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)

28 November 2024, 09:30am – 12:55pm,
Conference Suite, Riverside Innovation Centre, 1 Castle Drive, Chester, CH1 1SL

Public Speaking Time: 09:00am

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

Agenda

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
09:30am	**Preliminary Business**				
ICB/11/24/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain *ICB Chair*	For information	-
ICB/11/24/02	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/11/24/03	Experience and achievement story	Film		-	
09:45am	**Leadership Reports**				
ICB/11/24/04	Report of the ICB Chief Executive	Paper	Graham Urwin *Chief Executive*	For approval	P5
ICB/11/24/05 **09:55am**	Report of the ICB Director of Nursing and Care	Paper	Chris Douglas *Director of Nursing & Care*	For assurance	P29
ICB/11/24/06 **10:05am**	NHS Cheshire and Merseyside Finance Report Month 6	Paper	Claire Wilson *Director of Finance*	For assurance	P38
ICB/11/24/07 **10:15am**	Highlight report of the Chair of the ICB Finance, Investment and Resources Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	P66
ICB/11/24/08 **10:20am**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	P70
ICB/11/24/09 **10:30am**	Highlight report of the Chair of the ICB Quality and Performance Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	P100

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
ICB/11/24/10 **10:35am**	Consolidated report of the ICB Directors of Place	Paper	Simon Banks *Place Director (Wirral)* Laura Marsh *Place Director (Cheshire West)*	For assurance	P106
10:50pm	**Committee AAA Reports - matters of escalation and assurance**				
ICB/11/24/11	Highlight report of the Chair of the ICB Remuneration Committee	Paper	Tony Foy *Non-Executive Member*	For approval	P142
ICB/11/24/12	Highlight report of the Chair of the ICB System Primary Care Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	P152
ICB/11/24/13	Highlight report of the Chair of the ICB Women's Hospital Services in Liverpool Committee	Paper	Prof. Hilary Garratt *Non-Executive Member*	For assurance	P156
ICB/11/24/14	Highlight report of the Chair of the ICB Strategic Commissioning and Transformation Committee	Paper	Dr Ruth Hussey *Non-Executive Member*	For assurance	P159
ICB/11/24/15	Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership (HCP)	Paper	Raj Jain *ICB Chair/ HCP Vice Chair*	For assurance	P164
11:05am	**COMFORT BREAK**				
11:15am	**ICB Business Items and Strategic Updates**				
ICB/11/24/16	Shaping Care Together – establishment of a Joint Committee with NHS Lancashire and South Cumbria ICB	Paper	Clare Watson, *Assistant Chief Executive*	For approval	P168
ICB/11/24/17 **11:25am**	Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside	Paper	Prof. Rowan Pritchard-Jones *Medical Director*	For approval	P182
ICB/09/24/18 **11:40am**	NHS Cheshire and Merseyside ICB Constitution Updates	Paper	Graham Urwin *Chief Executive*	For approval	P239

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
ICB/11/24/19 **11:45am**	NHS Cheshire and Merseyside ICB Board Assurance Framework & Corporate Risk Register 2024-25 Q2 Update	Paper	Clare Watson, *Assistant Chief Executive*	For approval	P246
ICB/11/24/20 **11:50am**	NHS Cheshire and Merseyside ICB Corporate Risk Register 2024-25 Q2 Update	Paper	Clare Watson, *Assistant Chief Executive*	For approval	P289
ICB/11/24/21 **11:55am**	NHS Cheshire and Merseyside ICB Primary Care Access Recovery Plan Update	Paper	Clare Watson, *Assistant Chief Executive*	For assurance	P334
ICB/11/24/22 **12:15pm**	Intensive and Assertive Community Mental Health Care	Paper	Simon Banks, *Place Director (Wirral)*	For assurance	P358
ICB/11/24/23 **12:30pm**	Update on progress around Physical Health Checks for People with Severe Mental Illness in Cheshire and Merseyside	Paper	Simon Banks, *Place Director (Wirral)* Dr Chris Pritchard, *Primary Care Clinical Lead for Mental Health*	For assurance	P368
12:45pm	**Meeting Governance**				
ICB/11/24/24	Minutes of the previous meeting: • 26 September 2024 • 09 October 2024.	Paper	Raj Jain *ICB Chair*	For approval	P375
ICB/11/24/25	Board Action Log	Paper	Raj Jain *ICB Chair*	To consider	P395
12:50pm	**Any Other Business**				
ICB/05/24/26	Closing remarks and review of the meeting	Verbal	Chair / All	For information	-
12:55pm	**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/11/24/27	Board Decision Log - **CLICK HERE TO VIEW**	For information	-
ICB/11/24/28	Confirmed Minutes of ICB Committees: • *Finance, Investment and Our Resources Committee – 2024* • *Quality and Performance Committee – 2024* • *Strategy and Transformation Committee – 2024* • *System Primary Care Committee* • *Women's Hospital Services In Liverpool Committee* • *Cheshire and Merseyside Health and Care Partnership*	For assurance	P398

Date and start time of future meetings

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 13:25pm

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Report of the Chief Executive

Agenda Item No: ICB/11/24/04

Responsible Director: Graham Urwin, Chief Executive

Report of the Chief Executive (November 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
- ddisseminate and cascade key messages and information as appropriate

3. Executive Team Departures and New Starters

3.1 This is the last Board meeting that Claire Wilson (ICB Director of Finance) and Chris Samosa (ICB Chief People Office) will be in attendance at before they leave the ICB in December. Both have been with the ICB prior to its formal establishment and have been instrumental over the past two and a half years in developing the ICB to where itis now, ably navigating the complex challenges that we have faced as an ICB and as a system in their respective areas. I would like to put on record my gratitude for the service they have both undertaken on behalf of the ICB, NHS and on behalf of the people of Cheshire and Merseyside, and wish them both well in their future endeavors.

3.2 Mark Bakewell (current Place Director for Liverpool) will start in December as the Interim Director of Finance for the ICB. Mark has extensive first-hand knowledge and experience of Cheshire and Merseyside's financial landscape having served as our Deputy Director of Finance - prior to his appointment to the role of Place Director for Liverpool - and previously, as Director of Finance for the former Liverpool Clinical Commissioning Group.

3.3 Following a successful recruitment process, Mike Gibney will start in early January 2025 as the ICB Chief People Officer. Mike is currently the Chief People Officer for The Walton Centre NHS Foundation Trust and brings with him extensive experience of human resources, organisational development, education and innovation – both in the NHS and local government –including nine years with social services, and in several regional roles.

4. Secretary of State for Health and Social Care visit

4.1 Wes Streeting, Secretary of State for Health and Social Care, recently visited Southport and Alder Hey Hospitals**.** Following his visit meeting with a number of staff involved with responding to the tragic events of the 29 July 2024 and subsequent unrest, the Secretary of State took time to send a letter to the ICB and each of the Trusts outlining his gratitude and admiration for the care delivered and the professionalism of all staff involved. He reinforced the Government's commitment to supporting NHS staff and highlighted that ***"I want the staff involved in responding to the events of 29 July 2024 to know that whenever I talk about 'the best of the NHS', I very much have them in mind".***

5. Evolution of our operating model

5.1 Colleagues are aware that work has been underway with regards to reviewing our operating model so that we can better determine how best to align our resources and expertise in a way to both deliver on the ambitions of the ICB as well as be well prepared to meet the expectations and requirements on the NHS that will come from the publication of the 10 Year Health Plan.

5.2 Over the last few weeks we have heard from the Secretary of State and NHS England with regards their expectations of the NHS going forward, and we have been in receipt of a letter from NHS England (Appendix One) that was sent to all ICBs and NHS Trusts that outline these further including early information on NHS England's operating model proposals. We will take time to reflect on what has been outlined and consider these alongside the engagement work we have undertaken so far around our operating model, and we intend to bring further information to the Board at its next meeting in January 2025.

6. Change NHS - 10 Year Health Plan Engagement

6.1 The government launched in October the biggest national conversation about the future of the NHS, inviting the public and staff to share their experiences, views and ideas on the NHS via the change.nhs.uk portal to shape the 10 Year Health Plan. NHS Cheshire and Merseyside will be working with partners and providers to implement a wide-ranging programme of engagement with staff, stakeholders and patient groups across the Cheshire and Merseyside system.

6.2 We encourage staff, patient and the public to provide their valuable feedback via the online survey which is open to everyone click here to tell us how the NHS needs to change. In addition to the call to action for people to complete the survey, between November 2024 and the end of January 2025, we will be engaging staff and patient groups via a number of targeted workshops designed to engage local communities and staff, gathering their insights for the plan's development focusing on the three shifts outlined in Lord Darzi's report.

7. 2025-26 Commissioning Intentions

7.1 In recent years we have used our annually refreshed Joint Forward Plan to describe our key ICS and ICB priorities. In order to provide direction to the system as to our ICB priorities and approaches in 2025-26 we are currently co-creating our commissioning intentions with the system.

7.2 Whilst these commissioning intentions will take an evidence driven approach and build from existing priorities within our 2024-2029 Joint Forward Plan, reflecting The Health and Care Partnership Strategy (All Together Fairer our Health and Care Partnership Plan - published September 2024) and our nine Place based Health and Wellbeing Board Strategies, it will also reflect:

- emerging service pressures not reflected in the current Joint Forward Plan;
- how we are approaching and addressing the current financial pressures and financial context;
- wider public sector reform priorities emerging nationally e.g., local government devolution, "government" health shifts (hospital to community, treatment to prevention and analogue to digital)
- National NHS planning guidance (expected December 2024).

7.3 The process of developing the intentions has commenced and will include stakeholder engagement through our provider collaboratives and place partnership arrangements as well as internally using existing governance mechanisms including Board sub committees, such as Strategy and Transformation Committee. It is intended that the final draft commissioning intentions are to be brought to the January 2025 ICB Board meeting.

8. Change to the ICBs Integrated Research and Innovation Committee Terms of Reference

8.1 At its meeting in (add) 2024, the Board approved the Terms of Reference for the ICBs Integrated Research and Innovation Committee. As part of the establishment of the Cheshire and Merseyside Integrated Research and Innovation system, conversations have led towards the ICB Chair supporting minor changes to the TOR which includes removal of the current requirement for it to be chaired by one of the ICBs Non-Executives. Accordingly, the Board is asked to approve the minor amendments to the Committees TOR (Appendix Two). Subject to the Board, progress will then be made in confirming the Chair of the Committee.

9. Right Care, Right Person (RCRP)

9.1 Cheshire Constabulary and Merseyside Police have been leading the implementation of *Right Care, Right Person* across the Integrated Care System (ICS). *Right Care, Right Person* is a national approach designed to ensure that people of all ages who have health and/or social care needs receive the right

support, whilst also introducing thresholds to reduce the number of incidents the police are called to, where they are not the best agency to do so and particularly those involving mental health crises.

9.2 When people are in mental health crisis, they need timely access to support that is compassionate and meets their needs. While there will always be situations where the police need to be involved in responding to someone in mental health crisis, on many occasions they are not needed, and they are not able to handover care to a more appropriate professional quickly enough. This can then result in people with mental health needs experiencing greater distress and having poorer experience of the mental health care. This also negatively impacts the ability of the police to carry out their other duties effectively. *Right Care, Right Person* seeks to address this. Both Cheshire Constabulary and Merseyside Police will still attend mental health related incidents where there is a threat to life or a serious risk of harm to adults or a significant risk of harm to a child or young person.

9.3 Cheshire Constabulary and Merseyside Police have worked closely with NHS organisations, local authorities and the voluntary community faith and social enterprise (VCFSE) sector to deliver the first two implementation phases of Right Care, Right Person. Phase 1 introduced a new approach to concern for welfare calls. Phase 2 has addressed calls where an individual has walked out of a healthcare facility, these people will either be absent without leave (detained patients) or absconders (people not detained). Implementation of both phases is being actively managed with system partners. There is learning to be applied from Phase 2 that relates to circumstances when an individual absconds from an Accident and Emergency Department and which agency should respond. This is because not all patients who leave an acute hospital unexpectedly may have mental health needs. This is being addressed through the tactical groups set up by both Cheshire Constabulary and Merseyside Police and requires engagement by all NHS trusts, not just mental health services.

9.4 Cheshire Constabulary and Merseyside Police both intend to introduce Phase 3 of Right Care, Right Person from April 2025. Phase 3 applies to the powers of the police under s135 and s136 of the Mental Health Act 1983 to enter a premises to detain and convey people to places of safety for mental health assessment. Phase 3 will have the most impact for NHS trusts, acute, ambulance and mental health, and for local authority partners. There is a significant amount of activity underway through the Cheshire and Merseyside Mental Health Programme, overseen by the Crisis Oversight Group, that connects the Crisis Care Concordat requirements, the expansion and improvement of mental health services as set out the NHS Long Term Plan and RCRP implementation. This work seeks to connect all NHS trusts and local authorities to ensure that we are as ready as we can possibly be for Phase 3 implementation.

10. Liverpool Citizens Founding Assembly

10.1 On the 18 November 2024 I joined other public service leaders and over 500 people at The Liverpool Citizens founding assembly, held at St Georges Hall in Liverpool. Liverpool Citizens is a broad- based alliance of 17 diverse organisations – from educational and faith groups to health, housing, and third-sector bodies – united to drive change for the common good of the city of Liverpool. The alliance is independent and non-partisan. Driven by the success of Citizens UK, Liverpool Citizens aims to tackle pressing local issues.

10.2 Over the past year, alliance members have listened to thousands of people in local communities and will be taking action on issues they identified such as cost of living, healthcare, transport and neighbourhood improvements. At the Founding Assembly, citizens shared personal stories illustrating the impact of these challenges, and a number of questions were asked of key leaders in attendance.

10.3 I welcomed the opportunity for the ICB to be invited to speak at the founding assembly and committed to continue engaging positively with the alliance to help shape and improve access to local health services.

11. NHS Carols Concert

11.1 On Monday 16 December we will be celebrating the 38th annual carol concert at Liverpool cathedral. The concert brings together NHS staff past and present from across the region, as we celebrate the work we have achieved over the last 12 months. The concert will be a celebration and thanksgiving as we hear a number of readings from guest speakers and the NHS choir will take centre stage to perform some well-known festive carols. This year the event will support its chosen charity North West Air Ambulance. The event is open to all and is free to attend so the public can just turn up on the night. More information is available at: https://liverpoolcathedral.org.uk/events/nhs-carolsservice/

12. CAMRIN performance

12.1 The Cheshire and Merseyside Radiology Imaging Network (CAMRIN) is currently achieving a performance rate of 96.6% of patients being seen within 6 weeks for Magnetic Resonance Imaging (MRI) thanks to a range of service improvements including, mutual aid, staff commitment and the introduction of a CAMRIN Medical Physicist as part of the Medical Physics Service.

12.2 The Medical Physics Service, supported by The Clatterbridge Cancer Centre NHS Foundation Trust and funded by the Cheshire and Merseyside Cancer Alliance, has demonstrated the importance of medical physics across multiple Trusts in Cheshire and Merseyside. Within the Medical Physics Service, Magnetic Resonance (MR) clinical scientists work alongside MR radiographers and radiologists to ensure MR safety and efficiency.

12.3 The CAMRIN Medical Physicist has worked with radiologists and radiographers at Countess of Chester Hospital NHS Foundation Trust, Clatterbridge Cancer Centre, Liverpool University Hospitals NHS Foundation Trust and Mid-Cheshire Hospitals Foundation Trust to optimise the Advanced Acceleration Technology installed on MRI scanners in these Trusts. This has helped to reduce scan times, optimise imaging quality and enhance patient care.

12.4 So far, the service has helped to create an extra 5,800 30-minute appointment slots in the last 12 months. This also includes, 97 hours scanning time saved per month, 194 extra MRI scans per month and 13% increase in potential MRI capacity.

13. Lung Health Checks

13.1 More than 10% of cancers found through the national NHS lung health check programme have been detected in Cheshire and Merseyside – after a successful rollout of the checks in our area over the past few years.

13.2 More than 5,000 people in England have been diagnosed with lung cancer earlier, thanks to the NHS initiative that originated in Liverpool, which uses mobile scanning trucks to visit local communities. In Cheshire and Merseyside, 533 lung cancers have been detected since 2019, with around 80% at an early stage when successful treatment is much more likely and potentially curable.

13.3 NHS data also shows that more than a third of people diagnosed with lung cancer from the most deprived areas of England were diagnosed at an earlier stage since the checks began. People diagnosed with lung cancer at the earliest stages are nearly 20 times more likely to survive for five years than those whose cancer is caught late. Under the programme, current and past smokers aged between 55 and 74 are invited to speak with a healthcare professional about their lung health and, if they have a higher chance of developing cancer, are offered a scan of their lungs on a mobile unit.

13.4 Cheshire and Merseyside Cancer Alliance is helping to organise the checks in the region, and they have already taken place in Knowsley, Halton, Liverpool and south Sefton, with them also now rolling out across Wirral and Warrington. In coming years, the rest of Cheshire and Merseyside will be covered.

14. Cancer Alliance helps to fund new children's cancer project

14.1 A project aiming to understand the impact and benefits of delivering cancer care to children in their homes across the North West has been launched with help from the Cheshire and Merseyside Cancer Alliance.

14.2 The North West Children's Cancer Operational Delivery Network has received funding from regional cancer alliances to deliver an 18-month proof of concept

project across the region, working in partnership with Alder Hey Children's Hospital, in Liverpool, and Royal Manchester Children's Hospital.

14.3 The project, which launched its six-month planning phase at the beginning of November, aims to understand the impact and benefits of delivering cancer care to children in their homes and via the use of a mobile cancer care unit.

14.4 The project will include four phases: pre-planning, planning, home cancer care delivery and mobile cancer care unit. There will be evaluation throughout the life of the project and the project will be delivered via a method of co-production with patient and parent engagement in addition to the engagement of professionals working across the region.

15. Vaccination Program Update

15.1 **Covid-19 Autumn/Winter 2024.** The Campaign started on the 03 October with all cohorts opening together. So far over 1 million Covid-19 vaccinations have been delivered in the northwest, with 400,972 being delivered in Cheshire and Merseyside.

15.2 NHS Trust staff vaccination uptake in Cheshire and Merseyside is 16.4% for Covid-19 and 31.5% for flu. Trusts have been provided with additional funding by NHS England to support them to increase staff uptake.

15.3 Using Covid-19 access and inequalities monies the ICB is working with ICE Creates to offer 'vax chat' training to those working with people in areas of high deprivation and low uptake. This training aims to provide attendees with the skills needed to have vaccine hesitancy conversations and to support people to make informed choices regarding vaccination. We are focusing on CORE20PLUS5 areas in the first instance. This is open to NHS, Local Authority and VCFSE colleagues. Other key comms initiatives complementing National and Regional comms campaigns to drive uptake are:

- Out of home advertising, starts week commencing 18 November
- Digital screens in low uptake areas in Crewe
- 8 x Roadside advertising in Warrington
- Supermarkets screens in low uptake areas in Winsford, Ellesmere Port and Chester
- 2-week campaign of Bus advertising (Rears 100 and interiors 200) across Merseyside and Cheshire West
- Radio campaign working with L&SC using the same script. Greatest hits radio - Liverpool, geographically and demographically targeted focused in Cheshire.

16. Health and Housing Partnership

16.1 The Cheshire and Merseyside Health and Care Partnership, working with the Housing Association Charitable Trust (HACT) have recently launched the Cheshire & Merseyside Health and Housing Partnership (CMHHP).

16.2 The benefits of a closer collaboration between housing, health and care are clear, the provision of appropriate housing can help reduce hospital admissions, prevent readmissions and allow for care provision and support in homes and communities. Introducing this focus on Housing and Health was a clear recommendation from both our HCP and our All Together Fairer report produced by Sir Michael Marmot.

16.3 The partnership has identified four workstreams where it will seek to drive impact, these include:

- Housing quality, ensuring people's homes are not making them unwell or causing pre-existing health conditions to worsen.
- Suitable accommodation for mental health and learning disability patients waiting to be discharged from hospital.
- Creating employment opportunities within health and social care for Registered Social Landlords (RSL) tenants with an initial focus on the Opening Doors project.
- Finally, identifying opportunities to work in partnership to improve the health and wellbeing of RSL tenants and staff by embedding public health approaches to challenges such as food insecurity and being active.

16.4 We know that there is already great work happening across Cheshire & Merseyside and we want to build on that jointly with our partners in Housing and Local Government. We want to build on this, share and collaborate at scale, as well as identify what more we can do together in our integrated care system, to take these issues forward.

17. White Ribbon Day 2024 / 16 days of Activism

17.1 White Ribbon is a global campaign that encourages people, and especially men and boys, to individually and collectively take action and change the behaviour and culture that leads to abuse and violence. White Ribbon Day[1] will be recognised around the world on November 25, which is also the start of 16 Days of Action against domestic violence and abuse.

17.2 This White Ribbon Day, we are encouraging men to hold themselves accountable to women, and to each other, so we can affect positive behaviour change to transform harmful cultures. Gender equality is key to making this culture change happen. Gender equality is achievable if men and boys understand and assume their responsibility as allies.

[1] https://www.whiteribbon.org.uk/wrd24

17.3 As an organisation, we have a firm position of zero tolerance towards any form of harm through gender-based violence. We can all work together to build a culture that supports a workforce affected by domestic abuse, (including sexual safety in the workplace). Challenging norms and behaviours regarding gender-based violence is sometimes difficult if we`re not equipped with the right tools or not sure how to call it out.

17.4 To show our commitment to the white ribbon campaign and the sexual safety charter, we will launch our workplace scheme during the 16 days of action.

18. Power of Inclusivity (October 2024)

18.1 In October we supported various awareness days and months under the banner of the 'Power of Inclusivity'. They were World Mental Health Day, Black History Month, World Menopause Day, Speak Up Month.

18.2 In support of World Mental Health Day, Freedom to Speak Month and the launch of the Staff Survey, we held a session to learn and talk about the power of Active Listening for our staff. This session will be led by Dr Sinead Clarke, Associate Medical Director who also shared some early work about how we are looking to develop Schwartz Rounds in the organisation.

18.3 Race Equality Network also ran a webinar about understanding white privilege on Tuesday 15 October and on Tuesday 15 October, Dr Fiona Lemmens, Deputy Medical Director and Executive Sponsor of our Menopause Network led a session to provide a confidential space to ask any questions about all stages of the Menopause for those directly or indirectly affected.

18.4 Lastly, on Friday 18 October 2024 and in collaboration with our Race Equality Network, our Menopause Network hosted a session to explore the impacts and stages of menopause with a focus on our BAME Colleagues.

19. Adult Safeguarding Week (18 – 22 November)

19.1 National Safeguarding Adults Week was an opportunity for organisations to raise awareness of important safeguarding issues, start conversations about safeguarding and develop confidence in recognising signs of abuse and neglect.

19.2 To support this, we shared our local Safeguarding events with staff and the resources from the Ann Craft Trust on our social media channels promoting the national themed events throughout the week.

20. Employee and Team of the Quarter

20.1 In September 2024, as a direct result of staff feedback, we launched our new Employee and Team of the Quarter award, and which provides another means for us to acknowledge the hard work, dedication, and innovation of our colleagues. We have encouraged everyone in the ICB to participate by nominating deserving individuals and teams who make a difference in our ICB, system and citizens.

20.2 Our first Employee of the Quarter was Tim Thompson, Communications and Engagement Support Officer and Chair of our LGBTQI+ Staff Network and Team of the Quarter was the Liverpool's Dynamic Support Keyworkers, Ian Balmer, Sophie Melia and Nic Maguire.

21. Staff Suggestion Scheme

21.1 I am pleased to announce the launch of our new Staff Suggestion Scheme, a new initiative to encourage staff to submit helpful ideas, suggestions and identify potential improvements in relation to any aspect of our work. This scheme is a direct response to the asks from colleagues during our engagement sessions with staff about how we can all have a voice that counts. The scheme aims to complement our existing initiatives and is an opportunity for staff to get involved and improve our work.

21.2 A panel meets every six weeks to review all the ideas, and feedback will be given to all ideas that are submitted. The Panel is chaired by Mark Wilkinson, Cheshire East Place Director with representatives from the Staff Engagement Forum and an FTSU Ambassador.

21.3 For the first panel we had four suggestions. The three suggestions we were able to take forward were opening up appraisal training to all staff, ensuring our HR policies are more accessible and ensuring we value and thank our staff coming up to Winter.

22. Good news and Congratulations

22.1 I would like to extend my congratulations to Josette Niyokindi (Interim Associate Director of Quality, Safety and Improvement for Cheshire East Place), who has won a Royal College of Nursing (RCN) award to mark her outstanding contribution to equality, diversity and inclusion at the College's annual regional Black History Month conference. Josette received her award at a ceremony on Wednesday 16 October at the Quaker House in Liverpool.

22.2 I would also like to extend my congratulations to Sue Colbeck (ICB Chief Procurement Office – Non-Healthcare) for receiving the Procurement

Excellence Award at the HealthCare Supply Association Awards at its ceremony on 14 November 2024.[2]

23. Decisions taken at the Executive Committee

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

- **Flu Vaccination** - the Executive Team discussed and agreed that all staff should be encouraged to have a flu vaccination, and that if staff are not eligible for a free NHS flu vaccine that they can claim back up to £13 for flu vaccines via the ICB expenses system.

- **ICB Infrastructure/embedded estates team proposal** – the Executive Team discussed and approved the proposal to utilise ring-fenced underspend of allocated resources (currently held by CHP) to establish a short-term embedded supported function for the Estates team

- **Proposal for the development of our Mental Health First Aider (MHFA) Role, Network and Training Support** – the Executive team discussed and approved further investment in the development of MHFA roles within the ICB and agreed for further work to be undertaken to increase the diversity of those trained to be MHFA within the ICB

- **Vacancies** – the Executive team considered a paper on the approach to vacancies within the ICB and agreed that the ICB would keep it vacancy freeze until after the new year, with the exceptions being for clinical and statutory posts

- **Non-Emergency Patient Transport Services Interim tender outcome report –** the Executive Team discussed and approved the outcome of the initial stage of the Tender re-wind for Non-Emergency Patient Transport Services (NEPTS) and agree to notify unsuccessful bidders.

- **Mental Health Investment Standard** – the Executive Team considered and approved the release of Mental Health System Development funding.

23.2 At its meetings throughout October and November 2024, the Executive Committee has also considered papers on the following areas:
- Cheshire and Merseyside Health Estates Infrastructure
- ICB Operational Model
- Recovery Committee escalation reports
- Clinical Haematology - Commissioning Decision with associated Financial Impact
- Commissioning Intentions 2025-26

[2] https://www.nhsprocurement.org.uk/news/hcsa-awards-2024-announced-telford

- HSSIB report focused on out of area placements in mental health inpatient settings
- Primary Care System Development Funding
- Risk review
- Board Assurance Framework and Corporate Risk Register
- C&M Cancer Alliance Performance Update
- Mental Health Investment Standard
- Mental Health Crisis Feedback
- Mental Health Section12 Doctors
- Virtual Wards.

23.3 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.

24. Officer contact details for more information

Graham Urwin
Chief Executive

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

25. Appendices

Appendix One: NHS England letter PRN01700 - Evolution of our operating model (13.11.24)

Appendix Two: draft ICB Integrated Research and Innovation Committee Terms of Reference

To:
- Integrated care boards:
  - chief executive officers
  - chairs
- NHS trusts and foundation trusts:
  - chief executive officers
  - chairs

cc.
- NHS England regional directors

NHS England
Wellington House
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13 November 2024

Dear colleagues

Evolution of our operating model

Over the past year, we have been working with colleagues across the NHS and more widely on the development of our operating model. We are grateful for the enormous amount of time and input many of you have already given as part of this work. We are conscious, however, that there is much more work to do, and are writing both to provide an update following recent headline messages, and to ask for your input and support over the coming months. Please accept our apologies for the delay in communicating this to you formally. Lord Darzi's recent report was clear – we don't need another seismic reorganisation pulling focus from the important tasks, but the system we have needs to be optimised and every part of the NHS needs greater clarity on what they are accountable for. This is in line with many of the conversations we have been having with colleagues over the last year. So our work on the evolution of the operating model is designed to do just that; and to ensure that the way the NHS works supports delivery of today's priorities and sets us up to deliver the neighbourhood health model that will underpin a health and care system that is fit for the future.

The 4 actions that will guide our refresh of the current operating framework are set out below:

1) **Simplify** and reduce duplication, clarifying roles and responsibilities and being clear on the place of performance management.
2) **Shift** resources, time and energy to neighbourhood health, creating momentum that makes clear the role of the provider sector in neighbourhood health and how to work with local partners.
3) **Devolve** decision-making to those best placed to make changes, clarifying the role of integrated care partnerships (ICPs) and health and wellbeing boards.
4) **Enable** leaders to manage complexity at a local level, supporting leaders with new strategic commissioning frameworks to include national best practice.

Achieving this will require everyone in the NHS family to work together, alongside our partners in the wider system, to fully leverage the potential of ICSs, aligned around a clear purpose and each with a distinct role to play.

As our ways of working continue to develop and evolve, and as we strive to achieve our ambition of devolving decision-making to the local level, the functions where we as NHS England add most value will also change and may reduce.

Self-managing, self-improving systems
Lord Darzi, in his recent review, was unequivocal that the current NHS model is the right one, and that our structures can support delivery of the changes that we all want to see. Looking to the future, we want to see self-managing, self-improving systems, just as was set out in the Hewitt review. Integrated care boards (ICBs) are critical to delivery of the strategic shifts from treatment to prevention, from analogue to digital and from hospital to community, and will continue to be the system leader for the NHS, convening and working across all key partners within their integrated care system. We want systems to be empowered, and our goal is to give more freedoms for the top performers – those who are improving population health, reducing inequality of outcomes and who deliver high patient satisfaction and use resources effectively.

This also means that we will work closely with these high performers to help shape policy, frame national best practice and drive improvement. We will build on the work of NHS IMPACT to ensure systems 'in the middle' have the capability and support to improve, and we will refine our approach to recovery support to enable stronger and more rapid intervention for lower performing systems. We also recognise that we need to take account of contextual factors for each of the issues that are apparent in each organisation and system.

We intend to capture this approach through an updated NHS Oversight and Assessment Framework and underpin this with a new NHS Performance, Improvement and Regulation Framework.

As the NHS system leader, ICBs will need to refocus on strategic commissioning, and they will continue to be responsible for the planning and provision of services to a population. They will act as the system convener and are expected to plan, secure and arrange services in line with their statutory responsibilities. They will ensure the sustainability of primary care, rebuilding the provision of dentistry and community pharmacy, alongside developing strong GP practices and the wider primary care family that are attractive to newly qualifying GPs. We will support ICBs through the development of a new Strategic Commissioning Framework. They will have the primary responsibility for ensuring the delivery of neighbourhood health, identifying population health needs and acting on reversible risk factors to improve healthy life expectancy and reduce utilisation of secondary care. This vital work must continue at pace for us to deliver a neighbourhood health model.

All providers in a health system must still work together to deliver transformation, integration and improvement because these changes do not signal a move away from collaboration and system working and we will also ensure that the duty to collaborate mechanisms are tested in how we work with organisations.

Importantly, ICBs will continue to have oversight of how providers deliver the outcomes that they have been commissioned for. But where performance is below an acceptable level, and the use of commissioning levers has not secured improvement, NHS England will step in with both the ICB and provider to support rapid improvement and using our regulatory powers in a defined set of circumstances.

Supporting organisations to improve
The NHS Performance, Improvement and Regulatory Framework will have clear guidelines for interventions in organisations struggling with quality, finance, or access, ensuring transparency and consistency. This will include establishing a consistent regulatory approach for underperforming organisations, mandating recovery plans and maintaining

board accountability for effective delivery. As part of this approach, we will also use an independent diagnostic process to accurately assess and analyse the root causes of issues within organisations, providing targeted insights for improvement.

These changes should allow us to streamline how different parts of the health system work together to support our collective focus on improving the delivery and recovery of urgent and emergency care and elective performance, at the same time as the medium- and long-term changes required to meet the needs of our communities, shifting care to where it is delivered best in a joined-up and integrated way.

Board accountability
Strong boards are essential for all organisations if the NHS is to deliver its objectives. To be effective, boards need the right information at the right time and used in the right way. As part of our commitment to support leaders to deliver and improve, and to set them up for success, I am pleased that we have published this week the Insightful Board guides for both ICBs and providers. We recognise that ICBs have a unique role in supporting the wider primary care working to be sustainable, and the Insightful Board documents support that. These guides provide clarity around the critical information boards need to understand their organisations, and the culture and governance necessary to support information flow, so it can be used most effectively when overseeing their organisations.

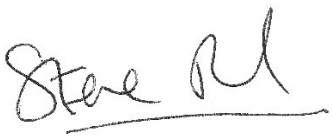
Working with you
We have heard consistently that clarification was needed, and while there has been broad consensus on much of this, we acknowledge there are different views on precisely what the roles and responsibilities should be and how this should work in practice. While we have set out the direction of travel, we want to work with you on how we refine and implement this. There are no immediate changes for 2024/25, and systems must continue to deliver their plans in the way that has been agreed.

We have set up an NHS System Development and Reform programme, working closely with colleagues in DHSC. This will include a regular advisory group of chairs and chief executives, among others, to help co-create the implementation plan.

We recognise there will be a need for extensive engagement about what the evolution of the operating model will mean in practice and how we best describe and implement it. We will hold an initial webinar with you next week, at 11am on Wednesday 20 November, and plan further engagement from there.

Finally, although the next steps in evolution of the operating model have been discussed extensively with some of you, we know that much wider engagement is needed to make this a reality, and we are committed to working closely with you on next steps, including plans for implementation.

Yours sincerely



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NHS Cheshire & Merseyside ICB

Research and Innovation Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
28.03.2024	1			
28.1.24	1.1	Change of Chair details		Matthew Cunningham

Review due: March 2025

V1.1 approved by the Board of NHS Cheshire and Merseyside on 28 November 2024

Research and Innovation Committee

Terms of Reference

1. Introduction and Purpose

The Research and Innovation Committee (the Committee) is established by NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside') as a Sub-Committee of its Board in accordance with its Constitution.

These terms of reference, which must be published on the NHS Cheshire and Merseyside website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board of NHS Cheshire and Merseyside.

The Committee is a non-executive led forum, and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS Cheshire and Merseyside.

The Committee's main purpose is to exercise the functions of the ICB relating to the legal duties on ICBs, as outlined within the Health and Care Act 2022 (the 2022 Act), regarding the facilitation and promotion of research relevant to health service and the use in the health service of evidence obtained from research.

These duties have been emphasised in NHS England's subsequent guidance to ICBs on Maximising the Benefits of Research[1] which makes a number of recommendations on how best to embed a culture of research and innovation within an Integrated Care System (ICS)

2. Role and Responsibilities

The Committee, through delegated authority from the ICB, will develop recommendations on to the Board of NHS Cheshire and Merseyside in line with the development of an Integrated Research Innovation System (IRIS), which will:

- create the most comprehensively networked system across the Cheshire and Merseyside Integrated Care System (ICS)
- build a system attracting investment and intellectual value because of its straight forward nature
- creates a functional network of research delivery because it is underpinned by the richest data science
- allow research to take place within each of the nine Places across Cheshire and Mersey-side
- cements academic and NHS relationships.

The Committee's duties are as follows:

- to approve an annual workplan

[1] https://www.england.nhs.uk/long-read/maximising-the-benefits-of-research/

- make recommendations to the Board of NHS Cheshire and Merseyside
- to involve and engage NHS and wider partners in IRIS, managing the interdependencies with similar systems across Cheshire and Merseyside (and beyond) and resolving any conflicts
- ensure the development of IRIS has sufficient resources drawn from all partners, with the right skills and capacity to deliver against its objectives
- identify and address risks and issues.
- report on progress, risks, issues and delivery to the Board of NHS Cheshire and Merseyside
- ensure that the voice of patients, public and stakeholders are integral to the programme
- receive and consider reports from the Cheshire and Merseyside Research and Innovation Steering Group, ensuring transparency, accountability, and alignment with the overarching healthcare strategy.
- establish working Groups (specialised groups responsible for specific research and innovation areas and initiatives) that will also report to the Committee.

3. Authority

The Research and Innovation Committee is authorised by the ICB 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 ICBs (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- obtain 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 constitution of the ICB, standing orders and SoRD but may /not delegate any decisions to such groups without the approval of the ICB Board.
- commission, review and authorise 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.
- approve the TOR for the IRIS Steering Group.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

4. Membership & Attendance

Membership

The Committee membership shall be confirmed by the Board of NHS Cheshire and Merseyside via approval of the Committee Terms of Reference and in accordance with the NHS Cheshire and Merseyside Constitution.

Membership of the Committee may be drawn from individuals employed by or appointed by NHS Cheshire and Merseyside, individuals drawn from partners within the wider health and social care system and other individuals / representatives as deemed appropriate for the delivery of the Committees remit.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The Committee Membership will be composed of:

- at least one Non-Executive Member from the NHS Cheshire and Merseyside Board ~~(also to be the Chair)~~
- ICB Medical Director
- Associate Medical Director for Transformation and Deputy Medical Director
- x2 ICB Directors of Research, Cheshire and Merseyside Integrated Care System
- x2 representatives from Universities within Cheshire and Merseyside
- ~~a representative from the University of Liverpool~~
- a representative from Alder Hey Childrens Hospital.

Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff and individuals to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be regularly attended by the following individuals who are not members of the Committee. Such attendees will not be eligible to vote.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

5. Meetings

5.1 Leadership

The Chair of the Committee shall be drawn from the membership of the Committee. ~~chaired by a Non-Executive Member of the NHS Cheshire and Merseyside Board.~~ Committee members may appoint a Deputy Chair from amongst its standing members.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative member of the Committee ~~NHS Cheshire and Merseyside Non-Executive Member or Executive Director~~ to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, the Deputy Chair will be asked to Chair the meeting. On the occasion where both the Chair and Deputy Chair are unable to Chair an item due to a conflict of interest, then another member of the Committee, without any conflicts, will be asked to chair the Meeting for that item. Where these requirements are unable to be met the meeting item will need to be deferred.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

A meeting of the Committee is quorate if the following are present:

- at least four Committee members in total, of which this must consist of
  - the Chair or Deputy Chair
  - at least one ICB Associate Director of Research and Innovation.

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.3 Decision-making and voting

Decisions will be taken in accordance with the Standing Orders and Operational Standing Orders of NHS Cheshire and Merseyside and within the authority as delegated to the Committee and its members. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote, and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next schedule meeting, the Chair may conduct business on a 'virtual basis through the use of telephone, email or other electronic communication'. Decisions will be recorded and formally minuted and ratified at a subsequent form meeting of the Committee.

5.4 Frequency and meeting arrangements

The Committee will meet in private.

The Committee will meet bi-monthly prior to the Research and Innovation Steering Group.

Additional meetings may take place as required.

At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule").

Members may call for a special meeting of the Committee outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair may, following consultation with the Committee members, confirm the date on which the special meeting is to be held and then issue a notice giving not less than one weeks' notice of the special meeting.

The Committee may meet virtually and members attending using electronic means will be counted towards the quorum.

6. Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair with the support of the executive lead
- good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

7. Accountability and Reporting

The Committee is accountable to the Board of NHS Cheshire and Merseyside and shall report to the Board on how it discharges its responsibilities.

The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will also submit copies of its confirmed minutes to the Board of NHS Cheshire and Merseyside following each of its meetings.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

8. Behaviours and Conduct

Members will be expected to conduct business in line with the NHS Cheshire and Merseyside values and objectives and the principles.

Members of, and those attending, the Committee shall behave in accordance with NHS Cheshire and Merseyside constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the NHS Cheshire and Merseyside Managing Conflicts of Interest Policy at all times. In accordance with the NHS Cheshire and Merseyside policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.

- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- Comply with NHS Cheshire and Merseyside policies on standards of business conduct which include upholding the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary
- Act as 'champions', disseminating information and good practice as appropriate
- Comply with the NHS Cheshire and Merseyside administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

9. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Meeting of the Integrated Care Board of NHS Cheshire and Merseyside

28 November 2024

Director of Nursing Report

Agenda Item No: ICB/11/24/05

Responsible Director: Christine 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 & Merseyside.

2. Executive Summary

2.1 An update is provided in relation to:

- A Children and Young People's showcase event, hosted by NHS Cheshire & Merseyside
- Position update regarding 2024 White Ribbon campaign and the introduction of Domestic Abuse and Sexual Safety allies within the workplace
- Health Care Associated Infection (HCAI) and Anti-Microbial Resistance (AMR)
- Urgent & Emergency Care & Patient Safety.

3. Ask of the Integrated Care Board & Recommendations

3.1 The Integrated Care 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 the C&M ICB related to the Executive Director of Nursing & Care portfolio and is for information purposes.

5. Focus Areas

5.1 **Children & Young People's Showcase Event.** Cheshire and Merseyside hosted the Northwest Regional NHSE Oversight Group on 11 November 2024 and showcased the ongoing work in the region to support children and young people. The event was chaired and facilitated by a young person, Izzy, who reflected on her experiences of health services across the transition between children's and adult services and how there needed to be a continued focus on person-centred care that met the needs of young people. Izzy is part of a group of young people involved in a voice and influence campaign, hosted by Beyond, to ensure that children and young people feel included in conversations about issues that affect them. Key issues were highlighted as areas of good practice during the showcase. These included:

- The system focus on CYP as a priority areas as evidenced through both the HCP and ICB strategy / Joint Forward Plan and through the establishment of the CYP committee.
- The strong multi-agency focus across C&M on strategic planning and delivery with partnership working across health, social care, education, VCFS and in partnership with parent / carers / children and young people.
- The work of Beyond as a key driver for transformation of cyp services across the region with a strong focus on health inequalities, early intervention / prevention through multi-agency delivery.
- Consultation with children and young people was shared which highlighted key issues that matter to them: Health, Home, Education and Community – but most importantly, Love.
- Progress against delivery of Virtual Wards / Hospital at home, led through Alder Hey NHS Foundation Trust. 20 virtual beds are now in place with plans to develop these further.
- All Together Smiling – Supervised Toothbrushing Programme: Starting from local delivery of the Tiny Teeth project through NHSE Early Intervention monies, the ICB has identified Beyond as the delivery partner for a 3 year STB programme. Over 200,000 toothbrush / toothpaste packs have distributed across Cheshire and Merseyside and 2 trailblazer Place areas are mobilising.
- Partnerships for Inclusion of Neurodiversity in Schools (PINS) – this project is running in 7 Place areas in C&M to focus on training and support for CYP with ND conditions. Two parents from the parent/carer forum shared their involvement and highlight the need to empower parents and ensure that they are viewed as experts in supporting their own children.
- Corporate Parenting: presented by the ICB safeguarding lead, and the Programme Director for the DCS Change and Integration Programme, highlighting the statutory duty to ensure support across all aspects of a young person's life - care, education, health, travel, accommodation, safety, leisure.

5.2 **White Ribbon Day & Domestic Abuse/Sexual Safety Allies.** White Ribbon Day will be recognised around the world on 25th November 2024 and will be the start of 16 Days of Action against domestic violence and abuse. The campaign encourages us all to take action and change the behaviour and culture that leads to gender-based violence (against women and young girls).“***It starts with men***” is the theme for White Ribbon Day 2024. The campaign encourages initially men and boys across society to create a positive culture change so that they feel confident to challenge belief systems regarding gender-based violence by becoming an ally.

- The challenge is to have the courage to confront restrictive ideas about genders within our own lives, public spaces and within our workplace
- Make the promise to never use, excuse or remain silent about men`s violence against women

5.3 The ICB plans to support the campaign by:

- Staff wearing a White Ribbon
- Calling out inappropriate language and use gender neutral language
- Learn how to, and call out, seemingly 'harmless' conversations, 'jokes and behaviour.
- Ongoing communication with staff regarding the 16 days of action (see below)
- Procurement of white ribbons for our employees to physically demonstrate our support.

Day	Date	Links to information and survivor story		Day	Date	Links to information and survivor story
1	25th Nov	sexual violence		9	3rd Dec	sexual abuse
2	26th Nov	Gaslighting		10	4th Dec	tech-abuse
3	27th Nov	coercive control		11	5th Dec	revenge-porn
4	28th Nov	street harassment		12	6th Dec	emotional abuse
5	29th Nov	post separation abuse		13	7th Dec	human-trafficking
6	30th Nov	forced marriage		14	8th Dec	stalking
7	1st Dec	FGM		15	9th Dec	physical abuse
8	2nd Dec	economic abuse		16	10th Dec	so-called-honour-based-violence

5.4 As an organisation, we have a firm position of zero tolerance towards any form of harm through gender-based violence. The ICB will work together to build a culture that supports a workforce affected by domestic abuse, (including sexual safety in the workplace). Challenging norms and behaviours regarding gender-based violence is sometimes difficult if we`re not equipped with the right tools or not sure how to call it out.

5.5 To show the ICB commitment to the white ribbon campaign and the sexual safety charter, we will call for volunteers to become workplace Domestic abuse and sexual safety allies during the 16 days of action

5.6 Working for the NHS is a privileged position of trust that enables all of us at some stage of our career to be confidants to colleagues who may disclose exposure to harm or abuse within their personal lives or work. An employer that fosters a culture of openness, commits to protecting workers from all forms of abuse and seeks to support victims is likely to be well placed to recruit and retain high-performing employees.[1]

5.7 Our historical approach towards safeguarding populations at risk of harm has tended to look outside our organisations and focus on communities or people who are in receipt of NHS care or support (our consumers). However, safeguarding has evolved over the past few years to focus on areas of prevention and compassionate approaches to identifying how lived experience of previous harm and trauma can significantly impact the decisions we make as individuals across our life cycle.

[1] https://www.farrer.co.uk/news-and-insights/domestic-abuse-in-the-workplace-an-emerging-issue-in-employment-law/

5.8 It is our ability to show empathy, compassion and a commitment to supporting others to cope, respond and react to life events that enable our workforce to thrive[2,3,4,5] and remain in the workplace.

5.9 The introduction of domestic abuse and sexual safety allies supports the organisation's firm position of zero tolerance towards any form of harm, be it domestic abuse or workplace harassment and reinforces a culture of respect and commitment to safeguarding the wellbeing of every staff member.

5.10 Establishing a culture that supports a workforce affected by domestic abuse, (including promoting sexual safety in the workplace[6]), requires a grassroots approach. This involves building awareness and understanding, where every employee, regardless of their position, recognises the significance of providing a safe and compassionate environment for colleagues.

5.11 It is very difficult to protect wellbeing and prevention of harm without exploring sexual safety within the workplace and domestic abuse jointly as both have a direct impact on our workforce. It is essential as an organisation that we are a safe place for our employees to disclose any concerns regarding their wellbeing or welfare and that we can offer a wraparound response to minimise risk and incidence of harm/abuse.

5.12 Through the introduction of Domestic Abuse and sexual safety workplace allies, individuals across all levels of the organisation will be trained to act as trusted, approachable sources of support. These workplace allies will be equipped to recognise the signs of abuse, respond compassionately, and offer guidance on safety measures and support systems in place. The success of this initiative depends on the active involvement of the entire workforce, ensuring that the principles of empathy, support, and safety permeate every aspect of the workplace.

5.13 Creating and establishing a culture that supports people affected by domestic abuse and promoting sexual safety requires a grass roots approach.

[2] Workplace support for victims of domestic abuse - GOV.UK (www.gov.uk)
[3] Domestic abuse: guidance for people professionals on supporting employees | CIPD
[4] Supporting NHS staff with domestic violence and abuse | NHS Employers
[5] NHS England » Sexual safety in healthcare – organisational charter
[6] New legal duty to prevent sexual harassment | NHS Employers

5.14 The workplace allies will be volunteers from all levels across our workforce who will become a safe 'go-to' person for colleagues to access support or advice regarding safety measures implemented in the workplace. The introduction of the Domestic Abuse and sexual safety allies will ensure our workforce feel safe and supported in their workplace which improves morale, productivity, and attendance.

5.15 By becoming a Domestic abuse and sexual safety workplace ally staff will ensure they can recognise, respond (through use of workplace policy and culture that supports disclosures), reassure and believe staff and signpost to the appropriate services.

5.16 All allies will undertake 4-day Domestic Abuse training delivered by a specialist external agency and an additional day on trauma informed practice. Domestic Abuse and sexual safety workplace allies will provide a vital role in being the link between their workplace, HR, freedom to speak up and safeguarding professionals and will be representative of the communities we serve within our geographical footprint.

5.17 We are currently negotiating with NHSE and our neighbouring ICBs to scope a joint initiative that will both support staff and set the standard for compassionate leadership safeguarding our workforce.

5.18 Further areas of development include:

- Identification of current process to support staff disclosing domestic abuse or concerns regarding sexual safety within the workplace
- Referral processes to ensure maximum confidentiality, ensuring staff "tell their story once"
- Developing safe and compassionate environments for potential victims or perpetrators to seek support.
- Embed compassionate care into appraisals and monthly reviews – focusing on wellbeing
- Agreement regarding optional training for business partners and HR team regarding domestic abuse and sexual safety within the workplace
- Nomination of allies
- Clear communication plan
- Scope for readiness assessment for cultural change within the ICB

- Working with STADA to develop a job description for the Domestic abuse and sexual safety coordinator
- Formal evaluation of the proposal (including legacy and sustainability).

5.19 **Health Care Associated Infection (HCAI) & Anti-Microbial Resistance (AMR).** The November 2024 Quality and Performance Committee received a focused paper relating to rates of HCAI within NHS providers and wider place-based systems. The report demonstrated the analytical differences between the delivery of Trust specific national thresholds for HCAIs and benchmarked analysis based upon Northwest and England rates.

5.20 The report indicated that seven of the twelve NHS acute Trusts have already breached their pre-determined thresholds, in at least one recorded HCAI at Month 6 2024/25.

5.21 Furthermore, at current rates, all bar one trust is on trajectory to breach some or all of their thresholds. The current trajectory for the ICB would see a breach to all tolerances by the end of the year. Whilst the position against tolerances indicates that there is work required across the whole system to reduce infection rates, it is key to note that the tolerances are based on previous rates within the trust and therefore an understanding of how rates compare with peers is also vital.

5.22 The HCAI rates were also benchmarked with peers across the Northwest & England and detailed where Trusts and/or Places were highlighted as statistical outliers. The paper highlighted that for C&M, there have been a variety of positive outlier alerts (low rates of infection) and negative outlier alerts (high rates of infection), based upon the position as at Q2 2024/25.

5.23 Negative outliers for Clostriodiodes Difficile were highlighted at Wirral University Teaching Hospital and the Wirral place-based system, with Liverpool University Hospital Trust identified as a negative outlier for rates of Gram-Negative Blood Stream Infections.

5.24 The committee were assured by the work being led by the ICB with support from NHS England to undertake a review of improvement work within Liverpool University Hospital Trust and Wirral place.

5.25 The committee also received an update that AMR assurance is being provided using the NHS System Oversight Framework (SOF) which previously included an ICB level metric relating to safe, high-quality care for AMR in relation to antibiotic prescribing in primary care. Within the metric there were two measures. One measure relates to the overall volume of prescribing of antibiotics (items/STAR PU) by primary care and the second relates to the percentage of broad-spectrum antibiotics prescribed by primary care. In the absence of newly set NHS NOF metrics for 2024/2025 the ICB will continue to assess performance of appropriate antibiotic prescribing against the legacy primary care metrics of items/STAR PU and the percentage of broad-spectrum antibiotics.

5.26 The committee were informed that using July 2024 data, NHS C&M is currently not meeting the legacy target set for the overall volume of prescribing of antibiotics in primary care however there is continued good performance at an NHS C&M level for the percentage of broad spectrum anti-microbial prescribing by primary care. Whilst not meeting the historic trajectories, the data presented did confirm a trend in performance at NHS C&M level of both measures which show a reducing proportion of broad-spectrum antibiotics being prescribed and a steady value of antibiotic per STAR-PU at NHS C&M level. This is following fluctuations caused initially caused by an increase in December 2022 because of increased incidence of invasive group A streptococcus (iGAS) and a significant reduction following this to December 2023.

5.27 The committee heard that as part of the National Hydration project, a training program for care home staff which began February 2024, has resulted in a 40% reduction in Sefton place and nearly 20% reduction in Wirral for hospital admissions for Urinary Tract Infections (UTI).

5.28 The success of reducing hospital admissions for UTIs in older adults highlights the importance of preventative healthcare and early intervention strategies. By shifting the focus towards managing health conditions within the community and care settings, health systems can better prevent the escalation of conditions that require hospitalisation.

5.29 **Urgent & Emergency Care – Patient Safety**.Work continues to embed the guidance in relation to maintaining patient safety for those experiencing long waits in non-clinical areas, now included in national guidance issued on the 18th September 2024 and described as 'Temporary Escalation Spaces.'

5.30 Place based assurance was provided at the November 2024 Quality & Performance Committee as to each providers implementation and review. Work is now underway to ensure that identified gaps in assurance are addressed and the work is sustained as operational pressures persist.

5.31 Alongside the assurance re safety in temporary escalation spaces, Directors of Nursing & Medical Directors from across the system will come together on a weekly basis through the coordination of a 'clinical cell' to provide senior ICS clinical input and oversight of the planning for, and response to, increasing pressures throughout the UEC pathway, supporting front line staff in decision making by assessing system level clinical risks, to maintain a safe standard of patient care. Other work includes senior clinical input into the daily system calls and the assessment of emergency environments by C&M Patient Safey Specialists.

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

6.1 The current work plan and programmes complements the CQC/ ICS Quality Statements and in particular:

- How we work as partners for the benefit of our population
- Population Health

- Learning Culture.

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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Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Cheshire and Merseyside Integrated Care System Finance Report Month 6 (2024/25)

Agenda Item No: ICB/11/24/0**6**

Responsible Director: Claire Wilson, Executive Director of Finance

Cheshire and Merseyside
System Finance Report Month 6

1. Purpose of the Report

1.1 This report provides an update to the Committee of NHS Cheshire and Merseyside on the financial performance of the Cheshire and Merseyside ICS ("the ICS") at Month 6 2024/25, in terms of relative position against its financial plan, and alongside other measures of financial and operational performance (e.g. efficiency, productivity and workforce).

1.2 The Committee is asked to note the contents of this report in respect of the Month 6 ICS financial position for both revenue and capital allocations within the 2024/25 financial year. There is considerable risk in the delivery of both Provider and ICB financial positions and corrective action is required to secure efficiency savings to support delivery of the overall system financial plan.

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 On 2nd May 2024 the System 'ICS' plan submitted was a combined £215.8m deficit, consisting of £40.9m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £256.7m. This plan was not approved by NHSE, and subsequently a revised plan of £150m deficit (£62.3m surplus for the ICB and £212.3m for providers) was agreed and submitted on 12th June 2024.

2.3 During month 6, NHS England have issued an allocation of £150m 'revenue deficit support' to the ICB to cover the deficit to allow the financial system plan to be modified to a balanced breakeven position. The £150m has been distributed as agreed by the ICB to providers and in turn collective provider plans have improved. The revenue deficit support is deemed repayable to NHSE, phased from 2026/27.

2.4 As of 30th September 2024 (Month 6), the ICS system is reporting a YTD deficit of £108.5m against a planned YTD deficit of £59.7m resulting in an adverse YTD variance of £48.8m (1.3% of allocation). The Month 6 YTD position excluding 6/12ths of the £150m revenue deficit support is £183.5m deficit, £48.8m adverse to plan.

2.5 The ICS financial position as reported to NHS England at Month 6 is set out in **Table 1** below. NB: NHSE require the forecast to remain on plan at month 6,

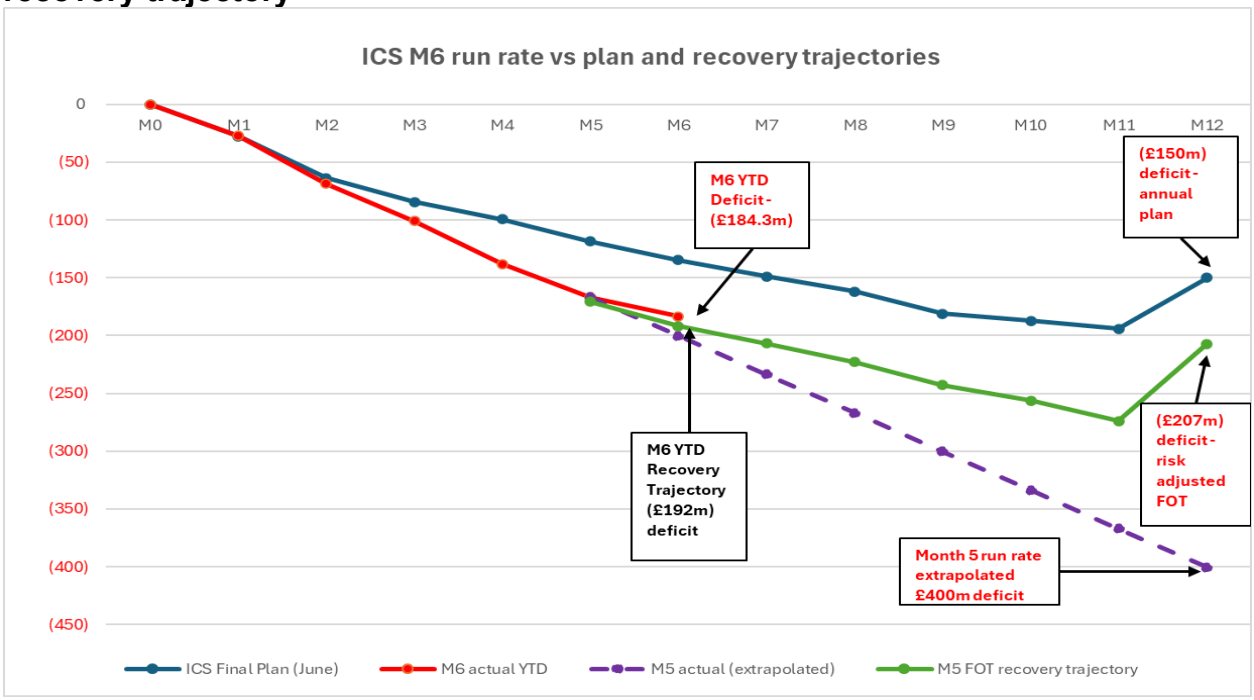
this forecast carries a significant amount of risk with risk adjusted forecast value of £57.3m representing a level of unidentified migrations as at Month 6.

Table 1 – Financial Performance Month 6 YTD and FOT

	M6 YTD				24/25 FY Plan				24/25 Risk Adjusted FOT (FY)		
	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	FOT £m	Variance £m	Variance %	FOT £m	Variance to plan £m	Variance to plan %
ICB	31.1	1.6	(29.5)	-0.8%	62.3	62.3	0.0	0.0%	37.5	(24.9)	-0.3%
Total Providers	(90.8)	(110.1)	(19.3)	0.6%	(62.3)	(62.3)	0.0	0.0%	(132.3)	(32.4)	-0.5%
Total System	**(59.7)**	**(108.5)**	**(48.8)**	**-1.3%**	**0.0**	**0.0**	**0.0**	**0.0%**	**(94.8)**	**(57.3)**	**-0.8%**
Total Providers (exc. £150m rev support)	(165.8)	(185.1)	(19.3)	0.6%	(212.3)	(212.3)	0.0	0.0%	(244.8)	(32.4)	-0.6%
Total System (exc. £150m rev support)	**(134.7)**	**(183.5)**	**(48.8)**	**-1.3%**	**(150.0)**	**(150.0)**	**0.0**	**0.0%**	**(207.3)**	**(57.3)**	**-0.9%**

2.6 **Chart 1** below shows the profile of the ICS I&E plan and recent revised recovery trajectories against the actual M6 YTD run rate. It excludes the £150m revenue deficit support to evidence the comparable run rate position month to month (actual and forecast).

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



2.7 It should be noted that a £183.5m Month 6 YTD deficit (excluding deficit support) now exceeds the full year £150m deficit plan within the first half of the year. This reflects the challenging profile of the plan where CIPs have been assumed to deliver towards the end of the year as well as a number of planned transactions in Month 12. 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 to support the recovery trajectories and mitigate the £57.3m gap.

2.8 A summary of those organisations currently reporting a risk adjusted FOT adverse to plan is set out in **Table 2**, and how this compares to the previous risk adjustment position at Month 5.

Table 2 – Risk Adjusted FOT vs Plan as at Month 6

Org	FY Plan 24/25	Month 5 (end of Aug)		Month 6 (end of		M5 to M6
		M5 Risk Adjusted FOT Position	M5 Risk Adjusted Variance vs Plan	M6 Risk Adjusted FOT Position	M6 Risk Adjusted Variance vs Plan	Movement on Risk Adjusted FOT Position
	£m	£m	£m	£m	£m	£m
Alder Hey Children's	3.4	3.4	0.0	4.4	1.0	1.0
Bridgewater Community	2.1	0.2	(2.0)	0.2	(2.0)	0.0
Cheshire & Wirral Partnership	1.5	1.5	0.0	1.5	0.0	0.0
Countess of Chester Hospitals	(23.6)	(23.6)	0.0	(23.5)	0.0	0.0
East Cheshire Trust	(14.4)	(14.3)	0.1	(14.3)	0.1	0.0
Liverpool Heart & Chest	14.1	14.1	0.0	14.1	0.0	0.0
Liverpool University Hospitals	(80.5)	(96.4)	(15.9)	(95.3)	(14.8)	1.1
Liverpool Women's	(28.5)	(28.5)	0.0	(28.5)	0.0	0.0
Mersey Care	7.1	7.1	0.0	7.1	0.0	0.0
Mid Cheshire Hospitals	(35.6)	(40.6)	(5.0)	(38.8)	(3.2)	1.8
Mersey & West Lancs	(26.7)	(26.7)	0.0	(26.6)	0.0	0.0
The Clatterbridge Centre	0.9	0.9	0.0	0.9	0.0	0.0
The Walton Centre	5.3	5.3	0.0	5.3	0.0	0.0
Warrington & Halton Hospitals	(27.8)	(36.2)	(8.4)	(34.8)	(7.0)	1.4
Wirral Community	6.5	6.5	0.0	6.5	0.0	0.0
Wirral University Hospitals	(16.3)	(23.3)	(7.0)	(22.9)	(6.6)	0.5
TOTAL (C&M Providers)	**(212.3)**	**(250.5)**	**(38.2)**	**(244.8)**	**(32.4)**	**5.8**
C&M ICB	62.4	37.5	(24.9)	37.5	(24.9)	0.0
TOTAL ICS	**(150.0)**	**(213.0)**	**(63.1)**	**(207.3)**	**(57.3)**	**5.8**

2.9 This risk value has been reported to NHS England and discussed via the regulator assurance and intervention meetings.

3. Financial Performance Month 6

ICS financial performance – M6

3.1 As of 30th September 2024 (Month 6), the ICS is reporting a YTD deficit of £108.5m against a planned YTD deficit of £59.7m resulting in an adverse YTD variance of £48.8m. Following the receipt of £150m system deficit funding, the system plan is now a breakeven position and therefore the YTD deficit of £108.5m must be recovered over the remaining 6 months of the year in order to achieve the revised plan.

3.2 The YTD variance against plan is due to a deterioration of both the ICB position and key pressures within providers. ICB pressures continue to relate to the cost of Continuing Health Care (CHC) and Mental Health packages. In addition, there are continuing pressures on prescribing following the receipt of Jun-24 prescribing data. Provider pressures relate primarily to the impact of industrial action in June and July, under-delivery of efficiency savings, underperformance on ERF targets at Wirral Teaching Surgical Centre and the cost of the review at Countess of Chester.

3.3 **Table 3** sets out the financial performance surplus/(deficit) at Month 6 at organisation level.

Table 3 – ICS Financial Performance M6 YTD by organisation

Financial performance surplus/(deficit) for the purposes of system achievement	M6 YTD Plan	M6 YTD Actual	M6 YTD Variance	M6 YTD Variance	M6 YTD Actual (excluding 6/12ths of £150m deficit support)	Full Year Annual Plan (exc £150m deficit support)	Month 6 YTD as a % of FY plan
	£m	£m	£m	%	£m	£m	%
C&M ICB	31.1	1.6	(29.5)	-0.8%	1.6	62.3	3%
Alder Hey Children's NHS Foundation Trust	(2.3)	(2.3)	(0.0)	-0.0%	(2.3)	3.4	-67%
Bridgewater Community Healthcare NHS Foundation Trus	(0.1)	(1.1)	(1.0)	-2.0%	(1.1)	2.1	-51%
Cheshire and Wirral Partnership NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1	1.5	7%
Countess of Chester Hospital NHS Foundation Trust	(7.4)	(12.6)	(5.3)	-3.0%	(19.6)	(23.6)	83%
East Cheshire NHS Trust	(5.4)	(5.7)	(0.3)	-0.3%	(10.0)	(14.4)	69%
Liverpool Heart and Chest Hospital NHS Foundation Trust	6.2	5.7	(0.5)	-0.4%	5.7	14.1	40%
Liverpool University Hospitals NHS Foundation Trust	(46.0)	(52.5)	(6.5)	-1.1%	(76.3)	(80.5)	95%
Liverpool Women's NHS Foundation Trust	(6.9)	(5.8)	1.1	1.3%	(14.2)	(28.5)	50%
Mersey Care NHS Foundation Trust (inc NWB)	2.8	2.8	0.0	0.0%	2.8	7.1	39%
Mid Cheshire Hospitals NHS Foundation Trust	(5.0)	(7.8)	(2.8)	-1.4%	(18.3)	(35.6)	51%
Mersey & West Lancashire Teaching Hospitals NHS Trust	(13.2)	(10.3)	2.9	0.6%	(18.2)	(26.7)	68%
The Clatterbridge Cancer Centre NHS Foundation Trust	0.2	0.2	0.0	0.0%	0.2	0.9	22%
The Walton Centre NHS Foundation Trust	2.6	3.0	0.4	0.4%	3.0	5.3	56%
Warrington and Halton Teaching Hospitals NHS Foundatio	(10.9)	(11.7)	(0.8)	-0.4%	(19.9)	(27.8)	72%
Wirral Community Health and Care NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1	6.5	2%
Wirral University Teaching Hospital NHS Foundation Trust	(5.8)	(12.4)	(6.6)	-2.6%	(17.2)	(16.3)	105%
Total C&M ICS	**(59.7)**	**(108.5)**	**(48.8)**	**-1.3%**	**(183.5)**	**(150.0)**	**122%**

ICB Financial Performance – M6

3.4 The ICB has reported a YTD surplus of £1.6m compared to a planned surplus of £31.1m, resulting in an adverse variance to plan of £29.5m as per **Table 4** below.

Table 4 – ICB Financial Performance M6 YTD

	M6 YTD			
	Plan £m	Actual £m	Variance £m	Variance %
ICB Net Expenditure				
Acute Services	1,709.9	1,708.6	1.3	0.1%
Mental Health Services	347.8	362.2	(14.4)	(4.1%)
Community Health Services	332.1	331.9	0.2	0.1%
Continuing Care Services	200.3	214.1	(13.8)	(6.9%)
Primary Care Services	317.0	324.1	(7.0)	(2.2%)
Other Commissioned Services	7.6	7.2	0.4	5.1%
Other Programme Services	31.7	30.9	0.8	2.5%
Reserves / Contingencies	(0.8)	0.0	(0.8)	100.0%
Delegated Specialised Commissioning	296.1	292.3	3.9	1.3%
Delegated Primary Care Commissioning	431.0	431.0	(0.1)	(0.0%)
Primary Medical Services	284.0	284.2	(0.2)	(0.1%)
Dental Services	95.6	93.5	2.1	2.2%
Ophthalmic Services	13.4	13.5	(0.1)	(0.7%)
Pharmacy Services	37.9	39.8	(1.9)	(4.9%)
ICB Running Costs	21.3	21.3	0.0	0.0%
Total ICB Net Expenditure	**3,694.0**	**3,723.6**	**(29.5)**	**(0.8%)**
Allocation adjustment for reimbursable items	0.0	0.0	0.0	0
TOTAL ICB Surplus/(Deficit)	**31.1**	**1.6**	**(29.5)**	**(0.8%)**

3.5 The year to date pressure is driven by the following issues:

a) Continuing Healthcare – continued pressures linked to cost and volume of eligible CHC clients exceeding planning assumptions. An adverse variance of £13.8m is reported at month 6 which represents an increase of £5.3m compared to the previous month.

b) Mental Health packages of care – overspend of £13.8m reported at month 6 compared to a £10.1m pressure at month 5.

The current forecast adverse variance to plan for Continuing Healthcare is £30.4m and £24.4m for complex packages of care.

c) A pressure of £7.3m is reported on the prescribing budget at month 6 based on July-24 prescribing data. This is a continuation of the trajectory of overspending observed in previous months.

Further analysis on the cost per prescribing day is included in chart 2 within paragraph 3.8.

d) Efficiency – The ICB reports a £10.8m shortfall against the planned efficiency savings plans for month 5. Key areas of slippage are within pathway

transformation (£1.9m), CHC efficiency (£1.6m) and prescribing efficiencies (£7.3m).

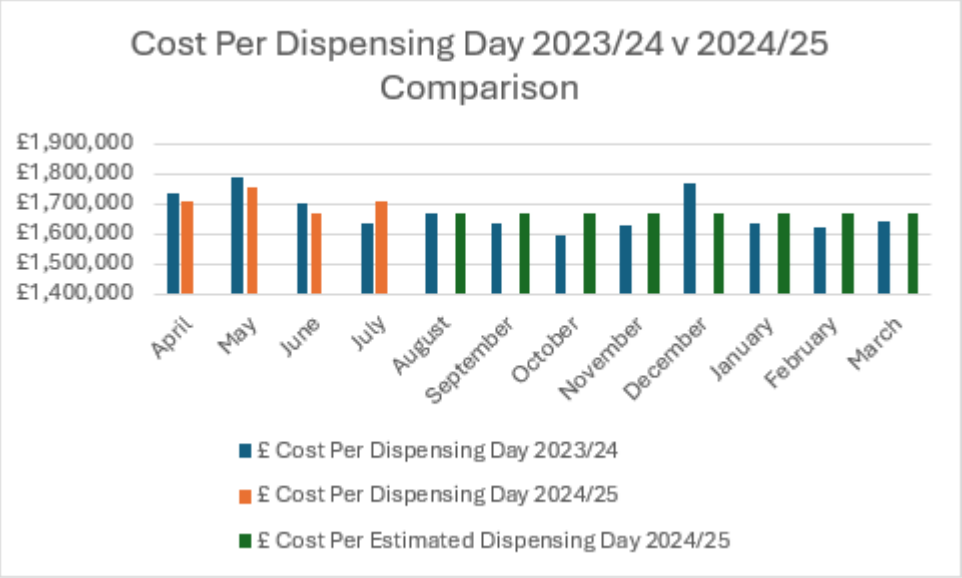
e) Delegated Dental, Ophthalmic and Pharmacy Services – underspends relating to delegated dental services offset by overspend relating to pharmacy services. We have been advised that prices later in the year will be adjusted for pharmacy services in line with the agreed national income cap and as such are not including this within the forecast outturn.

f) £3.9m of the shortfall shown on reserves is offsetting the surplus reported on the delegated specialised commissioning budget – as planned. This has been partly offset by an adjustment to reflect the expected change to pharmacy prices above.

g) Running costs - Costs remain within the running cost allowance following the reduction in allocation this year. The ICB will receive funding to cover the cost of the 2024/25 pay award and associated tariff uplift for providers in month 7.

3.6 For prescribing **Chart 2** shows that the cost per prescribing day has been approximately 2% lower in April, May and June than the previous year, however July was a 4% increase compared to July-23. No Cheaper Stock Obtainable (NCSO) costs from April have been reflected in the current forecast outturn.

Chart 2 – Cost per Prescribing Day



3.7 The current forecast adverse variance to plan for Continuing Care is £28.9m and £26.9m for Complex Care.

3.8 Details of ICB performance split by place, *before any adjustment to balance the forecast outturn as required by NHSE*, is shown below**. Table 5** sets out in summary the Month 6 Place performance:

Table 5 – Place M6 – Financial Performance

	M6 YTD Plan £000's	M6 YTD Actual £000's	M6 YTD Variance £000's
Cheshire - East	(26,016)	(31,351)	(5,335)
Cheshire - West	(21,321)	(23,159)	(1,838)
Halton	(4,689)	(5,929)	(1,239)
Knowsley	5,931	4,313	(1,619)
Liverpool	5,305	(1,389)	(6,694)
Sefton	(5,257)	(11,797)	(6,540)
St Helens	(5,570)	(7,574)	(2,005)
Warrington	(2,306)	(3,583)	(1,278)
Wirral	(10,361)	(16,428)	(6,067)
ICB	95,428	98,493	3,065
Total ICB	**31,145**	**1,595**	(29,550)

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

Table 6 – Provider M6 Financial Performance

Financial performance surplus/(deficit) for the purposes of system achievement	M6 YTD Plan £m	M6 YTD Actual £m	M6 YTD Variance £m	M6 YTD Variance %	M6 YTD Actual (excluding 6/12ths of £150m deficit support) £m	Full Year Annual Plan (exc £150m deficit support) £m	Month 6 YTD as a % of FY plan %
C&M ICB	31.1	1.6	(29.5)	-0.8%	1.6	62.3	3%
Alder Hey Children's NHS Foundation Trust	(2.3)	(2.3)	(0.0)	-0.0%	(2.3)	3.4	-67%
Bridgewater Community Healthcare NHS Foundation Trus	(0.1)	(1.1)	(1.0)	-2.0%	(1.1)	2.1	-51%
Cheshire and Wirral Partnership NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1	1.5	7%
Countess of Chester Hospital NHS Foundation Trust	(7.4)	(12.6)	(5.3)	-3.0%	(19.6)	(23.6)	83%
East Cheshire NHS Trust	(5.4)	(5.7)	(0.3)	-0.3%	(10.0)	(14.4)	69%
Liverpool Heart and Chest Hospital NHS Foundation Trust	6.2	5.7	(0.5)	-0.4%	5.7	14.1	40%
Liverpool University Hospitals NHS Foundation Trust	(46.0)	(52.5)	(6.5)	-1.1%	(76.3)	(80.5)	95%
Liverpool Women's NHS Foundation Trust	(6.9)	(5.8)	1.1	1.3%	(14.2)	(28.5)	50%
Mersey Care NHS Foundation Trust (inc NWB)	2.8	2.8	0.0	0.0%	2.8	7.1	39%
Mid Cheshire Hospitals NHS Foundation Trust	(5.0)	(7.8)	(2.8)	-1.4%	(18.3)	(35.6)	51%
Mersey & West Lancashire Teaching Hospitals NHS Trust	(13.2)	(10.3)	2.9	0.6%	(18.2)	(26.7)	68%
The Clatterbridge Cancer Centre NHS Foundation Trust	0.2	0.2	0.0	0.0%	0.2	0.9	22%
The Walton Centre NHS Foundation Trust	2.6	3.0	0.4	0.4%	3.0	5.3	56%
Warrington and Halton Teaching Hospitals NHS Foundatio	(10.9)	(11.7)	(0.8)	-0.4%	(19.9)	(27.8)	72%
Wirral Community Health and Care NHS Foundation Trust	0.1	0.1	0.0	0.0%	0.1	6.5	2%
Wirral University Teaching Hospital NHS Foundation Trust	(5.8)	(12.4)	(6.6)	-2.6%	(17.2)	(16.3)	105%
Total C&M ICS	**(59.7)**	**(108.5)**	**(48.8)**	**-1.3%**	**(183.5)**	**(150.0)**	**122%**

3.10 There are 8 Trusts reporting a year-to-date adverse variance to plan. An explanation of the key drivers of the YTD variances are set out below:

- **Bridgewater Community NHS Foundation Trust**
  £1.0m adverse variance YTD, risk adjusted FOT £2m adverse to plan.
  Key drivers of the £0.1m YTD variance are operational issues linked with premium paediatric locum spend and other pay pressures £1.0m; £0.7m

adverse YTD CIP variance; which is partially offset by £0.7m non recurrent items relating to prior year.
Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £2.0m adverse to plan. This is being escalated and addressed through the phase 2 intervention process.

- **Countess of Chester NHS Foundation Trust**
  £5.3m adverse variance YTD, forecast to plan
  £0.5m of the YTD variance is attributable to industrial action. Key drivers of the remaining £4.8m YTD variance are largely attributable to the YTD costs in relation to public enquiry. The trust is reporting an adverse CIP YTD variance from £3.8m against the plan, offset by budgetary underspends elsewhere. Schemes requiring a QIA are currently going through the trust's internal process and it is anticipated that further recurrent savings can be transacted October onwards.

- **East Cheshire NHS Trust**
  £0.3m adverse variance YTD, forecast to plan
  The £0.3m adverse to plan is attributable to £0.2m unfunded industrial action cost and loss of income and £0.1m of costs relating to support for medically fit mental health patients as well as additional costs from the independent sector related to increased activity.

- **Liverpool Heart & Chest Hospital NHS Foundation Trust**
  £0.5m adverse variance YTD, forecast to plan
  Key drivers of the £0.5m YTD variance are: £1.3m 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 an significant increase in the scanning of patients across Wirral, Warrington and North Sefton that will attract associated income as planned; and £1.1m from inflation above planning assumptions across licensed drugs and cathlab consumables. These pressures have been partially offset by £1.5m non-recurrent technical items over the first three months and £1.0m overperformance on inter system activity.

- **Liverpool University Hospitals NHS Foundation Trust**
  £6.5m adverse variance YTD, £14.8m risk adjusted FOT adverse to plan
  £1m of the YTD variance is attributable to industrial action net of funding received. Key drivers of the remaining £5.5m YTD variance are: £7.1m undelivered CIP; offset by £1.6m expected ERF overperformance, non-recurrent technical items and balance sheet release.
  Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £14.8m adverse to plan. This is being escalated and addressed through the phase 2 intervention process.

- **Mid Cheshire Hospitals NHS Foundation Trust**
  £2.8m adverse variance YTD, £3.2m risk adjusted FOT adverse to plan
  £0.3m of the YTD variance is attributable to industrial action. Key drivers of the remaining £2.5m YTD variance are: £3.9m under delivery on recurrent CIP plan YTD, £1.2m operational pressures linked to continuation of escalation

capacity, offset by £2.6m of additional income associated with ERF and commercial activities.
Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £3.2m adverse to plan. This is being escalated and addressed through the phase 2 intervention process.

