient detail or stretch in their timelines to fully assess progress, or it may be that the reporting regime is not robust enough to provide the necessary stretch or challenge.

9.3 The programme management resources to support this ongoing development need is limited and will need to be enhanced to support and assure delivery and

an ongoing assessment of priorities and use of resources by the Executive Team and Board.

10. Finance

10.1 Financial planning for 2024/25 is reflected in the 2024-29 JFP in all plans with a specific focus on the Recovery Programme and as one of our core strategies.

10.2 It is recognised that the challenging financial position we are operating in may constrain the scale of delivery in some of our identified priorities.

11. Communication and Engagement

11.1 Much of the content of the JFP and subsequently the NHS Delivery Plan has been developed through existing programmes, which have established mechanisms for engagement in developing the plans.

11.2 A public survey was undertaken in March/April 2023 to look at the content of the draft Interim Cheshire and Merseyside HCP Strategy, with the results assessed as part of developing the JFP. We have subsequently closed the loop on this and fed back via a 'you said we did' approach.

11.3 A copy of the draft NHS Delivery Plan has been shared with stakeholders at the start of May 2024, feedback received has been incorporated into the published version. The plan has also been reviewed by the ICB corporate executive team and Place Directors.

11.3 An engagement plan has been developed which focuses on our Recovery Programme.

12. Equality, Diversity and Inclusion

12.1 An Equality Impact Assessment (EIA) has been completed for the JFP, NHS Delivery Plan and the Recovery Programme, individual EIAs will be produced as required to assess the impact of the individual programmes and plans, including the Recovery Progamme.

13. Climate Change / Sustainability

13.1 Climate change and sustainability are included as priorities in the ***All Together Fairer: Our Health and Care Partnership Plan*** and associated HCP delivery plan and as one of our headline ambitions.

14. Next Steps and Responsible Person to take forward

14.1 The Strategy and Collaboration team will:

- work with system partners to finalise All Together Fairer: Our Health and Care Partnership Plan and the associated HCP/ATF plan by the end of September, with a final designed version being presented for final approval at the 01 October 2024 meeting of the Health and Care Partnership.
- finalise any remaining detail required for the NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan and complete any ongoing refinements.
- in monitoring progress in delivering the NHS Delivery Plan and NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan and specifically the Recovery Programme, agree a consistent approach across our sub-committees to capturing delivery of plans, and progress in impacting the agreed metrics through our existing sub-committees noting this will require additional programme management office support.

15. Officer contact details for more information

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Stephen Woods, Head of Strategy
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16. Appendices

Appendix One: NHS Cheshire and Merseyside Annual Business Plan

NHS
Cheshire and Merseyside

Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan

2024/25

NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan

This document describes the priority plans for NHS Cheshire and Merseyside in 2024-25 and reflects the following NHS Cheshire and Merseyside documents:

All Together Fairer: Our Health and Care Partnership Plan

Our 2024/25 NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan also includes the key actions we are taking to support delivery of our Health and Care Partnership Strategy - All Together Fairer: Our Health and Care Partnership Plan, which is due to be approved in October 2024.

Joint Forward Plan including the programme plans identified in our key priority programme plans, including our Recovery Programme.

The NHS Operational Plan

(describing delivery of the nationally determined priority areas in relation to clinical services, performance, quality and safety) It also includes details on our workforce priorities at a system and ICB level and outlines our financial and capital plans.

This plan covers the activities within the year of 2024-25 whereas the Joint Forward Plan reflects a five-year period, as well as being reflective of a whole Health and Care Partnership programme of work rather than the specific contribution of NHS Cheshire and Merseyside.

This ICB Annual Business Plan document is therefore focused on the role of the ICB and provides detail on the:

- Key organisational priority work programmes to develop our organisation and system capability and to fulfil our statutory duties
- Key Outcomes being improved as a result of these programmes and the timescales for delivery
- The governance overseeing the programmes including Committee and Executive Leadership and Accountability

The NHS Oversight and Assessment Framework

The NHS England Operating Framework is used to assess the development and delivery of Integrated Care Systems (ICSs). It describes how Integrated Care Boards (ICBs), providers, and wider system partners work together to improve local health and care outcomes, maximise value for taxpayer money and deliver better services for our patients.

As an ICS we are currently categorised as being in segment 3 of the NHS Oversight and Assessment Framework (NOF). During 24/25 we will look to improve performance against the NOF measures, however, recognise that our current financial performance means that our intention to move to segment 2 is likely to take longer to achieve.

In determining our priorities ICBs are required to show how we are setting local objectives against the four purpose of an ICS (also adopted in Cheshire and Merseyside as our Strategic Objectives):

- **Improve outcomes in population health and health care**
- **Tackle health inequalities in outcomes, experience and access**
- **Enhancing productivity and value for money**
- **Helping the NHS support social and economic development**

Our plans will demonstrate how we are fulfilling and developing in these areas.

Figure 1: Scope of the NHS Oversight Framework

National Priorities

On 27th March 2024 NHS England released priorities and operational planning guidance 2024/25 which highlights:

- The challenging outlook for 2024/25 with a flat real funding settlement for 2024/25 and the multi-year process of pandemic recovery of services. With the requirement of the ICB, Trusts and partners to work collectively to deliver a balanced financial plan.
- Focus on improving waiting times and safety in urgent and emergency care,
- Reducing the longest waits for tests and treatment for cancer and elective care,
- Making it easier for people to access primary care
- The need for a relentless focus on improvement, fewer delays and unnecessary processes to provide better care for patients, and greater value for taxpayers.
- Looking further into the future, the £3.4 billion investment of capital in data and technology – from 2025/26 onwards and delivery of the long-term workforce plan are highlighted.
- The guidance highlights that the overall NHS priority in 2024/25 remains the recovery of our core services and productivity following the COVID-19 pandemic. To improve patient outcomes and experience we must continue to maintain our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach whilst focusing on moving activity out of hospitals into the community.

The NHS nationally determined 2024-25 priorities are summarised in appendix 2.

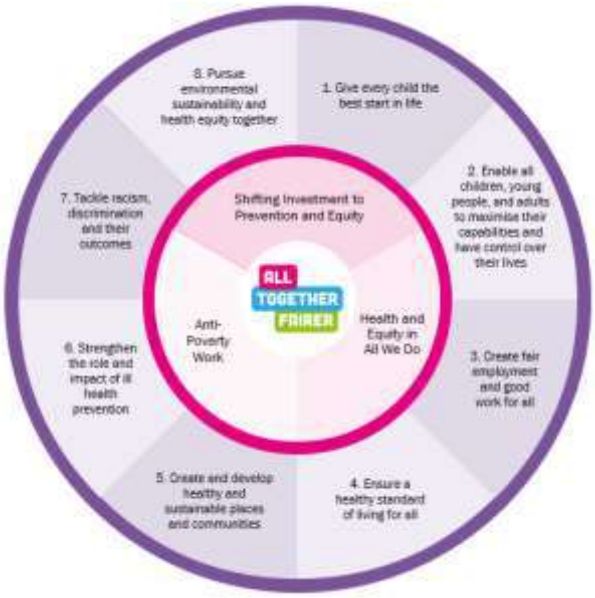
Local Priorities

In January 2022 Cheshire and Merseyside Health and Care Partnership (HCP) approved an Interim Strategy. There was strong feedback from members that there was a preference to develop a strategy more targeted at the existing Partnership commitments around health inequalities contained in All Together Fairer: Health Equity and the Social Determinants of Health in Cheshire and Merseyside.

Over the past year work has been undertaken to align the final HCP strategy with the existing and delivery of the priorities within this Programme. All Together Fairer: Our Health and Care Partnership Plan has been developed and is due to be presented for

approval in October 2024. Our Health and Care Partnership priorities and actions are described in the Health and Care partnership Delivery plan.

Figure 2: Health and Care Partnership – All Together Fairer: Our Health and Care Partnership Priority Themes:



All Together Fairer: Our Health and Care Partnership Plan focuses on the 8 Marmot principles described above it also describes three core Principles and six Headline Ambitions that the system will collaborate on we will thread these throughout our programmes and workstreams.

Figure 3: All Together Fairer HCP Headline Ambitions.

Joint Forward Plan

As part of our Joint Forward Plan our NHS Delivery Plan describes how NHS Cheshire and Merseyside, partner NHS Trusts and wider system partners intend to work together to address financial sustainability challenges whilst providing safe high-quality services to meet our population's physical and mental health needs.

The NHS Delivery Plan recognises the challenging context described in the national operational planning guidance and the need to balance delivery of immediate improvements in financial and operational performance, maintaining quality and patient safety whilst also maintaining our longer-term strategic focus on transforming the way we deliver improved services and outcomes for our population.

We will work collaboratively with our partners to: -

- Provide safe, effective and timely care
- Improve outcomes in Population Health and Healthcare and reduce inequalities
- Make decisions based on evidence (Data into Action) and have a culture of innovation and continuous improvement
- Increasingly focus on prevention reducing the need to treat ill health
- Find the optimum way to provide services, integrating and simplifying how we work
- Provide services within the funding available to us
- Deliver our Anchor principles to have a positive impact on our communities socially, economically and environmentally

Figure 4 Determining our key priorities for 2024-25:

Our approach to quality oversight and governance.

Our approach to system oversight and governance reflects a different more collaborative approach to the traditional contractor & provider relationships and arrangements that have been in place historically.

To manage this effectively, and where possible, align requirements within existing arrangements, the following principles are proposed to underpin the operating model going forward:

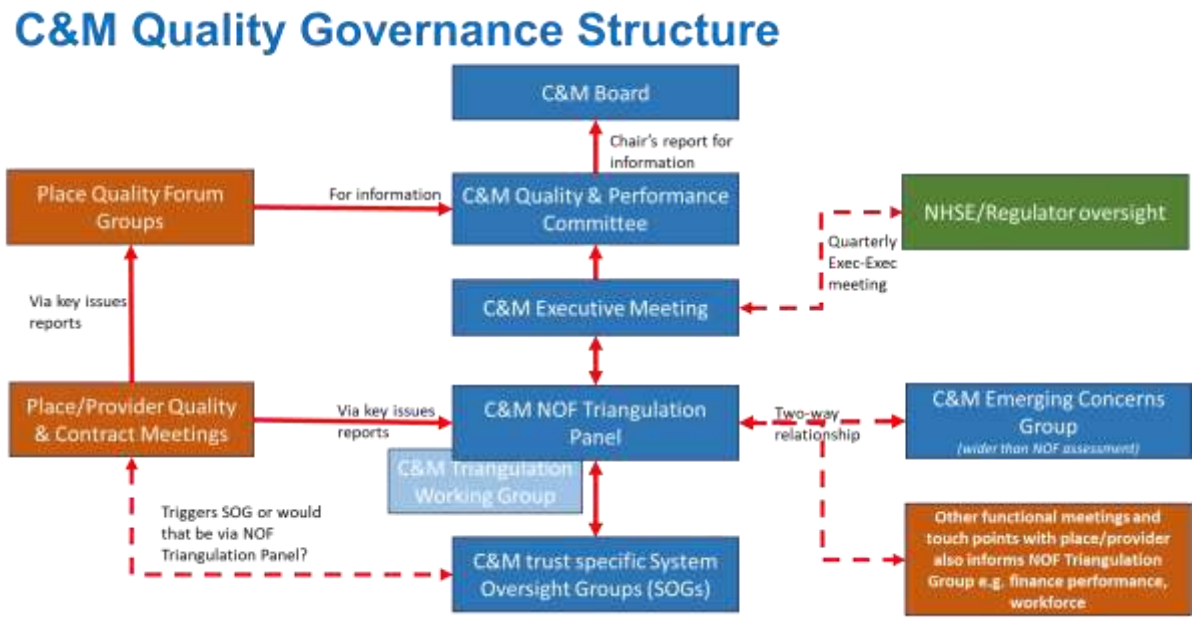
- A risk based and proportionate oversight framework with clear thresholds and criteria that are communicated and understood across stakeholders.
- A model that is joined up and aligned with other frameworks to encourage consistency and standardisation where appropriate to minimise duplication and encourage effective coordination.
- Open and transparent triangulation of intelligence to provide a holistic assessment combined with moderation across functions to provide consistency and maintain the integrity of the framework.
- An improvement focus throughout the framework to ensure high quality, safe patient care across our system. This will be enabled by coordination of support to optimise impact, sustainability, sharing of good practice and learning.
- An agreed and established shared purpose and narrative in relation to the framework to provide a 'one-team' approach across Cheshire and Merseyside where stakeholders understand their respective roles and responsibilities.
- A framework that is underpinned by trusted relationships and a collaborative approach across all stakeholders.

Quality Governance Infrastructure

To ensure effective oversight, decision-making and information flows, it is important that the ICB has clear and effective governance arrangements in place.

The diagram below provides an overview of the quality governance architecture and the relationships between the various groups:

Figure 5 Cheshire and Merseyside Quality Governance Structure:



Our Approach to the NHS Oversight Framework (NOF) Segments for NHS Cheshire & Merseyside Providers

In line with the principles, proposed above the ICB will adopt a proportionate approach to quality oversight of providers across the four NOF segments. The table below provides an overview and reminder of our agreed approach:

For All NOF Segments:

- ICB monitoring via scorecard (monthly) and quarterly triangulation review (ICB internal)
- Annual review for all providers as minimum

NOF –Segment 1 (LHCH, Walton Centre) • Material issues to be escalated by exception from ongoing in year dialogue with Provider (finance, quality, contract etc) • **BAU oversight via Place/Provider Quality & Contract meetings and optional annual bilateral meeting ICB/Provider**	**NOF – Segment 2 (DEFAULT SEGMENT)** (Alder Hey, Bridgewater Community Healthcare, Cheshire & Wirral Partnership, Mersey Care, Mid-Cheshire, NWAS, Southport & Ormskirk, St Helens & Knowsley, Warrington & Halton, Wirral Community Health & Care, Clatterbridge Cancer Centre) • Material issues to be escalated by exception in year • System wide issues impacting on NOF to be addressed as part of Place oversight • **BAU oversight via Place/Provider Quality & Contract meetings and annual bilateral meeting ICB/Provider**
NOF – Segment 3 (Countess, East Cheshire, LWH, WUTH, LUHFT) • If subject to SIB, SIB arrangements take precedence. SIB will be ICB led, with support from NHSE • Material issues to be escalated by exception in year • System wide issues impacting on SOF to be addressed as part of Place oversight • Quarterly review against SOF 3 exit criteria • **Quarterly bilateral meeting ICB/Provider**	**NOF – Segment 4** (no trusts) • NHSE led, with ICB support. Support via RSP • SIB arrangements take precedence • Review against SOF 4 criteria within SIB • Upon exit from SOF4, management as per SOF 3

Areas of Quality Improvement

While it is recognised that the ICB holds a regulatory and assurance function within the national oversight framework, in line with the principles set out above, it is important that the operating model incorporates a supportive and improvement focused approach. This will strengthen assurance and oversight and continue to build on the trusted relationships that have been developed with places and providers.

The ICB will continue to work with its providers of commissioned services to align to the national Patient Safety Strategy requirements and implement the Patient Safety Incident Response Framework (PSIRF). Positive progress has been made in 2024/25, with all NHS Trusts and some independent sector providers agreeing their patient safety priorities and plans. Work continues to ensure there is a risk-based approach to those smaller independent providers and the adoption of PSIRF within Primary Care. The ICB has undertaken pilot work with general practice in two of our places, and this work is currently being evaluated, so learning can be shared in the wider programme of adoption.

The ICB has identified a range of quality improvement priorities including working with its commissioned service providers to ensure that Infection Prevention & Control resource is aligned across the system, with a focus on reducing the rates of Health Care Associated Infections which has been identified as a quality priority and will form the basis of a system wide safety collaborative.

Aligned to the ICS recovery programme, there will continue to be a drive to reduce and eradicate ‘corridor care’. The development and adoption of the quality ‘red lines’ toolkit will continue to support in improving the safety and experience of our population who experience long waits within emergency departments. Work is also underway to develop a best practice approach to bed turnaround times to support system flow and improve patient safety and experience.

Continuous Improvement

To ensure services across Cheshire and Merseyside are the best they can be we will develop a culture of continuous improvement and innovation. To improve patient outcomes and experience we must maintain our collective focus on the overall quality and safety of our services, based on the approach set out in A shared commitment to quality and The NHS Patient Safety Strategy. This includes applying the Patient Safety Incident Response Framework (PSIRF) in the development and maintenance of patient safety incident response policies and plans.

We will invest in developing a system-wide quality improvement methodology and support staff across the system to deliver improvement through Improvement Networks aligned to Provider Collaboratives to promote innovation, share learning and build on existing improvement capacity and capability.

Workforce

As outlined in our NHS Delivery Plan NHS Cheshire and Merseyside recognises that our most valuable asset is our dedicated, skilled and knowledgeable workforce. We recognise that our staff consistently go above and beyond what is required of them to deliver outstanding care for our communities:

To support our workforce, we have made a People Promise and are committed to developing skills and opportunities. There are the national 10 outcomes of an ICB People Function that we are working towards – these are:

1. Supporting the health and wellbeing of all staff: people working and learning in the ICS feel safe and supported in their physical and mental health and wellbeing, and are therefore better able to provide high-quality, compassionate care to patients.