- **Warrington and Halton Teaching Hospitals NHS Foundation Trust**
  £0.8m adverse variance YTD, £7.0m risk adjusted FOT adverse to plan
  The £0.8m adverse variance to date relates entirely due to impact of industrial action over June and July. This is a net adverse variance after the distribution of funding via NHSE.
  Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £7.0m adverse to plan. This is being escalated and addressed through the phase 2 intervention process.

- **Wirral University Teaching Hospitals NHS Foundation Trust**
  £6.6m adverse variance YTD, £6.6m risk adjusted FOT adverse to plan

  £0.5m of the YTD variance is attributable to industrial action. Key drivers of the remaining £6.1m YTD variance are; £5.7m 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; £2.0m 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; £4.7m shortfall on CIP delivery YTD. The above has been mitigated to an extent by £4.0m of underspends and vacancies elsewhere across the Trust, and £2.3m balance sheet release.
  Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £6.6m adverse to plan. This is being escalated and addressed through the phase 2 intervention process.

3.11 **Table 7** sets out the provider year-to-date position compared to the Month 6 YTD plans by income, pay, non-pay and non-operating items. This shows that the aggregate YTD pay position is £39.9m (1.8%) 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 (0.3%); undelivered pay efficiencies YTD of £18.1m (1.0%); and selected operational pay pressures and underspends across several providers as set out in section 3.11 above. 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 5.9% YTD adverse variance on non-pay expenditure which requires further investigation. The remaining driver impacting non pay is a shortfall on YTD efficiency delivery of £9.4m (1.1%).

Table 7 – Provider Income and Expenditure vs YTD Plan

	M6 YTD			
	Plan	Actual	Variance	
	£m	£m	£m	%
Total Income	3,198.1	3,275.0	76.8	2.4%
Pay	(2,166.1)	(2,206.0)	(39.9)	-1.8%
Non Pay	(1,074.2)	(1,137.5)	(63.3)	-5.9%
Non Operating Items (excl gains on disposal)	(48.7)	(41.6)	7.1	14.5%
Total Provider Surplus/(Deficit)	(90.8)	(110.1)	(19.3)	-0.6%

NHS Provider Agency Expenditure

3.12 ICS NHS Providers set a plan for agency spend of £91.8m, 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 £120.6m.

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

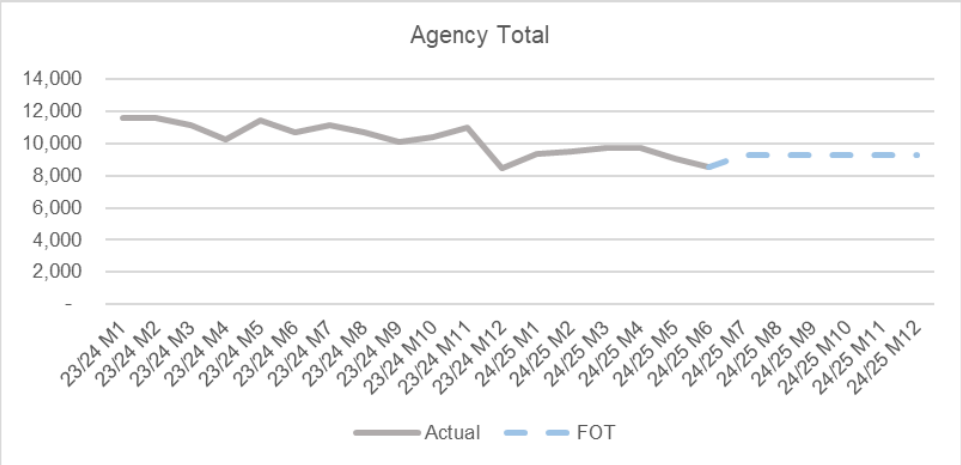
3.14 At Month 6, year to date agency spend is £55.9m (£7.7m above plan), equating to 2.5% of total pay. 11 Trusts are reporting a year-to-date adverse variance to plan. Trust level information on agency spend can be found in **Appendix 1**.

3.15 Table 8 below sets out the aggregate agency performance as a system. This indicates providers are forecasting a £19.7m adverse variance to plan however remain within the national agency cap by £9.1m. Chart 3 below sets out the agency expenditure monthly run rate from 23/24 to YTD Month 6 indicating a downward trajectory on track to deliver the forecast. Further work is ongoing in this area with providers and forms a key part of provider CIP plans and reductions in variable pay.

Table 8 – Provider Agency Expenditure

Agency Position against ICS ceiling	Plan YTD £m	Actual YTD £m	Variance YTD £m	Plan FY £m	FOT FY £m	Variance FY £m
All Providers Agency spend	(48.2)	(55.9)	(7.7)	(91.8)	(111.5)	(19.7)
ICS Agency Ceiling				(120.6)	(120.6)	
Variance to Ceiling				**28.8**	**9.1**	
Agency as a % of pay		**2.5%**			**2.6%**	

Chart 3 – Agency Expenditure Run Rate



Workforce

3.16 Workforce and its triangulation with finance, performance and productivity will continue to be key focus across the system. **Chart 4** sets out the provider WTEs run rate across 23/24 to Month 6 YTD 24/25 and the planned aggregate planned reductions forecast to the end of the year. **Appendix 2** sets out in more detail the movements at provider level.

Chart 4 – Workforce (WTE) Run Rate 23/24 and 24/25

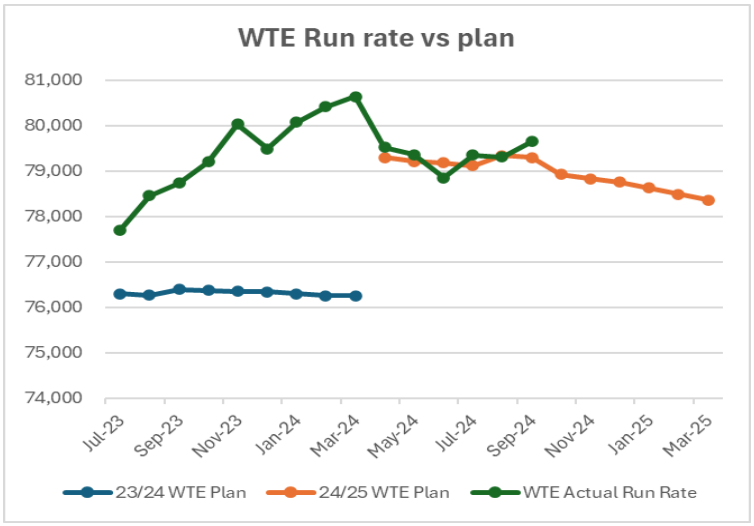


Table 9 – M6 Workforce movements vs M12 23/24 and M6 24/25 Plan

	2023/24	2024/25						M6 Variance		Movement vs M12		2024/25	
Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Actual	M6 Variance from plan trajectory favourable / (adverse)		M12 23/24 to M6 24/25 Actuals decrease / (increase)		M12 Plan (March 25)	Futher change expected M7-12 increase / (decrease)
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%	WTE	% move	WTE	WTE
C&M Providers Total	80,465	79,607	79,361	78,849	79,352	79,303	79,645	(349)	-0.4%	820	1.0%	78,354	(1,292)
by Sector													
Acute	50,353	49,719	49,687	49,296	49,704	49,604	49,616	(113)	-0.2%	738	1.5%	48,688	(927)
Specialist	11,423	11,353	11,386	11,431	11,382	11,436	11,495	(34)	-0.3%	(73)	-0.6%	11,384	(112)
Community / MH	18,689	18,444	18,289	18,123	18,265	18,263	18,534	(202)	-1.1%	155	0.8%	18,282	(252)
TOTAL Providers	80,465	79,516	79,361	78,849	79,352	79,303	79,645	(349)	-0.4%	820	1.0%	78,354	(1,292)

3.17 The Month 6 provider workforce data indicates that whilst WTE have reduced by 820 (1.0%) compared to Month 12 (23/24), there is a 349 adverse position against the YTD plan which predominately lies in the community and mental health sector. Based on recently revised workforce trajectories providers are planning a further 1,292 WTEs reduction by March 2025. This does not fully triangulate with the YTD CIP pay being adverse to plan and the 1.0% reduction in workforce does not fully align with the forecast reductions in pay expenditure to support plan delivery. As part of the investigation and intervention Phase 2 work the workforce trajectories and pay controls are being reported and reviewed on a weekly basis for all providers.

System Efficiencies

3.18 For 2024/25 providers and ICB are planning delivery of £368m and £72m efficiencies respectively. The aggregate system efficiency plan of £440m represents 6.1% of ICB Allocations / Provider Expenditure.

3.19 **Table 10** shows at Month 6 there is currently a shortfall on planned CIP delivery of £25.0m against the ICS YTD plan, with £14.1m attributable against providers and £10.8m against the ICB. The £119.9m efficiencies delivered YTD represent 4.2% of provider and ICS YTD expenditure/allocation against the annual plan of 6.1%, indicating a larger proportion of the savings required in the remaining months.

3.20 Furthermore only 57% of the system efficiencies YTD plan have been delivered recurrently as at Month 6. 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.

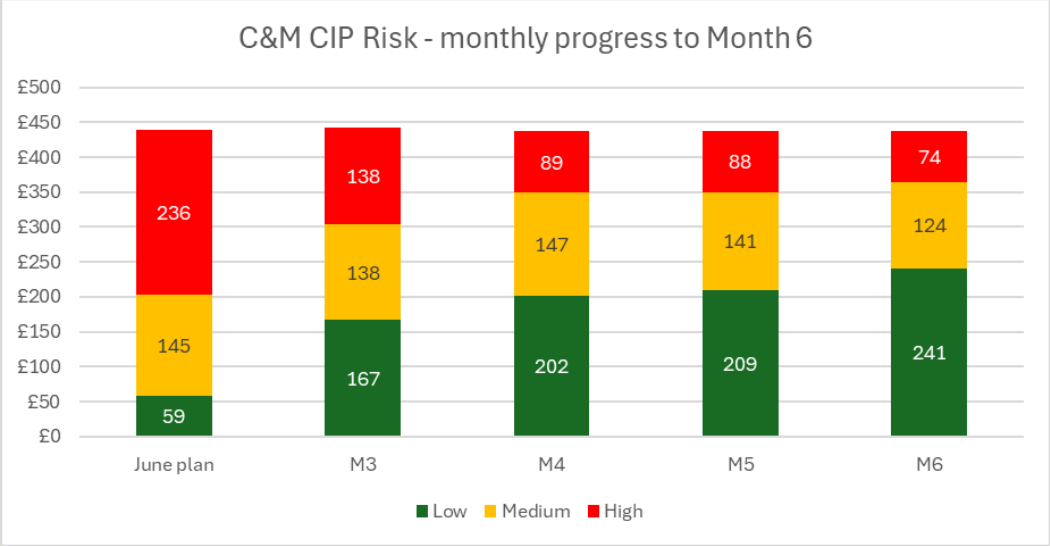
3.21 More detail on System efficiencies, by organisation, is included in **Appendix 3A**.

Table 10 – ICS M6 YTD Efficiency Delivery

	CIP Efficiency - YTD Delivery						CIP Recurrent / Non Recurrent YTD			YTD CIP as a % of FY CIP Plan	
	M6 YTD CIP Performance				Monthly CIP delivery - run rate						
	M6 YTD Plan	M6 YTD Actual	M6 YTD Variance	M6 YTD % Variance	M6 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	7,560	8,008	448	6%	3.7%	4.8%	5,727	2,281	76%	19,950	40%
Bridgewater Community	1,488	1,397	(91)	-35%	2.7%	6.9%	287	1,110	19%	6,939	20%
Cheshire & Wirral Partnership	6,252	4,944	(1,308)	-30%	3.4%	5.0%	1,873	3,071	30%	13,913	36%
Countess of Chester Hospitals	7,335	3,501	(3,834)	-53%	1.8%	5.3%	3,501	0	48%	19,822	18%
East Cheshire Trust	3,429	3,433	4	-1%	3.0%	5.0%	1,761	1,673	51%	11,225	31%
Liverpool Heart & Chest	4,865	3,571	(1,294)	-38%	2.9%	4.6%	2,742	829	56%	10,644	34%
Liverpool University Hospitals	43,858	36,746	(7,112)	-21%	5.3%	8.5%	13,516	23,230	31%	114,600	32%
Liverpool Women's	2,143	3,470	1,328	14%	3.8%	3.3%	1,160	2,310	54%	5,904	59%
Mersey Care	12,983	12,983	0	0%	3.4%	3.5%	12,083	900	93%	25,967	50%
Mid Cheshire Hospitals	10,537	7,014	(3,523)	-43%	3.2%	5.2%	3,668	3,346	35%	22,437	31%
Mersey & West Lancs	17,637	19,037	1,400	9%	4.0%	4.8%	13,137	5,900	74%	45,165	42%
The Clatterbridge Centre	5,000	5,000	(0)	0%	3.3%	3.4%	3,522	1,478	70%	10,000	50%
The Walton Centre	4,221	4,221	0	0%	4.3%	4.5%	3,643	579	86%	8,558	49%
Warrington & Halton Hospitals	5,663	5,830	167	5%	3.0%	5.1%	4,622	1,208	82%	19,433	30%
Wirral Community	2,377	2,056	(321)	-8%	3.9%	5.4%	494	1,562	21%	6,275	33%
Wirral University Hospitals	11,647	11,647	(0)	-29%	4.3%	5.2%	7,555	4,092	65%	26,878	43%
TOTAL Providers	**146,995**	**132,858**	**(14,137)**	**-10%**	**4.0%**	**5.5%**	**79,289**	**53,569**	**54%**	**367,710**	**36%**
C&M ICB	34,384	23,547	(10,837)	-32%	0.6%	1.0%	23,547	0	68%	72,236	33%
TOTAL ICS	**181,379**	**156,405**	**(24,974)**	**-14%**	**4.2%**	**6.1%**	**102,836**	**53,569**	**57%**	**439,946**	**36%**

3.22 **Chart 5** sets out the current risk and development status of efficiency schemes and how this has progressed since the June plan submission. As at Month 6, 17% of the CIP schemes are currently deemed high risk meaning there is still work to be undertaken the de-risk CIP delivery to support financial plan delivery. As part of the investigation and intervention Phase 2 work the CIP pipeline and delivery status of all CIP schemes is being reported and reviewed on a weekly basis for all providers. Further detail of the risk status of CIP at organisational level is included in **Appendix 3B.**

Chart 5 – CIP Risk status at Month 6 (ICS Position)



Productivity

3.23 The 2024/25 planning guidance set out an expectation for all providers, with a focus on the acute sector, to improve towards pre-pandemic levels (recognising potential adjustments for case mix change, structural factors and uncaptured activity). 'Implied Productivity Growth' of acute and specialist trusts is calculated by NHSE by comparing output growth (activity) to input growth (based on expenditure costs) against a baseline period. The measure examines the current year's YTD activity and costs with the same period in 19/20 and more recently, with 23/24. A negative value implies decreased productivity whilst positive implies productivity growth.

3.24 The most recently available comparative productivity data is from M5 24/25, and **Table 12** below sets out the aggregate position across all C&M acute and specialist providers compared to the national average.

Table 12 - Implied Productivity Growth M5

*Productivity Measure	C&M %	North West %	National Average %
Implied Productivity Growth M5 23/24 vs 19/20	-18.8%	-20.2%	-14.3%
Implied Productivity Growth M5 23/24 vs 23/24	0.2%	0.4%	1.6%

*acute providers only

Cash

3.25 The Providers' cash position at Month 6 was £432.1m, with the detail set out in **Appendix 4**. This is £88.5m lower than at the end of 2023/24. The majority of acute providers are forecasting a requirement for external cash support in 2024/25, with £94.7m cash support received to date at Month 6.

3.26 There are six organisations that have formally received external cash support from NHSE up to Month 6 of 2024/25 to support their I&E deficit plans – Mersey

and West Lancs Teaching NHS Trust, Mid Cheshire Hospitals NHST, Warrington & Halton Teaching Hospitals FT, Liverpool Women's NHS FT, Liverpool University Hospitals NHS FT and Countess of Chester Hospital NHS FT. Wirral Teaching and East Cheshire trusts are also forecasting cash support requirements in H2 of 2024/25. **Table 13** below set out the aggregate provider cash balance at Month 6, the level of distress cash requests received by NHSE to date and the Month 6 average Better Payment Practice Code (BPPC) position across providers. The aggregate provider BPPC performance has deteriorated from an average number of 93.2% of bills paid within the 95% target at M12 2023/24 to an average number of 89.4% at Month 6. Further detail of BPPC performance by provider is set put in **Appendix 5.**

Table 14 – Provider Cash and BPPC Performance – Month 6

Org	Cash Balance			External Cash Support*		BPPC % of bills paid in target	
	2023/24 M12 Closing Cash Balance £m	2024/25 M6 Closing Cash Balance £m	Movement £m	Received as at M6 £m	FOT £m	2024/25 M6 By number %	2024/25 M6 By Value %
TOTAL Providers	**520.6**	**432.1**	**(88.5)**	**94.7**	**134.5**	89.4%	93.2%

* External Cash support via NHS England's Revenue Support PDC process

System Risks and Mitigations

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

a. **Pay Award** – the final pay settlements for medical and agenda for change staff have been agreed and provider plans where set on the basis this would be fully funded. Providers are currently reporting a pay award gap of c£16m. This is a complex area and further clarity will be obtained when the payroll is properly calculated for month-end payments.

b. **Identification and delivery of recurrent CIPs** – this is subject to weekly reporting as part of the PwC phase 2 governance process.

c. **Non-achievement of ERF / activity requirements** – Month 4 data has been made available from NHS England, indicating that C&M ICB is on plan at 112.8%. However, the overperformance lies more within the Independent Sector than C&M NHS Providers, highlighting the risk of not achieving the productivity gains required in the 24/25 financial plans.

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

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

f. **Maintenance of core acute bed base year-round** – targeted improvement plan in development across the System in response to recommendations identified by National team.

g. **Industrial action disruption** – the plan assumes no further industrial action throughout 24/25.

The risks identified will be address through the actions outlined in the Intervention section of the PwC report.

ICB Recovery Update

3.28 For the ICB the recovery programme targets consist of 3 areas:

- Efficiency plans agreed as part of the plan.
- Stretch targets for Mental Health Pressures in A&E/Out of Area Placements, S117 Packages and Workforce agreed as part of the plan.
- Additional stretch targets identified for each programme.

3.29 The forecast savings against the combined recovery programme targets is £83.5m of which £68.9m relates to the efficiency plans agreed as part of the plan and £14.6m are additional savings identified by the programmes to contribute towards to recovery plan. **Table 14** sets out the latest position by programme.

Table 14 – ICB Recovery Programme Performance – Month 6

Programme Name	YTD			Forecast		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
All Age Continuing Health Care/Complex Care	10,504	8,453	(2,051)	53,300	31,814	(21,486)
Cheshire Urgent Care Improvement	2,482	466	(2,016)	4,965	4,965	0
Medicines Management	12,457	5,381	(7,076)	30,700	25,106	(5,594)
Mental Health - A&E/Out of Area Placements	0	0	0	10,953	0	(10,953)
Optimising Patient Choice Independent Sector Value	0	0	0	0	0	0
Unwarranted Variation	80	80	0	473	493	20
Workforce Optimisiation	4,962	4,962	0	10,924	10,924	0
Other	3,988	4,673	685	8,750	10,148	1,398
TOTAL	**34,473**	**24,015**	**(10,458)**	**120,065**	**83,450**	**(36,615)**

ICB Risk Adjusted Forecast

3.30 Following the review with the NHSE Nominated lead the ICB highlighted a likely scenario of £25m adverse to plan that needed significant further mitigations actions in order to achieve the annual plan. **Table 15** below provides a summary of the ICB financial forecast for 2024/25 as at month 6 and represents the latest most likely scenario.

Table 16 - ICB Forecast Risks and Mitigations

	£m
ICB Planned Position +/-	62.3
Risks	**£m**
CHC	-29.3
MH Packages	-26.9
Prescribing	-25.8
Efficiency Delivery	-4.5
MH Recovery Programme	-10.9
Complex Care Recovery Programme	-3.3
High Cost Drugs	-6.1
Other Risks	-4.0
Total	**-110.8**
Mitigations	**£m**
Place Mitigations	42.4
Complex Care Recovery Programme	10.0
Medicines Management Recovery Programme	4.1
Unwarranted Variation Recovery Programme	0.5
ERF	4.0
HI Slippage	0.8
Primary Care SDF	2.3
Mental Health SDF	4.7
Balance Sheet Review	15.0
Other Mitigations	2.0
Total	**85.7**
RISK ADJUSTED FORECAST	**37.3**
RISK ADJUSTED VARIANCE TO PLAN	**-25.0**

£14.6m additional savings above £68.9m efficiencies. **Total forecast savings £83.5m**

3.31 The CEO and CFO continue to hold meetings with each Place Director to review forecast against plans and the mitigations being pursued by each place team. There remains considerable risk in prescribing and CHC/Complex Packages positions given the levels of efficiency which are expected in the last

half of the year and the increasing pressures seen in these areas. At this stage in the year, prescribing forecasts are also based on only 4 months of data and prices remain volatile.

Provider and Primary Care Capital

3.32 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 set out an overprogramming position against allocation of c£12m with plans to spend £270.5m with an expectation that the overprogramming position would be managed in year.

3.33 **Tables 16 & 17** sets out the YTD Month 6 position capital expenditure against plan at a system level but also the ICB's primary care capital position. At Month 6 there is a £26.9m underspend against YTD plan, with a £14.7m forecast variance against full year plan largely 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.

3.34 The previous £12m overprogramming position at plan stage has at Month 6 been managed to £nil due to a review of capital lease expenditure and slippage of three contractually committed schemes into 25/26 across Mersey Care, Cheshire and Wirral Partnership and Alder Hey Children's. The £2.0m adverse variance to allocation reported at Month 6 relates to a new scheme at Wirral Teaching University to address RAAC within an existing building, of which the ICS is expecting an allocation uplift from NHSE at Month 7. Following this allocation uplift the system will be forecasting a compliant capital position for 2024/25.

Table 16 - System (Provider & ICB) - Charge against Capital Allocation M6

Provider - Charge against allocation	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT Year Ending £'000	Variance Year Ending £'000	%
Total Provider charge against allocation	**123,911**	**97,042**	**26,868**	**310,328**	**325,055**	**(14,726)**	**-4.7%**
Capital allocation (notified)					**323,101**		
Variance to allocation					(1,954)		
Allocation met					No		

Table 17 – ICB - Charge against allocation M6

ICB - Charge against allocation	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT 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		

3.35 **Appendix 6** sets out the detailed capital position M6 YTD and FOT by provider.

4. Ask of the Committee and Recommendations

4.1 The Committee is asked to note and comment the financial position and metrics reported at Month 6 and the risks to delivery of the financial plan which are described in the paper.

5. Officer contact details for more information

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6. Appendices

Appendix 1:	**Agency Expenditure M6 YTD by provider**
Appendix 2:	**Workforce Analysis M6 vs M12 trend and M6 Plan by Provider**
Appendix 3A:	**System Efficiencies: Current Performance M6**
Appendix 3B:	**System Efficiencies: Risk and Development of CIP Plan M6**
Appendix 4:	**Provider Cash at Month 6**
Appendix 5:	**Provider BPPC at Month 6**
Appendix 6:	**ICS Capital Expenditure YTD and FOT vs ICS Allocation at Month 6**

Appendix 1 – Agency Expenditure M6 YTD by provider

Agency Costs YTD and FOT	YTD Plan	YTD Actual	YTD Variance	Forecast Outturn Plan	Forecast Outturn Forecast	Forecast Outturn Variance	YTD agency as a % of YTD pay costs	FOT agency as a % of FOT pay costs
	£m	£m	£m	£m	£m	£m	%	%
Alder Hey Children's	(0.3)	(0.8)	(0.5)	(0.6)	(1.3)	(0.7)	0.6%	0.5%
Bridgewater Community	(1.0)	(1.2)	(0.2)	(1.5)	(1.7)	(0.2)	3.4%	2.6%
Cheshire & Wirral Partnership	(4.7)	(4.7)	0.0	(8.2)	(10.3)	(2.2)	4.3%	4.8%
Countess of Chester Hospitals	(2.5)	(2.5)	(0.0)	(4.9)	(5.3)	(0.4)	1.9%	2.1%
East Cheshire Trust	(3.6)	(3.2)	0.4	(7.3)	(7.1)	0.2	4.3%	5.1%
Liverpool Heart & Chest	(0.5)	(0.3)	0.1	(0.9)	(0.8)	0.1	0.5%	0.7%
Liverpool University Hospitals	(6.3)	(6.3)	(0.1)	(10.0)	(13.7)	(3.7)	1.5%	1.6%
Liverpool Women's	(0.7)	(0.3)	0.3	(1.4)	(0.5)	0.8	0.7%	0.5%
Mersey Care	(9.0)	(8.4)	0.6	(18.0)	(15.5)	2.6	3.0%	2.7%
Mid Cheshire Hospitals	(4.2)	(6.3)	(2.0)	(8.5)	(11.8)	(3.3)	4.3%	4.0%
Mersey & West Lancs	(9.0)	(12.7)	(3.8)	(17.9)	(21.9)	(4.0)	4.2%	3.6%
The Clatterbridge Centre	(0.4)	(0.7)	(0.3)	(0.7)	(1.0)	(0.3)	1.2%	0.9%
The Walton Centre	0.0	(0.4)	(0.4)	0.0	(0.8)	(0.8)	0.9%	0.9%
Warrington & Halton Hospitals	(3.7)	(1.8)	1.9	(7.3)	(7.3)	0.0	1.4%	2.9%
Wirral Community	(0.2)	(0.4)	(0.2)	(0.4)	(1.0)	(0.7)	1.0%	1.4%
Wirral University Hospitals	(2.1)	(5.8)	(3.6)	(4.2)	(11.5)	(7.3)	3.2%	3.4%
TOTAL	**(48.2)**	**(55.9)**	**(7.7)**	**(91.8)**	**(111.5)**	**(19.7)**	**2.5%**	**2.6%**

Appendix 2 – Workforce Analysis M6 vs M12 trend and M6 Trajectory Plan by Provider

	2023/24	2024/25							M6	M6 Variance		Movement vs M12		2024/25	
Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Actual	M1 to M6 Trend	in month movement vs M5 increase / (decrease)	M6 Variance from plan trajectory favourable / (adverse)		M12 23/24 to M6 24/25 Actuals decrease / (increase)		M12 Plan (March 25)	Futher change expected M7-12 increase / (decrease)
	WTE	WTE	WTE	WTE	WTE	WTE	WTE			WTE	%	WTE	% move	WTE	WTE
Alder Hey Children's	4,368	4,333	4,347	4,326	4,334	4,292	4,310		18	35	0.8%	58	1.3%	4,273	(37)
Bridgewater Community	1,434	1,453	1,462	1,447	1,454	1,445	1,459		14	12	0.8%	(25)	-1.7%	1,479	20
Cheshire & Wirral Partnersh	4,072	4,061	4,024	4,017	4,000	3,967	4,032		65	0	0.0%	40	1.0%	4,028	(4)
Countess of Chester Hospit	4,886	4,849	4,783	4,809	4,829	4,829	4,848		20	47	1.0%	37	0.8%	4,764	(84)
East Cheshire Trust	2,675	2,691	2,633	2,633	2,656	2,697	2,660		(36)	(7)	-0.3%	15	0.6%	2,625	(36)
Liverpool Heart & Chest	1,912	1,874	1,880	1,898	1,886	1,889	1,887		(2)	13	0.7%	25	1.3%	1,880	(7)
Liverpool University Hospita	15,448	15,261	15,163	15,041	15,228	15,170	15,128		(42)	(229)	-1.5%	320	2.1%	14,601	(527)
Liverpool Women's	1,687	1,703	1,718	1,717	1,715	1,748	1,760		12	(4)	-0.2%	(73)	-4.3%	1,764	4
Mersey Care	11,623	11,344	11,224	11,091	11,244	11,286	11,475		189	(212)	-1.9%	148	1.3%	11,263	(212)
Mid Cheshire Hospitals	5,687	5,445	5,425	5,398	5,429	5,428	5,380		(47)	(8)	-0.1%	307	5.4%	5,350	(31)
Mersey & West Lancs	10,614	10,458	10,538	10,478	10,556	10,551	10,547		(4)	101	1.0%	68	0.6%	10,564	17
The Clatterbridge Centre	1,893	1,890	1,919	1,920	1,896	1,906	1,930		24	(43)	-2.3%	(37)	-1.9%	1,907	(23)
The Walton Centre	1,562	1,554	1,522	1,570	1,552	1,600	1,608		7	(35)	-2.2%	(45)	-2.9%	1,559	(49)
Warrington & Halton Hospit	4,786	4,626	4,646	4,637	4,657	4,615	4,707		93	0	0.0%	78	1.6%	4,559	(149)
Wirral Community	1,560	1,587	1,579	1,567	1,566	1,564	1,568		3	(2)	-0.1%	(8)	-0.5%	1,512	(56)
Wirral University Hospitals	6,258	6,389	6,499	6,300	6,350	6,315	6,344		29	(18)	-0.3%	(87)	-1.4%	6,227	(118)
C&M Providers Total	**80,465**	**79,607**	**79,361**	**78,849**	**79,352**	**79,303**	**79,645**		**342**	**(349)**	**-0.4%**	**820**	**1.0%**	**78,354**	**(1,292)**
by Sector															
Acute	50,353	49,719	49,687	49,296	49,704	49,604	49,616		12	(113)	-0.2%	738	1.5%	48,688	(927)
Specialist	11,423	11,353	11,386	11,431	11,382	11,436	11,495		60	(34)	-0.3%	(73)	-0.6%	11,384	(112)
Community / MH	18,689	18,444	18,289	18,123	18,265	18,263	18,534		271	(202)	-1.1%	155	0.8%	18,282	(252)
TOTAL Providers	**80,465**	**79,516**	**79,361**	**78,849**	**79,352**	**79,303**	**79,645**		**342**	**(349)**	-0.4%	**820**	**1.0%**	**78,354**	**(1,292)**

Appendix 3A - System Efficiencies: Current Performance M6

	CIP Efficiency - YTD Delivery										CIP Recurrent / Non Recurrent YTD			YTD CIP as a % of FY CIP Plan	
	M6 YTD CIP Performance				Monthly CIP delivery - run rate as a % of Op Ex										
	M6 YTD Plan	M6 YTD Actual	M6 YTD Variance	M6 YTD % Variance	M2 CIP actual as a % of Op Ex	M3 CIP actual as a % of Op Ex	M4 CIP actual as a % of Op Ex	M5 CIP actual as a % of Op Ex	M6 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	7,560	8,008	448	6%	2.3%	2.4%	2.8%	3.2%	3.7%	4.8%	5,727	2,281	76%	19,950	40%
Bridgewater Community	1,488	1,397	(91)	-35%	1.2%	1.6%	1.7%	1.9%	2.7%	6.9%	287	1,110	19%	6,939	20%
Cheshire & Wirral Partnership	6,252	4,944	(1,308)	-30%	2.7%	2.9%	3.1%	2.8%	3.4%	5.0%	1,873	3,071	30%	13,913	36%
Countess of Chester Hospitals	7,335	3,501	(3,834)	-53%	0.1%	0.7%	1.4%	1.6%	1.8%	5.3%	3,501	0	48%	19,822	18%
East Cheshire Trust	3,429	3,433	4	-1%	2.0%	2.0%	2.5%	2.8%	3.0%	5.0%	1,761	1,673	51%	11,225	31%
Liverpool Heart & Chest	4,865	3,571	(1,294)	-38%	1.9%	2.3%	2.5%	2.6%	2.9%	4.6%	2,742	829	56%	10,644	34%
Liverpool University Hospitals	43,858	36,746	(7,112)	-21%	4.3%	4.4%	4.6%	5.0%	5.3%	8.5%	13,516	23,230	31%	114,600	32%
Liverpool Women's	2,143	3,470	1,328	14%	1.2%	1.6%	2.5%	3.8%	3.8%	3.3%	1,160	2,310	54%	5,904	59%
Mersey Care	12,983	12,983	0	0%	3.5%	3.4%	3.4%	3.4%	3.4%	3.5%	12,083	900	93%	25,967	50%
Mid Cheshire Hospitals	10,537	7,014	(3,523)	-43%	2.3%	2.5%	2.7%	3.0%	3.2%	5.2%	3,668	3,346	35%	22,437	31%
Mersey & West Lancs	17,637	19,037	1,400	9%	2.9%	3.2%	3.6%	3.8%	4.0%	4.8%	13,137	5,900	74%	45,165	42%
The Clatterbridge Centre	5,000	5,000	(0)	0%	3.3%	3.4%	3.3%	3.3%	3.3%	3.4%	3,522	1,478	70%	10,000	50%
The Walton Centre	4,221	4,221	0	0%	4.1%	4.3%	4.3%	4.3%	4.3%	4.5%	3,643	579	86%	8,558	49%
Warrington & Halton Hospitals	5,663	5,830	167	5%	1.7%	2.0%	2.5%	2.8%	3.0%	5.1%	4,622	1,208	82%	19,433	30%
Wirral Community	2,377	2,056	(321)	-8%	2.4%	4.0%	4.1%	3.8%	3.9%	5.4%	494	1,562	21%	6,275	33%
Wirral University Hospitals	11,647	11,647	(0)	-29%	3.1%	3.1%	2.7%	2.4%	4.3%	5.2%	7,555	4,092	65%	26,878	43%
TOTAL Providers	**146,995**	**132,858**	**(14,137)**	**-10%**	**3.0%**	**3.3%**	**3.4%**	**3.6%**	**4.0%**	**5.5%**	**79,289**	**53,569**	**54%**	**367,710**	**36%**
C&M ICB	34,384	23,547	(10,837)	-32%	0.6%	0.6%	0.6%	0.6%	0.6%	1.0%	23,547	0	68%	72,236	33%
TOTAL ICS	**181,379**	**156,405**	**(24,974)**	**-14%**	**3.7%**	**3.8%**	**3.9%**	**4.1%**	**4.2%**	**6.1%**	**102,836**	**53,569**	**57%**	**439,946**	**36%**

Appendix 3B - System Efficiencies: M5 Risk and Development of CIP Plan

	Month 6 (end of Sept 25) assessment										
	CIP RISK				CIP DEVELOPMENT					% of CIP High Risk	% of CIP Opportunity / Unidentified
	Low	Medium	High	Total	Fully	In Progress	Opportunity	Unidentified	Total		
	£m	£m	£m	£m	£m	£m	£m	£m	£m	%	%
Alder Hey Children's NHS Foundation Trust	12.9	5.0	2.0	**20.0**	12.7	7.3	0.0	0.0	**20.0**	10%	0%
Bridgewater Community Healthcare NHS Fou	2.5	1.3	3.2	**6.94**	3.8	0.0	0.0	3.2	**6.94**	46%	46%
Cheshire and Wirral Partnership NHS Founda	8.6	2.5	2.9	**13.9**	8.6	2.5	0.5	2.3	**13.9**	21%	21%
Countess of Chester Hospital NHS Foundatio	7.6	3.1	9.1	**19.8**	7.9	2.6	8.5	0.8	**19.8**	46%	47%
East Cheshire NHS Trust	5.1	2.3	3.8	**11.2**	1.2	6.3	3.7	0.0	**11.2**	34%	33%
Liverpool Heart and Chest Hospital NHS Four	5.3	3.2	2.1	**10.6**	2.7	5.4	2.5	0.0	**10.6**	20%	24%
Liverpool University Hospitals NHS Foundatio	65.7	32.5	16.4	**114.6**	106.1	0.9	7.6	0.0	**114.6**	14%	7%
Liverpool Women's NHS Foundation Trust	2.6	3.3	0.0	**5.9**	5.5	0.4	0.0	0.0	**5.9**	0%	0%
Mersey Care NHS Foundation Trust	11.6	14.3	0.0	**26.0**	9.8	16.2	0.0	0.0	**26.0**	0%	0%
Mid Cheshire Hospitals NHS Foundation Trus	15.0	2.6	4.8	**22.4**	16.9	1.5	4.1	0.0	**22.4**	22%	18%
Mersey & West Lancashire Teaching Hospital	37.1	10.9	0.0	**48.0**	42.4	5.5	0.0	0.0	**48.0**	0%	0%
The Clatterbridge Cancer Centre NHS Founda	8.2	1.6	0.2	**10.0**	8.2	1.6	0.2	0.0	**10.0**	2%	2%
The Walton Centre NHS Foundation Trust	5.3	3.1	0.1	**8.6**	2.5	6.1	0.0	0.0	**8.6**	1%	0%
Warrington and Halton Teaching Hospitals NH	12.8	6.3	0.3	**19.4**	13.1	5.5	0.8	0.0	**19.4**	2%	4%
Wirral Community Health and Care NHS Four	4.1	1.1	1.1	**6.3**	4.1	0.0	1.1	1.1	**6.3**	18%	35%
Wirral University Teaching Hospital NHS Four	24.6	1.4	0.9	**26.9**	18.7	8.2	0.0	0.0	**26.9**	3%	0%
C&M ICB	12.0	28.9	26.9	**67.8**	38.9	12.7	16.2	0.0	**67.8**	40%	24%
Total	**241.0**	**123.5**	**73.8**	**438.3**	**302.9**	**82.6**	**45.3**	**7.4**	**438.3**	**17%**	**12%**

Appendix 4: Provider Cash at Month 6

Org	Cash Balance			Operating Days Cash - Trend						External Cash Support*		BPPC % of bills paid in target	
	2023/24 M12 Closing Cash Balance	2024/25 M6 Closing Cash Balance	Movement	2023/24 M12	2024/25 M3	2024/25 M4	2024/25 M5	2024/25 M6	Trend	Received as at M6	FOT	2024/25 M6 By number	2024/25 M6 By Value
	£m	£m	£m	Days	Days	Days	Days	Days		£m	£m	%	%
Alder Hey Children's NHS Foundation Trust	78.3	55.1	(23.2)	63	52	47	52	50		0.0	0.0	93.0%	91.4%
Bridgewater Community Healthcare NHS Four	17.3	10.3	(7.0)	51	53	52	50	38		0.0	0.0	97.8%	98.3%
Cheshire and Wirral Partnership NHS Foundat	28.1	29.6	1.4	27	32	33	31	39		0.0	0.0	96.0%	94.2%
Countess of Chester Hospital NHS Foundatior	12.3	6.8	(5.5)	8	4	2	10	7		13.6	13.8	95.3%	95.6%
East Cheshire NHS Trust	17.9	8.4	(9.5)	21	18	18	13	14		0.0	0.0	91.7%	92.8%
Liverpool Heart and Chest Hospital NHS Foun	43.2	46.9	3.6	59	63	65	68	71		0.0	0.0	97.2%	97.6%
Liverpool University Hospitals NHS Foundatior	40.6	14.5	(26.1)	9	10	5	1	4		25.0	25.0	75.6%	91.7%
Liverpool Women's NHS Foundation Trust	2.0	2.7	0.7	3	7	4	2	6		7.0	7.0	92.8%	94.7%
Mersey Care NHS Foundation Trust (inc NWB	72.9	76.6	3.7	29	27	26	36	38		0.0	0.0	95.2%	96.1%
Mid Cheshire Hospitals NHS Foundation Trust	16.4	29.0	12.6	11	13	13	18	25		19.7	19.7	94.1%	94.1%
Mersey & West Lancashire Teaching Hospital	24.7	3.7	(21.0)	8	1	2	2	2		17.0	26.7	82.4%	92.1%
The Clatterbridge Cancer Centre NHS Founda	74.3	72.0	(2.3)	130	93	81	90	91		0.0	0.0	97.9%	99.3%
The Walton Centre NHS Foundation Trust	51.6	53.4	1.8	69	119	108	113	105		0.0	0.0	93.5%	94.2%
Warrington and Halton Teaching Hospitals NH	17.6	6.6	(11.1)	12	6	10	5	6		12.4	24.8	88.0%	90.7%
Wirral Community Health and Care NHS Foun	12.7	15.1	2.4	33	45	41	49	55		0.0	0.0	92.5%	94.0%
Wirral University Teaching Hospital NHS Foun	10.6	1.4	(9.2)	6	3	3	3	1		0.0	17.5	47.1%	74.5%
TOTAL Providers	**520.6**	**432.1**	**(88.5)**							**94.7**	**134.5**	89.4%	93.2%

* External Cash support via NHS England's Revenue Support PDC process

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Appendix 5: Provider BPPC at Month 6

Better Payment Pratice Code (BPPC)	BPPC % of bills paid within 95% target											
	By Number						By Value					
	2023/24 M12	2024/25 M3	2024/25 M4	2024/25 M5	2024/25 M6	Trend	2023/24 M12	2024/25 M3	2024/25 M4	2024/25 M5	2024/25 M6	Trend
	%	%	%	%	%		%	%	%	%	%	
Alder Hey Children's NHS Foundation Trust	94.0%	92.6%	93.0%	93.4%	93.0%		92.9%	91.4%	91.0%	91.3%	91.4%	
Bridgewater Community Healthcare NHS Foundation Trust	96.2%	96.6%	97.2%	97.5%	97.8%		96.8%	97.3%	97.7%	98.0%	98.3%	
Cheshire and Wirral Partnership NHS Foundation Trust	97.7%	94.6%	95.4%	95.7%	96.0%		97.1%	93.2%	93.5%	94.1%	94.2%	
Countess of Chester Hospital NHS Foundation Trust	86.3%	95.7%	95.8%	95.6%	95.3%		89.1%	95.7%	95.9%	95.5%	95.6%	
East Cheshire NHS Trust	94.9%	94.0%	94.6%	92.1%	91.7%		95.4%	93.3%	93.9%	92.8%	92.8%	
Liverpool Heart and Chest Hospital NHS Foundation Trust	96.4%	97.0%	96.9%	97.1%	97.2%		97.0%	97.1%	97.2%	97.4%	97.6%	
Liverpool University Hospitals NHS Foundation Trust	82.1%	76.6%	76.1%	76.9%	75.6%		92.8%	91.3%	91.4%	91.8%	91.7%	
Liverpool Women's NHS Foundation Trust	91.1%	92.2%	92.5%	92.9%	92.8%		93.6%	95.1%	95.1%	93.9%	94.7%	
Mersey Care NHS Foundation Trust (inc NWB)	95.2%	95.2%	95.3%	95.3%	95.2%		93.0%	96.3%	96.1%	96.2%	96.1%	
Mid Cheshire Hospitals NHS Foundation Trust	88.6%	93.2%	93.4%	93.9%	94.1%		92.8%	93.2%	93.7%	94.1%	94.1%	
Mersey & West Lancashire Teaching Hospitals NHS Trust	90.2%	83.8%	82.6%	82.5%	82.4%		92.6%	92.4%	93.2%	92.6%	92.1%	
The Clatterbridge Cancer Centre NHS Foundation Trust	97.6%	97.8%	98.0%	97.8%	97.9%		99.3%	98.9%	99.1%	99.1%	99.3%	
The Walton Centre NHS Foundation Trust	90.4%	93.5%	93.9%	93.8%	93.5%		92.5%	94.9%	94.8%	94.2%	94.2%	
Warrington and Halton Teaching Hospitals NHS Foundation Tr	91.5%	91.8%	87.4%	86.8%	88.0%		91.4%	91.2%	89.2%	90.3%	90.7%	
Wirral Community Health and Care NHS Foundation Trust	91.6%	92.4%	92.1%	92.1%	92.5%		93.4%	93.4%	94.1%	94.2%	94.0%	
Wirral University Teaching Hospital NHS Foundation Trust	92.3%	74.2%	60.3%	52.3%	47.1%		95.1%	87.0%	81.9%	76.7%	74.5%	
Average C&M Providers	**92.3%**	**91.3%**	**90.3%**	**89.7%**	**89.4%**		**94.0%**	**93.9%**	**93.6%**	**93.3%**	**93.2%**	

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

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT Year Ending £'000	Variance Year Ending £'000	%
Alder Hey Children'S NHS Foundation Trust	2,223	2,232	(9)	16,923	15,423	1,500	8.9%
Bridgewater Community Healthcare NHS Four	2,865	1,386	1,479	4,467	3,988	479	10.7%
Cheshire And Wirral Partnership NHS Founda	4,468	2,237	2,231	7,866	6,366	1,500	19.1%
Countess Of Chester Hospital NHS Foundatio	42,925	29,255	13,670	77,750	77,750	-	0.0%
East Cheshire NHS Trust	3,178	1,669	1,509	6,222	6,222	-	0.0%
Liverpool Heart And Chest Hospital NHS Four	2,613	2,173	440	7,811	7,811	-	0.0%
Liverpool University Hospitals NHS Foundatio	14,011	13,627	384	59,398	52,618	6,780	11.4%
Liverpool Women'S NHS Foundation Trust	3,430	1,537	1,893	5,035	5,035	-	0.0%
Mersey Care NHS Foundation Trust	7,388	3,497	3,891	36,254	34,605	1,649	4.5%
Mid Cheshire Hospitals NHS Foundation Trus	8,584	16,399	(7,816)	13,553	38,234	(24,681)	-182.1%
Mersey and West Lancashire Teaching Hospit	13,970	7,028	6,942	28,256	28,256	-	0.0%
The Clatterbridge Cancer Centre NHS Founda	3,568	3,583	(15)	11,110	11,110	(0)	0.0%
The Walton Centre NHS Foundation Trust	2,354	2,041	313	6,890	6,890	-	0.0%
Warrington And Halton Teaching Hospitals NH	4,995	3,663	1,332	9,470	9,470	-	0.0%
Wirral Community Health And Care NHS Four	2,348	1,925	423	6,453	6,453	(0)	0.0%
Wirral University Teaching Hospital NHS Four	4,991	4,789	202	12,870	14,823	(1,953)	-15.2%
Total Provider CDEL	**123,911**	**97,042**	**26,868**	**310,328**	**325,055**	**(14,726)**	-4.7%

Capital allocation					323,101		
Variance to allocation					(1,954)		
Allocation met					No		

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Highlight report of the Chair of the Finance, Investment and Resources Committee

Agenda Item No: ICB/11/24/07

Committee Chair: Erica Morris, Non-Executive Member

Highlight report of the Chair of the Finance, Investment and Resources Committee

Committee Chair	Erica Morris
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	19 November 2024

Key escalation and discussion points from the Committee meeting

Alert

M5/6 ICS Financial Position for Revenue/Efficiency/Capital & Cash

- During month 6, NHS England have issued an allocation of £150m 'revenue deficit support' to the ICB to cover the system agreed financial plan deficit to allow; this moves the financial system plan to be modified to a balanced breakeven position. The £150m has been distributed to providers as agreed. The revenue deficit support is deemed repayable to NHSE, phased from 2026/27.
- The system is reporting an adverse variance to plan for month 6 of £48.8m, which includes £29.5m relating to the ICB relating to care packages and prescribing.
- There is considerable risk in the delivery of both Provider and ICB financial positions and corrective action is required to secure efficiency savings to support delivery of the overall system financial plan.

Recovery Programme Update

- There is a £10.456m adverse variance against our recovery plan at M6, and an anticipated forecast gap of £36m, which will deliver a forecast efficiency saving across the Recovery programmes for this financial year of 83.5m.
- Particular focus given to Care Packages and Medicine Management. Exception reports were discussed with detail on actions being taken where schemes are off track.
- Comprehensive deep dive of the Primary Care prescribing recovery programme was presented to committee by Head of Medicines Optimisation, setting out current financial position, 24/25 priorities and 25/26 Opportunities.

- **Investigation & Intervention Phase 2 Update –** Proposed **c**ontract reviewed and recommended for board approval. Support includes weekly Financial Incident Control Centre, intensive support to All Aged Continuing Care (AACC) and four highest risk providers. FIRC will take forward periodic Value for Money appraisals against agreed scope.

- **Cash and Negative Impact on Better Payment Practice Code (BPPC)**
  - Provider cash position at Month 6 is £432.1m. This is £88.5m lower than at the end of 2023/24. The majority of acute providers are forecasting a requirement for external cash support in 2024/25, with £94.7m cash support received to date at Month 6. Action taken away to consider ow this system risk is reflected in risk register and will revert back to FIRC next time.

- Consequently, the aggregate provider BPPC performance has deteriorated from an average number of 93.2% of bills paid within the 95% target at Month 12 2023/24 to an average number of 89.4% at Month 6.

Advise

Workplan - discussed and agreed workplan until October 2025.

General procurement update and PSR decisions

• APPROVED and re-confirmed agreement of the PSR procurement route recommendations for a range of contract awards for 2025/26
• APPROVED the use of PSR Direct Award route C for the continuation of both historic NEPTS contracts.
• NOTED the update to the 2024/25 Procurement decision plans for both Health and Non-Health goods and services
• NOTED the procurement decision to endorse a recommendation for a contract modification at the Procurement Decision Review Group in September, in line with the SORD.
• ENDORSED that the ICB should implement the Government Commercial Function guidance in full, as it relates to ICB non-health activity, and utilise the template documentation on the NHS Futures website.

Approved recommendation for award for IPS Services.

• ACKNOWLEDGED that due processes were followed for the award of Individual Placement Support Service Lot 1 and Lot 2 Contracts
• ENDORSED to award contracts to Supplier 3 for Lot 1 and Supplier 5 for Lot 2.

Financial Strategy and approach to planning update

Focused discussion on financial strategy and agreement that addressing our underlying financial deficit will need to be addressed through:
- Efficiency and productivity improvements
- Transformational change across healthcare services
- Integration across health and care at locality level
- Population health management which addresses the causes of ill health

ICB Executives currently analysing output from recent Board Development sessions. Discussed need to develop financial strategy in line with C&M Population Health Priorities, Strategic Commissioning plan & focused shifts to Community/Primary Care, Digital & Prevention. Recommendations to be advised to Transformational Committee.
FIRC will continue to seek assurances regarding the delivery of a longer term financial strategy through the emerging transformational changes and will remain an agenda item for the bimonthly System focused 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**
F9 and F8– Place ADOFs have agreed to consolidate the two shared Place finance risks into a single risk, which is reflected in risk F8, therefore, proposing to close risk F9. (20)	Consolidation of F8/9 agreed but further work required on risk at Place to ensure consistency and alignment to System Financial Risk.
• P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives – this risk has reduced to 12, from a previous risk rating of 16. (12)	FIRC decision to maintain risk at remains at 16.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
• P7: The Integrated Care System is unable to achieve its statutory financial duties, currently rated as critical **(20)**	Agreed to maintain current risk level

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Integrated Performance Report

Agenda Item No: ICB/11/24/08

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 November 2024, see appendix one, provides an overview of key metrics drawn from the 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

15.1 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

28th November 2024

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

ACUTE TRUSTS		SPECIALIST TRUSTS		COMMUNITY AND MENTAL HEALTH TRUSTS		KEY SYSTEM PARTNERS	
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT	AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT	BCHC	BRIDGEWATER COMMUNITY HEALTHCARE NHS FT	NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
ECT	EAST CHESHIRE NHS TRUST	LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT	WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT	CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
MCHT	MID CHESHIRE HOSPITALS NHS FT	LWH	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	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 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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Oct-24	69.7%	68.9%	69.4%	68.9%	68.1%	71.9%	72.1%	71.1%	72.7%	74.4%	74.3%	72.9%	72.3%	75.4%	**78%** by Year end	71.0%	73.0%	23/42
	Ambulance category 2 mean response time	Oct-24	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	00:38:08	00:56:23	-	**00:30:00**	00:35:06	00:42:15	-
	A&E 12 hour waits from arrival	Oct-24	17.0%	16.6%	16.1%	18.5%	16.7%	15.7%	15.8%	16.8%	15.8%	15.6%	15.5%	16.6%	17.0%	-	-	13.9%	11.1%	37/42
	Adult G&A bed occupancy	Oct-24	96.5%	96.9%	95.3%	96.6%	95.9%	96.0%	95.3%	95.8%	95.9%	95.5%	94.9%	95.6%	96.3%	94.9%	**92.0%**	94.5%	94.7%	27/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Oct-24	20.1%	20.6%	20.8%	21.0%	19.8%	20.1%	21.6%	21.8%	21.3%	21.5%	19.9%	19.6%	20.4%	12.7%	*	15.5%	13.9%	41/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Sep-24	5,393	4,842	5,227	4,732	3,736	2,195	2,324	2,331	2,285	2,098	1,972	985		0	-	5,314	45,527	-
	Number of 52+ week RTT waits, of which children under 18 years.	Sep-24					1,497	1,446	1,471	1,505	1,542	1,493	1,295	1,029	1,063	1,381	-	n/a	n/a	-
	Total incomplete Referral to Treatment (RTT) pathways	Sep-24	376,230	369,440	372,974	369,750	371,542	365,756	367,759	369,179	368,967	370,607	372,357	369,065		374,565	-	1,070,741	7,643,214	-
	Patients waiting more than 6 weeks for a diagnostic test	Sep-24	20.0%	16.0%	17.2%	16.2%	10.7%	10.0%	10.2%	10.0%	10.1%	9.0%	10.1%	8.8%		10.0%	**10.0%**	19.2%	23.9%	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	Aug-24	70.1%	70.9%	71.8%	67.2%	69.0%	75.4%	70.9%	71.8%	72.1%	75.9%	74.6%			71.3%	**85.0%**	71.6%	69.1%	7/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Aug-24	93.4%	94.0%	95.0%	91.9%	93.2%	92.4%	91.8%	95.4%	94.5%	94.8%	94.3%			96.0%	**96.0%**	94.0%	91.7%	12/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Aug-24	70.0%	68.9%	70.2%	67.2%	74.8%	76.0%	71.3%	71.4%	73.8%	74.1%	73.2%			73.4%	**77%** by Year end	74.7%	75.6%	32/42
Mental Health	Access rate to community mental health services for adults with severe mental illness	Mar-24	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	Jul 24 YTD	70.0%	72%	75%	75%	76%	78%	78%	78%	78%	76%				60.0%	**60.0%**	75.0%	71.5%	19/42
	Access rate for Talking Therapies services	Mar-24	72.0%	67.0%	47.0%	66.0%	66.0%	59.0%								100.0%	**100.0%**	62.3%	61.8%	#
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	Q1 24/25		45.0%			57.8%			55.0%						-	**60.0%**	57.0%	59.0%	31/42
	Dementia Diagnosis Rate	Sep-24	66.5%	66.9%	66.4%	66.3%	66.8%	67.0%	67.0%	67.2%	67.4%	67.7%	67.6%	67.4%		66.7%	**66.7%**	70.3%	65.5%	17/42
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Sep-24	110	110	110	100	100	100	95	95	95	95	90	85		≤ 60	-	260	1,820	27/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Aug 24 YTD	34.8%	40.1%	45.4%	61.1%	76.0%	91.4%	3.1%	7.3%	12.0%	17.7%	23.9%			19.3%	**75%** by Year end	25.6%	24.3%	18/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Aug-24	85.0%	80%	83%	80.0%	82.9%	80.0%	84%	87%	85%	84%	86%			70.0%	**70.0%**	90.0%	85.0%	20/42
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Apr-24	81.0%	84.0%	73.0%	80.0%	90.0%	95.0%	81.0%	81.0%	80.0%	79.0%	76.0%	78.0%		100.0%	**100.0%**	84.0%	81.0%	26/42
	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Aug-24	102.7%	98.6%	94.3%	106.8%	109.2%	92.8%	122.2%	106.9%	94.0%	109.0%	94.8%			-	-	96.3%	97.6%	-
	Percentage of appointments made with General Practice seen within two weeks	Jul-24	89.3%	89.8%	90.8%	91.0%	90.6%	90.1%	88.9%	89.7%	89.5%	89.8%				85.0%	**85.0%**	88.5%	88.3%	13/42
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Jun-24	7.27%	7.24%	7.36%	7.33%	7.27%	7.19%	7.22%	7.17%	7.12%					10.0%	**10.0%**	-	7.68%	-
	Total volume of antibiotic prescribing in primary care	Jun-24	1.081	1.077	1.040	1.036	1.040	1.033	1.04	1.04	1.04					0.871	**0.871**	-	0.95	-
Note/s	* no national target for 2024/25																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-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)	Q1 24/25		262.5			262.8			244.4						-	-	238.1	200.4	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Aug-24	92.4%	92.5%	92.4%	92.8%	92.7%	93.4%	93.1%	93.4%	93.3%	93.1%	93.4%			-	-	94.3%	93.2%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)	Q1 24/25		607.0			531.5			535.3						-	-	472.5	419.0	-
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)	Jul-24	59.4%	59.4%	59.0%	59.0%	59.1%	59.1%	59.0%	59.0%	59.1%	58.9%				70.0%	75% by 2028	57.6%	58.7%	21/42
	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 24/25		65.89%			69.58%			65.82%						77.0%	80.0%	66.54%	66.9%	29/42
	Children and young people accessing mental health services as % of LTP trajectory (planned number)	Jul-24	90.0%	88.0%	89.0%	89.0%	91.0%	92.0%	93%	92%	92%	93%				100.0%	100.0%	114.0%	95.00%	-
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Oct-24		14.3%	14.2%	14.2%	14.1%	13.9%	13.9%	13.8%	13.7%	13.6%	13.7%	13.7%	13.6%	12.0%	12.0%	-	12.7%^	-
Continuing Healthcare (NEW)	Standard Referrals completed within 28 days	Q1 24/25		63.10%			62.40%			71.70%						>80%	>80%	73.8%	72.8%	26/42
	% DST's (Decision Support Tool) completed that were in Hospital	Q1 24/25		0.00%			0.00%			0.00%						<15%		0.2%	0.3%	26/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q1 24/25		24.48			25.33			28.75						<18		29.68	18.29	37/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q1 24/25		46.37			47.04			51.69						34.0		46.77	34.04	39/42
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Jul-24	3.02	3.51	3.12	3.14	2.69	2.95	2.78	2.58	2.79	2.68				-	-	-	-	-
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare associated)	12 months to Sep 24	583	576	575	578	582	608	636	655	655	694	710	726		439	439	2101	11905	-
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Sep 24	769	768	778	797	788	812	816	823	810	813	813	817		518	518	2137	14453	-
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	May-24	1.034	1.034	1.017	1.004	1.006	1.001	0.998	0.993						0.887 to 1.127 *		-	1.000	-
	Never Events	Oct-24	3	3	3	1	1	3	4	2	2	1	1	1	0	0	0	-	-	-
	21+ day Length of Stay	Oct-24	1,273	1,187	1,368	1,386	1,396	1,413	1,303	1,379	1,364	1,321	1,349	1,371	1,362	1,315	-	-	-	-
Workforce / HR (ICS total)	Staff in post	Sep-24	72,324	72,903	72,993	73,069	73,344	73,267	73,078	73,011	72,945	72,909	73,039	73,548		71,994	-	198,623	-	-
	Bank	Sep-24	5,425	5,662	5,246	5,739	5,881	6,086	5,230	5,262	4,833	5,339	5,255	5,122		3,246	-	16,424	-	-
	Agency	Sep-24	1,260	1,286	1,245	1,257	1,187	1,279	1,209	1,088	1,072	1,104	1,009	932		980.8	-	4,206	-	-
	Turnover	Jul-24	11.7%	11.5%	11.4%	11.2%	11.1%	11.2%	11.3%	11.2%	11.3%	11.0%				13.0%	-	12.3%	-	-
	Sickness	Jul-24	5.6%	5.6%	5.5%	5.5%	5.6%	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
** -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	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Aug-24	-128.2	-143.9	-80.8	-72.2	-79.8	-61.5	-98.7	-	-68.8	-101.0	-138.0	-166.9	-108.5	-59.7	↗	0.0	0.0	0.0
	Financial position £ms (ICS) VARIANCE	Aug-24	-56.7	-70.0	-42.2	-40.8	-57.8	-50.5	-98.7	-	-19.1	-16.5	-38.5	-48.5	-48.8		↘			
	Efficiencies £ms (ICS) ACTUAL	Aug-24	158.0	192.9	227.0	246.4	302.7	334.4	388.6	-	41.9	64.7	92.3	119.9	156.4	181.4	↗	439.9	438.3	-1.6
	Efficiencies £ms (ICS) VARIANCE	Aug-24	-11.0	-12.2	-14.0	-30.7	56.3	-16.8	-0.1	-	-15.2	-13.1	-20.2	-26.6	-25.0		↗			
	Capital £ms (ICS) ACTUAL	Aug-24	53.9	77.3	110.8	133.7	115.3	153.6	267.3	-	N/A	39.5	65.6	81.8	97.1	123.9		310.3	325.0	-16.4
	Capital £ms (ICS) VARIANCE	Aug-24	41.2	17.8	2.8	7.1	49.7	51.8	1.1	-	N/A	3.9	11.3	13.6	26.8					

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

Category	Metric	Latest period	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-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)	Oct-24	59.3%	51.4%	57.0%	73.7%	68.1%	73.1%	78.1%	89.2%	-	90.7%		-	-	-	-	-	-	72.3%
	A&E 12 hour waits from arrival	Oct-24	26.7%	13.5%	17.0%	21.7%	24.5%	16.0%	17.9%	#	-	0.0%	-	-	-	-	-	-	-	17.0%
	Adult G&A bed occupancy	Oct-24	99.4%	95.9%	92.3%	95.2%	97.3%	95.3%	98.2%	-	88.1%	62.5%	84.7%	90.6%					-	96.3%
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Oct-24	20.0%	13.8%	22.1%	17.3%	20.8%	22.8%	19.9%										-	20.4%
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Sep-24	185	10	145	178	93	131	147	2	10	15	0	2			2	-	65	985
	Number of 52+ week RTT waits, of which children under 18 years.	Oct-24	181	23	117	128	59	99	70	380	-	2	-	4						1,063
	Total incomplete Referral to Treatment (RTT) pathways	Sep-24	33,204	12,444	39,688	47,469	35,058	73,794	81,020	23,578	5,472	16,341	1,267	16,697			52	-	-	369,065
	Patients waiting more than 6 weeks for a diagnostic test	Sep-24	12.2%	10.6%	5.4%	4.1%	17.3%	5.2%	3.2%	14.9%	15.7%	6.5%	0.0%	1.2%	43.2%	0.0%	-	-	-	8.8%
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	Aug-24	84.9%	72.7%	67.3%	79.8%	75.1%	69.7%	80.2%	100.0%	74.4%	21.7%	86.7%	100.0%	85.2%				-	74.6%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Aug-24	94.1%	100.0%	83.7%	90.0%	100.0%	88.6%	86.8%	100.0%	100.0%	81.6%	99.5%	100.0%	92.3%				-	94.3%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Aug-24	78.5%	77.6%	70.2%	74.4%	68.0%	73.0%	74.4%	100.0%	66.7%	42.3%	63.6%	100.0%	91.7%				-	73.2%
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Jul-24	Mental Health service providers only														74.0%	80.0%	-	76.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Aug-24	89.0%	89.0%	88%	Community Service Providers only									-	92.0%	77.0%	-	80%	86.0%
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	Q4 2023/24	66.5%	66.7%	59.6%	59.0%	51.7%	72.3%	62.5%	-	48.1%	85.2%	39.2%	-	100.0%	-				58.9%
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Jul-24	2.06	2.03	4.30	2.44	2.46	-	2.12	-	-	2.91	-	-						2.68
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Sep 24	(88 vs 56)	(17 vs 6)	(56 vs 31)	(135 vs 71)	(92 vs 36)	(192 vs 133)	(112 vs 85)	(12 vs 0)	(1 vs 2)	(6 vs 0)	(9 vs 13)	(11 vs 6)						726
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Sep 24	(65 vs 35)	(46 vs 27)	(52 vs 24)	(92 vs 53)	(92 vs 54)	(256 vs 165)	(161 vs 121)	(10 vs 8)	(5 vs 6)	(6 vs 5)	(20 vs 10)	(12 vs 10)						817
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	May-24	0.9395	1.2030	0.8967	1.0212	0.9684	0.9599	1.0525											0.993
	Never Events (rolling 12 month total)	12 Months to Oct 24	1	2	0	1	4	2	2	1	0	4	0	3	0	0	0	0	2***	22
	21+ day Length of Stay (ave per day)	Oct-24	109.7	48.5	126.0	184.3	134.4	449.6	264.8	4.1	15.0	0.2	24.5	31.4						1,371
Workforce / HR (Trust Figures)	Staff in post	Sep-24	4,453	2,406	4,888	5,932	4,255	14,029	9,582	4,157	1,814	1,674	1,886	1,498	1,413	1,517	10,325	3,720	-	73,548
	Bank	Sep-24	371	200	405	366	385	971	800	141	68	75	23	101	23	46	910	238	-	5,122
	Agency	Sep-24	25	54	88	46	33	129	165	12	5	11	13	9	23	5	240	75	-	932
	Turnover	Jul-24	11.3%	10.5%	9.6%	9.5%	10.2%	10.3%	10.1%	9.6%	13.2%	11.3%	11.4%	12.2%	9.4%	10.3%	13.7%	13.3%	-	11.0%
	Sickness (via Ops Plan Monitoring Dashboard)	Jul-24	5.8%	5.6%	5.0%	6.0%	5.7%	6.3%	3.9%	5.6%	5.1%	6.0%	4.7%	5.6%	5.8%	6.5%	7.8%	6.6%	-	5.6%
Finance	Overall Financial position **Variance** (£m)	Sep-24	-5.26	-0.33	-2.77	-6.59	-0.76	-6.52	2.94	-0.00	-0.46	1.09	0.00	0.35	-0.97	0.00	0.00	0.00	-29.50	-48.77
	Efficiencies (Variance)	Sep-24	-3.83	0.00	-3.52	-0.00	0.17	-7.11	1.40	0.45	-1.29	1.33	-0.00	0.00	-0.09	-0.32	0.00	-1.31	-10.80	-25.04
	Capital (Variance)	Sep-24	13.67	1.51	-7.82	0.42	0.31	0.38	0.00	-0.01	0.44	1.89	6.94	-0.02	1.48	1.33	3.89	2.23	0.20	26.87
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 Murrayfield, 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)	Oct-24	54.9%	58.4%	33.6%	57.6%	73.6%	74.7%	76.8%	75.1%	61.3%		72.3%	75.4%	78% by Year end
	Ambulance category 2 mean response time	Oct-24	00:50:45		01:00:05	00:56:45	00:57:28	00:59:03	00:58:00	01:03:02	00:57:12		00:56:23		00:30:00
	A&E 12 hour waits from arrival	Oct-24	15.5%	22.4%	19.6%	22.0%	12.2%	21.0%	13.8%	24.8%	16.3%		17.0%	-	-
Planned Care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Sep-24	400		205	72	98	39	38	60	73		985	0	-
	Total incomplete Referral to Treatment (RTT) pathways	Sep-24	105,918		52,243	29,945	62,663	31,172	25,123	22,312	39,490		369,065	374,565	-
	Patients waiting more than 6 weeks for a diagnostic test	Sep-24	11.5%		4.5%	12.7%	5.8%	7.2%	4.1%	20.1%	6.1%		8.8%	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	Aug-24	69.3%	78.1%	81.9%	78.6%	75.7%	80.2%	77.8%	71.2%	66.5%		74.6%	71.3%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Aug-24	90.1%	90.6%	95.7%	95.2%	95.6%	97.0%	95.8%	85.9%	92.2%		94.3%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Aug-24	72.5%	75.4%	74.6%	75.8%	68.1%	78.1%	74.8%	73.6%	72.8%		73.2%	73.4%	77% by Year end
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Jul-24	89.0%		63.0%	92.0%	67.0%	80.0%	67.0%	100.0%	93.0%	62.0%	76.0%	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	Q1 24/25	55.0%		51.0%	64.0%	56.0%	47.0%	47.0%	64.0%	55.6%		55.0%	-	60.0%
	Dementia Diagnosis Rate	Sep-24	67.3%		67.0%	72.4%	66.3%	68.6%	62.7%	68.8%	67.3%		67.4%	66.7%	66.7%
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Sep-24	15		10	5	20	5	10	15	10		85	-	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Aug 24 YTD	23.4%		23.1%	23.2%	26.0%	20.9%	28.7%	30.0%	18.5%		23.9%	19.3%	75% by Year end
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Aug-24	89.3%		91.4%		72.5%	81.8%	84.6%		87.3%		86.0%	70.0%	70.0%
Primary Care	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Aug-24	95.7%	91.6%	94.1%	92.0%	95.0%	96.3%	101.3%	94.2%	96.7%		94.8%	-	-
	Percentage of appointments made with General Practice seen within two weeks	Jul-24	88.8%		89.2%	87.3%	91.6%	90.6%	91.0%	84.0%	92.1%		89.8%	85.0%	85.0%
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Jun-24	6.77%		9.06%	6.18%	7.21%	5.61%	6.58%	6.12%	7.75%		7.12%	10.0%	10.0%
	Total volume of antibiotic prescribing in primary care	Jun-24	0.93		1.12	0.95	1.05	1.18	1.19	1.08	1.10		1.04	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

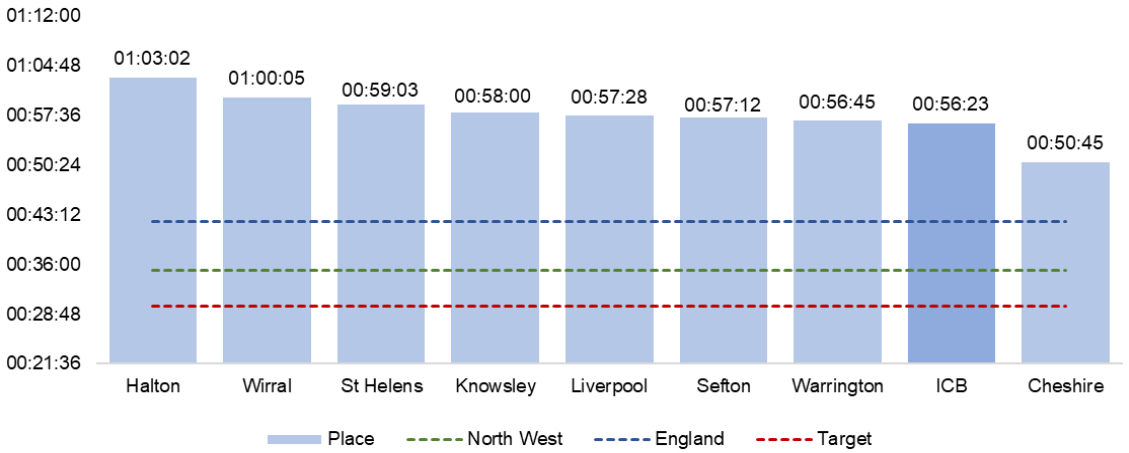
Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q1 24/25	193.9	214.3	244.3	175.8	341.7	264.8	331.4	213.3	219.7		244.4	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence ***	Aug-24	89.5%	90.2%	94.3%	95.8%	94.9%	94.0%	95.2%	95.4%	93.8%		93.4%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q1 24/25	495.2	524.2	481.6	370.6	757.5	537.4	720.1	479.7	451.8		535.3	-	-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 24/25	66.9%		64.4%	65.1%	67.5%	65.6%	60.8%	68.6%	64.1%		65.8%	77.0%	80.0%
	Children and young people accessing mental health services as % of LTP trajectory	Jul-24	77.3%		88.6%	110.7%	102.4%	142.1%	100.3%	62.7%	81.2%		93.0%	-	-
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Oct-24	11.3%	12.1%	14.0%	9.4%	16.1%	13.3%	16.8%	17.3%	13.4%		13.6%	12%	12%
Continuing Healthcare (NEW)	Referrals completed within 28 days	Q1 24/25	65.8%		83.7%	94.4%	38.7%	100.0%	89.5%	81.3%	48.3%	42.2%	71.70%	>80%	>80%
	% DST's (Decision Support Tool) completed that were in Hospital	Q1 24/25	0.0%		0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%	0.0%	0.20%	<15%	0.0%
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q1 24/25	22.09		32.82	18.24	23.43	43.88	18.86	22.12	58.79	61.66	28.75	<18	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q1 24/25	58.2		71.0	39.7	41.9	36.2	31.8	43.3	54.1	80.5	51.69	34	
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place totals	12 months to Sep 24	(204 Vs 156)		(140 Vs 131)	(68 Vs 45)	(129 Vs 172)	(45 Vs 47)	(48 Vs 47)	(39 Vs 33)	(65 vs 100)		726	439	439
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Sep 24	224		102	79	166	66	47	39	110		817	518	518
Finance	Overall Financial position Variance (£m)	Sep-24	-5.3	-1.8	-6.1	-1.3	-6.7	-2.0	-1.6	-1.2	-6.6		3.1	0.0	0.0
	Efficiencies (Variance)	Sep-24	-2.4	-2.1	-2.5	-0.3	-1.2	-0.5	-0.1	-0.5	-0.9		0.0	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	Sep-24	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Sep-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

Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (Oct-24)	00:56:23	National Ranking	n/a
Place Breakdown (Oct-24)			Deteriorated



Issue
- Cat 2 response time has deteriorated for Cheshire and Merseyside

Action
- At scale Ambulance improvement group has been set up and meeting fortnightly to bring providers and localities together. Good engagement from providers.
- AQUA are supporting work to baseline the barriers to ambulance handover delays with a focus on Whiston, Arrowe Park and Countess of Chester sites.
- ECIST Tier 1 Rapid improvement offer is underway (12-week programme) and is focussed on ward and board rounds and call before convey with sites ging live or augmenting their existing offer from December. NWAS engaged in the design of this work.
- Reset event planned for Whiston from 27th November supported by ICB, ECIST and NW regional colleagues to improve flow.

Delivery
- Within the UEC Recovery programme both localities and at scale workstreams are collectively working to improve Cat 2 response times

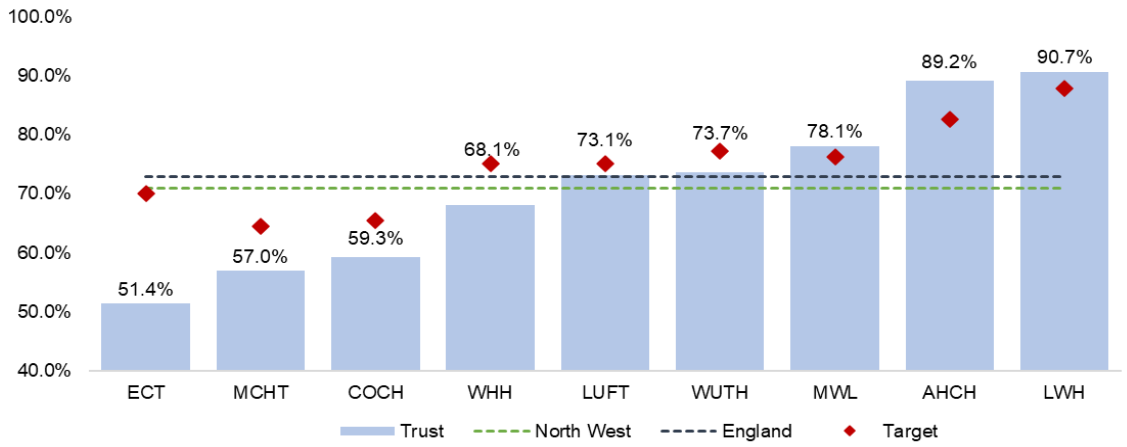
5. Exception Report – Urgent Care

Cheshire and Merseyside

A&E 4 hour waits from arrival

Latest ICB Performance (Oct-24)	72.3%	National Ranking	23/42

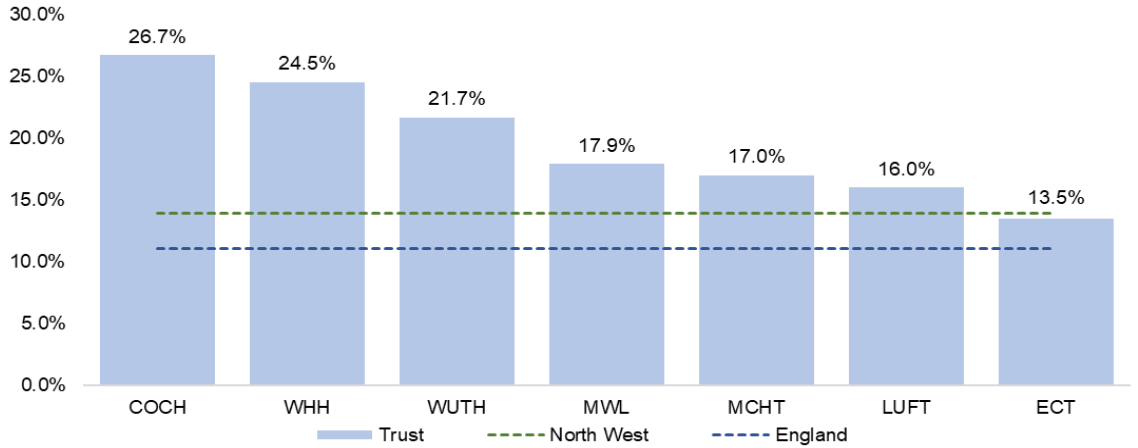
Provider Breakdown (Oct-24) — Deteriorated



A&E 12 hour waits from arrival

Latest ICB Performance (Oct-24)	17.0%	National Ranking	37/42

Provider Breakdown (Oct-24) — Deteriorated



Issue

- Cheshire and Merseyside performance is 3.1% below the in-year trajectory that has been set to achieve the 78% March 2025 ambition.
- 17% of Cheshire & Merseyside A&E patients were delayed over 12 hours compared to the North West average of 13.9% and the England average of 11.1%.