2. Growing the workforce for the future and enabling adequate workforce supply: the system is retaining, recruiting and, where required, growing its workforce to meet future need. The 'one workforce' across the ICS is representative of the local communities served.

3. Supporting inclusion and belonging for all and creating a great experience for staff: people working and learning in the ICS can develop and thrive in a compassionate and inclusive environment. Issues of inequality and inequity are identified and addressed for all people working in the system. The workforce and leaders in the ICS are representative of the diverse population they serve.

4. Valuing and supporting leadership at all levels, and lifelong learning: leaders at every level live the behaviours and values set out in the People Promise and make strides so that this is the experience of work for all of their 'one workforce'.

5. Leading workforce transformation and new ways of working: service redesign is enabled through new ways of working, which make the most of staff skills, use of technology and wider innovation – to both meet population health needs and drive efficiency and value for money.

6. Educating, training and developing people, and managing talent: education and training plans and opportunities are aligned and fit for the needs of staff, patients and citizens, including to enable new ways of working and support meaningful and personalised career journeys.

7. Driving and supporting broader social and economic development: leaders ensure that their organisations leverage their role as anchor institutions and networks to create a vibrant local labour market, promote local social and economic growth in the wider community, support all ICS partners to 'level up', address wider health determinants and inequalities at the heart of poor health.

8. Transforming people services and supporting the people profession: high quality people services are delivered by a highly skilled people profession to meet the future needs of the 'one workforce', enabled by technology infrastructure and digital tools.

9. Leading coordinated workforce planning using analysis and intelligence: integrated & dynamic workforce, activity and finance planning meets current and future population, service and workforce needs, across programme/pathway/place.

10. Supporting system design and development: the system uses organisational and cultural system design and development principles to support the establishment and development of the integrated care board (ICB), and the integrated care partnership (ICP). The organisational development approach creates a system-wide culture that: is driven by purpose; enables people, places and the system to fulfil their potential; is connected to the people served by the system and those delivering services; harnesses the best of behavioural, relational and structural approaches; and nurtures collaboration.

Learning from our experiences

As an ICB we now have two years of knowledge and know-how and can learn from our experiences to date. We are not only responding to the national and local challenges described above but also need to both respond to the need to operate with lower running costs and to ensure we work optimally to implement best practice across our whole footprint through:

Considering our Operating Model and Governance to maximise the skills, experience and capabilities whilst ensuring our relationships with communities and stakeholder organisations are maximised.

Ensuring we have an evidence-based approach to identifying where we need to improve services and outcomes, how best we can do this and the approaches we should apply. We have emerging approaches to this through our Digital and Data Strategy, Data intro Action, Research and Innovation, and Continuous Improvement Programmes.

Working in an integrated way across all sectors and with our communities. This includes:

- Working with partners at a Cheshire and Merseyside level, including:
- Health and Care Partnership
- Place Partnership
- Integrated Neighbourhood/Care Community
- Maximising opportunities from delegation from NHS England (Primary Care, Specialised Services and planning for Vaccination and Immunisation)

During 2024-25 we will undertake a review of our Operating Model to reflect on our learning and prepare us for the next period of development.

Financial Planning

The system financial plan for 24/25 reflects a deficit of £150m across Cheshire and Merseyside NHS organisations, as per the table below:

ICS Financial Plan 12.06.24			CIP Metrics June FPR Submission		
	Surplus / (Deficit)	Surplus / (Deficit) as a % of OP Inc	CIP £,000	CIP as % of Op Ex	Recurrent CIP as a % of total CIP
Provider	**£,000**	**%**	**£,000**	**%**	**%**
Alder Hey Children's	3,382	0.8%	19,950	4.8%	97%
Bridgewater Community	2,138	2.2%	6,939	6.9%	100%
Cheshire & Wirral Partnership	1,495	0.6%	13,913	5.0%	100%
Countess of Chester Hospitals	(23,995)	-7.0%	19,822	5.3%	100%
East Cheshire Trust	(14,376)	-7.2%	11,225	5.0%	100%
Liverpool Heart and Chest	14,141	5.9%	10,644	4.6%	92%
Liverpool University Hospitals	(80,481)	-6.9%	114,600	8.5%	100%
Liverpool Women's	(28,529)	-19.2%	5,904	3.3%	77%
Mersey Care	7,128	1.0%	25,967	3.5%	100%
Mid Cheshire Hospitals	(35,561)	-9.3%	22,437	5.2%	90%
Mersey and West Lancs	(26,674)	-2.9%	45,165	4.8%	80%
The Clatterbridge Centre	876	0.3%	10,000	3.4%	100%
The Walton Centre	5,347	2.9%	8,558	4.5%	100%
Warrington and Halton Hospitals	(27,793)	-8.2%	19,433	5.1%	100%
Wirral Community	6,500	5.5%	6,275	5.4%	100%
Wirral University Hospitals	(16,325)	-3.4%	26,878	5.2%	100%
Total	**(212,291)**	**-3.4%**	**367,710**	**5.5%**	**91%**
ICB	**62,291**		**72,235**	**1.0%**	**100%**

Total ICS System Position	**(150,000)**		**439,945**	**6.5%**	**93%**

As set out in the table, the efficiency programme equates to £440m – 6.6% of our allocation.

Key **risks** to achieving our financial plan are:

- **Urgent care/flow –** unplanned financial pressures associated with urgent care pressures.
- **CIP Efficiency Savings –** The financial plans include £440m (6.6% of system allocations/expenditure) of savings across the ICS. Delivery of significant efficiency savings is a risk when set against the operational and workforce pressures.
- **Industrial Action** – In line with national guidance, plans have been set on the basis of no industrial action in 2024/25, where industrial action does occur it is likely to incur additional staffing costs and a reduced level of ERF income from elective activity.
- **Cash –** Several providers will need to take support loans to manage financial obligations in 2024/25. Based upon the plans within this paper, some providers are forecasting the need to apply for Revenue Support Loans. Whilst measures are being taken to minimise the need for cash support, including ICB early payments, cash flow remains a risk for the system.

Capital Investment Plan

The current system capital investment plan for 2024/25 recognises the challenges of planning large and complex capital investment and reflects an allowance to "over-plan" of 5%. However, by the end of the year, spend must be within the ICS allocation.

	Core Operational Capital	UEC Incentive	RAAC	Total ICS Capital Exc IFRS16	IFRS16**	Total ICS Capital Inc IFRS16
Provider	£,000	£,000	£,000	£,000	£,000	£,000
Alder Hey Children's	11,923	5,000		16,923	-	16,923
Bridgewater Community	2,100			2,100	2,367	4,467
Cheshire & Wirral Partnership	6,790			6,790	1,076	7,866
Countess of Chester Hospitals	5,000		72,600	77,600	150	77,750
East Cheshire Trust	4,287			4,287	1,935	6,222
Liverpool Heart and Chest	7,461			7,461	350	7,811
Liverpool University Hospitals	25,653		20,000	45,653	13,745	59,398
Liverpool Women's	5,035			5,035	-	5,035
Mersey Care	32,341			32,341	3,913	36,254
Mid Cheshire Hospitals	6,806		2,816	9,622	3,930	13,552
Mersey and West Lancs	24,051			24,051	4,205	28,256
The Clatterbridge Centre	9,013			9,013	2,097	11,110
The Walton Centre	7,632			7,632	2,500	6,890
Warrington and Halton Hospitals	4,390			4,390	1,838	9,470
Wirral Community	4,684			4,684	1,769	6,453
Wirral University Hospitals	12,870			12,870	-	12,870
Total	**170,036**	**5,000**	**95,416**	**270,451**	**39,875**	**310,326**
ICS Allocation				**258,447**		****TBC**
Variance – (Overprogramming)				**(12,004)**		****TBC**
Overprogramming %				**4.6%**		

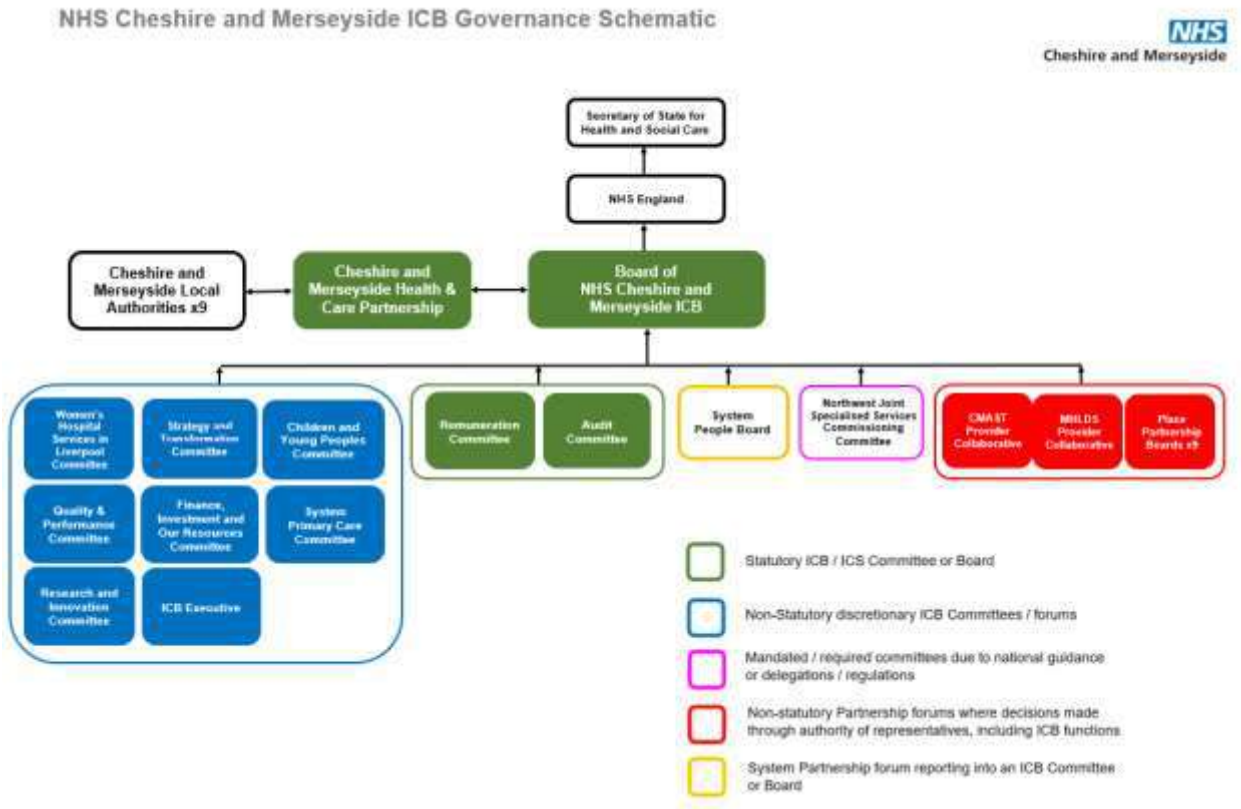
In addition to the provider capital, the ICB also has a primary care capital allocation for 2024/25 of £4.7m. An outline plan for GPIT and other local improvement grants was presented to the System Primary Care Committee in June and agreed they £3.388m for GPIT (mainly cyber security and routine kit replacement) with the balance to be held for GP premises improvement grants.

Governance and monitoring

Whilst the Integrated Care System (HCP) plan is owned and overseen by our Health and Care Partnership Board, the plans to deliver it the NHS Delivery Plan elements of it and this Integrated Care Board Annual Business Plan are owned and overseen by the NHS Cheshire and Merseyside Board.

Each of the programmes outlined in our plan focus on a number of key outcomes and a set of agreed measures and milestones. In 2024-25 we are adopting a consistent approach across our plan, using a robust programme management approach, aligned to our Board Assurance Framework to report progress to the Board and its sub committees. Our priority plans will also be overseen through a consistent PMO process and managed through the committee structure identified below. Each priority identies the accountable Executive and Committee.

Figure 6 NHS Cheshire and Merseyside ICB Governance:



In 2024-25 we have created a single Programme Management Office to focus on delivery of the Recovery Programme. This will use a robust reporting structure that communicates an accurate position into the programme. By having effective milestones, KPI's and risk tracking, communicating progress should be effective to key stakeholders, providing them with a clear understanding of whether the programme is on course to deliver, or to highlight any slippage.

Our key plans and objectives for 2024-25

The following sections outline our 24/25 ambitions/objectives set against our four strategic objectives:

- **Improve outcomes in population health and health care**
- **Tackle health inequalities in outcomes, experience and access**
- **Enhancing productivity and value for money**
- **Helping the NHS support social and economic development**

Each section includes a mapping to the Board Assurance Framework (BAF) risks and the ICB corporate risk log*.

The section provides detail on the key outcomes measure for each objective and outlines the reporting route and to the key driver behind these objectives. The majority of measures are drawn from the Board Integrated Performance Report (IPR) and these largely reflect those measures relating to national NHS Objectives for 2024-25. It is acknowledged that for some objectives further work is ongoing to fully define an appropriate outcome measure/metric.

In relation to the wider actions around improving outcomes in population health and health care and tackling health inequalities in outcomes, experience and access these are described in the Health Care Partnership Delivery Plan that accompanies All Together Fairer: Our Health and Care Partnership.

Our plans maintain a strong focus on achieving financial balance, protecting patient safety and prioritising access and quality of services with a strong emphasis on Urgent and Emergency Care. We recognise our long term commitment to increasingly shift the balance of our focus onto prevention and reducing the need to treat ill health. An example would be our intention to increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Whilst our measures reflect an overall Cheshire and Merseyside position this does not mean that our residents are receiving equality in access and quality across all places and communities. This is however measured in more detail elsewhere in our governance to try and address inequity.

***Note: -** *The BAF risks reflect the longer-term strategic challenges aligned to the 5-year strategy, are set top down by the Board and are likely to remain in place throughout 24-25. In contrast the Corporate Risk Report (CRR) reflects the operational risks which have been escalated bottom up by virtue of scoring 15+ and will fluctuate through the year as new or increasing risks are escalated or as mitigation strategies take effect and risks are de-escalated.*

Improve outcomes in population health and healthcare: -

ICB Core Purpose	Improve Outcomes in population health and healthcare: -									
Area	Objective	C&M 24/25 Planned ambition	Quarterly Trajectories				Board / Executive Lead	BAF /Corporate Risk	Reporting Route	Driver/s
			Q1	Q2	Q3	Q4				
Quality and patient safety	Implement the Patient Safety Incident Response Framework (PSIRF)	PSIRF priorities and plans in place and assurance that standards are consistently applied	**Q1** - All NHS providers have agreed PSIRF Priorities and plans **Q2** - Adoption of Patient Safety Incident Response Standards **Q3** - Assurance against the quality schedule **Q4** - Embedding robust processes to assure standards are consistently applied				Chris Douglas	P1 P3 P4 P5 P6 P8 P9 P11 QU08	Quality and Perform-ance Committee	NHS Oversight Framework
	Develop and adopt risk-based approach to smaller independent providers.	Numbers of independent providers with PSIRF plan Targeted risk-based approach with the current providers	**Q1** - Working with IS providers to align PSIRF methodology & plans **Q2** - Adoption of Patient Safety Incident Response Standards **Q3** - Assurance against the quality schedule **Q4** - Embedding robust processes to assure standards are consistently applied							
	Roll out PSIRF across wider Primary Care footprint.	Numbers of Primary Care Contractors adopting PSIRF	**Q2** - Commenced work on a national pilot rolling out PSIRF in P/Care **Q3** - Delivery of the national pilot **Q4** - Feedback into the national plan							
	Still births per 1,000 (rolling 12 months)									

	Healthcare acquired infections: Clostridium Difficile- provider aggregation	System Tolerance of 439 cases across all providers 24/25 Baseline 677	667	598	519	439				
	Healthcare acquired infections: E coli (Healthcare associated)	System tolerance of 518 cases Baseline 813	813	753	613	518				
	Never events	Zero system tolerance 29 rolling 12 months	0	0	0	0				
Urgent and emergency care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	78% by March 2025	73.4%	75.8%	77.2%	79.7%	Anthony Middleton	P3 P4 P5 P8 P10 QU08	Recovery Sub-Committee	Recovery Programme NHS Oversight Framework
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	30 Minutes	30 Mins	30 Mins	30 Mins	30 Mins				
	To eliminate corridor care over the course of 24/25 – evidenced by reduced instances and associated cost	Target March 25 is zero – our ambition is to eliminate corridor care and a measure has been developed to allow monitoring	-	-	-	0				
Primary and community services	Improve community services waiting times, with a focus on reducing long waits	Eliminate 52ww by March 2025	980	654	328	0	Clare Watson	P1 P5 P6 P8 P9	System Primary Care Committee	Recovery Programme NHS Oversight framework

	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	90% throughout 24/25	90%	90%	90%	90%	(MHLDC supporting)	PC1 QU08		LTP Dental Recovery Plan
	Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels	(Number of Adult patients seeing an NHS Dentist)	948,475	959,745	971,767	986,184				
	Increase the % of 2-hour Urgent Community Response referrals where care was provided within 2 hours	70% by March 2025 Currently exceeding the target	70%	70%	70%	70%				

Elective care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	Zero by September 2024 from Current waits over 65 wks. Apr 24 = 2,324	1,267	341	0	0	Anthony Middleton	P1 P3 P4 P8 P10 QU08	CMAST Q&P Committee	Recovery Programme NHS Oversight Framework
	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	110.9% cumulative by March 2025	109.2%	111.5%	111.0%	110.9%				
	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	43.1% by March 2025	43.0%	43.5%	43.1%	43.1%				
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025	70% by March 2025	70.7%	71.5%	72.3%	72.5%	Fiona Lemmens	P1 P3 P4 P8 P9	Cancer Alliance	NHS Oversight Framework LTP

	Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	77% by March 2025	72.0%	73.9%	75.5%	77.0%		QU08		
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	75% by 2028	70%				Fiona Lemmens	P1 P3 P4 P8 P9 QU08	Cancer Alliance	NHS Oversight Framework LTP
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	95% by March 2025 90%	90%	90%	92%	95%	Anthony Middleton	P3 P6 P9 P11 QU08	CMAST (Ann Marr)	Recovery Programme NHS Oversight Framework LTP
Maternity, neonatal and women's health	Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment	Halve the rates of stillbirths. 1.75 rate per 1,000 births by Mar 2025 Baseline 3.5	2.8	2.4	2.0	1.75	Chris Douglas	P1 P3 P4 P5 P8 P10 QU08 WSC3 WSC4 WSC7	Quality and Perform-ance Committee	NHS Oversight Framework
		Halve the rates of Neonatal mortality 0.95 rate per 1,000 births by Mar 2025 Baseline 1.9	1.3	1.1	1.0	0.95				
		Halve the rates on intrapartum brain injuries 1.95 rate per 1,000 births by Mar 2025	5.20	4.12	3.04	1.95				

		Baseline 3.9								
		Reduce the rate of preterm births 6% by Mar 2025 Baseline 7.1%	6.8%	6.5%	6.2%	6.0%				
	Establish and develop at least one women's health hub in every ICB by December 2024, with local target of one in each Place by the end of 2025, working in partnership with local authorities	A further Women's Health hub within C&M by Dec 2024	-	-	Hubs in St Helens and Sefton	-				
	Gynaecology and Maternity Hospital Services in Liverpool	Reduction in clinical risks in hospital-based maternity and gynaecology services in Liverpool.	Q3 Case For Change Completed and presented to Sept Board				Fiona Lemmens	P1 P3 P4 P5 P8 P10 QU08 WSC3 WSC4 WSC7	Quality and Perform-ance Committee	NHS Oversight Framework
Mental health	Improve patient flow and work towards eliminating inappropriate out of area placements	Zero throughout 24/25	0	0	0	0	Clare Watson (MHLDC supporting	P1 P3 P4 P5	Recovery Committee	Recovery Programme LTP

	Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)	12 months rolling	2,729	2,729	2,729	2,729	via their governance)	P10 QU08		
		12 months rolling	34,499	35,529	36,559	37,590				
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery	67% achieving reliable improvement throughout 24/25	67.0%	67.0%	67.0%	67.0%				
		48% reliable recovery throughout 24/25	48.0%	48.0%	48.0%	48.0%				
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual	60% by March 2025	62.29%	64.21%	62.47%	64.29%				
	Improve quality of life, effectiveness of treatment, and care for people with dementia by	66.7% throughout 24/25	66.7%	66.7%	66.7%	66.7%				

	increasing the dementia diagnosis rate to 66.7% by March 2025									
	Referrals on the Early Intervention in psychosis (EIP) pathway in 2 weeks	60% by March 2025 Currently exceeding	60%	60%	60%	60%				
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	85% in 24/25	10.2%	13.6%	27.2%	34.0%	Chris Douglas	P1 /P3 P4 P5 P6 P8 P9 QU05 QU08	ICB Board	NHS Oversight Framework
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population	End of period position	13.9 (rate)	13.9 (rate)	13.9 (rate)	13.9 (rate)				
Frailty	Reduced Emergency Admissions due to falls in people aged 65 and over - standardised rate per 100,000	Average Quarterly ICB baseline rate Q4 23/24 = 531.5	528.5	525.5	522.5	519.7	Ian Ashworth	P3 P4 P5 P6 P8 QU08	Recovery Committee	Recovery Programme

Children and Young People	Improve Oral Health - reducing the number of children requiring tooth extractions through education on tooth brushing and improving access to NHS Dentists	Year 1 measure - Increasing the Number of children accessing NHS dentists (Number of patients seeing an NHS Dentist)	315,377	319,125	323,122	327,916	Chris Douglas	P1 P3 P4 P8 P10 QU08	Children & Young People Committee (Beyond Programme Board)	Recovery Programme NHS Oversight Framework LTP
	Neurodiversity developing standardised pathways/models of care to reduce waiting times and improve access to early support	Reduce average waiting time to assessment for those requiring assessment/diagnosis (5% impact of work 24/25 will have limited impact on waiting list in this financial year but improvements expected in 25/26)	Programme in development		Pathway completed	Implementation anticipated 5% improvement				
	Implementation of a model of best practice for safe places for CYP who need alternatives to hospital care due to emotional well-being or social needs	An agreed best practice model of alternative care for children with complex emotional wellbeing & social care needs who: cannot be supported in their family home, are not assessed as being suitable for Tier 4 inpatient admission, and where Local Authorities are unable to source regulated provision to meet needs with trailblazer sites used to enable learning and support further development.				Sites live in Cheshire West & Warrington				

	Cross – organisational focus on earlier intervention for Children at the Edge of Care	Following a thorough leadership piece on system leadership commissioned by the CYP committee, there is some early design work to develop a proposal to work with a cohort of children and families to prevent entry into care and demonstrate Cheshire & Merseyside system leadership in action.	Outline development work		Initial Scoping work completed	Proposition signed of Jan – Mar/Apr Implementation plan and timeline completed				
Shaping Care Together	Urgent and Emergency Care Service sustainability for services delivered at Southport and Ormskirk Hospitals	Delivery of agreed programme milestones	NHSE assurance stage 1 strategic check Complete	Case for Change and Joint Committee Board approval (C&M ICB, L&SC ICB	Establish Joint Committee with LSC	Develop outline Business Case	Ann Marr /Deborah Butcher/ Claire Wilson	P4 P8 QU08	ICB Board	Recovery Programme
Sustainable Hospital Services (Liverpool)	Service sustainability for services delivered at Liverpool Hospitals	Development of Liverpool Five Year Plan in support of Clinical Services Review				Strategic Case	Mark Bakewell	P4 P8 QU08	ICB Board	Recovery Programme
Sustainable Hospital Services (East Cheshire)	Service sustainability for services delivered at East Cheshire Trust	Delivery of agreed programme milestones Checking with Katherine Sheerin as current review of milestones				Service Proposal	Mark Wilkinson (ECT Board)	P4 P8 QU08 QU09	ICB Board	Recovery Programme
Mid Cheshire new Hospital Healthier Futures	Development of the new Hospital at Mid Cheshire (Crewe)	Delivery of agreed programme milestones **NOTE:** that the Board will receive and be asked to support the Outline Business Case in summer 2025.		Strategic Outline Case Approved July ICB			Mark Wilkinson (MCHFT Board)	P4 P8 QU08	ICB Board	Recovery Programme

Tackle health inequalities in outcomes, experience and access: -

ICB Core Purpose	Tackle health inequalities in outcomes, experience and access: -									
Area	Objective	C&M 24/25 Planned ambition	Quarterly Trajectories				Board / Executive Lead	BAF Corporate Risk	Reporting Route	Driver/s
			Q1	Q2	Q3	Q4				
Prevention and health inequalities	Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025	77% local target Current position 69.6%	71.5%	73%	75%	77%	Ian Ashworth	P1 P10	Health and Care Partnership via Population Health Board	HCP Priority Core20 PLUS5
	Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	65% Current position 61.9%	62.7%	63.5%	64.2%	65%				
	Increase vaccination uptake for children and young people year on year towards WHO recommended levels - striving for 95% where this target is applicable	*Aiming for 95% where this target applies and a year-on-year increase in line with WHO until we achieve this.	*95% where this is applicable							
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	75% by 2028	See cancer section in the table above							
	Smoking Prevalence - % of those reporting as 'current smoker' on GP systems	12% by Mar 25 (C&M target 5% Prevalence by 2030)	13.7%	13.2%	12.7%	12%				

		Current performance July 24 13.6% (Note: reduced each month since Nov 23)								
	Children and Young People accessing mental health services as a % of LTP (Planned number)	Target 100% Current performance 90%	90%	93%	96%	100%				
	Smoking Status at Time of Delivery (SATOD) to 4% by 2030	National Target by March 25 6% Current position Mar 24 = 7.2% Reduced 2.3% during 23/24	6.9%	6.6%	6.3%	6%				

Enhancing productivity and value for money:

ICB Core Purpose	Enhancing productivity and value for money: -									
Area	Objective	C&M 24/25 Planned ambition	Quarterly Trajectories				Board / Executive Lead	BAF Corporate Risk	Reporting Route	Driver/s
			Q1	Q2	Q3	Q4				
Recovery Programme Delivery of Financial Benefits **Use of Resources**	Deliver a balanced net system budgeted financial position for 24/25	Budget to plan (Millions)	(84.5)	(134.7)	(181)	(150)	Claire Wilson	P1 P3 P7 P8 P9 P10 F8 F9 8DR 14DR	Recovery Committee	Recovery Programme NHS Oversight framework LTP
	Reduction in number of non-patient facing /non-clinical staff across the ICS, including the ICB	April 24 19739 - which is in line with Trusts workforce plans	19569	19556	19350	19180	Chris Samosa			
	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	Zero Off Framework Spend / Usage by July 2024	0	0	0	0	Chris Samosa			
		Agency Staffing from October 2024 onwards. Agency staff	1117	1073	993	946				
		Agency Spend to a maximum of 3.2% total pay bill across 24/25	(April 24 baseline 1123 see figures above these should keep us under the 3.2% target)							
Corporate Development	Continuous Improvement Roll Out – AQUA Module 4 leading for	Number of ICB staff receiving training	15	30	60	90	Fiona Lemmens/ Christine Samosa	P1 P3 P7 P8 P9	Executive Team	

	continuous improvement	(Initial target staff leading on recovery and transformation)						P10 F8 F9 8DR 14DR		
	We have an ambition to achieve bronze level in the Anti Racism Framework by April 25	Achievement of Bronze award	-	-	-	Achievement of Bronze award				
	Achieved the Navajo accreditation	Achieved Navajo Accreditation	Evidence gathered and application submitted		Navajo Accreditation confirmed Award Oct	2-year Delivery Plan in place				
Workforce	People - Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions	Maintain & enhance C&M's 'thriving' status in line with NHSE's Retention Plan Maturity Matrix by Mar-25. Deliver on the C&M retention plan & high impact retention actions, with a focus on Flexible Working & Menopause Support in 24/25. Support and deliver on all objectives with Cohort 2 of the People Promise Exemplar sites in C&M by Mar-25.	Maturity matrix- this is a self-assessment with no obligation from NHSE to complete. We could review 6 monthly with the retention forum and provide evidence to the board via case studies? The matrix is not data driven it is around system working and sharing learning				Chris Samosa	P1 P3 P7 P8 P9 P10 F8 F9 8DR 14DR	People Committee (ICB) People Board (ICS)	Recovery Programme NHS Oversight framework ICB Corporate Development
			-	-	-	100% of returns by Q4				
			-	-	-	By Q4 100% of the example sites reporting				

		Stabilising & continuing to work towards reducing an average sickness absence rate of 5.5% and turnover of 11% for C&M NHS Trusts by Mar-25.	Subject to monthly monitoring by Workforce assurance meetings	O4 average for year to be 5.55 for sickness and 11% turnover				
Digital Data	NHS App access rates	Number of times patients accessed the NHS app to view their records Position at end of Q1 24/25 1,062,277 views per month	Not cumulative - maintain activity throughout the year	626,000 Per month	John Llewellyn	P6 P10 P11 PC1	Strategy and Transforma-tion Committee	Oversight framework
	NHS prescription requests NHS App	Number of repeat prescription requests via the NHS app Position at the end of Q1 223,219 views per month	See note above	191,000 Per month				

Helping the NHS to support social and economic development: -

ICB Core Purpose	Helping the NHS to support social and economic development: -									
Area	Objective	C&M 24/25 Planned ambition	Quarterly Trajectories				Board / Executive Lead	BAF Corporate Risk	Reporting Route	Driver/s
			Q1	Q2	Q3	Q4				
Sustainability and Partnerships	Strengthen partnership work to embed Social Value, Anchor and sustainability requirements across the ICS	To have increased the number of organisations signed up to the Anchor Framework and Social Value Charter				100 Org's Signed Up to SVC	Clare Watson	P1 P10	Strategy and Transformation Committee	JFP (NHS Delivery Plan) Health Care Partnership Plan
Social value	The refreshed Green Plan will set revised targets to deliver net zero	Series of priorities measured across 10 themes, reported to Sustainability Board, HCP and regionally.				Develop a travel and transport strategy				

Appendices

Appendix 1 – National NHS Objectives for 2024-25:

Area	Objective
Quality and patient safety	• Implement the Patient Safety Incident Response Framework (PSIRF)
Urgent and emergency care	• Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
	• Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
Primary and community services	• Improve community services waiting times, with a focus on reducing long waits
	• Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	• Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	• Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
	• Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%
	• Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
	• Improve patients' experience of choice at point of referral
Cancer	• Improve performance against the headline 62-day standard to 70% by March 2025
	• Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
	• Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	• Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
Maternity, neonatal and women's health	• Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment
	• Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities
Mental health	• Improve patient flow and work towards eliminating inappropriate out of area placements
	• Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)
	• Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery
	• Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025
	• Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025
People with a learning disability and autistic people	• Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025
	• Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population
Prevention and health inequalities	• Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025
	• Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025
	• Increase vaccination uptake for children and young people year on year towards WHO recommended levels
	• Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people
Workforce	• Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
	• Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
	• Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan
Use of resources	• Deliver a balanced net system financial position for 2024/25
	• Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

NHS
Cheshire and Merseyside

Meeting of the Integrated Care Board of NHS Cheshire and Merseyside

26 September 2024

NHS Cheshire and Merseyside Population Health Programme Update

Agenda Item No: ICB/09/24/21

Responsible Director: Prof. Ian Ashworth, Director of Population Health

NHS Cheshire and Merseyside Population Health Programme Update

1. Purpose of the Report

1.1. This paper provides the Board with highlights of the progress made by the Cheshire and Merseyside Population Health Programme.

1.2. This report provides the opportunity for the Board to be briefed on the collaborative approaches taken in primary and secondary prevention, including the tackling of Health Inequalities by partners across the Integrated Care System.

1.3. Given the breadth of the Population Health Programme, the Board may consider requesting the opportunity for more specific spotlight updates on population health programmes in the future.

2. Executive Summary

2.1. The Cheshire & Merseyside Population Health Programme aims to improve population health outcomes and reduce health inequalities by embedding a sustainable shift towards prevention and health equity.

2.2. The Population Health Partnership oversees and leads the Population Health Programme and reports to the ICB Strategy and Transformation Committee and Health and Care Partnership (HCP).

2.3. As part of the ICBs commitment to deliver its core objectives in improving population health and tackling health inequalities it has created a uniquely integrated population health team. This is a blended team including ICB officers, Cheshire and Merseyside Public Health Collaborative (CHAMPs) and other hosted team members that supports our ambitious Population Health Programme.

2.4. We have established a new Population Health Academy and an All Together Inspired Platform for shared learning in tackling inequalities across our nine places. The ICB has established itself as a recognised specialist training location for public health, attracting new Registrars and Population Health Fellowships.

2.5. The establishment of our Population Health Academy and Population Health Alliance network is helping us create a successful vehicle to support our wider workforce in embedding Data into Action and continuous improvement learning to help achieve better health outcomes for our residents.

2.6. The Programme covers four key pillars, and they are:
1. Social Determinants of Health and our All Together Fairer HCP plan
2. Supporting Healthy Behaviors
3. Tackling Health Inequalities
4. Enhancing Screening and Immunisation services.

2.7. This update provides selected examples of good practice across all 4 pillars and demonstrates how we have successfully embedded both population health and prevention approaches across the ICB with our partners; it also highlights where focused improvements could also be made.

2.8. The population health programme also supports the HCP delivery of its six headline ambitions which focus on;
1. Children and Young People
2. Physical Activity and Healthy Weight
3. Housing and Health
4. All Together Smokefree
5. Work and Health
6. Social Value.

2.9. As the new Government Ten-Year NHS Plan is developed, consideration of its Missions for improving Health, their Manifesto commitments and focus on prevention, all need to continually shape our ICS approach to improving population health.