Action

- ECIST is working with C&M Emergency Departments through the Tier 1 rapid improvement offer with a focus on reducing the number of patients waiting over 12 hours in department.
- The SCC is working with acute sites to reduce time in department through monitoring long stay patients. A clinical cell has been set up to focus on quality and safety aspects of UEC across winter.
- ICB has set up a 'Reducing extended waits in ED' working group within the UEC Recovery programme. This involves all acute providers but with an initial focus on Arrowe Park, Whiston and Countess of Chester. AQUA are supporting via review of local escalation policies.
- Time in department data will flow into the C&M System Coordination Centre by the end of November to provide real time visibility of 12 hour, 24, 48, 72 hours waits.
- Call before convey tests of change are due to commence early December under the Tier 1 RIO programme across all sites with the aim of reducing conveyance to ED.
- 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 Tier 1 ECIST work and the LOS and acute discharge UEC recovery workstreams. WUTH, LUHFT and WHH continue to operate a continuous flow model to increase flow from ED on to AMU/wards.
- 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.
- Single model / best practice framework for UCR and Falls to reduce variation.
- 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

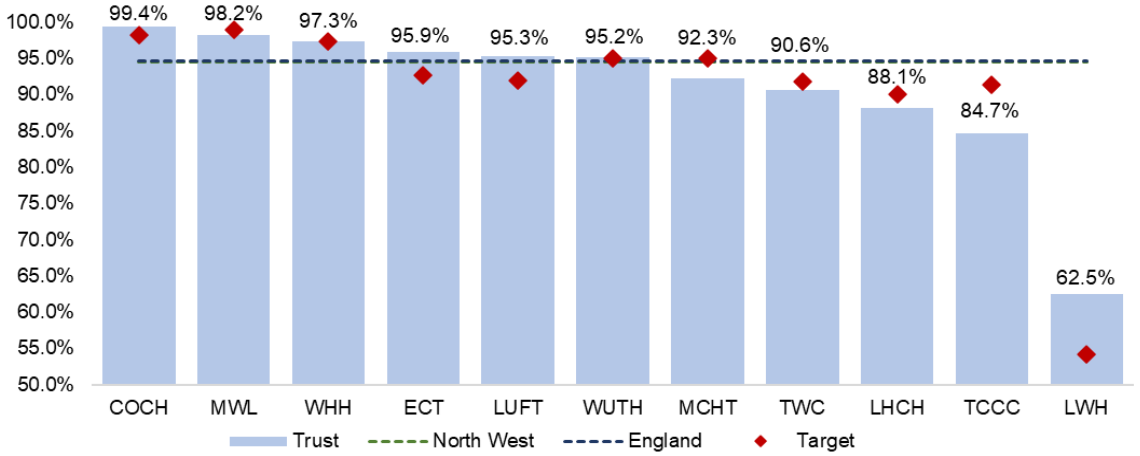
- C&M is adopting a recovery approach to UEC in 2024/25 and is committed to achieving 78% by the end of 2024/25 and a reduction in 12 hour waits

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (Oct-24)	96.3%	National Ranking	27/42
Provider Breakdown (Oct-24)	Deteriorated		



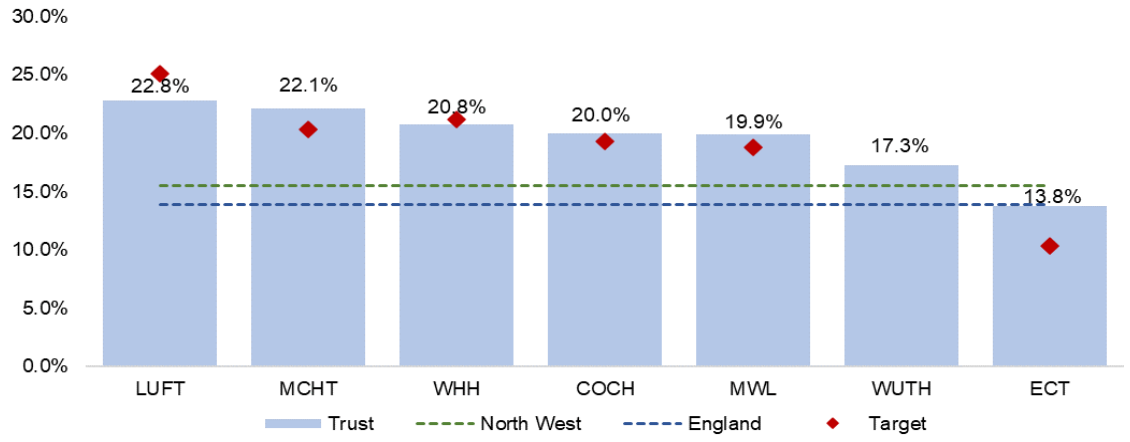
Issue
- General and acute (G&A) bed occupancy is consistently high across acute trusts in C&M.
- Long length of stay numbers are a key driver of high occupancy.

Action
- The Cheshire and Merseyside UEC Recovery Programme will focus on in hospital flow within the Length of Stay (LOS) workstream.
- Tier 1 Rapid improvement offer on each acute site includes support to ward and board round process on every site.
- To support site level improvement input, there is a ward and board round collaborative led by ECIST and embedded into the In hospital at scale workstream.
- Reset event planned for Whiston end of November with SCC on site and operational wrap around support to focus on unblocking barriers to discharge.

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 (Oct-24)	20.4%	National Ranking	41/42
Provider Breakdown (Oct-24)	Deteriorated		



Issue
- NCTR is at 20.4%, higher than England (13.9%) and North West (15.5%).

Action
- The C&M UEC Recovery Programme for 2024/25 has been aligned to 5 acute catchment areas: 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.
- Localities are focussed on the development of care transfer hubs.
- Reset event planned for Whiston end of November with SCC on site and operational wrap around support to focus on unblocking barriers to discharge.

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

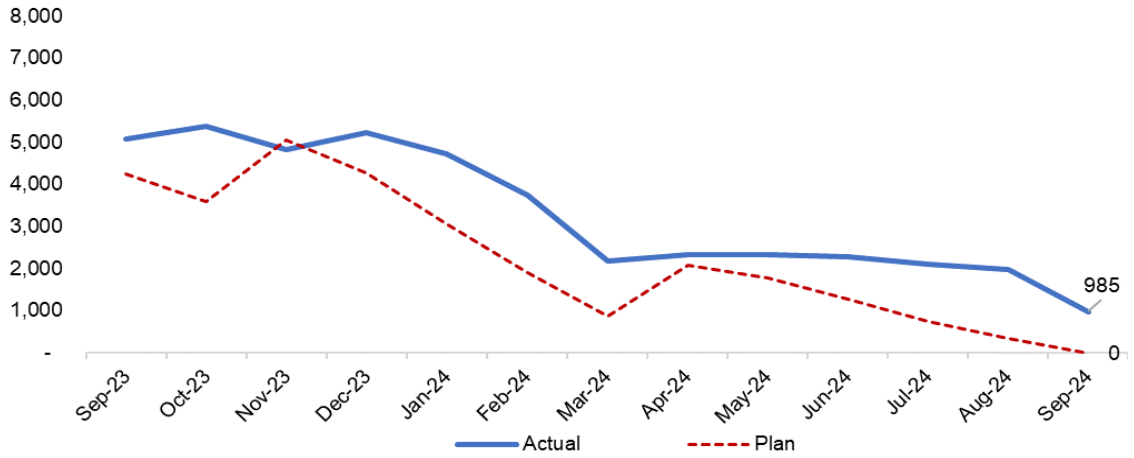
5. Exception Report – Planned Care

Cheshire and Merseyside

ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Sep-24)	985	National Ranking	n/a

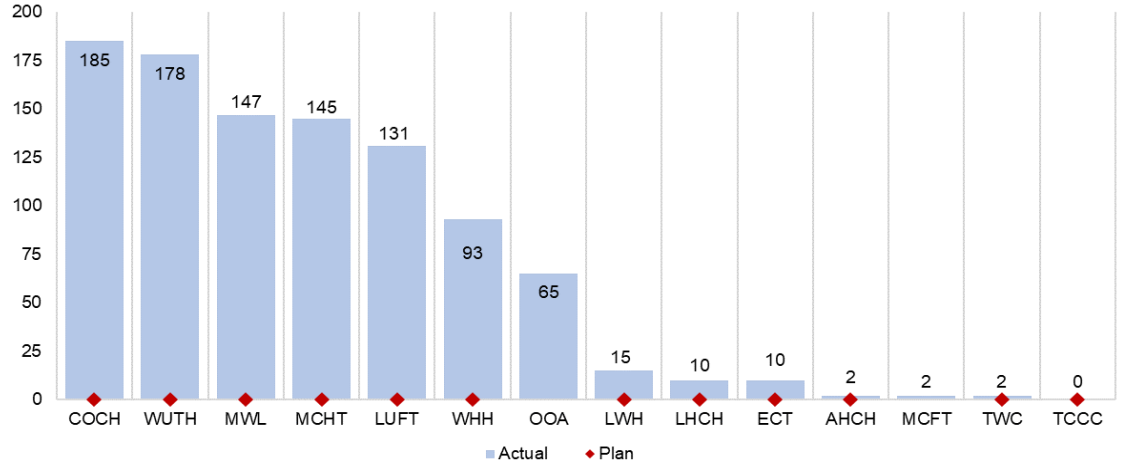
ICB Trend (Sep-24) — Improved



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Sep-24)	985	National Ranking	n/a

Provider Breakdown (Sep-24) — Improved



Issue

- There remains challenges for several trusts to clear 65 week wait patients, given patient choice and complexity issues. 9 providers are reporting anticipated breaches at month end.
- A residual position of 928 65-week breaches are reported for October month end, of which 467 are anticipated capacity breaches. The highest provider with capacity breaches is MCHT (173).

Action

- C&M have organisations who are anticipating residual risks around sustaining 65-week delivery in November, and the team are working closely with providers to ensure that all mutual aid and operational tactical measures undertaken to support the position. C&M currently have 11 active mutual aid requests within, Hysteroscopy & Biopsy, Oral & Max Fax, Plastics, General Surgery, Vascular, T&O, Gynae, and pain.
- Validation SDF funding agreed per Trust, detailed narrative/plans received and trajectories of performance improvement in development.
- At MCHT, the trust continues to experience pressures within Cardiology, Rheumatology and T&O. Outsourcing approval has been received for 80 Vascular and 100 T&O patients to be treated at Spire to support 65ww delivery. The trust has also submitted mitigation plans for other challenged specialties.
- At LUFT, ENT and Oral and Maxillofacial Surgery are the most challenged specialties. Mutual aid request shared with C&M providers and regional colleagues for OMF and an action plan is in place internally to reduce ENT numbers.
- At WUTH, Gynae is the area of concern with the trust reporting a potential breach of around 82 patients. Mutual aid for 300 patients has been offered via LWH to focus on ASI support conversions of clinic capacity to theatre lists and recovery plan is underway.
- At COCH, ENT insourcing has been approved to support the delivery of 65ww's, this will commence from end of Nov.
- Provider action plans have been received for the continued reduction of long waits. These are reviewed during regular trust PTL meetings.
- 65-week returns will continue to be submitted weekly to review patient numbers and plans, where complex patients are being identified and discussed during PTL meetings so that additional support can be provided.

Delivery

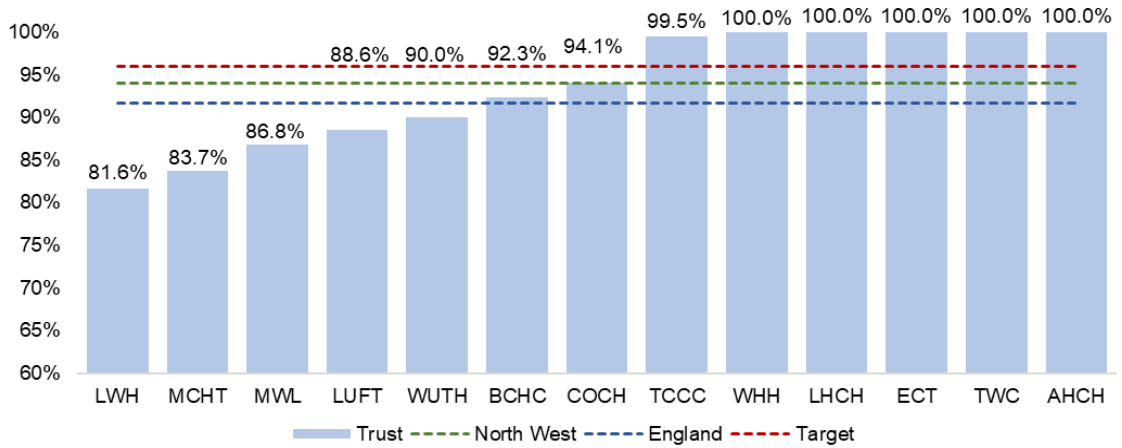
- There is a continued focus on improving the 65 week waits position and eradicating 78-week long waits. 87
- Working towards the ICB ambition of zero CYP patients waiting as at 31st March 2025.

5. Exception Report – Cancer Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (Aug-24)	94.3%	National Ranking	12/42
Provider Breakdown (Aug-24)			Deteriorated



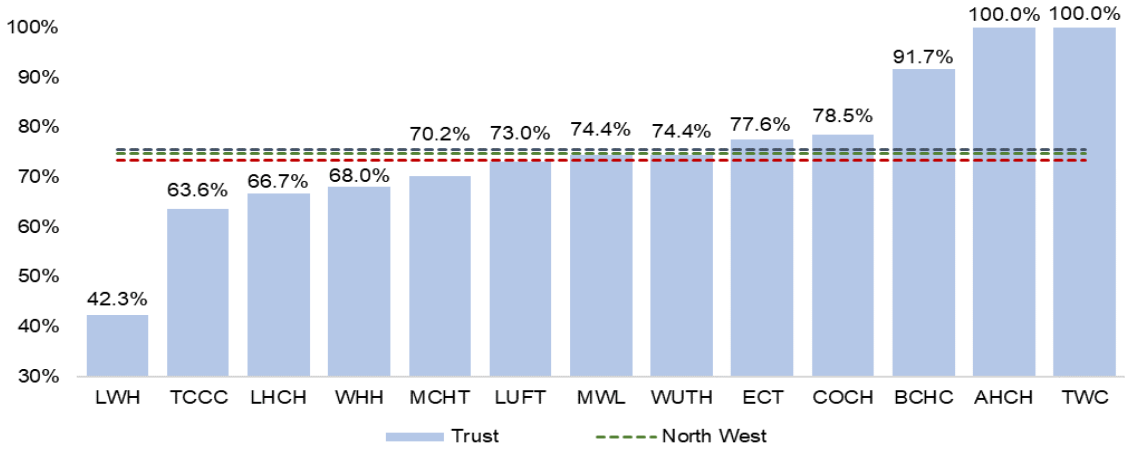
Issue
- C&M is not yet achieving the 96% 31-day combined standard required however, the figure of 94.3% is 4th amongst Cancer Alliances and 12th amongst ICBs in this latest month.

Action
- Continued delivery of 31-days. The position compares to an England 91.7%. Areas of underperformance are in first and subsequent surgery, predominantly for skin.
- Capacity and demand exercises for 25/26 are necessary to address this and short-term investment is already being made by the Cancer Alliance in key areas.

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.

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

Latest ICB Performance (Aug-24)	73.2%	National Ranking	29/42
Provider Breakdown (Aug-24)			Deteriorated



Issue
- Faster Diagnosis performance remains below the 77% target but is 18th amongst cancer alliances and 29th amongst ICBs.

Action
- Actions are in place against challenged services, notably LGI, Urology and Gynaecology. The Cheshire and Merseyside Performance Forum oversees provider improvement plans and supports funding of operational performance improvement initiatives.
- The Cheshire and Merseyside in depth review process has seen completion of multiple service reviews with strong improvement plans developed.

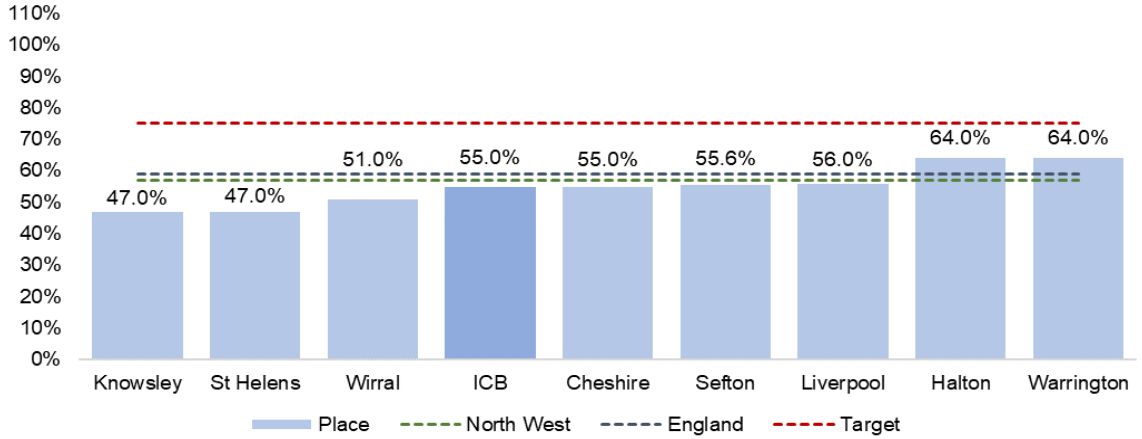
Delivery
- C&M remain on trajectory with some seasonal mitigation showing improvements year on year. Delivery is via improvement plans.

5. Exception Report – Mental Health & Learning Disabilities

Cheshire and Merseyside

People with SMI receiving a full annual physical health check

Latest ICB Performance (Q1-24/25)	55.0%	National Ranking	31/42
Place Breakdown (Q1 – 24/25)			Deteriorated



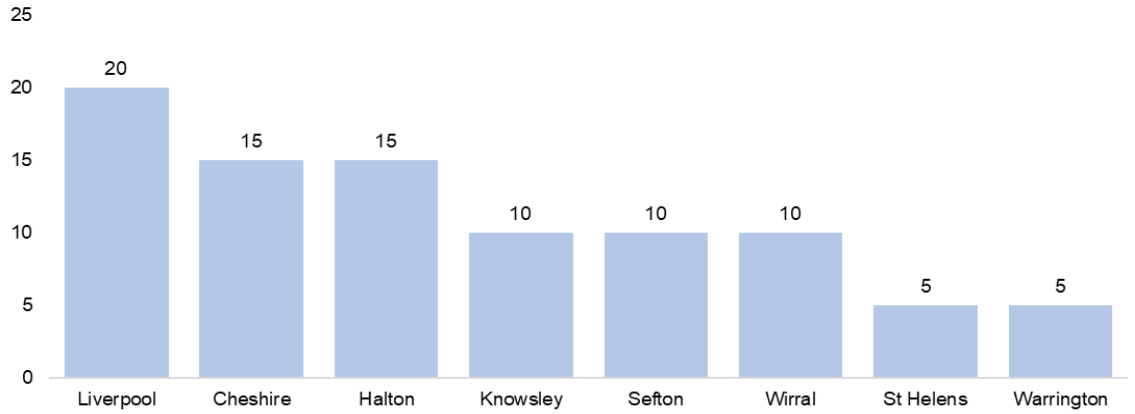
Issue
- C&M is not achieving the minimum 60% target for all 6 health checks. Changes to SMI health check QOF payments for GPs and GP Collective Action may have further impact.

Action
- New BIP report developed which allows drill down to PCN and practice level. Unwarranted variation identified within each place.
- Learning from high uptake areas and good practice ideas shared within and across places to drive improvement.
- ICB Board has requested a deep dive into PH in SMI at their November 2024 Public Board meeting.

Delivery
- Only two places meeting the minimum 60% national target for all 6 SMI Health checks.
- However, 64% of all C&M SMI patients having 5 checks so targeted work needed to identify and address missing health check.
- Historic annual trends indicate a surge in Q4 which minimises the opportunity of follow-up on non-attendance. This trend may not be repeated this year as a result of QOF income protection based on last year's activity, which was below target.

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Sep-24)	85 *	National Ranking	27/42
Place Breakdown (Sep-24)			Improved



Issue
- There are currently 86 adult inpatients as at 13 October 2024, of which 48 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 38 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. Of those 86 adults there are there are currently 17 individuals currently on Section 17 Leave. There have been discharges during Q2, but we expect that some of the existing section 17 individuals will be discharged in Q3 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 with Mersey Care and CWP.
- 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.

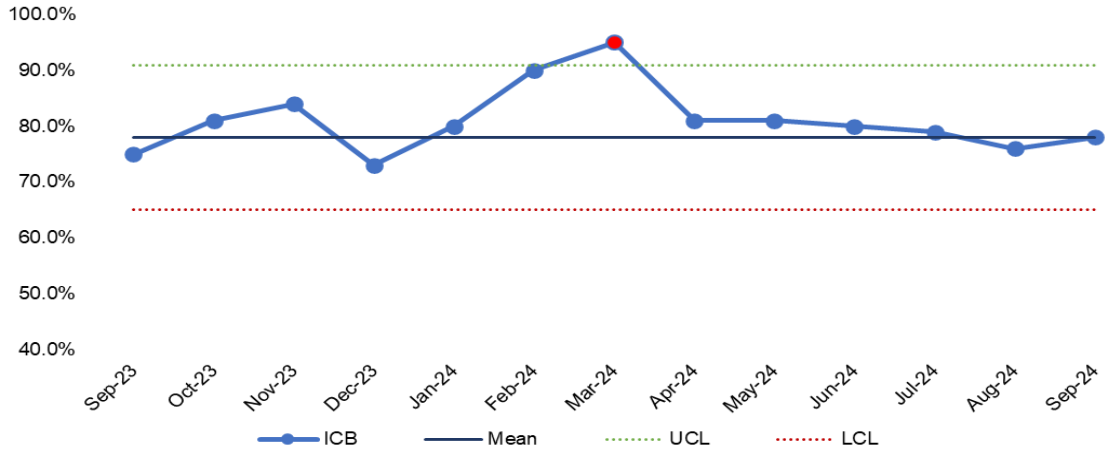
***** *Data rounded up/down to nearest 5: therefore, Place subtotals may not add up to the ICB total*

5. Exception Report – Primary Care

Cheshire and Merseyside

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

Latest ICB Performance (Sepr-24)	78.0%	National Ranking	26/42
ICB Trend (Sep-24)			Improved



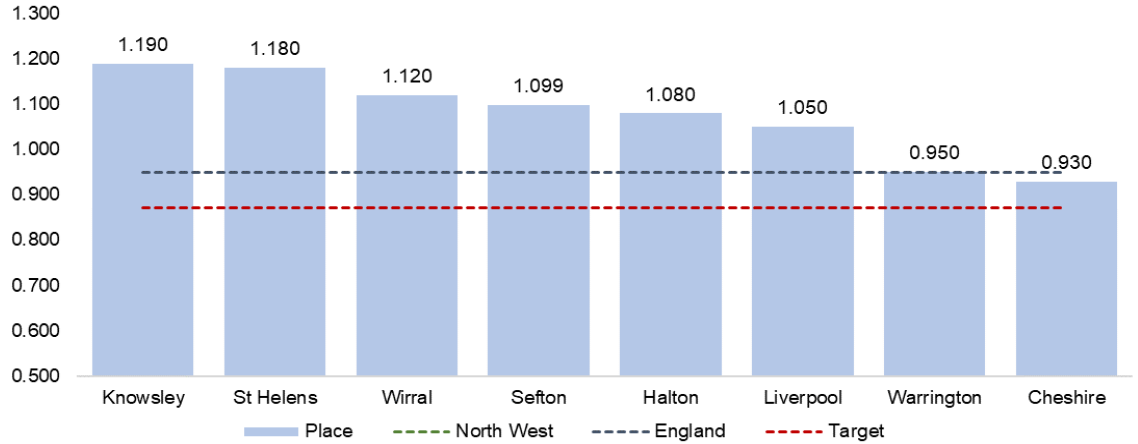
Issue
- C&M does not currently meet the 100% target

Action
- Providers underperforming have been 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 final Executive approval.
- Commissioners have reviewed Local Dental Plan progress and implementation of Pathways 1+2 and 3 continues.

Delivery
- Fluctuations in delivery of target are expected throughout the year such is the nature of national contract.
- Mid-year review of local dental improvement plan completed.
- Commissioners are using flexible commissioning arrangement to improve activity.

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Jun-24)	1.04	National Ranking	n/a
Place Breakdown (Jun-24)			Deteriorated



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 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.
- NHS C&M Comms teams, ADQs and MM AMR leads have collaborated and successfully launched the new 'superbodies' campaign aimed at reducing unnecessary antibiotic prescribing for common childhood infections and providing parents and carers with helpful advice regarding self-care and when to seek medical advice when their child is ill.

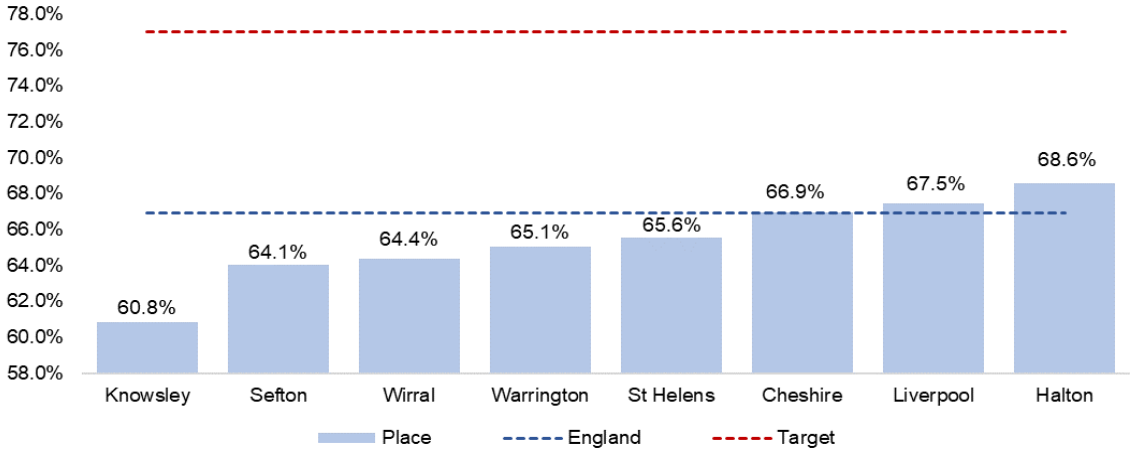
Delivery
- Further analysis will be undertaken on Q2 2024/25 data at Place and ICB level to identify if there are areas to focus on additional to the planned work happening across C&M.

5. Exception Report – Health Inequalities & Improvement

Cheshire and Merseyside

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

Latest ICB Performance (Q1-24/25)	65.8%	National Ranking	29/42
Place Breakdown (Q1-24/25)			Deteriorated



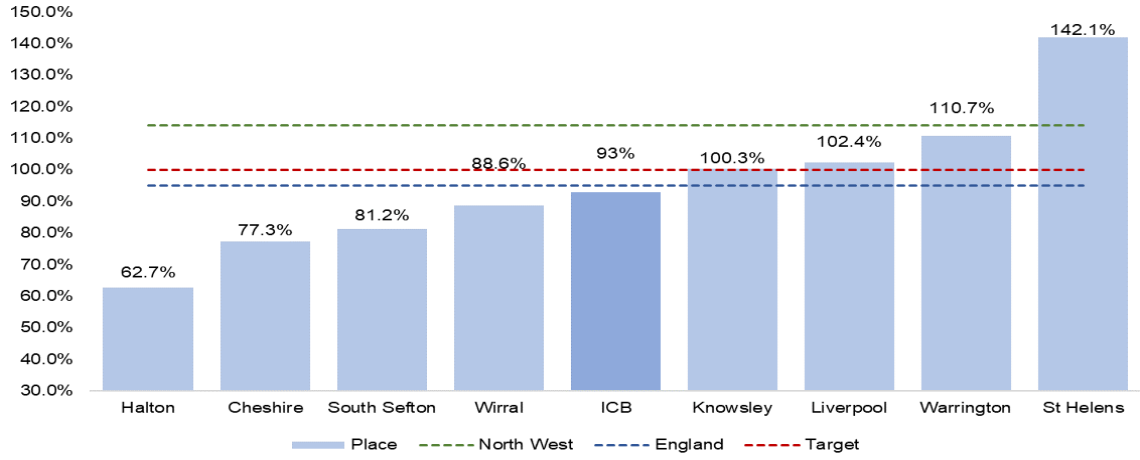
Issue
- Considerable variation in C&M, reductions in capacity & funding continue to affect performance; C&M does not currently meet the national target ambition.

Action
- Latest data relates to Q1 which regularly sees a lower % (with Q4 typically highest due to links with QOF).
- CVDP Board has met with opportunities to harmonise efforts across C&M.
- Agreement from all Places to collaborate on Health Checks, Hypertension & Lipid mgmt.
- GP and Community Pharmacy, extended access, Local Quality Incentive Schemes and secondary care interface opportunities to be explored.
- Conversations ongoing re: NR funded Familial Hypercholesteremia & CVD Prevention services.
- Planning continues re: hypertension case finding pilots in optometry with a delivery partner now identified.
- Work planned with the most deprived practices re: hypertension currently dependant on national funding from NHSE which has not been confirmed.

Delivery
- CVDP SRO, Programme lead and CVDP Board is the vehicle to coordinate C&M wide NHS activity alongside local Place CVD Prevention plans.

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

Latest ICB Performance (Jul-24)	93.0% *	National Ranking	n/a
Place Breakdown (Jul-24) **			Improved



Issue
- The CYP access target is 37,590 for C&M. July data indicates that the target is not currently being met, with 34,895 CYP accessing support in C&M over the last 12 months. There has been no significant change in overall C&M access rates during 2024, however there is more significant variance in place level trends.

Action
- Data quality plan in place to ensure data capture of all CYP mental health providers to reflect a more accurate picture. Not all VCSE services are able to flow data to the national data set.
- Roll out of 5 new wave 11 MH in school teams will support increased access.
- C&M CYP Access Development Workstream reviewing trajectories at sub-ICB level to identify actions to address downward trends in Cheshire, Halton and Wirral.

Delivery
- Overall, access levels for C&M masks variation at place level. Knowsley, Liverpool and St Helens continue to achieve their place level targets. Warrington continues to see a significant upward trend with access provided for an additional 535 CYP since April 2024: in-year growth of 19%

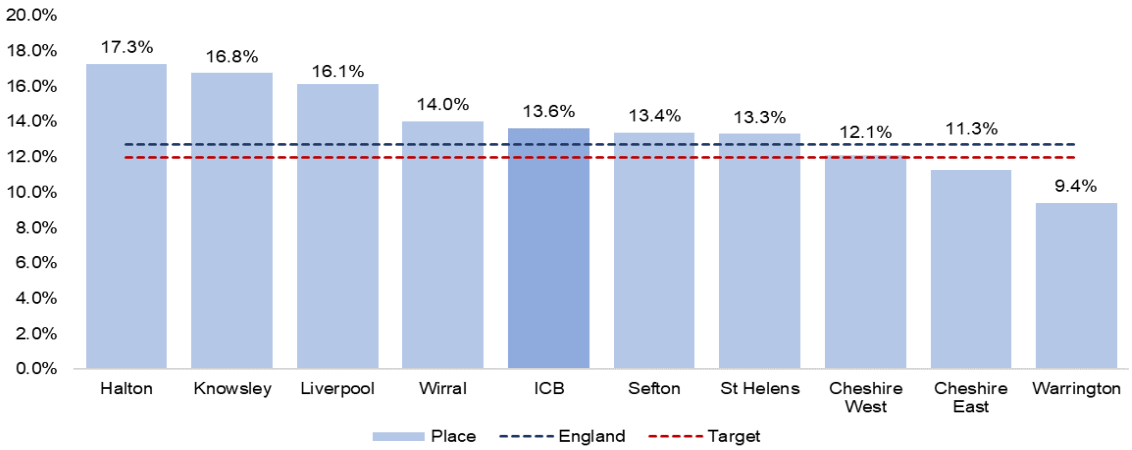
** ICB data uses number treated vs target*

*** 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 (Oct-24)	13.6%	National Ranking	n/a
Place Breakdown (Oct-24)			Improved



Issue

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

Action

- An NHSE business case has been approved securing funding for specialist face-to-face training to be delivered to newly recruited tobacco dependency treatment advisors across the NHS Trusts in C&M.
- An NHSE business case has been approved securing funding to support NHS Trusts to implement their smokefree policies ensuring that all NHS sites are health promoting environments.
- We are working with the Treating Tobacco Dependency leads within each NHS Trust to understand how we can improve the proportion of patients who have their smoking status assessed and recorded and are referred into the tobacco dependency service.

Delivery

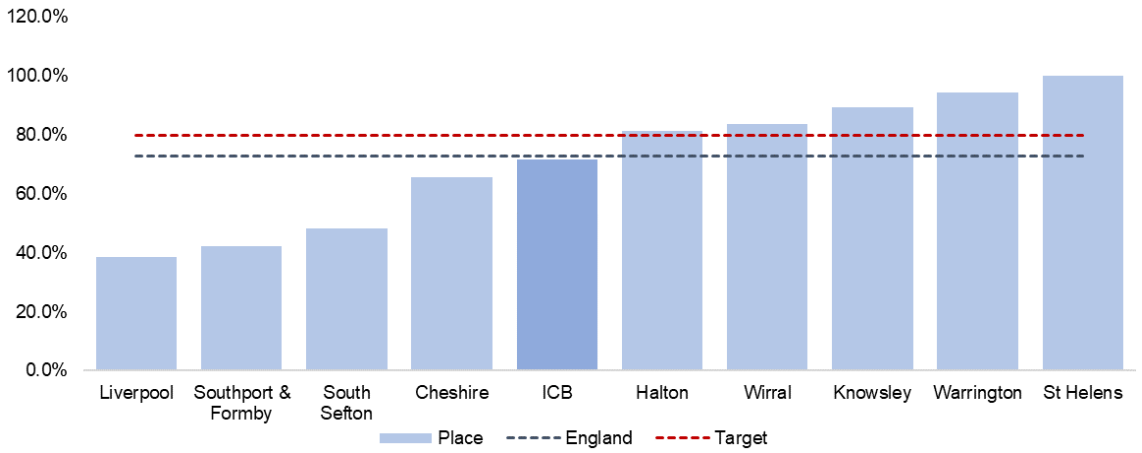
- Smoking prevalence continues to decline in C&M but requires a continued Whole System Approach to ensure progress is maintained.

5. Exception Report – Continuing Healthcare

Cheshire and Merseyside

Standard Referrals completed within 28 days

Latest ICB Performance (Q1-24/25)	71.7%	National Ranking	26/42
Place Breakdown (Q1-24/25)			NEW



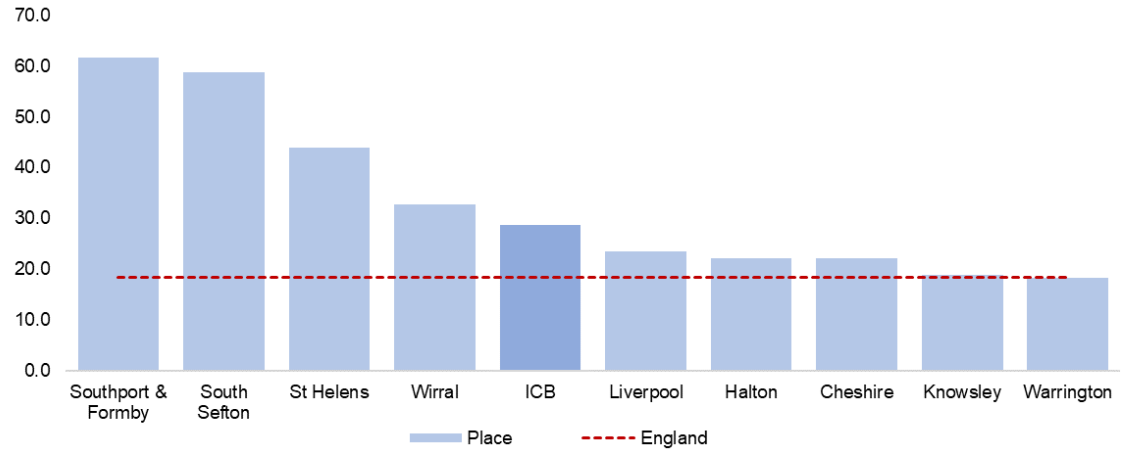
Issue
- Cheshire and Merseyside ICB is not currently meeting the NHS England KPI for Standard CHC referrals to be completed within 28 days.

Action
- A review of AACC delivery across C&M has taken place to develop a single structure and improve consistency and capacity across the 9 sub-locations. This includes the in-housing of Liverpool and Sefton place-based teams, which are the main outliers for this metric.
- Additional scrutiny of the in-housed service, alongside the appointment of an Interim Head of Service (pending permanent recruitment via the Management of Change process) has enabled allocated senior clinical resource to daily management of 28 day / long waits.

Delivery
- The ICB is already delivering at above the Quarterly trajectory agreed with NHS England. The Q1 projection was ≥65% to 69.9%.

Number eligible for Fast Track CHC per 50,000 population *

Latest ICB Performance (Q1-24/25)	28.75	National Ranking	37/42
Place Breakdown (Q1-24/25)			NEW



Issue
- Cheshire and Merseyside ICB currently has a higher conversion rate for the number of people eligible for Fast Track per 50,000 population than the national position.

Action
- NHS C&M ICB are producing a suite of supportive policies and procedures to support teams in delivering consistent delivery and application of NHS CHC across the C&M system. Some are already operational and published whilst others are in various stages of ratification and development.
- The main impact upon this metric is with the place teams that are, or were, outsourced; in-housing will enable improved scrutiny over delivery.

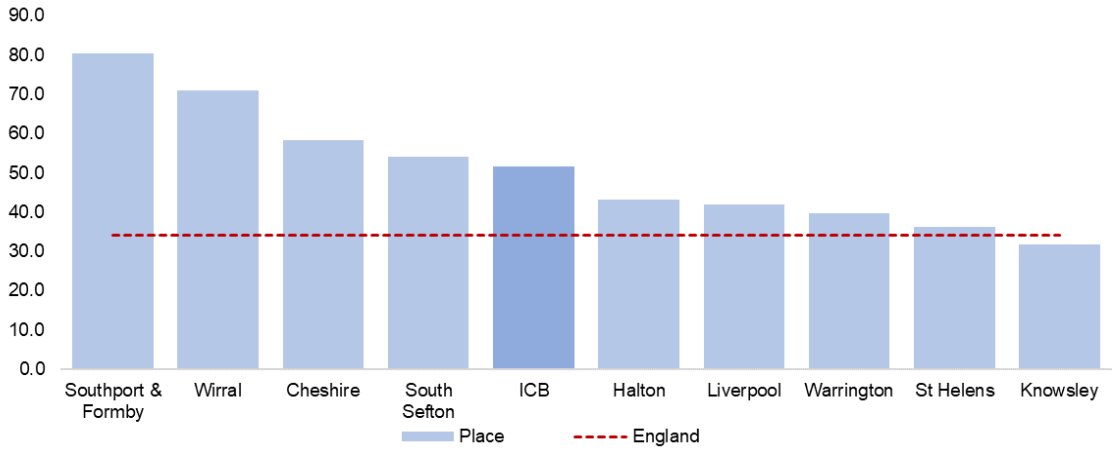
Delivery
- A focused piece of work in Liverpool and Sefton through outsourcing of Fast Track reviews as well as the implementation of the revised structure should ensure that only those individuals who are eligible for Fast Track are in receipt of the funding.

**snapshot at end of quarter*

5. Exception Report – Continuing Healthcare

Cheshire and Merseyside

Number eligible for standard CHC per 50,000 population *			
Latest ICB Performance (Q1-24/25)	51.69	National Ranking	39/42
Place Breakdown (Q1-24/25)			NEW



Issue

- Cheshire and Merseyside ICB currently has a higher conversion rate for the number of people eligible for CHC per 50,000 population than the national position.

Action

- The main outliers for this metric are Southport and Formby, Wirral, Cheshire and Sefton. Sefton, Southport and Formby are recently in-housed teams and some positive action has been seen within other metrics.

Delivery

- Delivery is not expected to be improved significantly within this financial year but the Management of Change and consistent application of processes is intended to support a revised position over the financial year of 25/26. (Figures may be impacted by demographics.)

**snapshot at end of quarter*

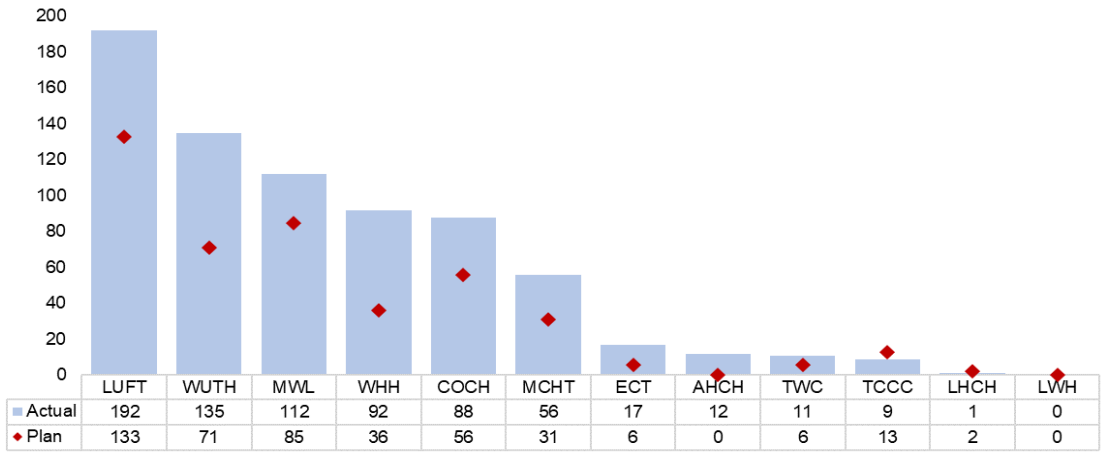
5. Exception Report – Quality

NHS Cheshire and Merseyside

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (12 months to Sep-24)	726	National Ranking	23/42

Provider Breakdown (rolling 12 months to Sep-24)

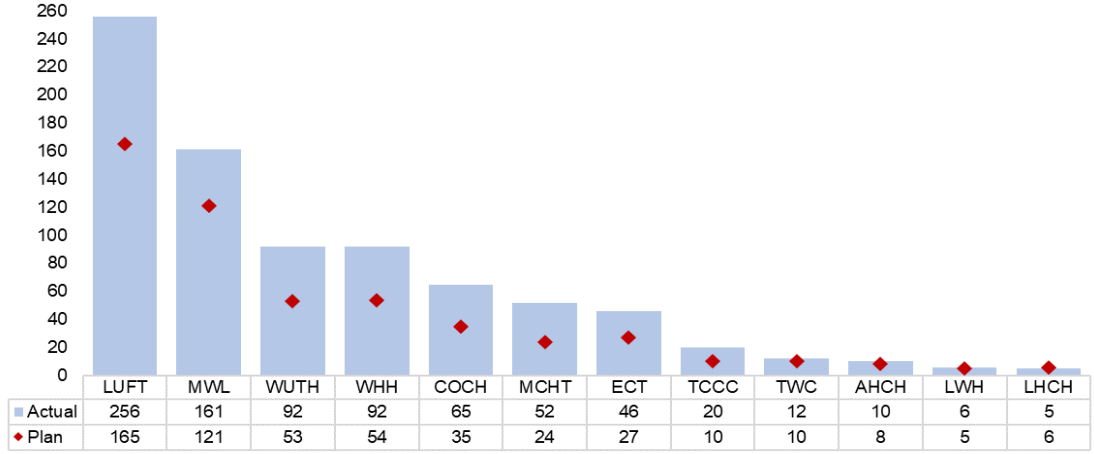


	LUFT	WUTH	MWL	WHH	COCH	MCHT	ECT	AHCH	TWC	TCCC	LHCH	LWH
Actual	192	135	112	92	88	56	17	12	11	9	1	0
Plan	133	71	85	36	56	31	6	0	6	13	2	0

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

Latest ICB Performance (12 months to Sep-24)	817	National Ranking	38/42

Provider Breakdown (rolling 12 months to Sep-24)



	LUFT	MWL	WUTH	WHH	COCH	MCHT	ECT	TCCC	TWC	AHCH	LWH	LHCH
Actual	256	161	92	92	65	52	46	20	12	10	6	5
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 based on improvements required from previous baselines. The provider HCAI rates are also considered in relation to the size and nature of their organisation leading to outlier alerts, currently (Q2 data) there are three low outlier alerts for C. Diff involving East Cheshire, Mid Cheshire and Mersey and West Lancashire Trusts, despite being over tolerance and one high outlier alert for Wirral University Teaching Hospital NHS FT. Within the data for E.Coli during Q2, there are no outlier alerts.

Action

- There is a generic focus on core measures to reduce HCAI across all providers with place-based teams seeking routine assurance against key actions.
- Additional actions are being implemented for all providers with high outlier positions both to understand and tackle risk
- Place-based teams are seeking to understand positive learning from providers with low outlier positions
- 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.

Delivery

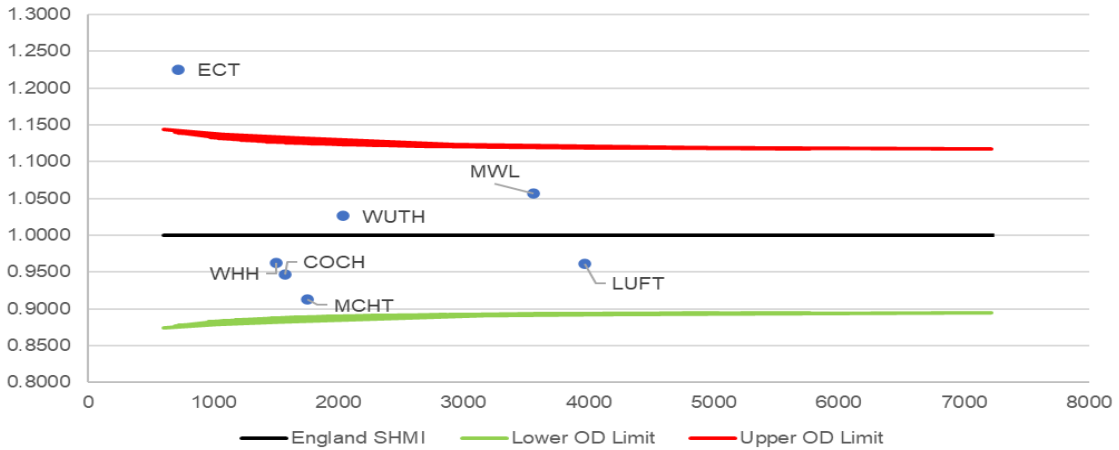
- Performance is monitored monthly via place-based reporting into Quality & Performance Committee and improvement plans assessed for efficacy and impact by place-based teams.

5. Exception Report – Quality

NHS Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (May-24)	0.993	National Ranking	n/a
Provider Breakdown (May-24)*			Improved



Issue

- C&M trusts are within expected tolerances except ECT, with a current value of 1.2030 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.
- Scrutiny continues between the ICB and trust in board-to-board meetings and system oversight reviews ensuring 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 Medical Directors.

Delivery

- A number of CRAB metrics have shown positive improvement, although not yet defined as sustained.
- The improvement culture in the trust is palpably improved.
- Further review in November will support further decision making.

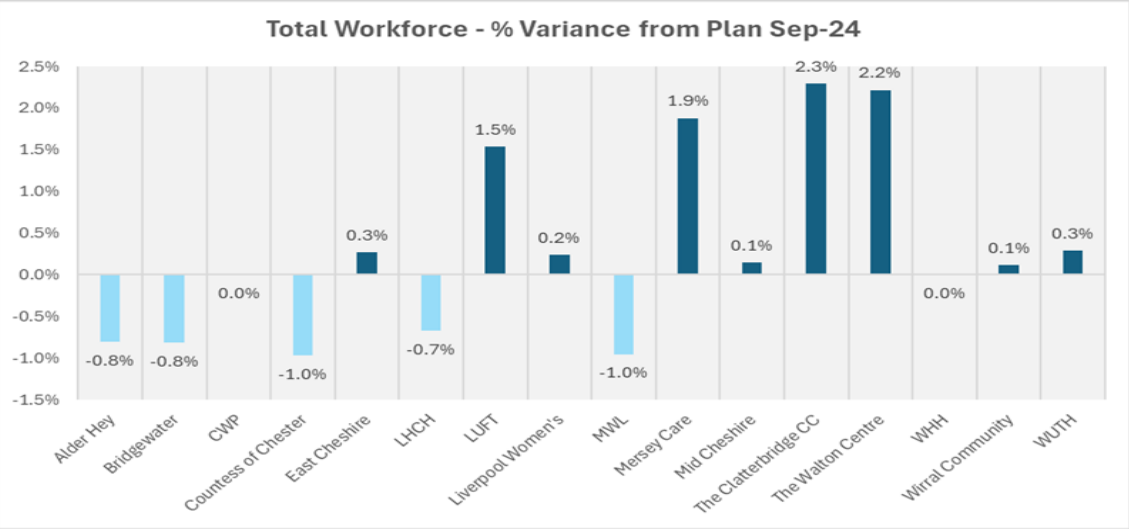
** OD, overdispersion, adds additional variance to the standard upper and lower control limits*

5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

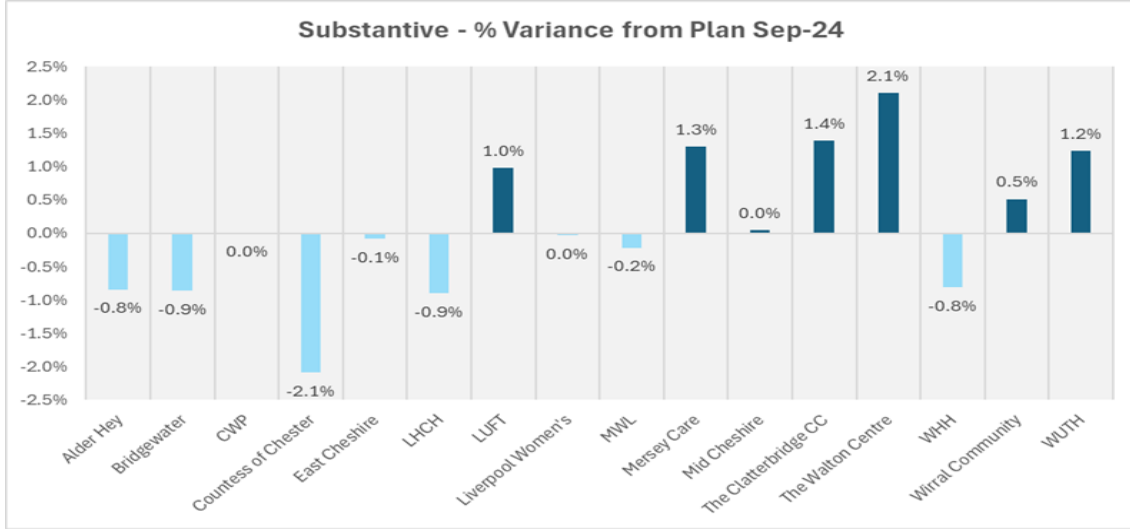
Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PWRs	
C&M ICB Performance (Sep-24)	**0.4%**

Provider Breakdown (Sep-24)



Substantive Variance from Plan % - via PWRs	
C&M ICB Performance (Sep-24)	**0.3%**

Provider Breakdown (Sep-24)



Issue

- In Sept-24, nine of the sixteen C&M Trusts reported their total workforce WTEs were above their plan as at M6, with a variance from plan of +0.4% (286 WTE).
- Seven of sixteen C&M Trusts reported substantive staff in post numbers higher than that forecast in their operational workforce plans (as re-submitted on 4th October 2024). The total system performance was a variance from plan of +0.3%. Of these Trust's a reduction in either bank and/or agency WTEs was observed in M6.
- At system level, substantive staffing increased by 509.6 WTE / 0.7% from the previous month – driven mainly by Community & Mental Health Trust WTE changes.

Action

- All Trusts have in place robust vacancy authorisation processes. Greater scrutiny of workforce and pay costs data at organisational and system level is now taking place – on a weekly basis. A workforce dashboard has been developed and shared with Trusts monthly – for review and feedback; where individual Trust performance can be interrogated in terms of WTE numbers & assumptions for the coming quarter / financial year.

Delivery

- C&M FICC (Financial Incident Command Centre) was stood up on the 8th Oct-24; all Trusts required to submit weekly workforce WTE for their total workforce & cost improvement plans progress.
- Proactive monitoring of workforce data & proposed actions now takes place with Chief People Officers as part of monthly assurance meetings & C&M Trust PDN Network focussed workstream.

Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

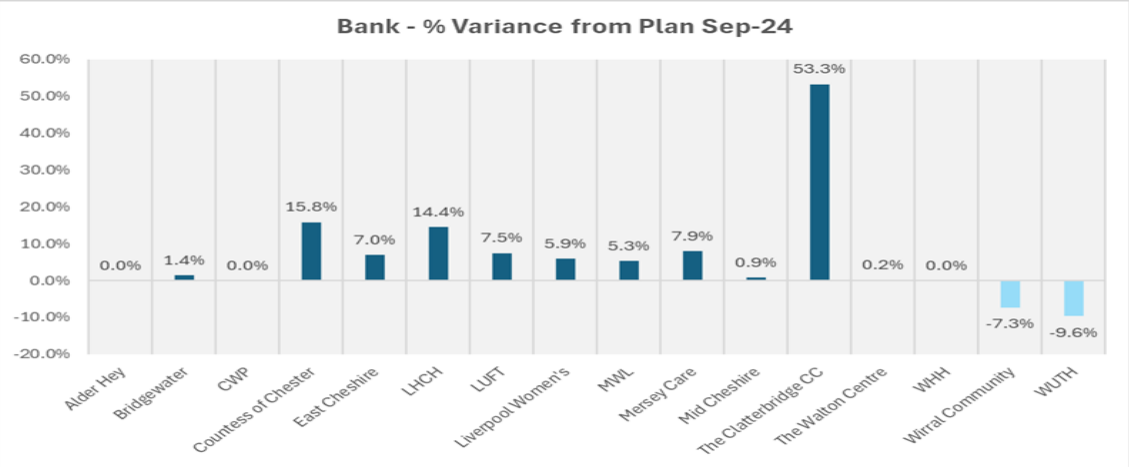
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Bank Variance from Plan % - via PWRs

C&M ICB Performance (Sep-24)	4.5%

Provider Breakdown (Sep-24)



Issue
- Eleven C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for September. The total system performance was a variance from plan of +4.5%
- Comparatively at a system level, the total bank usage decreased by 203.2 WTE / 3.8% from the previous month.

Action
- All Trusts are reviewing their internal workforce resourcing processes & specific organisational actions following the PWC Phase 1 Investigation & Intervention outcomes; reporting & monitoring feeds into FICC.
- Temporary staffing data (WTEs Utilised and Rates Charged) are being reviewed across all Trusts.

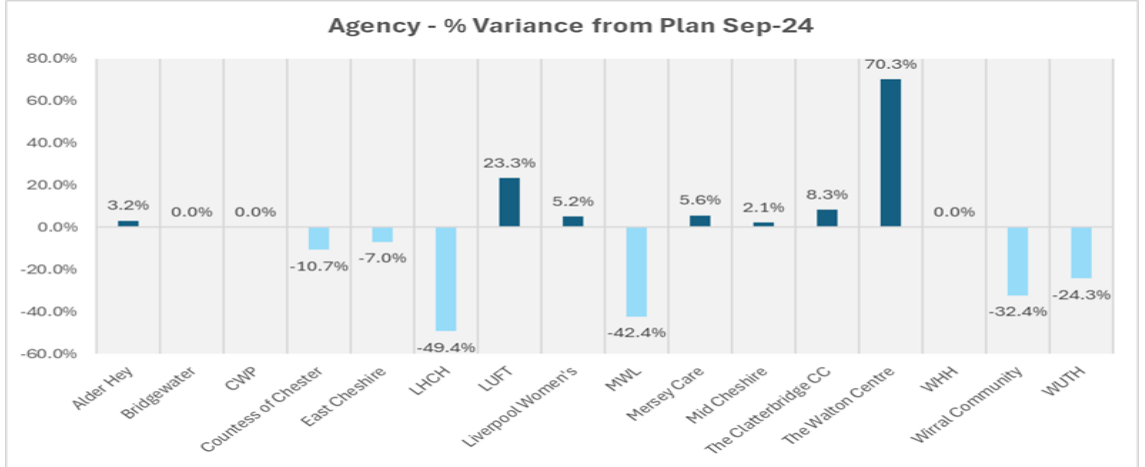
Delivery
- The C&M FICC (Financial Incident Command Centre) was stood up on the 8th October 2024; all Trusts are required to submit weekly workforce WTE agency for their total workforce WTE – with an additional ask around Bank & Agency rates.
- Proactive monitoring of workforce data & proposed actions now takes place with Chief People Officers as part of monthly assurance meetings & C&M Trust PDN Network focussed workstream.

Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

Agency Variance from Plan % - via PWRs

C&M ICB Performance (Sep-24)	-10.2%

Provider Breakdown (Sep-24)



Issue
- Six C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for September. The total system performance was a variance from plan of -10.2%
- At system level, Agency usage decreased by 63.3 WTE / 6.4% from the previous month. Apart from M4 24/25 - there has been a downward trend in Agency WTEs utilised across C&M.

Action
- Temporary staffing data (WTEs Utilised and Rates Charged) are being reviewed across all Trusts.

Delivery
- Proactive monitoring of workforce data now takes place with Chief People Officers as part of monthly assurance meetings.
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework and Agency Spend data (by staff group) is shared monthly.

Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

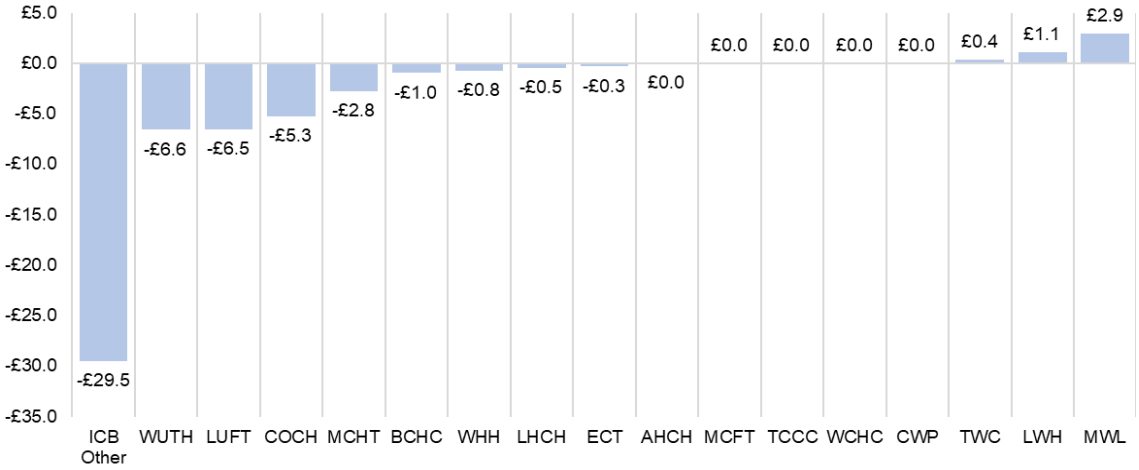
5. Exception Report – Finance

NHS Cheshire and Merseyside

Overall Financial position Variance (£m)

Latest ICB Performance (Sep-24)	-48.8	National Ranking	n/a

Provider Breakdown (Sep-24)



Issue

- The ICS reports a YTD deficit of £108.5m as at Sep-24 which represents a £48.8m adverse variance to plan. Within that, the ICB position is a YTD surplus of £1.6m which is an adverse variance of £29.5m compared to the £31.1m YTD surplus plan.
- ICB pressures are linked to CHC and MH packages of care where the cost of eligible clients exceeds planning assumptions. Pressure on the prescribing budget has also continued
- The adverse variance on provider positions (£19.3m) is driven by industrial action, undelivered CIP and ERF underperformance. In addition, there are costs associated with the Thirlwall Inquiry.
- 6/12ths of the £150m system revenue deficit funding is included in provider positions.

Action

- Investment decisions to be taken to improve position non-recurrently.
- Places must now implement the developed stretch mitigation plans to improve positions.

Delivery

- System reported a forecast in-line with plan to NHSE for M6. However, the level of unmitigated risk reported to NHSE was £63.3m across the system.

Efficiencies Variance (£m)

Latest ICB Performance (Sep-24)	-25.0	National Ranking	n/a

Provider Breakdown (Sep-24)

Issue

- ICS efficiencies - £156.4m achieved as at M6 – a £25m shortfall against the plan and a contributory factor to the YTD adverse variance reported.
- Currently the system is forecasting a shortfall of only £1.7m on the efficiency plan – as part of the overall forecast to deliver the financial plan for 2024/25.
- Recurrent Efficiency plans are forecast to slip by £96.6m primarily due to provider organisations – to be offset largely through non-recurrent measures.
- £55.7m of the ICB's £67.7m efficiency forecast classed as medium or high risk.

Action

- Expenditure controls in place including additional vacancy controls.
- Place focus on delivering additional mitigations where slippage occurs
- 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

28 November 2024

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: ICB/11/24/09

Committee Chair: Tony Foy, Non-Executive Member

Highlight report of the Chair of the Quality & Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date(s) of meeting	10 october 2024 and 14 November 2024

Key escalation and discussion points from the Committee meeting

Alert

Nantwich Health Centre (October)

A Cluster of patient safety incidents from two care home regarding general practice care, themes include: Lack of face-to-face rounds, Changes in pain medication prescribing with poor communication and Opioid medication being on acute prescription only with delays in processing requests for further medication leaving patients without analgesia. An Initial intelligence triangulation meeting held with ICB colleagues from Quality, Primary Care and Medicines Management, along with clinical leads and the PCN clinical director. All incidents discussed and initial action plans developed. A discussion with the PCN Clinical Director and the ICB place team has taken place to ensure that actions are being taken.

Health Care Associated Infection (HCAI) and Anti-Microbial Resistance (AMR) (November)

HCAI

The report indicated that seven of the twelve NHS acute Trusts have already breached their tolerance in at least one recorded HCAI at Month 6 2024/25. Furthermore, at current rates, all bar one trust is on trajectory to breach some or all of their tolerances. Finally, the current trajectory for the ICB would see a breach to all tolerances by the end of the year.

The HCAI rates are also compared to peers across the Northwest & England to benchmark where Trusts and/or Places are noted as outliers. Negative outliers for C. Difficile were highlighted as Wirral University Teaching Hospital and Wirral place-based system, with Liverpool University Hospital Trust identified as a negative outlier for rates of Gram-Negative Blood Stream Infection.

The committee was assured by the work being led by the ICB with support from NHS England to undertake a review of improvement work within Liverpool and Wirral place and to make recommendations for areas requiring further improvement. The committee also received assurance as to place based oversight and assurance mechanisms and requested future assurance is provided via place-based reporting.

AMR

The committee received information that AMR assurance within the NHS has previously been delivered by the NHS System Oversight Framework (SOF) which previously included an ICB level metric relating to safe, high-quality care for AMR in relation to antibiotic prescribing in primary care. Within the metric there were two measures. One measure relates to the overall volume of prescribing of antibiotics (items/STAR PU) by primary care and the second relates to the percentage of broad-

spectrum antibiotics prescribed by primary care. In the absence of newly set NHS NOF metrics for 2024/2025 the ICB will continue to assess performance of appropriate antibiotic prescribing against the legacy primary care metrics of items/STAR PU and the percentage of broad-spectrum antibiotics.

Using July 2024 data, NHS C&M is currently not meeting the legacy target set for the overall volume of prescribing of antibiotics in primary care however there is continued good performance at an NHS C&M level for the percentage of broad spectrum anti-microbial prescribing by primary care. Whilst not meeting the historic trajectories, the data presented did confirm a trend in performance at NHS C&M level of both measures which show a reducing proportion of broad spectrum antibiotics being prescribed and a steady value of antibiotic per STAR-PU at NHS C&M level. .

Hydration
The National Hydration project, a training program for care home staff which began February 2024, has resulted in a 40% reduction in Sefton place and nearly 20% reduction in Wirral for hospital admissions for Urinary Tract Infections (UTI).
The success of reducing hospital admissions for UTIs in older adults highlights the importance of preventative healthcare and early intervention strategies. By shifting the focus towards managing health conditions within the community and care settings, health systems can better prevent the escalation of conditions that require hospitalisation.

Advise

Maternity – Improving Data Capabilities (October)

The committee received and reviewed the latest data report which now includes some SP charts to highlight variation and where available, shows which providers are failing to meet a target. It also provides a benchmark across the three North West LMNS. The metrics within the report are from the NW Regional Maternity dashboard. The metrics are mainly MSDS (Maternity Services Data Set) and also Mental Health dataset and MBRRACE (mothers and babies Reducing Risk through Audit and Confidential Enquiries). The BI team is currently supporting the Women's Health & Maternity programme – part of that work is to enable local use of MSDS to enhance our reporting. 25 metrics for each of the 7 Providers are now subject to regular scrutiny and analysis by LMNS Board with escalations/positive progress reports made to the Committee as necessary.

The findings from the reporting pack show that although there is variation across providers and potential for improvement, for the metrics available, no provider is failing to meet the target.

Host Commissioning (November)

The committee received an update in relation to ICB responsibilities in ensuring those with Learning Disability and/or Autism, who are placed within residential settings are receiving high quality care. The committee were given assurance that work continues to ensure that the ICB has an established mechanism for sharing intelligence between commissioners who are placing people with a learning disability or autism and also gain feedback from patients and families. Through a range of governance mechanisms the ICB conduct regular visits to providers and respond to any escalation of quality and safety concerns. Further work is needed to ensure that the ICB better

understands the numbers and needs of those individuals placed from out of area, so that services can best respond to need.

Cancer care (November)

C&M is not yet achieving the 96% 31-day combined standard required however, the figure
of 94.8% is 3rd amongst Cancer Alliances and 8th amongst ICBs.

The position compares to an England average of 91.9%. Areas of underperformance are in first and subsequent surgery, predominantly for skin. Capacity and demand exercises for 25/26 are necessary to address this and short-term investment is already being made by the Cancer Alliance in key areas. 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 together with targeted improvement plans.

Assure

Pharmacy (October)

Polypharmacy Strategy draft was approved. It sets out the ICBs commitment to addressing this challenging issue and a specific commitment to reduce overprescribing and inappropriate polypharmacy as a priority by involving the whole system, using data to inform improvements, working with patients and clinicians to ensure a holistic approach to multi-morbidity and medicine burden.

The committee agreed that the risk of not approving the strategy and subsequent actions would mean over prescribing/problematic polypharmacy would continue to occur affecting both patient safety and inappropriate spend on unnecessary and /or unwanted medicines.

The strategy is structed across 3 domains – Patients (decision-making and awareness; Data and Technology; Skills, Education and Training with the focus also on reducing health inequalities.

Recent data shows that the ICB has considerable room for improvement. The ICS is ranked negatively (between the highest and third highest nationally) for

- the average number of unique medicines.
- % of patients prescribed 10 or more unique medicines
- % patients prescribed 15-20 or more unique medicines (worst performance nationally)
- injuries to due to falls (aged 65) – bed days per 100,000 population

The committee has requested a strategy update and action plan with trajectories/timelines to a future meeting.

Urgent Care – Temporary Escalation Spaces (TES) (October)

NHS England issued guidance on the 18th of September 2024 entitled ‘Principles for providing safe and good quality care in temporary escalation spaces.’ (TES). The guidance outlines a set of principles that support point-of-care staff to provide the safest, most effective and highest quality care possible when TES care has been deemed necessary. The guidance replicates and reinforces the work undertaken by

the ICB via its System Quality Group, in developing the 'Quality Red Lines Toolkit' which has been previously reported to the Board.

Given the ICB has already embedded this approach into contractual oversight arrangements with those providers utilising TES, assurance on outcomes will be provided by Associate Directors of Quality & Safety Improvement reporting to Quality Committee.

Safety (October)
Pilot work is now complete across Halton Place & Warrington Place to implement the Learning from Patient Safety Events (LFPSE) system as a replacement to previous incident reporting systems available within Primary Care.

An LFPSE rollout report is being produced which will help to inform the next steps for the project that the Central Patient Safety team are overseeing and will be carried out by C&M Places. Once LFPSE is implemented in Primary Care there will be a more efficient process for reporting interface incidents that involve more than one Provider, which will improve sharing and learning.

Work is underway to develop a robust project plan to implement a proportionate approach to the implementation of PSIRF with Independent Providers. The Central Patient Safety Team is working with the Central Contracts team to assess and allocate a level for each Provider as this will ascertain the approach needed and what they are required to produce for PSIRF.

The Committee recommended that consideration be given to including Patient Safety in mandatory training and this to be communicated via People's Committee.

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**
QU08 Standards of Care QU11 AACC Performance	Report from Cheshire East re GP Primary Care – actions agreed Service challenges (Liverpool)

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P3 Elective Care (Cancer care standards)	Received assurance on meeting targets

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	Reviewed NHSE TES letter/ Red Lines Toolkit
Maternity Service Quality and Safety	LMNS report – data improvements

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Report of the ICB Directors of Place

Agenda Item No: ICB/11/24/10

Responsible Director: Laura Marsh, Cheshire West Place Director
Simon Banks, Wirral Place Director

Report of the ICB Directors of Place

1. Purpose of the Report

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

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

1.3 This paper is a regular update to the Board with regards to Place work, providing assurance to the Board on how teams are working towards the delivery of the 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 November. Our agenda included – as always – celebrating the work of one of our excellent care communities. This time it was Nantwich and Rural.

We have a developed performance dashboard with key metrics for urgent and emergency care. We are starting to use this information, and also to develop stronger accountability for performance.

Key items on the agenda included using population health data to identify specific patient cohorts e.g. frailty and identify local health interventions and sharing specific proposals for Cheshire health and care transformation.

4.2 **Cheshire West**

Following a Place Committee Development Session at the end of the summer, work has taken place to update the local Joint Transformation Priorities, with a new priority of Cardio-Metabolic Prevention identified. With the identification of this new Programme of work, the Place Work has been re-scoped and defined as follows:

- Mental Health
- Complex Care Models and Accommodation for people with Mental Health and Learning Disabilities
- Cardio-Metabolic Prevention - delivered via Community Partnerships and Integrated Communities.

For the new priority area, a Steering Group meeting of key Place partners has taken place, identifying ideas for a programme of work within the short, medium and long-term, and relevant next steps to develop a structured and impactful programme.

As described above, the delivery model of Community Partnerships and Community Response Hubs continue to be developed. The Third Sector are currently rolling-out a Social Value tool to identify and demonstrate the cost benefits of their input, whilst Integrated Communities are being rolled-out across the entirety of the winter period.

Finally, Place Leaders have undertaken work to identify and understand their ability to influence each other and act as one team for the need to make joint decisions. These joint leadership sessions will continue to develop this way of working for the benefit of the Cheshire West population.

4.3 **Halton**

One Halton Partnership Board's last meeting in September received an update on One Halton Community Health and Wellbeing Grants Programme and noted twenty-three grants had been awarded to nineteen local community

organisations. Representatives from "Bowl for Health" attended the Board and gave a presentation which highlighted how the small grant they had received supported a wellbeing project under the Ageing Well workstream. Local authority partners also updated on Family Hubs and the development of the Perinatal Mental Health Strategy.

Further updates were provided on Warrington and Halton's UEC Improvement programme. The Board discussed its objectives, the current position and progress, and current challenges. A progress report was also provided on the Warrington and Halton Integration Project and the opportunities being pursued to improve patient pathways through integration.

4.4 **Knowsley**

Knowsley Healthier Together Board met in early November with a focus on female life expectancy. Public health gave an overview of the decreasing life expectancy of the women within Knowsley, each partner provided an overview of the work they are undertaking to help address the challenges detailed.
The Board recorded a thanks to Mike Harden who has chaired the board since its inception. The Board is now in recess for December and January to support focus on winter pressures, therefore the next meeting is scheduled for February.

4.5 **Liverpool**

The One Liverpool Partnership Board last met on 9th October 2024. The meeting included an agenda item / presentation by Merseyside Police on the 'Right Care Right Person' (RCRP) project, which highlighted the extensive partnership working undertaken to ensure that residents of Liverpool are in touch with the right agency at the earliest opportunity. Partners around the table commended the joint working that had informed and influenced the design of RCRP approach in Merseyside. Partners including NWAS, Local Authorities (including 3rd sector links), Mental Health Trusts, Acute Hospitals, Primary Care, Housing Associations, Care Providers, DWP, schools and regional police forces have all received regular communications regarding the RCRP approach. Further discussions are taking place at a strategic level to fully evaluate the impact. Work is also continuing on the refresh of the 'City Plan' which will help define the objectives and priorities for the Partnership Board in 2025/26.

4.6 **St Helens**

ICB Operating Model - To feed into the current review of the ICB's Operating Model, Cheshire and Merseyside local authorities commissioned PPL and Inner Circle to co-ordinate input across the 9 council areas, including NHS partners.
St Helens Cares - On 9th October 2024, a Tackling Stigma in Helens workshop was held with 65 participants attended the event. This was jointly hosted by the St Helens Inequalities Commission and Institute for Voluntary Action Research (IVAR).

4.7 **Sefton**

Specific areas of focus this period include:

Continued work on the maturity of the Transfer of Care Hub for Southport as part of Sefton Council's Adult Social Care and Sefton Place transformation programme called ***Better at Home***.

We have seen a further reduction in use of care home beds aligned to the programme's objectives and an increase in people returning home following their hospital treatment. There is more use of domiciliary care and the commissioning approach led by the Council in relation to market management has led to greater availability of domiciliary care. There will be continued focus in the next period on hospital avoidance and frailty.

The Home First "offer" for people leaving hospital in particular use of reablement continues.

We are continuing to jointly commission a bed-based service to support recovery with the Council's over winter and discussions with the Trust have taken place to ensure better use of resources.

We have taken a steer from Sefton's Health and Wellbeing Board regarding expansion of the respiratory service in Sefton and will be producing a joint strategy with Public Health to help reduce respiratory admissions for children and adults in Sefton.

Access to good housing is a factor in improving health outcomes. A joint strategy has been approved by the Council's Cabinet which describes the approach in Sefton to Supported Housing with Care for people with a learning disability and or autism. This has been well received by Cabinet. An integrated approach led by strategic housing and the Place commissioning team will ensure support and housing are joined up and accessible meeting the demand in Sefton.

The Care Quality Commission will be undertaking their assurance visit in Sefton in the coming weeks and have already approached providers regarding feedback on partnership approaches between system partners as well as starting to visit individuals who have received services. Preparation is underway by the leadership team in Sefton across Adult Social Care and ICB Place teams to ensure that our good practice and partnership approaches are central to feedback to CQC when they arrive.

4.8 **Warrington**

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

The endorsement of a proposed Intermediate Care Facility which will replace existing outdated provision and will house 64 beds in one location to provide an intermediate facility to support the discharge and flow of patients from hospital on their Home First journey. The proposal is scheduled to be discussed at Warrington Borough Councils Cabinet meeting in December.

The Board has also approved the use of the Health Inequalities funding (see the Health Inequalities section for more detail).

The Board recently undertook a stocktake and a number of proposals were supported – a review of the Boards priorities in light of the Darzi report, a continued emphasis on integrating services (which the integration of Warrington

and Halton Hospital (WHH) and Bridgewater (BW) will support) and pooling budgets under a Section 75 agreement. To have a closer focus on data to ensure that the work being undertaken is having the desired impact on the metrics and to potentially widen the membership to address some of the work on Poverty e.g. Housing representatives.

The Board has also received updates on the following topics:

- Flu plans
- WHH and BW integration programme
- Quality deep dive into the learning from Palliative Care incidents
- Health Protection Board report
- Children and Young People and Warrington's 'Starting Well' programme and its delivery plan.

It is also worth noting that partners have been notified of two meetings related to SEND and progress against last inspection report, the first with DFE in November and the second with OFSTED in December.

4.9 **Wirral**

Meeting of 17/10/24 included updates on:

- Place Finance Report incorporating Pooled Fund Update
- Quality and Performance Report
- Wirral Health and Care Plan Programme & Workforce Programme
- Delivery Dashboard
- Unscheduled Care Improvement Programme
- Supporting Group Chairs' Reports

BCF 24/25: Approval for updated 24-25 Wirral plan and permission to spend NHS minimum contribution received.

Monthly Wirral Review group established to support national quarterly submissions.

5. Place Risks and actions to address

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

Table One

Rank	Risk	Key Actions
1	**Performance:** Urgent care flow / no criteria to reside	Current controls include daily collaborative discharge monitoring and escalation, system winter plans and additional capacity, and admissions avoidance services. Further action and initiatives are being developed and progressed through the urgent care recovery programme.
2	**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.
3	**Quality:** Neurodevelopmental assessment delays	Current controls include the assessment framework, performance monitoring of commissioned providers, clinical networks, SEND improvement plans, and quality and performance reporting. Key further action underway to develop joint and strategic approach to commissioning for Autism and ADHD.
4	**Quality:** Reduced standards of care	Current controls include key policies and standards, incident reporting and harm review process, standard contracts, System Quality Group and quality dashboard reporting. Key further actions planned include development of UEC patient safety principles, development of primary care quality forum and strengthening of host commissioner arrangements.
5	**Transformation:** Limited access to specialised weight management services	Current controls include interim measures to delay withdrawal of services in Liverpool, St Helens and Halton. Key further actions include the development and adoption of a minimum service specification, options appraisal and pursuit of funding opportunities.

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

5.3 In addition, there is a significant risk in Halton and Wirral that the health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services, currently rated as extreme (16).

5.4 A further potential risk in common has been identified in relation to place partnership financial resources, and the ability of partners across the system in a number of places to contain spend within the available collective partnership resource envelope. There is the potential that the action required to address the forecast overspend affects services and prevents delivery of strategic objectives impacting the health of the population. This is currently being assessed in each place, but indications are that this will meet the criteria for escalation to the Corporate Risk Register.