2.10. The recently published Independent Investigation[1] of the National Health Service in England commissioned by the government and led by Lord Darzi, advises that the NHS needs to shift to provide more care closer to home, with a proportional increase in preventative investment upstream into primary care, mental health, and community-based services. It also acknowledges the impact of the social determinants on health / health inequalities and highlights that we are becoming a sicker and less productive society, which the government will aim to address through its health and growth missions.

3. Ask of the Board/Committee and Recommendations

3.1 **The Board/Committee is asked to:**

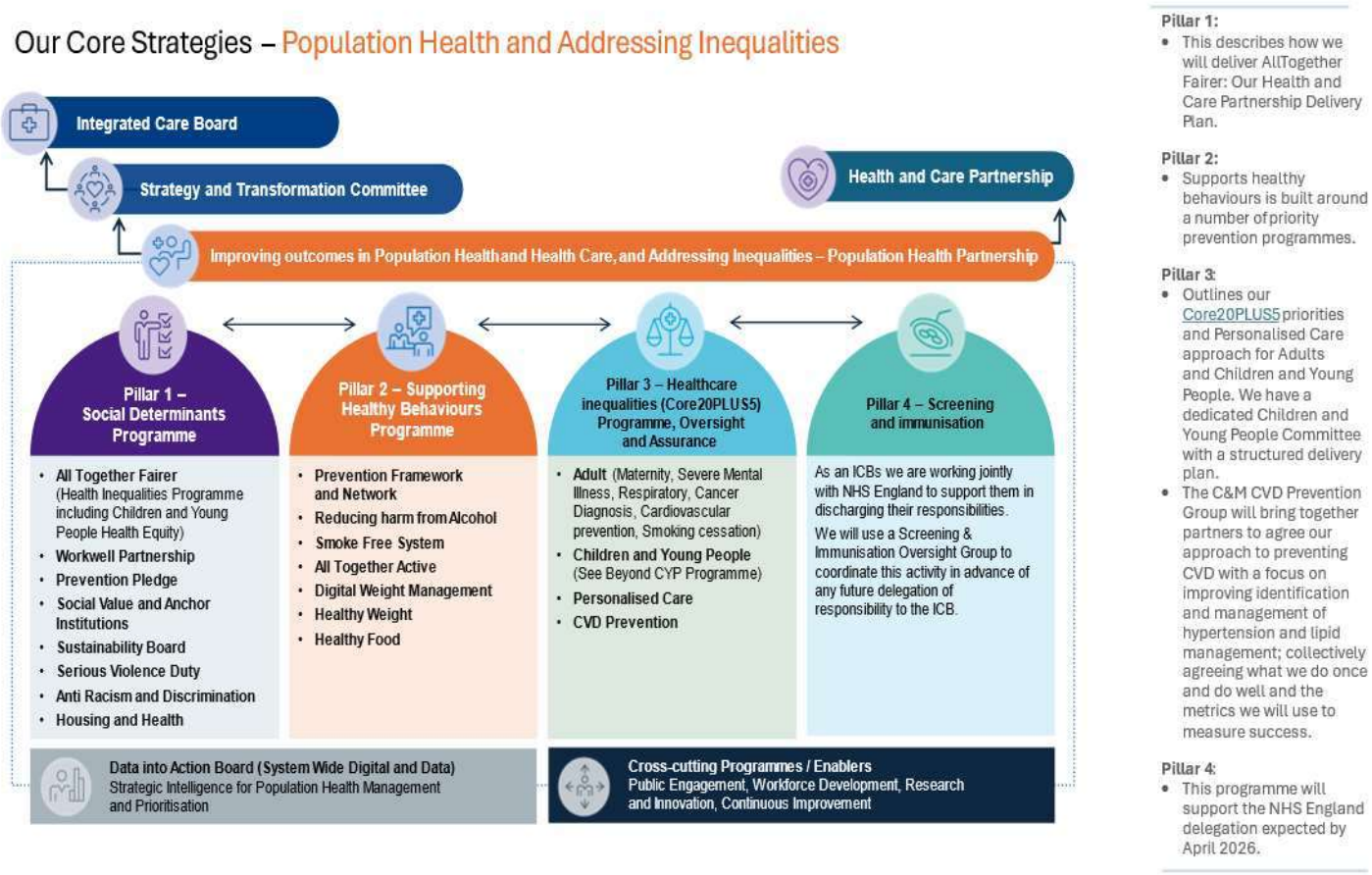
- Note the progress of the Population Health Partnership and provide comment on any spotlight areas to receive in the future.

4. Background

4.1. The overarching role and responsibilities of the ICB population health programme are described in Figure 1 Plan on a Page for 2024/ 25.

[1] www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england#

Figure 1 Population Health Plan on a Page 2024/ 25



4.2. Figure one describes the population health priorities of the ICB across four pillars of work. It includes priority health inequality and prevention programmes that have been set both nationally and locally and informed by our joint health needs analysis, Joint Forward Plan and Health and Care Partnership (HCP) priorities.

4.3. Oversight is provided through the new Population Health Partnership, which has a strategic and collaborative membership, with senior representatives from across our Integrated Care System partners. The Partnership reports directly to the ICB Strategy and Transformation Committee and to the Health and Care Partnership providing assurance and regular updates on each thematic area delivered.

4.4. As part of the significant work of the Health and Care Partnership, the ICB has also been reporting on a six-monthly basis to the Joint Health Overview and Scrutiny Committee for Cheshire and Merseyside, most recently on 13th September 2024.

4.5. During the last year, our HCP has made a clear commitment to adopt the delivery of our Marmot All Together Fairer Strategy as its new Health and Care Partnership Plan. At the heart of the plan is embedding prevention, tackling

poverty and inequalities across all our communities in Cheshire and Merseyside.

4.6. It recognises the fundamental importance of improving the social determinants of health, and that to do this we require an All Together Fairer approach. Within the new plan are six headline ambitions described in Figure 2.

Figure 2 - Health Care Partnership Headline ambitions

4.7. Collaborating with our partners and providing system leadership to improve population health and tackle inequalities are fundamental principles to our approach. The ICB does not act in isolation, and the strength and opportunity to work with our Integrated Care System partners is described within this paper, working jointly towards reducing the growth in prevalence of ill health and reducing the demand on wider health and care services.

4.8. The Population Health Partnership is also factoring the new Governments manifesto commitments and current national policy thinking on the establishment of a Health mission, in line with reported progress on the Hewitt Review [2] recommendations.

4.9. A potential national re-emphasis on primary prevention is emerging that requires significant input across central and local government and wider society. For example, preventing ill health in the first place by supporting healthier lives with action on smoking, obesity, alcohol, and physical activity. As captured in our own Marmot Community led work, a focus to improve the social determinants of health in areas related to air quality, housing and planning, employment conditions and early years development will be key to success. The Tobacco and vapes bill announced during the King's Speech [3]

[2] www.nhsconfed.org/long-reads/hewitt-review-where-are-we-one-year
[3] www.gov.uk/government/speeches/the-kings-speech-2024

advises of the introduction of legislation which will create a smoke-free generation by phasing out the ability to legally purchase tobacco products. The bill will also restrict vape products, limiting children's ability to access them.

4.10. For the ICB and NHS services that enable secondary prevention i.e., identifying risks or issues earlier and preventing disease progression, there are existing priorities and good practice to build on captured in this report. There are also areas for improvement which will require a more systematic approach across the NHS and its partners. These are aligned to the current thinking for national policy priorities and include areas such as mental health early intervention, improved CVD, and hypertension (blood pressure) management, weight management and earlier detection and awareness through Cancer Screening.

5. Our approach to Population Health and Prevention at scale

5.1. To enable the successful delivery of prevention and population health outcomes within our large integrated care system, the ICB Population Health Partnership provides system leadership, and is a convenor for collaboration with our committed partners from our Local Authorities, Public Health leaders, NHS Providers and Voluntary Community Faith and Social Enterprise Sector (VCFSE).

5.2. The following sections provide:

- an overview of the role of key partners in delivering our shared ambitions, including:
  - our Voluntary Community Faith and Social Enterprise (VCFSE) Sector
  - the Cheshire and Merseyside Public Health Collaborative (CHAMPs)
  - our NHS Providers in both Primary Care and Trusts
  - Cheshire and Merseyside Cancer Alliance.
- the types of prevention and social determinants work that our partners are leading
- detail of how we are growing and developing our population health workforce
- examples of some of the work being delivered against each of the 4 Pillars including:
  - Pillar 1: Prevention Pledge
  - Pillar 2: All Together Smokefree
  - Pillar 3: Cardiovascular Disease Prevention and the Targeted Lung Health Checks programme
  - Pillar 4: Screening and Immunisations, including the Living Well service.

The Role of Voluntary Community Faith and Social Enterprise (VCFSE) Sector

5.3 Building on the first ever State of the Sector review commissioned by the ICB, our system continues to recognise the vital role the sector plays in tackling inequalities and improving population health within local communities. The ICB has invested in establishing VCFSE infrastructure and also welcomed the

sectors contribution as full members of the ICB Board and Co-chairs of the HCP.

5.4 VCFSE will be leading the agenda at the October 2024 HCP meeting and highlighting examples of effective partnership working and delivery to increase wider health outcomes for population. An example of its success includes its unique role with the Cancer Alliance and promoting the early detection of cancer. Over the last two years the Alliance was able to facilitate investment of £600,000 via CVSs to 100 plus VCFSE providers, delivering effective hyperlocal engagement, supporting early cancer diagnosis and prevention, and encouraging people to attend for cancer screening.

5.5 This work achieved reach into targeted communities as trusted local organisations promoting health awareness messages. Conversations with 12,000 people from diverse communities were achieved over an 18-month period. This contributed to the Cheshire and Merseyside Cancer Alliance ranking joint top in most improved rates of early diagnosis of cancer in England over the past year. An academic evaluation referenced working with VCFSE's through CVSs as a key success factor. NHS England have referenced the approach in draft planning guidance for Cancer Alliances in 2024 – 2025.

Cheshire and Merseyside Public Health Collaborative (CHAMPs) including work on All Together Smokefree, Child Poverty and Healthy Advertising

5.6 Building on the strong public health collaboration established with our nine Local Authority Partners, and their Directors of Public Health, the ICB has established and resourced a uniquely integrated population health team which is a blended team including ICB officers, CHAMPs Collaborative and other hosted team members. This approach ensures alignment and joint working to be achieved with all our local areas.

5.7 Our Local Authorities are primarily responsible for delivering primary prevention and are best placed to maximise the impact of tackling the social determinants of health. The joined up strategic approach to All Together Fairer[4] has been able to achieve some of the following examples of prevention and best practice that has been shared nationally and locally. This work primarily delivers against Pillars 1 and 2.

5.8 Our joined-up approach received national recognition and provides a foundation for delivering effective prevention programmes at scale. No other area in the country benefits from a Directors of Public Health Executive Board with NHS presence, distributed leadership, and a dedicated support team – making Cheshire and Merseyside's model truly unique. The CHAMPs Board has representatives from key public health system partners and collaborates with a wide range of sub-regional and national organisations.

5.9 An example of what can be achieved using this approach is our shared ambition around All Together Smokefree and influencing national public health policy development, Child Poverty and Healthy Advertising.

[4] All Together Fairer | Champs Public Health Collaborative

All Together Smokefree

5.10 All Together Smokefree is our jointly funded programme between all nine local authorities and the ICB, that brings together our NHS Treating Tobacco services and Council commissioned community services with a clear aim to end smoking everywhere for everyone in Cheshire and Merseyside.

5.11 Smoking harms are well understood. Smoking kills two in three smokers and is the leading modifiable risk factor responsible for health inequalities. One in four patients in a hospital bed is a person who smokes, causing 500,000 admissions each year, with smokers seeing GPs over a third more than non-smokers. Smoking accounts for half the difference in life expectancy between the richest and poorest, costing the Cheshire and Merseyside economy £1.9bn with the costs to healthcare totaling £73.2m.

5.12 Cheshire and Merseyside smoking rates have fallen to 11.7% in 2022, below the England average of 12.7%. However, to be classed as smokefree, this prevalence rate must be below 5% by 2030.

5.13 The Cheshire and Merseyside Strategic Framework (Appendix 1) builds on our strong history of tobacco control and has developed from locality plans and insights, using a sector led improvement approach. The framework builds from the evidence base, describing how we plan to deliver on national 2030 targets including the WHO MPOWER framework[5], and Action on Smoking and Health (ASH) principles for developing a system-wide tobacco control programme[6]. It takes an iterative approach to delivering a Smokefree 2030 over the next five years, reviewed annually to build on and deliver a co-owned and cohesive tobacco control programme.

5.14 Bringing together the NHS Treating Tobacco Dependency programmes alongside our Local Authority commissioned community specialist stop smoking services is a critical success factor for this programme.

5.15 Having a unified collegiate approach to achieving smokefree also helps us to strongly advocate for national policies that can make significant improvements to us locally. For example, the return of The Tobacco and Vapes Bill will create a historic piece of legislation that will see the first Smokefree Generation in this country.

Child Poverty

5.16 In 2024, a Child and Family Poverty in Cheshire and Merseyside situational analysis was commissioned by CHAMPs following recognition of poverty as a key determinant of health equity. Work to challenge poverty was agreed as an overarching principle of the Health and Care Partnership strategy.

[5] www.who.int/initiatives/mpower
[6] www.ash.org.uk/resources/local-toolkit/developing-a-system-wide-tobacco-control-programme

5.17 The analysis has been completed, and the report[7] setting out a framework for action was published in September 2024. The analysis found that there are 100,300 children aged under 16 years in Cheshire and Merseyside living in relative low-income families. Between 2021/22 and 2022/23, Cheshire and Merseyside's position for this measure moved from being significantly better than the England average to significantly worse. Developing actions to respond to this work will be a key focus of the All Together Fairer programme for the remainder of 2024 and 2025.

Healthy Advertising

5.18 Of note in 2024, is the development of council led Healthy Advertising Policy. This activity is based on research showing the impact of food advertising on population obesity levels and the positive impact that can be achieved when such advertising is restricted in council owned advertising space.

5.19 The work in Cheshire and Merseyside was initially led by the public health team in Knowsley. To date, Knowsley, Sefton, Cheshire West & Chester and Liverpool City Councils now have a Healthy Advertising Policy in place. Other councils in Cheshire and Merseyside are working towards adopting similar policies.

The Role of our NHS Providers in tackling Health Inequalities

5.20 Our NHS Prevention Pledge programme (Pillar 1) that all Cheshire and Merseyside NHS Trusts have signed up to is delivering against the 14 core commitments which include the systematic application of Making Every Contact Count (MECC) to increasing the number of brief/ very brief interventions with patients supporting them to eat well, be physically active, reduce harm from alcohol and tobacco and promote mental well-being.

5.21 The Prevention Pledge Annual Summit planned for 15th October 2024 will bring together Cheshire and Merseyside's provider Trusts and key stakeholders from across the system to celebrate the successes and learning to date in the roll out of the NHS Prevention Pledge to both Trusts and Primary Care Networks. The work of the ICB, Health Equalities Group and all our Trusts was recognised in a recent NHS Confederation publication to reduce health inequalities.

5.22 Our Provider Trusts continue to innovate and develop approaches to tackle healthcare inequalities. Working with the Provider Collaboratives we have established a Health Inequalities Quality Contract Schedule with our NHS providers to help utilise and monitor the use of best practice tools, embedding the NHS Prevention Pledge and NHSCORE20PLUS5 approaches including Implementing the Northwest Black, Asian and Minority Ethnic Assembly Framework within their organisations. Our Audit Committee Chairs network have also proactively engaged in how to support the requirements of the schedule and the new health inequalities duty.

5.23 Our Primary Care providers are also crucial in both the delivery of primary and secondary prevention advice and the interventions they offer to support our

[7] Joint statement on child and family poverty in Cheshire and Merseyside | Champs Public Health Collaborative

populations health needs. Further work is described in para 5.10. about their key role in CVD Prevention. Building on the successful NHS Prevention Pledge described above with Trusts we are supporting Primary Care Networks in adopting the Pledge approach. Five Primary Care Networks (PCN's) are currently taking part from Warrington, Wirral, Liverpool (x2) and Cheshire East.

Growing and developing our Population Health Workforce

5.24 Contributing to the development of our workforce and embedding the use of our innovative Population Health Management platforms, such as CIPHA, is essential to ensure we turn Data into Action. Working with Health Innovation Northwest Coast we have established a new Population Health Academy. Three supported cohorts made up of approximately 70 ICS staff will be going through the academy in 2024/25.

5.25 As part of the Academy, we have established an Analyst Development programme with the University of Liverpool, offering modules to over 150 analysts from across our ICS including NHS providers, Locals Authorities, Police, Housing and Fire and Rescue.

5.26 The Academy has also established a network of online leaning with 4/5 Masterclass sessions planned per year. We have prioritised learning on the use of our Enhanced Case Finding Tools, Waiting List tools and Health Inequalities which colleagues can use back in their respective organisations. We have already seen an increase to over 420 users of the enhanced case finding tool and 234 users of the fuel poverty dashboards. Targeted analytical work has also seen 130 diabetic patients on waiting lists being proactively offered prehabilitation programmes in Wirral.

5.27 The ICB has also established itself as a nationally approved training location for specialist public health training and attracted Registrars and new Population Health Fellows. Our Cheshire and Merseyside ICS workforce continues to show their passion for prevention and tackling inequalities, with the take up of 27 NHSCORE20PLUS5 [8]Ambassadors and new Healthcare Financial Management Association Health Inequality Fellowships. We have also established a Population Health Alliance Network.

5.28 Our All Together Inspired Online Learning Hub is a new platform that brings together the latest resources, case studies, tools and training relating to health inequalities and the social determinants of health for all our partners.

5.29 The Cheshire and Merseyside Cancer Alliance (CMCA) has established an innovative and impactful '1,2,3 Approach' to Health Inequalities Training programme which following an initial pilot has been used to develop a successful and sustainable approach to tackling health inequality. It has been successful within CMCA in helping staff to understand and use Health Inequalities and Patient Experience (HIPE) insights with a 34% reported

[8] www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

increase in knowledge and confidence in tackling health inequalities among its attendees.

5.30 The programme has been designed in collaboration with people who have lived experience of cancer and NHS colleagues working across the cancer pathway. The course has been fully funded, CPD accredited and aligned to the ACCEND framework. It should take between 60 – 90 minutes to complete. There is an opportunity to build on this locally developed training programme across the ICS and adapt the principles of the training to non-cancer related areas.

5.31 There are now more than 75 members within the HIPE Staff Network from a wide range of services across the region including maternity services, Integrated Care Boards, Primary Care, Tertiary Care and psychosocial support teams.

Cardiovascular Disease (CVD) Prevention

5.32 One of our priority areas is CVD Prevention (Pillar 3). CVD affects around 7 million people in the UK and is a significant cause of disability and death. It is the biggest contributor to the gap in life expectancy in the Northwest of England and a leading cause of premature death and health inequalities in Cheshire and Merseyside. It is associated with deeply embedded inequalities and those in the most deprived 10% of the population are twice as likely to die as a result of CVD, than those in the least deprived 10%.

5.33 A person has high risk of CVD if they have atrial fibrillation (AF), high blood pressure (B: hypertension) or high cholesterol (C). Early detection and treatment of these high-risk ABC conditions reduces mortality and morbidity and improves quality of life. Our Primary Care colleagues have a key role to play in preventing cardiovascular disease. In Cheshire and Merseyside, it is estimated that improved blood pressure control alone could prevent around 1,500 additional heart attacks and strokes over the next 3 years. The NHS England Long Term Plan has committed to a number of key ambitions around CVD prevention.

5.34 NHS Cheshire and Merseyside provide leadership and programme management for the CVD Prevention programme. A renewed and co-ordinated focus on CVD Prevention in the ICB provides an opportunity to build on the excellent work already undertaken and underway across the Health Care Partnership by the NHS, Local Authorities, our VCFSE partners and many others.

5.35 The role of and work being undertaken in Primary Care is crucial and includes not just the plethora of ABC work delivered in General Practice, but in Community Pharmacy as part of the Pharmacy First programme to support identification and treatment of high Blood Pressure. The ICB has also been successful in securing national funding for an Atrial Fibrillation and Blood Pressure Optometry pilot in a small number of Opticians in Cheshire and Merseyside.

5.36 We will also be working with OHID and our Local Authority partners who hold the mandated responsibility for commissioning NHS Health Checks to proactively increase the numbers of health checks delivered and the benefits of support and intervention.

5.37 The ICB has been funding a Familial Hypercholesterolaemia (FH) service pilot which diagnoses both the primary case with FH and their familial contacts via genetic testing and cascade screening. Without treatment at least 50% of men with FH will develop CHD by age 50, and 30% of women by age 60. Once identified, treatment with statins reduces the risk of CHD to approximately general population levels.

5.38 The ICB have also been funding a CVD Prevention service which is linked to and receives referrals from the Targeted Lung Health Check (TLHC) programme for people whose low dose CT scans show a new incidental finding of Coronary Artery Calcification (CAC) as part of routine TLHC (circa 1800 patients a year). CAC puts patients at higher risk of having a cardiovascular event in the future and the CVD Prevention service enables those patients to be seen and treated appropriately. This work supports both our approach to tackling health inequalities and supports our commitment to early Cancer diagnosis and CVD prevention which are key clinical areas in the CORE20PLUS5 framework. Further information on the TLHC programme is detailed below.

5.39 Immediate plans for CVD Prevention with partners include:

- Work with those GP practices furthest away from the hypertension target ambition.
- A renewed focus with OHID and Local Authorities on NHS Health Checks.
- Ensuring optimum use of Data into Action enhanced case finding tools.
- Review CVD Prevention dashboard and agree key metrics to measure progress
- Raise the profile of CVD Prevention within the ICB and with all partners.
- Re-establish Cheshire & Merseyside CVD Prevention group as the key forum to drive improvements.

Targeted Lung Health Check (TLHC) Programme

5.40 The recent introduction of the Targeted Lung Health Check (TLHC) programme is another strong example of secondary prevention in action. TLHC is a screening programme for people aged between 55 and 74 who have ever smoked. They are currently offered in certain parts of England where there is a high incidence of smoking and lung cancer. In Cheshire and Merseyside, they are being offered in Liverpool, Halton, Knowsley, St Helens and South Sefton and more recently in Wirral. In June 2023, the Government announced that TLHCs was now a national screening programme, which would roll out to cover the whole of the country over the next several years.

5.41 CMCA continues to lead the TLHC programme across Cheshire and Merseyside, with support from ICB Place teams where the checks are being

conducted, and in partnership with Liverpool Heart and Chest Hospital, which administers the checks and associated CT scans.

5.42 It is CMCAs biggest programme of work in terms of complexity and finance and is successfully shifting a proportion of diagnosis of lung cancer in the areas it covers from later stages 3 and 4 to early stages 1 and 2. This has a significant impact on outcomes for these patients with a much higher proportion of them having successful curative treatment, which is also simpler to perform.

5.43 In Cheshire and Merseyside, up until the end of March 2024, 127,680 invitations for a check had been sent out, with 55,247 Lung Health Check appointments attended. High risk patients are offered a CT scan in a mobile unit near to where they live, and 35,829 scans have been carried out. These scans prompted 832 suspected cancer referrals, and 412 cancers were identified – 1.2% of total participants – and 85% of those were identified at stages 1 and 2, compared with only 28% from the normal diagnostic route.

5.44 The uptake in Phase 3 (St Helens and South Sefton) increased when a direct booking service was introduced. Considerable work took place during 2023/24 on arrangements to support the rollout of Phase 4 of the programme in the sub-region, with CMCA liaising with Place teams and Primary Care to ensure smooth implementation to Wirral, Warrington and North Sefton.

5.45 Lung health checks are now being rolled-out to the rest of the population of Cheshire and Merseyside with Warrington due in early September 2024 and then in January 2025 North Sefton.

5.46 Phase 5 of the programme is due to begin in the remaining parts of Cheshire during 2025/26. We have also worked across the system to ensure adequate smoking cessation and spirometry services are available to participants.

5.47 TLHCs are now the fourth national screening programme and Cheshire and Merseyside is well placed to have invited 100% of its eligible population by March 2027.

Immunisations and Screening including targeted Outreach Approaches

5.48 Increasing uptake in our immunisation and screening programmes (Pillar 4) provides significant preventative health benefits to our residents. This is why we have established a new Screening and Immunisation Oversight Group (SIOG) which is co-chaired by the ICB and NHS England Northwest. The SIOG brings together those who are both working on and who have an interest in Screening & Immunisation Programmes in the Cheshire & Merseyside system to:

- agree our shared ambitions and align our priorities
- work together on improving uptake, coverage and participation in all screening and immunisation programmes
- support joining up pathways and
- ensure that collectively we make the best use of our resources to provide the best services for our population

5.49 As we approach the winter months a key focus for the system is our winter vaccination programmes including seasonal influenza and COVID-19 programmes. There is also the introduction of the new respiratory syncytial virus (RSV) vaccination programme for those who are pregnant and those aged 75 – 79. RSV is a common cause of coughs and colds, and most people will get it several times during their life. Vaccinating during pregnancy helps to protects babies after they are born.

5.50 The Board have previously seen the importance of our partnership work in promoting childhood vaccination programmes to prevent Measles and Pertussis (whooping cough), and this work remains at the forefront of the SIOG.

5.51 With regards to Screening, a vital secondary prevention service, the ICB is working with colleagues in NHS England Northwest and the Cheshire and Merseyside Cancer Alliance to improve screening data for the Breast, Bowel and Cervical screening programmes which will support targeted interventions to improve uptake and participation in the populations we need to work with most.

5.52 A renewed focus will be on the Abdominal Aortic Aneurysm (AAA) screening programme which is a way of checking if there is a bulge or swelling in the aorta. It can be serious if it's not spotted early as it could get bigger and eventually rupture. Screening is offered to men during the year they turn 65. However, it isn't as well-known as other screening programmes so work will be undertaken during 24/ 25 to promote it.

5.53 In April 2026, the expectation is that commissioning responsibility for all Section 7a Screening and Immunisation services will be delegated to ICBs. The current commissioner are NHS England. The SIOG will help to ensure that this transition is as seamless as possible.

Living Well Service Evolution

5.54 The Living Well Outreach services was initially introduced to specifically improve access to COVID vaccination within communities identified as under-served by mass vaccination provision. Its potential is being realised, to improve both low vaccination uptake and wider health inequalities work, that is driven by NHSCore20Plus5 priorities. The service has begun to evolve its offer which now includes:

- Seasonal vaccinations: over 24,000 COVID vaccinations delivered to date and over 785 Flu and they will support the new RSV programme
- Physical Health Checks that have seen over 31,000 health checks conducted with a 21% referral rate into Primary Care
- MECC, Mental Health support and wider wellbeing guidance with 11,000 MECC interventions provided
- Migrant health project – increasing routine vaccination uptake in our migrant health population with 821 new individuals protected by vaccinations
- Cervical screening – increasing uptake of cervical screening in non-responders to GP invites (Sefton place) with 202 Cervical screens delivered in the first 10 weeks of the pilot with further venues planned in other parts Cheshire and Merseyside in quarter 4

5.55 The service delivered through the Cheshire and Wirral Partnership NHS Foundation Trust [9] has continually demonstrated its agility to support and provide preventative services to some of our most deprived and less connected communities.

5.56 The mobile health and wellbeing service was recently a finalist and highly commended in the Estates Optimisation Project of the Year at the HSJ Partnership Awards in 2023 in recognition of its achievements to date addressing key health inequalities.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic development**

6.1 This paper provides an update on the Population Health programme and All Together Fairer, Our Health and Care Partnership Plan that is based on all eight Marmot priorities. The paper provides an overview of primary and secondary prevention examples by the ICB and its partners. It gives examples of how we are improving population health outcomes, tackle inequalities, creating financial benefits. It also reinforces the specific benefits that our Hospital Trusts create, in supporting broader and economic development as part of the NHS Prevention Pledge programme.

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

7.1 This report directly addresses the Population Health objectives [10] described within the Annual Delivery Plan.

8. Link to meeting CQC ICS Themes and Quality Statements

8.1 **Theme One: Quality and Safety**
The paper identifies the importance of equity of access and inequalities created by limited access to health services, examples provided in the paper include the delivery of screening and immunisation programmes within targeted communities.

[9] www.cwp.nhs.uk/livingwellservice
[10] www.cheshireandmerseyside.nhs.uk/media/2kvcnuzm/summary-version-of-the-jfp-delivery-plan-260623.pdf

8.2 **Theme Two: Integration**
The introduction of the Data into Action Programme and Population Health Academy enables staff and teams to gain Intelliegnce and insight into their patients and their communities health needs to inform service planning and population level responses.

8.3 **Theme Three: Leadership**
The paper provides multiple examples around the importance of system leadership and partnership work across all public agencies to improve the quality of health outcomes. The work of the Screening and immunisation Oversight Group will also be reporting progress to the Quality and performance committee of the ICB.

9. Risks

9.1 The Population Health Partnership regularly updates its Board Assurance Framework on *P1 The ICB is unable to meet its statutory duties to address health inequalities*.

9.2 Longstanding social, economic and health inequalities exist across Cheshire and Merseyside, when comparing outcomes both between different communities in our area and the national average for Health Inequalities.

9.3 Population health and wellbeing is shaped by social, economic, and environmental conditions in which people are born, grow, live, and work. This can only be addressed through collective systemwide effort and investment across the partnership, our communities, the NHS, Local Government, and Voluntary and Private sectors. This risk relates to the potential inability of the ICB to secure the necessary investment and influence priorities across multiple organisations, agencies and communities covered by the ICB. This ICB paper describes these complexities, whilst also providing examples of positive interventions.

9.4 As the NHS and its partners face significant economic challenges, the main risk to addressing health inequalities remains systemwide investment levels.

10. Finance

10.1. There are no new financial asks within the paper as it is providing an update to the board on progress. However, programmes that are delivering prevention and tackling health inequalities featured in the report, still face significant uncertainty in the scale, pace and continuation of their services.

11. Communication and Engagement

11.1. The paper provides an overview of system wide responses to population health that have been informed by significant local engagement, staff and patient engagement such as the Cancer Alliance Health Inequalities and Patient Experience programme or targeted communication campaigns for childhood immunisations.

12. Equality, Diversity and Inclusion

12.1. The paper complements the work of Equality Diversity and Inclusion, referencing the inclusion of implementing the Northwest Black, Asian and Minority Ethnic Assembly Framework into the Quality Contracts of our NHS providers.

12.2. The work of All Together Fairer also has a dedicated recommendation focused on Tackling Racism and Discrimination and all of its Outcomes. Our approach improves migrant health outcomes, the Living Well service provides evidence toward this.

13. Climate Change / Sustainability

13.1 The Population Health partnership provides governance to the Sustainability Board and the priorities reference the importance of tackling poor air quality to improve health outcomes.

14. Next Steps and Responsible Person to take forward

14.1. The Board have been provided with an update on the Population Health Programme with examples on primary and secondary prevention approaches being taken by the ICB, NHS sectors, Central and Local Government.

14.2. The breadth of the work covered by the Population Health Partnership and the Integrated Care System partners is significant, it is recommended that more focused spotlight updates are provided on the four Pillars of Population health in the future.

14.3. Any recommendations from the Board will be progressed by the Director of Population Health who is responsible for the programme.

15. Officer contact details for more information

15.1 Prof. Ian Ashworth, Director of Population Health
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16. Appendices

Appendix 1: The C&M All Together Smokefree Strategic Framework

MPOWER Components	All Together Smokefree Framework Actions – Ending Smoking. Everywhere. For Everyone.
Monitor tobacco use and prevention policies	Support the achievement of national targets through commiting to 2030 targets at CM and local levels. Develop digital platform for data collection, analysis and monitoring (and engagement). Ensure programmes and projects are built on evidence and insight and build national leadership role for CM research, innovation and development partnerships.
Protect people from tobacco smoke	Expand smokefree policies and places including through the Prevention Pledge. Work with housing partners to support smokefree homes and wider partners to support healthy streets and spaces for children. Advocate for legislation promoting smokefree environments.
Offer help to quit tobacco use	Enhance access to quit support including integrating NHS Tobacco Dependency support with community support. Develop standardised universal offers, including 24/7 digital stop smoking offers, with targeted support for priority populations. Promote awareness of available support.
Warn about the dangers of tobacco	Implement multimedia campaigns at scale embedding at system and local level. Target messaging to priority populations. Amplify national campaigns. Deliver a programme of proactive PR. Deliver resources and communications approaches to prevent uptake of CYP vaping and smoking supported through locality community, schools and youth education programmes. Advocate through the Smokefree Action Coalition including for pack inserts and warnings on individual cigarettes.
Enforce tobacco regulation	Collaborate with regulatory agencies to enforce high levels of compliance with existing tobacco *and vaping* regulation. Work with Smokefree Action Coalition partners to advocation for stronger tobacco and vape regulation including through the current Tobacco and Vapes Bill and ban on disposable vapes. Continue to advocate for a levy on the Tobacco Industry to fund tobacco control activity .
Raise taxes on tobacco	Advocate for continued tobacco tax escalator. Implement a comprehensive illicit tobacco programme to maintain the price driver.