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.	16	12↓	12↓	12↑	12	10	12	8↓	8	16
PC8	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.	15	15	12	9	12	TBC	16	12	12	15
QU04	Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm	15	15	12	8	3	16	6	9	9	8
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	16↓	16	12	12	8	16	16↑	16	16	16↓
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	16↓	9↑	6↓	12	12↓	16	16↓	6	9	16
T2	Limited Access to Specialist Weight Management Services across Cheshire and Merseyside and non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drug / Specific Place Risks in relation to potential loss of existing services	16			9		20		16		
PF1	Common place risk in relation to urgent care flow / 'no criteria to reside'	20	12	20		9			16	12	20

6. Action on Health Inequalities at Place

6.1 **Cheshire East**

Planning is underway on the allocation of health inequalities funding approved at the September Board.

6.2 **Cheshire West**

The Cheshire and Merseyside Health Inequalities fund has now been approved and is being utilised to support Mental Health and crisis interventions for Children, Young People and their families. In addition, a new programme of work has been stepped-up to work across Place Partners to carry out joint interventions to improve Primary, Secondary and Tertiary prevention of Cardio-Metabolic diseases. This work is found upon the basis of a focus on those who are suffering health inequalities, as set out within the Place Partnership Development session above.

6.3 **Halton**

Work on developing the Halton Poverty Truth Commission (PTC) continues, with a wide range of One Halton partners actively involved. The project is currently supported by the Lloyds Bank Foundation. Representatives from Halton recently met with the Poverty Truth Network (PTN), an umbrella organisation that supports new PTCs, to gain advice on initiating, promoting, and sustaining a PTC. Halton will now apply to the PTN for a £5,000 grant to help launch the project. Additionally, Halton Partners have submitted an Expression of Interest (EOI) to Legal & General's Health Inequality Fund for £75,000. If successful, this will fund a PTC Coordinator within the VCFSE Sector for two years.

Halton's Core20PLUS5 Connector Project was recently awarded 'exemplar' status by NHSE, a fantastic achievement as only five sites nationwide received this status. Exemplar sites can draw down an additional £20,000 in funding for their VCFSE partner. Halton's project was commended for its innovative use of partnerships, including collaborations with the Health Creation Alliance, the National Institute of Health Research, and various community organisations.

Halton's Connectors are currently engaged in several projects, including supporting the development of the PTC, creating a 'Connector Garden', and developing a Community Wellness Project in Halton Lea.

A member of the Transformation and Partnerships Team has recently been accepted onto the NHSE Core20 Ambassador Programme. Ambassadors are supported to enhance their knowledge, skills, and insights to tackle healthcare inequalities and form local, regional, and national networks with others who seek to improve healthcare inequalities. This is a great opportunity to support the existing Core20 Connector Programme.

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. 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.

Northwood – Health Inequalities Programme

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**

Liverpool has continued to develop its 'Proactive Care' model which acts as a 'sustainability programme' centred around (rather than at the expense of) inequalities. As a community care model that uses a team of health and social care professionals to work with a patient's GP, the overall aim of proactive care is to improve health outcomes and patient experience by delaying the onset of health deterioration; helping patients maintain independent living and thereby reducing the need for unplanned care and reducing unnecessary hospital visits. The model places a strong emphasis on prevention and using data to identify specific groups of patients.

In October 2024 Liverpool's Proactive Care model focused on areas including Telehealth, Integrated Care Teams (ICTs), diabetes, respiratory, frailty, complex households and social prescribers (North Liverpool PCN is developing criteria to target people for a social prescribing offer using sources such as the Fuel Poverty Dashboard or Enhanced Case Finding Tool (ECFT).

As part of this programme, a large piece of work has commenced to replicate the Civic Health Innovation Labs (CHIL) methodology with Graphnet to create Complex Household (CHH) dashboards. In partnership with Liverpool City Council, the CHH Dashboard is now being tested at scale in Liverpool for vulnerable families who would benefit from an offer of early help. To support education and awareness amongst stakeholders and patients five city-wide drop-in sessions are also planned in the coming months.

6.6 **St Helens**

The inequalities Commission set its work priorities some time ago and review them regularly:

- Best start in life, including school readiness
- Improving the quality of jobs and employment
- Tackling poverty and low pay
- Supporting people in distress and tackling isolation
- Tackling stigma and overcoming barriers
- Tackling inequalities between and within wards and localities
- Services being focused on self-esteem and independence
- Inclusive growth and the St Helens 'Pound'

Work on best start has progressed through Family Hubs and we are doing work raising youth expectations. We have done a lot on tackling poverty through our work on establishing food pantries and a food alliance and increased support to the voluntary sector for purchasing food and essentials as well as work on tackling fuel poverty.

The main focus of the St Helens Inequalities Commission over the last few months has been our work with Institute of Voluntary Action Research (IVAR) on tackling loneliness and isolation and linked to this is a focus on tackling stigma.

We held a multiagency workshop with representation from local residents on the 9th October on stigma. At the workshop we showed a film which local people in recovery produced calls Sticks and Stones film and we discussed a Stigma Charter. We had a presentation from Dr Andy Knox.

The key themes from the workshop were:

- humility,
- leading by example,
- being curious,
- promote positive St Helens stories
- seek to understand, not be understood
- The importance of language and communication
- Power of stories from those with lived experience

6.7 **Sefton**

No significant update to provide

6.8 **Warrington**

Warrington Together Partnership Board has agreed that the Health Inequalities funding assigned to Warrington will be used in the following areas for the next 12 months:

- Oral Health
- Child Poverty
- School Readiness

In anticipation of recurrent funding resources aligned to reducing health inequalities from 2025/2026 and to give every child the best start in life, Warrington Place partners will work together through the Starting Well Board to agree the focus of the recurrent funding from Oct 2025 onwards based on need, impact and community insight.

6.9 **Wirral**

Neighbourhoods

Due to the current NHS funding position, Wirral Place have withdrawn unallocated 24/25 funding. Community Chairs have stepped down in the two pilot neighbourhoods – Birkenhead A and Wallasey Thrive 36, however projects continue to be delivered in Wallasey. A meeting is being convened with Wirral Place, Public Health and the CVS to discuss next steps

Cancer

Targeted Lung Health Checks have been complete for 2 of the 10 Wirral Blocks. Significant community engagement was undertaken to support this work including primary care, community groups and Elected Members. In addition, significant numbers of patients were referred to smoking cessation, spirometry and the CVD service – data is currently unavailable. Targeted Lung Health Checks are complete for 9 GP practices in the Birkenhead area. As an outcome patients are attending Low Dose CT scans, spirometry, smoking cessation and a number of referrals have been made to primary and secondary care.

CVD

Promotion of the national Know Your Numbers week in September locally – focused on CVD self-care/ home blood pressure readings. Florence digital app scheme roll out continues, with most GP practices now signed up – two-way messaging with primary care and patients supported by AI. Plan agreed for community focused CVD prevention events with the Voluntary, Charitable Foundation Social Enterprise (VCFSE) sector. Engagement events/ workshops commence in Q3.

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**

Halton continues to work in partnership with the two UEC improvement programmes within Warrington and Mersey and West Lancs focussing primarily on the admission avoidance and discharge workstreams.

Increasing the utilisation of the alternatives to the emergency department has seen increased referrals to the urgent community response services and higher utilisation of frailty virtual ward beds. Targeted promotion of the service with care homes has reduce the number of ambulance calls and conveyances to hospital.

The two UTCs, although have some staffing pressures over the last few months, have maintained good through put with over 3,000 attendances each per month with over 95% seen within 4 hours.

Discharge demand remains high for the community pathways from both main acute hospitals. Additional reablement capacity as been commissioned to support the discharge to assess pilot with Warrington Hospital which has seen improvement in the discharge lead time.

Halton Urgent Care lead continues to support the SCC operational programme while the team is being established and will continue to offer support as required.

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 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.

Local Urgent Community Response (UCR) teams continue to work with NWAS to increase appropriate referrals to the team to prevent hospital attendances and admissions, the navigator pilot has been completed and the admissions avoidance group is exploring alternative routes for NWAS to refer patients in the most efficient manner.

Additional discharge capacity has been created 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 for Knowsley NCTR rate is 11-12%.

UCR links to support Care Homes and referrals from Out of Hours (OOH) have been reenforced. Care Homes can refer directly into the UCR service. We have also audited attendances and admissions into Whiston hospital from Knowsley Care Homes which has shown that a referral to UCR may have prevented admission for a significant proportion of these patients, so we are working with the care homes to increase utilisation of the service.

There is a pilot running within North Mersey where a member of UCR staff is present in Primary Care 24 (GP out of hours provider) to accept patients over the weekend period, this has continued and is showing an increase of referrals for North Mersey.

7.4 **Liverpool**

The North Mersey Urgent & Emergency Care (UEC) Recovery Programme continues to make positive progress in relation to flow and discharge indicators including Length of Stay (LoS), Non-Criteria to Reside / pathways and discharges.

Length of Stay – length of Stay (LoS) and NMC2R: 14+ and 21+ day LoS metrics are reducing, showing 'special cause variation' as the last 15 weeks have been below the mean. Efforts are focused on sustaining this reduction, particularly on those patients with the longest stays to ensure prompt discharge. 60+ day LOS remains around the mean, indicating normal variation, whilst there has been a reduction in bed days occupied by 'Not Met Criteria to Reside (NMC2R) patients for the last 8 weeks. Special cause variation noted in the week of 19/08/24 with a low point of 330 patients. Strategies are in place to further reduce these numbers.

Acute Discharge – the top 60 longest Length of Stay (LLoS) cohort continues to be managed with real success. Agreement has been reached on the proposed changes to the 'Brokerage Function'. Transfer of Care hub (TOCH) 'task and finish' group is now in place with a deadline of 17th December 2024 agreed for completion of the 4-stage plan. Metrics and reporting continue to be refined with the support of all partners, whilst governance arrangements are aligned with C&M expectations (including VERTO reporting).

Admission Avoidance – further work has progressed on Virtual Ward provision under the new 'Prime Provider' model, with partners continuing to work alongside the Provider collaborative and others to increase utilisation and scope to expand into other specialties (i.e. gastro and renal). Falls / Frailty also progressing well with access to Geriatric Rapid Access Clinical Evaluation (GRACE) clinics, whilst Liverpool Place is overseeing the recommissioning of the Falls Lifting Service.

7.5 **St Helens**

Progress continues to be made with the Urgent Care Recovery Programme, but the prospect of a difficult winter looms large. NHSE and DHSC Discharge Support and Oversight Group (DSOG) require a review meeting chaired by Lesley Watts, National Lead for Discharge and Flow and Chief Executive of Chelsea and Westminster Hospital NHS Foundation Trust. This meeting will take place on 28 November 2024 with a focus on:

- Improvements in out-of-area discharges across the system
- To address admissions avoidance across the system, including targeting frequent care home attendees and working together across health and social care.
- To address admissions avoidance across the system, including targeting frequent care home attendees and working together across health and social care.
- To improve P1 flow by reviewing and driving improvements in hospital processes to make use of available capacity and reduce LOS.

There is also a Winter Summit to be held on 9th December 2024.

St Helens have been working with system partners on mental health flow meetings. Initial focus has been on ensuring that the right people are in attendance at the MADE meetings, with the right social care and housing and complex care leads linked in. We are aiming to run MADE meetings consistently across Cheshire and Merseyside and leads are working to progress this. However, long term sickness has slowed down the development of our local MADE meetings, as the intention is that the ICB lead commissioner will chair these across C&M, but we have a current sickness gap in this area.

7.6 **Sefton**

No significant update to provide.

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 continuing to make progress. Most notably:

- Average time spent on the corridor per stay continues to run lower than the previous year.
- Consistent reduction in attendances to ED resulting in a shift to the least challenged quartile nationally
- Achieving trajectory set for NCTR over last few weeks
- Increased utilisation of the Frailty Assessment Unit and Same Day Emergency Care Unit
- Increased utilisation of the Urgent Community Response Service in the community
- Winter escalation capacity opened as planned in November compared to September in the previous year
- Warrington population delay days post No Criteria to Reside running below the England average
- Achieving a left shift reduction in complex discharges addressing the Newton Diagnostic challenge of reducing over prescribing of care
- Sustained reduction in length of stay for patients discharged to Intermediate Care beds in Warrington supporting increased throughput
- 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**

Within the Mental Health programme, a Rapid Improvement Event is taking place for Wirral due to being an outlier for admission to inpatient beds for those without an open referral or previously being known to services. The focus of the work is to identify opportunities for earlier access to services and support.
Waiting time for appointments and diagnosis have reduced from approximately 23 weeks to 13 weeks. This reduction has been due to an increase in capacity in those processing referrals and completing initial assessments. Work will continue to reduce waiting times with a target of 4 weeks from referral to diagnosis

NCTR continues to remain stable at around 120-130 patients per day = ~13 % of bed base.

Wirral UEC Programme Hospital Discharge Group now established – Focus areas include P3 Audit, Morbidly Obese Care Home Bed Business Case and other complex care pathways such as Delerium/ Homelessness.

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.

There are few apparent significant implications from the taking of collective action to date. We have seen:

- GPs stepping back from the kind of leadership roles that they have historically occupied, and
- Some withdrawal of cooperation with shared prescribing initiatives.

More positively, local GPs are continuing their work to develop a GP Federation (a provider collaborative for GP primary care) with work on proposed governance due to be completed in the next month or so.

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. Part of this proposal has now been approved and the Primary Care Team are working collaboratively with PCNs to step-up Acute Hubs over the winter period.

8.3 **Halton**

Research in Primary Care: A Halton Place application is in development for 2024 / 25 Research Capability Funding (RCF.) RCF is awarded to trusts and ICBs on an annual basis to help research-active NHS organisations to attract, develop and retain the research workforce necessary to deliver high quality health research. Each place within Cheshire and Merseyside is eligible to apply for a fixed amount of £2,416.00.

Halton's Primary Care Lead has drafted the application, working collaboratively with the lead research active GP, and Runcorn & Widnes PCNs. The application outlines our plan to:

- Increase the number of practices undertaking clinical research activities.
- Increase the number of participants engaged in clinical research activities from our local population.
- Increase the number of clinical research studies undertaken.

This will be supported by developing a PCN based Clinical Research Model in each PCN, which integrates with the Halton Clinical Research Alliance and

secondary care, and which supports Practices to identify and commence appropriate research studies, via an at scale approach to research and research governance.

Integrated Neighbourhood Model - Same Day Primary Care: Cross-organisational booking has commenced via the Widnes Urgent Treatment Centre (UTC) and Practices. This ensures patients who require acute on the day care can access booked appointments in the UTC, and patients who present at the UTC with complex health needs, can be triaged back into their Practice for appropriate follow up. Work is underway to develop a pathway between the UTCs and Pharmacy First, to further embed the Pharmacy First service into our Halton Place care navigation programme and improve patient access to services.

New PCN Clinical Director: Dr Zoe Rog commenced in post as the PCN Clinical Director for Runcorn PCN on 1st October 2024.

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 engaged Mersey Internal Audit Agency (MIAA) to undertake a review of PCN systems, processes and governance arrangements to support further development with final reports, providing a range of recommended priorities for action, being shared with PCNs and local ICB team in November.

In line with PCN Network agreement timescales Central and South Knowsley PCN worked with Local Medical Committee in undertaking a process to identify applicants for and elect an Accountable Clinical Director (CD) following the completion of current CD's term. Dr Paul Conway and Dr Dawn Health were successful in their bid to take on this role on a shared basis and arrangements are in train to ensure transfer of responsibilities by 1st December 2024.

PCNs are also progressing in their engagement with wider system partners and stakeholders following dedicated protected time event with MCFT was held in July to identify opportunities for improved collaboration and development of integrated delivery in both physical and mental health. PCNs are fully engaged in development of Women's Health initiatives for Knowsley.

Following confirmation of Primary Care Service Development funding arrangements 2024/25 actions have been taken to utilise funding for PCN development and, in collaboration with MCFT, to rapidly develop a medical leadership model strengthening local Urgent Response Team capacity ahead of the winter period.

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. 69.9% 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 has 9 PCNS which continue to collaborate and engage with the wider system with the aim of strengthening ways of working with system partners and stakeholders to provide more anticipatory care - particularly for people with long-term conditions and complex lives. PCNs are also now contributing data regularly to the ICB's 'Enhanced Access' appointments monitoring dashboard. Data analysed over the last three quarters has highlighted that a number of PCNs are providing more capacity over their contractual requirement.

8.6 **St Helens**

The North PCN have been piloting an urgent care hub over the last 6 months. Each practice within the PCN are part of the hub and can refer urgent, on the day appointments to the hub. This has not only created extra capacity for urgent care, but it has meant that practice time has been freed up to undertake proactive management of patients. Staff and patient feedback has been very positive and the attendances at the local UTC have dropped by almost 9%, which, although it is difficult to absolutely prove a link, is likely to be at least partially due to the hub. The North are working on a way of sustaining this hub using the new GP ARRS funds and the PCN will present their findings to the other PCNs to encourage a similar approach.

The SDF funds have been allocated. Although these were reduced due to the financial position faced by the ICB, the winter schemes that the PCNs had proposed were protected as far as possible, as were the workforce schemes led by the training hub. Each PCN has developed a plan for additional capacity over winter, specific to the needs of their population, although due to the reduced funds plans have had to be scaled back.

Unfortunately, this has meant there is no funding available for the System Optimisation Team and Digital Optimisation Team as these have historically been funded via the SDF. These teams have been very effective at supporting primary care IT and supporting patients becoming digitally aware and their loss will impact negatively on Primary Care and on the digital inclusion of our population.

8.7 **Sefton**

Both PCNs in Sefton have raised concerns about the lack of adjustment to the Additional Roles Reimbursement Scheme (ARRS) budget that forms part of the Network Contract Directed Enhanced Service. As both PCNs had projected to spend the budget fully the application of the National pay award means that PCNs are now applying a vacancy freeze which will impact on service delivery.

Plans have been amended to spend System Development funding targeting access over winter. Both PCNs will be operating appointments via hubs offering same day appointments. South Sefton's hub is an expanded offer from the access hubs that operates all year, whilst Southport and Formby have commenced a new service.

Lincoln House Surgery has now closed after completing the managed dispersal of the registered list (circa 2000 patients). After a period of engagement all patients were allocated a new practice. Signposting for former patients regarding queries is available via the website and the PALs team.

Southport Recovery - A stakeholder communication has now been developed. A health and wellbeing offer is in development and will be shared in a future report.

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.

Central and West Warrington PCN is an accredited Research PCN, with 6 Practices receiving Unified Learning Environment (ULE) status. The PCN has also achieved Multi-Provider Organisation status. The PCN have actively expressed an interest in new trials complementing the existing trials in which the PCN is currently engaged.

Warrington PCNs are currently implementing a number of PCN led initiatives to further develop the networks including but not limited to; Clinical Advisory Teams, quality/clinical effectiveness and subgroup, Practice Managers Operational Group, Piloting of Children's and Young Persons Mental Health Practitioners and Care Coordinators and Leaning Environment Facilitator (LEF) roles

All 5 Warrington PCNs have identified priorities for SDF funding, in addition, an at scale proposal has been developed that will provide pre-winter checks appointments between November and February. Appointments will be offered to patients within the 3 highest avoidable admission categories, namely COPD with exacerbation of 2 or more in the past 12 months, Heart Failure and Falls.

8.9 **Wirral**

New PCN: Implementation from 1 August continues and is going well to date.

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

ARRS roles: Progress as planned as per recruitment plans. Challenges and use of MH practitioner role continues with a further PCN serving notice to CWP.

Within the Primary and Community Care Programme a Project Initiation Document has been approved to roll out the current Moreton and Meols Integrated Frailty Team pilot across the remaining PCNs. Positive discussions have taken place with PCNs who are all supportive in this work and supporting those experiencing frailty.

A "Keeping Well in Winter" event is being arranged for November to support people with falls prevention, infection prevention and wider advice. The event will support accessing people that may not already be known to services, as data has identified that the majority of unplanned attendances for falls relate to a fall in a person's own home.

Access & Primary Care Access Recovery Plan (PCARP) 2024-25 - Work continues on the recovery plan for 2024-25 building on the achievements from 2023-24. There is a continued focus on patients being assessed with the same day and seen within 2 weeks in line with clinical need.

Service Development Fund (SDF) 2024-25 - SDF funding is divided into two parts, one for working *At Scale* across the system, and the other for transformation work - the transformation element is currently being held centrally by the ICB and is likely to be used to support financial recovery programme. It is anticipated the At Scale allocation will be released to fund an Acute Respiratory Hub for Winter (work has already started among Wirral partners on agreeing the best utilisation of a Hub for the Wirral system.

Estates – after the merger of Moreton Health Clinic and Moreton Cross Group Practice, a premises review concluded that the site at Chadwick Street, Moreton was no longer required and has been vacated at the end of September 2024.

COVID-19 Vaccination Programme – Autumn / Winter 2024-25 - the COVID-19 Autumn / Winter 2024-25 vaccination campaign is due to commence on Thursday 3rd October 2024.

Enhanced Access Evaluation Report – Healthwatch Wirral presented findings from their commission. Healthwatch reviewed plans developed by Primary Care Networks to fulfil their Direct Enhanced Service

Service Development Fund: At Scale - ARI Hub being explored for Winter period. Transformation – PCN plans in development for ICB approval.

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.

The original case for change has now been refreshed. The Trust has identified a new preferred option which is being discussed with ICB Executives before Christmas.

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 Autumn 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**

No significant update to provide.

9.3 **Halton**

Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust continue to work together on integration supported by NHS Cheshire and Merseyside and the senior clinical representatives for primary care from each of the two Places to consider how best to improve health care delivery for local communities by ensuring strong, resilient clinical services which are fit for purpose and sustainable for the future.

This work builds upon the existing partnership objectives in Halton Place for improved patient services and integrated neighbourhood delivery. As healthcare needs change, we must continue to change and evolve in providing the best care

possible to meet people's needs through better integration of services and greater use of technology. Our focus in Halton will be to work with primary care and the wide range of partners across the various agencies to deliver these goals.

Through One Halton Partnership Board, we continue to explore and progress opportunities for better strategic alignment and integration of services across the range of local partners. We have previously outlined on-going work on Runcorn Health and Education Hub, Halton Health Hub at Runcorn Shopping City, as well as via the One Halton Strategic Estates Group which has been re-focused to support better 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 Group is jointly chaired between Health and Local Authority.

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, across both Health and Social Care.

9.5 **Liverpool**

No significant update to provide.

9.6 **St Helens**

A programme to support children unable to attend school due to health or care issues of either the child or the family. The focus is initially on primary school children in this PCN. This multi-disciplinary approach has been welcomed by all system partners, and currently education providers are identifying children relevant to be supported by the programme. The first MDT event is due to be held in December. Newton and Haydock PCN have reviewed their 18-30s with mental health conditions and known to more than one partner agency (mainly social care) and will also be progressing the school attenders work in the next quarter, with a focus on high school children. Central PCN are working through their High Intensity Users and will be developing their care community meetings in Quarter 4, with South PCN expected to follow soon after.

We have started to focus on SMI health checks and have developed a steering group to look at how uptake can be improved. The first meeting was held in November, with some key outcomes and an action plan being developed as a result.
This involves a few areas:

- Ensuring that the data is correct
- Ensuring that all actions are recorded correctly where people outside primary care undertake elements of the checks
- Developing the role of the engagement lead employed by Merseycare and ensuring that the role is recruited in to and used to its maximum effect.
- St Helens have been part of a C&M wide procurement for IPS services, a service to support people with severe mental illness to gain sustainable employment. This has moved from 9 place contracts to 2 contracts, 1 for Cheshire and one for Merseyside, and it will represent a significant expansion to current services. The new provider will be expected to work closely with mental health and primary care services to identify people for referral, as well as promote the service for self-referrals. They will also work with local partners and employers to actively seek opportunities that centre around each person's specific needs.

We are currently mobilising a new contract with Ladders for Life. This will offer support to adults with ADHD in relation to managing the symptoms of ADHD and being able to live a full life with ADHD. This is about skills rather than a clinical model, and it will work alongside our clinical service to ensure that where medication is needed, it is available. However, the waiting lists for adult ADHD remain very long, at current investment lists are many years long, and growing monthly, unless new funding is made available, the lists will continue to grow, despite actions being taken across C&M to support adult ADHD pathways.

9.7 **Sefton**

Shaping Care together – Engagement on the Case for Change has come to a close and the outputs will inform the development of the full list of options. These will be evaluated and support the development of a Pre-Consultation Business Case (PCBC) which will form the basis of public consultation in 2025. The OSC has been engaged in this process.

9.8 **Warrington**

The integration programme between Warrington and Halton Hospital Trust is progressing well.

Joint working with Warrington Borough Council continues predominantly via the Better Care Fund as well as undertaking a review of Adult 'Joint Packages of Care' activity and spend to identify opportunities to improve outcomes, experiences and control costs.

- Ongoing 'Place making' activity continues with a focus on Estates.

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 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 10 property Independent Living Pilot with Magenta Living is now able 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 29th September and the 1st October, along with discussions around potential procurement timelines

CYP: The Emotional Wellbeing Alliance contract launched in April 2024 and service delivery commenced from this date with the 5 providers. Branch, online mental well-being hub for children and young people in Wirral, from 0 to 18. The website has built in referral access to these services and up to 20 other Wirral services supporting CYP is currently in a soft launch phase with the go live date of 13th November 2024. 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 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 NPOPs 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**
No significant update to provide.

10.3 **Halton**
Halton will be an early adopter in Cheshire and Merseyside of a needs assessment tool/ Portsmouth model for children with suspected neurodiversity. The Portsmouth model assesses nine developmental strands (speech and language, energy levels, attention skills, emotion regulation, sensory levels, flexibility and adaptability, and empathy) of a child or young person aged 0-19.

Demand for neurodevelopment assessments in Halton has increased, leading to an increased waiting time for a diagnosis outcome. We have heard from Halton families that they would like earlier support and support whilst they are waiting for a diagnosis. The ambition is to support early identification of children and young people's needs and support these needs at the earliest opportunity, in advance of possible future referral for a neurodiversity assessment. This will support a move from the current diagnosis led model to a needs-led model.

This approach aligns with the Children's commissioner's recommendation in her, "Waiting times for assessment and support for autism, ADHD and other neurodevelopmental conditions, October 2024" report that profiling tools should be rolled out across nurseries and schools for children who are likely to have a neurodevelopmental condition. The report sets out that there is growing evidence that early support reduces the risk of children's needs from escalating, and the need for future interventions.

Work has commenced, taking a local area partnership approach recognising that adoption of the Portsmouth model will rely upon interventions and support across education, social care, health care, and families of young people. A strategic steering group and operational group is in place with relevant stakeholders providing the mechanism for key decisions and supporting coproduction. We are working with Halton Family Hubs to explore how they will provide support within the model. Co-ordination of children and their families care to meet their early needs is being considered with partners.

Halton Borough Council is working with education settings to roll out the thrive approach to support children's and young people's emotional health and wellbeing. Discussions have commenced to ensure the Portsmouth model dovetails with education's thrive approach. There has been interest from some education settings in becoming early adopters of the neurodiversity needs assessment in advance of formal invites to Halton education settings for expressions of interest.

The work undertaken with partners now is setting the foundations to commence the Halton pilot by March. Learning incorporated into the approach will facilitate roll out across all Halton schools and nurseries following the pilot. The learning will be shared with other places.

10.4 **Knowsley**

Knowsley Children's Scrutiny Committee met on Thursday 19th September 2024 and our local providers presented Mental Health and Wellbeing Support in Schools. The report and presentation provided an overview of the model and approach to mental health for school age children in Knowsley and described the provision and partnership provision, including performance, impact and successful outcomes achieved.

Knowsley are developing a children's joint commissioning plan which will support the introduction of a Section 75 for CYP. Work is progressing with commissioners from both the ICB and Local Authority (LA) to understand and agree priorities for the Borough.

Knowsley have commissioned with St Helens, Halton, and Warrington a CYP Intensive Support Function, which will be provided by MCFT. Mobilisation meetings are in place and recruitment for posts has started in preparation for the service to start early 2025.

Knowsley, alongside St Helens have implemented a Tics and Tourettes pathway which will start on 14th November 2024. The service will provide a paediatric clinic appointment to aid understanding of the diagnosis and psychological support associated with the diagnosis. The clinic will offer a variety of services including psychological education, bespoke understanding of need and individual and school support where needed. Following diagnosis, parents will be offered an opportunity to attend an annual online seminar, facilitated by Tourette's Action. There is also a free training course that can be accessed by GPs.

10.5 **Liverpool**

The Paediatric Liaison Service has recently been re-specified and is now being implemented across acute providers. This service plays a critical role in the safeguarding pathways for C&YP and their families and demonstrates a much more effective and streamlined approach to sharing information and protecting relevant patients.

Focused work on implementing the recommendations from the 16-25 Mental Health review has also continued in quarter 3, with the aim of improved data / intelligence and strengthening pathways / collaboration across existing providers (CYP and Adult MH) – demonstrating a more streamlined approach to sharing information and protecting relevant patients.

10.6 **St Helens**

Children's Social Care Getting to Good and Beyond Practice Sharing Event held by NWADCS on 20th September. St Helens presented with 2 other LAs who got

good ratings in ILACS. This event was much appreciated, and our staff were thanked for their contribution.

Our Care leavers had a successful and fun week to celebrate Care Leavers Week with fun filled Halloween themed activities. Events were enjoyed by mixed age group including UASC. Photographs and videos clearly demonstrate the success.

Education and Learning DfE's implementation Regional Improvement for Standards Excellence (RISE) team
Jo Davies and Sarah Platt attended a webinar with colleagues from the DfE to learn more about the new initiative and ensure practice in St Helens is aligned with national guidance. The goal of RISE teams will be to raise standards for all children in all schools across the country, as part of the government's Opportunity Mission:

1. Every school can self-navigate a path to improvement drawing on all necessary support within and beyond their LA / Trust.
2. Every part of the country has a coherent set of local area priorities, so all partners work collaboratively to solve issues affecting children in their communities.
3. Schools facing challenges improve rapidly, with sharply targeted support for 12-24 months.

The support will be offered over three levels: universal, targeted and intervention.

Ofsted inspections Five school inspections have taken since the start of the new academic year. All of these inspections have been conducted as Section 5 graded inspections and under the new regime, e.g., removal of overall judgement outcome.

The finalised reports which recognise the schools' achievements, strengths and affirm the schools' already identified areas for continued improvement will be published on Ofsted's report portal over the coming weeks.

To aid preparation for school inspection, the Local Authority has facilitated training sessions for school leaders and school governors (training took place on 12 and 26 Sept) focusing on changes to the inspection handbook and implementation of new national measures - both of these sessions were delivered by Senior HMIs and the agendas were co-constructed with leaders from Education and Learning.

Virtual School The Virtual School has facilitated a variety of training sessions for Designated Teachers, Social Workers and Foster Carers during the autumn term. October saw the launch of our newest course, Foetal Alcohol Spectrum Disorder (FASD). Multiple education colleagues had specifically requested training in FASD as there is very little information known about the condition (including its change in name from ‘syndrome’ to ‘spectrum disorder’).

Our Primary PEP Coordinator and Advisory Teacher Helen Lee attended training and undertook extensive research into FASD in order to deliver the training session to school staff. Extensive theory behind FASD was delivered to delegates including how the condition presents; appropriate language to use; overlap with other conditions; medical comorbidity; diagnosis and strategies to help and support children and young people with FASD. There were also guest speakers during the session who were themselves parents or carers of children with FASD and provided an inspiring first-hand lived experience of caring for children with this condition. Evaluations showed that for 100% of delegates, training covered what participants expected it to cover and 100% of delegates also stated that they would recommend training to others.

10.7 **Sefton**

Waiting Times: There continue to be improvements in Dietetics, SALT and CAMHS waiting times with revised trajectories agreed for SALT and CAMHS for March 2025, which continue to be monitored via the contractual route.

Service improvements are being progressed by providers including skill mix, recruitment to alternative models, engagement with HEIs, triage, prioritisation, pre and post diagnostic support and streamline pathway for ASD/ADHD. The ICB Children and Young People Neurodiversity Pathway will also support the future ASD/ADHD health commissioned model.

Graduated Offer: The health partnership continues to support the “delivering better values” work including the developments of the graduated offer.

- The launch of the Sefton Integrated Early Years Speech and Language and Communication Pathway developed by the partnership which is in the process of being disseminated across the partnership.

- The neuro diversity toolkit is also being launched with a series of training sessions planned to be delivered across the partnership.

Sefton Place and the health partnership have supported the Preparing for Adulthood Conference on 9 October and the Local Offer Live Event on 30 October coordinated by Sefton Parent Carers Forum.

National ADHD medication shortage: There remains a national supply issue affecting medications for the treatment of ADHD. Ongoing mitigation remains in place across ICB medicines management teams, community pharmacies, Alder Hey and Mersey Care to minimise the impact. This includes information and signposting for additional support via trust websites and the Local Offer website. The consequential impact on waiting times has been noted and reported to the ICB neurodiversity leadership and medicines management who are reviewing as part of C&M, regional and national response. the ICB Chief Pharmacist continues to be involved at a national level.

In April 2024, the Minister for Children Families and Wellbeing directed the local authority to act on the report and recommendations from Sefton’s Commissioner for Children’s Services, with a requirement of the partnership to address four recommendations as part of the Ministerial directive. Preparation for Ofsted re-

inspection has commenced following the series of monitoring visits. The partnership will be meeting monthly to review data and Annex A submissions, in preparation for next full inspection anticipated in February 2025.

External support from Leeds partnership is progressing with the 3 Key Safeguarding partners, to help progress support for leaders to improve partnership working of leadership and culture, as one of the three partnership priorities.

The ADQSI Sefton is engaged in the new established Merseyside Pan Masa meetings to ensure key areas for the region are prioritised including Harm outside the Home.

The Pan Merseyside and Isle of Mann Child Death Overview Panel (CDOP) annual report has been published with the report being shared with Health and Wellbeing Boards across Merseyside. The report has also been received by Sefton Safeguarding Partnership to support actions from the partnership to reduce modifiable factors identified within the report.

10.8 **Warrington**

In support of the C&M Appropriate Places of Care work, Warrington's Complex Needs Hub model is progressing well with the building being handed over in January 2025 and provision planned to go live in February 2025. This jointly funded and multi-agency provision will provide 4 short term residential therapeutic beds, and a community outreach offer for some of our most vulnerable and complex Children and Young People (CYP) aged 11-18.

Emergency admissions of CYP to hospital for self-harm up to March 2024 shows that there are less admissions and are below average for total admissions in the previous 2 years. This is also reflected in A&E activity and in length of stay for admitted CYP with mental health presentations.

Baby Attachment & Bonding Service (BABS) service has been launched and is now operational following significant investment and expansion of the model.

Mental Health Support Teams in Schools (MHST) - Wave 11 roll out is taking place in November 2024. All schools in Warrington will be covered by MHST or by a local 'School Link Worker Mental Health Programme.

My Happy Mind's secondary school programme, 'My Mind Coach', piloted in 5 Warrington High Schools for 24/25 academic year. Majority of Warrington Primary Schools have now integrated 'My Happy Mind' programme into curriculum and are joint funding with ICB at Place.

CAMHS wait to first appointment is 2 weeks, achieving the 6-week internal target (Oct 2024)

Follow up waiting time is average 8 weeks, ahead of the 18-week target, with the longest wait 12 weeks for CYP (Oct 2024).

The ICB in Place is working with key stakeholders to manage the ongoing pressures across SEND services in particular the Neuro-developmental Pathway. Halton and Warrington Places are working with Bridgewater Community NHS Foundation Trust to explore how we can work to ensure CYP and families/carers are supported whilst waiting for assessment and diagnosis. This includes ongoing risk assessment and triage of those waiting.

10.9 **Wirral**

Paediatrics - Development of Wirral University Teaching Hospital (WUTH) Children & Young People's (CYP) Occupational Therapy (OT) specification through Q2. Work progressing to incorporate CYP therapies service specifications including Occupational Therapy and Speech & Language Therapy services into a Section 75 agreement (joint commission between Wirral Council and Wirral Place).

Women - Birthrate Plus review of maternity staffing at WUTH progressing in the period. Maternity update given to the Core20Plus5 meeting. Service is targeting continuity of carer model in the areas where the majority of our BAME (Black, Asian, Minority Ethnic) population live on Wirral in line with national recommendations.

11. Use of Resources

11.1 **Cheshire East**

At the end of Month 6, Cheshire East Place reported a deficit of £36.8m, which is a £6.5m lower than the planned deficit of £30.3m.

The predicted deficit at the end of the financial year is £62.2m, which is a £10.2m adverse variance to the planned deficit of £52m. A review of potential risks and mitigations has identified a potential further net deterioration of £5.9m.

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 and this is continued to be delivered by the teams alongside actively working 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 £2.8m worth of savings compared to the £4.7m that was included as part of the financial plan. However, it should be noted that Cheshire East Place has delivered £3.3m of non-recurrent savings in Month 7 and is currently forecasting that £12.6m of the £13.2m planned savings target will be delivered by the end of the financial year. Additional recovery plans are also being considered to mitigate the known risks and some of these have been included to date, however, 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 6, Cheshire West Place reported a deficit of £23.2m, which is a £1.8m worse than the planned deficit of £21.3m.

The predicted deficit at the end of the financial year is £44.8m, which is £2.1m adverse variance to the planned deficit of £42.6m. A review of potential risks and mitigations has identified a potential further net deterioration of £4.8m, and therefore the risk adjusted forecast outturn is a projected deficit of £49.6m which is a £6.9m adverse variance to plan.

Cheshire West place has delivered £1.8m worth of savings compared to the £3.9m 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 close of Month 6, Halton reported a year-to-date deficit of £5.9m and was forecasting a full-year outturn deficit of £12.8m, the latter representing an adverse variance of £3.5m from Plan (a £9.4m deficit). Although the year-to-date variance (£1.24m) had deteriorated marginally from the previous month (£1.1m), this was more than compensated for by the improvement in the forecast outturn variance (of £0.2m). Year-to-date performance against the annual QIPP target of £3.1m is reasonable, with an in-year shortfall of £0.53m reported at Month 6.

Review of Place risks and mitigations has identified potential for further net risk deterioration of £0.56m to that position, although in deriving this, there has been offset by upside actions technically regarded as recovery measures leading to c £0.45m understatement of the net risk value for Month 6. The Month 6 risk adjusted outturn variance from Plan, which is the target to be recovered, is therefore more correctly stated as £4.5m (adverse). The main components of Halton's risk at Month 6 includes a £0.74m delivery shortfall in Prescribing cost efficiencies, as well as unbudgeted costs associated with the transfer of Learning Disability services (£0.21m) and commissioning responsibility for Tier 3 Specialist Weight Management Service (£0.21m) from Halton Borough Council.

Recovery actions continue to be actively progressed and managed at Place in attempt to deliver to Plan, but as with other Places across Cheshire and Merseyside, this remains a substantial risk principally due to uncontrollable demand- and inflationary-led cost pressures within Continuing Healthcare, Mental Health packages and Prescribing. In addition, Halton has been required to prioritise the much-needed investment to support the delivery of Halton SEND Improvement Action Plan which arose from the CQC's review in 2024. Furthermore, the challenging outlook of the local authority potentially reduces the scope for new joint cost-efficiency opportunities and increases the risk on current arrangements.

11.4 **Knowsley**

At the end of Month 6, Knowsley Place reported surplus was £4.3m, which is a £1.6m adverse position to the planned surplus of £5.9m.

The predicted surplus at the end of the financial year is £8.5m, which is £3.4m below the planned surplus of £11.9m. A review of potential risks and mitigations has identified a potential further net improvement of £0.5m to that position, and therefore the risk adjusted surplus is projected to be £9.0m. The Financial Recovery target, to deliver the financial plan, is maintained at £2.9m and mitigations have been identified to deliver against this.

Knowsley Place has delivered £1.7m worth of savings in line with the planned levels to date and projections are 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 6, Liverpool Place deficit was £1.4m which is £6.7m above the planned surplus of £5.3m and reflects an adverse position.

The predicted deficit at the end of the financial year is £1.4m which is £12m 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 £7.5m give a risk adjusted deficit of £14m.

Liverpool Place has delivered £4.2m worth of savings compared to a plan of £5.4m. 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 £8.5m have been developed, which leaves a remaining risk of £6.5m 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 6, St Helens Place reported deficit was £7.6m, which is a £2.0m adverse position to the planned deficit of £5.6m.

The predicted deficit at the end of the financial year is £14.6m, which is £3.4m adverse to the planned deficit of £11.1m. This is an improvement on the position reported at month 4 by £0.8m. However, a review of potential risks and mitigations has identified a potential further net deterioration of £1.5m to that position – primarily related to the GP prescribing budget, and therefore the risk adjusted deficit is projected to be £16.1m.

For the 5% planned cost reductions, St Helens Place has delivered £1.9m worth of savings compared to a plan of £2.4m, which is an adverse variance of £0.5m.

This adverse position is mainly related to AACC savings plans due to staff shortages and IT system transition, but it is anticipated that this position will improve as the year progresses. Furthermore, the St Helens team are identifying further cost reduction opportunities as part of the financial recovery and expect to report an improved position at month 7.

St Helens continues to have an active Strategic Estates Group that focus on how all partners work collaboratively to maximise available space in buildings where costs are fixed, and increased utilisation improves efficiency without increasing costs.

The most recent project that the SEG has supported is the utilisation of space at Newton LIFT site to add up to 11 extra beds on site alongside the intermediate care facility, that can be used flexibly to support the system. The works are funded through CHP so the work comes at minimal cost to the ICB yet creates significant capacity.

The SEG has also supported sever S106 bids for infrastructure support to primary care where housing developments are planned. This has secured well over £500,000 to date and more possible funding if planning permissions are granted.

11.7 **Sefton**

At the end of Month 6, the Sefton Place financial position was a deficit of £11.8m which is £6.5m above the planned deficit of £5.3m and reflects an adverse position.

The predicted deficit at the end of the financial year is £23.3m which is £12.7m 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 required to address the remaining savings required to deliver the agreed financial plan. £2.6m recovery savings have been achieved to date but cost pressures also continue to increase, which impacts the overall financial recovery.

In respect of the agreed efficiency target included in the financial plan for 2024/25, Sefton Place has reported £3m worth of savings within the Month 6 position and is on target to achieve the full efficiency plan of £7.795m by the end of the financial year.

11.8 **Warrington**

At the end of Month 6, Warrington Place reported deficit was £3.6m, which is £1.3m adverse to the planned deficit of £2.3m.

The predicted deficit at the end of the financial year is £7.5m, which is £2.9m above the planned deficit of £4.6m. A review of potential risks and mitigations has identified a potential further net improvement of £0.1m, therefore the risk adjusted deficit is projected to be at £7.4m.

Warrington Place has delivered £1.9m worth of efficiency savings year to date, compared to a plan of £2.2m (i.e. £0.3m adverse). With anticipated annual savings of £4.1m against a plan of £4.5m (i.e. £0.4m adverse).

To mitigate all the current risks, the month 6 financial savings recovery target is £2.8m, 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 6, Wirral Place deficit was reported as £16.4m which is £6.0m above the planned deficit of £10.4m and reflects an adverse position.

The predicted deficit at the end of the financial year is £36.0m which is £15.3m above the planned deficit of £20.7m. A review of potential risks and mitigations has identified a potential net improvement of £4.2m and the risk adjusted deficit is therefore £11.1m.

Wirral Place has delivered £1.8m worth of savings compared to a plan of £4.2m which is an adverse variance of £2.4m. Wirral Place is indicating that the full efficiency plan of £11.2m will be delivered by the end of the financial year.

12. Officer contact details for more information

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Meeting of the Board of NHS Cheshire and Merseyside

26 November 2024

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/11/24/11

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	03 October 2024

Key escalation and discussion points from the Committee meeting

Alert

The Remuneration Committee at its meeting on 03 October 2024:

- considered and approved the ICBs Board Member Nomination and Appointments Policy. Committee members noted that the approved Policy would require minor changes to be made to the nomination and appointments processes made within the ICBs Constitution, which would be undertaken and then considered by the Board at its meeting in November 2024. The adoption of the Policy also required minor changes to be made to the Committees Terms of Reference (Appendix One).

The Board is asked to approve the updated Terms of Reference for the Remuneration Committee

Advise

The Remuneration Committee at its meeting on 03 October 2024:

- received a report on and approved the recommendation to support a proposal around the redundancy application for an ICB Very Senior Manager due to the lack of suitable alternative employment.
- received a report on the proposed arrangements for the appointment of the ICBs interim Executive Director of Finance following the ICBs recent unsuccessful recruitment process for this position. The Committee supported the recommendation to support the proposed remuneration for the individual undertaking the position on an interim basis and noted that this remuneration amount is within the nationally determined pay range for an ICB Director of Finance. Committee members noted that the interim arrangement would be in place for a period of no less than 6 months and no greater than 12 months, with the intent to reinitiate the recruitment process again within the first quarter of 2025.
- received a report on and noted a paper on the formal interim cover arrangements that the ICB was to put in place during the end of October and beginning of November 2024 to cover two of the ICBs Executive Team positions due to retire and return.
- received a report on and noted a paper on the agreed reduction in hours of two Very Seniors Managers
- received and approved the Committees Annual Report for 2023-24 (Appendix Two)
- received and noted the results of the Committees annual effectiveness self-assessment survey

Assure

n/a

Appendices

Appendix One: v1.4 draft Remuneration Committee Terms of Reference
Appendix Two: Remuneration Committee Annual Report 2023-2024 **(CLICK HERE)**

NHS
Cheshire and Merseyside

NHS Cheshire & Merseyside ICB

Remuneration Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
1 July 2022	1.0	Initial ToRs		Ben Vinter
29 September 2022	V1:1	Changes made by Remuneration Committee at its September 2022 meeting		Matthew Cunningham
13 October 2022	V1.2	Changes made by Remuneration Committee at its October 2022 meeting		Matthew Cunningham
12 September 2023	V1.3	Changes made by Remuneration Committee at its September and December 2023 meeting		Matthew Cunningham
03 October 2024	V1.4	Amendments to TOR to reflect role of Commmittee in Board member Appointments in line with agreed Board Member Appointments Policy		Matthew Cunningham

Review due:
01 September 2025

V1:4 approved by the C&M ICB Board (28 November 2024)

Remuneration Committee

Terms of Reference

Introduction

NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside') has been established to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

1. Purpose

The Remuneration Committee (the Committee) is established by NHS Cheshire and Merseyside as a Committee of the Board in accordance with its Constitution.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006.

The Committee will:

- adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective
- advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.

2. Responsibilities / duties

The Board has delegated the following functions and duties to the Committee:

For the Chief Executive, Directors and other Very Senior Managers:

- determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, allowances, pensions and cars
- determine arrangements for termination of employment and associated severance payments, and other contractual terms and non-contractual terms
- advise on and propose the appointment process for the ICBs Chief Executive, in line with the national process.

For Partner Members on the Board:

- approve any ICB Pay and Allowances/Benefits policies and frameworks for Partner Members on the ICB Board

For Non-Executive Directors of the Board:

- determine the ICB remuneration policy (including the adoption of pay frameworks)
- oversee contractual arrangements.

None of the ICBs Non-Executive Directors will be involved in the decision making regarding the determination of their renumeration and any other allowances. On the occasion where this is required the Committee membership be composed of the ICB Chair and up to two Non-Executive Directors drawn from NHS Providers or neighbouring ICBs.

For all staff:

- determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change).
- oversee contractual arrangements
- determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.
- approve disciplinary arrangements for employees, including the Chief Executive (where he/she is an employee of the ICB).

Additional functions that the ICB has chosen to include in the scope of the committee include:

- ~~functions in relation to nomination and appointment of Board members through the convening an ICB Appointments Panel, and as outlined within the ICB Constitution~~
- provide support to the ICB Chair and ICB Chief Executive in the undertaking of Board Member appointments and as outlined within the ICB Board Member Nomination and Appointments Policy
- functions in relation to the performance review/oversight and appraisals for Executive Directors/Senior Directors, including the Chief Executive and the Chair in line with NHSE guidance on appraisals for Chairs and Chief Executives
- oversight of the succession planning for the Board member positions and Executive Directors
- assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation and including such things as Fit and Proper Person Regulation (FPPR).

3. Authority

The Remuneration 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
- 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 SoRD but may /not delegate any decisions to such groups without the approval of the ICB Board
- commission, review and authorise 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.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

4. Membership & Attendance

Membership
The Committee members shall be appointed by the Board in accordance with the ICB Constitution and as outlined within these Terms of Reference.

The Board will appoint no fewer than three members of the Committee, drawn from the Non-Executive Directors of the Board. All Non-Executive Directors of the ICB may be members of the committee recognising that there may be times when the ICB Audit Chair needs to abstain from taking part in the meeting. Other members of the Committee need not be members of the Board, but they may be.

The Committee may also choose to appoint other individuals to be members of the Committee, drawn from:
- up to two Non-Executive Directors drawn from NHS Providers or neighbouring ICBs, ideally with experience of remuneration committees and / or remuneration decisions for members of Board.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The ICB Chair will also receive a standing invitation to attend and will only sit as a member when there is a need to maintain quoracy or when a decision involving ICB Non-Executive Director remuneration or allowances is to be made.

Attendees
Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:
- Chief People Officer or their nominated deputy
- Director of Finance or their nominated deputy
- Chief Executive or their nominated deputy
- Associate Director of Corporate Affairs and Governance.
- Independent HR Advisors.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Management of Conflicts of Interest

No individual should be present during any discussion or decisions relating to:

- any aspect of their own remuneration
- any aspect of the remuneration of others when it has a direct impact on them.

5. Meetings

5.1 Leadership

In accordance with the constitution, the Committee will be chaired by a Non-Executive Director of the Board. Committee members may appoint a Deputy Chair from amongst the standing ICB Non-Executive Directors , with the exclusion of the Non-Executive Director undertaking the role of the ICB Audit Chair.

In the absence of the Chair, or Deputy Chair, the remaining ICB Non-Executive Directors present shall elect one of their number to Chair the meeting recognising that this may not be the ICB Chair, or Audit Chair.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

For a meeting to be quorate a minimum of two Non-Executive Directors of the Board are required, including either the named Chair or the Deputy Chair of the Committee. ICB Board members must form the majority of the membership at a meeting of the Committee, with the exception only being when the Committee is determining the remuneration and allowances of the ICBs Non-Executive Directors .

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If on an occasion a Committee meeting is due to start but the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. Alternatively, the meeting can be called to a halt and an agreement reached to rearrange an additional meeting.

5.3 Decision-making and voting

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Decisions will be taken in accordance with the Standing Orders of the ICB and within the authority as delegated to the Committee. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote, and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Decisions will be recorded and formally minuted and ratified at a subsequent formal meeting of the Committee.

5.4 Frequency and meeting arrangements

The Committee will be held in private.

The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice or agreement.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.5 Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- records of conflicts of interest members' appointments and renewal dates. Provide prompts to renew membership and identify new members where necessary
- good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual, and agreed with the chair. Keep a record of matters arising, action points and issues to be carried forward. Minutes of the meeting will be circulated to all Committee members within 10 working days of the meeting, highlighting actions by individual members
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

5.6 Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information.

The Committee will provide the Board with an Annual Report timed where possible to support finalisation of the ICB Annual Report and Accounts. The report will summarise its conclusions from the work it has done during the year.

6. Behaviours and Conduct

Benchmarking and guidance
The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England, and the wider NHS in reaching their determinations.

ICB values
Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

7. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Highlight report of the Chair of the ICB System Primary Care Committee

Agenda Item No: ICB/11/24/12

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	17 October 2024

Key escalation and discussion points from the Committee meeting

Alert

- Lack of resource in Digital Clinical Safety has detrimental impacted delivery of some PC Digital programs.
- Additional scrutiny in place by Executives for discretionary spend.
- Current system pressures across Primary Care ;
  - GP
    - Build of collective action which could impact on existing winter pressures
    - Concerns over finance and SDF allocation
  - Community Pharmacy
    - Ballot on Collective Action
    - Increasing pressure on cost of medicines
    - Winter Pressures
  - Optometry
    - lack of focus on this contractor group in PC Digital strategy
    - Post code lottery still evidenced
  - Dentistry
    - handback of NHS contracts still in evidence despite support as unable to deliver care within envelope
    - impact being felt due to pause of vulnerable patient pathway as discretionary spend paused.
  - Medicine(s) Management
    - overspend in excess of projections - deep dive in Nov. FIRC.

Advise

- Approval of APMS Direct Award procurement for St Helen's Place.
- Note and assurance received on progress of Sefton Place dispersal - all patients relocated and close working with Healthwatch.
- Recommissioning of UDA - SPCC confirmed partial agreement subject to further approval from Executive Committee - additional scrutiny implemented for discretionary spend.
- Update on PC Digital programs. Approval of GPIT capital spend subject to financial ratification that within PC Capital allocation. Approval of 80k (pro rata) spend to provide equity of SMS charges for this Financial year only. Finance held within 23/24 Access Improvement Plan monies.
- Full update of commissioning, contracting and policy for all 4 contractor groups.
- PCNs wary of GMP inclusion in ARRS, funding this year for 6 m and then written into baseline but lower than NW average at 8.3k v 10.5k.
- PC Finance -Detailed information at M6 with alert on Medicines Management as already highlighted.

- Digital Primary Care Sub Strategy - Welcomed and appreciated by SPCC. Approved subject to closer working with all 4 contractor groups. Challenge set that the strategy should be more aspirational than built on existing contractors digital landscape.
- Local Dental Improvement Plan - Update on current position of pathways and positive feedback from Comm. especially around the provision to new patients. Great support from Healthwatch who sit on the program Board. General consensus that we are keen to do more should funding allow which is currently directly linked to underspend and need to understand Access Improvement Plan v Recommissioning of UDA's.
- Primary Care Quality Update - Significant progress, QSAG effective and regular meetings and reporting in place. Quality issues advised to Q & P as a matter of course. Primary Care Patient Safety Strategy launched and included within current discussions.
- Primary Care Performance Update - First sight of baseline indicators for General Practice that have been agreed by all Places, Comm confirmed that this is a great start and that they would welcome the future build to include all 4 contractors. Continuity suggested as a potential indicator to be included and will be explored.

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**
• Risk ○ 31 Risks included in SPCC review, 1 BAF, 3 Corp and 27 Place. ○ 3 Corporate and the extreme Place discussed and actioned ○ 1 - Corp risks to remain at same level ○ 2 - 1PC - declined to reduce workforce risk and small group to consider if this needs to be split into contractor groups to provide a better/accurate assurance. ○ 3 - 8PC - collective action - great progress and should have final analysis for next SPCC. ○ 4 - Place risks around Quality and Estates - actions to look at consistency on Quality and first PC strategic estates meeting in Nov which will report to SPCC in Dec.	

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**

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.
Dental Improvement Plan	Full update

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Agenda Item No: ICB/11/24/13

Committee Chair: Prof. Hilary Garratt, Non-Executive Member

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Committee Chair	Hilary Garratt
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	13.09.2024

Key escalation and discussion points from the Committee meeting

Alert

N/A

Advise

The Committee considered the following at its meeting in July:

NW Clinical Senate – Desk-top Review of the Case for Change

The Committee received the Senate review of the case for change.

A dedicated panel had been established for the review that included NW Senate members and clinical experts from outside the North West area.

The panel expressed strong support for the case for change, describing it as one of the most compelling cases they have seen from a clinical perspective.

The Committee noted the NW Clinical Senate review of the case for change.

Final Draft Case for Change

The Committee received the final draft case for change for hospital gynaecology and maternity services in Liverpool.

Revisions to the case for change since July were highlighted. Assurance was received that, where possible, stakeholder feedback has been reflected in the final draft and some feedback will be considered as part of the design phase.

It was noted that comparative data has been difficult to source. The Liverpool Women's Hospital is difficult to compare to other hospitals as it is the only tertiary provider of women's services in England that does not have co-located services. Therefore, the case for change has had to rely primarily on internal data and reviews, and demonstrating trends.

The Committee supported and endorsed the final draft case for change and agreed to recommend it to the Board of NHS Cheshire and Merseyside.

Assure

The Committee considered the following:

Programme Update

The Chair of the Programme Board provided an update on programme activity since the July meeting. This included:

- Progress and activity related to the final draft clinical case for change including the NW Clinical senate review.
- Establishment of the Lived Experience Panel.
- Plans for the public engagement period.
- Progress on delivering clinical improvement plans at LWFT.
- Activities planned for September - November.

The Committee noted the programme update and progress made to date.

Communications and Engagement Update
The Committee received an update on communications and engagement including a report about the plans for public engagement (formally referred to as 'pre-consultation engagement').

The engagement will commence in October for 6 weeks, following Board approval of the case for change.

The engagement will include face-to-face and online engagement events, a dedicated website, a public facing version of the case for change (including an easy read version). There are also plans to commission third sector organisations to support the engagement with harder to reach groups and communities.

The Committee noted that the Lived Experience Panel has been established and has been contributing to the planning for the public engagement.

The Committee approved the plans for public engagement.

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Highlight report of the Chair of the Strategy & Transformation Committee

Agenda Item No: ICB/11/24/14

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/
Date(s) of meeting	21 November 2024

Key escalation and discussion points from the Committee meeting

Alert

Advise

A report on the non-recurrent Transformation Programme informed that all programmes in receipt of non-recurrent transformation funding have been reviewed to establish a recommended course of action for 2025/26.

Committee approved the recommendations detailed in the report, including the cessation of three schemes and approval to continue to fund recurrently:

- £310,197 annually for Familial Hypercholesterolaemia and CVD Prevention services.
- £300,000 annually for the Efficiency at Scale Programme.
- £448,843 Medicines Optimisation Transformation funding recurrently by moving it into the central medicines management budget for which it will be ring fenced to continue transformation activity subject to reviewing that there is no duplication with other budgets.

The committee endorsed the plans to develop a case for the expansion of service and associated funding of the IV at Home Elastomeric service as part of the commissioning intentions process for 2025/26 but supported maintaining the funding of the core service into next year to avoid service instability (£242,702).

Assure

- Committee conducted a deep dive on Cheshire and Merseyside Women's Health Strategy considering how well it addresses the strategic aims of the ICB and to also provide recommendations on the focus and priorities for the WHaM programme in 2025/26. The strategy outlines the priorities and actions that will be taken to addressing the health and social inequalities and health care services for women and girls. To support the discussion the committee was presented with relevant data, including the social determinants of health, maternal health, physical health and mental health and noted variations across Cheshire and Merseyside. Committee noted the significant amount work in progress and areas that continue to need attention. It was recommended that the programme should agree strategic outcomes to help prioritise activity. In addition, a women's health lens should be applied through all the core programmes to ensure there is appropriate priority where there is evident gender inequity in health or access to health care. Committee recommended that the community services work, including neighbourhood health models, should ensure that women's health and care models are included. There may

be general lessons from the women's health programme in terms of value for money and system care pathways.

- Committee received a report outlining a set of commissioning intentions to help direct the ICB and wider partners planning and prioritisation of service provision and transformation in 2025-26. The approach described for the commissioning intentions outlined the three main stages. The Executive Team will oversee the process using a subgroup to support the development of plans. Committee endorsed the draft principles, the process and approach proposed for developing commissioning intentions. Committee agreed on the need for more emphasis on outcomes and system productivity as well as individual organisational productivity. It was confirmed that public engagement will be done in tandem with the 10 Year Plan consultation.

- Committee was presented with the regular risk report. The report detailed the three principal risks, and four corporate risks escalated in accordance with the Risk Management Strategy. Committee approved the escalation of risk T2 (Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs). Committee also approved the escalation of risk T4 (SDF Funding and lack of clarity on what will be received for the next financial year). The Specialised Commissioning Risk Register was also noted which identifies and lists those open risks sitting within this separate risk register.
.
- There was an opportunity for updates from relevant boards/groups, including DTCI, CMAST, Population Health Board and ADs of Transformation & Partnerships at the meeting which Committee noted.

- Committee will be undertaking a deep dive on plans in relation to community health services at its next meeting in January 2025. An update on Specialised Commissioning Services covering services that have been transferred to the ICB this year and services to be transferred next year will also be presented as well as an update on the ICB's 2025-26 commissioning intentions.

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**
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 /	Committee noted the further planned actions include delivery of the system wide Cyber Security Strategy, improvements to supplier management and continued training and awareness raising.

Corporate Risk Register risks	
Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	
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	Commiittee noted the key further actions planned, including the refresh of the Green Plan and proposed inclusion of Net Zero in Anchor criteria.
T2 - Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs	Committee noted this is currently being mitigated through interim measures to delay withdrawal of services in Liverpool, St Helens and Halton. Further actions include the development and adoption of a minimum service specification, options appraisal and pursuit of funding opportunities. **Committee agreed to include the risk on its risk register**
T3 – Health Inequalities funding	Committee noted the that the full amount of HI funding for 25/26 is not yet known. It is anticipated that the implications and timescales from the financial planning process may impact on planning for next year across the ICB.
T4 - SDF funding	Committee noted that the ICB awaits further information regarding its SDF funding for the next financial year and it is unknown whether any mandated ring fencing of monies will be expected in 25/26. **Committee agreed to include the risk on its risk register**

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. Committee noted planned mitigation is focused on delivering the All Together Fairer: Our Health and Care Partnership Plan, including

Board Assurance Framework Risks	
	securing health inequalities investment allocation. The planned actions will be affected by the ICB financial review. Some delay to some aspects of work, will be applied to support the 2024-25 financial challenges.
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 notes 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 continues to be made on these key programs to develop case for change and consultation proposals during 2024-25 but are not expected to be complete or impact on the risk level until 2025-26 and beyond.
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. In year funding, secured through national cyber resilience funding, will fund the delivery of priorities in the programme and it is anticipated that will maintain the risk at the current level.

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership

Agenda Item No: ICB/11/24/1**5**

Committee Chair: Cllr Louise Gittins

Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership

Committee Chair	Cllr Louise Gittins
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	1st October 2024

Key escalation and discussion points from the Committee meeting

Advise

All Together Fairer - Our Health and Care Partnership Plan

The All Together Health Care Partnership plan was presented to Partnership members.

Members were advised that £11m had been allocated to the health inequalities budget by the ICB at the beginning of the financial year. However, due to financial pressures on the NHS this had now reduced to £1.5m and there was still a commitment to address this in collaboration with partners. It was acknowledged that local authorities spent much more than the NHS on health inequality ambitions, and it would be beneficial to determine the rate of return on the total budget of the whole partnership in order to inform future decision making.

It was discussed that the other element of the partnership plan was the Marmot Strategy which was now embedded in every Local Authority Health and Wellbeing board strategy as a golden thread. It acts as a good enabler to progress things and to establish the ambitions as to how the whole Health Care partnership, including Local Authorities, Housing, Police, Fire and Rescue and the VCFSE can contribute to Health Inequalities.

Members were asked if they were now happy as a Partnership to approve the All Together Fairer, Our Health Care Partnership Plan.

Assure

State of Sector Report and Update

VCFSE Representatives presented the State of Sector Report and update to the HCP.

The update prompted a number of discussion points and actions which are summarised below.

- It was felt there could be a greater focus on opportunities to respond to climate and nature emergencies. It was acknowledged that there was a lot of public interest in nature issues and groups of volunteers planting trees and beach combing. The environmental climate was also a Marmot indicator.

- The report had a strong focus on the strength of the partnerships across the various partners and the voluntary and faith sector, as well as the size of their contribution. It was felt that it was important to formally react to the report as a partnership and to determine the next steps. It was disappointing to see the recorded low score of 8% which was the view of the sector in relation to the overall strength of relationships with the NHS.

- It was queried if there was capacity within the voluntary and faith sector to develop local authority led preventative work as there was a real opportunity for collaborative work.

- There was a discussion how the apprenticeship levy could be used more effectively across the HCP members.

- It was reported that the three local authorities in Cheshire and Warrington were in discussion with the Government about a potential devolution deal and queried how Liverpool City Region combined authority benefited from this agreement and whether they were able to share any learning. Advice was given to get the voluntary sector embedded at the beginning of the process as had happened in the Mersey region.

- It was agreed that it was important to collectively respond to the State of Sector report as a partnership with measurable actions. There should also be further discussions as to how to strengthen the impact of the anchor institutes.

Child and Family Poverty Report-CHAMPS

The Cheshire and Merseyside Child and Family Poverty Report was presented to the Partnership. The HCP was advised that CHAMPS had commissioned an independent consultant for Public Health to carry out a rapid situational analysis on child poverty within the sub region due to emerging concerns about the rising tide of child poverty.

The Report and update prompted a number of discussion points and actions which are summarised below:

- 103k children are living in poverty in the sub region and the Partnership were asked to think about what could be done collectively to support the detailed action plan to reduce this number. It was suggested that a workshop session would be beneficial in the New Year to look into this in more detail. The HCP were advised that there was a national task force for Child poverty which was keen to visit parts of the country to listen to voices from local communities and they will be invited to visit Cheshire and Merseyside to see the fantastic work being undertaken to tackle child poverty.

- It was noted that the report had highlighted that there was a high poverty rate within the Pakistan and Bangladeshi communities, and it was asked if the data could be analysed at place level to see these figures in more detail across the region. Unfortunately, it was difficult to provide this detailed level of data but acknowledged that it was important to undertake a deep dive on the data in order to focus energies and approaches with particular cohorts of the community.

- The members were informed that a session was held at Alder Hey Children's Hospital the previous week on health inequalities in which a panel of young people attended. Key points from the voice of children and young people were that every child should have a warm, clean home and an ask for Professionals to acknowledge that families are complex and are not always two adults and two children. There was also an ask to embrace neurodiversity. It was also noted that the NHS ICB had established a children and young people committee in which there was also representation from children and young people.

- It was discussed that further pressure needed to be made on addressing the more difficult decisions with the government in relation to child poverty, as it would be beneficial to make child poverty illegal as well as the removal of the two-child cap on child welfare payments. Work had been undertaken via the Anchor Institute and there was also a commitment in relation to the real living wage. It was felt that the Every Child Matters work had been effective in changing lives at a local level as it was able to target

specific vulnerable children and families. There was also a gap in community services within some Places following the closure of the Childrens centres.

- It was recommended that a piece of work would be undertaken to map out healthcare commissioned services for ages 0-19 within Warrington and Cheshire patch as this had been a beneficial exercise when undertaken by Merseycare for the Liverpool City Region.

- It was agreed that a workshop would be a good opportunity to highlight good practice across the region and in making commitments to focus efforts together as a partnership. It was agreed that preparation will be undertaken prior to the workshop to establish where the areas of good practice are within the region that could support the reduction in child poverty and these examples could be shared at the workshop.

- Members advised that a recent report had highlighted that a significant amount of benefits per year were going unclaimed. In response, a small amount of money has been provided by the government through the household support fund to provide additional resource to the Benefits Team to allow them to directly contact and support relevant people in accessing benefit support. It was also considered that it would be beneficial to set up a system which automatically provided free school meals to children who were eligible without completing a separate application.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Shaping Care Together – establishment of a Joint Committee with NHS Lancashire and South Cumbria ICB

Agenda Item No: ICB/11/24/16

Responsible Director: Clare Watson, Assistant Chief Executive
Dr Fiona Lemmens, Deputy Medical Director

Shaping Care Together – establishment of a Joint Committee with NHS Lancashire and South Cumbria ICB

1. Purpose of the Report

1.1 The purpose of the report is to present for consideration by the Board the proposed Terms of Reference for the Shaping Care Together Joint Committee with NHS Lancashire and South Cumbria Integrated Care Board (ICB).

2. Executive Summary

2.1 The Shaping Care Together (SCT) programme is a health and care transformation programme operating across Southport, Formby, and West Lancashire. Organisations involved in this partnership programme are NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB and Mersey and West Lancashire Teaching Hospitals NHS Trust. Its aim is to improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money, and buildings to maximum effect.

2.2 Following agreement at each of the July 2024 Board meetings of NHS Cheshire and Merseyside ICB and of NHS Lancashire and South Cumbria ICB to support the establishment of a Joint Committee of between the two ICBs for future decisions for the SCT programme, a Terms of Reference (TOR), appended to this report as Appendix one, has now been developed for approval at the November's Board meetings of each ICB. NHS Lancashire and South Cumbria ICB approved the TOR at its meeting of its Board on 13 November 2024.[1]

2.3 This paper also includes a summary update on the programme and the case for change engagement to date.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **consider** the update on the programme and progress made to date
- **approve** the Joint Committee Terms of Reference
- **approve** the recommendation that the ICB Chair and Chief executive identify and agree the NHS Cheshire and Merseyside ICB representatives on the Joint Committee.

[1] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers/previous-board-meetings/11-september-2024-board-meeting-2

4. Reasons for Recommendations

4.1 The Board is required to approve any Terms of Reference for Committees of the ICB Board.

5. Further information

5.1 The Shaping Care Together (SCT) programme is a health and care transformation programme operating across Southport, Formby, and West Lancashire. Organisations involved in this partnership programme are NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB and Mersey and West Lancashire Teaching Hospitals NHS Trust. Its aim is to improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money, and buildings to maximum effect.

5.2 The programme is diligently following the NHS England guidance on '*Planning, assuring, and delivering service change for patients'* including effective public involvement, enabling us to reach robust decisions on change in the best interests of our patients.

5.3 A Case for Change detailing the current and future needs of the local population, the provision of local services and the key challenges facing the health and care system was approved at the Board of NHS Cheshire and Merseyside ICB at its meeting on 25 July 2024[2], and at the meeting of the Board of NHS Lancashire and South Cumbria ICB on 17 July 2024.[3]

5.4 An extensive period of pre consultation engagement has taken place to share this Case for Change with residents to gain views on future service provision. All this feedback will be inputted into the next stage of the process, and an outcome report produced. Highlights from the period July – October 24 include;

- 2,900+ surveys completed
- Over 600 residents, patients and staff engaged with at face-to-face events
- 11,000 website visits and a reach of over 101,000 on social media as well as a reach of 800,000 non-digitally through radio advertising
- Other non-digital avenues include advertising through 54,000 pharmacy bags, adverts the Liverpool Echo Newspaper and Ormskirk Advertiser.

5.5 **Decision Making and the Joint Committee.** The Shaping Care Together programme is now in the options appraisal process (October – November 2024) following which a Pre-Consultation Business Case (PCBC) will be developed (December 2024 – January 2025).

[2] https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/2024/25-july-2024/
[3] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers/previous-board-meetings/17-july-2024-board-meeting

5.6 As the commissioners for the programme, NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB will be required to consider this PCBC for approval in early 2025.

5.7 To enable effective decision making, a proposal was approved at the Board of NHS Cheshire and Merseyside ICB at its meeting on 25 July 2024, and at the meeting of the Board of NHS Lancashire and South Cumbria ICB on 17 July 2024 for the establishment of Joint Committee between the two ICBs so as to be able to undertake jointly future decisions for the SCT programme.

5.8 As a Joint Committee of the two ICBs, the Joint Committee is ultimately accountable to the respective Boards of NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB. It is to be noted that C&M ICB are the lead commissioner.

5.9 The Joint Committee will be responsible for the approval / consideration of:

- the PCBC in relation to the SCT Programme
- Agreeing the commencement of public consultation in relation to the SCT programme and consideration of the Public Consultation outcomes, ensuring the business case meets all relevant tests/stages as set out by NHS England, including public engagement/involvement outputs and impact assessments.
- the Decision-making Outline Business Case.

5.10 Any financial matters related to Shaping Care Together will be settled before the Joint Committee meeting. These will be reviewed during the NHS England Stage 2 assurance process during January 2025, where additional approval is necessary before the PCBC is published at the Joint Committee.

5.11 It is anticipated that the first formal meeting of the Joint Committee will be in early 2025 and it is expected that the Committee will meet, as a minimum, on two occasions in public (once to consider/approve the Pre-Consultation Business Case and once for the Decision Making Case). More meetings will be included if required.

5.12 **Joint Committee Terms of Reference.** The Joint Committee TOR (Appendix One) have now been developed between the governance leads of NHS Cheshire and Merseyside ICB, NHS Lancashire and Cumbria ICB and Mersey and West Lancashire Teaching Hospitals NHS Trust. The TOR been considered and endorsed by the SCT Programme Board.

5.13 The TOR sets out the proposed role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the statutory duties of an ICB. These TOR, once approved, will need to be published on the website of each ICB.

5.14 The TOR stipulate the following regarding membership; '***Members.*** *The Committee shall draw its membership from the two Partner ICBs. The two Partner ICBs will each identify three individuals to sit on the Joint Committee as a member. For each ICB, one member will be drawn from its ICB Executive*

Officers, and one will be drawn from its ICB Non-Executive Members. Each ICB has the discretion to identify who its additional member will be.'

5.15 It should be noted that in being a named member of the Joint Committee, each member, regardless of which organisation they are drawn from, are there as a member on the Committee representing the two ICBs and are undertaking Committee duties and making binding decisions on behalf of and in the interests of both ICBs.

5.16 It is proposed that, subject to approval of the TOR by the Board, the Chair and Chief Executive of the ICB determines which three individuals are drawn from NHS Cheshire and Merseyside to form part of the membership of the Joint Committee.

6. Next Steps

6.1 Subject to the decision of the Board, the approved TOR will be published on the ICB website by the A. Meetings of the Joint Committee held in public will be published on the ICB website along with papers.

7. Officer contact details for more information

Clare Watson
Assistant Chief Executive
NHS Cheshire and Merseyside ICB

8. Appendices

Appendix One: draft Shaping Care Together Joint Committee Terms of Reference

Shaping Care Together Joint Committee

Terms of Reference

Version 0.6

Date	Version	Revision	Comment	Author / Editor
04.10.24	0.5	Update to section 2, section 5 and section 7	Updated to reflect agreements between ICBs	Matthew Cunningham, Debra Atkinson, Halima Sadia
28.10.24	0.6	Update to section 2	Removed reference to oversight of finances in the roles and responsibility section	Debra Atkinson, Halima Sadia

Review due:

V0.6 approved by the: Board of NHS Cheshire and Merseyside ICB, xx2024
Board of NHS Lancashire and South Cumbria ICB, xx2024

Partner Organisations

Organisation Name	Address	Lead Contact Officer	Website
NHS Cheshire and Merseyside ICB	No1 Lakeside, Centre Park, Warrington, WA1 1QY	Clare Watson	www.cheshireandmerseyside.nhs.uk
NHS Lancashire and South Cumbria ICB	Level 3, Christ Church Precinct, County Hall, Fishergate Hill, Preston, PR1 8XB	Sarah O'Brien	www.lancashireandsouthcumbria.icb.nhs.uk

Document control

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1. Introduction and purpose

1.1. Shaping Care Together (SCT) is a health and care transformation programme operating across Southport, Formby and West Lancashire. This partnership programme is supported by Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), NHS Cheshire and Merseyside Integrated Care Board (ICB) and NHS Lancashire and South Cumbria ICB. Its aim is to improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money and buildings to maximum effect, and it is starting with Urgent and Emergency Care as phase one.

1.2. Pursuant to section 65Z5 of the National Health Service Act 2006 as amended ('the NHS Act') NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB have agreed to establish a Joint Committee, which will be known as the **Shaping Care Together Joint Committee** (referred to as 'Joint Committee' for the purposes of this Terms of References). In accordance with Section 65Z5 of the NHS Act, ICBs can establish and maintain joint working arrangements, overseen by the Joint Committee, to jointly exercise their commissioning functions.

1.3. The Joint Committee will be responsible for the key programme decisions for the Shaping Care Together programme, supporting the Partners to collaboratively make decisions on the planning and delivery of the Programme.

1.4. These terms of reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the statutory duties of an ICB. These Terms of Reference will be published on the website of each Joint Committee partner organisation.

2. Role and responsibilities of the Joint Committee

2.1 The Joint Committee will safely, effectively, efficiently and economically discharge the joint functions in scope of the Shaping Care Together Programme and as delegated to the Committee by both ICBs through the following key responsibilities:

- determining the appropriate structure of the Joint Committee and programme governance arrangements;
- oversee the development, implementation, performance and review of the Shaping care Together Programme;
- making joint decisions in relation to the planning and commissioning of services, and any associated commissioning or statutory functions, within the scope of the Shaping Care Together programme, for the population of Southport, Formby and West Lancashire
- have due regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources in all decision-making;
- having due regard and assuring against NHS Planning, assuring and delivering service change for patient's guidance including assurance for each NHSE gateway assurance checkpoints and 5 tests (public and patient engagement, patient choice (and EIA), clinical evidence, support from GP commissioners, NHSE Bed closure test (if applicable) and Finance)
- ensuring the Joint Committee has access to appropriate clinical advice and leadership, including through Clinical Senates

- ensuring that, prior to a decision being made by the Joint Committee in relation to the services areas in scope of the Shaping Care Together Programme, that proposals for future delivery of these services are clinically led, informed by clinical evidence, research, and intelligence, and can demonstrate that they meet the needs of the population who access them;
- Consider longer-term planning of services within scope of the Shaping Care Together Programme, including the opportunities for transformation and integration of the services and functions;
- ensuring that there are effective engagement arrangements in place, and that there is meaningful involvement of the public, patients, carers, and stakeholders in the development of proposals;
- ensuring that relevant Oversight and Scrutiny Committees and appropriate local, regional and national bodies are engaged and that the ICBs and other partners comply with statutory and regulatory requirements, in particular the duties of consultation should any major service reconfiguration be recommended;
- ensure that all significant proposals undertake all relevant integrated impact assessments so that their impact can be assessed against the objectives of the Shaping Care Together Programme;
- make recommendations to the Boards of each ICB on any changes to the mandate of and scope of the services within the Shaping Care Together programme which impact on any functions, statutory duties, quality and safety of services and financial implications;

2.2 For the avoidance of doubt, in the event of any dispute when making any decisions or recommendations, the Standing Orders, Standing Financial Instructions and the Schemes of Reservation and Delegation of each ICB will prevail over these Terms of Reference.

3. Accountability and reporting

3.1 As a Joint Committee of the two ICBs, the Joint Committee is ultimately accountable to the respective Boards of NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB.

3.2 The Joint Committee will report separately and consistently to each of the two ICBs. Highlight reports and confirmed minutes of meetings of the Joint Committee will be published within the papers of ICB Board meetings held in public.