NHS
Cheshire and Merseyside

Meeting Held in PUBLIC of the Board of
NHS Cheshire and Merseyside

Held at the Bridge Suite, DCBL Stadium Halton, Lowerhouse Lane, Widnes, Cheshire, WA8 7DZ

Thursday 25 July 2024
09:30 – 13:45

Unconfirmed Draft Minutes

Recording available at: NHS Cheshire and Merseyside Integrated Care Board - 25th July 2024 (youtube.com)

ATTENDANCE	
Name	**Role**
Members	
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, Cheshire & Merseyside ICB (voting member)
Claire Wilson	Executive Director of Finance, Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Neil Large, MBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof. Hilary Garratt, CBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof. Joe Rafferty, CBE	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Ann Marr, OBE	Partner Member, (NHS Trust), Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care) Cheshire and Merseyside ICB (voting member)
Dr Naomi Rankin	Partner Member (Primary Care), Cheshire & Merseyside ICB (voting member) Partner Member (voting member)
In Attendance	
Andrew Lewis	*Incoming* Partner Member (Local Authority), Cheshire & Merseyside ICB
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (Regular Participant)
Christine Samosa	Chief People Officer, Cheshire & Merseyside ICB (Regular Participant)
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)
Dave Wilson	Chief Executive, Healthwatch Halton
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)

Jennie Williams	(Minutes) Senior Executive Assistant, Cheshire & Merseyside ICB
Rev Canon Dr Ellen Loudon	Vice Chair, Cheshire and Merseyside Health and Care Partnership, (Regular Participant)
Rob Cooper	Managing Director, Mersey and West Lancashire NHS Trust
Claire James	Mental Health Programme Director
Rachel Smethurst	Mental Health Programme Manager
Isla Wilson	Chair of Cheshire and Wirral Partnership Trust, Chair of Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services Provider Collaborative
Tony Maher	Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services Provider Collaborative
Louise Robson	Chair of Health Innovation North West Coast (Regular Participant)
Tony Leo	Halton Place Director, Cheshire and Merseyside ICB
Carl Marsh	Warrington Place Director, Cheshire and Merseyside ICB

Apologies	
Name	**Role**
Warren Escadale	Chief Executive, Voluntary Sector North West (Regular Participant)
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (Regular Participant)
Prof. Steven Broomhead, MBE	Partner Member (Local Authority), Cheshire & Merseyside ICB (voting member)

Agenda Item, Discussion, Outcomes and Action Points
Preliminary Business
ICB/07/24/01 - Welcome, Apologies and Confirmation of Quoracy
All present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. Apologies for absence were noted as above.
ICB/07/24/02 - Declarations of Interest
There were no declarations of interest made by Members that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.
ICB/07/24/03 - Report of the ICB Chair
The Chair introduced and welcomed Andrew Lewis, the new partner member of the Board who will represent Local Authorities, and confirmed the re-appointment of Erica Morriss in a further term as Non-Executive Director. **The Board Resolved to -** **Note the updates as outlined within the report.**
ICB/07/24/04 - Experience and Achievement Story
The Board received an experience and achievement video on the subject of measles from Professor Ian Ashworth.

The Chair summarised the importance of proactively protecting the children of Cheshire and Merseyside, which the system does well.

ICB/07/24/05 - Report of the ICB Chief Executive

The Chief Executive highlighted to the Board –

- GP Collective Action – the new government has commenced talks with junior doctors on industrial action. General Practitioners have taken a ballot, described as collective action, GPs are not directly employed by the NHS. GP's, the Department of Health and NHS England could not reach an agreement on the contract for the year already commenced, therefore the contract of an uplift of 1.9% was imposed. GP's will take collective action to improve their negotiation position with the government, specifically around financial settlement. GP's will not break contract, the BMA have published a list of 9 items that GPs should consider, varying how they work when collective action commences. GP's will not co-operate with schemes that are designed to reduce the cost of prescribing and they may restrict the number of appointments per GP, per day, however patients with an urgent medical need will be seen. Emergency planning response will be set up for collective action, responses will be monitored, and appropriate contingency action will be taken where necessary if pressures emerge within the system. The right for GPs to take collective action is respected.

- GP Survey Results - high level GP survey results have been received, and practices have received their own data. The ICB has received PCN level data, the GP patient survey results identify that in Cheshire and Merseyside patients are likely to have slightly better experience of GP services than the England average, however there is wide variation when measured across PCN's. Practices with the poorest results will be supported to improve the quickest.

- Investment in inequalities – dealing with the challenges of today, crowds out the ability to make investment in health and care for the future. Through the Health and Care Partnership a modest investment has been made in ensuring money is spent on upstream primary prevention, priorities have been agreed with a mechanism for some of the monies to be spent on a single approach. Decisions on spend will rest at Place level, however a strong steer has been made towards children and young people.

- After 37 years' service to the NHS the ICB Chief People Officer has announced that she will leave the ICB in December 2024. The process for full, open and transparent recruitment to the role has been commenced.

The Board Discussed –

- Diagnostics – World Patient Safety Week commences on 17th September 2024, with a focus on improving diagnosis for patient safety, the slogan used is "Getting it Right, Making it Safe". The focus of the System Quality Group in September will be around diagnostics delivered within the system.
- Impact of the Microsoft outage on the services of NHS Cheshire and Merseyside – there were significant impacts on services, however, were remediated quickly. The biggest impact was in Primary Care, community services and urgent care with EMIS going offline completely. There were significant issues with the Allocate system used for planned shift work and allocation of resources in hospital settings. There are a number of lessons to be learned and work to be undertaken with suppliers around offline systems. Primary Care and Practice colleagues were thanked for their efforts, the pressures that they were put under were of note.

The Board Resolved to -
Note the updates as outlined within the report.

ICB/07/24/06 - Report of the ICB Director of Nursing and Care

The Director of Nursing and Care provided an update to the Board highlighting –

- All Age Continuing Health Care is a focus for recovery priorities to ensure that there is quality provision and equity of service, along with financial spend. A complete review of the target operating model for all age continuing health care for the system was commenced and is still in progress and will go out to consultation with staff involved. The plan to implement the proposed model by early October 2024. Following the implementation, metrics will be further developed to ensure quality performance targets for all age continuing health care are met. Launch sessions have been undertaken and a set of frequently asked questions have been created.
- Patient Safety Strategy – there has been a review of all system partner patient safety investigation priorities. The development of wider patient safety collaboratives is underway, working within the system to look at initial focus. Following the successful implementation of the patient safety incident response framework with non-NHS Providers, now progressing on implementation proportionately in Primary care and care home sector.

The Board Discussed –

- The efficiencies of all age continuing health care review – the recovery plan for this year includes a target in line with current CIP plans and is assumed to be delivered in position. The target operating model is a separate piece of work to the recovery plan, the recovery programme is assumed within the position. Previously, agency staff have been used to assess patients, using a team from within the ICB will create savings. The ICB are not on target to hit predicted reduction of spend on CHC in the first quarter. The Director of Nursing is working closely with the SRO leading on financial recovery to address finance and quality provision. Arrangements to agree spend and packages of care are in progress.
- The development of the patient safety strategy to include primary care was welcomed.
- Patients on low income who don't qualify for continuing health care fall back on local authority social care provision.
- The assurance processes in place for safeguarding to highlight when the ICB are not meeting statutory functions, this is picked up through system oversight board and feeds into quality and performance committee. This is monitored and measured working closely with the national team around who can deliver this area of provision. There are escalation process in place where there are specific instances that the ICB are not meeting statutory duties, the ICB have the ability to respond, despite having vacancies. The Director of Nursing will follow this up at the Quality and Performance Committee.
- Patient Safety Strategy – each organisation has a patient safety strategy, there is no ICB specific strategy, however a clinical and care strategy is being developed led by the Medical Director that focuses on quality and safety.

Action –

- **The Director of Nursing and the Chair of the Quality and Performance Committee to consider whether the ICB should have a patient strategy with a clear rationale.**

The Board Resolved to -
Note the updates as outlined within the report

ICB/07/24/07 - NHS Cheshire and Merseyside Finance Report Month 2

The Executive Director of Finance provided an update to the Board for Month 2 to the end of June 2024 and highlighted the following key areas –

- There is an agreed a deficit plan of £150m for the system by the end of the year. At month 2 there was a deficit of £68.8m against a planned deficit of £64.5m, which means the ICB is off plan by £4.3m. The bigger risk is the amount of assumptions currently within the remainder of the plan for the remainder of the year around efficiencies to be delivered. The profile of efficiencies within the planned position across all organisations is profiled towards the end of the year. In two months, a deficit of almost 50% of the full year deficit plan has been incurred.

- The year-to-date variants of £4.3m is the ICB. The ICB's cost improvement programmes are more evenly distributed than providers, however, is experiencing overspends already in complex care packages in both all age continuing care and mental health packages.
- The ICB has been identified as one of 10 systems subject to an external review and support process looking at all cost improvement programmes and grip and control of financial governance processes across all organisations with a view to helping and supporting identify areas where we need to do more to deliver this year's plan. This is a welcomed mandated process. Getting a grip on the financial position is important to deliver on statutory duties, but to enable to provide more sustainable services for patients in the future.

The Board Discussed –

- In year position being very challenging with CIP being one of the biggest risks, and having an update on month 3 and update on progress with PWC at the Board Development Session in August 2024.
- Underlying position and the progress being made on a 3-year service and financial strategy to make assumptions and understand if it is achievable to support the system. Assumptions over the next 5 years have been mapped out and the size of the challenge is known. A long-term financial model enables the estimated gap to be seen. The recovery programme will help to address the gap. High level estimates have been undertaken on how much can be saved, which will be owned by the recovery programmes. An update will be received at the September 2024 Board meeting. The long-term financial plan previously received at Board in winter 2023 can be refreshed to include recovery plans for deficit organisations.
- Assurance in relation to capacity and capability in the recovery programmes in undertaking impact assessments. The opportunity of 9 places coming together and breaking down silos to plan something more effective, and tackling fragility in services and reorganising services to improve them. There is clinical leadership in every part of the recovery plan and within each of the workstreams there are quality impact assessments. The patient must always come first, and the clinical voice must be heard.
- The importance of clinical leadership and co-ownership in the recovery space. The only way success will be achieved is with a unitary board with clinical, operational and financial teams working together, with joint ownership of joint priorities.
- Provider in year delivery of Cost Improvement Plans – the ICB is working closely with providers collecting detail on all plans to review and gain assurance. Peer support and peer learning is more important across providers. The ICB Director of Finance meets with provider Directors of Finance fortnightly face to face, each provider runs through their CIP approach, PMO approach and detail of schemes with their colleagues. This enables sharing of best practice, peer accountability and transparency. Looking for organisations who are delivering non-recurrent efficiencies to challenge that they really are non-recurrent, and if they can be converted to a recurrent saving by working with clinical operational teams.
- At month 2 the ICB is behind expectation, the principal variance for the ICB position is continuing health care. The team have been upscaling activity in the recovery programme ensuring a full understanding of the drivers and costs. The Chief Executive is clear there is opportunity. The ICB will need to be very careful about the unintended consequences of any actions undertaken.

Actions -

- **Chair of the Quality and Performance Committee to look at the level of assurance needed through the Quality Committee in terms of capability and capacity of the ICB to undertake impact assessments in a robust way**.

The Board:

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

ICB/07/24/08 – Highlight Report of the Finance, Investment and Resources Committee

The Chair of the Finance, Investment and Resources Committee provided an update to the Board. The frequency of meetings have been changed to monthly, held on the third week of the month, one meeting will be focussing on the here and now with more focus on long term sustainability, looking at the three / five year plan. The following meeting will focus on the month position, recovery plan position and the impact, and the recommendations from PWC. The current challenges are having the right people in the right programmes, the need to ensure the ICB is acting as fast as it can, and the need to ensure a clear understanding of cash and non-cash efficiencies. Metrics that ensure delivery are being developed.

The Board noted the content of the report.

ICB/07/24/09 – NHS Cheshire and Merseyside Integrated Performance Report

The Director of Performance and Planning provided the Board with an overview of the integrated performance report for July 2024, which provides an overview of key metrics drawn from the 2023/24 and 2024/25 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance. The following was highlighted to the Board –

Development of recovery programme around urgent care improvement which has been through the 9 Places. The approach was changed this year following listening to providers. Locality programmes have been wrapped around provider footprints. The strength of the recovery programmes has been examined, all 5 programmes have significant governance, consistent aims and scope and ownership across 3 workstreams. There are 4 at scale workstreams –

- Ambulance improvement in its entirety of which North West Ambulance Service have taken the SRO role.
- Admission avoidance in community services – the MHLBCS collaborative are the lead.
- An at scale in hospital discharge interface workstream lead by Dan Grimes in connection with the 9 Local Authority Directors of Adult Social Services.
- Oversight and resilience and the real time delivery.

Planned care – Cheshire and Merseyside were the first ICB to achieve a 6-week target objective and the position remains strong.

Elective – there is a headline objective to achieve 65 week by the year end, aiming to achieve by the end of September 2024. The level of insourcing that providers are seeking to manage capacity has much diminished for the first quarter of the year.

The Board Discussed –

- Having 2 sentinel metrics for continuing health care routinely on the board report, discharge to assess and time to assessment.
- Healthcare acquired infection and deaths – a deep dive has been requested into hospital acquired infections through the Quality and Performance Committee. Each provider trust has a Director of Infection Prevention Control and teams who is working on the reduction. Learning has been taken from the South West of England who have undertaken a collaborative piece of work on the reduction of c-difficile toxin, which is related to antimicrobial resistance, focused work on recovery around medication, an AMR and IPC assurance forum working together with all providers. Learning from any deaths occurred happens through serious incident reviews. Every death in hospital associated with reportable infection is investigated, individually discussed and reported, and again through thematic reviews if there are patterns within an organisation which can be escalated.
- The need for a Patient Safety Strategy so that the ICB can clearly understand its role in the system, promoting high standards of patient safety.
- Planned care for children under 18 – there are currently 1542 children waiting more than 52 weeks. The national operating model is uniform for children and adults, 65 weeks is the target by year end. Work has been undertaken with the provider collaboratives to understand, based on trajectory, and

specialty by specialty whether a stretch objective can be set. This is expected to conclude in the next few months. It is of note that these are children that are recognised on an open RTT pathway. A report will be taken back to the Children's Committee to highlight.

Actions -

- **The new indicator for severe mental illness on the GP register receiving a full annual physical health check in previous 12 months is a new annualised measure. A deep dive into numbers to be undertaken and reported back to a future board meeting.**
- **Sentinel metrics around CHC to be incorporated into regular reporting.**

The Board –

- **Noted the contents of the report and took assurance on the actions contained.**

ICB/07/24/10 – Highlight Report of the Chair of the ICB Quality and Performance Committee

The Chair of the ICB Quality and Performance Committee provided an update to the board, highlighting -

- Special Education Needs and Disability Inspections - rolling programme of inspections, the committee received a report on learning to date. Consistent themes emerging are the need for stronger partnership working at a senior and strategic level and waiting times for community paediatrics therapies and neurodevelopmental assessments taking too long. Quality improvement will only be effective if there is a joint undertaking involving parent carer forums and local authority partners working together.
- Report on end-of-life care - credit for improvements made having received an award for joined up population-based thinking, however it has identified significant gaps in current performance. Information capture needs to be correct on GP systems.
- Cheshire East Council have reported a significant drop in safeguarding referrals, a deep dive is underway.

The Board noted the content of the report.

ICB/07/24/11 – Report of the ICB Place Directors

The Halton and Warrington Place Directors provided an update to Board members which gave an overview of key areas of focus and delivery being undertaken at Place within the Integrated Care System which included –

- Supporting the delivery of the ICB priorities at Place, working alongside partners. Each Place Director is the SRO for at least one recovery programme and is secondly working on the urgent and emergency care recovery element. There are a limited number of key priorities which are important to maintain in Place to maintain momentum.
- Place partnership development – working to drive forward integrated approaches with local authorities, NHS partners, third sector and housing, which underpins the work and initiatives trying to take forward.
- Progress is being made on the integration agenda working locally at Place with care communities, integrated care development and strengthening collaboration with local authority colleagues.
- A number of local authorities have received notice that they will be subject to CQC inspections.
- Health inequalities agenda – all places are active in this space via health and wellbeing boards and partnership boards tackling issues such as fuel poverty, food poverty and victims of domestic violence. There is a North Liverpool prototype being developed around a data led multi-agency intervention approach. Knowsley are developing an asset-based approach to reducing identified inequalities in the North Ward, which has the greatest inequalities in their borough.
- Cheshire East Place are involved in the sustainable hospital services programme at East Cheshire Trust and are working on a healthier futures programme in relation to the redevelopment at Leighton Hospital.
- There is an accessible health hub at Runcorn shopping city where residents can access services locally. Community providers and third sector and Citizens Advice all operate from the same space.

- Warrington Place are working with Warrington Council and Warrington Hospital co-ordinating the use of land and property to use the space to effectively to deliver components of the health and wellbeing strategy.
- Urgent and emergency care flow – there are 9 places, set up on 5 catchments. Warrington and Halton have been approaching flow ensuring that the people of Warrington are cared for in the optimal care setting. Newton Europe undertook diagnostics which demonstrated that not all people are in the optimal care setting. Of all the people over 65 admitted, 30% could have been managed in a more optimal care setting. Length of stay and no criteria to reside is significantly higher than expected. 30% of people discharged from Warrington Hospital go onto a care pathway that is greater than the need. An executive oversight group meets weekly to keep strategic place and escalate, attended by local authorities and chief executives and trust providers and both Warrington and Halton Place Directors. North Star metric is eradicating corridor care and is coming down, non-criteria to reside is also coming down.