4. Authority

4.1 The Joint Committee is authorised to:

- receive and approve on behalf of both ICBs, any case for change for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs, any Pre-consultation business cases and any associated capital strategic outline case for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs any Outline Business Case or Full Business Case for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs the associated materials involved with and the initiation of any engagement or formal consultations with the

public, patients, carers and stakeholders, , in respect of the services within the scope of the Shaping Care Together Programme
- receive, consider and decide on any further next steps after receiving the outcomes of any engagement or formal consultations with the public, patients, carers and stakeholders, in respect of the services within the scope of the Shaping Care Together Programme
- 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 two ICBs (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- 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 partner ICBs for obtaining legal or professional advice.

5. Membership

5.1 **Members.** The Committee shall draw its membership from the two Partner ICBs. The two Partner ICBs will each identify three individuals to sit on the Joint Committee as a member. For each ICB, one member will be drawn from its ICB Executive Officers, and one will be drawn from its ICB Non-Executive Members. Each ICB has the discretion to identify who its additional member will be.

5.2 In being a named member of the Joint Committee, each member, regardless of which organisation they are drawn from, are there as a member on the Committee representing the two ICBs and are undertaking Committee duties and making binding decisions on behalf of and in the interests of both ICBs.

5.3 **Member Deputies**. Each ICB will need to identify named Deputies to attend meetings of the Joint Committee if their named Members are unavailable or if they are unable to attend or participate in the decision-making because they are conflicted. The named deputies will undertake the duties of and have the authority of their respective members at these Committee meetings when attending on their behalf. Members of the Committee must ensure that any such named deputy(s) are suitably briefed and qualified to act in that capacity.

5.4 **Chair and Deputy Chair(s).** At the first meeting of the Joint Committee in each financial year, the Membership shall select a Chair, and its Deputy Chair. The Chair and Deputy Chair must be selected from the non-executive members drawn from each ICB. The Chair and Deputy Chair may not be appointed from the same organisation

5.5 The incumbent(s) in the role / position of Chair and Deputy Chair shall hold office until such time as an individual is formally confirmed at the first meeting of the Joint Committee in the next subsequent financial year. At the first scheduled Joint Committee meeting after the expiry of the Chair's / Deputy Chairs term of office, the Committee Membership will select a Chair, and Deputy Chair(s), who will assume office at that meeting and for the ensuing term.

5.6 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.7 **Regular Participants.** The Joint Committee may invite regular participants or observers at its meeting in order to inform its decision-making and the discharge of its functions as it sees fit. These regular participant / observers will not form part of any formal decision making arrangements as outlined within Section 7 of these Terms of Reference.

5.8 Participants will receive advance copies of the notice, agenda and papers for Committee meetings. They may be invited to attend any or all of the Committee meetings, or part(s) of a meeting. Any such person may be invited, at the discretion of the Chair presiding over the meeting to ask questions and address the meeting but will not partake in any decision making.

5.9 The following may be invited to be regular participants to the Committee:

- representatives from Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL)
- other Officers of the two Partner ICBs
- representatives of Shaping Care Together Programme Team
- representatives of NHS England
- representatives from Provider Collaboratives
- representatives of Clinical or Research networks
- representatives from Local Government
- any other person that the Chair considers can contribute to the matters under discussion.

5.10 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.11 **Membership lists.**The Joint Committee shall ensure that there is a prepared and up-to-date list of the members and regular participants of the Committee and that this list is made available to the Partners.

5.12 **Quorum.** A Joint Committee meeting is quorate if at least the following members are in attendance:

- the Chair, or Deputy Chair
- an Executive Officer (or deputy) from both ICBs.

6. Meeting arrangements

6.1 The Joint Committee shall meet at least two times per year. Meetings may occur more frequently in line with any key decision milestones

6.2 At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year (“the Schedule”).

6.3 The Chair (or in the absence of a Chair, the Deputy Chair) shall see that the Schedule is notified to the members.

6.4 The two partner ICBs (individually or collectively) may call for a special meeting of the Joint Committee outside of the Schedule as they see fit, by giving notice of their

request to the Chair and Deputy Chair. The Chair may, following consultation with the two partner ICBs, confirm the date on which the special meeting is to be held and then issue a notice giving not less than one weeks' notice of the special meeting.

6.5 Use of video, telephone or other electronic communication means to conduct meetings of the Joint Committee is permissible with prior agreement of the Chair of the meeting. The Chair of the meeting will take into account the difficulties that might be posed to ensure proper access by members and attendees to the meeting should it, on occasion, be necessary to hold remote meetings and will make adjustments where possible.

6.6 The Joint Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the Joint Committee is at the discretion of the Partners. All members in attendance at a Joint Committee are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.

6.7 Meetings of the Joint Committee will be held in public where there is the agreement between the Partner ICBs and where it is deemed in the public interest to do so in relation to the decisions required to be undertaken by the Committee.

7. Decisions making arrangements

7.1 The aim of the Joint Committee will be to achieve consensus decision-making by its members wherever possible, and decisions made by the Joint Committee will be consistent with the powers provided to it within these terms of reference and in line with the Constitutions and Schemes of Reservation and Delegation of each ICB.

7.2 The Partner ICBs must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations to take place, however this may not always be possible for urgent issues.

7.3 Where it has not been possible, despite the best efforts of the Committee, to come to a consensus decision on any matter before the Joint Committee, the Chair, in agreement with all members present, may defer the matter for further consideration at a future meeting of the Committee or require the decision to be put to a vote in accordance with the following provisions:

- each Committee member will have one vote
- a vote will be passed with a simple majority
- there is no recourse for abstention.

7.4 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

7.5 In no circumstances may a member, or nominated deputy contribute to the business of the committee meeting or decision-making by proxy.

7.6 Decisions undertaken by the Joint Committee are binding on the two ICBs.

8. Dispute Resolution

8.1 Where helpful, the Joint Committee may draw on third-party support to assist them in resolving any disputes, such as peer review or support from NHS England.

9. Administrative Support

9.1 The partner ICBs shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint Committee.

9.2 The Joint Committee shall be supported with a secretariat function which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair and Deputy Chair with the support of the relevant officer lead to the Committee
- records of conflicts of interest members' appointments and renewal dates. Provide prompts to renew membership and identify new members where necessary
- good quality minutes are taken and agreed with the Chair. Keep a record of matters arising, action points and issues to be carried forward. Minutes of the meeting will be circulated to all Committee members within 10 working days of the meeting, highlighting actions by individual members
- the Chair is supported to prepare and deliver reports to the Boards of each partner ICB
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

10. Publication of notices, minutes and papers

10.1 The Chair (or in the absence of a Chair, the ICBs themselves) shall see that notices of meetings of the Joint Committee, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one week (or, in the case of a special meeting, two days) prior to the date of the meeting.

10.2 The proceedings and decisions taken by the Joint Committee shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The Joint Committee shall confirm those minutes at its next meeting.

11. Conduct and conflicts of interest

11.1 Members of the Joint Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies.

11.2 Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life).

11.3 Members should refer to and act consistently with the NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations.

11.4 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, either by participating in discussion or by voting. An ICB whose Committee Member is conflicted in this way may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that member.

11.4 Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs.

11.5 Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

12. Review

12.1 The Committee will review its effectiveness at least annually.

12.2 These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board of each ICB for approval.

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside

Agenda Item No: ICB/11/24/17

Responsible Director: Prof. Rowan Pritchard-Jones, Medical Director

Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside

1. Purpose of the Report

1.1 The purpose of the paper is to seek approval from the Board of NHS Cheshire Merseyside ICB to progress with the commencement of a period of public consultation, regarding ICB funded gluten free (GF) prescribing.

1.2 The approval will enable the commencement of a six-week consultation involving patients, public, staff and other key stakeholders, starting January 2025.

2. Executive Summary

2.1 Currently within NHS Cheshire and Merseyside there are differences in the prescribing of gluten free products for patients due to previous arrangements of the individual predecessor Clinical commissioning Group (CCG) organisations. As the ICB has commissioning responsibilities for all of Cheshire and Merseyside patients, work has been undertaken to rectify this position and recommend a harmonised approach to prescribing.

2.2 Across the 9 Places in Cheshire and Merseyside, there are GP Practices within 8 Places that currently offer gluten free prescribing in line with the 2018 national Department of Health and Social Care (DHSC) consultation outcome, which was to reduce prescribing to bread and bread mixes only. It is of note that St Helens CCG and NHS Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). For Cheshire West Place, the area that was covered by the former NHS Vale Royal CCG did not opt to withdraw prescribing, and as such there are still parts of Cheshire West were gluten free prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

2.3 In Cheshire and Merseyside, over 13,300 patients have a diagnosis of coeliac disease or other conditions which requires management through a gluten free diet. Most people choose to purchase their gluten free foods at supermarkets or other retailers however 2,314 patients receive their gluten free bread and bread mixes via prescription. It should be noted that of the gluten free prescriptions issued, 99% are exempt from prescription charges, with 73% being due to age (under 16 or 18 if in full time education, or over 60 years old) and over 60% of these being over the age of 60.

2.4 Under the ICBs Unwarranted Variation Recovery programme, a number of options were considered in order to address the unwarranted variation. The option to maintain the current arrangements was not considered, due to the

current unharmonised position, and the need to ensure equity across Cheshire and Merseyside. In order to achieve this, the two main options considered were to either fully prescribe across Cheshire and Merseyside at an estimated additional cost of £130k per year (increase annual spend on the service of c.£655k) or to withdraw prescribing completely, offering an estimated annual saving of £525k. (The full options appraisal can be found in Appendix One of this report).

2.5 Initially the review of the current gluten free prescribing policies was undertaken as part of the Clinical Policy Harmonisation programme which involved a clinical working group who recommended to reinstate prescribing across all of Cheshire and Merseyside which is in line with the DHSC consultation outcome. However, this position was not supported by the ICBs Finance, Investment and Our Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside.

2.6 In the context of NHS Cheshire and Merseyside needing to consider how and where to allocate the fixed resources allocated by NHS England to best meet the healthcare needs of the population they serve, the Unwarranted Variation programme has proposed that gluten free prescribing is stopped across Cheshire and Merseyside due to the following rationale:

- availability of gluten free foods is much greater than it was when the original policies were implemented, and in the six years since the DHSC consultation. It should also be noted that bread is not classed as an essential food item and people can maintain a healthy diet without bread through choosing naturally gluten free foods
- whilst the cost of gluten free bread is still more expensive than non-gluten free there are other gluten free products (e.g. pasta) which are the same price. In addition, improved food labelling and increased awareness enables people to make informed and healthy choices
- Coeliac UK now say that 40% of ICBs have stripped or reduced prescribing. Our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offer to under 18s only
- consideration was given to prescribing to under 18s only, however, Cheshire and Merseyside data shows that over 60% of gluten free prescriptions are for patients 60 years old, and therefore could be seen as discriminatory against the older population
- gluten free prescriptions are in the main received by patients who have exemptions from payment, with the majority of this being due to age (73%). Because age exemption does not take into account financial capacity, it is difficult to evidence the individual financial impact on the impacted patients.
- withdrawing prescribing has already been implemented in St Helens and part of Cheshire West and to date we are not aware of any unforeseen consequences
- ceasing ICB funded gluten free prescribing across Cheshire and Merseyside would enable achievement of a harmonised policy and remove existing unwarranted variation in access to these products based on the rationale set out in this document. In addition, it would harmonise the approach to prescribing other foods for conditions impacted by “standard” products e.g.

lactose intolerance, as NHS Cheshire and Merseyside does not currently prescribe food alternatives for other food allergies / intolerances
- a number of neighbouring ICBs including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

2.7 A decision to withdraw gluten free prescribing would require a public consultation, and which will also include engagement and/or consultation with our Local Authority colleagues through 8 of the 9 Local authority Health Overview and Scrutiny committees. Included in this report is the proposed engagement and consultation plan, subject to approval received from the Board (see Appendix Two).

2.8 The feedback from the consultation, together with that of the Local Authority Health Overview and Scrutiny Committees will inform the final proposal that will come to Board in 2025 for consideration and decision.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**
- **approve** the commencement of a consultation exercise with the public and stakeholders regarding the proposed option to withdraw ICB funded gluten free prescribing across all of Cheshire and Merseyside.

4. Reasons for Recommendations

4.1 A decision by the Board to withdraw ICB funded gluten free prescribing needs to be informed with evidence including the outcome and outputs of a consultation exercise with the public and key stakeholders. It is a legal requirement and duty on the ICB to engage and consult with the public as well as local Health Overview and Scrutiny arrangements.

5. Background

5.1 Currently NHS Cheshire and Merseyside has unwarranted variation in the prescribing of gluten free products across all Places. St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely prior to the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. For Cheshire West Place, the area that was covered by the former NHS Vale Royal CCG did not opt to withdraw prescribing, and as such there are still parts of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

5.2 Coeliac disease is an autoimmune condition associated with chronic inflammation of the small intestine, which can lead to malabsorption of nutrients. Population screening studies suggest that in the UK 1 in 100 people are

affected. The complications of coeliac disease (which may or may not be present at diagnosis) can include osteoporosis, ulcerative jejunitis, malignancy (intestinal lymphoma), functional hyposplenism, vitamin D deficiency and iron deficiency. People with conditions such as type 1 diabetes, autoimmune thyroid disease, Down's syndrome and Turner syndrome are at a higher risk than the general population of having coeliac disease. First-degree relatives of a person with coeliac disease also have an increased likelihood of having coeliac disease.

5.3 Management of coeliac disease is a lifelong gluten free diet. Historically, availability of gluten free foods was limited and expensive, so patients obtained these products via prescribing, however, all major supermarkets now commonly stock a wide range of gluten free foods and the price differential is reducing as demand grows. It should be noted that there have been a number of recent national news articles on the higher cost of these “free from” alternatives and the impact of withdrawing prescribing in context of cost-of-living increases.

5.4 Initially the former CCGs gluten free prescribing policies were reviewed as part of the Clinical Policy Harmonisation programme, the objective of which was to review existing policies and the latest evidence base to recommend a single set of policies which would enable all patients to have equitable access. Therefore, the option to continue with the current arrangements was discounted. The review of the gluten free prescribing policy involved a clinical working group who recommended to reinstate prescribing across all of Cheshire and Merseyside in line with the DHSC consultation outcome. However, as this would result in additional annual expenditure of c.£130k, this position was not supported by our Finance, Investments and Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside.

5.5 The review was then progressed under the Reducing Unwarranted Variation programme and the non-prescribing option was considered in context of the patient safety risks, and the requirement to support NHS Cheshire and Merseyside to deliver the financial objectives of the Recovery programme.

5.6 It is difficult to evidence the impact of stopping gluten free prescriptions for bread and bread mixes and understanding the impact on affected patients. Whilst there are known risks to not adhering to a gluten free diet, which could have long term health impacts and lead to greater demand on wider health services, there is now greater availability of gluten free foods in supermarkets and other retailers (both in store and on-line), improved food labelling and greater awareness of the impact of non-adherence, which all support the patient to make good food choices for a healthy diet.

5.7 The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported for progression. It was subsequently presented to the Recovery Committee on 16 September 2024 and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19 September 2024. The S&T committee supported the recommendation to present the preferred option, to cease

prescribing to the Board and that we progress to a public consultation to inform the outcome. It is of note that the options appraisal was also reviewed and considered by the Clinical Effectiveness Group on 2 October 2024 and the group supported progressing consulting of the proposed preferred option to withdraw prescribing across Cheshire and Merseyside.

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

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

- The proposal seeks to remove unwarranted variation in access to prescribing for gluten free bread and bread mixes. It is of note that prescriptions are not available for other food allergies / intolerances, so this will further remove unwarranted variation. GF goods are much more widely available in supermarkets and other retailers both in store and on-line and therefore more accessible to patients. Food labelling has improved so patients are able to identify naturally gluten free foods, and there is greater awareness of the impact of not following a GF diet, so patients are more informed to make healthy diet choices. In addition, it would harmonise the approach to prescribing other foods for conditions impacted by "standard" products e.g. lactose intolerance.

Objective Two: Improving Population Health and Healthcare

- The ICB has a duty to consider how and where to allocate the fixed resources that it receives from NHS England, and this proposal to stop prescribing GF bread and bread mixes will enable the ICB to save an estimated £525k per year which could be allocated to more critical services.

Objective Three: Enhancing Productivity and Value for Money

- The ICB has a duty to consider how and where to allocate the fixed resources that it receives from NHS England, and this proposal to stop prescribing GF bread and bread mixes will enable the ICB to save an estimated £525k per year which will support delivery of the financial recovery plan or allow funds to be reallocated to more critical services.

Objective Four: Helping to support broader social and economic development

- This proposal does not directly contribute to this objective.

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

This proposal is aligned to the annual delivery plan through the Effective Use of Resource element contributing to the delivery of clinical policy harmonisation and supporting the finance efficiency and value programme.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
Key to both the clinical policy harmonisation and unwarranted variation programmes is the focus on ensuring all Cheshire and Merseyside residents have equal access to services. In addition, sustainability of services must be considered when making decisions on how to spend limited resource. A QIA has been completed and reviewed by the Associate Directors of Quality who support the proposal to stop prescribing based on re-allocation of this resource to focus on other critical services. (The QIA is available in appendix four).

Theme Two: Integration
The proposal does not directly relate to this theme, however, in relation to the 'safe systems' quality statement, if supported by the Board the next step will be a public consultation which will enable the views of the population to help shape the outcome.

Theme Three: Leadership
If the proposal is supported by the Board, there will be a public consultation exercise through which we will work with wider partners and stakeholders, including providers of NHS services, local authorities, Healthwatch, and voluntary, community, faith and social enterprise (VCFSE) organisations to support us to engage with the right people. We will engage throughout with our Local Authority colleagues through the Health Overview and Scrutiny committees in the impacted Places. This relates to the 'partnerships and communities' quality standard.

9. Risks

9.1 It is difficult to evidence the impact of Coeliac patients not being able to access gluten free bread and bread mixes, but there are known risks to not adhering to a gluten free diet which could have long term health impacts and lead to greater demand on wider health services. An example given by Coeliac UK states it costs £195 a year per patient to support gluten free on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.

9.2 Mitigation: A published DHSC Impact Assessment examines the issue of adherence in detail and concludes that adherence to a gluten free diet cannot be isolated to any single cause. Evidence shows that many factors are at play including product labelling, cost and information when eating out and managing social occasions. Adherence requires a range of knowledge and skills to avoid all sources of gluten. Gluten free foods are now much more readily available in supermarkets and other retailers, both in store and on-line, making them more accessible. In addition, there is improved food labelling across all foods and greater awareness of adherence to gluten free diet helping people to make healthy choices. It should be noted that although gluten free bread and bread mixes are still more expensive, the cost of these products has been reducing

over time and there are other GF foods at comparable prices to standard foods for example 500g of GF pasta being the same price as 500g of standard pasta. It is also worth noting that bread is not an essential food item and there are many naturally occurring GF foods.

9.3 There is a reputational risk to the ICB if the proposal to stop prescribing is accepted. Due to the current cost of living, there have been a number of national articles on the increased cost of "free from" foods despite them being much more available. In addition, 99% of the cohort of patients receiving prescriptions have an exemption in that they do not pay for prescriptions so could be seen that we are disadvantaging our most vulnerable population.

9.4 Mitigation: A public consultation would be held in those Places who currently prescribe, the outcome of which will inform the final decision. It should be noted that the ICB does not prescribe food products for other conditions that are associated with or affected by types of food.

10. Finance

10.1 If the proposal is supported by the Board and implemented following a public consultation exercise, this would offer the ICB an estimated annual saving of £525k and a cost avoidance of a further £130k (the estimated cost of harmonising prescribing across all Places).

10.2 The public consultation exercise would be led by NHS Cheshire and Merseyside's in-house communications and engagement team; however, it is anticipated that up to £12,000 one-off enabling funding will be required to support delivery. This would include analysis of consultation findings and production of a report to inform the final decision, and funding for additional formats, including easy read versions and other languages. It is standard practice for public consultation reports to be produced by an external organisation.

11. Communication and Engagement

11.1 A supporting comms and engagement plan is available in appendix two.

12. Equality, Diversity and Inclusion

12.1 An equality, diversity and inclusion assessment (EIA) was undertaken and can be viewed in appendix three.

13. Climate Change / Sustainability

13.1 This proposal does not directly relate the ICB green plan or net zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 If the recommendation to progress consulting on our proposal for ICB funded gluten free prescribing, a public consultation exercise will be held, with proposed start date of January 14th 2025 continuing for six-weeks until Tuesday February 2025.

14.2 Engagement will commence with Local Authority Health Overview and Scrutiny committees to determine how best to engage and/or consult with them.

14.3 Feedback on the consultation will inform the final recommendation put to the which will be presented to a future Board meeting for Board decision.

14.4 The work will be taken forward by the Reducing Unwarranted Variation Programme Team under the direction of Anthony Leo as Senior Responsible Officer, Professor Rowan Pritchard-Jones as Clinical Lead and Natalia Armes as Programme Director.

15. Officer contact details for more information

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16. Appendices

Appendix One: Gluten Free Prescribing Options Appraisal document
Appendix Two: Communications and Engagement Plan
Appendix Three: Equality, Diversity and Inclusion Impact Assessment
Appendix Four: Quality Impact Assessment

Options Appraisal ICB funded Gluten Free products Prescribing across Cheshire and Merseyside

Contents

Glossary

Term	Definition
Coeliac Disease	Coeliac disease is a lifelong autoimmune disease caused by a reaction to gluten. Once diagnosed, it is treated by following a gluten free diet for life
Gluten	Gluten is a protein found in wheat, rye and barley.

1 Executive Summary

Currently NHS Cheshire and Merseyside has unwarranted variation in the prescribing of gluten free products across all Places. St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (to note the footprint previously under Vale Royal CCG within Cheshire West Place still undertake some prescribing) prior to the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018.

In Cheshire and Merseyside, over 13,300 patients have a diagnosis of coeliac disease or other conditions which requires management through a gluten free diet. Most people choose to purchase their gluten free foods at supermarkets or other retailers however 2,314 patients receive their gluten free foods via prescription. It should be noted that of the prescriptions issued, 99% are exempt from prescription charges, with 73% being due to age (under 16 or 18 if in full time education, or over 60 years old) and over 60% of these being over the age of 60.

Under the Unwarranted Variation Recovery programme, a number of options were considered in order to address the unwarranted variation, but the 2 main options were to either fully prescribe across Cheshire and Merseyside at an estimated additional cost of £130k per year (increase annual spend on the service of c.£655k) or to withdraw prescribing completely offering an estimated annual saving of £525k.

Initially the review of the current gluten free prescribing policies was carried out under the Clinical Policy Harmonisation programme and involved a clinical working group who recommended reinstating prescribing across all of Cheshire and Merseyside which is in line with the DHSC consultation outcome. However, this position was not supported by our Finance, Investments and Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside.

In the context of the financial challenge facing NHS Cheshire and Merseyside, the Unwarranted Variation programme has reviewed all options and are proposing that gluten free prescribing is stopped due to the following rationale:

- Availability of gluten free foods is much greater than it was when the original policies were implemented, and in the six years since the DHSC consultation. It should also be noted that bread is not classed as an essential food item and people can maintain a healthy diet without bread through choosing naturally gluten free foods.
- Whilst the cost of gluten free bread is still more expensive than non-gluten free there are other products (e.g. pasta) which are the same price. In addition, improved food labelling and increased awareness enables people to make informed and healthy choices.
- Coeliac UK now say that 40% of ICBs have stopped or reduced prescribing, our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offering to under 18s only.
- Consideration was given to prescribing to under 18s only, however, C&M data shows that over 60% of the population receiving prescriptions are over 60 years and therefore could be seen as discriminatory against the older population.
- Gluten free products are in the main received by patients who have exemptions from payment, with the majority of this being due to age (73%) and because exemption does not take into account financial capacity, it is difficult to evidence the individual financial impact on the impacted patients.
- Withdrawing prescribing has already been implemented in St Helens and part of Cheshire West and to date we are not aware of any unforeseen consequences.
- NHS Cheshire and Merseyside do not currently prescribe food alternatives for other food allergy / intolerances e.g. lactose intolerance.
- A number of our ICB neighbours including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

A decision to withdraw gluten free prescribing would require a public consultation in 8 of the 9 Places including engagement with our Local Authority colleagues through Oversight and Scrutiny committees.

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported for progression. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board for approval to progress to a public consultation to inform the final decision.

It is of note that the options appraisal was also reviewed and considered by the Clinical Effectiveness Group on 2nd October and the group supported progress of the proposed option to withdraw prescribing across Cheshire and Merseyside.

The Board is asked to approve the recommendation to progress a proposal for a non-prescribing option for gluten free bread and bread mixes in order to commence a public consultation starting in January 2025. The feedback from this exercise, together with that of our Oversight and Scrutiny Committees will inform the decision whether to continue with this recommended option. In addition, the Board is asked to receive the feedback from this exercise at the first available board meeting.

2 Background

Currently NHS Cheshire and Merseyside has unwarranted variation in the prescribing of gluten free products across all Places. St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely prior to the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. Further information about this consultation and the revised regulation subsequently put in place is available on the NHS England website (NHS England » Prescribing Gluten-Free foods in Primary Care: Guidance for Clinical Commissioning Groups – frequently asked questions). For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

Coeliac disease is an autoimmune condition associated with chronic inflammation of the small intestine, which can lead to malabsorption of nutrients. Population screening studies suggest that in the UK 1 in 100 people are affected. The complications of coeliac disease (which may or may not be present at diagnosis) can include osteoporosis, ulcerative jejunitis, malignancy (intestinal lymphoma), functional hyposplenism, vitamin D deficiency and iron deficiency. People with conditions such as type 1 diabetes, autoimmune thyroid disease, Down's syndrome and Turner syndrome are at a higher risk than the general population of having coeliac disease. First-degree relatives of a person with coeliac disease also have an increased likelihood of having coeliac disease.

Management of coeliac disease is a lifelong GF diet. Historically, availability of GF foods was limited and expensive, so patients obtained these products via prescribing, however, all major supermarkets now commonly stock a wide range of GF foods and the price differential is reducing as demand grows. It should be noted that there have been a number of recent national news articles on the higher cost of these “free from” alternatives and the impact of withdrawing prescribing in context of cost-of-living increases.

Initially the former CCGs gluten free prescribing policies were reviewed as part of the Clinical Policy Harmonisation programme and involved a clinical working group who recommended to reinstate prescribing across all of Cheshire and Merseyside in line with the DHSC consultation outcome.

However, as this would result in additional annual expenditure of C.£130k, this position was not supported by our Finance, Investments and Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside

The review was then progressed under the Unwarranted Variation programme and the non-prescribing option was considered in context of the patient safety risks, and the requirement to support NHS Cheshire and Merseyside to deliver the financial objectives of the Recovery Programme.

It is difficult to evidence the impact of stopping GF prescriptions and understanding whether the impacted patients would continue to follow a GF diet. Whilst there are known risks to not adhering to a GF diet, which could have long term health impacts and lead to greater demand on wider health services, there is greater availability of GF foods in supermarkets and other retailers, improved food labelling and greater awareness of the impact of non-adherence, which all support the patient to make good food choices for a healthy diet.

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board and that we progress to a public consultation to inform the outcome. In addition, the Clinical Effectiveness Group also supported progression of the proposed option on 2nd October.

3 Approach

The gluten free prescribing policy was initially reviewed under the Clinical Policy Harmonisation Programme (CPH) the objective of which was to review existing policies and the latest evidence base to recommend a single set of policies which would enable all patients to have equitable access. The review of the gluten free prescribing policy focused on the published evidence base DH&SC and Coeliac UK recommendations with input from clinicians, dieticians and pharmacists and was led by the CPH Steering Group which includes commissioners, GP, Pharmacist and public health leads. An options appraisal was carried out to consider a number of options to harmonise the prescribing position and an EIA and QIA were developed to consider all options. Therefore, the option to continue with the current arrangements was discounted.

The CPH programme recommended that the harmonised policy be to implement gluten free prescribing in accordance with DHSC guideline, however, this comes at an additional annual cost of C.£130k and this was not able to be supported by the Finance, Investment and Resources Committee at the time. It is of note that this work was placed on hold, due to the financial pressures and pre-election activity so it was brought into the scope of the Reducing Unwarranted Variation Recovery Programme (noting that 3 members are consistent with the previous Clinical Policy Steering Group) and review has also been completed by the Deputy Medical Director and Clinical Lead for Reducing Unwarranted Variation (RUV) Programme.

In the context of the ICB financial recovery plan, the RUV programme carried out a further review which considered Cheshire and Merseyside data, prices and availability of GF foods in supermarkets and other retailers, both instore and on-line, improvements in food labelling and increased information via websites on how to maintain a GF diet. Following discussions on these findings with Place Clinical Directors and Associate Directors of Quality, the Reducing Unwarranted Variation Steering group **is recommending as a financial decision, prescribing is stopped across Cheshire and Merseyside** and this view is supported by the Deputy Medical Director and Programme Clinical Lead.

The group recognised that this goes against the latest published guidance, however, it should be noted that this is now 6 years old, and this is not a medicine or prescription for an essential food item (as it is for bread or bread mixes only). In addition, the group noted that this is a similar stance as taken with other food allergies / intolerances and dietary requirements where we do not offer alternative food items by prescription and increasing affordable gluten free products are available at supermarkets. This

recommendation would result in a financial saving of circa. £525k and avoid additional expenditure of £130k.

3.1 Current Cheshire and Merseyside Activity and Spend on Gluten Free Prescribing

Across Cheshire and Merseyside, 8 Places still have a Policy that includes GF prescribing at an annual cost of circa £525k for the year 2023/2024. Prior to the establishment of the ICB, two of the former CCGs (St Helens and West Cheshire) withdrew GF prescribing as a cost cutting policy, although it is of note that GP practices in the former Vale Royal CCG footprint still prescribe as shown within the table below.

Cheshire and Merseyside - Gluten Free Prescribing 2023/24

				per 1,000 Wtd Pop.	
Row Labels	Sum of Items	Sum of Actual Cost	Weighted Pop	Items	Actual Cost
Sefton	3816	£87,559	310666	12.28	£281.84
CHESHIRE EAST	4909	£97,731	429865	11.42	£227.35
Knowsley	2156	£46,220	196251	10.99	£235.52
Halton	1551	£32,413	149417	10.38	£216.93
Wirral	3724	£77,017	385940	9.65	£199.56
Liverpool	5953	£122,669	646320	9.21	£189.80
Warrington	1953	£41,160	232237	8.41	£177.23
CHESHIRE WEST & CHESTER	939	£19,396	410116	2.29	£47.29
St Helens	20	£413	231122	0.09	£1.79
Grand Total	**25021**	**£524,579**	**2991933**	**8.36**	**£175.33**

Gluten Free Prescribing Exemption in Cheshire and Merseyside

In Cheshire and Merseyside over 13,300 patients have a diagnosis of coeliac disease, with only 17.4% (2,314) receiving prescription gluten free food.

The table below details the breakdown of GF prescriptions across Cheshire and Merseyside and shows that 99% of prescriptions issued are currently exempt from prescription charges.

	Chargeable at Current Rate		Exempt	
Row Labels	Number of Items	Proportion	Number of Iter	Proportion
Cheshire East	21	1.03%	2020	98.97%
Cheshire West	11	2.72%	393	97.28%
Halton	6	0.93%	637	99.07%
Knowsley	5	0.57%	869	99.43%
Liverpool	24	0.96%	2465	99.04%
Sefton	5	0.32%	1556	99.68%
St Helens		0.00%	10	100.00%
Warrington	6	0.76%	785	99.24%
Wirral	14	0.93%	1488	99.07%
Cheshire and Merseyside	92	0.89%	10223	99.11%

Of these exemptions, 73% is due to age (under 16 or 18 if in full time education, or over 60 years old), with the majority being over the age of 60.

According to Coeliac UK, most people are diagnosed from 50 years old and coeliac disease is most common in people aged between 50-69 years old.

Row Labels	Exempt	
	Number of Items	Proportion
Aged 60 Or Over	6253	61.17%
No Declaration/Declaration Not Specific	1950	19.07%
Under 16 / Aged 60 Or Over	898	8.78%
Pre-Payment Certificate	315	3.08%
Aged 16-18 And In Full Time Education	311	3.04%
Medical Exemption	287	2.81%
Income Support	87	0.85%
Universal Credit	64	0.63%
HC2 Charges	19	0.19%
NHS Tax Credit Exemption Certificate	19	0.19%
Maternity Exemption	15	0.15%
Income Based Job-seekers Allowance	3	0.03%
HRT Pre-payment Certificate	1	0.01%
Pension Guarantee Credit	1	0.01%
Unassigned		0.00%

3.2 Current Prescribing Approaches across England (where available)

Coeliac UK state that 40% of ICBs have stopped or reduced prescribing. Where the information was published, our research shows that 32% have stopped completely with 61% prescribing bread and bread mixes, 6% prescribing to under 18s only and 6% prescribe bread only. (see appendix E).

The table below shows the policy stance of local ICBs:

Prescribe bread & bread mixes	Do not prescribe – all ages
• Greater Manchester – all ages • Staffordshire – for those under age of 18 only	• Lancashire and South Cumbria • Shropshire, Telford and Wrekin

3.3 Guiding principles:

- To reduce unwarranted variation and harmonise access to services across Cheshire and Merseyside.
- Use the latest evidence base to develop harmonised policies
- Consider sustainability of Cheshire and Merseyside ICB in context of financial requirements

3.4 Strategic Context

The main objectives identified are:

Objective 1	
Objective	Tackling health inequality, improving outcomes and access to services
Current Arrangement	7* of 9 Places currently offer gluten free prescribing in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area). In addition, there are other patients who are diagnosed with food related allergies / intolerance conditions who do not receive prescriptions to

Objective 1	
	manage their diet and therefore could be argued that those patients are disadvantaged by a prescribing option.
Gap/Business Needs	In order to harmonise the position across C&M, there are 2 options, one to implement prescribing across all 9 Places at a potential additional cost of £130k per year; a total estimated cost of £655k per year or to withdraw prescribing across all 9 places at a potential saving of £525k per year.
Objective 2	
Objective	Enhancing quality, productivity and value for money
Current Arrangement	7* of 9 Places currently offer gluten free prescribing in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area). In addition, there are other patients who are diagnosed with food related allergies / intolerance conditions who do not receive prescriptions to manage their diet and therefore could be argued that those patients are disadvantaged by a prescribing option. There is a risk to patient safety if patients do not follow a GF diet (quality) and potential impact on wider services in the future.
Gap/Business Needs	In order to harmonise the position across C&M, there are 2 options, one to implement prescribing across all 9 Places at a potential additional cost of £130k per year; a total estimated cost of £655k per year or to withdraw prescribing across all 9 places at a potential saving of £525k per year.

4 Options and considerations

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
1	Do nothing ***-discounted option***	Inequity of prescribing for patients across C&M	No EIA completed	No change to current situation, but unwarranted variation across C&M	Current **annual spend of circa £525,000** will be maintained
2	NHS C&M adopt prescribing to national guidelines across all Places	Harmonised C&M policy in line with evidence base. Public involvement exercise could be minimal as there has already been a full consultation by DHSC.	In line with DHSC EIA guidance following extensive public consultation and EIA completion (see appendix F). If not prescribed will be contrary to national published guidance, however, this EIA is now 8 years old. Minimal equality impact identified. (see appendix A)	Equity across C&M and improves access to patients in the Places who do not currently receive prescribed gluten free goods. **Overall Risk rating: 1 Green – Low risk** (see appendix B)	Estimated increase in spend of £130,000. **Estimated annual spend £655,000**
3	NHS C&M to withdraw prescribing across all Places	Harmonised C&M policy contrary to published guidance however, this is now 6 years old. Public consultation exercise would be required in 8 Places	A number of groups of patients could be at risk of dietary neglect as clear links were identified between: - age (those aged under 16, those aged 16, 17 and 18 in full time education, and those aged 60 or over are eligible for prescription exemptions) - Gender (reported cases of coeliac disease are two to three times higher in women than men), -pregnancy and maternity (e.g. Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications) (see appendix C)	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. (see appendix D)	Most current spend would cease leading to an estimated saving of £525,000 with further estimated cost avoidance of £130k **Estimated annual spend £0**

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
			- Families on low income (due to eligibility for exemptions from prescription charges)	**Overall Risk rating: 4 Amber – moderate**	
4	Prescribe to under 18s only – ***discounted option***	Harmonised policy but only for young people, therefore inequity of access for patients across C&M. Public consultation would be required in all 9 Places.	This option is against published guidelines (& this would benefit less than 15% of the C&M population receiving GF prescriptions). A number of groups of patients could be at risk of dietary neglect as clear links were identified between: - age and in particular those aged 60 or over are eligible for prescription exemptions - Children and young people are not financially independent so this option would support them to adhere to a GF diet - Gender (reported cases of coeliac disease are two to three times higher in women than men), -pregnancy and maternity (e.g. Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications) - Families on low income (due to eligibility for exemptions from prescription charges)	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. Whilst this option would support younger people, they make up less than 15% of the C&M population receiving GF prescriptions.	Based on 10% of current spend estimated costs would be £50,000 - £60,000 per annum. This results in a saving of £465,000 - £475,000

4.1 Risks, Constraints & Dependencies

The following risks, constraints and dependencies have been highlighted as part of the development of the case for change.

Risks

The following risks have been identified with the achievement of the programme outcomes:

Risk	Mitigating actions
It is difficult to evidence the impact of Coeliac patients not being able to access Gluten Free (GF) bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts and lead to greater demand on wider health services. An example given by Coeliac UK states it costs £195 a year per patient to support GF on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.	A published DHSC Impact Assessment examines the issue of adherence in detail and concludes that adherence to a GF diet cannot be isolated to any single cause. Evidence shows that many factors are at play including product labelling, cost and information when eating out and managing social occasions. Adherence requires a range of knowledge and skills to avoid all sources of gluten. Gluten free foods are now much more readily available in supermarkets, with clear gluten free labelling. It should be noted that although GF bread and bread mixes are still more expensive the cost of these products has been reducing over time and there are other GF foods at comparable prices to standard foods for example 500g of GF pasta being the same price as 500g of standard pasta. It is also worth noting that bread is not an essential food item and there are many naturally free GF foods e.g. potatoes, rice. If the option to stop prescribing was accepted, signposting on how to adhere to a gluten free diet would be made available on the ICB website and GPs would continue to monitor these patients as usual. Also engagement with supermarkets in Cheshire and Merseyside would be undertaken to advise of the change in prescribing with a request for them to manage their stock levels accordingly.
Risk	**Mitigating actions**
There is a reputational risk to the ICB if the option to withdraw prescribing is accepted. Due to the current cost of living, there have been a number of national articles on the increased cost of “free from” foods despite them being much more available. In addition, 99% of the cohort of patients receiving prescriptions have an exemption in that they do not pay for prescriptions so	The ICB does not prescribe for other conditions that are associated with, or affected by the types of food they eat, so this would result in a fairer approach for these patients. A public consultation exercise would be held in those Places who currently prescribe in line with the approach in St Helens and the relevant area of Cheshire West.

could be seen that we are targeting our most vulnerable population.	
If the option to re-instate prescribing is accepted, there is a financial risk to the ICB in that an additional £130k per year would be required to support this, meaning an estimated annual spend of £655k. This may result in other critical funded services not being funded as a consequence of the further cost pressure.	Place based Medicines Management teams would review prescribing quantities to ensure they are in line with Coeliac UK guidance. This may mitigate some of the cost. Noting that this option is not the recommended option of the Reducing Unwarranted Variation Steering Group.

Constraints

- The review is being undertaken in context of the recovery programmes.
- Due to the significance of the change, a public consultation exercise would be required if any option to withdraw prescribing was accepted. In addition, it would be necessary to engage and consult with the Oversight and Scrutiny Committees in all affected Places. A Joint OSC meeting would need to be formed, composed of the Local Authorities where the population would be impacted. The availability and timing of these meeting would be largely dictated by the Local Authorities. This would impact the timing of benefits delivery.
- Engagement/communication would also be required with local MPs.
- Consideration is needed regarding any delays to benefits delivery caused by the potential for 'call in' to the SoS for Health & Care of any proposed service change – members of the public or organisations can write to the Secretary of State at any stage of the process.

Dependencies

- NHS Cheshire and Merseyside's communications and engagement team is currently focused on a number of pieces of public involvement work. Any public involvement requirements around gluten-free prescribing will need to be considered alongside existing work plans.
- Public involvement activity has resource implications. It is standard practice to commission independent analysis and reporting of feedback from public consultation, aside from any additional requirements around delivery of consultation activity. There is a need to scope out the requirements and identify the necessary budget.

5 Options Appraisal and Financial Case

For completeness a range of options have been considered as part of the case for change, a brief description of full range of options is below:

Option 1: Do nothing – 8 of 9 Places prescribe GF products, St Helens and part of Cheshire West do not prescribe (Option discounted)

Pros	Cons
• The financial position of the ICB does not change.	• There is unwarranted variation across Cheshire and Merseyside in unequal access to GF bread and bread mixes for our patients. • There is an increased risk of challenge by Equalities and Human Rights commission re inequality in service access. • Financial impact remains at circa £525k per annum.

Option 2: Implement Prescribing of bread and bread mixes across whole of Cheshire and Merseyside

Pros	Cons
• Harmonised access to GF bread and bread mixes across C&M • In line with evidence base • Supported by Quality and EDI Teams and Clinicians • Review of the quantities prescribed in each Place could mitigate the additional cost	• Additional estimated annual cost of £130k making a total of estimated annual cost £655k per annum • This may impact the ability to support other areas of need due to financial constraints across the Integrated Care System. • There are other patients who suffer from other food allergies or intolerances who do not receive prescribed food goods, this option could be seen as increasing inequity for these patients.

Proposed next steps and estimated timeframe for Option 2:

1) Recovery Committee (September 16th) and Strategy & Transformation Committee (STC) (19th September) supported recommendation to withdraw prescribing
2) The recommendation from STC to be considered and decision to be ratified by Board – 28th November 24
3) Public Involvement exercise in St Helens and Cheshire (West Vale Royal GP Practices) (working assumption is this would be a communications exercise)
4) Harmonised policy to be launched across all Places – no change for 8 of 9 – December 24

Option 3: Withdraw Prescribing across whole of Cheshire and Merseyside

Pros	Cons
• Harmonised access to GF products across C&M • Financial benefit to the ICB of £525k per annum • Increased fairness in prescribing policies as NHS does not provide food on prescription for other groups of patients who conditions are associated with, or affected by, the type of food they eat.	• Contrary to the latest published guidance, however, this is now 8 years old and the prices of GF goods have been reducing, therefore would be purely financial rationale • Concerns identified through the EIA and QIA process particularly around the impact on vulnerable patients (particularly age) and for those patients on low income the risk of increasing health inequalities. • Consultation required in 8 places. Time delay and potential cost to develop outcomes report. • Risk of negative publicity for ICB particularly in local press. • Increased risk of challenge by EHRC (as per above) • Increased risk of judicial review raised by individuals/organisations

Proposed next steps and estimated timeframe for Option 3:

1) Recovery Committee (September 16th and Strategy & Transformation Committee (19th September) support recommendation
2) Public consultation plan and materials to be developed.
3) The preferred option (subject to public consultation), and public consultation plan, to be approved by Board – 28th November 24
4) Public consultation exercise 8 weeks (subject to further discussion around timings and resources) – January 25 to February 25
5) Feedback and analysis report on consultation completed (approx. 4 weeks required) – March 25
6) Engagement with OSC on feedback from consultation exercise – to be confirmed
7) Feedback on consultation exercise presented to Board. Board asked to decide on whether to proceed with no GF prescribing approach – to be confirmed
8) Feedback on consultation exercise and Board decision presented to OSC - TBC
9) Subject to outcomes of public consultation and final decision-making, policy launch & benefits realisation start – to be confirmed

Option 4: Prescribe to under 18s only (Option discounted)

Pros	Cons
• Harmonised approach to prescribing of GF bread and bread mixes across C&M • Financial benefit to the ICB of £465,000 - £475,000 per annum • Would support the younger coeliac patients to follow a correct diet until adulthood.	• Contrary to evidence base • Concerns identified through the EIA and QIA process around the impact on vulnerable patients particularly age (as over 60% of issued GF prescriptions are due to patients being aged 60+) and for those adult patients on low income as there is a risk of increasing health inequalities • Would require public engagement in all 9 Places • Risk of negative publicity for ICB particularly in local press. • This option does not provide a service for the majority of patients who are currently receiving GF prescriptions (15% under 19yo) • Increased risk of challenge by EHRC (as per above) • Increased risk of judicial review raised by individuals/organisations

5.1 Financial Case: Following the initial options assessment, Options 1 and 4 have been discounted.

Options	Description (*Committed costs)	Non-recurrent Year 1	Non-recurrent Year 2	Recurrent costs (Annual)	Comments
Option 1: Do nothing – 8 of 9 Places prescribe GF products, St Helens and part of Cheshire West do not	£525,000	£525,000	£530,000	£538,000 (yr 3)	Based on ONS population growth projection
Option 2: Implement Prescribing across whole of Cheshire and Merseyside	£650,000	£650,000	£661,700	£672,287 (yr 3)	Based on ONS population growth projection, however, could increase if cost of products or activity increases. Place prescribing Teams would also review prescribing quantities to ensure all in line with guidance.
Option 3: Withdraw Prescribing across whole of Cheshire and Merseyside	-£525,000	-£525,000	-£525,000	-£525,000	Provides a consistent approach to prescribing for food intolerances. Whilst this does not adhere to published guidance, this is now 6 years old. It is of note that the £525k is a cash releasing saving with a further cost avoidance of £130k.
Option 4: Prescribe to under 18s only	-£465,000 - £475,000	-£465,000 - £475,000	-£465,000 - £475,000	-£465,000 - £475,000	Not in line with published guidance and does not reflect the need of C&M demographics

6 Recommendation

In the context of the Recovery Programme and following further review and the formation of this options appraisal, the Reducing Unwarranted Variation Steering Group recommend the progression to public consultation of option 3, to withdraw prescribing of bread and bread mixes. This recommendation has also been discussed by the Deputy Medical Director and Associate Directors of Quality, and also with the Clinical Effectiveness Group who also support based on the QIA risk scores and EIA.

The context of this recommendation is that availability of GF foods has increased since the original policies were implemented, and whilst the cost of GF bread and bread mixes is still higher, some GF products (e.g. pasta) is the same price. Food labelling is much improved supporting patients to make healthy choices, and in addition, this is not a prescribed medication and bread and bread mixes are not considered an essential food item.

In addition, the withdrawal of prescribing of GF foods has already been implemented in St Helens and part of Cheshire West and so far, we are unaware of any unforeseen consequences; and NHS Cheshire and Merseyside do not prescribe products for other food alternatives for other food allergy / intolerances.

It should be noted that 99% of GF prescriptions issued are subject to payment exemption, the reason for the majority (73%) is that of age. A number of our ICB neighbours including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

In accordance with the framework methodology established as part of the decommissioning policy, this has been undertaken for Gluten Free prescribing and the output is as follows:

The combined impact of the individual criterion scores, when put through the Prioritisation Framework tool is an overall score of 4.86. This equates to an overall assessment of “Consider Decommission / discontinue” indicating that this investment carries a relatively low priority within the context of financial recovery. (see appendix G).

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board and that we progress to a public consultation to inform the outcome.
The recommendation to withdraw prescribing is also supported by the Recovery Committee and the Strategy and Transformation Sub-Committee based on the financial case and the QIA and EIA feedback. It is of note that the options appraisal was also reviewed and considered by the Clinical Effectiveness Group on 2nd October and the group supported progress of the proposed option to withdraw prescribing across Cheshire and Merseyside.

6.1 The Ask:

The Board are asked to:

- **approve** the recommendation put forward by the Reducing Unwarranted Variation Steering Group and supported by the Recovery Committee and Strategy and Transformation sub-committee to progress a proposal for a non-prescribing option for gluten free bread and bread mixes in order to commence a public consultation starting in January 2025. The feedback from this exercise, together with that of our Oversight and Scrutiny Committees will inform the decision whether to continue with this recommended option.

Appendices

Appendix A – EIA for option 2 – prescribe across all Places

Appendix A EIA Clin070 GlutenFree S1

Appendix B – EIA for option 3 – stop prescribing across all Places

Appendix%20B%20revised%20EIA%20Glut

Appendix C – QIA for option 2 –- prescribe across all Places

Appendix%20C%20CM%20ICB%20QIA%2(

Appendix D – QIA for option 3 – stop prescribing across all Places

Appendix%20D%20NHS%20Cheshire%20a

Appendix E – National Gluten Free Prescribing Offers (where available)
https://westcheshireway.glasscubes.com/share/s/62deuiccpflvuqvc4kedtu31qo

Appendix F – DHSC EIA
https://assets.publishing.service.gov.uk/media/5a823231e5274a2e87dc1a59/Equality_impact_assessment_-_GF_food.pdf

Appendix G – NHC C&M Decommissioning Framework review
https://westcheshireway.glasscubes.com/share/s/ku6ksdqu610ekti92nuci6rj07
https://westcheshireway.glasscubes.com/share/s/v8g9ga836ob739m35697hq4d1e

Gluten-free prescribing proposal

Draft plan for public consultation

Introduction and background

Gluten free (GF) products are sometimes prescribed to individuals who suffer from coeliac disease.

Updated national guidance on prescribing of GF products was introduced in 2018, with the intention of reducing previous variation in what was prescribed. The new guidance meant that GF products that fell outside the category of a bread or a mix were no longer prescribed at NHS expense. Local commissioners were encouraged to align their local policies with the amended regulations, but could also choose to restrict further by selecting bread only, mixes only or choose to end prescribing of all GF foods, if they felt this was appropriate for their population.

As the successor body to nine former clinical commissioning groups (CCGs), NHS Cheshire and Merseyside inherited each CCG's commissioning policies, including those for GF prescribing. Currently, there is not a single approach to prescribing of GF products across Cheshire and Merseyside. Seven areas or 'Places' (Cheshire East, Halton, Knowsley, Liverpool, Sefton, Warrington and Wirral) offer gluten free bread and bread mixes on prescription to eligible patients, while St Helens and Cheshire West do not offer this (although there are still some parts of Cheshire West where prescribing is undertaken – Winsford, Northwich, Middlewich and surrounding area).

On 28 November 2024, the Board of NHS Cheshire and Merseyside will be asked to give the go-ahead for a public consultation about a proposal to end ICB funded gluten free prescribing across Cheshire and Merseyside.

This document outlines NHS Cheshire and Merseyside's plan for holding a public consultation on this proposal from 14 January to 25 February 2025, pending the Board's approval. It should be read alongside the following paper being presented to Board: *Proposal for ICB funded Gluten Free Prescribing across Cheshire and Merseyside*, which contains additional background and rationale for the proposed change.

Objectives

The public consultation will present a single option – the cessation of GF prescribing across Cheshire and Merseyside. The objectives of the consultation are:

- To inform patients, carers/family members, key stakeholders, and the public of proposed changes to gluten free prescribing.

- To engage with people who currently receiving gluten free bread and bread mixes on prescription, organisations which support them (where applicable), their carers/family members, and the wider public, to gather people's views about the proposed changes, including how individuals might be impacted.

- To use these responses to inform final decision-making around the proposal.

Legal and statutory context

The main duties on NHS bodies to make arrangements to involve the public are set out in the National Health Service Act 2006, as amended by the Health and Care Act 2022 (section 14Z45 for integrated care boards.

Involvement also has links with separate duties around equalities and health inequalities (section 149 of The Equality Act 2010 and section 14Z35 of the National Health Service Act 2006). As part of our work, we need to involve people with protected characteristics, social inclusion groups and those who experience health inequalities.

The courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles. These are:

1. Consultation must take place when the proposal is still at a formative stage.

2. Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response.

3. Adequate time must be given for consideration and response.

4. The product of consultation must be conscientiously taken into account.

Methods of engagement and materials

NHS Cheshire and Merseyside will produce clear and accessible public-facing information about the proposal, details of who is likely to be impacted and how, setting out the background to the issue and explaining why NHS Cheshire and Merseyside is proposing to make a change.

This information will be accompanied by a questionnaire containing both qualitative and quantitative questions, designed to gather people's views and perspectives on the proposals. Both the information and questionnaire will be available in Easy Read format. All materials will be made available on the NHS Cheshire and Merseyside website, with printed versions and alternative formats/languages available on request (via email or telephone). People who are unable to complete the questionnaire will be able to provide their feedback over the telephone.

The consultation will be promoted across NHS Cheshire and Merseyside's internal and external communication channels. Wider partners and stakeholders, including providers of NHS services (hospitals, community and mental health providers and primary care), local authorities, Healthwatch, and voluntary, community, faith and social enterprise (VCFSE) organisations, will be asked to share information using their own channels, utilising a toolkit produced for this purpose.

To ensure that those who would be most impacted by any potential change have an opportunity to share their views, NHS Cheshire and Merseyside will seek to work with colleagues in general practice and local pharmacies, to ensure that those who currently receive gluten free bread and bread mixes on prescription are made aware that the consultation is underway.

While specific events will not be organised as part of the consultation, if individual groups/networks request further information, NHS Cheshire and Merseyside will offer to attend meetings to provide additional briefings if required/appropriate.

Audiences

The following is an overview of key groups who we will seek to engage and/or communicate with during the consultation, either as a party with a direct interest or as a means of promoting the consultation to a wider audience.

Internal/NHS

- NHS Cheshire and Merseyside Integrated Care Board (ICB)
- NHS C&M staff
- General practice
- Primary care networks (PCNs)
- Local medical committees
- Local pharmacy committees
- NHS England

External

- General public in Cheshire and Merseyside
- People in Cheshire and Merseyside who currently receive prescriptions for GF bread and bread mixes (approx. 2,300)
- Local authorities
- Champs Public Health Collaborative
- MPs
- Local voluntary, community, faith and social enterprise organisations (VCFSEs)
- Local Healthwatch organisations
- Local/regional media outlets
- Coeliac UK (Liverpool, Cheshire and Warrington branches)

Governance and approvals

This plan has been developed by NHS Cheshire and Merseyside's Communications and Engagement team, which will also be responsible for leading public consultation activity. The plan will be presented to the Board of NHS Cheshire and Merseyside for approval before consultation commences.

Local authority scrutiny

NHS commissioners must consult local authorities when considering any proposal for a substantial development or variation of the health service. Subject to the board's approval of this plan, NHS Cheshire and Merseyside will commence discussions with each of the relevant local authorities.

Responding to enquiries

Members of the public will be directed to contact engagement@cheshireandmerseyside.nhs.uk with any enquiries about the consultation (a phone number will also be supplied). NHS Cheshire and Merseyside's Patient Experience

Team will be briefed on the engagement so that any enquiries that come through central routes can be directed appropriately.

Analysis, reporting and evaluation

When the consultation closes, the findings will be analysed and compiled into a report by an external supplier. The feedback received will be used to inform final decision-making about the proposal, and will therefore be received by a future meeting of the Board of NHS Cheshire and Merseyside. The outcome of this will be communicated using the same routes used to promote the consultation.

It's important to understand the effectiveness of different routes for reaching people, so that this can be utilised for future activity, and the questionnaire will ask people to state where they heard about the engagement. We will summarise this information – along with other measures such as number of enquiries received and visits to the website page – in the final consultation report.

ENDS

NHS
Cheshire and Merseyside

Equality Analysis Report
Pre-Consultation/ Post-Consultation/Full Report* *(Use the same form but delete as applicable. If it is post-consultation it needs to include consultation feedback and results)*

Cheshire & Merseyside wide

Start Date:	October 2024	
Equality and Inclusion Service Signature and Date:	Nicky Griffiths	30 October 2024
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**	Katie Bromley	30 October 2024
***Finish Date:**		
***Senior Manager Sign Off Signature and Date**		
***Committee Date:**	28th November 2024	

1. Details of service / function:
Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.
In 2016 – 2017 the Department of Health and Social Care undertook a review of prescribing for gluten free products and following a public consultation recommended that prescribing was limited to bread and bread mixes only. When gluten free prescribing was first introduced, the availability of these foods was limited, however, all major supermarkets and other retailers stock gluten free foods both in store and on-line. In addition, food labelling has improved, and awareness has increased which means people are able identify which foods contain gluten and choose healthy options. Currently in Cheshire and Merseyside 7* out of 9 Places offer Gluten Free Prescribing for patients with diagnosed coeliac disease in line with DHSC guidelines (*St Helens CCG and part of Cheshire West CCG stopped prescribing around 5 years ago). Therefore, there is inequity across Cheshire and Merseyside. NHS Cheshire and Merseyside was created in July 2022 and, as the statutory body, took over commissioning responsibilities from the 9 former CCGS. NHS C&M has to consider how to use the fixed resource allocation from NHS England to enable them to fulfil their

duties and have to decide how and where to allocate resources to best meet the healthcare needs of the population they serve.

Under the Policy Harmonisation programme, and based on the DHSC consultation and clinical opinion, the recommendation was to re-instate prescribing for bread and bread mixes however this would result in an estimated additional annual spend of £130k. However, because of the need for NHS Cheshire and Merseyside to consider how they allocate funding to ensure it is being allocated to areas of highest risk, a review has been undertaken regarding the continuation of spend on gluten free prescribing and a recommendation to Board to stop gluten free prescribing is being presented. This would of course be subject to a public consultation exercise in order to inform the final decision.

A number of other ICBs have stopped prescribing, one of our neighbouring ICBs Lancashire and South Cumbria do not offer this service, and as an ICB we do not prescribe other food products for patients with other food intolerances or allergies.

What is the **legitimate aim** of the service change / redesign

For example

- Demographic needs and changing patient needs are changing because of an ageing population.
- To increase choice of patients
- Value for Money-more efficient service
- Public feedback/ Consultation shows need/ no need for a service
- Outside commissioning remit of ICB/NHS
-

- To ensure a harmonised approach across Cheshire and Merseyside to prescribing food products for patients with coeliac disease and with other food intolerances / allergies
- To support the ICB to achieve financial savings - stopping prescribing across 8 places which would offer an estimated saving of £525k per year.
- To carry out a public consultation exercise to inform the final decision on gluten free prescribing

2. Change to service.

Currently 7* out of 9 Places offer Gluten free prescribing for bread and bread mixes, St Helens and Cheshire West CCG opted to stop this prior to the DHSC consultation. *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

The proposal would stop prescribing across all of Cheshire and Merseyside. This proposal is based on the much wider availability of gluten free goods, which has increased in the 6 years since the DHSC consultation, the clearer food labelling which makes healthy choices easier and whilst bread is still more expensive that non gluten free options, the difference in price has reduced and bread is not required for a healthy diet.

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.

Primarily this will affect patients with coeliac disease and related conditions. However, the eligibility criteria states that gluten free products will be commissioned for patients diagnosed as suffering from established gluten-sensitive enteropathies, including dermatitis herpetiformas and coeliac disease. Other impact on protected characteristic groups will be no different to that on other members of the public who suffer with this disease.

Awareness raising about alternative gluten free available foods will be available via GPs.

There is no evidence to suggest that any protected group has higher prevalence of gluten intolerance.

Diabetics and patients with food allergies are the most immediate comparator where alternative foods are not prescribed by the NHS. Gluten intolerance patients do not need to eat wheat based products to maintain good health.

Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications, such as giving birth to a low birth weight baby. However, if pregnant women adhered to Gluten Free diet and their disease is under control then pregnancy related risk would be similar to pregnant women without coeliac disease. Pregnant women with coeliac disease get advice on managing their condition from both General Practitioners and hospital doctors.

Coeliac disease is 3 times more common in women than in men and so any policy changes will affect women more than men.

This assessment recognises that advice needs to be given to the public on healthy eating for patients with coeliac disease and we need to particularly reach out to women with healthy eating messages - this may help to mitigate against some patients with coeliac disease may not adhere to gluten free diet.

Consideration should also be given to older people (who tend to be less mobile) or less mobile people (e.g. due to physical disability) are more likely to find it difficult to source gluten free foods.

Protected Characteristic	Issue	Remedy/Mitigation
Age	Coeliac UK have identified that it is key for younger people to have the right diet and have in the past supported stopping prescribing for all but under 18s. According to Coeliac UK, the majority of people are diagnosed from 50 years old	C&M data shows that less than 12% of prescriptions are allocated on the basis of being under 18s, and therefore prescribing to just this group could be

	and it is most common in people aged between 50 – 69 years. C&M data shows that 60% of GF prescriptions are allocated because patients are aged 60 and above and therefore our older age population may feel disadvantaged by stopping prescribing or prescribing for just under 18s. However, although only 11% of gf prescriptions are allocated to children and young people, they are not financially independent, and this data does not take into account their parents' financial capacity. According to Coeliac UK, non-adherence to a gluten free diet puts patients at a higher risk of long-term complications, including osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency. This could lead to patients requiring additional care and support from NHS. An example given by Coeliac UK states it costs £195 a year per patient to support GF on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.	seen as discriminatory for the older population. GF products are much more widely available in supermarkets and other outlets both in store and on-line, and improved food labelling means that patients are able to make more informed decisions about a healthy diet. In addition, bread is not necessary for a healthy diet as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. GP would continue to monitor patients and information is widely available on how to avoid gluten and follow a healthy diet.
Disability (you may need to discern types)	Currently, patients can get free NHS prescriptions if, at the time the prescription is dispensed, they: • have a continuing physical disability that prevents them from going out without help from another person and have a valid MedEx • hold a valid war pension exemption certificate and the prescription is for an accepted disability. People with coeliac disease, amongst these groups of people, may therefore be negatively impacted as a result of this proposal. People in this cohort may feel that this has a detrimental effect on their finances and so on their overall quality of life. • People with learning difficulties may find the GF labelling confusing and could be at greater risk of not adhering to a GF	Many supermarkets now have outlets on-line offering home deliveries which would support those with mobility issues to access GF products. GPs could offer prescriptions through the Individual Funding Request (IFR) process if their patient could demonstrate exceptionality. GP would continue to monitor patients

	diet without these products being prescribed. • Patient with mobility issues may struggle to get to shops to buy GF foods.	
Gender reassignment	No greater impact	
Marriage and Civil Partnership	No greater impact	
Pregnancy and maternity	Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications, such as giving birth to a low-birth weight baby.	Only 0.15% of the prescription exemptions are because of maternity exemption which implies the number of patients impacted is minimal. If pregnant women adhered to Gluten Free diet and their disease is under control then pregnancy related risk would be similar to pregnant women without coeliac disease. Pregnant women with coeliac disease get advice on managing their condition from both GPs and hospital doctors. The prescription exemption applies to pregnant women from the time they are pregnant to one year after either the due date or delivery date. This equality group will have short term effect.
Race	No greater impact	
Religion and belief	No greater impact	

Sex	According to NICE the prevalence in females is higher than in males (0.6% compared to 0.4%). C&M data reflects this with 65% of patients being female. This could result in females being more impacted than men, and they feel that this has a detrimental effect on their finances and so on their overall quality of life.	Food labelling is much improved and supports people to make healthy choices. In addition, bread is not necessary for a healthy diet as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. There are many websites with information on how to remain GF. GP would continue to monitor patients
Sexual orientation	No greater impact	
Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. the North/South divide, urban versus rural). *Examples of groups to consider include:* *refugees and asylum seekers, migrant, unaccompanied child asylum seekers, looked-after children/ care leavers, homeless people, prisoners and young offenders, veterans, people who live in deprived areas, People living in remote, and rural locations.* *Health inclusion groups* *https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/* *For a more in-depth assessment of health inequalities please use the HEAT toolkit* https://www.gov.uk/government/publications/health-equity-assessment-tool-heat		
refugees and asylum seekers	No greater impact	
Looked after children and care leavers	Children and young people in care are not financially independent and often rely on GF specific products.	
Homelessness	No greater impact	
worklessness	No greater impact	
People who live in deprived areas	No greater impact	
carers	No greater impact	
Young carers	No greater impact	
People living in remote, rural and island locations	There is a risk that people in more remote areas will not have the same access to	Many supermarkets offer on-line shopping and deliver to homes,

	supermarkets with gluten free alternatives to bread. People in this cohort may feel that this has a detrimental effect on their finances and so on their overall quality of life.	and bread is not necessary for a healthy diet as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. GP would continue to monitor patients
People with poor literacy or health Literacy	No greater impact	
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	No greater impact	
Sex workers	No greater impact	
People or families on a low income	There is a risk that people or families on low income will not be able to adhere to a gluten free diet because the cost of GF bread and bread mixes compared to a standard loaf and flour is higher. People on low income who choose to purchase gluten free products because they can no longer obtain them on prescription may feel that this has a detrimental effect on their finances and so on their overall quality of life. The financial capacity of patients over 60 receiving prescription payment exemptions due to age is unknow and therefore still a risk that they will be impacted because of low income. Children and young people are at risk from not being able to adhere to a GF diet if the cost is too expensive. According to Coeliac UK a weekly gluten free food shop can be as much as 20% more expensive than a standard weekly food shop	C&M data shows that less than 2% of the prescription exemptions are because the patient is in receipt of tax credit or income based job seekers allowance. Whilst the cost of bread and flour is more expensive, there are other GF products e.g. pasta which is the same price as standard, and there are other natural GF foods. There are websites with information on how to maintain a GF diet. GP would continue to monitor patients
People with addictions and/or substance misuse issues	No greater impact	
SEND / LD	No greater impact	
Digital exclusion	No greater impact	

4. What data sources have you used and considered in developing the assessment?

NHS England Guidance: 'Prescribing Gluten-Free Foods in Primary Care: Guidance for CCGs' NICE guidance regarding coeliac disease: https://www.nice.org.uk/guidance/qs134, Department of Health & Social Care website, Coeliac UK website, C&M prescribing data
5. Involvement: consultation/ engagement
Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)
No engagement has taken place yet as the work to date has been an options appraisal to recommend an ICB proposal. This EIA is part of paper to ICB Board meeting to establish support for a non-prescribing option and at that point, if appropriate, public consultation would be initiated in order to inform the final decision.
6. Have you identified any key gaps in service or potential risks that need to be mitigated
Guidance note: Ensure you have action for who will monitor progress. Ensure smart action plan embeds recommendations and actions in Consultation, review, specification, inform provider, procurement activity, future consultation activity, inform other relevant organisations (NHS England, Local Authority).

Risk	Required Action	By Who/ When
If the option to withdraw prescribing is accepted, there is a risk that patients who previously received prescriptions will not adhere to a GF diet which could have significant health implications for them and will potentially increase demand (& cost) on future NHS Services. An example given by Coeliac UK states it costs £195 a year per patient to support GF on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.	A published DHSC Impact Assessment examines the issue of adherence in detail and concludes that adherence to a GF diet cannot be isolated to any single cause. Evidence shows that many factors are at play including product labelling, cost and information when eating out and managing social occasions. Adherence requires a range of knowledge and skills to avoid all sources of gluten. Gluten free foods are now much more readily available in supermarkets, with clear gluten free labelling and greater awareness on healthy eating choices. Whilst bread and bread mixes are still more expensive that non GF products (according to Coeliac UK a gluten free loaf of bread is on average 4.3 times more expensive than a standard gluten containing loaf) it can be said that the cost of these products has been reducing over time and there are other GF products that are comparable prices to standard goods (e.g.500g of GF pasta is the same price as 500g of pasta containing gluten). In	Medical Directorate would ensure this happened following a decision

	addition, there are naturally free gluten free products e.g. rice, potatoes. In C&M the majority of patients receiving GF Prescriptions are exempt from charges, with over 70% of this being due to age. Because this exemption does not take into account financial capacity it is difficult to evidence what the individual financial impact on the impacted patients would be. It should be noted that there are less than 2% of prescription exemptions identified as being on tax credits or income support. If the option to stop prescribing was accepted, information on how to adhere to a gluten free diet would be made available and GPs would continue to monitor these patients as usual.	
There is a reputational risk to the ICB if the option to withdraw prescribing is accepted. Due to the current cost of living, there have been a number of national articles on the increased cost of "free from" foods despite them being much more available. In addition, 99% of the cohort of patients receiving prescriptions have an exemption in that they do not pay for prescriptions so could be seen that we are disadvantaging our most vulnerable population.	See above regarding non-GF options. In addition, the ICB does not prescribe for other conditions that are associated with, or affected by the types of food they eat, so this would result in a fairer approach for these patients. A public consultation exercise would be held in those Places who currently prescribe in line with the approach taken in St Helens and West Cheshire CCG before a final decision is made.	n/a

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
Analysis post consultation
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.
Analysis post consultation
PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
Analysis post consultation
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
Analysis post consultation
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (consider whether this is engaged. If engaged consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Analysis post consultation
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
[ENTER RESPONSE HERE]
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Analysis post consultation
8. Recommendation to Board
Guidance Note: will PSED be met?
[ENTER RESPONSE HERE]
9. Actions that need to be taken
[ENTER RESPONSE HERE]

QUALITY IMPACT ASSESSMENT					
Project Name	Gluten Free Prescribing – Option 3 All Places Withdraw Gluten Free Prescribing				
Verto/PMO reference		Date of QIA	10/07/24	Date QIA reviewed	Stage 1 (local) 21/08/2024 Stage 2 (regional) 06/09/24
Name of Project Manager	Katie Bromley	Name of Programme manager	Natalia Armes	Clinical Lead	Rowan Pritchard Jones
Confirm date discussed at PDG or appropriate Place forum.	n/a ICB Wide Recovery Programme	Is this QIA part of an options appraisal?	Yes	Is the place of care expected to change?	n/a
Is this a permanent or temporary change? (e.g., a GRANT or a PILOT scheme?)	Permanent	If temporary – what are the expected timescales?	n/a	What will happen to the cohort of patients in progress when the service ends?	They will have to fund their own Gluten Free products
It is a nationally, or regionally, mandated service?	No	Is it identified as clinically essential?	No	Is it a statutory service? Y/N and details	No
Confirm if a Digital Impact Assessment has been undertaken	n/a	Confirm if a DPIA is required. (Remember this on **all** the data involved – not just the data held by NHS C&M)	n/a	An EIA is advised. Confirm if it has been undertaken.	Yes
Number of patients affected	2570 (23/24 data)	**Mitigated quality risk if project progresses.**	Moderate - 4	**Mitigated Quality risk if project is NOT Progressed**	Low - 1
Current costs	£520,000	Proposed costs	£0	Does it impact on another C&M Place?	8 of 9 Places: Liverpool Wirral Sefton

					Knowsley Warrington Halton Cheshire East Cheshire West (excluding GP practices in Cheshire West CCG footprint)

Background and overview of the proposals *(can be copied from PID on Verto or from National/Regional commissioning guidance)*

In 2016 – 2017 the Department of Health and Social Care undertook a review of prescribing for gluten free products and following a public consultation recommended that prescribing was limited to bread and bread mixes only.
When gluten free prescribing was first introduced, the availability of these foods was limited, however, all major supermarkets and other retailers stock gluten free foods both in store and on-line. In addition, food labelling has improved, and awareness has increased which means people are able identify which foods contain gluten and choose healthy options.

Currently in Cheshire and Merseyside 7* out of 9 Places offer Gluten Free prescribing for patients with diagnosed coeliac disease in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above).
*For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area. Therefore, there is inequity of access to these products across Cheshire and Merseyside.

NHS Cheshire and Merseyside was created in July 2022 and, as the statutory body, took over commissioning responsibilities from the 9 former CCGS. NHS C&M has to consider how to use the fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of the population they serve.

Under the Policy Harmonisation programme, and based on the DHSC consultation and clinical opinion, the recommendation was to re-instate prescribing for bread and bread mixes however this would result in an estimated additional annual spend of £130k. However, because of the need for NHS Cheshire and Merseyside to consider how they allocate funding to ensure it is being allocated to areas of highest risk, a review has been undertaken regarding the continuation of spend on gluten free prescribing and a recommendation to Board to stop gluten free prescribing is being presented. This would of course be subject to a public consultation exercise in order to inform the final decision.

The purpose of the QIA is to help articulate the risks to patients as it is hard to evidence the impact of withdrawing Gluten Free prescribing.

Risks if the project did not go ahead.

If this option was not supported, this would leave unwarranted variation in access to these services.

Patient safety

Please confirm the specific patient groups affected. Advise the impact on health inequalities	There are over 13,300 patients diagnosed with Coeliac Disease and other conditions which would deem them eligible for gluten free prescribing. Most patients choose to purchase their GF products themselves, however, 2,314 patients receive their GF bread and bread mixes through a prescription. Currently 99% of patients currently receiving Gluten Free prescriptions are exempt from charges. The highest categories are as follows: Aged 60 or over – 61% Under 18 – 12% Pre-payment certificate – 3% Medical Exemption – 3% Non specified Declaration – 19% The data shows the biggest impact would be to patients over 60.		
	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level
Explain how the project minimises the risk of harm and impacts patients. Include any risks	This would save the ICB over £500,000 per annum which could be spent on other priorities.	The majority of patients receiving prescriptions are exempt from charges, and this is mainly due to age. Because this exemption does not take into account financial capacity it is difficult to evidence that these patients would not be able to afford to purchase their own GF bread and mixes. The 2 CCGs that have withdrawn prescribing have advised that they have not experienced an increase in patients presenting with issues relating to not following a GF diet.	It is difficult to evidence the impact of Coeliac patients not being able to access Gluten Free (GF) bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts and lead to greater demand on wider health services. According to Coeliac UK, non-adherence to a gluten free diet puts patients at a higher at a higher risk of long-term complications, including osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency. This could lead to patients requiring additional care and support from NHS.

Explain how the project may impact upon adults at risk and children and provide assurance that safeguarding process are in place with the provider		A gluten free diet may be maintained with items such as potatoes and rice, and bread is not essential	The patient groups that will be most impacted by this decision are older adults (over 60yo) and young people (under 18 & in full time education). These patient groups may potentially be at greater risk (incl. osteoporosis / long term conditions for younger patients) if they do not adhere to a GF diet. It is of note, however, this policy only relates to bread and bread mixes and bread is not an essential food item as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. and improved labelling on food and website with information on how to maintain a healthy GF diet. Due to the current cost of living, there have been a number of national articles on the cost of “free from” foods despite them being much more available. In addition, 99% of the cohort of patients receiving GF prescriptions have an exemption in that they do not pay for prescriptions so could be seen that we are disadvantaging our most vulnerable population. Because 73% of these exemptions are due to age, and this exemption does not take into account financial capacity, it is difficult to evidence that these patients would not be able to afford to purchase their own GF bread and mixes
Describe the impact on processes for reducing and	n/a	n/a	n/a

preventing patient harms and Healthcare Associated Infections? (e.g., falls, pressure ulcers, MRSA / CDI, VTE, etc)			

Clinical Effectiveness			
Please confirm how the project uses the best, knowledge based, research	The review of GF prescribing was carried out initially by Pharmacists and Dieticians, with support from other clinicians as part of the CPH Steering Group and was then continued under the ICB Unwarranted Variation Programme due to the financial constraints. Evidence from Dept. Health & Social Care, Coeliac UK was also reviewed. The recommendation from DH&SC is now to prescribe only bread and bread mixes, however, in the "Prescribing Gluten-Free Foods in Primary Care: Guidance for CCGs" document, published following the consultation in 2018 it does state "CCGs may further restrict the prescribing of GF foods by selecting bread only, mixes only or CCGs may choose to end prescribing of GF foods altogether".		
	Positive impact Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	Neutral impact May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level
Explain if/how the project improves hospital flow or improves length of stay		These patients would not be treated in a hospital environment, so no impact on length of stay.	
Describe the impact on			It is difficult to evidence the impact of Coeliac patients not being able to access

clinical outcomes and how this will be monitored.			GF bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts (e.g. osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency), and lead to greater demand on wider health services. However, availability of gf products has improved, as has food labelling. Patients would continue to be supported by their GPs as usual. Feedback from the 2 CCGs who have withdrawn prescribing have not reported any unforeseen consequences.
Does the project result in a higher likelihood of clinical recovery?			If patients cannot afford or cannot get to a supermarket to buy their own GF bread and bread mixes, there could be a negative impact on their long term health.
Does the project provide better access to wider care pathways?			No this would end prescribing
Does the project follow the latest NICE guidance/other relevant best practice evidence?			No. DH&SC and Coeliac UK guidance recommend prescribing bread and bread mixes
Describe the feedback of clinical leads	A number of clinicians have expressed support for the withdrawal, some noting that they have seen requests reduce over the last couple of years potentially due to wider availability of GF products in shops.	Where Clinical Leads support the withdrawal of prescribing, they have noted a potential financial impact to lower income patients.	The Dieticians who were part of the Clinical Policy Harmonisation programme did not support stopping prescribing through concern over those patients who may not follow a GF diet if not prescribed. However, feedback from those Places who have withdrawn

			prescribing is that they have not experienced unforeseen consequences. GPs would continue to support patients and information on how to maintain a GF diet is widely available

Patient Experience			
Please confirm the specific patient groups affected and how they are impacted.	A policy not to prescribe gluten free products may have an impact on vulnerable patients because gluten free products, while readily available in supermarkets, are more expensive that standard products, and some patients may not be able to access supermarkets easily.		
	Positive impact Improved patient and carer experience anticipated	Neutral impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels
Explain how the project will impact on the experience of care and better access to services	Not prescribing GF products will save over £500k which can be invested in other services. In addition, GF products are also the only food product that is offered on prescription, but there are other food allergies that don't have this offer, so could argue that stopping prescribing further reduces unwarranted variation.	This option withdraws prescribing and therefore does not impact access to services, however for patients who currently receive prescriptions they may reflect that experience of care is impacted by this, but access to supporting services is unchanged.	