The Board Discussed –

- Place Risks have evolved from CCG's, there is variation when risks are pulled together on aggregate. There should be significant risk for finance for Warrington and information should be re-evaluated.
- Partnership working – noting that reports do not reflect mental health, given that mental health is the single biggest driver of disability in the system. Turning the information into data driven action on impact of the prevention of ill health.

The Chair summarised how optimistic and buoyed up the ICB are with partnership working, however there are challenges with data reflecting the desired outcomes, and there must be better outcomes for mental health. The risk matrix needs to be consistent with corporate risk registers.

The Board –

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

Committee AAA Report – Matters of Escalation and Assurance

ICB/07/24/12 – Highlight Report of the Chair of the ICB Audit Committee

The Chair of the ICB Audit Committee provided an update to the Board, highlighting the close of last year's accounts and the putting in place of this year's plans.

The Board noted the content of the report.

ICB/07/24/13 – Highlight Report of the Chair of the ICB Remuneration Committee

The Chair of the ICB Quality and Remuneration Committee provided an update to the Board, highlighting recommendation of people within clinic roles will move towards and employed model rather than the current complex model inherited from CCG's. An extension has been agreed for roles in pharmacy, optometry and dentistry, with a view to bring about a standardised version.

The Board noted the content of the report.

ICB/07/24/14 – Highlight Report of the Chair of the ICB Children and Young Peoples Committee

The Chair of the ICB Children and Young Peoples Committee provided an update to the Board, highlighting that the last meeting was held in Warrington Youth Zone. The committee focused on the Lundi model for child participation, which is the framework to help ensure young people are given the opportunity to express their voices. The development of a children and young person's summit was

discussed at the committee. A consolidated single line of sight report is being developed outlining the work undertaken by multiple agencies across the system.

The Board noted the content of the report.

ICB/07/24/15 – Highlight Report of the Chair of the ICB Women's Hospital Services in Liverpool Committee

The Chair of the ICB Women's Hospital Services in Liverpool Committee provided an update to the Board, highlighting there are still a number of engagement sessions to complete. A conversation was held at the committee to discuss inequalities, and a deep dive will be undertaken to get comparative data for the geographical patch. Funding has been received for lay members and every effort will be made to get diversity in the cohort.

The Board noted and endorsed the content of the report.

ICB/07/24/16 – Highlight Report from the North West Specialised Commissioning Committee

The Chair of the North West Specialised Commissioning Committee provided an update to the Board, highlighting that it is a joint committee between Cheshire and Merseyside ICB, Greater Manchester and Lancs and South Cumbria ICB's who have responsibility for 59 delegated services. The joint committee considers services and commission jointly. Cheshire and Merseyside has a specialised commissioning operational group which has oversight on the services that affect its population only. The financial aspects of specialised services will be reported through Finance Committee and quality and performance issues through Quality and Performance committee. The committee will be working together to prepare for a further 25 services taking on delegated responsibility from April 2025.

The Board noted the content of the report.

ICB/07/24/17 – Highlight Report of the Cheshire and Merseyside Health and Care Partnership

The Vice Chair of the Cheshire and Merseyside Health and Care Partnership provided an update to the Board, highlighting the health inequalities funding discussion identifying priorities spending money effectively and remaining challenges.

The Board noted the content of the report.

ICB Business Items and Strategic Updates

ICB/07/24/18 – Shaping Care Together – A Case for Change

Rob Cooper, Managing Director of Mersey and West Lancashire NHS Trust (MWL) gave an update to the Board on the Shaping Care Together programme, a case for change and spoke to the presentation provided in the pack, highlighting that -

Shaping Care Together covers Southport, Formby and West Lancashire and sits across 2 ICB's; Cheshire and Merseyside are the lead ICB. Various reviews have been undertaken since 2015, all of which described the need to sustainably manage services. Certain services were identified as fragile, and solutions needed to be put into place to stabilise services. In July 2023 two trusts came together to become Mersey and West Lancashire Trust.

Phase 2 cannot be undertaken by MWL alone, services on the Southport and Ormskirk site will not be sustainable until issues are resolved and will require capital and transition funding.

Extensive public engagement has taken place along with community groups and the voluntary sector which has helped shape thinking in service change and requirements and the focus on urgent and emergency care, which underpins the case for change today. There has been a level of engagement with oversight and scrutiny committees and councillors and elected officials. Urgent and emergency care services are fragile, particularly in Southport and Ormskirk and configuration is not helping. A 24/7

paediatric AED is lacking, resulting in the paediatric emergency department on the Ormskirk site closing overnight. The increase in housing developments in Southport and Ormskirk means that the population is growing

The Case for Change document has been considered by the Board of NHS Lancashire and South Cumbria on 17th July 2024 where approval was received for the Case for Change and the commencement of the pre-consultation engagement process. The Board of MWL also considered and supported the Case for Change at its meeting on 29th May 2024.

The Shaping Care Together programme has also completed the NHS England Stage 1 Assurance sense check on 3rd June 24. Feedback from NHS England has been positive in the work undertaken so far regarding clinical engagement and work to identify sustainable solutions for the services described in the case for change.

The case for change is to objectively inform and enable participation, it does not seek to lead stakeholders toward preferred options, it is to signal the start of engagement and consultation, led by the ICB.

It is anticipated, subject to approval from NHS Cheshire and Merseyside ICB in July 2024, that the pre-consultation engagement will commence soon after the 25th July 2025 for a period of between 8-10 weeks.

Whilst the draft Case for Change has so far been presented separately to each ICB and to MWL for their approval and support, further governance options have been explored to determine the optimal governance arrangements going forward. It is considered that a Joint Committee of the two ICBs, with MWL as a member, would provide a more effective and streamlined governance vehicle for consideration and approval of the key decisions that are required to progress this programme over the next year. If the Board of Cheshire and Merseyside ICB supports progressing the establishment of a Joint Committee with NHS Lancashire and South Cumbria ICB, then a further update will come to both Boards in September 2024 seeking approval of the Joint Committees Terms of Reference and Committee establishment. It should be noted that at its meeting on 17th July 2024, the Board of NHS Lancashire and South Cumbria ICB supported progressing the work to establish a Joint Committee between the two ICBs.

The Board Discussed:

- Case for change NHS guidance, one of the five criteria is a review of the financial considerations. The Managing Director of Mersey and West Lancs advised that at this stage in the case for change is about resources, revenue and capital will be worked up at the next stage. There will need to be some investment at some degree which will be worked through.
- Joint committee – the case for change has been presented to 2 ICB's; the proposal is to establish a single joint committee so that this can be considered once. Terms of Reference will be brought to the September 2024 ICB Board meeting if the board are in agreement. Checkpoint meetings will be arranged going forward.
- It was acknowledged that a lot of work has gone into the case for change.
- Public, patient and staff feedback on choices – public engagement will commence from 26th July 2024 and will continue until October / November 2024 as the list of options is worked through. This will then feed into the pre-consultation business case which will then go to full public consultation. Public, patient and staff engagement will be at the heart of, and in the option appraisal process.

The Board –

- **Reviewed and approved the draft Case for Change.**
- **Approved the commencement of the pre-consultation engagement.**
- **Approved progressing the work to establish a Joint committee of the two ICBs.**
- **Noted that a further update will be provided to the Board at its meeting in September 2024, including the recommendation to approve the Terms of Reference and establishment of a Joint Committee between the two ICBs.**

ICB/07/24/19 – NHS Cheshire and Merseyside Children and Young Peoples Mental Health Plan 2024-2026

Claire James, Mental Health Programme Director provided an update to the Board on the NHS Cheshire and Merseyside Children and Young Peoples Mental Health Plan 2024 – 2026 highlighting that local transformation plans for children's and young people mental health, is not something new and has been in place in England since 2015, historically set at CCG level. This moved to a system wide children and young people's mental health plan in 2020, delayed slightly due to covid, and subsequently published in December 2021, with a lot of stakeholder involvement.

Improvements have shown a 33% increase on children and young people who have been able to access NHS funded care, 26 mental health in school teams mobilised in Cheshire and Merseyside, with a further 5 being mobilised this year. Every area now has access to 24/7 mental health provision for children and young people.

NHS England have asked for a refresh of all children and young peoples mental health plans. A piece of work was started earlier this year in collaboration with stakeholders, including the voices of children and young people. The plan was presented to the children and young peoples committee on 12th June who offered their full support and recommended to ICB Board that it is approved. Subject to approval, the ICB requirement is to publish a plan and animation with an easy read document on the public website in summer 2024.

Work has been undertaken with the 9 Directors of Children's Social Services across the 9 local authorities in production of the plan. Work will be undertaken with the Cheshire and Merseyside Children's Emotional Wellbeing and Mental Health Programme Partnership where a number of programmes at scale work together to focus on areas of challenge in health and social care.

The Board Discussed –

- The implementation plans in Place are being developed with a view to place plans being considered within place governance. Sign off of Place plans will need to be agreed with each of the place directors in terms of their own governance structures. Subject to plans being approved at ICB Board, to have full implementation plans signed off by September 2024. Work is being undertaken on system level oversight on the implementation together with metrics which will be reviewed each quarter by the programme partnership and reported into the Children's Committee. Work will be taken back to the children and young people so they can hold us to account.
- The complicated governance structure within the plan –
- The new government have made a commitment to access to mental health in schools in their new manifesto.

The Board –

- **Noted the requirements for the ICB to develop and publish a Children and Young People's Mental Health Plan.**
- **Noted the Engagement Report and activities that have taken place in supporting development of the plan priorities**
- **Approved the Cheshire and Merseyside Children and Young People's Mental Health Plan (2024-2026).**
- **Agreed that the plan will be reviewed after the first year and will be overseen by the Cheshire and Merseyside Children and Young People's Emotional Wellbeing and Mental Health Programme Partnership on behalf of the Children's Committee.**

ICB/07/24/20 – NHS Cheshire and Merseyside Draft Involvement Plan 2024-2026

The Assistant Chief Executive brought an update to the board on the Cheshire and Merseyside Draft Improvement Plan which has previously been endorsed and approved by the Quality and Performance Committee. The inaugural report was brought to the first Board meeting in 2022, future versions of the plan will be brought back to Board in a few years' time.

The plan sets out the overall ambition for working with people and communities reflecting national guidance, highlighting how the ICB works with partners, including Healthwatch. It is important to put in place individual arrangements for specific pieces of work.

Lay members will be engaged to work with women's and children's services in the Liverpool programme, there are conversations around the citizens panel, changes to community voices and how we work with the general population around GP practices. Two co-production training sessions have been held for staff providing practical advice on how the ICB involve local people in equal partnership.

The Board discussed –

- Public engagement – the ICB are committed to supporting people to work with the organisation, with inclusive recruitment to formal posts with a joined-up approach asking staff and public to work with us. Reimbursement would be looked at case by case.
- The plan in its early draft has appeared twice at Quality and Performance committee where there was some significant challenge, which was taken on promptly. Strong issues raised from the local authority partner member was that it was essential for co-production.

Actions –
The Assistant Chief Executive to respond to the following questions posed by the Chair –

1. **The Plan was created 2 years ago, do we have a view of how impactful the plan has been to date.**
2. **Looking forward, what are the key metrics that will be monitored at board level to enable understanding of engagement that will achieve desired outcomes.**

The Board –

- **Approved the NHS Cheshire and Merseyside Involvement Plan for 2024-26.**
- **Noted that there are resource requirements associated with involvement activity, including engagement and consultation linked to service change. NHS Cheshire and Merseyside will need to consider and review how this area is adequately and consistently resourced across programmes, as appropriate.**
- **Noted that there will also be a review of NHS Cheshire and Merseyside's involvement governance and the Public Involvement Policy.**

ICB/07/24/21 – Cheshire and Merseyside Key Delivery Plans

The Assistant Chief Executive provided an update to the Board on the Cheshire and Merseyside key delivery plans which is a core component of the refreshed 2024-29 joint forward plan. The NHS delivery plan is one part of a trilogy of documents which form the joint forward plan; the other two are the Health and Care Partnership All Together Fairer delivery plan which will go to HCP in August 2024, and the Place Partnership Delivery Plans.

The focus for 2024/25 will focus on recovery, transformation of services, innovation and new use of technology and improving outcomes in population health and addressing health inequalities. The challenge for this year is to focus on the future and to deliver today in terms of finance, recovery, urgent and emergency care and workforce. Keen to represent and respect the ICB partners priorities and talk to all four of the ICB's objectives – improving population health, reducing health inequalities, achieving financial balance and contributing to the social and economic development of Cheshire and Merseyside. Neil Evans and Steven Young were thanked for their leadership and work.

The ICB needs to continue to deliver and act on priorities and objectives within the plan which represents the focus on today's priorities while representing the enormity of the work and responsibilities the ICB has.

A new 10-year health plan will be delivered in spring 2025. Our plan is to set the ICB on the right path to meet the challenges ahead.

The Board –

- **Approved the NHS Delivery Plan element of the Joint Forward Plan and authorised publication in advance of 31st July 2024 ensuring that the final linked plans related to the Recovery Programme and Transformation Plans are included.**
- **Endorsed the proposal to provide the Board with an NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan by the end of August 2024.**
- **Noted that the Cheshire and Merseyside Health and Care Partnership are due to receive the revised strategic plan *All Together Fairer: our Health and Care Partnership Plan* and the associated HCP/All Together Fairer Delivery Plan at the next meeting on 20th August 2024. Copies of the final draft documents will be shared with the ICB Board as soon as they are available.**

ICB/07/24/22 – ICB Board Assurance Framework Quarter One 2024-25

The Assistant Chief Executive provided an update to the board on the BAF for approval and to provide an update for quarter 1 progress. The risk committee received the principal risks in light of progress from last year and undertook a review of strategic challenges and revised priorities for this year. This years BAF retains 9 of the existing principal risks and proposes that P3 is de-escalated to the operational risk register and proposes to introduce a new Risk P11 Digital Infrastructure for Key Clinical Systems.

Two critical risks are P3 and P7 which are the ICB's key area of focus behind recovery programmes, which are finance and urgent and emergency care. The BAF has been taken to Audit Committee and introduced 4 levels of assurance – significant, partial, acceptable and no assurance.

Quarter 1 of 24/25 – the 10 principal risks, subject to board approval, P7 and P9 Statutory Finance Duties and ICS Workforce require greater scrutiny and are awaiting further intervention.

The Board Discussed –

- Digital risk – last years BAF was focused on provision of analytics capability to provide population health insight. Questions have been raised at previous board meetings on cyber security risk. The proposed new risk is a BAF risk that represents potential impact if the cyber security measures are not robust. The ICB has responsibility for the systems it uses and manages on behalf of its staff and wider primary care and the wider system risk managed at this Board. The new BAF risk aggregates the two issues. Currently scoring 16, there is a detailed plan being implemented with some of the assurances showing as amber. There is a joint endeavour manging supply chain, in the medium term looking to pool resources to create a central cyber security team. The plan envisages bringing assurance data back to Board through appropriate committees in autumn 2024.
- The consequences on smaller organisations and third sector partners and harmonisation of standards required for good commissioning could cause them disadvantage. The current plans are NHS focused.
- The collective action of GP's and the risks to the wider system being incorporated onto the risk register – this is discussed at System Primary Care Committee and is a corporate risk, rather than a BAF risk. This will be escalated through System Primary Care Committee and placed onto the corporate risk register.
- Health inequalities – reported as Green as it is around health inequalities duty and the definition within the BAF. There is a substantive agenda item on the forward plan for September 24 on population health and health inequalities.
- Financial Risk – a strategic plan for services which incorporates a financial element is not captured clearly in the BAF. Wording can be changed in the BAF to incorporate. A refresh of the long-term financial model and the key areas of opportunity will be brought to September 24's Board meeting.
- The NHS Delivery plan – there are 4 chapters, delivering today and focusing on recovery, and also service transformation. Within this there are a raft of programmes and priorities, each one has a plan and workstream. There is a chapter around health inequalities and population which will come through the HCP plan. The delivery plan that the ICB has just signed off should cover off the ICB's work on services and programmes for the coming year.

The Board –

- **Approved the refreshed Board Assurance Framework for 2024-25 including the proposed target scores at section 9.5, the de-escalation of risk P2 and the addition of a new risk P11 subject to comments made.**
- **Noted the current risk profile, progress in completing mitigating actions, assurances provided and priority actions for the next quarter; and consider any further action required by the Board to improve the level of assurance provided or any new risks which may require inclusion on the BAF.**

ICB/07/24/23 – ICB Corporate Risk Register Quarter One 2024-25

The Assistant Chief Executive provided an update to the Board on the ICB Corporate Risk Register Quarter one 2024/25 which comprises risks escalated from committees and directorate risk registers with a score of over 15+. There are 10 risks, 5 critical and 5 are extreme. A lot of risks have been covered in BAF and corporate risk register have been covered in discussion at today's Board meeting, which gives confidence that the ICB are aligning and providing oversight of risks presented to board.

The Board –

- **Noted the Corporate Risk Register, progress in completing mitigating actions, further action planned, and assurances provided; and considered any further action required by the Board to improve the level of assurance provided.**
- **Approved the closure of risk 8DR subject to approval of new BAF risk P11 and the de-escalation of risk QU07.**

ICB/07/24/24 – Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative – Annual Work Plan

Ann Marr, Executive Lead for CMAST provided a presentation and update to the Board on the Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative annual work plan highlighting the priorities which are clinical improvement and transformation sustainability and value, with 4 programmes of work, diagnostics, elective recovery and transformation, clinical pathways and efficiency at scale. The workstreams are led by a senior responsible officer who are Trust Chief Executives from membership.

Some of the achievements in 23/24 include –

- Cheshire and Merseyside being the first ICB to achieve the 6 week faster diagnostic standard. Community diagnostic centres delivered an additional 279,000 additional tests. Secured an additional £34.4m revenue to pay for activity.
- Trust boards of all acute providers have approved a single unified laboratory information management system enabling trusts to share results.
- Reduced over 200,000 long waiting patients in the past year.
- Facilitated over 9000 mutual aid moves.
- Improving theatre productivity, setting up a theatre academy training up 50 members of staff to run operating theatres most efficiently.
- Efficiency at scale programme started in quarter 2; procurement at scale saved £3.9m during the course of the year largely within trust CIP plans.
- Meds optimisation programme save £18.5m.
- All eligible trusts signed up to a national energy contract which will deliver an £8m saving from next year.

There are plans against each workstream, diagnostics will reduce waiting times and inappropriate demand. For 24/25 managed to achieve £28m capital and a cardiac CT scanner has been purchased for Liverpool, finishing the community diagnostic centres in Halton and East Cheshire and the pathology systems.

Elective recovery have maintained a zero 78 and 104 week position with a target to eliminate 65 week waits by September 2024. A validation programme is underway so that 85% of all patients who have waited over 12 weeks will be validated to ensure their condition has not changed.

There is a key focus on reducing variation between providers, increasing the utilisation of the elective hub theatres. Looking to reduce outpatient follow ups to free up time to see new out patients. There has been a lot of work undertaken looking to reduce the reliance on capacity related insourcing and outsourcing.

The finance workstream are working towards creating a single ledger across the ICB. A lot of money has been spent on HR and legal which could be reduced if it was undertaken together.

Cheshire and Merseyside has the 5th highest cost for the size of its population for primary care prescribing, has the highest number of patients in the country who are prescribed 20 or more medicines and are the 3rd highest in the country for bed days per 100,000 following falls in the community which result in fractures.

There is a workstream on infection control with a quality lead who ensures all work programmes undertake quality impact assessments. Cheshire and Merseyside spend more on infection control than the average ICB, and have one of the highest levels of hospital acquired infection. Some of this can be described by deprivation as Cheshire and Merseyside have high areas of deprivation.

The Board Discussed –

- The benefits seen from the CMAST work has a bigger impact on the wider NHS system particularly in general practice, which then has a positive impact on patient experience and patient care.
- Dermatology AI has already been through safety checks and is registered as a class 2 medical device by the MHRA. Technology directly impacts the outcomes for all patients.
- Falls – working together with Place, voluntary, community and faith sectors. Frailty and falls is a part of data into action, often the fall is the end product of the struggle with frailty. There is now the ability to identify who is at high risk which then needs the right community response. Voluntary, community and faith sectors are involved in this piece of work.
- Health inequalities metrics – 40% of the highest risk patients come from the 20% most deprived households in Cheshire and Merseyside. Work pioneered from Whiston meant that patients were being prioritised. Data flows from every trust and prehabilitation offerings are embedded into a business-as-usual approach.
- Polypharmacy – there is a programme of work around polypharmacy in the ICB's Medicines Management Team aligned to the national polypharmacy programme, and also forms part of the recovery programme.

The Chair thanked the Executive Lead for CMAST for her leadership and Chairing CMAST with some incredible results.

Actions –

- **The Medical Director to create a report to be brought to future Board meetings that measures health inequalities metrics.**
- **The Associate Medical Director to bring a polypharmacy agenda item to a future Board meeting.**

The Board –

- **Reviewed the Annual Work Plan and provide any comment.**
- **Noted the scale, breadth and alignment of the CMAST commitments with ICB priorities.**
- **Endorsed the programme of work.**

ICB/07/24/25 – Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services Provider Collaborative Update – Annual Plan

Isla Wilson, Chair of Cheshire and Wirral Partnership Trust and Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services Provider Collaborative provided the Board with an update on the Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services Provider Collaborative annual plan and spoke to the presentation provided within the meeting pack.

Joe Rafferty highlighted to the board –

- Significant progress has been made with access to care issues and community urgent care, however when unpicked, it was clear that there was either no data, or there were data quality issues with standards of the data already held. It was therefore effectively impossible to create a comparative context across Cheshire and Merseyside. Work has been undertaken to describe the data that is needed to be collected and to standardise the data already collected. There is now a reliable community data set and dashboard. Waiting times position in Cheshire and Merseyside is now accurate.
- Commissioning of services has been lumpy. The Collaborative have been trying to work out and subtract what issues are due to variability in the commissioning against standard and what issues lie with variation of provider choice.
- The workforce programme will not be a collaborative venture, it will be an inter-provider venture.
- The mental health programme has been focused very hard on, and although data isn't the best, it is an order of magnitude still different to community services. There has been a 79% increase on delivery of physical health checks to people with severe mental illness, not just through the annual health check, but using the principle of every contact counts. The two mental health trusts use their physical health internal capability to pick up patients on every contact. There are risks with annualised health checks. There has been an 82% increase in people accessing community mental health services, there isn't the ability to keep mental health patients on corridor care; people who would have been admitted to hospital become high risk community patients. There is an improvement in the quality of community services and the ability to handle complex patients in the community. Merseycare handle 14,000 calls every month from patients who are in mental health crisis or in need. Both mental health providers in Cheshire and Merseyside are starting to use regenerative AI and sophisticated telephony with call back. There is a 170% increase in women accessing perinatal mental health services. A 33% increase in children and young people accessing mental health services, which is where the biggest single level of demand is seen. 70% of children and young people who have a mental health presentation do not get seen by any service. Reduction of 90% of patients in Cheshire and Merseyside who have been placed out of area for an inpatient service, this is terrible for patients and their carers, and is also a huge waste of public money.
- The workplan is tightly driven by the work undertaken by Newton Europe and gives a clear view of high benefit opportunities. This involves continuing the development of virtual wards, urgent care response falls and IV at home. Each virtual ward contact costs £650 less than standard cost, community IV is cheaper and more satisfactory for patients than hospital based IV systems. There is a huge amount of work that can be undertaken that benefits patients and provides cheaper care.
- There are theoretical opportunities to review almost 78,000 bed days saved, or the equivalent of 213 beds, or convert a potential saving of nearly £33m.
- The request of the ICB is to engage in an integrated community care programme, making a change to services is important to the health of the population. It is possible to provide better care at a cheaper cost. The infrastructure needs to be built. More project and change management capability is required. Clinical services investment is needed in some places. ICB executive sponsorship is requested to agree a plan and to think about how to look at historic investment problems.

The Board discussed –

- Virtual Wards – the figures include the children's virtual ward, however, are quite limited. Of the 430 beds, only 20 are paediatric. Work has been undertaken with Alder Hey linking with DGH's and other areas to help them to provide paediatric virtual wards in the same way as Alder Hey.
- Shift left, moving to more proactive care, getting more work outside of the hospital footprint and into the upstream shift in investment. As we come out of recovery, for each of the recovery programmes

in place that are consuming programme management resource, there is then the need to review how this will be put back into business as usual and release the resource to support this type of programme.
- When the collaborative was started it was clear that the relationship with place was important, however there were some colleagues at place who struggled to reconcile the potential threat. The collaborative was set up to only look at NHS providers and conditions, not social care. It is important to organise at scale and would look for leadership from local authority for capacity to enable widening the collaborative.
- The variation of Place and services available; the very variation at present wastes money.

The Chair thanked the collaborative for their hard work and illustrated the enormity of the gap in the care that we need to give patients.

Actions –
- **The ICB Chief Executive to engage with the Provider Collaborative to discuss ICB executive sponsorship, PMO & Change Management and to address the asks this year, and in future years. To be discussed further at September 2024 ICB Board meeting.**

The Board -
- **Noted the content of the report.**

ICB/07/24/26 – Cheshire and Merseyside Consolidated Workforce Plan

The People Director provided an update to the board of the Cheshire and Merseyside Consolidated Workforce Plan. A lot of work has been undertaken at trust and ICB level on staff survey results, to ensure appropriate action has been undertaken, on a "you said we did" approach. The ICB turned 2 on 1st July 2024 and the scale of the challenges faced by staff at the start of a new organisation was unsettling for many. The ICB have worked hard to create a culture, been clear on values and behaviours.

Staff networks have worked hard with staff who have protected characteristics or have issues that interest them and impact their ability to do their job. There are early careers network, working carers network, networks for staff who foster or adopt children.

The People Committee has been established which reports to the Finance and Resources Committee. Good progress is being made on ICB equality objectives and priorities from 2022 – 2026; there is a small team that looks at equality and diversity.

The ICB people function also has a system wide responsibility; there are over 87,000 staff who work for NHS Cheshire and Merseyside made up of a range of substantive, bank and agency staff. In the last year collectively achieved the national target of agency staff not exceeding 3.7% of the pay bill. It has been reported through the Director of Nursing and Care the impact of having high levels of agency staff has on care and trusts have been working proactively. From July 2024 no Trusts are using off-framework agency staff.

There are 7 people promise exemplar sites across Cheshire and Merseyside that are looking at the retention of staff, with positive results and retention going up and turnover reducing, which is now at 11%, last year's being 13.5%.

The 7 people promise themes looks at how individual trusts did in terms of the staff survey. Most improved results across Cheshire and Merseyside were - we are always learning, we are recognised and rewarded and the morale of our staff. Liverpool Heart and Chest hospital again scored highest across all 8 themes when benchmarked against peer groups. The ICB are now 8 weeks away from the next staff survey.

The Board Discussed –

- Freedom to speak up and the voice of staff – each theme has had a work group looking into and "we have a voice" has been difficult and complicated due to the routes people take. A lot of work has been undertaken by the new Freedom to Speak Up Officer and the benefits of this work are starting to show as more freedom to speak up concerns are being raised.
- The Chair expressed his disappointment in the percentage of ICB staff who are from a BAME background which is decreasing and below the percentage of the general population and the 22% average of the NHS.
- The ICB Bronze Award for the antiracism strategy – would like more visibility at a Board level with objectives to have a strategic objective for EDI.
- Spotting and protecting talent of the global majority, particularly in times of austerity when posts are being frozen or reduced.
- Some of the Cheshire and Merseyside Trusts are making remarkable improvements in recruiting from the most deprived areas in cheshire and Merseyside. Liverpool University Foundation Trust is now up to 34% of its staff recruited from those most deprived areas.

The Board -

- **Noted the content of the report.**

Meeting Governance

ICB/07/24/27 – Minutes of Previous Meeting

The Board reviewed the minutes of the meeting held on 28th March 2024 and 20th June 2025. The minutes of the NHS C&M ICB Board meeting of 25th January 2024 were approved as an accurate record of the meetings.

ICB/07/24/28 – Board Action Log

The Board acknowledged the completed actions and updates provided in the document. The Board noted the Action Log and recommendations to close the completed actions.

Any Other Business

ICB/07/24/29 – Closing Remarks and Review of the Meeting

The Chair summarised that it was a good meeting, with good discussion and challenges. The Chair thanked Board members for their continued contributions and support, and thanked members of the public for their attendance.

Consent Items

ICB/07/24/30 – Board Decision Log

The Board reviewed the decision log and confirmed that the information presented was an accurate record of substantive decisions made by the Board up to 25th July 2024. It was further noted that there were no emergent actions arising from those decisions that were due for review at this meeting.

The Board noted the Decision Log

ICB/07/24/31 – Confirmed Minutes of ICB Committees

- Audit Committee – May 2024
- Children and Young Peoples Committee – April 2024
- Finance, Investment and Our Resources Committee – May 2024
- Health and Care Partnership – March 2024
- Quality and Performance Committee – May 2024
- Quality and Performance Committee – June 2024
- Women's Hospital Services in Liverpool Committee – March 2024

CLOSE OF MEETING

Date of Next Meeting:
26th September 2024 - The Wrights Lounge, The Mornflake Stadium, Gresty Road, Crewe, CW2 6EB

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

#NAME?

Action Log 2023 - 2025

Updated: **17/09/2024**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-22-41	27/04/2023	**Cheshire & Merseyside System Month 12 Finance Report**	CWI and SBR to work together on the production of a position paper covering social care provision and funding	Claire & Steven Broomhead	TBC	Claire to discuss further with Stephen Broomhead	ONGOING	
ICB-AC-22-57	27/07/2023	**NHS Long Term Workforce Plan**	CSA to provide a quarterly update to Board on the progress against the NHS LTP	Chris Samosa	Jan-24	No update nationally yet on LTP	ONGOING	
ICB-AC-22-59	28/09/2023	**Report of the Chief Executive**	Right Care Right Place - GPU to return Right Care Right Place to board in due course to understand what we can do as in integrated system through each place.	Graham Urwin	Nov-23		ONGOING	
ICB-AC-22-63	25/01/2024	**Welcome, Apologies and Confirmation of Quoracy**	Following on from the Public speaking time RJA confirmed an action for GPU / RPJ / CDO to bring a paper to a future Board meeting explaining how we have the right staff, at the right quantity at the right time for our patients.	GPU / RPJ / CDO	Nov-24		ONGOING	
IBC-AC-22-69	25/01/2024	**NHS C&M Quality and Performance Report**	Board to receive information on secondary prevention measures in primary care (link to QOF)	CWA	Jul-24		ONGOING	
IBC-AC-22-70	25/01/2024	**NHS C&M Quality and Performance Report**	The Director of Performance and Planning to investigate the data we currently collect regarding Patient Reported outcomes and incorporate into future reports to Board	AMI	May-24		ONGOING	
IBC-AC-22-71	25/01/2024	**Report of the Directors of Place**	Board to receive a high level summary report at its November 2024 meeting on the Operating Model for Place, an understanding of the maturity of each , the learning across each Place and a focus on the priorities of each Place to drive out unwarranted variation	GPU, CWA	Nov-24	On Board Forward Plan and due at November 2024 meeting	ONGOING	
ICB-AC-22-78	25/07/2024	**Report of the ICB Director of Nursing and Care**	The Director of Nursing and TF Non-Executive Director to consider whether the ICB should have a patient strategy with a clear rationale	CDO / TF	Nov-24		ONGOING	
ICB-AC-22-79	25/07/2024	**NHS Cheshire and Merseyside Finance Report Month 2**	Tony Foy to look at the level of assurance needed through the Quality Committee in terms of capability and capacity of the ICB to undertake impact assessments in a robust way.	TF	Nov-24		ONGOING	
ICB-AC-22-80	25/07/2024	**NHS Cheshire and Merseyside Integrated Performance Report**	The new indicator for severe mental illness on the GP register receiving a full annual physical health check in previous 12 months is a new annualised measure. A deep dive into numbers to be undertaken and reported back to a future board meeting.	FLE	Nov-24		ONGOING	

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Action Log 2023 - 2025

Updated: **17/09/2024**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-22-81	25/07/2024	**NHS Cheshire and Merseyside Integrated Performance Report**	Sentinel metrics around CHC to be incorporated into regular reporting.	AMI	Sep-24		ONGOING	
ICB-AC-21-82	25/07/2027	**Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative – Annual Work Plan**	The Medical Director to create a report to be brought to future board meetings that measures health inequalities metrics.	RPJ	Nov-24		ONGOING	
ICB-AC-21-83	25/07/2024	**Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative – Annual Work Plan**	The Associate Medical Director to bring a polypharmacy agenda item to a future board meeting.	FLE	Sep-24	Scheduled for November 2024 meeting	ONGOING	
ICB-AC-21-84	25/07/2024	**Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services Provider Collaborative Update – Annual Plan**	The ICB Chief Executive to engage with the Provider Collaborative to discuss ICB executive sponsorship, PMO & Change Management and to address the asks this year, and in future years. To be discussed further at September 2024 ICB board meeting.	GPU	Nov-24		ONGOING	
ICB-AC-21-85	25/07/2024	**NHS Cheshire and Merseyside Draft Involvement Plan 2024-2026**	The Assistant Chief Executive to respond to the following questions posed by the Chair – •The Plan was created 2 years ago, do we have a view of how impactful the plan has been to date. •Looking forward, what are the key metrics that will be monitored at board level to enable understanding of engagement that will achieved desired outcomes.	CWA	Sep-24		ONGOING	

Meeting of the Board of NHS Cheshire and Merseyside

26 September 2024

Agenda Item No: ICB/09/24/25

Confirmed Minutes of ICB Committees

Click on the links below to access the minutes:

- Audit Committee – 17 June 2024 **(CLICK HERE)**
- Audit Committee – 25 June 2024 **(CLICK HERE)**
- Finance, Investment and Our Resources Committee – July 2024 **(CLICK HERE)**
- Quality and Performance Committee – July 2024 **(CLICK HERE)**
- Strategy and Transformation Committee – May 2024 **(CLICK HERE)**