Describe any consultation or engagement with the population that has occurred or is planned.		Public consultation would take place following a decision from the ICB Board as to whether withdrawing prescriptions would be considered	
Describe any change of location or setting of care.	n/a	n/a	n/a

Have any risks been identified in the following areas? (please list risk and escalation process)				
Area	Risk identified	If escalated, identify where escalated to	Date escalated	Mitigations put in place
Staff Experience	no			
Service Delivery	no			
Disinvestment	no			
Contingency plans	no			
Interdependency	no			
Sustainability	no			

RISKS where the project is progressed				
	Comment to explain rationale (include mitigations where applicable)	Likelihood of risk (L) (see table below)	Risk Impact / Consequence (C) (see table below)	Multiplication Total L x C
Quality risk to progress project	If the option to withdraw prescribing is accepted, there is a risk that patients who previously received prescriptions will not adhere to a GF diet due to affordability of free from products, which could have significant health implications for them and will potentially increase demand on health services as a result. There is a risk that this will widen health inequalities in deprived areas.	2	3	6
MITIGATED RISK to progress project				
Quality risk to progress project	In line with Cheshire West CCG actions when they stopped prescribing, we would improve the information and advice available to patients with coeliac disease that will help them to have a healthy, nutritious and balanced diet with all the necessary vitamins and minerals. Coeliac patients can still eat all naturally gluten-free foods such as meat, fish, fruit, vegetables, rice, and potatoes. We will provide advice to the following: Coeliac UK website for guidance and advice NHS Choices Website BBC website on gluten free diet The Eatwell Guide - NHS). Engage with supermarkets within C&M footprint to advise of prescribing decision with ask of them to manage their stock levels.	2	2	4

RISKS if project is NOT progressed				
	Comment to explain rationale (include mitigations where applicable)	Likelihood of risk (L)	Risk Impact / Consequence (C)	Multiplication Total for not progressing project

		See table below	See table below	L x C
Quality risk if project does not proceed	If the option to withdraw prescribing is not supported, then C&M have unwarranted variation in access to these products. The alternative option is to re-instate prescribing, however, there is a financial risk to the ICB in that an additional £130k would be required to support this and a total estimated annual expenditure of £650k.	1	1	1
MITIGATED RISK if project is NOT progressed				
Mitigated quality risk to progress project	Place based Medicines Management teams would review prescribing quantities to ensure they are in line with Coeliac UK guidance. This may mitigate some of the cost.	1	1	1

Summary

Decision made	Score	Mitigated score	Impact
Progress	6	4	moderate
Not progress	1	1	Low
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 to 6	8- 12	13- 25

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients. **Health Outcomes & Inequalities** – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	Moderate (25% > - 50%)	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget

		Reputation - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	**1**	**2**	**3**	**4**	**5**
Unlikely (2)	**2**	**4**	**6**	**8**	**10**
Possible (3)	**3**	**6**	**9**	**12**	**15**
Likely (4)	**4**	**8**	**12**	**16**	**20**
Almost Certain (5)	**5**	**10**	**15**	**20**	**25**

Low Risk	**Moderate Risk**	**High Risk**	**Extreme Risk**	**Critical Risk**

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	**A**	**B**	**C**

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
Katie Bromley	Project lead		4/9/24
Sinead Clarke	Clinical lead		4/9/24
Natalia Armes	Programme manager		4/9/24
	PMO lead		
Once signed off by all above, then the QIA is submitted to QIA review group			

This section to be completed following review at the QIA review group					
Name	Role	Approved	Rejected	Signature	Date
ADs of Quality	QIA review group chair (after group meeting)	Yes			6/9/24
Denise Roberts (supported by Maxine Dickinson)	AD of Quality	Yes			21/08/24
	C&M ICB QIA lead (if necessary)				

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Amendments to the Constitution of NHS Cheshire and Merseyside

Agenda Item No: ICB/11/24/18

Responsible Director: Graham Urwin
Chief Executive

Amendments to the Constitution of NHS Cheshire and Merseyside

1. Purpose of the Report

1.1 The purpose of the report is to present for consideration by the Board the proposed amendments to the Constitution of NHS Cheshire and Merseyside, and to provide an outline of the process that is required of Integrated Care Boards to seek and receive approval of any changes.

2. Executive Summary

2.1 Every Integrated Care Board (ICB) must have a Constitution approved by NHS England and it must be published on its website and made available to members of the public. It sets out various matters including the arrangements to allow NHS Cheshire and Merseyside including its Board to discharge its functions. It includes details on the establishment and composition of NHS Cheshire and Merseyside, its Board and relevant committees and includes the Standing Orders for the ICB.

2.2 Constitutions can only be amended through instruction by NHS England or following approval by NHS England following receipt of an application to vary its Constitution by the ICB, following approval of the ICB Board of any amendments. When considering any amendments to the Constitution the Board is required to consider whether to engage on the changes with the Integrated Care Partnership or other key stakeholders such as the public. Engagement should be undertaken if the Board believes the changes materially affect the operation of the ICB or its relationship with partners.

2.3 NHS England has recently provided updated governance guidance to ICBs which included instructions on amendments to be made to their Constitutions. Many of the amendments put forward by NHS England are already reflected in the ICBs Constitution following its last update in January 2024, however there are few minor amendments to include as a result of the updated guidance/instructions. The changes relate to the following areas:

- ensuring reference is made that one of the non-executive board members is identified as the deputy chair (which cannot be the Audit committee chair)
- ensuring reference is made that one of the non-executive board members is identified as the senior independent member
- ensuring reference is made the Chair's period of office as a maximum, rather than a fixed term
- ensuring reference is made confirming that a proposal for the Chair or a non-executive to serve on the board for longer than six years will be subject to rigorous review, and they will not serve as a board member for longer than nine years in total

- updating references to procurement rules: to take account of the introduction of the Provider Selection Regime
- removing clauses related to ICB establishment and updating cross-references to legislation.

2.4 Additionally, amendments have been made to the Constitution with regards the details that outline the appointments process for Board Members (Section 3 of the Constitution). The amendments now mirror that which have been agreed as part of the ICBs Board Member Nomination and Appointments Policy.[1] Appendix One summarises the changes made and where within the updated Constitution. Appendix Two provides the Board with the updated amendments with track changes.

2.5 Subject to the approval of the Board to the proposed amendments and proceeding with the application for variation of the Constitution to NHS England, it is also recommended that the Board delegates responsibility to the Chief Executive to approve any further minor amendments to the Constitution following any feedback from NHS England. Any substantial changes will require the Constitution to be brought back to the Board for its approval. It is not believed that the changes to the Constitution require any further engagement or consultation with the Health and Care Partnership or other stakeholders.

2.6 Following approval of the application to vary its Constitution by NHS England, the revised constitution, and any necessary changes to supplementary governance documents within the ICB's Corporate Governance Handbook, should be published on the ICB website.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **consider** the amendments to the ICB Constitution and whether it believes the proposed amendments are such that engagement with the Cheshire and Merseyside Health and Care Partnership and other stakeholders is required
- **approve** the proposed amendments to the Constitution
- **approve** progressing the process to submit an application to vary the Constitution to NHS England
- **approve** the recommendation to delegate authority to the Chief Executive to approve any minor changes to the Constitution following any feedback from NHS England.

4. Reasons for Recommendations

4.1 The Board is required to approve any amendments to the ICB Constitution that have been put forward by the ICB, and approve the submission of the amended Constitution to NHS England for review and approval.

[1] https://westcheshireway.glasscubes.com/share/s/40c18hs3v1aokk8h5q2b703b4v

4.2 Only following approval from NHS England will the changes to the Constitution come into effect.

5. Further information

5.1 In submitting requests to NHS England to vary their Constitutions, ICBs are required to follow the guidance outlined with the NHS England publication *'Guidance to integrated care boards on applying to NHS England to amend their constitution*.'[2]

5.2 ICBs are expected to discuss their proposed changes with the NHS England regional team in advance of the submission of the application to vary the Constitution. Following this discussion and agreement to progress, an application should be submitted outlining:

- the reason for why the change is being sought
- assurance on and details of meaningful engagement with all relevant stakeholders that has been undertaken if required and as proportionate to the nature of the changes proposed, and how the ICB has given proper consideration to the views and feedback received
- confirmation of Board level approval to the proposed changes
- assurance that the ICB has considered any need for legal advice on the implications of the proposed changes
- an impact assessment of the proposed changes
- the proposed revised Constitution with the amended clauses clearly identified.

5.3 Upon receipt of the application to vary, NHS England will consider:

- whether the revised constitution meets the requirements of legislation
- whether the revised constitution complies with the policy requirements set out in any guidance on varying the Constitutions
- whether the ICB has made appropriate arrangements to ensure it is able to discharge its functions following any proposed change
- whether the Board of the ICB affected by the proposed changes would be correctly constituted in accordance with the legislation and statutory guidance
- whether the process for appointing partner members, and any other ordinary members, would comply with the Act, relevant statutory guidance and policy as set out in the ICB model constitution
- whether the likely impact of the proposed change on the persons for whom the ICB has responsibility has been given proper consideration, including on equalities and health inequalities
- whether the likely impact of the proposed change on the discharge of NHS England's functions has been given proper consideration5
- whether the support, or otherwise, for the proposed change from the integrated care partnership (ICP) affected by it has been given proper consideration

[2] https://www.england.nhs.uk/wp-content/uploads/2021/06/B1650-guidance-to-integrated-care-boards-on-constitutional-change.pdf

- whether the views of patients and the public have been sought on the proposed change where appropriate and the ICB has given proper consideration to those views, as part of a transparent process open to the public.

5.4 It is for the ICB to determine what information, in addition to the requirements set out in the application process above, it should submit to help NHS England decide on the application for constitution change.

5.5 NHS England may ask for clarification or additional information at any stage. Additionally, NHS England may consider any other material it considers relevant to making its decision, not just material submitted by the ICB. All stages of the procedure will involve communication between NHS England

5.6 NHS England will acknowledge all applications for changes to ICB constitutions within two weeks of receipt. Typically, NHS England will notify the ICB in writing of its decision on the ICB's application to change its constitution within four weeks of receipt. Where applications relate to changes of a minor or administrative nature, NHS England will expect to notify the ICB of its decision well within this timescale. However, should NHS England require supplementary information from an ICB before reaching its decision, such information must be provided in a timely fashion, and the final decision may take longer

5.7 It is expected that decisions regarding applications for changes are taken within NHS England regional teams at a level proportionate to the change requested. There is no appeal or review process for the decision.

6. Finance

6.1 There are no financial implications arising directly from the recommendations of the report.

7. Communication and Engagement

7.1 Subject to the decision of the Board regarding the materiality of the changes to the Constitution. Members of the public and stakeholders have opportunity to comment on the proposed changes through the publication of this paper and revised Constitution on the ICB website and consideration at the meeting of the Board held in public.

8. Equality, Diversity and Inclusion

8.1 It is not envisaged that the proposed changes to the Constitution is likely to have any detrimental impact on or potentially discriminate against people from different characteristics groups

9. Climate Change / Sustainability

9.1 There are no implications arising directly from the recommendations of the report.

10. Next Steps and Responsible Person to take forward

10.1 Subject to the approval of the proposed amendments to the Constitution and progressing the application to NHS England to vary the Constitution, the Chief Executive with support from the Associate Director of Corporate Affairs and Governance will liaise with the NHS England Regional team and progress the formal application. Upon confirmation of approval to the proposed changes to the Constitution, Board members will be informed and confirmation provided within the Chief Executives Report to Board.

11. Officer contact details for more information

Matthew Cunningham
Associate Director of Corporate Affairs & Governance / Board Secretary
NHS Cheshire and Merseyside ICB

12. Appendices

Appendix One: Summary of amendments to the Constitution

Appendix Two: **CLICK HERE** to view the draft ICB Constitution v1.3

Appendix One: Summary of amendments to the ICB Constitution

Amendment	Constitution Page No(s)
Removed para 1.5.2 as per NHSE guidance	8
Updated para 2.3.2 to reflect current agreed list of regular attendees to the ICB Board	12
Amended sentence in 3.1 Eligibility Criteria for Board members regarding Nolan Principles by adding text as per NHSE guidance	13
Added text as per NHSE guidance in para 3.2.7 defining further what a Health Care Professional means	14
As per NHSE guidance, firmed up reference in para 3.34 to the maximum number of terms and years that an individual can be a chair of the ICB	15
Removed para 3.35 as an establishment linked statement and no longer needed	15
para 3.36 (which will replace 3.3.5) added NHSE statement regarding review of individuals if Chair being proposed to serve for longer than 6 years	15
Para 3.4.2 removed as per NHSE guidance in relation to approval of Chief executive appointment	15
Updates to paragraphs 3.5.4 and 3.5.5 to reflect the ICB Board Member Nomination and Appointments Policy	16-18
Updates to paragraphs 3.6.5 and 3.6.6 to reflect the ICB Board Member Nomination and Appointments Policy	19-21
Updates to paragraphs 3.7.4 and 3.7.5 to reflect the ICB Board Member Nomination and Appointments Policy	21-23
Updates to paragraphs 3.8.4 and 3.8.5 to reflect the ICB Board Member Nomination and Appointments Policy	24-26
Updates to paragraph 3.9.3 to reflect the ICB Board Member Nomination and Appointments Policy	26
Updates to paragraph 3.10.3 to reflect the ICB Board Member Nomination and Appointments Policy	26
Updates to paragraph 3.11.3 to reflect the ICB Board Member Nomination and Appointments Policy	27
Updates to paragraph 3.12.2 to reflect the ICB Board Member Nomination and Appointments Policy	27-28
Para 3.12.5 and 3.12.6 – made changes in line with NHSE guidance regarding review of Non-Execs looking to do more than 6 years on the Board	28
Para 3.12.7 made changes in relation to Senor Independent Director (SID) as per NHSE guidance. Amendments also made to reflect local agreement regarding role of Deputy Chair and SID	29
Para 6.2.1 updated reference to key ICB policies to manage conflicts of interest	37
Changes to para 7.3.8 and the inclusion of reference to the Joint Forward Plan as per NHSE guidance	39
Para 7.3.8 inclusion of additional bullets regarding ICBs forward plan outlining steps to address needs of CYP (as per wording provided by NHSE)	40
Para 7.4.3 removal of out of date reference to Provider Selection Regime as per NHSE guidance	40
Updated appendix one to reference forward plan and level of services provided condition as per NHSE guidance	44-45
Standing Orders - para 4.7.2 – addition of NHSE wording reaffirming voting authority of nominated deputies in meetings	49

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Board Assurance Framework 2024-2025 and Quarter Two Update Report

Agenda Item No: ICB/11/24/19

Responsible Director: Clare Watson, Assistant Chief Executive

Board Assurance Framework 2024-2025 and Quarter Two Update Report

1. Purpose of the Report

1.1 The purpose of the report is to present the quarter two update of the Board Assurance Framework (BAF).

2. Executive Summary

2.1 The 2024-25 BAF and principal risks were approved by the Board in July. The principal risks are those which, if realised, will have the most significant impact on the delivery of the ICB's strategic objectives.

2.2 There are currently 10 principal risks, including 2 critical risks, 4 extreme risks and 4 high risks. Of these, 6 are at the agreed target for 2024-25 and the focus will be on assurance that controls remain effective and on continuing to progress actions to further mitigate the risk over the longer term. The remaining 4 remain above the agreed target for 2024-25 and the focus will be on delivering the planned actions to further mitigate these risks by year end.

2.3 The critical risks are:

- P5 - Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience, currently rated as critical (20).
- P7 - The Integrated Care System is unable to achieve its statutory financial duties, currently rated as critical (20).

2.4 Since the July report:

- P1 - The ICB is unable to meet its statutory duties to address health inequalities, planned mitigating actions have been delayed due to financial constraints and as a result the anticipated timescale to moderate this risk in line with the Board's risk appetite score of 8 has extended from 2-3 years to 3-4 years. While the current score remains at the 24-25 target level of 15, any further delays may result in this not being met.
- P6 - Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population, **current rating has reduced** from extreme (16) to high (12) and is now meeting the target for 24-25. This reflects ongoing delivery of the Primary Care Access Recovery and Dental Improvement Plans, but there is the potential that collective action by GP practices, and potentially by community pharmacies, could drive up the score.

- P9 - Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives. Due to resource constraints, it is not now anticipated that a reduction in the score will be achieved by year-end and the target score **has been increased** to 16.

2.5 The report and appendices set out the controls that are in place, an assessment of their effectiveness and further control actions planned in relation to all principal risks. Planned assurances have been identified in relation to each principal risk and these are provided through the work of the Committees and through Board reports over the course of the year.

2.6 Acceptable assurance is available in relation to 5 of the principal risks but further assurance is required in respect of the remaining 5 and further details are provided in section 9.9 and appendix two.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **APPROVE** the reduction in the current risk rating for P6, and the increase in the target score for P9 as described in section 2.3.

- **NOTE** the current risk profile, progress in completing mitigating actions, assurances provided and priority actions for the next quarter; and consider any further action required by the Board to improve the level of assurance provided or any new risks which may require inclusion on the BAF.

4. Reasons for Recommendations

4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

- identifying risks which may prevent the achievement of its strategic objectives
- determining the organisation's level of risk appetite in relation to the strategic objectives
- proactive monitoring of identified risks via the BAF and Corporate Risk Register
- ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
- receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
- demonstrating effective leadership, active involvement and support for risk management.

5. Background

5.1 As part of the annual planning process the Board undertakes a robust assessment of the organisation's emerging and principal risks. This aims to identify the significant external and internal threats to the achievement of the ICB's strategic goals and continued functioning. The principal risks identified for 2024-25 were approved for adoption by the Board in July and form the basis of the Board Assurance Framework reported quarterly to the Board.

5.2 The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. Risks will be taken in a considered and controlled manner, and the Board has determined the level of exposure to risks which is acceptable in general, and this is set out in the core risk appetite statement.

5.3 The Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The Board Assurance Framework (BAF) is a key component of this. The Board is supported through the work of the ICB Committees in reviewing risks, including these BAF risks, and providing assurance on key controls. The outcome of their review is reported through the reports of the committee chairs and minutes elsewhere on the agenda.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic**

6.1 The BAF supports the objectives and priorities of the ICB through the identification and effective mitigation of those principal risks which, if realised, will have the most significant impact on delivery.

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

7.1 The Annual Delivery Plan sets out linkages between each of the plan's focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
Theme Two: **Integration**
Theme Three: **Leadership**

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the BAF underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability.

9. Risks

9.1 The quarter 2 BAF is summarised in the heat map below:

ID	Risk	Inherent			Current (Q2)			Target 2024-25			Risk Appetite (Optimal)	
		L	I	R	L	I	R	L	I	R	Rating	Timescale
P1	Health inequalities	4	5	**20**	3	5	**15**	3	5	**15**	High (8)	2027-28
P3	Elective care	5	5	**25**	3	5	**15**	2	5	**10**	Moderate (5)	2026-27
P4	Major quality failures	3	5	**15**	2	5	**10**	2	5	**10**	Moderate (5)	2026-27
P5	Urgent & emergency care	5	5	**25**	4	5	**20**	3	5	**15**	Moderate (5)	2026-27
P6	Primary care access	5	4	**20**	3	4	**12**	3	4	**12**	Moderate (6)	2025-26
P7	Statutory financial duties	5	5	**25**	4	5	**20**	3	5	**15**	High (8)	2026-27
P8	Provider sustainability	4	4	**16**	3	4	**12**	3	4	**12**	Moderate (6)	2026-27
P9	ICS workforce	4	4	**16**	4	4	**16**	4	4	**16**	Moderate (6)	2026-27
P10	Focus on long term strategy	4	4	**16**	3	3	**9**	3	3	**9**	Moderate (6)	2025-26
P11	Digital infrastructure	5	4	**20**	4	4	**16**	4	4	**16**	High (8)	2025-26

9.2 The key changes proposed from the quarter 1 position are as follows:

P1 – **an extension of the period for achieving the risk appetite score of 8** from 2026-27 to 2027-28, reflecting re-profiling of mitigating actions due to financial constraints.

P6 – **a reduction in the current score from 16 to 12,** reflecting ongoing delivery of the Primary Care Access Recovery and Dental Improvement Plans.

P9 – **an increase in the target score from 12 to 16**, reflecting resource constraints and resulting delays in planned mitigations.

9.3 A summary of the principal risks and high-level mitigation strategies is provided at appendix one. Further detail in respect of each risk, including the assessment and scoring rationale, current controls and assessment of their effectiveness, gaps identified, planned actions and progress, assurances provided and a

current position statement in relation to progress towards target, is provided in the individual risk summaries at appendix two.

9.4 There are currently 2 critical risks, 4 extreme risks and 4 high risks. Of these, 6 are at the agreed target for 2024-25 and the focus will be on assurance that controls remain effective and on continuing to progress actions to further mitigate the risk over the longer term. The remaining 4 remain above the agreed target for 2024-25 and the focus will be on delivering the planned actions to further mitigate these risks by year end.

9.5 The majority of the planned actions are on track, but there is one action assessed as problematic - delivery remains feasible, actions not completed, awaiting further interventions. This is:

9.5.1 In relation to P7 – statutory financial duties, action to conclude and secure agreement to the medium-term financial strategy. This reflects the scale of the challenge and the work still to complete in testing and finalising delivery metrics, timescales and quantifying associated financial impact for recovery programmes.

9.6 As progress is made in implementing and strengthening controls, with resulting reductions in the level of risk, the focus will shift to assuring that key controls are embedded and effective in continuing to mitigate the risk to an acceptable level. The ICB's committees provide scrutiny and challenge of risk independent of the management line and are an important source of 2nd line assurance to the Board. Their discussion and decisions in relation to BAF risks were summarised in the chair's highlight reports considered by the Board on 25/7/24, 26/9/24 and appearing elsewhere on this agenda.

9.7 In addition the following assurance reports have been provided to the Board during quarter two:

9.7.1 Director of Nursing Report – 25/7/24, 26/9/24 (P4)
9.7.2 Integrated Performance Report – 25/7/24, 26/9/24 (P3, P4, P5, P6, P9)
9.7.3 Finance Report – 25/7/24, 26/9/24 (P7)
9.7.4 Shaping Care Together – A Case for Change – 25/7/24 (P8)
9.7.5 Key Delivery Plans – 25/7/24 (P1, P10)
9.7.6 CMAST Annual Work Plan (P8)
9.7.7 Consolidated Workforce Update – 25/7/24 (P9)
9.7.8 Urgent Emergency Care Improvement Programme Update – 26/9/24 (P5, P8)
9.7.9 Children and Young People's Elective Wait Recovery – 26/9/24 (P3)
9.7.10 Annual Business Plan – 26/9/34 (P1, P10)
9.7.11 Population Health Update – 26/9/24 (P1)
9.7.12 Gynaecology and Maternity Hospital Services in Liverpool – Case for Change – 9/10/24 (P8)

9.8 A summary of the assurance ratings for each of the principal risks is provided below:

ID	Risk	Committee	Current Score (Q1)	Controls					Assurance Rating
				Policies	Processes	Plans	Contracts	Reporting	
P1	Health inequalities	S&T	**15**	**G**	**G**	**G**	**G**	**G**	**Acceptable**
P3	Elective care	Q&P	**15**	**G**	**A**	**G**	**G**	**G**	**Acceptable**
P4	Major quality failures	Q&P	**10**	**A**	**A**	**A**	**A**	**G**	**Acceptable**
P5	Urgent & emergency care	Q&P	**20**	**G**	**A**	**A**	**G**	**A**	**Partial**
P6	Primary care access	SPCC	**12**	**G**	**A**	**A**	**G**	**G**	**Acceptable**
P7	Statutory financial duties	FIRC	**20**	**G**	**G**	**A**	**A**	**G**	**Partial**
P8	Provider sustainability	S&T	**12**	**G**	**G**	**A**	**A**	**A**	**Partial**
P9	ICS workforce	FIRC	**16**	**A**	**A**	**A**	**G**	**A**	**Partial**
P10	Focus on long term strategy	Execs	**9**	**G**	**G**	**A**	**A**	**G**	**Acceptable**
P11	Digital Infrastructure	S&T	**16**	**A**	**A**	**A**	**A**	**A**	**Partial**

9.9 There are a number of risks assessed as having only partial assurance - some confidence in delivery of existing mechanisms / objectives, some areas of concern. These are:

P5 where key performance measures indicate that, despite existing controls, service delivery is not yet meeting required national and local standards.

P7 where additional assurance is required that there is an agreed and approved ICS medium-term financial strategy to address the financial deficit.

P8 where additional assurance is required that there is a credible case for change and sustainable transformation plans in relation to a number of fragile services.

P9 where further assurance is required regarding action planned to address priority gaps in control with the reduced resource available.

P11 where additional assurance is required regarding organisation and system level cyber security compliance and risk, and robust plans to address any identified gaps.

Further detail is provided in the risk summaries at appendix two.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the report does cover a number of financial risks which are described in section 9 and detailed in the appendices.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 Principal risks P3, P4, P5, P6, P8 and P9 have the potential to adversely impact on equality, diversity and inclusion in service delivery, outcomes or employment. The mitigations in place and planned are described in more detail in the risk summaries at appendix two.

12.2 Principal risk P1 has the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at appendix two.

13. Climate Change / Sustainability

13.1 There are no identified impacts in the BAF on the delivery of the Green Plan / Net Zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 Senior responsible leads and operational leads for each risk will continue to develop and improve the controls in line with the targets and progress the priority actions and assurance activities as identified in appendix one and in the individual risk summaries at appendix two. Updates will be provided through the regular BAF report to the Board.

15. Officer contact details for more information

Dawn Boyer
Head of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB

16. Appendices

Appendix One: Board Assurance Framework Summary
Appendix Two: BAF Risk Summaries

Board Assurance Framework 2024/25 – Quarter 2 review

Appendix One – Summary

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score 2024-25	Priority Actions / Assurance Activities
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience						
P1: The ICB is unable to meet its statutory duties to address health inequalities	Strategy & Transformation Committee Clare Watson	**4x5=20**	**3x5=15**	No change	**3x5=15**	Assurance on progress and effectiveness of delivery of All Together Fairer: Our Health and Care Partnership Plan. Focus remains the building of the foundations that would lead to a reduction in health inequalities over the longer term.
Strategic Objective 2: Improving Population Health and Healthcare						
P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes	Quality & Performance Committee Anthony Middleton	**5x5=25**	**3x5=15**	No change	**2x5=10**	Further action to strengthen controls. Key actions are the Elective Recovery Team and increasing diagnostics capacity through Community Diagnostic Centres and elective capacity through elective hubs.

P4: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience	Quality & Performance Committee Chris Douglas / Rowan Pritchard-Jones	**3x5=15**	**2x5=10**	No change	**2x5=10**	Significant controls in place. Priority will be to continue to embed and strengthen controls and provide assurance on continuing effectiveness of control framework.
P5: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience	Quality & Performance Committee Anthony Middleton	**5x5=25**	**4x5=20**	No change	**3x5=15**	Urgent Care Recovery Programmes in 5 areas are focused on the key objective of eliminating corridor care in 24-25, as well as reducing the number of hospital attendances and admissions and improving discharge pathways and processes.
P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	Primary Care Clare Watson	**5x4=20**	**3x4=12**	Score reduced from 16 to 12	**3x4=12**	Assurance on progress and effectiveness of delivery of Primary Care Access Recovery Plan and Dental Improvement Plan.
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money						
P7: The Integrated Care System is unable to achieve its statutory financial duties	Finance, Investment & Our Resources Committee Claire Wilson	**5x5=25**	**4x5=20**	No change	**3x5=15**	Key aim of Recovery Programme is to improve use of resources. Key further action is to secure agreement to the Medium-Term Financial Strategy.
P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services	Strategy & Transformation Committee Rowan Pritchard-Jones	**4x4=12**	**3x4=12**	No change	**3x4=12**	Further action to implement and strengthen controls. Ongoing action to progress the development of case for change across multiple programmes.

P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives.	Finance, Investment & Our Resources Committee Chris Samosa	**4x4=16**	**4x4=16**	Target increased from 12 to 16	**4x4=16**	Further action to implement and strengthen controls. Key actions are to develop and enhance system workforce planning and scaling up of Peoples Services.
Strategic Objective 4: Helping the NHS to support broader social and economic development						
P10: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population.	ICB Executive Graham Urwin	**4x4=16**	**3x3=9**	No change	**3x3=9**	Assurance on progress and effectiveness of delivery of All Together Fairer and Joint 5-Year Forward Plan.
P11: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside.	Strategy & Transformation Committee Rowan Pritchard-Jones	**5x4=20**	**4x4=16**	No change	**4x4=16**	Further action to implement and strengthen controls. Key actions are C&M wide baseline analysis and benchmarking, identifying and progressing opportunities for collaboration and standardisation, and identifying and addressing supply chain risks.

Appendix Two – BAF Risk Summaries

ID No: P1	Risk Title: The ICB is unable to meet its statutory duties to address health inequalities
Risk Description (max 100 words)	Longstanding social, economic and health inequalities across Cheshire and Merseyside, when comparing outcomes both between different communities in our area and the national average for HI. Population health and wellbeing is shaped by social, economic, and environmental conditions in which people are born, grow, live, and work. This can only be addressed through collective systemwide effort and investment across the partnership, our communities, the NHS, Local Government, and Voluntary and Private sectors. This risk relates to the potential inability of the ICB to secure the necessary investment and influence priorities across multiple organisations, agencies and communities covered by the ICB.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Prof. Ian Ashworth	Assistant Chief Executive	Strategy & Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services	Transformation	C – beyond 12 months	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	14/10/24	16/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3			3	31/03/25	Our longer-term ambition is to moderate to a (2x4=8) level of risk but will only be achievable over 3-4 years due to resource allocation and capacity. This equally applies to systemwide inequalities due to financial pressures and capacity.
Impact	5	5	5			5		
Risk Score	20	15	15			15		

Rationale for score & progress in quarter (max 300 words)	There is potential for a major reduction in health outcomes and/or life expectancy and major increase in the health inequality gap in deprived areas or for socially excluded groups (impact 5). Current controls are effective in reducing the likelihood, but this is still possible (3). There have been delays in mitigating action due to financial constraints and any further delay is likely to increase the risk score to 20 (critical). Planned mitigation is focused on delivering the All Together Fairer: Our Health and Care Partnership Plan, including securing health inequalities investment allocation. The planned actions will be affected by the ICB financial review, some delay to some aspects of work, will be applied to support the 2024-25 financial challenges. The delay would be for the remainder of this financial year. As a result, the completion dates for All Together Fairer and Health Inequalities approaches with place-based partnerships and implementation of Population Health Group sub-groups have been delayed. Our focus remains the building of the foundations that would lead to a reduction in health inequalities and contribute to our ambition of a score of 8, but this is now expected to take longer over the next 3-4 years. It is vital that the ICB Recovery Programme consistently reviews opportunities to reduce demand and avoidable admissions, whilst taking action on reducing the impact of health care inequalities.

Current Key Controls		**Rating**
Policies	Constitution, membership & role of HCP Partnership Board, 'All Together Fairer;(Marmot Review)' Core 20+5 stocktake, Prioritisation Framework, Public Engagement / Empowerment Framework.	**G**
Processes	Strategic planning, consultation & engagement, financial planning, Population Health Partnership group support, advice, and scrutiny of the Population Health Programme.	**G**
Plans	***All Together Fairer: Our Health and Care Partnership Plan,*** HCP Interim Strategy, 5 Year Joint Forward Plan, Financial Plan (including ringfenced health inequalities funding) approved by HCP, Joint Health, and Wellbeing Strategies	**G**
Contracts	NHS Trust contracts (including contract schedule to support reducing health inequalities)	**G**
Reporting	C&M HCP Partnership Board, Population Health Partnership Group, Place-Based Partnership Boards, Strategy & Transformation Committee, ICB Board.	**G**

Gaps in control

Lack of long-term sustainable funding across a number of programmes that are contributing to Population Health Priorities
A reduced investment in Health Inequalities funding in year 24/25 from the
This will lead to a delay in some programme commencement dates until April 2025.

Actions planned	**Expected outcome**		**Owner**	**Timescale**	**Rating**
	Likelihood	**Impact**			
Finalise Joint 5-year Forward Plan aligned to All Together Fairer			Neil Evans	01/10/24	**Complete**

Secure ICB ring-fenced Health Inequalities budget allocation			Clare Watson	31/03/25	**Complete**
Agree All Together Fairer and Health Inequalities approaches with place-based partnerships (incl allocation, guidance & reporting)	Reduce	Reduce	Ian Ashworth	31/03/25	**On Track**
Implement Population Health Group sub-groups aligned to population health programme plan on a page	Reduce	Reduce	Population Health Consultants	31/03/25	**On Track**
Develop of performance framework, underpinning data & intelligence to enable demonstration of progress.	Reduce	Reduce	Cerriann Tunnah	31/03/25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme, or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
ICB Board approval to Joint 5 Year Forward Plan	October 2024	1/10/24	**Acceptable**
Progress reports to C&M HCP Board on delivery & implementation of programmes and projects. Green	Quarterly	26/09/24	
Progress reports to Strategy & Transformation Committee on delivery & implementation of programmes and projects.	Bi-monthly	April & May June & July August & September	
Core20+5 Health Inequalities Stocktake for NHSE/I reported to Population Health Partnership Group & C&M HCP Board.	Quarterly	QT 1 submitted July	
Gaps in assurance			
Limitations on scale and pace of investment due to challenging financial environments for all partners. Population Health Group Sub-Groups to develop where required. Programme metrics and impact reporting requires review.			

Actions planned	**Owner**	**Timescale**	**Rating**
Secure ICB ring-fenced Health Inequalities budget allocation – 2025-26	Clare Watson	31/03/25	**On Track**
Review of Programme reporting metrics and Impacts	Cerriann Tunnah	31/12/24	**On Track**
Develop assurance role of Population Health Group Sub-Groups	Ian Ashworth	28/02/25	**On Track**

ID No: P3	Risk Title: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes
Risk Description (max 100 words)	The COVID 19 pandemic generated significant backlogs due to reduced capacity and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes. Supply side constraints, including industrial action, impact on the available capacity in the system to tackle the longest waits. This risk relates to the potential inability of the ICB in this context to deliver these plans against national targets for recovery of electives, diagnostics and cancer services, which may result in patient harm and increased health inequalities.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Andy Thomas	Finance	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Performance	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	11/10/24	16/12/2024

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	3	3			2	31/3/25	The ICB has a low tolerance for risks impacting patient safety and the aim is to reduce to a moderate/low level acknowledging that this will take 2-3 years to achieve in line with national improvement trajectories.
Impact	5	5	5			5		
Risk Score	25	15	15			10		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths or irreversible health effects, or harm to more than 50 people, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood to possible (3). Elective Recovery, Diagnostics and Cancer Programmes are focused on increasing activity, faster diagnosis and treatment and reducing long waits. The planned actions are currently on track, and it is anticipated that this will reduce the likelihood further to unlikely (2) and that the target risk score of 10 will be achieved by year-end. The safety and quality impacts will also be lessened but due to the breadth and nature of the service, the potential remains for catastrophic (5) impact.							

Current Key Controls		Rating
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, NHS elective recovery plan published February 2022 '**Delivery plan for tackling the COVID-19 backlog of elective care'**	**G**
Processes	System level operational planning, performance monitoring, contract management, system oversight framework, diagnostics mutual aid,	**A**
Plans	C&M Operational Plan, Elective Recovery Programme and Plans, Diagnostics Programme and Plans, Cheshire & Merseyside Cancer Alliance work programme, Place Delivery Plans, Winter Plan, EPRR	**G**
Contracts	NHS Standard Contract – contracting round for 23/24 concluded	**G**
Reporting	Programme level reporting, Quality & Performance Committee, Primary Care Committee, ICB Board, Regional Elective Board (chaired by NHSE)	**G**

Gaps in control
Scale and frequency of future industrial action unknown and likely to continue to impact on workforce capacity.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
CMAST Elective Recovery Improvement Programme	Reduce	Reduce	Anthony Middleton	2024/25	**On Track**
Increase diagnostics capacity through CDCs and elective capacity through elective hubs	Reduce	Reduce	Anthony Middleton	2024/25	**On Track**
Cancer Alliance targeted investment and support to priority cancer pathways	Reduce	Reduce	Anthony Middleton	2024/25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Performance reporting to Quality & Performance Committee & ICB Board	Monthly & bi-monthly	Monthly & bi-monthly	**Acceptable**
Programme delivery reporting to Strategy & Transformation Committee, ICB Board	Bi-monthly	Bi-monthly	
Children and Young People's Elective Wait Recovery: accelerated delivery proposal	-	26/9/24	
Gaps in assurance			
All Trusts are committed to eliminate waits over 65 weeks by September per 24-25 operational plans, however it is noted that certain specialties are particularly pressured, including ENT, T&O, Plastics and Gynaecology, and that the majority of Cheshire & Merseyside Trusts therefore have not eliminated as at the end of September 65 week waits. Each of the "breach" patients are validated and tracked on a daily and weekly basis, and we are looking at additional opportunities for mutual aid and shared support between the trusts.			

Actions planned	Owner	Timescale	Rating
Weekly patient tracking list meetings all trusts	Anthony Middleton (via CMAST)	2024-25	**On Track**
C&M Elective Recovery Mutual Aid Team broker mutual aid	Anthony Middleton (via CMAST)	2024-25	**On Track**

ID No: P4	Risk Title: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience
Risk Description (max 100 words)	The ICB has a statutory responsibility to improve the quality of commissioned services and safeguard the most vulnerable, the quality governance framework that has been established supports early identification and triangulation of risks to quality and safety. This risk pertains to the potential failure of the established framework, with the consequence of a major impact on the safety and experience of services by our population.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Chris Douglas / Rowan Pritchard-Jones	Kerry Lloyd	Nursing & Care / Medical	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	01/10/24	15/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	3	2	2			2	31/3/25	The ICB has a low appetite for risk that impacts on patient safety. Our longer-term aspiration remains to reduce further to a moderate (1x5=5) level.
Impact	5	5	5			5		
Risk Score	15	10	10			10		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood, to unlikely (2). Good progress has been made in establishing the quality oversight framework providing a firm foundation for identifying emerging concerns and appropriate intervention. The increased focus on the resources available and our need to increase our productivity in 2024-25 makes it increasingly important to mitigate any potential impact to the quality and safety of commissioned services, and as a result it is anticipated that progress in further reducing this risk will be limited during the current financial year.							

Current Key Controls		Rating
Policies	Clinical Quality Strategy, National Quality Board guidance on risk management and escalation, Safeguarding legislation and policy alignment, Patient Safety policy alignment, including Patient Safety Incident Response Framework	**A**
Processes	System Quality Group, Emerging Concerns Group, Clinical Effectiveness Group, Multi- agency safeguarding boards/partnerships, Infection Prevention Control/Anti-Microbial Resistance Board, Place based quality partnership groups & serious incident panels, Quality Assurance Visits, Rapid Quality Reviews, Independent Investigations & other reviews and responses to national enquiries and investigations.	**A**
Plans	Development of Clinical and Care Professional Leadership Framework & Associated Steering Group, Approach to NHS Impact	**A**
Contracts	Place based quality schedule within NHS standard contract, Development of standardised C&M quality schedule, Service specifications, Safeguarding commissioning standards	**A**
Reporting	System Oversight Board, Quality & Performance Committee ICB Board, National quality reporting	**G**

Gaps in control
Need to ensure NHS Impact & PSIRF are embedded and extended Development of data and intelligence platforms to identify and triangulate quality concerns / failures.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Closedown Serious Incident Framework	Reduce	Maintain	Richard Crockford	31/12/24	**On Track**
Continuous review and alignment of quality reporting requirements	Reduce	Maintain	Chris Douglas	2024-25	**On Track**
Embedding NHS Impact approach	Reduce	Maintain	Fiona Lemmens	2024-25	**On Track**
Extending and embedding PSIRF	Reduce	Maintain	Richard Crockford	2024-25	**On Track**
Continue to develop BI capability to support intelligence led approach	Reduce	Maintain	Becky Williams	2024-25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Quality reporting to Quality & Performance Committee & ICB Board	Monthly	30/5/24, 25/7/24, 26/9/24	**Acceptable**
Executive Director of Nursing & Care report to ICB	Bi-monthly	30/5/24, 25/7/24, 26/9/24	
Regional quality group reporting	Bi-monthly		
Gaps in assurance			
Work to strengthen quality, safety and experience reporting through intelligence led approach			

Actions planned	Owner	Timescale	Rating
Continue to develop ability to be intelligence led	Chris Douglas / Rowen Pritchard Jones	2024-25	**On Track**
Strengthen approach to the use of patient experience insight and feedback to ensure the early identification of negative impact on patient experience	Kerry Lloyd	2024-25	**On Track**

ID No: P5	Risk Title: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience.
Risk Description (max 100 words)	The wider urgent and emergency care system, spanning all sectors, is under significant pressure with similar demand, capacity and flow challenges impacting on the ability of patients to access the right urgent or emergency care at the right time in the right place. Within the acute sector, high bed occupancy, driven by delayed discharges and longer stays, results in reduced flow from emergency departments, which in turn impacts waiting times in ED and ambulance response times. Such delays may result in patient harm and poor patient experience, and increased health inequalities.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Claire Sanders	Finance	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	11/10/24	15/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4			3	31/3/25	The ICB has a low tolerance for risks impacting patient safety and the aim is to reduce to a moderate/low level acknowledging that this will take 2-3 years to achieve.
Impact	5	5	5			5		
Risk Score	25	20	20			15		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood, but this is still likely (4). Urgent Care Recovery Programmes in 5 areas are focused on the key objective of eliminating corridor care in 24-25, as well as reducing the number of hospital attendances and admissions and improving discharge pathways and processes. The planned actions are currently on track, and it is anticipated that this will reduce the likelihood further to possible (3) and that the target risk score of 15 will be achieved by year-end. The safety and quality impacts will also be lessened but due to the scale and nature of the service, the potential remains for catastrophic (5) impact.							

Current Key Controls		Rating
Policies	NHS Delivery plan for recovering urgent and emergency care services. Winter Planning Guidance. SCC Review of Standards. Revised OPEL framework	**G**
Processes	System Coordination Centre, System wide operational planning, NHS Oversight Framework. Winter Planning process	**A**
Plans	UEC Recovery Programme, C&M Operational Plan, Place Delivery Plans	**A**
Contracts	NHS Standard Contract	**G**
Reporting	UEC Recovery and improvement Group, Strategy & Transformation Committee, Quality & Performance Committee, ICB Board	**A**

Gaps in control

Scale and frequency of future industrial action, GP collective action is unknown and likely to continue to impact on workforce capacity.
Demand exceeds planned capacity levels in a range of sectors, and fuller understanding of demand and capacity across all sectors is required.
Variation in processes C&M wide, e.g. application of patient choice, discharge processes.
Revaluation of NEPTS is required as part of procurement process.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
At scale work stream admission avoidance	Reduce	Reduce	Tony Mayer	2024/25	**On Track**
At scale work stream ambulance improvement	Reduce	Reduce	Ian Moses	2024/25	**On Track**
At scale work stream acute discharge	Reduce	Reduce	Dan Grimes	2024/25	**On Track**
At scale work stream acute length of stay	Reduce	Reduce	Dan Grimes	2024/25	**On Track**
At scale work stream oversight resilience	Reduce	Reduce	Claire Sanders	2024/25	**On Track**
Urgent Care Improvement Programme – Liverpool	Reduce	Reduce	Mark Bakewell & Deb Butcher	2024/25	**On Track**
Tier 1 rapid improvement offer from National UEC/ECIST	Reduce	Reduce	Claire Sanders	31/12/24	**On Track**
Urgent Care Improvement Programme – Mersey and West Lancashire	Reduce	Reduce	Mark Palethorpe & Deb Butcher	2024/25	**On Track**

Urgent Care Improvement Programme – Cheshire	Reduce		Laura Marsh & Mark Wilkinson	2024/25	**On Track**
Urgent Care Improvement Programme – Warrington and Halton	Reduce		Carl Marsh	2024/25	**On Track**
Urgent Care Improvement Programme – Wirral	Reduce		Simon Banks	2024/25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
UEC Recovery and Improvement Group	Monthly		**Partial**
Recovery Programme delivery reporting to Recovery Committee & ICB Board	Monthly & bi-monthly	26/9/24	
Performance reporting to Quality & Performance Committee & ICB Board	Monthly & bi-monthly	30/5/24, 25/7/24, 26/9/24	
Gaps in assurance			
Performance against the majority of urgent and emergency care measures is below target and England average.			

Actions planned	**Owner**	**Timescale**	**Rating**
Urgent Care Improvement Programmes (as above)	Place Directors (as above)	2024/25	**On Track**

ID No: P6	Risk Title: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population
Risk Description (max 100 words)	The COVID 19 pandemic generated significant backlogs due to reduced capacity to meet routine healthcare needs and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes. This risk relates to the potential inability of the ICB to ensure that local plans are effective in delivering against national targets for recovery of primary care access, which may result in poorer outcomes and inequity for patients and loss of stakeholder trust and confidence in the ICB.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Chris Leese & Tom Knight	Assistant Chief Executive	Primary Care

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Primary Care	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
10/05/23	02/10/24	15/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	3			3	31/03/25	The aim is to reduce to a moderate level of risk over the 2024-26 lifetime of access recovery / improvement plans.
Impact	4	4	4			4		
Risk Score	20	16	12			12		
Rationale for score & progress in quarter (max 300 words)	There is potential for significant reduction in health outcomes and/or life expectancy, significant increase in health inequality gap in deprived areas or socially excluded groups, adverse public reaction and significant impact on trust and confidence of stakeholders (impact 4). Current controls are effective in reducing the likelihood to possible (3). Ongoing delivery of Primary Care Access Recovery and Dental Improvement Plans is on target and currently achieving the target risk score of 12. From a Primary Medical perspective, the ongoing collective action by GP practices could drive up the score during the remainder of the year if patients are becoming impacted. There will be Place variation with the scoring. In addition, there is also a potential impact on community pharmacies due to the collective action which will also be monitored and could impact the scoreduring the remainder of the year. A new risk for the Collective Action has been drafted and discussed at the System Primary Care Committee who have oversight							

Current Key Controls		Rating
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, National Stocktakes and Guidance in relation to Primary Care, Primary Care Access Recovery Plan, National Dental Recovery Plan 2024	**G**
Processes	System and place level operational planning, performance monitoring, contract management, system oversight framework, place maturity / assurance framework.	**A**
Plans	Primary Care Strategic Framework version 1, Developing Primary Care Access Recovery Plan, System Development Funding Plan, Dental Improvement Plan, ICS Operational Plan, Place Level Access Improvement Plans x 9.	**A**
Contracts	GMS PMS APMS Contracts, Local Enhanced/Quality Contracts, Directed Enhanced Services – Primary Care Networks – Enhanced Access, GDS&PDS Contracts	**G**
Reporting	System Primary Care Committee, NW Regional Transformation Board, Quality & Performance Committee, ICB Board, HCP Board. Place Primary Care forums. Local Dental improvement plan delivery board	**G**

Gaps in control
Primary Care Strategic Framework version 2 to be completed & formally signed off. Ongoing successful delivery of the access recovery / improvement plans required over a 2-3 year period to close gap, specifically dental workforce and funding for primary medical baselines as reported by contractors.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Complete & secure approval to Primary Care Access Recovery Plan Y2			Chris Leese	30/11/24	**On Track**
Delivery of Access Recovery and Improvement Plans			Corporate & Place Primary Care Leads	2024-26	**On Track**
Delivery of Dental Improvement Plan 2024-26			Tom Knight	2024-26	**On Track**
Collective action EPRR process in place			Chris Leese	2024-26	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Reporting on delivery to System Primary Care Committee & ICB Board	Quarterly	18/4/24	**Acceptable**

Performance Reporting to ICB Board	Bi-monthly	30/5/24, 25/7/24, 26/9/24	
ICB Board approval to Primary Care Access Recovery Plan Y2	November 24		

Gaps in assurance
No Phase 2 of strategic framework

Actions planned	**Owner**	**Timescale**	**Rating**
Secure approval to Primary Care Access Recovery Plan Y2	Chris Leese	30/11/24	**On Track**

ID No: P7	Risk Title: The Integrated Care System is unable to achieve its statutory financial duties
Risk Description (max 100 words)	There is a substantial underlying financial gap across the Cheshire and Merseyside healthcare system between current spending levels and the national formula-based allocation. If the ICB is unable to secure agreement to and deliver a long-term financial strategy which eliminates this gap whilst also enabling delivery of statutory requirements and strategic objectives, then it will fail to meet its statutory financial duties. This is further exacerbated by the relative' distance from target, convergence adjustments for both core ICB allocations and specialised services and inflationary pressures anticipated in the short -medium term above funding settlements.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Claire Wilson	Rebecca Tunstall	Finance	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Finance	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	24/10/24	16/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4			3	31/03/25	The ICB is willing to pursue higher levels of risk while maintaining financial sustainability and efficient use of resources. The aim is to reduce to a moderate level over the 3-year financial plan.
Impact	5	5	5			5		
Risk Score	25	20	20			15		
Rationale for score & progress in quarter (max 300 words)	There is potential for a major financial loss, special measures and major impact on trust and confidence of stakeholders (impact 5). The scale of the financial gap means that the likelihood is currently likely (4). Planned actions to secure ICS wide agreement and NHSE approval to a Medium-Term Financial Strategy are in progress. It is anticipated that will reduce the likelihood to possible (3) achieving the target risk score of 15 by year end. The longer-term aim is to reduce to a moderate level over the lifetime of the medium-term financial strategy. A medium-term financial model has been shared with the Board which sets out the financial challenge and drivers of the deficit. The medium-term financial strategy will be developed as the associated transformation and commissioning strategies are progressed.							

Current Key Controls		Rating
Policies	Standing Financial Instructions, Scheme of Reservation & Delegation, Delegation Agreements (ICB / Place), Financial Policies	**G**
Processes	Financial planning	**G**
Plans	ICS Financial Plan 2024/25, Medium Term Financial Strategy	**A**
Contracts	NHSE/I Funding allocations (Revenue & Capital), NHS Standard Contracts	**A**
Reporting	ICB Executive Team, Finance Investment and Resources Committee, ICB Board, NHSE/I	**G**

Gaps in control
Medium Term Financial Strategy including Recovery Plan to be agreed.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Conclude 24-25 contracts	Reduce	Reduce	Claire Wilson	31/07/24	**Complete**
Develop Medium Term Financial Strategy including Financial Recovery Plan	Reduce	Reduce	Claire Wilson	30/09/24	**Problematic**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
ICB Board approval of Medium-Term Financial Strategy	September 24		**Partial**
System Financial Report to ICB Board	Bi-monthly	25/7/24, 26/9/24	
NHSE ICB Assessment	Annual (July)		
Gaps in assurance			
ICS Medium Term Financial Strategy including Recovery Plan yet to be agreed			

Actions planned	Owner	Timescale	Rating
Secure approval to Medium Term Financial Strategy	Claire Wilson	30/09/24	**Problematic**

ID No: P8	Risk Title: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services
Risk Description (max 100 words)	There are significant service sustainability challenges across the Cheshire and Merseyside system, including significant clinical risk and challenges identified by the Liverpool Clinical Services Review, and Trusts at SOF3, and a number of fragile hospital and other services across C&M. This risk concerns the potential inability to maintain services in their current configuration and inability to deliver the necessary transformational business cases in relation to our most challenged services.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard Jones	Fiona Lemmens/Carole Hill/ Mark Wilkinson	Medical	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	30/10/24	16/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3			3	31/03/25	The ICB has a low appetite for risk that impacts on patient outcomes. Our longer-term ambition is to moderate to (2x3=6) level of risk but will only be achievable over 2-3 years.
Impact	4	4	4			4		
Risk Score	16	12	12			12		

Rationale for score & progress in quarter (max 300 words)	There is potential for major effect on quality of clinical care and non-compliance with national standards posing significant risk to patients, and significant impact on trust and confidence of stakeholders (impact 4). Current controls are maintaining the likelihood at possible (3). Strategic transformation programmes have been established to address service sustainability issues and work will continue to develop case for change and consultation proposals during 2024-25 but are not expected to be complete or impact on the risk level until 2025-26 and beyond. Progress has been made on key programs over the last quarter: • Shaping Care Together (SCT) case for change published and SCT programme in formal stage of public engagement in September and October 2024.

	• C&M Continuous Improvement Programme Steering Group and Cheshire and Merseyside Improvement Network established, and Delivery plan developed with a focus on supporting the ICB recovery programmes. • Women's services in Liverpool programme case for change approved by ICB board and formal public engagement started on 15th October. In parallel work will begin on the design phase and development of a clinical model at a Clinical Reference group meeting in December 2024. A Lived Experience Panel has been established to support the programme. • Liverpool Clinical Services Review - Liverpool University Hospitals Foundation Trust and Liverpool Women's FT come together as University Hospitals of Liverpool Group from 1 November. This will streamline decision-making and develop further collaboration opportunities in terms of service quality, access, workforce capacity and finance. Plans for other acute and specialist trusts to join a group structure, retaining their status as separate Trusts, are in development. • C&M CMAST clinical pathways programme - Cardiology options appraisal workshops established to develop plans for optimising cath lab provision across C&M in order to address poor performance and outcomes in Acute Coronary Syndrome (ACS)

Current Key Controls		Rating
Policies	NHSE Major Service Change Guidance, NHSE Standard Operating Framework	**G**
Processes	NHSE Major Service Change Process	**G**
Plans	C&M Clinical Improvement and NHS Impact programme, Liverpool Place provider collaboration on urgent care pathways, CMAST Clinical Pathways Programme, Shaping Care Together Programme in Sefton Place, ECT/Stockport Foundation Trust (SFT) Programme in East Cheshire Place, Women's Services Programme in Liverpool Place	**A**
Contracts	Provider contracts held at Place. NHSE Specialist Commissioning Contracts held at NHSE region	**A**
Reporting	Provider Boards and internal governance arrangements, Programme Boards, Liverpool Provider Joint Committees, ICB Women's Services Committee, ICB Strategy & Transformation Committee, ICB Board	**A**
Gaps in control		

Progression through programme plans including where appropriate business case development, consultation and approval of key strategic transformation programmes is required to improve controls.					
Actions planned	**Expected outcome**		**Owner**	**Timescale**	**Rating**
	Likelihood	**Impact**			
Continuous Improvement Approach	Maintain	Maintain	Fiona Lemmens	2024-25	**On Track**
Oversight of Shaping Care Together Programme delivery and milestones	Maintain	Maintain	Deb Butcher, Fiona Lemmens, Clare Watson	2024-25	**On Track**
Oversight of ECT Sustainable Hospitals Programme delivery and milestones	Maintain	Maintain	Mark Wilkinson, Fiona Lemmens, Clare Watson	2024-25	**On Track**
Oversight of Liverpool Clinical Services Review Programme delivery and milestones	Maintain	Maintain	Mark Bakewell	2024-25	**On Track**
Oversight of Womens Services in Liverpool Programme delivery and milestones	Maintain	Maintain	Fiona Lemmens, Chris Douglas	2024-25	**On Track**
Oversight of CMAST programmes	Maintain	Maintain	Fiona Lemmens	2024-25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Continuous Improvement updates to ICB Executives Committee	As required		**Partial Assurance**
Shaping Care Together Programme Board updates to Strategy & Transformation Committee	Bi-monthly	Board – 25/7/24	
ECT Sustainable Hospitals Programme Board updates to Strategy & Transformation Committee	Quarterly		
LCSR Programme updates to One Liverpool Board and Strategy & Transformation Committee	TBC		
Womens Services in Liverpool Programme updates to ICB Women's Services Committee	Quarterly	3/7/24 & Board – 9/10/24	

Recovery Programme delivery reporting to Recovery Committee & ICB Board	Fortnightly and Month Bi-Monthly	May – Sept (fortnightly) & Board – 30/5/24, 26/9/24	
CMAST programme updates to Strategy & Transformation Committee and Board	Quarterly	Board – 25/7/24	

Gaps in assurance

Issues in relation to affordability and timescales will need to be addressed in pre consultation business cases for key programmes.
The impact of the current ICB financial situation and associated planning processes on the various transformation processes remains uncertain.

Actions planned	Owner	Timescale	Rating
Shaping Care Together (SCT) – conclude public engagement, analyse feedback and commence options appraisal process.	Deb Butcher, Fiona Lemmens, Clare Watson	2025-26 Q1	**On Track**
Women's services in Liverpool programme - conclude public engagement, analyse feedback and commence options appraisal process	Fiona Lemmens, Chris Douglas	2025-26 Q2	**On Track**
All other programmes – oversight and assurance of milestone progress	Mark Bakewell, Mark Wilkinson, Fiona Lemmens, Clare Watson, Chris Douglas	2025-26 and beyond	**On Track**

ID No: P9	Risk Title: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives
Risk Description (max 100 words)	Ensuring that we have a workforce with the necessary skills and experience, and that is reflective of our local population, is essential to the delivery of our strategic objectives. The C&M system has significant workforce challenges including recruitment, retention and sickness absence.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Samosa	Sarah Smith	Nursing & Care	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity & Value for Money	Workforce	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	19/11/24	16/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	4	4			4	31/03/25	Our longer-term ambition is to moderate to a (2x3=6) level of risk but will only be achievable over 2-3 years due to resource allocation and capacity.
Impact	4	4	4			4		
Risk Score	16	16	16			16		
Rationale for score & progress in quarter (max 300 words)	There is potential for a major effect on quality of clinical care and significant financial loss (impact 4). Current controls are maintaining the likelihood at likely (4). Workforce Recovery Programme, supporting the implementation of the C&M Workforce Plan in 2024-25, is focused on identifying opportunities to optimise our resources to support a reduction in workforce costs whilst not compromising quality of care and the patient experience. Financial constraints have limited ability to increase workforce planning capacity but realignment of existing Peoples Team resources will enable a more limited work programme in the short term. Due to resource constraints, it is not now anticipated that a reduction in likelihood to possible (3) will be achieved by year-end and the target score has been increased to 16, with further reductions over a 2-3 year period dependent on resources.							

Current Key Controls		Rating
Policies	Provider Recruitment & Selection, Apprenticeship, Retention Strategies.	**A**
Processes	Organisational development, workforce planning, PDR, training & development, communication & engagement, recruitment, demographic profiling, international recruitment, apprenticeship levy, C&M retention forum, NHSE/HEI supply data	**A**
Plans	C&M People Plan, NHS People Promise, provider workforce plans	**A**
Contracts	TRAC, ESR, Occupational Health, Payroll, EAP	**G**
Reporting	WRES, WDES, Staff survey, reporting to People Board. System workforce dashboard (manual).	**A**

Gaps in control

Financial constraints have limited / deferred investment in workforce development capacity
While manual System Workforce dashboard has been developed, need still exists for broader automated options.
Limited maturity of collaborative working at system level
Inconsistent workforce planning process/methodology across the system
Insufficient links to educational institutions and local authorities
Technology and inconsistent use of workforce systems across the region (ESR, ERoster, TRAC, NHS jobs, OH system)

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Develop and enhance workforce planning capabilities across the system	Reduce	Maintain	Emma Hood	30/09/24	**Complete**
Scaling of Peoples Services	Reduce	Maintain	Sarah Smith	Review Apr 25	**On Track**
Plans to further develop and enhance workforce planning capabilities across the system as resources and capacity allow	TBC	TBC	TBC	2025-26	**TBC**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**

Integrated Quality & Performance Reports to ICB Board	Bi-monthly	30/5/24, 25/7/24, 26/9/24	**Partial Assurance**
System workforce reporting to People Board	Quarterly		
NHS Equality Diversity and Inclusion Improvement Plan updates	Quarterly		
WRES & WDES reporting	Annual		
CQC Well Led review	Annual		

Gaps in assurance
CQC approach to assessing integrated care systems is still evolving.

Actions planned	**Owner**	**Timescale**	**Rating**
Respond to CQC framework	Clare Watson	2024/25	**On Track**

ID No: P10	Risk Title: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population
Risk Description (max 100 words)	Delivery of our shared aims, strategy and 5-year plan is dependent on collective ownership and collaborative effort by communities and organisations across Cheshire & Merseyside. The ICB has a key role in system leadership and promoting greater collaboration across the NHS and with local partners. This risk relates to the potential that focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of the population.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Graham Urwin	Clare Watson	Assistant Chief Executive	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Helping the NHS to support broader social & economic development	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	29/10/24	16/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3			3	Achieved	Interim target score achieved based on what is feasible for 2024/25. Our longer-term aim is to limit to a moderate level of risk, but this is unlikely before 2025/26.
Impact	4	3	3			3		
Risk Score	16	9	9			9		

Rationale for score & progress in quarter (max 300 words)	The current national and local quality, safety, performance and financial pressures during the post COVID recovery period gives rise to potential for significant reduction in health outcomes and/or life expectancy and significant increase in health inequality gap in deprived areas or socially excluded groups, criticism or intervention by NHSE and significant impact on trust and confidence of stakeholders (impact 4). This is mitigated by a refreshed Joint Forward Plan which includes a focus on urgent care and financial recovery during 24/25 which also need to reflect impacts on Core20+5 populations and our strategic ambitions. A revised HCP Strategy has been approved which aligns the HCP to the All Together Fairer plan to address health inequalities. In support of this a delivery plan has been developed together with a plan for investment into health inequalities which was presented to the Health and Care Partnership in July 2024 with a focus on smoking, healthy weight and housing, building on previous commitments, for example children and young people schemes. It is recognised

	that in the short term the level of resources available for this wider focus on longer term population health investments is constrained and may limit further progress in reducing this risk during the current financial year.

Current Key Controls		Rating
Policies	Constitution & membership of ICB Board & HCP, Public Engagement / Empowerment Framework, Prioritisation Framework.	**G**
Processes	Strategic planning, communication & engagement, programme & project management, culture & organisational development, Provider Collaboratives, C&M and sub-regional networks	**G**
Plans	HCP Strategy 2024-29, Joint 5-year Forward Plan 2024-29, Joint Health & Wellbeing Strategies x 9 places, Operational Plan, Communications & Engagement Plan, Provider Collaborative Business Plans, Financial Plan.	**A**
Contracts	MOU with NHSE for system oversight is in development	**A**
Reporting	C&M HCP Partnership Board, Place-based partnership boards & H&WB Boards, ICB Board	**G**

Gaps in control
ICB operating model under review

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Refocus HCP Strategy 2024-2029 aligned to 'All Together Fairer'	Maintain	Maintain	Neil Evans & Ian Ashworth	30/08/24	**Complete**
Complete JFP 2024-29 *(delayed Board approval until post General Election)*	Maintain	Maintain	Neil Evans	31/07/24	**Complete**
Develop an update to propose a refreshed ICB operating model	Maintain	Maintain	Clare Watson	30/11/2024	**On Track**
Identify ICB health inequalities funding that will be overseen by the HCP Committee to support delivery of Marmot the C&M All Together Fairer strategy and ambitions. To be presented to July HCP Meeting	Maintain	Maintain	Ian Ashworth	31/07/24	**Complete**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Approval of updated HCP Strategy (To be approved by HCP – August) & Joint Forward Plan 2024-29 (ICB Board - July)	July 2024	Board 25/7/24 & 26/9/24 HCP 1/10/24	**Acceptable Assurance**
Reporting on progress of delivery plans during 2024-25 (ICB Board and delegated Board Committee)	In line with delivery dates in plan		
Joint Overview & Scrutiny of HCP Strategy and Joint Forward Plan	As required		
NHSE Systems Oversight Framework	Quarterly Review with NHS England		
Gaps in assurance			
JFP requires annual refresh and needs to reflect both short and longer term (five year) description of ICB priorities.			

Actions planned	Owner	Timescale	Rating
Seek approval to updated HCP Strategy and JFP	Clare Watson	31/08/24	**Complete**
Development of ICB Integrated Business Plan to describe delivery of Joint Forward Plan and ICB Corporate, Operational and Financial Planning priorities	Neil Evans	31/08/24	**Complete**
Development of MOU with NHS England in relation to system oversight operating model	Clare Watson/Anthony Middleton	31/08/24	**Complete**

ID No: P11	Risk Title: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside.
Risk Description (max 100 words)	The ICB is responsible for leading ICS-wide cyber security. C&M is a complex system including the ICB, all 16 NHS providers, 349 GP practices and other related health and care services. Risks may arise from a Cyber security attack (either direct to one or more organisations or to one of their suppliers), lack of investment in resilient infrastructure and / or lack of appropriately skilled staffing. This could lead to possible financial and / or data loss, disruption to the delivery of patient care and/or damage to the reputation of one or more organisations in Cheshire and Merseyside.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard-Jones	John Llewelyn	Medical	Strategy & Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services Enhancing quality, productivity and value for money	Transformation	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
27/6/24	25/10/24	16/12/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4			4	31/3/25	The ICB has a low tolerance for risks impacting patient safety. The aim is to moderate to a (2x8) over two years as resources and capacity allow.
Impact	4	4	4			4		
Risk Score	20	16	16			16		
Rationale for score & progress in quarter (max 300 words)	There is the potential for patient harm, major effect on quality of clinical care, significant financial loss, significant loss of trust and confidence of stakeholders and adverse national media (impact 4). Current controls are sufficient to reduce the likelihood to likely (4). The possibility of a cyber-attack cannot be completely removed, and a residual risk will remain, but the implementation of the 5-Year Cheshire and Merseyside Cyber Security Strategy aims to reduce likelihood to unlikely (2) over the lifetime of the strategy. It is anticipated that limited investments possible in 2024-25 will maintain the risk at the current level. In year funding secured through national cyber resilience fund and that will fund the delivery of priorities in the programme. New programme manager appointed for the Cyber Strategy delivery. We anticipate a further round of funding next year and this year's programme will build the business case to support securing further funding. Issues in relation to cyber security							

	manager vacancy but this is being mitigated through support from our IT providers. Anticipate this risk level will be maintained for the remainder of the year but controls should reduce likelihood but is always subject to new threats arising.

Current Key Controls		Rating
Policies	IT Security Policy (individual IT Service providers and organisations); IT Umbrella Policy, NHS England's CareCERT process, National Cyber security policy for England, What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies.	**A**
Processes	Cyber security systems & processes, Security audits & penetration tests, Digital maturity assessment, DSPT assessment & submissions, Cyber Associates Network, ICB monitoring of system wide cyber security standards. Clear incident management and support in major incidents agreed with ICB providers	**A**
Plans	ICS Cyber Security Strategy, Digital and Data Strategy 2022-2025, Investment (280k) & delivery plan in 2024/25, Cyber incident / Business continuity plan. National funding £620k revenue & £640k capital	**A**
Contracts	Cyber security monitoring tools inc. IT Health and Cynerio, IT provider contracts, data sharing agreements	**A**
Reporting	Digital Services Delivery Board (ICB infrastructure only), Digital Transformation & Clinical Improvement Assurance Board, Strategy & Transformation Committee	**A**

Gaps in control

ICS / ICB Capacity and investment to respond to continuously evolving threat.
Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity.
Lack of organisational & system level monitoring and reporting of standards, compliance & risks.
Further work required to raise awareness and understanding of cyber security at Board level & for all staff.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Cyber Security training for ICB Board	Reduce	Maintain	RPJ / JL	TBC	**On Track**
Further desktop Cyber exercise	Reduce	Maintain	JL / SP / MIAA	21/11/24	**On Track**

Benchmarking BAF/digital/cyber risks and associated processes across all healthcare organisations in Cheshire and Merseyside	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Develop a process for the transparent governance of provider level risks	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Define clear incident management and support in major incidents with ICB providers	Maintain	Reduce	CTO	30/09/24	**Complete**
Scope options and define requirements for Cyber security delivery model	Reduce	Maintain	JL / SP / MIAA	31/12/24	**On Track**
Explore opportunities to improve collaboration and sharing of Cyber resource across the Cheshire and Merseyside system	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Investigate and conclude upon the need for third party incident response capacity creating a business case for investment if deemed appropriate.	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Explore opportunity to standardize cyber tooling across C&M and procure at scale	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Analyse & map across C&M organisations, critical service/supply chain security assurances and gaps. Identify significant exposure points and report with recommended actions	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Work with ICB procurement & IG to create standard security and assurance procurement & contracts requirements & share across all organisations within the ICS.	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
DSPT becomes aligned to Cyber assessment framework in 24/25	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Cyber dashboard reporting to Digital Services Delivery Board / S&T Committee / Board	Quarterly (from Sept 24)		**Partial**
S&T Committee and Board approval of ICS Cyber Security Strategy	March 2024	28/03/24	
Penetration testing – IT Providers and Trusts	March 2025 Annual		

Cyber Essentials accreditation – IT Providers and Trusts	Annual		
MIAA audit of DSPT in line with the mandated scope set out in the DSPT Independent Assessment Guide reported to Audit Committee	Annual	25/06/24	
2024-25 delivery plan progress reports	September 2024 Quarterly		
Approval of delivery plans for future years.	April 2025 Annual		

Gaps in assurance
No oversight of compliance with cyber security standards at organisation and system level across C&M Funded delivery plans beyond 2024-25 yet to be established

Actions planned	**Owner**	**Timescale**	**Rating**
Develop cyber dashboard to provide oversight of compliance with key Cyber standards at organisation level	JL / SP / MIAA	31/03/25	**On Track**
Formalise Cyber risk reporting to the Board	JL / SP / MIAA	31/03/25	**On Track**
Review provider SLA's and existing Cyber investment to realign to requirements in the Cyber strategy.	JL	31/03/25	**On Track**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

ICB Corporate Risk Register – Quarter Two

Agenda Item No: ICB/11/24/**20**

Responsible Director: Clare Watson, Assistant Chief Executive

Corporate Risk Register – Quarter Two

1. Purpose of the Report

1.1 The purpose of the report is to present the Corporate Risk Register (CRR) for review by the Board.

2. Executive Summary

2.1 The ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 15+.

2.2 There are currently 10 risks on the CRR at appendix one, including 1 critical risk and 9 extreme risks. The most significant risk is:

- QU09 – East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm, currently rated as critical (20).

2.3 Further details of the mitigation strategies are provided in section 9 below and in the individual risk summaries at appendix three. All of the risks on the CRR have been subject to scrutiny and review by the relevant ICB Committee and further information is included in the highlight reports elsewhere on the agenda.

2.4 Since the July report:

- PC1 – Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services) has reduced from extreme (16) to high (12) and **is proposed for de-escalation**.
- PC8 - Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services, currently rated as extreme (15) **is proposed for escalation** by the Primary Care Committee.
- T2 - Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs, currently rated as extreme (16) **is proposed for escalation** by the Strategy and Transformation Committee.
- QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm **has reduced** from critical (20) to extreme (16).
- WSC6 - If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely **has reduced** from critical (20) to extreme (15).
- F8 - 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 **has reduced** from critical (20) to extreme (16). This follows re-assessment by place finance leads to ensure consistent scoring across places in accordance with risk matrix criteria.

- There has been movement in the risk scores for some places as indicated in appendix two.

2.5 In addition there are a number of risks in the pipeline listed below, including one critical risk, which meet the criteria for escalation to the Corporate Risk Register, but which have not yet been reviewed or agreed by the Quality and Performance Committee. The Committee were expected to review the risks at their November meeting, in accordance with the quarterly risk management cycle approved by the Audit Committee, but this has been deferred to their December meeting. These pipeline risks are listed below:

- QU04 - Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm has increased from high (8) to extreme (15) and **is proposed for escalation subject to agreement** by the Quality and Performance Committee.
- PF1 - Common risk across places in relation to urgent care flow, including 'no criteria to reside', with a potential impact on safety and quality of care, currently rated as critical (20) **is proposed for escalation subject to agreement** by the Quality and Performance Committee.
- HPDAF2 / WiPDAF2 – Halton / Wirral health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services, currently rated as extreme (16) **is proposed for escalation subject to agreement** by the Quality and Performance Committee.
- QU12 - NWAS have stated that they may be unable to manage a high volume of mental health calls leading to a patient safety risk if calls not managed in a timely manner, currently rated as extreme (16) **is proposed for escalation subject to agreement** by the Quality and Performance Committee.

2.6 A further risk has been identified in relation to Place Partnership Financial Resources, and the ability of partners across the system in a number of places to contain spend within the available collective partnership resource envelope. There is the potential that the action required to address the forecast overspend affects services and prevents delivery of strategic objectives impacting the health of the population. This is currently being assessed in each place, but indications are that this will meet the criteria for escalation to the Corporate Risk Register.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

3.1.1 **NOTE** the Corporate Risk Register, progress in completing mitigating actions, further action planned, and assurances provided; and consider any further action required by the Board to improve the level of assurance provided.

3.1.2 **APPROVE** the de-escalation of risk PC1, and the escalation of risks PC8 and T2.

4. Reasons for Recommendations

4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

- identifying risks which may prevent the achievement of its strategic objectives
- determining the organisation's level of risk appetite in relation to the strategic objectives
- proactive monitoring of identified risks via the Board Assurance Framework and Corporate Risk Register
- ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
- receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
- demonstrating effective leadership, active involvement and support for risk management.

5. Background

5.1 The ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 15+.

5.2 The Corporate Risk Register is distinct from the BAF as it reflects the significant risks escalated up from across the organisation for the attention of the Board (bottom up). These require additional scrutiny and potentially cross organisational response by virtue of their potential to disrupt achievement of the ICB's strategic and operational objectives. The scale of the corporate risk register reflects the current risk environment and covers the full scope of organisational activity. The BAF in contrast reflects a smaller number of principal risks (6-10) identified by the Board as the significant strategic challenges to delivery of the ICB's strategic objectives (top down).

5.3 The Corporate Risk Register has been compiled from current Committee and Directorate Risk Registers and provides an update on the report presented to the Board in July 2024.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic**

6.1 The CRR supports the objectives and priorities of the ICB through the identification and effective mitigation of the most significant risks across the organisation which, if realised, may impact on delivery.

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

7.1 The effective mitigation of the most significant risks across the organisation supports the achievement of the Annual Delivery Plan.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
Theme Two: **Integration**
Theme Three: **Leadership**

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the CRR underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability.

9. Risks

9.1 There are currently 10 risks on the CRR, including 1 critical risk and 9 extreme risks. A summary of the current and proposed mitigations in respect of each risk is set out below with further detail provided in the individual risk summaries at appendix three.

9.1.1 **QU09 - East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm,** currently rated as critical (20). Actions planned to increase control have been

completed or are now established as on-going control measures. The impact continues to be monitored but the data is not yet available to confirm that the control measures are effective and as a result the Quality and Performance Committee are currently unable to support a reduction in score.

9.1.2 **WSC6 – In relation to women's services, if patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely**, currently rated as extreme (15). Current controls include oversight by LMNS and local CQPGs and the Patient Safety Incidence Response Framework. Key further action is the clinical design work for medium and long term in the programme plan.

9.1.3 **F8/9 - Common risk across places that 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**, current rating has reduced from critical (20) to extreme (16). Current controls include delegated budgets, budgetary control and expenditure approvals process, financial recovery programmes and efficiency schemes, and financial 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.

9.1.4 **QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm**, current rating has reduced from critical (20) to extreme (16). The mitigation strategy includes a range of place level service and pathway improvement programmes in collaboration with partners, supported by the ICB at scale priority workstream.

9.1.5 **QU08 - Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience**, currently rated as extreme (16). Risk score across the ICB has reduced from 25 down to 16. Plans to address gaps in controls have progressed, with work on-going to establish reporting dashboards to support assurance and oversight. ICB Business Intelligence Team have developed Power BI tools to facilitate this work and are now reporting a progress update whereby the Quality Dashboard is ready to be tested and, if successful, rolled out.

9.1.6 **WSC3 - Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals**, currently rated as extreme (16). The C&M system is already financially challenged and therefore the risk score reflects that new expenditure and investment may not be possible in the

current financial climate; this is as much about the wider availability of public sector capital as the C&M situation. A Finance and Estates Group is due to be established in January 2025 (as part of the emerging Programme governance and reporting arrangements). Further actions include baseline mapping to support the design phase and finance and estates modelling to support the options development – the latter action has a longer-term timescale of January – June 2025.

9.1.7 **WSC4 - If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north-west region**, currently rated as extreme (15). A 'Clinical Leaders Group (CLG)' has been established to support the programme board. The CLG is leading the model of care work on behalf of Programme Board, with Specialised Commissioning and Clinical Network Leads also involved in the design work. Capital and revenue implications of the future model of care, interim model of care and counterfactual case are to be formulated by the Finance and Estates Group from January 2025.

9.1.8 **14DR - There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / data loss, disruption to services and patient care and/or damage to the reputation of the organisation**, currently rated as extreme (16). Current controls include a range of policies, cyber security software systems and associated processes to detect and prevent potential attacks. Further planned actions include delivery of the system wide Cyber Security Strategy, improvements to supplier management and continued training and awareness raising.

9.1.9 **PC8 - Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services**, currently rated as extreme (15). This is being managed through place and ICB level monitoring, reporting and escalation and the ICB EPRR incident response process.

9.1.10 **T2 - Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs**, currently rated as extreme (16). This is currently being mitigated through interim measures to delay withdrawal of services in Liverpool, St Helens and Halton. Further actions include the development and adoption of a minimum service specification, options appraisal and pursuit of funding opportunities.

9.2 All committees and sub-committees of the ICB are responsible for ensuring that risks associated with their areas of responsibility are identified, reflected in the

relevant corporate and / or place risk registers, and effectively managed. Each of these risks has been scrutinised and reviewed by the relevant ICB Committee. Risks considered and actions / decisions taken are detailed in the highlight reports elsewhere on the agenda.

9.3 The Finance, Investment and Our Resources Committee were not in agreement with the reduction in risk scoring for F8 from 20 to 16 as it does not align with their perception of the scale of the risk or direction of travel. However, this has been objectively calculated at a forecast of between 2.5 and 5% of delegated place budgets, resulting in a major impact (4), and there is consensus between place finance leads of a 50-75% likelihood (4), reflecting planned mitigations before year end. As a result, it is proposed to review the finance criteria in the ICB risk matrix with the Director of Finance to consider whether the thresholds are appropriate and recommend any changes as required.

9.4 A summary of the assurance ratings for each of the risks escalated to the CRR is provided below:

ID	Risk	Committee	Current Score (Q1)	Controls					Assurance Rating
				Policies	Processes	Plans	Contracts	Reporting	
PC8	Collective Action	SPCC	**15**	**G**	**G**	**G**		**G**	**Partial**
WSC3	Women's Services investment	Women's	**16**	**G**	**G**	**G**	**G**	**G**	**Partial**
QU09	ECT SHMI	Q&P	**20**	**G**	**G**	**G**	**A**	**G**	**Partial**
14DR	Cyber attack	S&T	**16**	**A**	**A**	**A**	**A**	**A**	**Partial**
WSC4	Women's Services model of care	Women's	**15**		**G**	**G**		**G**	**Partial**
T2	Weight management	S&T	**16**	**G**	**A**	**R**	**A**	**A**	**Partial**
QU05	Neurodevelopmental assessments	Q&P	**16**	**A**	**G**	**A**	**G**	**A**	**Partial**
QU08	Standards of care	Q&P	**16**	**A**	**A**	**A**	**A**	**A**	
WSC6	Women's Services safety and quality	Women's	**15**	**G**	**G**	**G**	**G**	**G**	**Acceptable**
F8/9	Place cost pressures / efficiencies	FIRC	**16**	**G**	**A**	**A**	**A**	**G**	**Partial**

9.5 Sources of assurance in relation to key controls are detailed in the individual risk summaries in appendix three.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the report does include financial risk F8, which is described in section 9 above and detailed in the appendices.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 Risks QU05, WSC3, WSC4 and WSC6 have the potential to impact on equality, diversity and inclusion in service delivery, outcomes or employment. The mitigations in place and planned are described in more detail in the risk summaries at appendix three.

11.2 Risks QU09, QU08, T2 and PC8 have the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at appendix three.

13. Climate Change / Sustainability

13.1 There are no risks currently on the CRR which impact on the delivery of the Green Plan / Net Zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 Senior responsible leads and operational leads for each risk will continue to develop and improve the controls in line with the targets and progress the mitigation actions described in section 9 above and in the individual risk summaries at appendix three. Updates will be provided through the regular CRR report to the Board.

12. Officer contact details for more information

Dawn Boyer
Head of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB

13. Appendices

Appendix One: Corporate Risk Register
Appendix Two: Place Risk Distribution
Appendix Three: Risk Summaries

Appendix One

Corporate Risk Register – November 2024

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
Assistant Chief Executive Directorate								
PC1	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services) **FOR DE-ESCALATION**	Primary Care	Clare Watson	**16**	**12**	**16**	9	A – Within 3 months
PC8	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services. **ESCALATED Q2**	Primary Care	Clare Watson	**15**	**15**	**N/A**	12	B – Within 12 months
Finance Directorate								
WSC3	Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals.	Women's Services	Claire Wilson	**16**	**16**	**16**	8	C – Beyond 12 months
Medical								
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm.	Quality & Performance	Rowan Pritchard-Jones	**20**	**20**	**20**	10	A – Within 3 months
14DR	There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	Strategy & Transformation Committee	John Llewellyn	**16**	**16**	**16**	12	A – within 3 months

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
WSC4	If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north west region	Women's Services	Christine Douglas	**15**	**15**	**15**	10	C – Beyond 12 months
T2	Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs **ESCALATED Q2**	Strategy & Transformation	Fiona Lemmens	**16**	**16**	**N/A**	9	A – Within 3 months
Nursing and Care								
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	Quality & Performance	Christine Douglas	**20**	**16**	**20**	8	A – Within 3 months
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	Quality & Performance	Christine Douglas	**25**	**16**	**16**	10	A – Within 3 months
WSC6	If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely	Women's Services	Christine Douglas	**20**	**15**	**20**	8	A – Within 3 months

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
Place Directorates								
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.	Finance, Investment & Our Resources	Place Directors	**25**	**16**	**20**	12	B – Within 12 months

Appendix Two

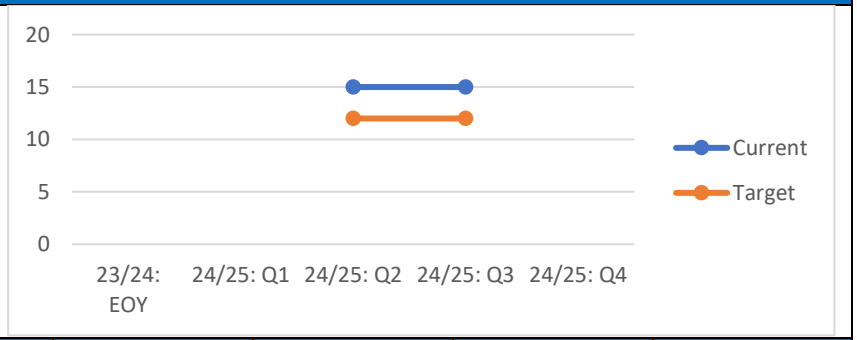
Place Risk Distribution – November 2024

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.	16	15↓	12↓	12↑	12	12↑	12	8↓	8	16
PC8	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.	15	15	12	9	12	12	16	12	12	15
QU04	Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm	15	15	12	8	3	16	6	9	9	8
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	16↓	16	12	12	8	16	16↑	16	16	16↓
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	16↓	9↑	6↓	12	12↓	16	16↓	6	9	16
T2	Limited Access to Specialist Weight Management Services across Cheshire and Merseyside and non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drug / Specific Place Risks in relation to potential loss of existing services	16			9		20		16		
PF1	Common place risk in relation to urgent care flow / 'no criteria to reside'	20	12	20		9			16	12	20

Appendix Three
Risk Summaries

ID No: 8PC	Risk Title: Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.			
		Likelihood	Impact	Risk Score
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*		3	5	**15**
Current Risk Score		3	5	**15 ↔**
Target Risk Score		3	4	**12**

Trend



Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
15	**12**	**9**	**12**	**12**	**16**	**12**	**12**	**15**

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
System Level – Clare Watson, Assistant Chief Executive	Christopher Leese, Associate Director of Primary Care	Assistant Chief Executive/ Primary Care	System Primary Care Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Primary Care/ Quality/ Performance	B – within this financial year	Corporate and Place	Manage/ Mitigate *(removal will depend on factors nationally)*

Date Raised	Last Updated	Next Update Due
June 2024	Oct 2024	Dec 2024

Risk Description

Following the release of the national contract terms related to finance, there are national and local pressures from some GPs to take collective action in relation to concentrating only on delivering core essential services as per contractual agreements. This would impact on patient care and services to varying degrees depending on the services and scale of the action (e.g. whether localised or spread out across the system). The universality of the action isn't clear at present with responses and feedback being worked through. This may impact on other providers including secondary care and community pharmacists, as well as patients. **September Update**: Score **remains** 15 (possible (3) likelihood by a catastrophic (5) impact. There are a number of practices who have indicated that they will be taking a form of this action, and this is currently being managed at place level; with the EPRR team managing the total operational picture of the impact on the system and providing twice weekly escalation to NHSE of a summary of issues from places. EPRR team can provide further information as required. As at 30/09 there has been no formal notification of a serious system, or practice, operational impact yet. This is being closely monitored and will be assessed over time. The ICB is in continuous dialogue with NHSE re: any national actions to mitigate this action.	
Linked Operational Risks	Sustainability of General Practice Workforce Place related risks

Current Controls		**Rating**
Policies	Region have issued supporting documentation and template for system readiness and assessment	**G**
Processes	Escalation systems in place – place and corporate Escalation and reporting in place ICB to Region Informal temperature check-ins with Region ICB EPRR process in place ICB corporate meetings with all LMCS – regular agenda item	**G**
Plans	A regional temperature check/status template was completed for Region	**G**
Contracts		
Reporting	System Primary Care Committee regular update/Standing agenda item Place Primary Care Forums EPRR / System Control Centre Regional ICB Check-ins now in place	**G**

Gaps in control

- 24/25 Contract offer is a nationally-led process

Actions planned	**Owner**	**Timescale**	**Progress Update**
Further ICB / Regional Reporting	JG/CL	In progress	

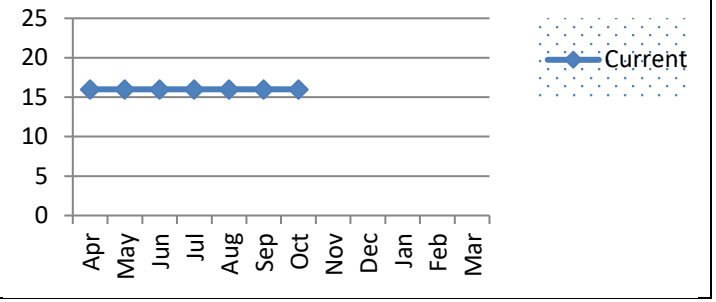
Place/Corporate regular check ins – initially fortnightly primary care leads	CL	Ongoing	Places developing place-level risk as appropriate – some places have had practices indicate they will be taking some form of action; other places this is still in discussion.
Place individual actions/plans (see Place level risk/plans)	Place PC Leads	Ongoing	Place level risk reporting varies in maturity across the nine places – as above.

Assurances		
Planned	**Actual**	**Rating**
Inter ICB readiness Assurance – more formal EPRR type readiness	Considered but not in place at this stage depending on how things progress	**Partial**

Gaps in assurance
As above

Actions planned	**Owner**	**Timescale**	**Progress Update**
Maintain continuous dialogue with NHSE re: national steer.	EPRR Team/ CL	Ongoing	

ID No: WSC 3	Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool will negatively impact on the successful delivery of proposals.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	**16**	
Current Risk Score	4	4	**16**	
Risk Appetite/Target Risk Score	2	4	**8**	

Senior Responsible Lead	Operational Lead	ICB Directorate	Responsible Committee
Claire Wilson	Frankie Morris / Jenny Hannon	Finance	Women's Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Productivity and Value for Money	Finance	C – beyond 12 months	Principal	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	11/11/24	16/12/24

Risk Description ***[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]***

Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool will negatively impact on the successful delivery of proposals. The appraisal of options will consider relative capital costs / revenue implications and the deliverability of proposals in this context. It is likely that all proposals will require a level of capital funding. In addition, a dedicated programme budget is required that will include the budget for key programme roles and involvement activities.

Current Controls		Rating
Policies	ICB SOs and SFIs	**G**
Processes	Finance and estates group to be established; applications for national capital if available; programme budgeting	**G**
Plans	C&M Joint Forward Plan 2023-2028; NHSE 3-year delivery plan for maternity plan (2023); Involvement activity plan(s)	**G**
Contracts	N/A	**G**
Reporting	Regular reports to the Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint Committee.	**G**

Gaps in control **[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]**

C&M system is already financially challenged – any new expenditure and investments may not be possible in the current financial climate.

Actions planned	Owner	Timescale	Progress Update
Agree programme budget / resourcing plan	CW / CP	Sept 24 - Complete	C&E budget and additional programme resources agreed.
Establish finance and estates group	CW / JH	Jan 25	To support options process.
Undertake baseline mapping to support design phase	CW / JH	From Jan 25	
Undertake finance and estates modelling to support options development	CW / JH	Jan - Jun 25	

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances		
Planned	**Actual**	**Rating**

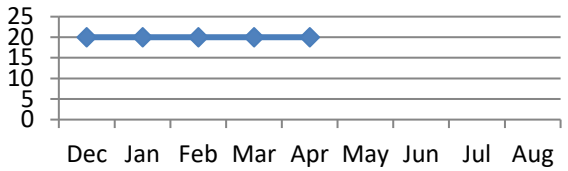
Women's Services in Liverpool Programme updates to ICB Women's Services Committee	Women's Services Committee – 3/7/24 & ICB Board – 9/10/24	**Partial Assurance**
Independent financial / economic modelling may be required to support the development and assessment of options – to be considered as part of programme budgeting		

Gaps in assurance ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

The programme is not yet at the point where investment needs can be quantified or funding secured

		Timescale	Progress Update

ID No: QU09	Risk Title: East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	5	20	
Current Risk Score	4	5	20	
Risk Appetite/Target Risk Score	2	5	10	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Medical Director - Rowan Pritchard- Jones	ADQSI – East Cheshire	Medical	Quality and Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/09/23	01/07/2024	Sept-2024

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]

The SHMI is the ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge. A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance and instead should be viewed as a 'smoke alarm' which requires further investigation. SHMI is not a direct measure of quality of care and cannot be directly used to identify avoidable deaths, however, it may be an indication of poor quality of care which could lead to increased avoidable harm and avoidable deaths.

Current Controls	Rating

Policies	Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalization, England, May 2022 to April 2023; National Guidance on learning from deaths, National Quality Board, 2017; Acutely ill adults in hospital: recognizing and responding to deterioration NICE clinical guideline (CG50); Acute Kidney injury: prevention, detection, and management NICE (NG148); Sepsis: recognition, diagnosis and early management NICE (NG51); Intravenous fluid therapy in adults in hospital NICE (CG174); Acute Hospital Discharge '100 day challenge', Letter David Sloman July 2022; Hospital discharge and community support guidance, NHS England, July 2022	**G**
Processes	Rapid Quality Review (RQR) and subgroups **(RQR stepped down and now moved to bimonthly SHMI Quality Improvement Meeting)**; Quarterly mortality reports to East Cheshire Trust (ECT) Safety and Quality standards committee and ECT Board; Contract Quality and performance Meeting (CQPM) to monitor performance of NHS commissioned services; Reports to Cheshire and Merseyside Quality and Performance Committee Quality leads meetings and Quality and Performance Assurance Group at Place; C2Ai monthly analytics and reports	**G**
Plans	CQPM workplan to ensure ongoing mortality/ SHMI reporting and oversight; ECT SHMI reduction action plan; ECT deteriorating patient group established; Winter Plan to support timely discharge and admission avoidance. SHMI driver diagrams and improvement plan	**G**
Contracts	NHS Cheshire and Merseyside ECT contract; Quality schedules- Mortality Reviews	**A**
Reporting	SHMI Quality Improvement Meeting reporting into NHS Cheshire and Merseyside Quality and Performance Committee; ECT reporting into Safety and Quality Standards Committee and ECT Board; Mortality and SHMI performance oversight through CQPM and Place Quality and Performance Assurance Group- escalations to NHS Cheshire and Merseyside Quality and Performance Committee made through Place Key Issues report	**G**

Gaps in control ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

QR SHMI Improvement Plan- developed and being refined. Driver diagrams now in place. These have been informed through work within the 'In hospital' and 'out of hospital' subgroups (which have now been stood down). Quality improvement work in ECT on hydration and deteriorating patient has started. Mortality Reviews/ Structured Judgement reviews (SJR) are being rolled out across medicine. Development of the SHMI dashboard is ongoing. Some assurance has been received around: coding of palliative care- this is being done in general practice. The analysis showed more work required to prevent dehydration of frail elderly and recognition and timely escalation of deteriorating patient. No care delivery issues identified with out of hospital care and support. The Trust regularly report to their board on learning from deaths. This is being strengthened as part of the improvement plan.

C2Ai data is now being reported monthly. Analysis and case review of people who die out of hospital within 30 days of discharge has been completed.

SHMI dashboard in development with ICB BI and Trust BI support.

Actions planned	Owner	Timescale	Progress Update
RQR SHMI Improvement Plan (in development)	John Hunter	December 2023	SHMI improvement plan in place. This has been supplemented by SHMI driver diagrams. Completed (updated Feb-24)
Subgroups to meet to complete analysis of issues and agree diagnostic actions	Paul Bishop/ John Hunter	November 2023	Review of people dying within 30 days of discharge has been completed. This showed no lapses of care and that most were expected to die. Areas for improvement around discharge planning (seen in two cases) is being followed with through Place quality leads meetings. Completed (updated Feb-24)
RQR meetings to continue until assurance that the issues are understood and agreement of the improvement plan	Rowan Pritchard-Jones	November 2023	It was agreed in November to close down the rapid quality review meetings and replace them with a SHMI quality improvement meeting which will meet bimonthly. The first meeting was held on 15th December 2023. Completed- now had 2 SHMI quality improvement meetings. Next meeting April 2024
Improvement plan to be developed	Amanda Williams	Draft by September Final by November 2023	As above: Improvement plan and driver diagrams completed. Ongoing review of progress to be through the SHMI Quality Improvement Meeting. Completed (updated Feb-24)
Quality improvement work around hydration and deteriorating patient to be progressed	Kate Daly-Brown	October 2023	Quality Improvement work agreed and commenced with medical wards. This is part of the SHMI Improvement Plan. Update provided at SHMI quality improvement meeting on 23rd Feb. Ward staff are actively engaged with quality improvement work.

Monthly data analysis/ scrutiny of report from C2Ai	John Hunter/ Rowan Prtichard-Jones	ongoing	Monthly reports are now being received, analysed and will inform the SHMI dashboard. Ongoing review monthly by Medical Director and John Hunter.
Case review of out of hospital deaths within 30 days of discharge	Paul Bishop	November 2023	Case reviews were completed and reported back to the RQR group in November 2023. Completed (updated Feb-24)
Peer review of mortality reviews in ECT	John Hunter	tbc	These are no longer required. Noted for removal (updated Feb-24)

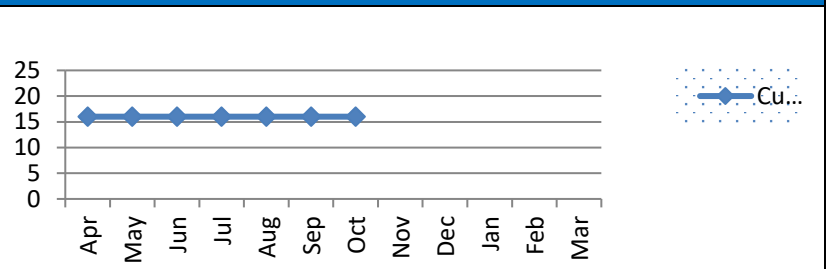
Assurances		
Planned	**Actual**	**Rating**
Need a regular focus and report to NHS Cheshire and Merseyside Quality and Performance Committee- frequency to be agreed	SHMI quality improvement meetings bimonthly to monitor progress against improvement plan. Updates will inform reports to Quality and performance Committee.	
Ongoing oversight and scrutiny of improvement plan both within ECT and across the system at Place through CQPM	Regular reporting/ updates to CQPM, however, the oversight will be through SHMI quality improvement meetings until assurance of progress received.	

Gaps in assurance ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

Some assurance given around:
Mortality review process being embedded in all divisions.
Reporting of avoidable harm being routinely measured and reported (C2AI data)
Evidence of Quality Improvement methodology relating to fundamentals of care.
However, ongoing oversight required until improvements seen.

Actions planned	**Owner**	**Timescale**	**Progress Update**

ID No:14DR	Risk Title: There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score without any controls applied]*	4	4	**16**	
Current Risk Score	4	4	**16**	
Target Risk Score	3	4	**12**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
John Llewellyn	Cathy Fox	Medical	Strategy & Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services Enhancing quality, productivity and value for money	Digital	A – within 3 months	Corporate	Manage

Date Raised	Last Updated	Next Update Due26/1/24
26/1/24	30/10/24	16/12/24

Risk Description (max 100 words)
The ICB is dependent on IT and information systems to deliver its statutory functions and strategic objectives. There is a significant threat of cyber-attack from a wide range of sources with NHS organisations being a potential target, and new types of threat emerging on a regular basis. This risk concerns the potential for a successful attack on the ICB's systems which could disrupt service delivery and patient care, and lead to data loss, financial loss and reputational damage.

Current Controls	Rating

Policies	IT Security Policy (individual IT Service providers); IT Umbrella Policy, NHS England's CareCERT process, National Cyber security policy for England, What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies.	**A**
Processes	Cyber security systems & processes, Security audits & penetration tests, Digital maturity assessment, DSPT assessment & submissions, Cyber Associates Network, incident management	**A**
Plans	ICS Cyber Security Strategy, Digital and Data Strategy 2022-2025, Cyber incident / Business continuity plan. Local / national funding and investment benefiting ICB	**A**
Contracts	Cyber security monitoring tools inc. IT Health and Cynerio, IT provider contracts, data sharing agreements	**A**
Reporting	Digital Services Delivery Board, Digital Transformation & Clinical Improvement Assurance Board, Strategy & Transformation Committee	**A**

Gaps in control

ICB Capacity and investment to respond to continuously evolving threat.
Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity.
Lack of organisational level monitoring and reporting of standards, compliance & risks.
Further work required to raise awareness and understanding of cyber security at Board level & for all staff.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Cyber Security training for ICB Board	Reduce	Maintain	RPJ / JL	TBC	**On Track**
Further desktop Cyber exercise	Reduce	Maintain	JL / SP / MIAA	21/11/24	**On Track**
Benchmarking BAF/digital/cyber risks and associated processes across all healthcare organisations in Cheshire and Merseyside	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Develop a process for the transparent governance of provider level risks	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Define clear incident management and support in major incidents with ICB providers	Maintain	Reduce	CTO	30/09/24	**Complete**
Scope options and define requirements for Cyber security delivery model	Reduce	Maintain	JL / SP / MIAA	31/12/24	**On Track**
Explore opportunities to improve collaboration and sharing of Cyber resource across the Cheshire and Merseyside system	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**

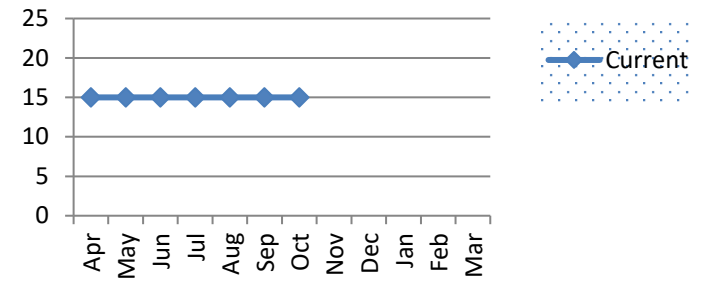
Investigate and conclude upon the need for third party incident response capacity creating a business case for investment if deemed appropriate.	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Explore opportunity to standardize cyber tooling across C&M and procure at scale	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Analyse & map across C&M organisations, critical service/supply chain security assurances and gaps. Identify significant exposure points and report with recommended actions	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Work with ICB procurement & IG to create standard security and assurance procurement & contracts requirements & share across all organisations within the ICS.	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**
DSPT becomes aligned to Cyber assessment framework in 24/25	Reduce	Maintain	JL / SP / MIAA	31/03/25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Cyber dashboard reporting to Digital Services Delivery Board / S&T Committee / Board	Quarterly (from March 2025)		**Partial**
S&T Committee and Board approval of ICS Cyber Security Strategy	March 2024	28/03/24	
Penetration testing – IT Providers and Trusts	March 2025 Annual		
Cyber Essentials accreditation – IT Providers and Trusts	Annual		
MIAA audit of DSPT in line with the mandated scope set out in the DSPT Independent Assessment Guide reported to Audit Committee	Annual	25/06/24	
2024-25 delivery plan progress reports	September 2024 Quarterly		
Approval of delivery plans for future years.	April 2025 Annual		

Gaps in assurance			
Funded Cyber Security Strategy delivery plans beyond 2024-25 yet to be established No oversight of compliance with cyber security standards at organisation and system level across C&M			
Actions planned	**Owner**	**Timescale**	**Rating**
Develop cyber dashboard to provide oversight of compliance with key Cyber standards at organisation level	JL / SP / MIAA	31/03/25	**On Track**
Formalise Cyber risk reporting to the Board	JL / SP / MIAA	31/03/25	**On Track**
Review provider SLA's and existing Cyber investment to realign to requirements in the Cyber strategy.	JL	31/03/25	**On Track**

ID No: WSC 4	If the programme is unable to deliver an agreed model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the North West region.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	5	**15**	
Current Risk Score	3	5	**15**	
Risk Appetite/Target Risk Score	2	5	**10**	

Senior Responsible Leads	Operational Leads	Directorate	Responsible Committee
Chris Douglas / James Sumner	Mandish Dhanjal / Lynn Greenhalgh / Fiona Lemmens	Medical	Women's Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Respons
Tackling Health Inequalities in access, outcomes and experience; Improving Population Health and Healthcare	Medical	C – beyond 12 months	Corporate	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	11/11/2024	16/12/24

Risk Description ***[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]***

Without an agreed clinical model of care that meets the required commissioning specifications, there is a risk that complex services requiring specialist multidisciplinary support may be de-commissioned or lost from Liverpool. For example LWHT already has to send pregnant women with complex cardiac conditions to Manchester for co-located specialist care, and may not be able to continue as the Maternal Medicine Centre for C&M without the required infrastructure, expertise and support. A snowball effect may follow the loss of any complex obstetrics and gynaecology services from Liverpool due to the loss of reputation and consequent difficulties with recruitment and retention of senior

medical staff. This could significantly affect higher risk obstetric services in Liverpool and would necessitate a region-wide clinical reconfiguration. Any major impact on obstetrics services in Liverpool would also create a higher residual level of risk for women experiencing acute emergencies.

Current Controls		Rating
Policies	N/A	
Processes	Establishment of Clinical Leaders Group and clinical engagement forum; NHSE Service Change Assurance Process	**G**
Plans	C&M Joint Forward Plan 2023-2028; NHSE 3 year delivery plan for maternity plan (2023)); Programme engagement plan(s)	**G**
Contracts	N/A	
Reporting	Regular reports to the Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint Committee.	**G**
Gaps in control [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]		

Actions planned	Owner	Timescale	Progress Update
Clinical Leaders Group (CLG) to lead model of care work on behalf of programme board.	CLG	Autumn 24 -Complete	Engagement event 2 (design) planned for December.
Specialised commissioning and clinical network leads to be involved in design	CLG	Autumn 24 -Complete	Included in invitations.
Clinical engagement event 2 – model of care – planned for December	CLG	Dec 24	
Finance, estates, workforce and digital workstreams to support model of care design and modelling work	CP	From Dec 24	
Capital and revenue implications of future model of care, interim model of care and counterfactual case (do nothing) to be worked up	Finance grp	From Jan 25	

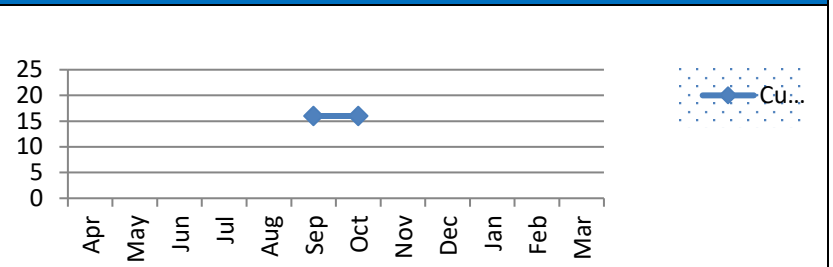
Support for model of care from Liverpool and C&M NHS leaders to be sought	FL / LG / JS	Spring / Summer 25	

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances		
Planned	**Actual**	**Rating**
Women's Services in Liverpool Programme updates to ICB Women's Services Committee	Women's Services Committee – 3/7/24 & ICB Board – 9/10/24	**Partial Assurance**
As required, independent clinical senate to review case for change, model of care, options appraisal and business case.		
NHS Service Change Assurance – Stages 1 & 2 (dates TBC)		

Gaps in assurance ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***		
Work to develop model of care yet to be concluded		
Actions planned	**Timescale**	**Progress Update**
Actions as described above to conclude model of care	Summer 25	

ID No: T2	Risk Title: Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	16	
Current Risk Score	4	4	16	
Risk Appetite/Target Risk Score	3	3	9	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Fiona Lemmens	Neil Evans	Medical / ACE	Strategy and Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve Population Health	Quality	A – within 3 months	Corporate	Manage

Date Raised	Last Updated	Next Update Due
January 2024	24/10/24	16/12/24

Risk Description *[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]*

Across Cheshire and Merseyside we have nine separately commissioned Specialist Weight Management Services (referred to as Tier 3). These services are included in the current NICE Guidance (CG189) and provide specialist support to patients with complex support needs in relation to weight management, including being a mandated part of the pathway for people seeking/requiring bariatric surgery or prescribing of GLP1 Weight Loss Drugs.

Historically services in Liverpool, Knowsley, Halton and St Helens have been commissioned by the Local Authorities however in line with statutory responsibility sitting with the NHS the Local Authorities have served notice on this provision (other than Knowsley where this hasn't

impacted in 2024-25). Interim funding arrangements have been required to maintain interim skeleton services. Further work is required as a minimum to avoid total absence of services in these Places in 2025-26.

In the other five Places we have minimal service access levels and variable funding and service models and across all 9 Places need/demand far outstrips capacity leading to extended waits and acceptance criteria thresholds being raised well above recommended NICE standards, as well as being inconsistent.

No service is currently providing access to GLP1 medication (TA 664 and TA875 and pending TA11156) and the capacity and prescribing costs are currently assessed as unaffordable in Cheshire and Merseyside and would require significant investment. Cheshire and Merseyside was due to be a pilot site (nationally funded) for implementation of this prescribing model in primary care but NHS England withdrew the pilot due to the pending TA – which is due to include primary care prescribing as a routine prescribing approach)

The picture described above is not unique to Cheshire and Merseyside and the ICB is working with NHS England (Obesity Team) and peer ICBs to identify approaches that may allow development of Tier 3, wider weight management services and prescribing of GLP1 medications.

During September 2024 ICBs across England were made aware that a company (Oviva) had been awarded a contract by an ICB in the South West which the Provider said fell within the “Right to Choose” contracting requirements as a digital provider of SWMS. NHS England have investigated and during October confirmed they believe this to be correct. This means patients from anywhere in England can be referred to the provider. Due to the absence of local capacity and no service prescribing GLP1 this has led to significant levels of enquiries from the Public and GPs requesting referrals to the Provider. At present this has been limited as we have issued a holding position to GPs pending the ICB Contracting Team validating the nature/compliance of the Oviva contract. The provider has been communicating intensively with both public and GPs to make them aware of the service and we are aware that some referrals have been made.

Current Control		Rating
Policies	NICE Obesity: identification, assessment and management Guidance (Updated July 2023); Technology Appraisal for Provision of Obesity Drugs; (CG189, TA 664 and TA875 and pending TA11156)	G
Processes	C&M Tier 3 Weight Management Group, including provider representation NHS England led Obesity Working Group and aligned ICB Working Group commencing work Sept 2024 supporting by NHS Confederation.	A
Plans	Development of a business case to invest in SWMS and delivery of NICE TA, this is dependent on confirmation national funding will be available to support the NICE TA.	R
Contracts	Nine separate contracts across 6 Providers all with different specifications	A
Reporting	The plans outlined below were reported to Board in January 2024 and Executive Team March 2024 but plans have been delayed due to identification of a future funding source and delays in the updates to NICE guidance.	A

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*			
No C&M wide minimum service specification for the provision of Tier 3 Weight Management Services. Non compliance with NICE guidance (including Technology Appraisals) and implementation would require significant investment.			
Actions Planned	**Owner**	**Timescale**	**Progress Update**
A full review of the pathway and delivery of Specialist Weight Management Services is underway C&M	Neil Evans	Complete	Summary of current services captured
Development and adoption of a minimum Cheshire and Merseyside service specification for the provision of Tier 3 services.	Neil Evans/Adam Major	June 25	Workshop held in March outlining model, including ICB, LA, Providers and service users. Implementation is constrained by financial investment required.
Implementation of GLP1 through funding ringfenced for Tirzepatide roll out	Neil Evans/Adam Major	June 25	ICB are part of national working group and as an ICB directly working with NHS England Obesity Team to see if can attract national funding to implement both model and GLP 1 prescribing
Development of interim plans in the four Places where Local Authorities are withdrawing from commissioning services	Neil Evans and Place nominated leads"	April 25	Agreeing common approach to developing interim solutions that won't destabilise a single C&M approach in medium term. **Tony Mcleod, Danielle McCulloch, Neil Meadowcroft and Judith Neilson*
Validate Oviva contract with BNSSG ICB as complying with Right to Choose requirements. Based on the outcome of this work we will consider options to manage the scale of referrals e.g. compliance with locally defined clinical criteria.	Val Atwood/Alison Picton	November 25	Holding communications shared with GPs alerting them to the fact that we are still validating the status of Oviva and we don't hold a contract. Responding to individual complaints and enquiries with holding position.

Assurances		
Planned	**Actual**	**Rating**
The development of a robust options appraisal presenting options on how we can fully or partially mitigate the risks in relation to health outcomes, inequalities and litigation.	We have partial assurance in that there will be some national funding associated with the NICE TA for	**Partial**

Modelling of the impact (including financial) of Oviva being a Right to Choose Provider.	Tirzepatide implementation which will enable some mitigation of the risk by enabling the actions identified	

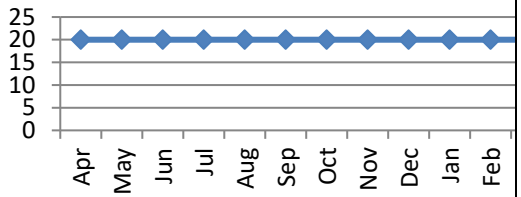
Gaps in assurance *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

The NICE TA for Tirzepatide has slipped to November 2024 and at present NHS England are not able to confirm the funding availability which constrains developing a viable options appraisal.

The award of a Right to Choose contract in the South West means patient referrals/expenditure to a digital provider presenting an inconsistent offer to GLP 1 drugs to those in local services. This also means ICB investment could be targeted at lower priority patients and not into local services supporting the more complex patient needs.

Actions planned	Owner	Timescale	Progress Update

ID No: QU05	Risk Title: Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	20	
Current Risk Score	5	4	20	
Risk Appetite/Target Risk Score	2	4	8	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
16	12	12	8	9	12	16	16	20

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Douglas	Lisa Ellis	Nursing and Care	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/11/2022	01/07/2024	04/10/2024

Risk Description *[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]*

ASD and ADHD services have suffered from demand outstripping capacity causing significantly long waiting times. There is a risk of harm due to the significant, adverse impact of long waiting times on children, young people and adults with suspected Autism and/or ADHD. The impact includes:

1. Crisis leading to poorer individual outcomes and avoidable acute and mental health hospital admissions.
2. Increased risk of self-harm and suicide (people with Autism are 16 times more likely die because of suicide than the general population
3. Poorer mental health and wellbeing outcomes and greater risk of school exclusion and family breakdown.

4. Perpetuating the risk of health inequalities for people with neurodevelopmental and other co-existing conditions including learning disabilities.

There is a financial risk due to the increased costs/ spend in the system due to the increasing demand. There is an increase in non-contract spend on private providers as more people seek access via Right to Choose and opt out of long NHS waiting lists.

Current Controls		Rating
Policies	Autism Assessment Framework; The assessment pathways for Autism and ADHD are governed by NICE Clinical Guidelines. Autism: CG128 (CYP) and CG142 (Adults) and ADHD: CG72; Transforming Care Programme.	**A**
Processes	CQPGs/ CQPMs to monitor performance of NHS commissioned services; Reports to Cheshire and Merseyside Quality and Performance Committee; Close working with Parent Carer Forums at Place - co-production. Performance reports presented to Quality and Performance Committee; Quality and Performance Groups at Place; LD focus area at Cheshire and Merseyside System Quality Group- April 2023; Quality schedules - long wait harm reviews	**G**
Plans	Cheshire Neurodevelopmental Clinical Network - strategic plans and implementing best practice; ASD/ ADHD included in SEND improvement plans at Place; Quality schedules - long wait harm reviews	**A**
Contracts		**R**
Reporting	Quality and Performance reported through: CQPG/ CQPM, Quality and Performance Groups at Place/ C&M Quality and Performance Committee, SEND/ LA reporting - SEND scorecards and dashboards at Place. Reporting from SEND Sub-Group to System Oversight Board (SOB)	**A**

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

C&M ICB Commissioners developing joint and strategic approach to commissioning for Autism and ADHD; No lead across C&M for ASD/ ADHD; Increased investment for both assessment and evidence-based support required - but difficult in current financial climate.

Actions planned	Owner	Timescale	Progress Update
Multiple strategic actions across health & education and to reduce waiting times.	TP Programme Leads/ Transformation ADQs		

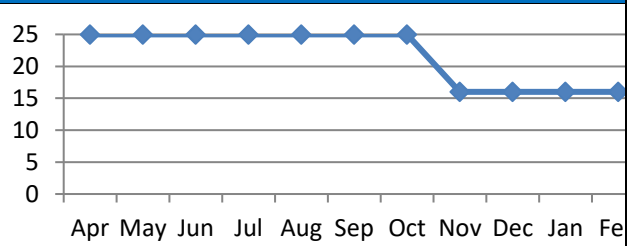
Assurances

Planned	Actual	Rating

NHSE Baseline assessment of demand, data, demographics etc.	Q&P key issues reporting- monthly standard agenda item	**A**

Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]			
Quality & Performance Committee require regular reporting for oversight and assurance.			
Actions planned	**Owner**	**Timescale**	**Progress Update**
SEND Lead to provide focus report to Q&P Committee (frequency to be agreed)	Julie Hoodless	TBC	

ID No: QU08	Risk Title: Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	5	25	
Current Risk Score	4	4	16	
Risk Appetite/Target Risk Score	2	5	10	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
8	9	12	15	16	16	6	9	16

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Douglas	Lorna Quigley	Nursing and Care	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/11/2023	01/07/2024	Sept-2024

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]
Demographic issues aging population & global pandemic and underinvestment in workforce, latent harm through pandemic, increasing demand, capacity issues, retention issues due to stress / pressure, social care impact preventing flow out of Trusts, under investment social care, market forces, delays to follow ups.

Current Controls	Rating

Policies	Discharge Policy; UEC Standards; Long waits guidance; National FNC / CHC Framework; D2A guidance; SCC guidance, Fuller Report; PSIRF	**A**
Processes	C&M ICB SCC, Local harm review process, Incident reporting, pathways; Risk stratification; CQRM / CQPG at place;	**A**
Plans	Urgent Care Recovery Plan 2023; People Cell; Workforce Recruitment and Retention Programme (including international recruitment); Virtual Ward Expansion; Winter Plans; Local delivery of plans to mitigate workforce shortage.	**A**
Contracts	NHS Standard Contract; shortened version, individual patient contracts.	**A**
Reporting	System Quality Group; Quality Dashboard Reporting to Q&P Committee; Q&P Group at each 'Place'; Local Quality reporting mechanisms e.g. CQPG.	**A**

Gaps in control ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

Synthesis & consistency of policy into action; Maturity of processes and shift from 9 CCGs to single entity; Quality dashboard not fully established & inconsistency between places.

Actions planned	Owner	Timescale	Progress Update
Development of UEC patient safety principles for Trusts. Primary Care Quality forum being developed. Host commissioner arrangements to be strengthened	EW CW HM	Q1	Work on track to enable roll out and adoption across all Trusts. Preparatory work commenced. Process in place, to be implemented and tested.

Assurances

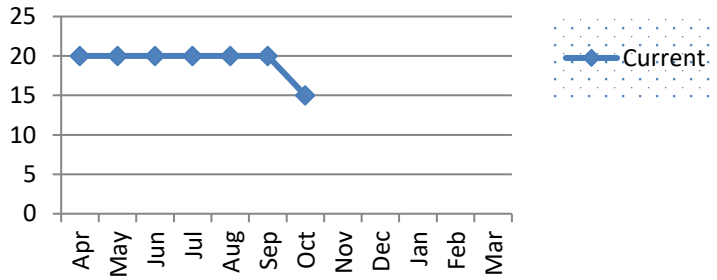
Planned	Actual	Rating
Oversight will be established ensuring consistency for providers		

Gaps in assurance ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

Data Gaps in relation to quality dashboards not fully established to give oversight of risks and issues.

Actions planned	Owner	Timescale	Progress Update
Further development of the quality dashboard	AM	Q2	

ID No: WSC6	If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely, with a greater impact on the socially deprived and those from ethnic minority groups.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	5	20	
Current Risk Score	3	5	15	
Risk Appetite/Target Risk Score	2	4	8	

Senior Responsible Lead	Senior Responsible Lead	ICB Directorate	Responsible Committee
Christine Douglas / James Sumner	Lynn Greenhalgh / Natalie Hudson / Oliver Zuzan	Nursing and Care	Women's Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequalities in access, outcomes and experience Improving Population Health and Healthcare	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	11/11/2024	16/12/24

Risk Description ***[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]***	
The case for change sets out the clinical risks the programme is seeking to resolve. These risks are driving the Women's Hospital Services Programme to find solutions that enable the long-term clinical sustainability of these services, as well as identifying short and medium term solutions to reduce clinical safety and quality risks and support the stability of services.	
Current Controls	**Rating**

Policies	Patient Safety Incidence Response Framework (PSIRF)	**G**
Processes	LUHFT / LWFT individual boards and Partnership Board oversight of clinical risks / issues. Local CQPGs and Quality forums; LMNS ICB monitors and oversees safety ambition trajectories and outlier status of providers	**G**
Plans	LWFT Improvement Plan	**G**
Contracts	Standard NHS Contract; Specialised services contracts; NHSE Maternal Medicine Network Centre contract.	**G**
Reporting	Reporting to System Oversight Group, Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint Committee.. Exception reporting to NHS C&M ICB.	**G**

Gaps in control **[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]**

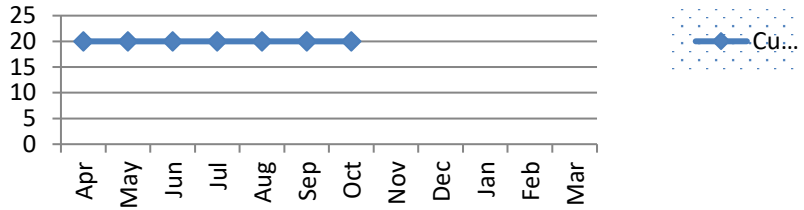
Actions planned	Owner	Timescale	Progress Update
Deliver LWFT improvement plan that includes short term actions and mitigations.	JS	From Feb 24 - Complete	LWFT Trust Board, System Oversight Group, Programme Board and WSC have had updates. Programme Board SRO report to all key stakeholders in March. Routine reporting into WSC on progress.
Clinical design work for medium and long term in programme plan for winter.	CP	From Dec 24	Clinical engagement event 2 – model of care – planned for December
Health inequalities in outcomes to be a key factor in design work.	CP	From Dec 24	And included in case for change.
Insights from hard-to-reach groups and equalities groups to be reflected in design work.	CP	From Dec 24	Public engagement feedback / VCFSE orgs feedback / Lived Experience Panel feedback to be considered in design process.

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances		
Planned	**Actual**	**Rating**
Women's Services in Liverpool Programme updates to ICB Women's Services Committee	Plan for short term mitigations of safety and quality risks in place and being managed by LWFT and the LWFT / LUHFT Partnership Board.	**Acceptable**
Quality reporting to Quality & Performance Committee & ICB Board	ICB Board – 30/5/24,25/7/24,26/9/24	
Executive Director of Nursing & Care report to ICB	ICB Board – 30/5/24,25/7/24,26/9/24	

Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]			
		Timescale	**Progress Update**

ID No: F8	Risk Title: 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.

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score without any controls applied]*	5	5	25	
Current Risk Score	5	4	16	
Target Risk Score	4	3	12	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
15	12	12	12	12	12	8	8	16

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Place Directors	Place ADOFs	Place Directorate	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Finance	B – within 12 months	Place	Manage

Date Raised	Last Updated	Next Update Due
April 2024	15/11/24	16/12/24

Risk Description (max 100 words)
The potential for significant overspends against place budgets is a risk in common escalated by multiple places, driven by increasing demand, inflationary pressures, and restricted options, delays in or inability to deliver efficiency savings. Taken collectively this may affect the ICB's ability to meet statutory financial duties.

Current Controls	Rating

Policies	ICB SORD, SFIs, detailed financial policies	**G**
Processes	Budget setting, financial monitoring & control, appointment of / allocation to budget holders / managers	**A**
Plans	Annual financial plan & place allocations, recovery & efficiency plans	**A**
Contracts	Contracts with NHS & other providers	**A**
Reporting	Place SLT & Finance Groups, Finance, Investment and Our Resources Committee, ICB Board	**G**

Gaps in control

Nationally prescribed budget setting assumptions insufficient to meet anticipated costs e.g. inflation
Inherent or inherited deficit positions in some places require recovery plans / recurrent efficiency savings
Unanticipated increases in demand and / or costs
Gaps / delays / reductions in planned efficiencies

Actions planned	Owner	Timescale	Progress Update
Oversight of financial position & efficiency delivery	Place SLTs	2024-25	
Place based financial / recovery plans	Place ADoFs	2024-25	
Place based actions as indicated by specific place risks	Place ADoFs	2024-25	

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances		
Planned	**Actual**	**Rating**
Finance Reports to Finance, Investment & Resources Committee	Monthly – April to October 2024	**Partial Assurance**
Finance Reports to ICB Board	25/7/24, 26/9/24	

Gaps in assurance
Month 4 position indicated deficits for 8 out of 9 places, totaling £24m.

Actions planned	Owner	Timescale	Progress Update
Place based financial / recovery plans	Place ADoFs	2024-25	
Place based actions as indicated by specific place risks	Place ADoFs	2024-25	

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Update on the Cheshire and Merseyside Primary Care (General Practice) Access Improvement Plan(s)

Agenda Item No: ICB/11/24/21

Responsible Director: Clare Watson, Assistant Chief Executive

Update on the Cheshire and Merseyside Primary Care (General Practice) Access Improvement Plan

1. Purpose of the Report

1.1 To update the Board on progress of the ICB's Access Improvement Plan at both system and place level(s), following initial approval by the Board in November 2023 and update in March 2024. This paper also reflects updated policy asks for 2024/25.

1.2 It should be noted that the ask for Boards to be updated during Autumn 2024 was mandated by NHS England.

2. Executive Summary

2.1 On 09 May 2023 NHS England released 'Recovering Access to Primary Care' with a national commitment to 'tackle the 8am rush' and make it easier and quicker for patients to get the help they need from primary care. https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/. The Policy concentrated on four domain areas as detailed in the Guidance.

2.2 In April 2024 there was a subsequent Policy update NHS England » Delivery plan for recovering access to primary care: update and actions for 2024/25 which narrowed the plan further into key reporting areas. **Appendix 1** gives the reported areas against this revised Policy document - and the latest updated version, which continue to be requested monthly by NHS England.

2.3 To support delivery of the Access Improvement Plan, the ICB continues to have a programme management governance structure/delivery board, under the Executive leadership of the Assistant Chief Executive. Colleagues from key enabling teams across the ICS including digital, finance and business intelligence, are represented at the Board. At Place level, Place level improvement plans are managed through Place governance. The System Primary Care Committee receives updates on the indicators in Appendix One plus supporting narrative, at each meeting.

2.4 In response to the national asks, the ICB developed a system level plan, with granular details and delivery of improvements supported through nine place level plans, all of which were reported to Board in November 2023. NHS England subsequently requested that ICB reported an updated plan to their Board's in Autumn 2024. They requested that the plan covers:

- progress against all the four elements of the national delivery plan
- outlined the local plans to improve access and progress against the primary and secondary care interface,
- a breakdown of the use of the funding streams for primary care in 2023/24

- projected use in 2024/25, including for service development funding **(**SDF) for high quality online consultation software and transformation funding
- an update on how many PCNs have claimed the 30% CAIP (Capacity Access and Improvement) payments.

2.5 In response therefore a revised System Level Plan Update is presented along with Place Level Improvement Plan (s) which are included (minus appendices) in **Appendix 2.** Places were asked to provide the granular level detail of spend, impact and quantifiable improvements of their November 2023 plans. It should be noted that not all spend had been agreed for 24/25 at the time of writing this paper so some elements of this remain unconfirmed.

2.6 This update is given mindful of the current ongoing GP Collective Action and pressures on general practice workload, set against the current ICB financial situation.

3. Ask of the Board and Recommendations

3.1 The Board is asked to ***discuss and note*** the update on the System Level and Place Level Improvement plan(s).

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

- Tackling Health Inequalities in outcomes, experience and access (all 8 Marmot Principles)
- Improve population health and healthcare.

5. Link to meeting CQC ICS Themes and Quality Statements

- Supporting to People to live healthier lives
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes
- Care provision, integration and continuity
- How staff, teams and services work together.

6. Risks

6.1 Risks are detailed in the paper appendices but support the following BAF risks ;

- P1
- P3
- P5
- P6.

7. Finance

7.1 Full financial information was contained within the original plan and updated in this paper.

8. Communication and Engagement

8.1 A communications plan summary was contained within the original plan and any updates by exception are included in this paper.

9. Equality, Diversity and Inclusion

9.1 An Equality and health inequality analysis and report was included with the original plan and any updates are by exception within the papers. At Place Level specific health inequalities updates are given.

10. Next Steps and Responsible Person to take forward

10.1 The Programme Board and System Primary Care Committee and 9 Place Primary Care Fora are taking forward the relevant system and place actions to support the improvement of access to primary medical services.

10.2 An update is to return to the Board in March 2025 which should include patient experience outcomes via colleagues at Healthwatch - and confirmed spend for 24/25

10.3 The SPOC for overall delivery at system level, working with our 9 places, is Christopher Leese, Associate Director of Primary Care

11. Officer contact details for more information

Christopher Leese, Associate Director of Primary Care –
chris.leese@cheshireandmerseyside.nhs.uk

12. Appendices

Appendix One: Year 2 Primary Care Access Reported Metrics

Appendix Two: Place Level Improvement Plans

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside ICB Access Improvement Plan Update

Report Author	Christopher Leese Associate Director of Primary Care
Author Contact email	Chris.leese@cheshireandmerseyside.nhs.uk
Version	Final
Date	November 2024

1. Contents and Introduction

1.1 Introduction

The plan is presented as below ;

- **Section 2.0** lifts the original aims of the Access Improvement Plan submitted to Board in November 2023, and gives progress in key areas, with some supportive data. The aims of the original plan were;
    - Enabling better, easier access to more appointments
    - Workforce retention, recruitment and investment
    - Support all our practices to have the key elements of the 'Modern General Practice Access Model' in place by December 2024
    - Measuring Success of our plans through meaningful engagement
- **Section 3.0** gives more details on key enablers of improved access, such as implementation of digital tools, within the four policy areas of the original national policy (this layout is as requested by NHS England). These support delivery of the ICB ambitions above.
- **Section 4.0** summarises overall key actions required for the remaining quarter of 24/25 and moving into 25/26.
- **Section 5.0** appendices include the place level improvement plans which need to be read alongside this system level plan update. The place plans give some of the granular localised achievements and actions that support the overall plan to improve access across the ICB.

2. ICB Plan Aims and Progress

2.1 Patient Perspective

For the November 2023 plan, Healthwatch summarised the challenges patients face in accessing GPs and the improvements expected to be made as a result of the work under the Access Improvement Plan, *some of those are given below* ;

- Feel valued and important/understood from their first point of contact with their GP surgery by encountering less hurdles and receiving friendly, clear information about how to access appointments and services
- Are able to make or manage appointments by visiting the Surgery; by an uncomplicated telephone system that is answered in a timely manner; or by online systems where appropriate and accessible to people. Each of these methods should respect people's privacy.
- Understand what the process/system is for apps and technology for those that want to use it, with clear information of when it is available and what the alternative is, particularly for those that require reasonable adjustments for access.
- Get an appropriate appointment from first contact with a date, time and name of who they will be seeing, and they understand the different roles within practices.

2.2 Aims of ICB Plan with progress

2.2.1 Enabling better, easier access to more appointments:

- **Access to a routine appointment within two weeks**
  Using the previous IIF (Investment and Impact Fund) indicator measurement and data collection from booking to appointment the aim was for 90 per cent of appointments offered within two weeks as a minimum across the ICB.

  The latest average of appointments offered within that period and number of practices achieving over 90 per cent is given below – within each place plan there will be specific plans to work with practices to support this. These figures demonstrate that further work is required to ensure that this figure increases and variations reduced, led through Place conversations with local practices.

Time Period	Performance	Practices >= 90%
Apr-23 to Aug-23	88.6%	209
Apr-24 to Aug-24	88.3%	206

- **Same day appointments for patients who require them**, with all patients provided with an appropriate response following initial contact, that same day, in line with the recent national contract amendments. Again, this is supported by specific plan level plans using more localised data.

  The proportion of appointments that are on the same day has increased when comparing current year to date against the same two time period in 2023 and 2024. There were more same day appointments in the 2024 period (2,929) compared to 2023 period (2,784) (47.1 per cent of appts were offered the same day for the same period and then 46.9 per cent). It should be noted that clinical triage is clearly important when considering this.

Time Period	Same Day	1+ Days	Unknown	Total
Apr-23 to Aug-23	2,784	3,145	5	5,934
Apr-24 to Aug-24	2,929	3,282	8	6,218

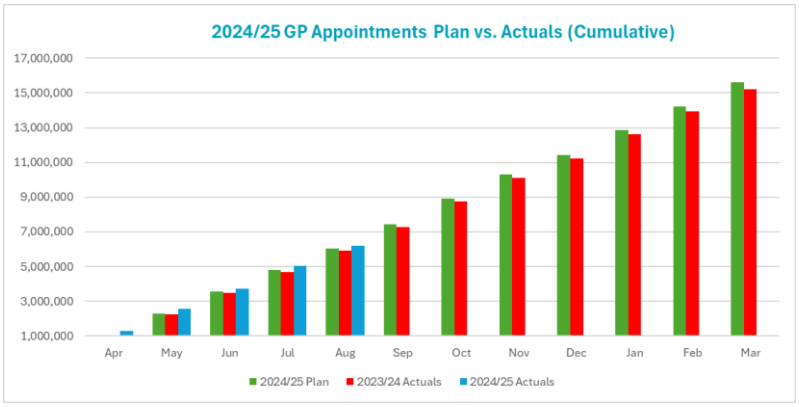
Time Period	Same Day	1+ Days	Unknown	Total
Apr-23 to Aug-23	46.9%	53.0%	0.1%	100.0%
Apr-24 to Aug-24	47.1%	52.8%	0.1%	100.0%

- **That patients can easily access the practice by all available means** but noting the specific feedback via the GP Practice Survey and our Healthwatch colleagues that patients want to see the biggest improvement in **telephone access.**

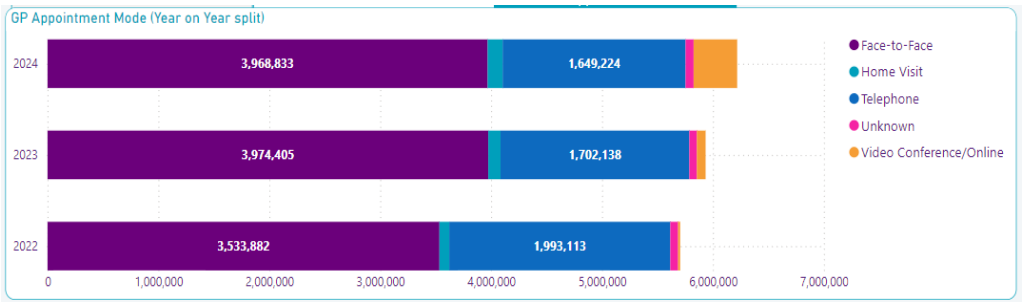
  Investment in digital telephony and increasing use of the NHS App and some of the benefits of these actions that support the above aim, **are given in section 3.0.**

- **Delivering more appointments overall** by all available means, with an agreed target and trajectory for 24/25 and beyond.

  The data below shows overall that the number of appointments in 2024/25 is exceeding both 2023/24 (2.0% more appointments target), and the Operational Plan (2.7% more appointments overall target). Within this, places will be working using local data with Practices where there may be additional support required.



The chart below provides a breakdown of appointments by Mode in the last 3 years. Overall there more appointments in 2024, with a greater number of Video / Online appointments, broadly the same number of Face-to-Face, and slightly fewer Telephone appointments.



Actions to support appointments offered under **Enhanced Access** and any additional schemes commissioned locally such as appointment hubs are given in the place level plans. An update on self-referral numbers is given in Section 3.0 which further supports management of overall capacity.

Further work is in terms of quantifying **demand** for local populations remains an area for further development.

- **Addressing Health Inequalities and Access**
  - As part of embedding our systematic approach on tackling health inequalities, our local placed based primary care teams and their Primary Care Networks (PCN) have been utilising the range of health inequalities tools and recommendations that were identified in the Equality and Health Inequality Assessment (EQHIA), that was previously presented to Board, Our Place leads have been taking account of their local assets and forums with their partners in tackling localised access issues, and understanding the local challenge to overcome to promote health equity to their patients.
  - Some examples of this positive work includes implementing the Population Health Management Tools through the Combined Intelligence for Population Health Action (CIPHA) platform and attending our new Population Health Academy masterclasses about how to proactively identify patients impacted by health inequalities and deprivation to improve their outcomes. For example, in St Helens,

they have built on their successful award-winning Health Inequalities commission with the Local Authority and partners to ensure all PCNs have Frailty teams who are supporting Enhanced Health in Care Home requirements and proactively visiting frail and Housebound patients. As part of the Development of their Care Communities, the CIPHA enhanced case finding tools proactively identify the most vulnerable people/known to multiple services and high deprivation areas. Two priority groups have been identified: 18-30's, living in most deprived area, history of living in a care home and have Mental Health conditions and GP Frequent flyers known to multiple services. St Helens Place are then working with the Local Authority to provide technology enabled care which allows patients to be monitored remotely in their own home to prevent falls and deterioration of medical conditions

- Many of our PCNs have been maximising the partnership work with their Social Prescribers and VCFSE sector partners, such as Halton where they are a lead site for the NHSE-led Community Connectors Pilot programme. This work with their local VCFSE leads has been able to recruit and support local people, to become 'Connectors', who then act as a conduit to communication with their community, and to gather local intelligence on accessing services which can be used to inform change. The Connectors are representative of geographical neighbourhoods such as Murdishaw and Ditton, but also of 'PLUS' communities such as Military Veterans, Care-leavers, and the Learning Disability Community.

- Another example of the EQHIA recommendations being implemented locally is within Liverpool Place, where each PCN now has a Health Inequalities Lead and are starting to utilise the Health Equity Assessment Tool (HEAT[1]) to document their plans and bring to the established Prevention and Health Inequalities Group (PHIG) with their local Public Health partners for review and input. In 2023 Liverpool City Council established a new neighbourhood model which saw the appointment of 13 Neighbourhood Managers. Liverpool PCNs have been building links with Neighbourhood Managers to explore areas where they can work in partnership in tackling health inequalities and reaching communities. For example, this has included PCNs working closer with community groups and being an active part of community events for targeted health promotion, early diagnosis and prevention.

- The 2024/25 Liverpool GP Spec also introduced a new qualitative indicator aimed at developing PCN vaccination strategies to increase vaccination uptake through new approaches to the delivery of vaccination services and collaboration with community-based partners. This collaboration is seeing our PCNs working with Living Well with other community services to offer a wider range of interventions and community-based events e.g. cancer screening, liver health, smoking advice, AAA screening team, immunisations. And using autumn/winter vaccine clinics to target patients who meet the criteria for cancer screening. Liverpool is part of Phase 2 of the mobile cervical screening pilot in collaboration with the Living Well

[1] https://www.gov.uk/government/publications/health-equity-assessment-tool-heat

bus to deliver a number of sessions at locations across Liverpool aimed at different ethnic minority groups with lower uptake.

- As part of our successful NHS Prevention Pledge that has been adopted by all our Hospital Trusts, we have been piloting this unique model, recognised by the NHS Confederation as best practice to support a number of our Primary Care Networks and GP practices in Cheshire and Merseyside, This has included specific community cancer screening Programme that is trying to address health inequalities in South Liverpool, to a host of workplace and wellbeing interventions that have been implemented at a GP practice in Alsager. Learning from this was shared at the recent Prevention Pledge Summit with both regional and national NHSE leaders in attendance. We will continue to maximize this local learning and collaboration to help support the approaches to tackling health inequalities with our wider primary care teams.

- Further examples of the Place based working approaches to improving health equity can be found in the individual place reports.

2.2.2 Workforce retention, improvement and investment

- **Investing in our primary care workforce** including wellbeing offers, retaining GPs and responding to the asks in the National Long-Term Workforce Plan:
- **A clear plan to retain GPs within the ICB** – patients tell us they value direct contact with their 'GP', and the ICB has a considerable percentage of GPs in their 50s who may be considering leaving the profession in the next few years
- **Maximising ARRS (Additional Roles)** in terms of spending and recruitment by March 2024.

Section 3.4 outlines progress against these areas. In addition the continuation of schemes such as the GP Fellowship/Mentoring scheme, career conversations, support for workforce planning for Practices/PCNs and bespoke Place retention surveys have been commissioned from our delivery partner the Cheshire and Merseyside Training Hub – an update on this work was given to the System Primary Care Committee in October.

- **Prioritisation of Wellbeing offers,** recognising the huge pressures facing our primary care workforce, working with our Local Medical Councils (LMCs) and practice staff, the ICB has recommissioned the **Employee Assistance Programme (EAP)** until May 2025. This is a confidential employee benefit designed to help you deal with personal and professional problems that could be affecting home life or work life, health, and general wellbeing. Its available to all practice staff (clinical and non-clinical). Any Places that have commissioned local further staff support this will be expanded on in their Place level plan. LMCs (Local Medical Committees) have flagged the issue of further support for practices in working with patients in challenging situations in recognition of the added stress this can bring to practice staff.

2.2.3 Support all our practices to have the key elements of the 'Modern General Practice Access Model' in place by December 2024

- The 'Modern General Practice Access' model underpins all of our access ambitions in line with the national definitions of what a modern general practice model 'looks like' and many of the key enablers are given in **Section 3.4**, which also outlines progress to date within that section. Current declaration of this by practices, in line with the national policy ask are given below (this is to receive the corresponding payment under the Directed Enhanced Service), which NHS England have asked us to include in this update.

Modern General Practice Access Declarations As At October 24			
Place	Complete implementation of **better digital telephony**	Complete implementation of **on line journeys**	Complete implementation of **faster care navigation and response**
Wirral	0	0	0
Cheshire EAST	0	0	0
Cheshire WEST	3	17	8
Liverpool	10	18	18
Warrington	25	26	10
Sefton	0	0	0
St Helens	23	23	23
Knowsley	0	0	0
Halton	14	14	14
Total	75	98	73
Total number of practices	339	339	339
Percentage	**22%**	**29%**	**21%**

- In addition, during 23/24 Practice staff were supported through 2 schemes funded both nationally and locally, in respect of **Care Navigation Training**. Practices also had access to the national **General Practice Improvement Programme** funded by NHS England, which is currently in its 2nd year, with 26 practices accessing this across 4 cohorts for 24/25. Place Improvement Plans also reference any additional support for primary care development at Place level.

2.2.4 Measuring Success of our plans through meaningful engagement

- It was recognised that by working with Healthwatch and other key stakeholders, it is important to collect meaningful patient feedback, particularly in our most challenged areas and populations. The Board previously supported the need to understand the impact on patients of this collective work, and that this was making a difference outside of any numerical data findings, in a qualitative way.
- The national GP patient survey was released in the summer of 2024 but the field work for this was carried out in January 2024 meaning the full impact of any of the enabling actions in this paper may not have been felt. The key findings of that survey were ;
    - The ICB benchmarks slightly higher than the national average with 76% of patients reporting a good overall experience of GP practices compared to 74% nationally.
    - Our patients still prefer to contact Practices by phone (68 per cent of respondents when asked about last contact) but there was a notable variation in results between the top and bottom results when asked to assess ease of access by phone.

- Overall experience of making contact being in the good range was 68 per cent, slightly ahead of the national average – and 70 per cent felt the appointment given was within the right timeframe, 4 points above the national average.
- Confidence remains high in the treatment and care from our GP Practice staff with high results for those indicators.
- Usage of other access points and service utilisation such as on- line and the NHS app for ordering repeat prescriptions for example, are in line with the rest of the country but remain comparatively low when compared to other routes such as tel-ephone.

- Given the above gap in understanding the impact of these changes at a more recent point in time, our Healthwatch colleagues are undertaking further survey work between now and February 2025. This work will cover all our 9 places using the headlines of the national policy, but framed to ensure that we are getting feedback on the areas patients have told us they find challenging in respect of access. The current plan is for an interim update to go to System Primary Care Committee in December, and then the final report alongside an update to this Improvement Plan, to Board in March 2025.

2.2.5 Place Achievements - headlines

- **Wirral** is above the England average of 432 appointments provided per 1,000 population and averages c194,000 appointments per month with an average of 486 appointments per 1,000 patients – the highest in C&M (this excludes enhanced access appointments 399hrs per week). Wirral offers 83.02 GP FTE per 1,000 population which is highest in C&M and also one of the highest nationally.
- **St Helens** - Urgent Care Hubs are being developed to support general practice and will also benefit the wider system, in particular A&E who receive the fallout of an overwhelmed and overburden primary care urgent demand. 1 PCN has successfully piloted the Hub and plans are being developed to mainstream the Hub other PCNs. Have plans to increase capacity over winter to avoid additional pressure on other parts of the system e.g. children's hubs.
- **Sefton** - An Acute Visiting Scheme supported access and provided benefit to the wider system, the ARI hub in South Sefton was also maintained
- **Liverpool** -Total number of appointments is generally increasing in the 2024 data compared to 2023, in March 2024 (April 2023 – Feb 2024) the mean average number of appointments per month last 11 months was 191,853. Currently (Sept 23 – Aug 2024) this is 194,190 over the latest 12 months. Average percentage of appointments being delivered within 14 days over the last 12 months was 92%, exceeding the ICS ambition
- **Halton** -100% have online registration available. This exceeds the national target of more than 90% of practices using the on-line registration system by December 2024
- **Cheshire West** Place agreed a range of metrics to measure improvement in access for patients in our practices - 91% (38) of practices achieved improvements in 100% of the metrics.
- **Cheshire East** All practices within Cheshire East had transitioned to cloud-based telephony systems with the support of the National Procurement Hub. Most practices

have migrated to either X-On or CheckComm with one practice choosing to use C-Talk. These systems have advanced features such as call-back and call queuing functionality. This transition ensured improved communication efficiency and reduces waiting times for patients calling into practices. 33/34 Practices had completed this action before 31st March 2024.

- All 5 PCNs in **Warrington** have engaged in and followed the National Association of Primary Care (NAPC) framework. Ongoing Schemes for new developments and repurposing existing estates for Primary Care use will lead to an increase in the physical space available to Primary Care to accommodate the increased workforce.

3. Progress on Key Enablers

3.1 Empowering Patients

3.1.1 Expanding Community Pharmacy Services

- The focus of activity has been to ensure delivery of the 7 Pharmacy First services alongside the Pharmacy Contraception Service and Hypertension Case Finding Service.
- During July 2024 there were 16,274 BP consultations compared to 12,344 in June – 31.8% increase. National growth was 11.5%
- C&M have delivered a total of 6,201 contraceptive consultations since Nov 23 (available data), or 5.0% of National delivery.
- Since the launch of Pharmacy first C&M have delivered 50,968 clinical pathway consultations or 5.4% of National delivery.
- 526 (96.7%) C&M Pharmacies have opted in to provide Pharmacy First Service. National opt in is 96.5%
- We continue to work with local service providers who refer into services to understand barriers or concerns and have a plan in place to support and resolve where these occur based on individual services and promotion of learning and best practice across the wider system.

3.1.2 Use of the NHS App

- Year 1 saw a focus on increasing the functionality for patients around appointment bookings, prescriptions and record access enablement. The second year has seen a focus on increasing the usage from the patient perspective particularly in ordering prescriptions and accessing records through the NHS App as the digital front door to the NHS.
- The ICB has have run digital inclusion campaigns to encourage the use of digital for health and care support, this was particularly signposting people to the NHS App during Get Online week in October. We also have had huge success in a GP practice in Cheshire West, who recruited a number of young people volunteering once per week to support people to download, register and use the NHS App. In the first 6 months, the

practice saw an increase of 900 prescriptions ordered through the NHS app, with a time saved of approximately 46 hours per month and a cash releasing saving of around £6000 per year.

- We will also be working with practices who have a low number of NHS app registrations to support them to look at increasing this in line with others

	C&M	National
NHS App Registrations (aged 13+)	56%	57%
Prescription (September)	250,558 (+1.33% from previous month	4,490,770 (+2.05% from previous month)
Record views	909,169 (-48% from previous month owing to data discrepancy)	17,958,995 (-42.5% from previous month owing to data discrepancy)

- **Benefits to the patient include the App can** save time – on average a patient can same over 18 minutes by ordering online through the NHS App and feedback from one practice is that phone lines seem to be clearer and this is assumed to be connected with an extra 900 repeat prescriptions being ordered digitally

3.1.3 Expanding Self Referrals

- Progress in 23/24 was challenging and the ICB remained consistently below target but Progress in 24/25 has improved following national review and issuing of new targets. The ICB now has a target of 9,109 self-referrals per month and as of July 24 was achieving 10,291. We will continue to work with the Provider Collaborative to reduce variation and ensuring healthcare staff and patients can readily understand availability of self-referral locally.

3.2 Implementing Modern General Practice Access

3.2.1 Better digital telephony (Cloud Based Telephony)

- In 2023/2024 funding was made available to support a switch from Analogue to Advanced Cloud Based Telephony solutions to support the delivery of modern general practice. Across Cheshire and Merseyside 173 practices were part of this programme which funded exit costs from current suppliers and implementation costs

- At the end of October 2024, 149 Cheshire & Merseyside ICB practices had implemented Advanced Cloud Based Telephony Solutions as part of the funded programme with the remaining 24 scheduled to go live before Christmas 2024.The pace of deployment across Cheshire & Merseyside ICB is reflective of that across other ICB's across the country.

Benefits for GP practices

- Installing Advanced Cloud Based Telephony provides the functionality to support practices to manage calls more effectively and provides data that helps practices understand and manage demand.

- Advanced Cloud Based Telephony systems phone lines are now connected to the internet, making it less likely that they will become unavailable due to technical difficulties.

- NHS Staff can access Advanced Cloud Based Telephony systems anywhere in the practice, this means GP practices are now more flexible to deal with requests and less reliant on a single reception team.

Benefits for patients

- When patients call the practice, they will come through to an automatic call menu, which will give a range of call options, rather than sending them straight to a call handler. By listening to and using the Appropriate option for their call, they will be able to speak to an appropriate member of staff quicker and free up the phone line for other patient queries that are not covered in the call menu.

- Patients will experience proper call queuing on the phone line when more than 4 patients are waiting. This means they will no longer have their call rejected if the lines are busy, they will instead be placed in a first come first served call queue.

- Advanced-Cloud Based Telephony (ACBT) allow call-back features. This means when patients reach the phone they will have the option to request a call back. Using this option will save their place in the phone queue and prompt the reception team to give them a call back when they reach the front of the queue. This is a great option if they have a busy day because they can continue to carry out tasks whilst they wait in the phone queue.

- ACBT has text integration. This means that for certain patient enquiries such as information about clinic dates or routine Appointments they may receive a text message rather than speaking to an operator. This can save them from having to wait in phone queues and frees up the call handlers to deal with other enquiries.

- ACBT has automatic priority call handling. This means if patients are calling from the number they have registered with the practice, the smart telephone system will check their medical records and if they have a serious medical condition like heart failure or if they have an access requirement such as being housebound, they will be able to speak to a member of the team sooner.

- ACBT systems are also connected to its records, meaning care navigators can identify whether or not a patient is registered with the system, meaning there will be fewer checks to verify their identity when you call.

3.2.2 Simpler online requests - Register with a GP Surgery Service

- Patients and a selection of GP practices across England have been testing a new “Register with a GP surgery” service which aims to make registration simpler, easier, and more inclusive for both patients and practices, whilst reducing the administrative time required to complete the process. This service gives all GP practices in England a standardised way of taking registrations online and is free for NHS GP practices to use.

- Since September 2023, practices across England were invited to sign up for the service, supported by a dedicated national programme team and online resources which can be found here Register with a GP surgery service - NHS Digital.
- This service has been mandated within the 24/25 GP Contract and all practices in the UK that are currently not using the service are to enroll by the end of October 2024. The ICB Digital Team are working with national implementation leads, Primary Care Leads and the three Digital service providers to support the mobilisation and engagement planning.

Month	Number of practices enrolled	% practices enrolled
November 23	119	33.6%
February 2024	148	42.8%
April 2024	156	45.1%
May 2024	174	50.4%
June 2024	217	62.9%
July 2024	222	64.3%
August 2024	225	64.7%
September 2024	275	80.1%
October 2024	313	91.3 %

- There has been a positive response from GP Practices that have enrolled with the service. **From a practice perspective,** benefits reported have been Reduced administrative workload – less paperwork and fewer phone calls relating to registrations. **From a patient perspective**, it' is more convenient - patients can register any time without having to visit the practice.

3.2.3 Faster navigation, assessment and response

- Practices have access to a number of digital tools commissioned by the ICB to support with faster navigation, assessment & response. Many of these tools were commissioned by CCG's resulting in a myriad of solutions and contracts. The ICB draws down funding for centrally commissioned solutions
- In August 2024 a transformational opportunity was launched, offering practices a chance to participate in a pilot to evaluate the effectiveness of Blinx PACO to support the delivery of modern general practice and realise system working benefits. 105 practices across the ICB have signed up to be part of this pilot.
- This work has been complemented by Care Navigation training and work undertaken through the National General Practice Improvement Plan where some of the learning has been focused around using the tools effectively in peer practice groups.

3.3 Building Capacity

3.3.1 Workforce

- The overall general practice workforce has grown by a third since 2019 (nationally, and reflected in C&M trends), this reflects growth in direct patient care staff funded through the Additional Roles Reimbursement Scheme (ARRS – see table below) and doctors in GP training. In contrast, growth in general practice nurses has not kept pace with other settings and qualified GP numbers have also reduced, more detailed workforce planning and numbers around this are available separately.

- Despite a significant increase in GP training there has been a net loss of GP capacity due to the rate of leavers and those who stay are working differently – more salaried doctors and more doctors reducing their hours

The chart below shows the number of ARRS (WTE) roles since September 2021 – there has been a steady growth in the WTE numbers, with a drop at the latest quarterly submission.

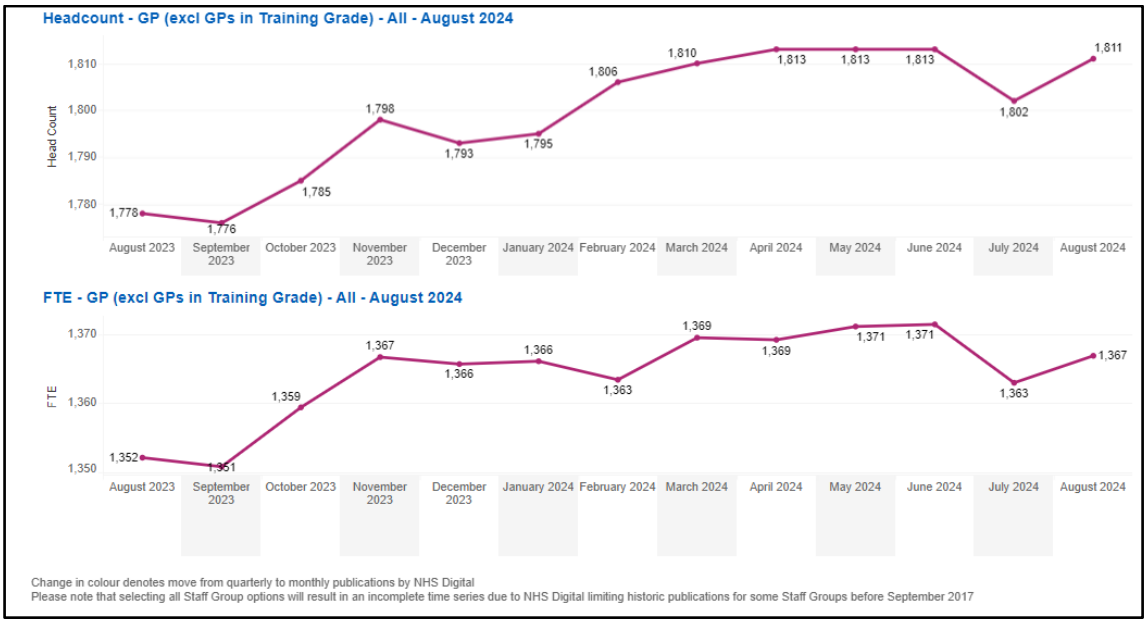
The table below provides a breakdown of ARRS Staff Role and associated WTE. This is compared to the baseline position (2018/19).

Staff_Role	Baseline Value	Collated ARRS	Collated ARRS Net of Baseline
Care Coordinators	0.0	372.2	372.2
Pharmacists	37.1	280.7	243.6
Social Prescribing Link Workers	0.0	167.4	167.4
General Practice Assistants	0.0	120.7	120.7
Pharmacy Technicians	0.0	113.8	113.8
First Contact Physiotherapists	0.0	90.2	90.2
Nursing Associates	2.1	62.7	60.6
Mental Health Practitioners	0.0	59.1	59.1
Physician Associates	3.5	57.8	54.3
Paramedics	0.0	54.3	54.3
Health and Wellbeing Coaches	0.0	48.0	48.0
Other Direct Patient Care	11.0	41.9	30.9
Advanced Pharmacist Practitioners	0.0	25.0	25.0
Trainee Nursing Associates	0.0	20.1	20.1
Advanced Paramedic Practitioners	0.0	17.7	17.7
Therapists - Occupational Therapists	0.0	17.1	17.1
Healthcare Assistants	180.1	196.7	16.6
Advanced Physiotherapist Practitioners	0.0	13.7	13.7
Health Support Workers	0.0	9.0	9.0
Dieticians	0.0	5.4	5.4
Physiotherapists	0.4	4.0	3.6
Mental Health and Wellbeing Practitioners	0.0	3.0	3.0
Total	278.8	1,834.8	1,556.0

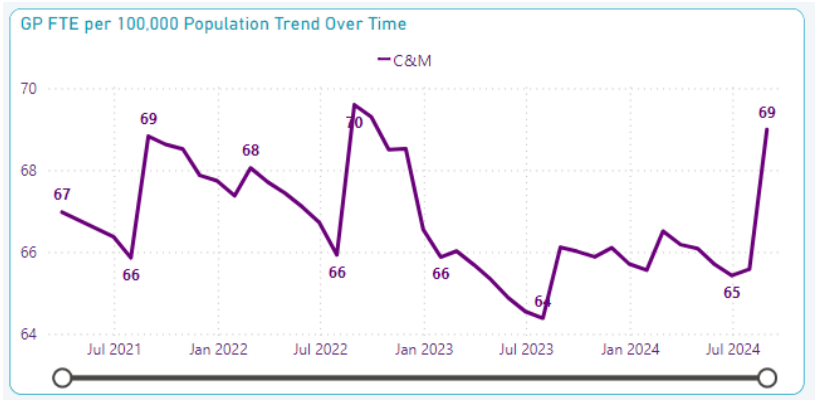
- **Increasing our headcount GPs** based on the national ambition was identified as a key enabler. The work set out through the national **Long Term Workforce Plan LTWP (June 2024) which is currently under review nationally**, is necessary but not sufficient to address the challenge of GP growth, as it was estimated that we would need the

equivalent of 15,000 additional GPs FTE (nationally) by 2036/37. This included an assumption of existing unmet demand, a continued pipeline of doctors completing GP training, and no increase to the current loss rate. However, the modelling showed a residual gap of 5,000 FTE by 2036/37. If we plan to continue moving activity from secondary to primary care, we will need to continue to retain the existing experienced GP workforce and go beyond the activity set out in the LTWP. It should be noted that salaried GPs have recently been added to the ARRS allowances though the numbers recruited are not yet available.

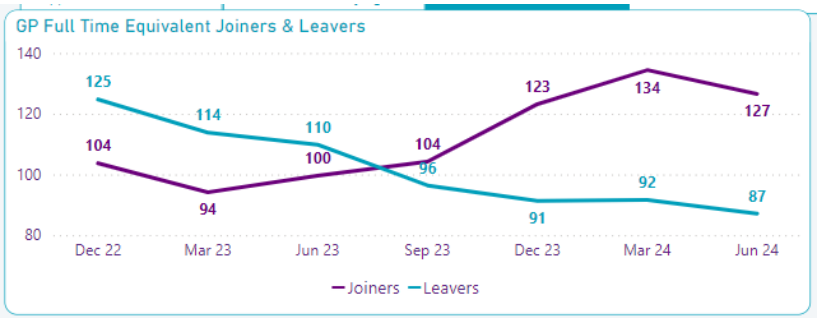
In Cheshire & Merseyside, GP's have seen slow growth & been almost at a 'steady state' in relation to GP WTE per 100,000 population.



The chart below shows the number of GP WTE per 100,000 population over time. It can be seen that the rate has never dropped below 64, with the latest performance (August 2024) at 69



The chart below shows the GP WTE Joiners and Leavers over time – since September 2023 there have been more Joiners than Leavers.



- **A clear delivery plan to respond to the NHS Long Term Workforce plan** was identified as a key enabler**.** As outlined in the C&M Joint Forward Plan 24/25; planning and delivery of services should be co-produced with our communities, as well as health & care providers through the place level improvement plans. Therefore, there will be different actions / responses to the LTWP trajectories and workforce needed to deliver the best patient experience. Further work in respect of workforce retention challenges and actions are given in the Place Level Improvement plans and overall further work is needed on this pending the review of the national workforce plan,

- The **remaining issues and challenges in relation to C&M General Practice Workforce** Plans can be summarised as:

    - Less GPs in areas of deprivation – with ongoing recruitment & retention challenges; compounded by the shortage of supply overall & decreasing participation rate.
    - More GPs are leaving or reducing work than ever before; the recent (Oct-24) RCGP members survey found that over 40% of the GP workforce across the UK said it was unlikely that they would be working in practice in five years' time. This figure has grown from 31% in 2019.
    - General Practice Nursing has not kept pace with the growth / changes in the wider Direct Patient Care workforce; compounded by the drop in students applying for & starting any adult nursing course as a pipeline into all nursing roles (inc. Secondary/Acute Care),
    - Workload is increasing / changing with an increased shift to digital / telephony-based triage & signposting.
    - Capacity – both in physical estate and supervision capacity to accommodate new workforce and learners safely
    - The above will need to form part of any further strategic planning, currently being overseen through the People Board.

3.3.2 Building capacity through Estates

- This remains an area of concern raised by Practices looking to create capacity. The ICB's new Strategic Estates Board will be working with the 9 place Strategic Estates Groups to ensure the agreed Infrastructure Strategy, supports the delivery of additional capacity where prioritised against agreed funding. Investment into Primary Care Estates through improvement grants (IG) is given below ;

  23/24 13 approved IG schemes value £1.65m
  24/25 29 approved IG schemes value 1.67m

3.4 Cutting bureaucracy

3.4.1 Primary Secondary Care Interface

- NHS Cheshire and Merseyside has been working on the Primary Secondary Care Interface for some time. The intent behind this initiative is to improve pathways for patients who otherwise can find themselves stuck between services. Improving the Interface improves patient experiences, and also has the potential to increase capacity in General Practice thus reducing presentation to the ED. Our published Consensus document has received national recognition and we have had opportunity to share our work at several national events and conferences including RCGP Annual Conference, The King's Fund, NHS Confederation Primary Care Conference, Best Practice Birmingham and at national NHSE leadership events.
- The consensus is reinforced by our Communications Toolkit which provides clear information on each topic within the consensus itself. The communications toolkit is designed for Trusts to be able to use either disseminating the document as a whole, or a topic at a time.
- We have a dedicated ICB webpage for the Primary Secondary Care Interface: Primary and Secondary Care Interface - NHS Cheshire and Merseyside
- NHS England has subsequently produced the Primary Care Access Recovery Plan, within which we find the pillar of 'Cutting Bureaucracy'. There are four specific areas we are asked to work on, and all of these are covered within the consensus document:
    - Onward referrals
    - Complete care (fit notes and discharge letters)
    - Call and recall
    - Clear points of contact
- We have established 6 Local Primary Secondary Care Interface (PSCI) Groups based around the footprints of local Trusts:
    - North Mersey
    - Mid Mersey
    - Warrington
    - Wirral
    - Cheshire West
    - Cheshire East
- These PSCI groups are all established and meeting to discuss local issues including the four asks above. In addition, we have now completed two returns for NHSE where Trusts are asked to self-assess their current compliance with the four areas. All local PSCI groups will be discussing the return and taking forward specific actions to ensure Secondary Care engagement and progress at a per place/trust level – this will include collating numbers / trajectories for the four areas. The place level plans give further granular detail on the progress in these areas. In addition, the ICB have recently established a system-wide PSCI group that meets 4-6 monthly, to support the local PSCI groups and also direct pieces of work common to all to avoid duplication.

3.5 Finance

- The summary of funding for 23/24 and 24/25 is given below, noting for 24/25 some elements are still being finalised ;

SDF and Primary Care Access Recovery Funding	2023/24	2024/25
	Total £000	Total £000
GP Practice Fellowships (training hub)	£1.677	£2.577
Supporting GP Mentors (training hub)	£0.392	
GP IT and Resilience	£0.568	£0.610
C&M GP Retention and Training	£0.329	£0.229
Top Slice for Digital Funding	£0.600	
Transformation Funding Pool	£3.054	£2.000
Uncommitted		£3.679
Total SDF	**£6.620**	**£9.095**
Capacity and Access Support Fund (CAP)	£11.595	£13.789
Capacity and Access and Improvement Payment (CAIP/CASP)		
Transition Cover and Transition Support Funding	£2.050	£2.050
Cloud Based Telephony	£3.161	N/A- 1 Yr NHSE Funding
Additional Roles Reimbursement Scheme	£65.782	£68.361
Primary Care Access Recovery Support Funding	**£82.588**	**£84.200**
Total Funding	**£89.208**	**£93.295**

24/25 (note elements of this still being finalised)

3.6 Communications

- The ICB supported the national communications plans in relation to Access Improvement and available toolkits, which were also adaptable by practices, to help promote information around, for example, Additional Roles (ARRS) to help patients understand the many different staffing roles within general practice.

- The ICB has in addition identified opportunities to develop localised content, for example, to promote the use of the NHS App and local GP soundbites on additional roles locally.
  https://campaignresources.dhsc.gov.uk/campaigns/help-us-help-you-primary-care/nhs-general-practice-team/campaign-toolkit/

  NHS outlines how it will help improve access to GP practices across Cheshire and Merseyside - NHS Cheshire and Merseyside

- The outputs from the Healthwatch work outlined will give a further review point for any future targeted area of work for communications to support patients understanding of

some of the key enablers of improved access, plus for example accessing enhanced access appointments.

4. Summary of Further Key Actions

4.1 The results of the Healthwatch surveys will give further insight to the ICB on the impact of many of the key enablers such as digital tools, on the overall patient experience of accessing services. Further actions will follow once this starts to be collated and this will form part of the update to this Board in March.

4.2 Further work is required to ensure a consistent achievement of 90 per cent of appointments offered within 2 weeks across the ICB, and Places will be supporting further targeted work with Practices around this to understand variation further. In addition, understanding demand better remains a key priority.

4.3 Refining further, the work required to support access in our most challenged communities remains a key, ongoing action and further place level progress to support this is a priority, as part of our overall approach to reducing health inequalities across the ICB.

4.4 Outcomes from planned spend in terms of SDF in 24/25 and the impact of additional salaried GP roles into the ARRS process will form part of the March update.

4.5 In response to the challenges in section 3.3.1, the ICB will need to continue to refine our approach to workforce planning - and in particular GP retention actions need to be detailed further, as part of an overall action plan. This action plan will need to be finalised pending the current national review of the Long-Term Workforce Plan, noting the work some places are already doing in relation to workforce challenges where local bespoke place plans may exist.

4.6 Supporting patients to understand and make further use of the new technology and services such as using the NHS App, self referrals and Pharmacy First remains a key priority.

4.7 Further progress on Secondary/Primary Care interface including per Trust progress on the numbers around the four areas outlined in 3.4.1. Recent announcements by the Secretary of State around the ‘red tape challenge’ have given added impetus to this area. There is an expectation that numerical targets and trajectories are used to report on the 4 areas of the national documentation, but that reporting systems are not yet in place to enable this consistently across our Trusts.

4.8 The impact of national GP Collective Action, rising demand for services and pressure on existing staff is an important consideration in understanding issues around access. Challenges in relation to finance, recruitment and demand management are an ongoing challenge for our practice colleagues. The ICB will continue to prioritise well- being offers for staff and further work is ongoing to look at support for practices in relation to challenging patients outside of Special Allocations Scheme(s), which is an area of concern highlighted by LMC colleagues.

4.9 The ICB will need to review this plan against the outcomes of the current work on the 10 Year NHS Plan, including patient feedback and any new policy announcements. Access to general practice appointments however, remains a key ICB priority.

5. Appendices

<table>
<tr><td>A1</td><td>NHS England Monthly Reporting Template
October return attached – to inform the board of the monthly metrics being collected by NHS England
https://westcheshireway.glasscubes.com/share/s/i33e09vmfud8htjp0jadra14l5</td></tr>
<tr><td>A2</td><td>Place Access Improvement Plans - all place appendices have been removed for the purposes of this paper size but are available on request

<table>
<tr><td>Cheshire East</td><td>https://westcheshireway.glasscubes.com/share/s/eaipbu656bc75ej99n1ojkl8nj</td></tr>
<tr><td>Cheshire West</td><td>https://westcheshireway.glasscubes.com/share/s/dj6re2v12blvjlv3htul7mh86n</td></tr>
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Meeting of the ICB Board of NHS Cheshire and Merseyside

28 November 2024

Intensive and Assertive Community Mental Health Care

Agenda Item No: ICB/11/24/22

Responsible Director: Simon Banks, Place Director (Wirral)
ICB Strategic Lead for Mental Health, Learning Disabilities and Autism

Intensive and Assertive Community Mental Health Care

1. Purpose of the Report

1.1 This report provides an overview of the gaps in provision identified against nationally published guidance regarding the ability to comprehensively identify, maintain contact and meet the needs of people who require intensive and assertive community mental health care and follow-up.

2. Executive Summary

2.1 The 2024/25 operational planning guidance[1] outlined a requirement for ICBs to review their community services to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge. Safety is pivotal for this patient cohort.

2.2 An internal self-assessment of service provision was undertaken by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and Mersey Care NHS Foundation Trust (MCFT) to identify key challenges and gaps. This included a review of policies and standard operating procedures and obtaining initial feedback from internal services and VCSFE partners via a short questionnaire.

2.3 A number of barriers and challenges were identified to the provision of intensive and assertive community mental health care as described in the national guidance. These include limitations relating to workforce, finance and extended working hours.

2.4 An ICB action plan has been drafted to address potential gaps in provision, as highlighted as part of the review process. An action plan has been developed outlining short-term actions with minimal resource implications, as well as potential longer-term actions, which may have resource implications.

2.5 Further engagement is planned with a range of stakeholders, including people with lived experience and their carers, to ensure that learning is as open and honest as possible and can inform improvements to local services.

[1] NHS England » Priorities and operational planning guidance 2024/25 (see Page 25)

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- Note the requirements for this review report and action plan to be presented to ICB Public Boards by 31st December 2024.
- Note the actions that will need to be addressed to ensure that intensive community treatment and follow-up can be provided.
- Agree that regular updates on progress against the action plan will be presented via established MH governance processes.

4. Reasons for Recommendations

4.1 Identification of gaps and mitigating actions is required to improve the care and treatment of individuals who require an intensive and assertive approach from health services, as mandated by NHS England.

5. Background

5.1 Many people who experience psychosis are able to receive evidence-based care and treatment which enables them to recover from their psychotic episode and/or be supported to live a life that is meaningful to them alongside the management of ongoing symptoms.

5.2 Some people who experience psychosis, particularly where paranoia is present, struggle to access evidenced-based care and treatment. This can be due to core services not being able to meet people's needs, the impact of symptoms such as paranoia or a lack of understanding from the individual that they are unwell. For this group of people, it is critical that mental health services are able to meet the person's needs by adapting the approach to engagement, providing continuity of care, and offering a range of treatment options for people experiencing a varying intensity of symptoms.

5.3 People with these needs can be very vulnerable to harm from themselves and from others; for a very small number of people relapse can also bring a risk of harm to others. Integrated care boards (ICBs) have a duty to provide care and treatment in a way that meets the needs of this group. This does not have to be through a standalone team, but there should be dedicated provision in place within Community Mental Health Teams, or other specialist services, to support this population group.

5.4 Improving the care and treatment of individuals who require an intensive and assertive approach from health services is a priority for the NHS. National guidance[2] was published in July 2024, along with an "ICB review outcome

[2] https://www.england.nhs.uk/long-read/guidance-to-integrated-care-boards-on-intensive-and-assertive-community-mental-health-care/

template" to be completed and returned to NHS England regional office by 30th September 2024.

5.5 Guidance outlined requirements to seek a range of input from colleagues across services and other partners, including seeking direct engagement with patients who have lived experience of using services, to ensure that learning is as open and honest as possible and can inform improvements to local services.

5.6 An internal self-assessment of service provision was undertaken by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and Mersey Care NHS Foundation Trust (MCFT) to identify key challenges and gaps. This included a review of policies and standard operating procedures and obtaining initial feedback from internal services and VCSFE partners via a short questionnaire.

5.7 The short timescales for completion of the review limited the ability to seek wider engagement, including with people with lived experience, and this is a priority action for the next stage of the review process.

5.8 Both trusts advised that it was challenging to define the patient cohort within reporting systems and electronic patient records and this, therefore, hampered the ability to review compliments, comments and complaints which related to this specific group of people.

5.9 The outcome of the trust self-assessments was considered by a small panel in advance of a formal submission being made to NHS England. The submission confirmed that "Did Not Attend" policies are never used as a reason for discharge for this patient group, and that discharges are always overseen by a multi-disciplinary team. However, it was acknowledged that further work was required to ensure that practice is fully embedded.

- A number of barriers and challenges were identified to the provision of intensive and assertive community mental health care as described in the national guidance. These include;
  Workforce- Capacity and Resource e.g. gaps in specialist roles and specialist training, 24/7 service availability in Community MH Teams
- **Governance and Systems** – whilst escalation processes are in place, they are not specific to this vulnerable population. Limited monitoring systems are in place to identify people in local communities who may need this treatment approach.
- Current **policies, legal frameworks, and insufficient system-wide guidance** contribute to the fragmentation of services, preventing a seamless, integrated approach to mental health care. There is a lack of a specific outcomes framework for an Assertive Outreach approach.
- **Finance and resource limitations** including the need for additional funding to address workforce gaps, support the extension of service hours, enhancement of roles, training, and digital gaps. In addition, funding for VCSFE partners to provide additional support.

5.10 An ICB action plan has been drafted to address potential gaps in provision, as highlighted as part of the review process. The action plan in appendix 1 includes short-term actions with minimal resource implications, as well as potential longer-term actions, which may have resource implications.

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

- Specific actions will be addressed to prevent barriers to access and reduce health inequalities for this population group. Local population mental health and physical health needs (including health inequalities) will be reviewed, existing support available will be mapped, and gaps in provision will be identified. Support will be aligned to the CORE20PLUS5 approach to reducing health inequalities.

Objective Two: Improving Population Health and Healthcare

- People with mental health problems such as psychosis are at increased risk of poor physical health and die on average 15 to 20 years earlier than the general population.
- Services will provide holistic care that is engaging, evidence-based and trauma informed. This is often a complex service-user group, therefore services should be well equipped to support people with co-occurring needs.
- A whole system approach will be adopted. Services will aim to ensure good integration exists across wider community teams, inpatient, and primary care as well as clear working protocols with housing, criminal justice, social care, local government, VCSFE, and substance misuse services. Fragmented care pathways which hinder effective care delivery will be addressed.

Objective Three: Enhancing Productivity and Value for Money

- Workforce will be equipped with the right skills and competencies to support this service user group ensuring that they can respond to individual's needs and presentations and support people to become medically stable.
- The identification of gaps in provision will inform any investment decisions in respect of the mental health investment standard (MHIS) and any wider resources available to deliver improved care.

Objective Four: Helping to support broader social and economic development

- Ensuring that community provision is in place for people with severe and relapsing mental illness will alleviate pressure on other parts of the health system and the wider public sector.
- The health and wellbeing of our workforce, our ability to retain, develop and grow, will contribute to wider social and economic sustainability.
- Actions focus on a service user group who have been traditionally excluded from social and economic opportunities, helping to curate more inclusive and resilient societies.

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

Improving the care and treatment of individuals who require an intensive and assertive approach from health services is a priority for the NHS. It is directly linked to both population health objectives and the priority to increase access to community mental health services.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

QS1 Supporting People to live healthier lives
By providing ongoing support we will 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.

QS3 Safe and effective staffing
There needs to be enough qualified, skilled and experienced people, who receive effective support, supervision and development working together effectively to provide safe care that meets people's individual needs.

QS4 Equity in access
An intensive and assertive community approach will ensure that everyone can access the care, support and treatment they need when they need it.

QS5 Equity in experience and outcomes
By involving those with lived experience we will actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We can then tailor the care, support and treatment in response to this.

QS6 Safeguarding
People with these needs can be very vulnerable to harm from themselves and from others; for a very small number of people relapse can also bring a risk of harm to others. Integrated care boards (ICBs) have a duty to provide care and treatment in a way that meets the needs of this group.

Theme Two: Integration

QS7 Safe systems, pathways and transitions
Partner organisations need to be able to refer or escalate cases for this high-risk group of individuals and safety needs to be managed, monitored and assured.

QS8 Care provision, integration and continuity
Care needs to better coordinated and responsive for this cohort of individuals and need to ensure continuity of care when people move between different services.

QS9 How staff, teams and services work together
All relevant staff, teams and services are involved in assessing, planning and delivering people's care and treatment and staff work collaboratively to understand and meet people's needs.

Theme Three: Leadership

QS13 Governance, management and sustainability
ICBs need to be assured that the services in their area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up.

QS14 Partnerships and communities
Steering groups understand the duty to collaborate and work in partnership, so that services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

QS15 Learning, improvement and innovation
Steering groups focus on continuous learning, innovation and improvement across organisations and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

9. Risks

9.1 The review of local service provision has highlighted a number of gaps which will need to be addressed. These relate to the following ICB principal risks:

P1 – the ICB is unable to progress meeting its statutory duties to address health inequalities. This risk will be mitigated via immediate short-term actions and further prioritisation of longer-term actions.

P4 - Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience. As outlined in national guidance, the review has been used as an opportunity to reflect on the community provision in place for people with severe and relapsing mental illness, and in particular the specific actions services need to take to ensure people are receiving and engaging in the care they need. Safety is a pivotal consideration. Progress against identified actions will mitigate this risk.

P9 - Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives. There is a limited pipeline for certain MH professions and a need, therefore, to think innovatively about career routes and

workforce development. Collaborative work is being undertaken to develop a MH workforce strategy to mitigate this risk.

10. Finance

10.1 The action plan in appendix 1 includes short-term actions with no, or minimal resource implications, as well as potential longer-term actions, which may have resource implications. Approval to progress longer-term actions will be sought via appropriate governance structures as transformation work continues.

10.2 NHS England has requested an initial estimate of the direct cost implications of addressing identified gaps in provision. This estimate is to build understanding of the total scale of funding required nationally. A consistent North West approach has been adopted to calculate this estimate, based on NHS benchmarking data for community MH services.

10.3 Using weighted population for working age adults in Cheshire and Merseyside, it is estimated that an additional 98 WTE staff will be required, at a cost of £6.8m, to address gaps in provision. However, no commitment to funding is currently being sought.

10.4 More detailed work will be required to better understand the skills, competencies and training requirements for both existing and additional staff. Consideration will also be given to any additional digital and estates requirements to provide out-of-hours services to meet the needs of this cohort.

11. Communication and Engagement

11.1 The review has been informed by feedback from teams within NHS mental health providers and some VCSFE organisations via survey response. This feedback indicated that there is an awareness of escalation processes for high risk individuals, but some barriers and challenges were highlighted, including;

- Some teams respond quickly via duty teams, but other agencies may face barriers in escalating concerns.
- Long waits for appointments and brief interventions without proper follow-up are common.
- High Community MH Team caseloads cause delays and sometimes lead to A&E or emergency service involvement.
- Gaps exist for individuals with complex needs who do not meet crisis thresholds, and waiting lists for therapies are long.

11.2 Further engagement is planned with a range of stakeholders, including people with lived experience and their carers.

11.3 The National NHS England team will collate national trends from the reviews, use it to inform future policy, as well as communicate the outcomes to the CQC and Department of Health and Social Care.

12. Equality, Diversity and Inclusion

12.1 People within this cohort may be socially excluded and typically experience multiple overlapping risk factors for poor health, such as violence and complex trauma. It is important to ensure that opportunities are not missed for preventative interventions to improve health outcomes, reduce inequalities and reduce cost in other services.

13. Climate Change / Sustainability

13.1 Supporting people within this cohort to live healthier more active lives will facilitate delivery of the ambitions of the Cheshire and Merseyside Marmot Community Programme.

14. Next Steps and Responsible Person to take forward

14.1 Following approval by ICB Board, delivery of actions will be progressed via the Cheshire and Merseyside MH Programme, in conjunction with NHS mental health providers and relevant stakeholders. Oversight of delivery will be via established MH governance structures.

15. Officer contact details for more information

- Claire James, MH Programme Director, Cheshire and Merseyside Mental Health Programme
- Clair Haydon, Clinical Director for Mental Health Complex Care for North West England

16. Appendices

Appendix One: Action plan

Project Name: Intensive and Assertive Outreach Review Action Plan

Scope: To oversee implementation of actions relating to recommendations from the Intensive and Assertive Outreach review

NHS Cheshire and Merseyside

No	Timescale	Overarching action	National Ask	Actions	Action Lead
1	Immediate Asks	Financial Planning	Costing estimates for long-term actions requested by 15th November	Adopting NW approach to estimating the cost of providing Intensive and Assertive Outreach against guidance.	ICB
2		System Improvement	Facilitate working group and onward action implementation	Repurpose the Community MH Transformation group as a working group for this specific programme. ICBs to identify an SRO to oversee the development and define Roles and Responsibilities. Refresh the Terms of Reference and extend its membership as needed.	ICB
3			Creation and monitoring of a system-wide improvement plan	C&M to present action plan, alongside the review outcomes, to ICB public board in November.	ICB
4				C&M involvement in a regional Intensive & Assertive Community Treatment Review Forum, exploring best practice examples to share across the NW.	System Wide
5	National Ask - Short Term	Policy and Practice Review	Policies have been reviewed to ensure that patient family and carers are involved, particularly at times of nonengagement	Trusts will review their policies to ensure this ask is included.	Trusts
6				Trusts will review and align policies to include Intensive and Assertive Outreach standards.	Trusts
7				Once policies are reviewed, Trusts will communicate to local services and VCFSE to support effective escalation and referral to CMHT.	Trusts
8			Eliminate 'blanket' policies and practices of using DNA as a reason for discharge	Trusts to review and amend their policies and practices to ensure DNA is never a reason for discharge for this group.	Trusts
9				Trusts to escalate any areas of concern or require system support.	Trusts
10		Identify the group requiring Intensive and Assertive Outreach Teams	All providers will be able to identify the population of people with serious mental illness where engagement is a challenge and in need of intensive and assertive community treatment.	Across C&M we will explore how to develop a shared approach across Trusts to identify and define the group of people who may require intensive /assertive support, including potential engagement with Holmusk.	System Wide
11				Across C&M agree a standardised process for each provider to identify and report on this group of people.	System Wide
12				Trusts to review and identify gaps in EPR systems to identify this group, link to incidents, compliments, comments and complaints quality metrics, and ensure robust governance processes in place.	Trusts
13		Eligibility Assessment	All service users are assessed to see if they are eligible for intensive and assertive community treatment	Develop a Standard Operating Procedure (SOP) to support the identification and the eligibility	Trusts
14		Development of a Standard Operating Procedure (SOP)	Ensure all service users in this group have an assigned, and appropriately experienced and competent key worker (or care coordinator)	Trust to work across C&M to agree implementation of these standards and what is possible without resource.	Trusts
15			Discharge plans should include early warning signs of relapse and subsequent actions. These plans are shared with the patient, the family, detailed on the patient record, and shared with other agencies.	Trust to review relapse/risk documentation to ensure this ask is met.	Trusts
16				Trust to review the skills and competency in the workforce to be able to complete this ask and escalate any training needs.	Trusts
17			Rapid re-referral/easy access is possible in the case a service user is discharged but requires additional support due to increasing needs.	Trusts to review/revise processes for re-referral for this group.	System Wide
18				Trusts to share processes for escalation and rapid referral with wider health and social care teams and VCFSE, housing and support providers.	Trusts
19			Key workers (or care coordinators) stay in contact with the service user (and their inpatient care team) during inpatient admissions	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	Trusts
20			Assessments and care plans are coproduced with the service user and their family or carers	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	Trusts
21			Daily planning meetings and weekly MDTs for all service users requiring intensive treatment	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	Trusts
22			Personalised risk management procedures are in place.	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	Trusts
	***The following actions are dependent on a business case being developed (including outline costs, resource requirements, risks, impact assessment and potential inclusion of Children and Young People) and resource being available. Timeframes will align to potential National investment.**				
23	National Ask - Long Term	Business Case Development*	There is a dedicated provision in place that can support this service user group	Trusts to identify how the dedicated provision would be implemented and share the workforce and resource needs for this system support.	Trusts
24			Clear pathways for 'step up' care to services like rehab and assertive outreach	Trusts to review the processes for accessing rehab and identify how access to a dedicated provision for Intensive and Assertive Outreach should be provided.	Trusts
25			Out of hours access to service for users who need it	Revision of the workforce models and costs to inform a business case for implementation.	System Wide
26			Staff working with this service user group have small caseloads.	The system to support trusts to identify groups requiring dedicated Intensive and Assertive Outreach, using reporting mechanisms and agree workforce required to ensure small caseloads.	System Wide
27			Staff have access to relevant training and clinical supervision to support them to work with this service user group	Trust to undertake staff training analysis, to identify training needs.	Trusts
28				Trust to review existing supervision structures, identifying any gaps that require further development.	Trusts
29				Trusts to identify need for training to support managing psychosis, to improve care delivery and present gaps in provision to the ICB for system support.	Trusts
30			NICE, recommended medication principles are followed. Pharmacy expertise is available to staff supporting this cohort. Ensure Staff are following a process for people who are non-concordant with medication and process for checking and reviewing medication. To ensure staff have training and supervision structures to access should there be complexities around medication interventions	Trust to include medication principles and processes in the training needs analysis and ensure pharmacy support is available.	Trusts
31				Trusts to ensure NW Clozapine guidance is embedded in practice.	Trusts
32			Providing access to a full range of evidence-based treatment and interventions, including psychological Therapies	Ensure access and availability of evidence based treatment and interventions withing trust provision.	Trusts
33				Trusts to identify any gaps and plans to address these.	Trusts
34			Risk assessments are individualised and risk formulation is part of every psychosocial assessment.	Trusts to review existing processes and identify any areas for development for this group.	Trusts
35			Holistic support is provided, including support with housing and substance misuse	System support to identify relevant stakeholders to support the delivery of services and include this offers within the business case and service development plans.	System Wide
36			There are measures in place to evaluate the impact of services, including the regular reporting of appropriate Outcomes	System to build on the work completed as part of the community mental health transformation, agree outcome measures and reporting as part of service development plans.	System Wide
37			There is 24-hour access to interpreters and translation services available	Trusts to review their current contracts/access for interpreters and translation services and identify what would be required for this to be provided 24/7.	System Wide

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Update on Physical Health Checks in Severe Mental Illness

Agenda Item No:

Responsible Director: Simon Banks, Place Director (Wirral)
ICB Strategic Lead – Mental Health, Learning Disabilities Autism

Update on Physical Health Checks in Severe Mental Illness

1. Purpose of the Report

1.1 NHS Cheshire and Merseyside Integrated Care Board (ICB) requested a deep dive into physical health checks for those people with severe mental illness (SMI) following presentation of performance data on 25 July 2024. This report provides the background and context to an accompanying presentation being delivered by Simon Banks, Place Director, Wirral and Dr Chris Pritchard, Cheshire and Merseyside Primary Care Lead for Mental Health.

2. Executive Summary

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2.1 People with mental health problems such as psychosis are at increased risk of poor physical health and die on average 15 to 20 years earlier than the general population.

2.2 NHS England (NHSE) monitor the uptake of physical health checks for those people living with SMI and have issued a publication describing 10 key actions to improve uptake[1].

2.3 GPs are expected to hold an up to date register for people with a diagnosis of SMI. Operational planning guidance outlines an ambition to 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.

2.4 Physical health checks for people living with SMI are essential in raising parity of esteem to ensure that they are proactively offered opportunities to improve their health and consequently, life expectancy, in line with NICE guidance and NHSE recommendations.

2.5 It is important to note that whilst current NHS targets for SMI health checks are aimed at undertaking the health checks, the message of “don’t just screen intervene” is paramount in reducing inequalities for this cohort of people and ensuring they are actively supported to live as healthy a lifestyle as possible.

2.6 Long term consequences of not addressing these issues will lead to further reliance on the NHS and subsequently increase costs to the system as a whole.

[1] NHSE 10-key actions improving the physical-health-of-people-living-with-severe-mental-illness/

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- Note the content of this report and the accompanying presentation.
- Support the sharing of the good practice identified within the presentation to improve uptake of the checks and interventions where needed.

4. Reasons for Recommendations

4.1 This report and the accompanying presentation should provide the assurance needed to the Board that the uptake of SMI physical health checks are being monitored, support is being offered locally to improve the uptake and best practice is being shared to improve outcomes.

5. Background

5.1 People with mental health problems such as psychosis are at increased risk of poor physical health and die on average 15 to 20 years earlier than the general population.

5.2 The main causes of premature death are chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory diseases.

5.3 These physical conditions are associated with modifiable risk factors such as smoking, obesity and high blood pressure, and are also associated with side effects of psychiatric medication.

5.4 They are seen as preventable with comprehensive assessment, treatment and the recommended safe monitoring of physical health and the side effects of medication.

5.5 NHS England (NHSE) advise that Integrated Care Systems (ICSs) should ensure a local comprehensive model of care is provided so that people with SMI receive an annual physical health check in a way that meets their needs[2].

5.6 ICSs should develop a protocol outlining the roles and responsibilities across Primary Care, Secondary Care and voluntary, charity, faith and social enterprise (VCSFE) organisations. The protocol should follow the recommendations in NICE guidance CG178 and should specifically define;

- Data sharing arrangements across clinical areas
- Clarity on who is responsible for each step, including undertaking the check, analysing the results and supporting access to interventions and care as needed.

[2] NHSE (2024) Improving the physical health of people living with severe mental illness – Guidance for integrated care systems

5.7 ICSs should consider commissioning enhanced or dedicated services and outreach programmes.

5.8 SMI physical health checks are part of the GP contracts and payments under the quality outcomes framework are awarded for completion of all six mandated checks. In addition, the NHSE guidance also recommends a number of additional health checks.

5.9 There are established SMI Physical Health Steering Groups in each of Cheshire and Merseyside's nine places with a remit of supporting the uptake of physical health checks and identifying approaches to improve outcomes.

5.10 There is an overarching Cheshire and Merseyside SMI Physical Health Steering Group, attended by the chairs of the local place meetings and chaired by the Mental Health Programme Team. On a quarterly basis this extends to include wider stakeholders, including providers of locally commissioned SMI health check services to share best practice and discuss any challenges.

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

Mental illness is a protected characteristic. By providing SMI physical health checks and interventions as needed we are working towards prevention and improving mortality rates across this cohort. This programme ensures that those with SMI have parity of esteem with other long term physical health conditions. Where possible tailored support is considered such as inviting people for appointments when surgeries are quieter and offering longer appointments.

Objective Two: Improving Population Health and Healthcare

By prevention from screening and intervening early we are contributing to the overall health of the Cheshire and Merseyside population and reducing premature mortality from preventable conditions.

Objective Three: Enhancing Productivity and Value for Money

By providing initiatives such as the use of long-term conditions Ardens multimorbidity tool, described in the accompanying presentation, we are providing one appointment and diagnostics that can be used many times, reducing the need for multiple appointments and tests.

Objective Four: Helping to support broader social and economic

By providing SMI physical health checks we are supporting people to 'live well' reducing the burden on the NHS and combined with links to social prescribing, VCFSE

organisations and Individual Placement Support services we are able to offer wider access to activities, volunteering and potentially employment opportunities.

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

Physical Health checks for SMI links with the Population Health Service Programme and with other long term conditions described in the plan such as diabetes and cardiovascular service programmes.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

QS1 Supporting People to live healthier lives
By undertaking and providing ongoing support to access interventions we will 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.

QS4 Equity in access
By being flexible in the approach to engaging people with SMI we will make sure that everyone can access the care, support and treatment they need when they need it.

QS5 Equity in experience and outcomes
By involving those with lived experience we will actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Theme Two: Integration

QS8 Care provision, integration and continuity
By using the data available through the NHS Futures website and the ICB Business Intelligence Portal we are better able to 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
By working across primary care, secondary mental health services, public health, social care and the voluntary, charity, faith and social enterprise organisations, we are able to work effectively to support people. By working towards system data sharing agreements and exploring interoperability we aim to ensure service users only need to tell their story once so we can share their assessment of needs when they move between different services.

Theme Three: Leadership

QS14 Partnerships and communities
Within our steering groups we understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

QS15 Learning, improvement and innovation
At our steering groups we focus on continuous learning, innovation and improvement across our organisations and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

9. Risks

9.1 There are no risks pertinent to the ask within this report

10. Finance

10.1 There are no current financial implications directly related to this report, however, there is potential for longer term savings associated with prevention and health improvements for those living with SMI.

10.2 The ICB may want to consider how investing in the uptake of SMI physical health checks could realise the long term financial benefits and the overall health improvements of an increase in people benefitting from the checks.

11. Communication and Engagement

11.1 Work will continue through the groups already established.

12. Equality, Diversity and Inclusion

12.1 People living with SMI have protected characteristics under the Equality Act. SMI physical health checks form part of the Public Health Core20PLUS FIVE requirements.

13. Climate Change / Sustainability

13.1 The physical health checks and subsequent interventions support people with SMI to live healthier more active lives and supports the ambitions of the Cheshire and Merseyside Marmot Community Programme.

14. Next Steps and Responsible Person to take forward

14.1 Work will continue to improve uptake of SMI physical health checks. Sharing of good practice and innovation will continue through the Cheshire and Merseyside Physical Health in SMI quarterly network meetings.

15. Officer contact details for more information

Julie Chadwick, Adult Mental Health Programme Manager
Julie.chadwick7@nhs.net
Claire James, Mental Health Programme Director
Claire.james12@nhs.net

NHS
Cheshire and Merseyside

Meeting Held in PUBLIC of the Board of
NHS Cheshire and Merseyside

Held at The Wrights Lounge, The Mornflake Stadium, Gresty Road, Crewe, CW2 6EB

Thursday 26th September 2024
10:30 – 13:45

Unconfirmed Draft Minutes

Recording available at: NHS Cheshire and Merseyside Integrated Care Board - 26 September 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)
Ann Marr, OBE	Partner Member – NHS Trust
Prof. Steven Broomhead, MBE	Partner Member – Local Authority (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)
Adam Irvine	Partner Member – Primary Care (voting member)
Dr Naomi Rankin	Partner Member - Primary Care (voting member)
Andrew Lewis	Partner Member – Local Authority (voting member)
Trish Bennett	Partner Member – NHS Trust (voting member)
Warren Escadale	Partner Member – VCFSE (voting member)
In Attendance	
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (Regular Participant)
Christine Samosa	Chief People Officer, Cheshire & Merseyside ICB (Regular Participant)
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)
Kate Little	Deputy CEO, Community and Voluntary Services, Cheshire East
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
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (Regular Participant)

Mark Palethorpe	St Helens Place Director, Cheshire and Merseyside ICB
Louise Barry	Chief Executive, Healthwatch Cheshire
Alison Lee	Knowsley Place Director, Cheshire and Merseyside ICB
James Burchall	Strategic Estates Manager, Cheshire and Merseyside ICB
Louise Robson	Chair, Health Innovation for North West Coast
Stephen Woods	Senior Programme Manager, Cheshire and Merseyside ICB

Apologies	
Name	**Role**
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)

Agenda Item, Discussion, Outcomes and Action Points
Preliminary Business
ICB/09/24/01 - 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/09/24/02 - 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/09/24/03 - Report of the ICB Chair
The Chair was delighted to welcome Trish Bennett as partner member, Andrew Lewis as Local Authority partner member and Warren Escalade partner member on behalf of the voluntary, community and faith sector to the Board. **The Board Resolved to -** **Note the updates as outlined within the report.**
ICB/09/24/04 - Experience and Achievement Story
The Medical Director introduced an experience and achievement video to the Board on the subject of lung health checks. Cancer outcomes are worse for patients from deprived backgrounds, the programme is finding earlier detection of cancers which are more treatable, with better outcomes and a less difficult treatment journey for the patient.
Leadership Reports
ICB/09/24/05 - Report of the ICB Chief Executive
The Chief Executive highlighted to the Board – • Publication of Darzi review which was a piece of work the government requested as a current status of the NHS to inform the publication of the governments ten-year plan for the NHS. It is expected that the ten-year plan will publish in April 2025. Engagement events will take place in each ICB across the country, giving opportunity for the co-production engagement events with the National team. • The Deputy prime minister wrote to the parts of the country who were not part of a government devolution deal, which includes East Cheshire, West cheshire and Warrington. The Chief Executive

has written to all three Local Authority Chief Executives to offer support in the bid for the devolution deal. There will be opportunities to progress issues that come under All Together Fairer agenda.

- Crown Street site & waiting lists – modelling has been undertaken on waiting lists; gynaecology waiting lists are currently too long. Investment has been secured through the targeted investment fund to open up more procedure rooms and treatment facilities at the crown street site to tackle this. Investment will continue on the Crown Street site which is a fundamental part of the NHS and fundamental to the delivery of women's services.

The Board Discussed –

- Digital workforce initiative & Electronic Patient Records - one Trust in the ICB has a system that no longer supports electronic patient records. The current system is due to be replaced in 18 months; the old system will need an additional support wrapped around until the new system is deployed. There are four Trusts currently looking at procurement, typically deployment time post award is eighteen months to two years. It will be approximately three years before there is a common level of digital maturity in electronic patient records.

Actions –

- **The Medical Director to discuss under 18's being members of the Data into Action Patient Advisory Group to input into public advisory work at the Data into Action Board, and report to the ICB Chair.**

The Board Resolved to -

• Considered the updates to Board and sought further clarification and detail.
• Approved the minor amendments to the ICBs Standing Financial Instructions.

ICB/09/24/06 - 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 care – management of change for staff concluded this month; it is anticipated that the new structure will be in place by the end of October 2024. Key performance indicators for Q1 of this year highlights the number of people within Cheshire and Merseyside eligible for continuing health care, compared to regional and national eligibility. Transfer rates for fast-track conversion for end-of-life patients allowing support at home or an alternative placement to hospital. All age continuing health care is a major area of expenditure and a main area of focus for recovery. A dedicated recovery programme has been established with a senior responsible officer; a weekly care assurance panel has been established to scrutinise packages of care costing more than £5000 per week.

- Local Maternity and Neonatal System – in line with perinatal safety and surveillance framework, the LMNS are undertaking visits with all trusts in the next two months focusing on on-going assurance on the delivery of the three-year plan and implementation of essential actions from Ockenden recommendations. The Cheshire and Merseyside maternity and neonatal dashboard was presented to the LMNS assurance board and will be shared in future Board reports.

The Board Discussed –

- Continuing Health Care – what is next regarding focus, themes and demand that are emerging in terms of demand. An area of focus is to continue to monitor high packages or care, ensuring that the right packages are commissioned whilst achieving good value for money.
- Rapid assessment and end of life resource – there are different models of end-of-life care with variation across the ICB footprint, some of which have utilised all age continuing health care funding to enhance end of life care.
- Conversion rates are higher than the national conversion, which could be due to the complexity and health outcomes across the system, or due to the expertise and experience approach to assessment. Areas of focus lie in good professional practice and good commissioning of packages of care. Support

from Executives would be welcomed to become more digitally enabled to support processes in all age continuing health care.

- The care assurance panel provides evidence of a robust decision-making process to commissioning packages of care and examines the clinical appropriateness, quality and costs. The weekly care assurance panel meets every Friday, attended by clinical, finance and contracting members of staff, where the clinician who has developed the case, presents to the panel. Of significance is the variation of payment when a patient requires one to one or enhanced levels of care, which affects both the ICB and the Local Authority, with a variation between £18 and £30 per hour for an enhancement. Clinicians are asked to carefully consider the cases presented, and what existing services already exist
- Concern about the significant impact all age continuing health care has on patients and staff, which is a key driver for the ICB's adverse finance position. The Board require further assurance that significant change will be identified for better outcomes for the patients served with value for money represented by financial expectation. The Chair thanked Alison Lee for leading the complex and difficult piece of work.
- All Age Continuing Care staff were thanked for continuing with this piece of work whilst going through management of change.
- Mental health packages of care – work is underway with Cheshire and Wirral Partnership and Merseycare for patients who are detained under the Mental Health Act on a Section 117, a rehabilitation package on discharge from hospital, to use their clinical expertise with the ICB and Local Authority colleagues to review packages of care and to review existing services.
- Welcoming further discussion with Local Authority and place-based partnerships, as cost pressures are also faced at Local Authority level, and not shifting cost pressures to another part of the system.
- The biggest impact can be sought through joined up commissioning with the larger providers who are contracted so that the weight of commissioning between nine Local Authorities and NHS Cheshire and Merseyside can enable better value for money. There are areas where legal framework of responsibility should be tested.
- The Chair of Finance Investment and Resource Committee has asked the Chief Executive for permission to undertake a deep dive of all age continuing health care at their October 2024 meeting with comprehensive documentation to allow for extensive scrutiny, which will then be reported back to the Board.

Action –

- **Alison Lee to bring a detailed recovery report on All Age Continuing Health Care to a future Board.**
- **A full report on All Age Continuing Health Care at the Finance Investment and Resource Committee meeting taking place in October 2024 to be brought to future board meeting.**

The Board Resolved to -
Note the updates as outlined within the report.

ICB/09/24/07 - NHS Cheshire and Merseyside Finance Report Month 4

The Executive Director of Finance provided an update to the Board to the end of month four for the whole system 2024 and highlighted the following key areas –

- At the end of month four the whole system reported a deficit of £138m, planned deficit was to be £99.5m, therefore are £38.5m away from plan. The month five position has continued with this trend.
- The ICB is £21m away from plan at month four and providers £17.5m away from plan.
- Actual financial position is tracked against the planned profile for the remainder of the year. The uptick of the plan is ambitious, with a significant amount of savings needed to be delivered on for the later part of the year, which the run rate is not demonstrating.
- The downward trajectory is concerning with no improvement between month three and four and no improvement of month four. There is also no improvement in month five.
- Drivers for the in-year position are the levels of efficiencies all providers and the ICB are planning for this year are behind, those that are delivered are delivering non-recurrently than planned. There is a £9m cost identified for providers for industrial action; funding allocation has been notified that will

cover some of the costs if industrial action from NHS England. Cheshire and Merseyside will receive £4.5m to support the cost. The pressures on continuing health care and mental health packages of care impact on patients and the significant increase of cost last year into this year, funded an outturn of £60m overspend last year and are seeing significant growth this year. The year to date overspend on mental health and CHC packages is £14.5m.

- Prescribing is showing early signs of overheating; prescribing data is received two months late.
- The ICB is in a national, high intensity financial recovery and support regime and has been subject to a number of external reviews into the financial arrangements within all of the sixteen providers. Recommendations of the review will be brought back to the next Board meeting in November 2024 along with actions to address the recommendations.
- The ICB and providers need to take critical action to correct the position to look at the current risk, with a gap of £63m to deliver the plan of £150m deficit. This is of concern to the ICB and regulators.
- Phase two of the support package will kick in around interventions with individual organisations, and support and intervention to the ICB in particular with CHC and mental health packages to identify quick actions to pull the budget back in line by the end of the year.
- A deficit plan of £150m nationally has been agreed and the urgency of actions to be undertaken are significant.

The Board Discussed –

- For assurance, the ICB suspended business as usual operations and decision making and placed on an emergency footing. A recovery committee has been established along with a number of recovery programmes focusing on taking actions to get costs under control. A number of budgets are ringfenced for certain areas and purposes as some services are demand led. The ICB will not commit another pound of expenditure where not legally obliged to do so, a report will be brought back to a future board meeting on the consequences and impact of this. Arrangements have been put in place for providers that require each provider to have specific controls in place, with some pan-system controls. For any non-clinical post above a certain paygrade, the organisation wishing to fill the post would come to a system wide peer review panel to determine if the post is essential to deliver either statutory duty, or to protect quality and safety of services. The ICB has a near complete vacancy freeze in place.
- The Recovery Committee taking into account a collaborative co-production approach with local government given concerns regarding cost shunting. The Chief Executive was clear that cost shunting is not the answer.
- Concern regarding missing £150m deficit control total. Recovery plans focussed on CHC, mental health and prescribing have not delivered. Need a handle on longer term service and financial strategy.
- The Chair summarised that the Board all share concern that the precarious position with regard to the delivery of the agreed plan. The Board do not remain assured that the ICB will deliver the position.
- The Chief Executive highlighted that the ICB will not seek to balance the budget at all costs, there is a threshold for the quality and safety of services that should never go beneath. Decisions are being made that take front line services in a difficult set of circumstances. The government have stated there will be no further funding for the NHS without reform. It is likely that the ICB will not get planning guidance, which sets the financial envelope for future years, until the last working day before Christmas. The ICB will set out its own planning guidance for all parts of the system in the context of a three-year recovery plan. Deficits must reduce year on year, every opportunity must be exploited to integrate services and remove duplication and there is a clear acceptance that the size of the hospital system should not grow further, and investment money must be in transformational services outside of hospital in primary, community and related settings. Work will be undertaken over the next month to set out a new framework for next year, which will be brought back to a future Board meeting.
- There is no relief from NHS England for costs outside of the ICB's control such as prescribing. The prescribing forecast for this year is an overspend of £14m.

Actions -

- The Director of Finance to provide an update to Tony Foy on the pressure of £7.7m in the prescribing budget and issues with no cheaper stock options.

The Board:

- Noted 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.
- Noted 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.

ICB/09/24/08 – Highlight Report of the Finance, Investment and Resources Committee

The Finance Director provided an update to the board on the Finance Investment and Resources Committee highlighting that the committee considered a number of procurement decisions ratified. A six-month review was undertaken of the financial and non-financial benefits of the in-housing of the Midlands and Lancashire Clinical Support Unit. The system strategy for infrastructure was reviewed.

The Board noted the content of the report.

ICB/09/24/09 – 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, The integrated performance report for September 2024 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.

- UEC - a further announcement of tiering has been made with a fresh focus on ED metric on the run up to winter. Cheshire and Merseyside will have approximately 15.5% of patients who will experience a wait of over twelve hours in an emergency department, compared with the England average wait of 8.6%. Support offered is mobilised from GIRFT and ESIS teams in the response to requests from organisations; clinical teams will be on site for the next twelve weeks.
- Ambulance repose times in Cheshire and Merseyside have improved and are improving year on year. The latest period shows delivery of the standard. There is minor improvement in year-on-year performance in 78%.
- Planned care – the objective of the elimination of 65 weeks by the end of the year, the primary aim was to complete by end of September 2024 and was impacted by industrial action earlier on in the year. It is expected that approximately 450 patients will have waited in excess of 65 weeks by the end of September.
- Diagnostic performance – waiting lists are now at the lowest level since the pandemic, and is half of what it was last year.
- Cancer performance remains strong with some challenges with the 28-day diagnostic standard for those patients who have experienced referral onwards into a tertiary centre. Overall, 62-day performance is where it is expected. Issues with 31-day standard at Liverpool Women's, the Cancer Network are providing wraparound support; this is expected to improve over the next few months and an expected recommendation of a reduced tiering support into Liverpool Women's as a result.

The Board Discussed –

- Methodology of measuring out of hospital services, whilst in some cases still being reliant on old Cerner data, where inputs and not outputs were measured. In some areas of the footprint, there are some community providers developing significant improvement in the use of information systems. There are projects supporting better data in primary care being undertaken looking at demand and supply for appropriate targeted investment.
- The development of an out of hospital and community strategy that describes the baseline. The strategy to be reflected in quality and performance monitor.
- Community and mental health services have a vast range of indicators and measurements in terms of waiting, urgent care treatment centres, district nurses and psychology etc. The development of an out of hospital and community strategy would be welcomed so that the whole issue of capacity can be assessed.
- What "Good" looks like and articulating into a strategy to measure progress.

- The need for principles around thinking through the best ways of integrating and developing models from a bottom-up approach, taking into consideration the different needs of the communities across Cheshire and Merseyside.
- Out of hospital services must be with the core principle of integration between all partners and with organisational principles.
- Healthcare associated infection – the ICB monitor hospital acquired infection, Place have quality schedules for each provider organisation and healthcare associated infection is a part of the schedule discussed at quality performance meetings. The Director of Nursing will ensure that the governance route for each of the provider organisations is clear and embedded within the quality schedule. How data is displayed also need to be looked into to understand normal variation in data. CMAST have commenced an ICB collaborative approach focusing on reducing C difficile toxin as a part of the efficiency at scale programme.
- Consistent antibiotic prescribing – harmonised formularies for out of hospital has come to pass with work being undertaken with Liverpool University on antimicrobial resistance.
- Infection prevention control processes and antimicrobial resistance will be discussed at next month's Quality and Performance Committee.
- Some elements of hospital acquired infection are due to overcrowding and corridor care.
- Cheshire and Merseyside are in the third quartile of indicators for performance.

The Board –

- **Noted the contents of the report and took assurance on the actions contained.**

ICB/09/24/10 – 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 -

- Issues with the Hospice of the Good Shepherd and Marie Curie in Liverpool, both of which had to close to admissions. The committee has requested a detailed assurance to outline the contractual oversight.
- Cheshire and Wirral Partnership – the committee looked at a recommendation due to the limited assurance received to date in the assurance process. The Trust should be moved from a rating of segment 2 to a 3, which has been approved by NHS England at a regional level. A system oversight group has been set up.

The Board discussed –

- How patient feedback and experience is included in the improvement plans. The Director of Nursing explained that patient feedback and experience was not explicit in the exit criteria.

Action –

- **The Director of Nursing to pick up patient feedback and experience not being explicit in the exit criteria with Trish Bennett outside of the Board meeting.**

The Board noted the content of the report.

ICB/09/24/11 – Consolidated Report of the ICB Place Directors

The St Helens and Knowsley 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 –

- Ruth Hussey, Non-Executive Director has visited Place-based partnerships in her role as Transformation Committee Chair.
- There is a focus across all teams on urgent care and financial recovery, at a local level and an ICB level.
- Thanks were placed on record to Deborah Butcher, Sefton Place Director for the work undertaken on the recovery cell after the Southport incident.

- Leadership on improving capacity in general practice continues, GP's are delivering more appointments than before the pandemic, with up to 70% of appointments face to face. There is a plan for further expansion of appointments across winter. Patient experience is being recorded, Healthwatch colleagues were thanks for supplementing the annual patient survey
- Patient experience in corridor care.
- Children and young people's mental health is a focus for a number of Places. Knowsley held a scrutiny meeting with Local Authority colleagues with support from voluntary sector colleagues.
- Health inequalities – Cheshire West are focussing on young people and mental health. Halton have a wellbeing bus. In Knowsley, severe mental illness is a contributing factor for people dying twenty years earlier. Work is underway in Liverpool around care communities across the Council and NHS using the data into action tool. St Helens inequalities commission chaired by the Chief Executive of the YMCA. Sefton are doing a lot of work on adverse childhood experiences.
- Patient flow and discharge – home first model predicated on people going home and reducing the number of people going into pathway 2 and 3. Halton have a focus around discharge information linking to UEC work.
- A piece of work is being undertaken across Cheshire and Merseyside where the Care Quality Commission is continuing its roll out of assurance visits to local authorities to present evidence of their interface with local NHS partners.
- A piece of work is being commissioned at no cost to the local authority looking at edge of care for children which will be tested out in St Helens, looking to roll out across Cheshire and Merseyside, possibly nationally.

The Board Discussed –

- The strength of relationships built and collaboration.
- Data that underpins the initiatives to look at impact.
- The tragic events in Southport and the ongoing ramifications and the lessons learned. Once the major incident as a whole system was stepped down through the resilience forum, Sefton Council stood up to lead the recovery cell. A bid has been put in to central government for additional resource to help business and community in the area, and services including health. Alder Hey and Mersey Care stood up immediately at risk to offer services. Wider reviews are not able to take place whilst criminal proceedings are ongoing. The Medical Director attended and supported a full day where a clinical team walked through minute by minute the journey of all thirteen patients. Outstanding care emerged. A formal report will be formulated and shared across trauma networks.
- Bringing local initiatives and out of hospital activity to the Boards attention.

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 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.

Committee AAA Report – Matters of Escalation and Assurance

ICB/09/24/12 – Highlight Report of the Chair of the ICB Audit Committee

The Chair of the ICB Audit Committee provided an update to the Board, highlighting that the executive risk committee was stepped down, the closure of last year's accounts and the putting in place of this year's plans. Information Governance services have changed from the CSU to MIAA.

The Board –

- **Noted the content of the report.**
- **Approved the amendments to the ICBs Operational Scheme of Reservation and Delegation.**
- **Noted the 2023-24 Annual Report of the Audit Committee.**

ICB/09/24/13 – 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, with no significant issues to highlight.

The Board noted the content of the report.

ICB/09/24/14 – Highlight Report of the Chair of the ICB System Primary Care Committee

The Chair of the ICB Remuneration Committee provided an update to the Board on behalf of the Chair of the System Primary Care Committee, highlighting that the work undertaken on the GP survey which will go back to a future committee meeting. Risks of collective actions and access to data sharing. Significant progress of the Primary Care Quality System Group covering all four contractor groups in in place and operating.

The Board noted the content of the report.

ICB/09/24/15 – 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 fabulous presentation from children and young people.

Action -

- **The Chair asked for the ICB to undertake work on further understanding the pros and cons of whether people who leave care, should be used as a protected characteristic in the same way that statutory protected characteristics are used. Chris Samosa to bring a report to November Board meeting.**

The Board noted and endorsed the content of the report.

ICB/09/24/16 – Highlight Report from the ICB Strategy and Transformation Committee

The Chair of the ICB Strategy and Transformation Committee provided an update to the Board, highlighting an issue escalated where the committee was asked to support funding familial hypercholesterolemia and CVD prevention services. In its Terms of Reference the committee is not authorised to make recommendations, which was therefore escalated to the executive team. The committee was held as a workshop looking at a basic strategy for Cheshire and Merseyside and discussed affordable models of care and what system leavers could influence change.

The Board noted the content of the report.

ICB Business Items and Strategic Updates

ICB/09/24/17 – Cheshire and Merseyside Urgent and Emergency Care Improvement Programme Update

The Director of Performance and Planning provided an update to the board on the Cheshire and Merseyside Urgent and Emergency Care Improvement Programme.

UEC challenges Nationally were recognised in September 2023 when NHS England launched its UEC tiering system, this was not undertaken in a way to critique systems, but to channel improvement resource as a supportive measure. This looked at a range of metrics across the UEC system such as ambulance response times, long wait in ED and occupancy levels. For Cheshire and Merseyside the most challenged systems were Liverpool and Warrington. The ICB asked for diagnostic support from Newton who provided the output of the diagnostic work in Spring 2023. This work provided clarity on the factors of how the UEC system was panning out across the sectors and developed a level of ownership of where issues stood and how they could be collectively addressed. A number of engagement sessions were held with providers looking at rolling this out through the system. One output was to have the improvement programme based around primarily the provider footprint.

There are now five locality programmes with five Place Directors as the SRO's as conveners of the systems, with five cross cutting at scale programmes including ambulance improvement.

Nine metrics were drawn up across the entire urgent care system leading to a north star metric of the elimination of corridor care. A plan has been built with impact expected for each of the five localities. There has not been a massive change in today's delivery, a plan is in place to take to a very different position to last year. There are some individual areas where there has been progress, Wirral has made a significant inroad in terms of the number of patients that are ready for discharge but still residing within the hospital, which has sustainably reduced. Work has been undertaken in Liverpool on the discharge interface.

The system is in the best place in terms of governance ownership and objectives, however there is not a huge difference in delivery today, some of which is due to plans not being geared to delivery from September onwards. There are no winter monies, so the solution has to be for the system to use the strength of its governance and the developed plan. The ICB govern this through the performance committee and the dual role of Cheshire and Merseyside UEC improvement group. The Chief Executive and Director of Performance and Planning have sessions with each of the five localities to run through the risks, progress and forward plan.

Sentinel metrics within the board report will be changed and some of the delivery will inform the information coming through from the system pressures bulletin shared weekly, which is due to be reinstated as we head into winter.

The Board discussed –

- Supporting the redline toolkit that was developed in Cheshire and Merseyside and continue to focus the audit of the usage to support eliminating corridor care. The toolkit will be used as an audit proforma at quality visits. Healthwatch are keen to use toolkit as a part of their ED visits over the winter.
- Sentinel metrics – should there be information on re-admission rates on the discharge pathway. Within each programme there are wider indicators, of which readmission is one.
- Corridor care – is unprecedented and a redline that has been crossed, however is a big figure to shift and the longer a patient is on corridor care the larger a package of care could be on discharge.
- Would be useful for the Board to have month on month oversight of the redlines crossed and what this means for the individual.
- Whilst labelled an urgent care issue, this is a whole system issue directly linked to financial pressures, and one symptom of a wider challenge giving rise to cost pressures both in local government and the NHS.

The Chair summarised that the Board strongly supported this piece of work and gave good challenge to ensure the board understands quality, bringing it to life through patient stories.

Actions-

- **Anthony Middleton to explore patient experience and quality as a part of sentinel metrics.**

The Board –
Noted the contents of the report for information and continued to oversee the impact of the UEC Recovery Programme in delivering performance improvement across the UEC pathway across Cheshire & Merseyside.

ICB/09/24/18 – Cheshire and Merseyside Health Infrastructure Strategy

The Director of Finance introduced the Cheshire and Merseyside Health Infrastructure Strategy to the Board and welcomed James Burchall to the meeting. The draft Cheshire and Merseyside Health Infrastructure Strategy is due for submission to NHS England. The estates strategy came into fruition in March 2024 and is a ten-year aspirational strategy to pull all NHS assets and estates into one document.

The key functions are where are we now, where do we want to be and how will we get there. The strategy has a number of people involved including directors of estates, mainly from acute trusts involved along with contributions from community care, with comments from the ICB. There are nine strategic estates groups that support Place in the decisions. Contribution from Primary Care has been made through work undertaken regarding PCN, clinical and estates strategies.

Key pieces of work are governance and establishing the strategic estates board, which will be taking place in October, to look at the development framework and push back to strategic estates groups. The risk of a poorly utilised / poor estate and how this is impacts on clinical strategies.

The Board Discussed –

- Local authority assistance with the strategy, local government has a mission-based approach to government policy; to include growth and development with attendance from growth directors from local council at strategic estates board.
- Section 106 is a development agreement from the town and planning act 1954 where developer contributions towards assets, of which health is a component. The ICB interacts closely with the planning department of each council who advise of developments of 10+ houses. The ICB will put a requirement in for NHS monies to contribute to NHS services. NHS property services are employed to give guidance on housing developments of in excess of 200+. Contributions are tied in to the build rate of houses.
- LIFTCo concessions – progress is being made with CHP, the main LIFTCo provider, ending in the next six years. This will be highlighted in the infrastructure strategy and conversations have started with central estates team at NHS England.
- The ICB plan links with the ICS plan, how do we make one public estate whilst supporting primary care contractors.
- Aligning closely with the sustainability board and opportunities for the net zero agenda.
- Opportunities for efficiencies and better shared spaces for public, working with other public agencies and local / neighbourhood areas such as and job centres and libraries, for local conversations at a place level. Local authority representatives are invited to each place strategic estates group and voluntary sectors are encouraged to attend. Options such as Citizens Advice in GP practice is being explored.
- Design services with users in mind for all sectors of the community.
- The estates strategy is iteration one for submission to support NHS England requirements, which has a specific scope. A huge amount of work will be needed to develop the implementation plan and move into the next iteration of the strategy.
- Productivity – feedback received is that the point on productivity is not strong enough, it is described as financial sustainability. The Director of Finance will make adjustments to the productivity in the strategy and gain assurance from the Chair before submission.
- PFI & equipment – the ICB does not have a capital and revenue plan, this will be part of the implementation plan. Multiyear capital allocations are expected in Spring 2025 which will support some of the work undertaken.
- The strategy is ambitious and has not yet been costed, however is a baseline.

The Chair summarised that it is misleading to call the document a strategy at this moment in time, it is a work in progress document that will inform the strategy. It is important for the ICB's statutory obligations to include to social value. The Chair would like this to be called something other than a strategy. The Governance arrangements of the strategic estates group and who will chair, and its reporting arrangements need to be made clear.

The Board –

- **Noted the content of the report.**
- **Recommended changes to the report to enable the submission of a document to NHS England with the caveat of a stronger section on driving productivity. For submission to NHS England once approved by the ICB Chair.**

ICB/09/24/19 –Cheshire and Merseyside Children and Young Peoples Elective Wait Recovery; Accelerated Delivery Proposal

The Director of Performance and Planning provided an update to the Board on the Cheshire and Merseyside Children and Young Peoples Elective Wait Recovery Accelerated Delivery Proposal highlighting an ambitious timeline to reduce waits for children and young people with a return to the NHS constitutional standards around eighteen weeks by no later than September 2025.

Long waits for children can have a significant consequence in terms of development. There are at least 1400 patients in Cheshire and Merseyside of a young age who are waiting in excess of 52 weeks. This is made up of half on secondary care waiting lists and half on the tertiary centre of Alder Hey. A timescale of resolution is likely to be March 2027.

CMAST have worked up engagement with providers to understand the art of the possible and have developed a proposed timeline to see a return to constitutional standards no later than September 2025. Waits in secondary providers can be eliminated by spring 2025 with elimination across tertiary with the same September timescale.

10% more work beyond core hours is required to get progress already seen to date, which will mean a further 10-20% dependent on provider over the next twelve months. This will equate to an approximate £4m of additional costs to the system, recovered as a part of ERF arrangements already in place, dependant that activity is provided within tariff. There are productivity and efficiency improvements that could be achieved in some units, particularly paediatrics. The proposal will have no financial consequence but will have a welcomed impact for patients.

If acceptable to the Board, individual performance trajectories will be developed and built into performance arrangements linked to board reporting

The Board Discussed –

- Funding – elective recovery funding is directly related to elective recovery activity as a system. The more elective activity is undertaken, the more funding is received from NHS England. If investment is needed to incrementally increase capacity, provided it is undertaken with tariff, it would not worsen the financial position.
- Looked after children – the cut off age is 18, could it be considered for care leavers extending the age to 25. The Director of Performance and Planning confirmed that this can be applied.

The Chair would like this to be looked at again, and be more ambitious about reducing the long waiting times for children, meeting constitutional standard interpreted by the ICB at 92% at eighteen weeks. A child of five years of age waiting a year to be seen can have a significant impact on the child's outcome for years to come. Capacity is already stretched at 10%, and will take it to 20% for a period of time

Action –

- **To be brought back to November 2024 board meeting for further discussion and updates from the Director of Performance and Planning.**

The Board –

- **Considered the 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.**
- **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.**

ICB/09/24/20 – Cheshire and Merseyside Annual Business Plan

The Deputy Chief Executive presented to the board the annual plan which collates and provides details of the delivery plans from key organisational documents, the 24-29 joint forward plan including the NHS

delivery plan and operational finance and workforce plans. It reflects the Health Care Partnership plan and priorities which are hoped to be signed off on 1st October 2024. The annual plan describes what is needed to deliver local and national priorities and the responsibilities of the ICB. This also provides assurance of how the ICB will meet its requirements under the NHS oversight and assessment framework. A new framework is due for publication shortly.

The annual plan focusses on the areas the ICB is responsible for and includes key areas for 2024 / 25 recovery programme. The plan is built around the four strategic objectives of the ICS which the ICB have adopted which are improving outcomes in population health care, tacking health inequalities, enhancing productivity and helping the NHS support social and economic development.

The table provided in the report will be used to monitor ongoing progress against each of the identified outcomes. The plan has been reviewed by corporate executives and separate meetings with the Chair, Chief Executive and Director of Finance.

The Chair thanked Stephen and his team for the work that was put into the document. This is an internal document for the board to determine what is delivered and fulfils an important gap in assurance and enables the ICB to have one place to inform the performance report and will evolve over time.

The Board –

- **Approved the attached NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan.**
- **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 1st October 2024. Copies of the final documents will be shared with the ICB Board as soon as they are available.**

ICB/09/24/21 – Cheshire and Merseyside Population Health Update

The Director of Population Health provided a population health update to the board. The key highlights of the programme are –

- Pillar 1 - altogether fairer social determinants of health, primary prevention and tackling the causes of ill health. This is undertaken with local authority partners, community sector and business partners.
- Pilar 2 - supports healthier behaviours to help reduce harm from alcohol, tackle smoking and improve healthy weight,
- Pillar 3 – health care inequalities.
- Pilar 4 – screening and immunisation.

Prevention helps to reduce the demand on health care services and collective investment is required. Most of the benefits seen from national government policies such as the smoking ban, alcohol strategy and vaping ban have had major changes in improving population health. Since 1992 every government has identified obesity as a major health issue.

A population health alliance has been established bringing together NHS and wider local authority staff as a part of a network and peer support for prevention promotion. The CHAMPS collaborative work with the nine local authorities. The third sector have won a prestigious award with the cancer alliance. Data into action is crucial, a population health academy has been established working with colleagues from the innovation agency. 150 analysists from the NHS, local authority, fire, police and housing have come together with the university as part of a development programme.

Child poverty is significant with regards to the priorities of the health care partnership; there are approximately 100,000 families living in poverty in Cheshire and Merseyside. All trusts are signed up to the prevention pledge. The cancer alliance have undertaken training on health inequalities aimed at cancer patients which is a validated tool and could be rolled out to all areas.

The link between lung cancer and smoking is well established, through the work undertaken through targeted lung health checks, people have higher risks for CVD and shows the importance of outreach and what can be done. The Director of Population Health and The Chair visited the live well bus in Aintree; cervical smears have now been introduced on the live well buses.

The Board Discussed –

- Congratulated the Director of Population Health and his team on the huge achievements.
- The scale of the inequality challenge and poor health and the impact needed to turn the dial.
- Vaccination and screening - being ready and equipped to undertake the huge programmes of work. Delegated services have been received from NHS England for a number of services, community pharmacy, dental, optometry and specialised services, and are due a further 29 specialised services in April 2025. Screening and immunisation will be received in April 25, due diligence will be undertaken before services are taken on.
- The ICB has four strategic priorities, population health and health inequalities touches all of them.
- Smoke free is the key priority for the coming year.

The Board –

- Noted the progress of the Population Health Partnership and provided comment on any spotlight areas to receive in the future.
- Agreed to receive a population health state of the nation report twice a year.

Meeting Governance

ICB/09/24/22 – Minutes of Previous Meeting

The Board reviewed the minutes of the meeting held on 25th July 2024. The minutes of the NHS C&M ICB Board meeting of 25th July 2024 were approved as an accurate record of the meetings.

ICB/09/24/23 – 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.

- Right care right place – The Chief Executive to clarify end date.

Any Other Business

ICB/09/24/24 – 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/09/24/25 – 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 26th September 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/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

CLOSE OF MEETING

Date of Next Meeting:
28th November 2024, 09:00am, Churchill Building, Queen's Park, Queen's Park Road, Chester, CH4 7AD

NHS
Cheshire and Merseyside

Extraordinary Meeting Held in PUPLIC of the Board of NHS Cheshire and Merseyside

Liverpool 1 Suite, Holiday Inn, Lime Street, Liverpool, L1 1NQ

Wednesday 9th October 2024, 9:00am – 10:45am

Unconfirmed Draft Minutes

ATTENDANCE	
Name	**Role**
Members	
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, 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)
Ann Marr, OBE	Partner Member – NHS Trust (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof. Hilary Garratt, CBE	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Dr Naomi Rankin	Partner Member - Primary Care (voting member)
Andrew Lewis	Partner Member – Local Authority (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Trish Bennett	Partner Member – Local Authority (voting member)
Steve Broomhead	Partner Member – NHS Trust (voting member)
In Attendance	
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (Regular Participant)
Rev Canon Dr Ellen Loudon	Vice Chair, Cheshire and Merseyside Health and Care Partnership
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)
Sarah Thwaites	Chief Executive, Healthwatch
Jennie Williams	(Minutes) Senior Executive Assistant, Cheshire & Merseyside ICB
Lyn Greenhalgh	Chief Medical Office, Liverpool Women's Hospital
James Sumner	Chief Executive, Liverpool University Teaching Hospital & Liverpool Women's Hospital

Clare Powell	Programme Director, Liverpool Women's Case for Change
Dianne Brown	Chief Nurse, Liverpool Women's Hospital
Alison Lee	Knowsley Place Director, Cheshire and Merseyside ICB
Mark Bakewell	Liverpool Place Director, Cheshire and Merseyside ICB

Apologies	
Name	**Role**
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (Regular Participant)
Warren Escadale	Chief Executive, Voluntary Sector North West (Regular Participant)
Claire Wilson	Executive Director of Finance, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member – Primary Care (voting member)
Christine Samosa	Director of People, Cheshire & Merseyside ICB (Regular Participant)

Agenda Item, Discussion, Outcomes and Action Points
Preliminary Business
ICB/10/24/01 - Welcome, Apologies and Confirmation of Quoracy
All present were welcomed to the meeting and advised that this was a single agenda item meeting held in public. The meeting was declared quorate. Apologies for absence were noted as above.
ICB/10/24/02PV - 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 item.
ICB Business Items
ICB/010/24/04 – Gynaecology and Maternity Hospital Services in Liverpool - Case for Change
The Director of Nursing and Care and Associate Medical Director introduced the Gynaecology and Maternity Hospital Services in Liverpool - Liverpool Case for Change. The Women's Hospital Services in Liverpool programme was established to address the challenges and clinical risks in hospital-based gynaecology and maternity services in Liverpool. The development of the case for change is the first stage which sets out the challenges and the main reasons for change. Proposals or solutions are not being provided and no decisions have been made. The historical significance of Liverpool Women's Hospital is recognised, as is the love the people of Liverpool have for the hospital, along with the amazing work the staff do every day to ensure it is a safe place for women and their babies; this is a priority for the ICB. It is not only the people who identify as women who use women's health services; trans men and non-binary individuals assigned female at birth also access services. Each year nearly 30,000 procedures are performed and around 7500 babies are delivered. Staff are passionate about the care that they provide. Liverpool Women's Hospital has previously had three different locations, the latest being on Crown Street which was opened by Princess Dianna in 1995. In recent years the service has been the focus of national

policy and independent investigations, the most recent policy for maternity care as set out in the three-year delivery plan which is focused on four key areas. In 2023 Liverpool Women's Hospital was inspected by the Care Quality Commission and gave an overall rating of "requires improvement", with a programme of work undertaken to address. There were examples of positive feedback including gynaecology services, which received an overall rating of good.

The NHS is committed to providing services from Crown Street, which is a vital part of the local health system and will not be closing. £5m has been invested on the site to establish a centre for gynaecology services which will open in Spring 2025. Crown Street hosts a community diagnostic centre which has delivered improved access for scans and tests.

Subject to the Board's approval, a widescale programme of engagement will commence working with partners, stakeholders and members of the public.

The Board were shown a video of a clinician story from Liverpool Women's Hospital.

In 2022, NHS Cheshire and Merseyside ICB commissioned the Liverpool Clinical Services Review which looked at how hospitals in Liverpool could work better together to improve care and outcomes for patients. Resolving the challenges that faced the Women's hospital services in the city was one of three urgent priorities identified. The ICB's response was to set up the Women's Services Committee which reports to the ICB Board; the role of the committee is to oversee the development of safe and sustainable future model of care for women's services. The Programme Board will develop and deliver the work to achieve this. The Programme Board is led by providers in the city – Alder Hey, Clatterbridge Cancer Centre, Liverpool University Teaching Hospital and Liverpool Women's hospital. The programme board reports into the Women's Services Committee and the public boards of each constituent providers.

The Programme Board has led the development of the case for change by talking to clinicians from across the city alongside engagement with stakeholders. The draft case for change was accepted by the Women's Services Committee on 13th September 2024 and the committee recommend to the Board that it approves the case for change.

A programme of work has been set up specifically looking at hospital based gynaecology and maternity services in Liverpool with a very specific scope looking at just hospital services. Out of hospital women's services are being looked at within other pieces of work. Most hospital gynaecology and maternity care that happens in Liverpool, happens at Liverpool Women's Hospital, separately from other hospitals. This care includes specialist tertiary care. Liverpool is the only place in the country where specialist and tertiary maternity and gynaecology services are delivered on a site that is not co-located with other emergency services.

The new case for change is more developed, includes additional data and considers outside of the walls of Crown Street in providing services for women across all hospitals in the city. The case for change deliberately does not provide proposals or potential solutions. The next phase will be design, looking at clinical models of care, and an options appraisal which will be undertaken with other hospitals in the city, stakeholders, patients and the public.

The majority of patients who use Liverpool Women's Hospital come from North Mersey, predominantly Liverpool, with significant numbers from Sefton and Knowsley for both maternity and gynaecology services.

Main headlines from the case for change are that Liverpool Women's Hospital provides most of the care, and is geographically isolated from other hospitals, meaning that the hospital is less able to manage acutely ill or rapidly deteriorating patients, those with complex surgical needs, or those with significant other medical co-morbidities, which is the first significant risk to address. The acute, emergency and specialist services are predominantly located in the Royal Liverpool and Aintree Hospitals, meaning patients who need those services are transferred by ambulance, often when at their most vulnerable.

Liverpool Women's Hospital is isolated from other hospital services, when a critically ill woman is transferred distance is not the only issue, the process of arranging the transfer can often take an entire shift to facilitate safely. Clinicians are also taken away from their work during a transfer causing delays in procedures and care for other patients, impacting on the quality of care, delays, clinical outcomes of patients and patient experience. There is increasing evidence of psychological harm with significant impacts on patients. Staff are experiencing stress and moral injury by providing care in a setting that they know is not the optimum for their patients. There is significant evidence of general inequality, highlighted by the independent equalities review undertaken on the case for change. Services for men are not arranged in this way when they are having surgery for cancer. Pregnancy is a protected characteristic, and services are not being provided that best protect this vulnerable group. In Cheshire and Merseyside there are significant issues with inequalities, data has shown that those women who are most likely to end in a critical care transfer or present to A&E in another part of the city are most likely to be from a socially deprived background or an ethnic minority background.

The Five Overarching Risks are –
Risk 1 - Acutely deteriorating women cannot be managed on site at Crown Street reliably, which has resulted in adverse consequences and harm.
Risk 2 - Women presenting at other acute sites (e.g. A&E), being taken to other acute sites by ambulance, or being treated for conditions unrelated to their pregnancy or gynaecological condition at other acute sites, do not get the holistic care they need.
Risk 3 - Failure to meet service specifications and clinical quality standards in the medium term could result in a loss of some women's services from Liverpool.
Risk 4 - Recruitment and retention difficulties in key clinical specialties are exacerbated by the current configuration of adult and women's services in Liverpool.
Risk 5 - Women receiving care from women's hospital services, their families, and the staff delivering care, may be more at risk of psychological harm due to the current configuration of services.

Over 2000 women who are pregnant or have had gynaecological conditions present at A&E's in Liverpool. It is felt that these women are not getting the wraparound care that they need. From 2018 – 2022, there were 69 episodes of critical care transfers from Liverpool Women's to the Royal, with another 12 who had anaesthetists who attended the transfer. There were 150 clinical incidents over a 21-month period from clinicals who felt the incident was due to being on an isolated site. Each year there are approximately 220 ambulance transfers between the women's and the Royal or Aintree Hospitals which are either category 1 or category 2 transfers.

The population of Liverpool has changed since the Liverpool Women's Hospital opened in 1995. Complex health needs managed alongside pregnancy require an increasing amount of support. When the Women's first opened, approximately 25% of women were aged over 30 when they had their first child, it is now approximately 50%. Approximately 60% of women booked onto maternity pathways have intermediate or intensive pathways. Only 14% are eligible for delivery on the midwifery led unit. Demand for gynaecological services is increasing as women are living longer. Cancer rates have been rising due to changes in lifestyle and diet, and better screening.

If patients are transferred to other hospitals, senior doctors will attend to ensure the patient is safe during transfer. The teams in the Liverpool hospitals work closely together to share knowledge, training and resources, looking at bespoke care pathways for maternity and gynaecological patients with complex care needs. There is a weekly joint operating list at the Royal Liverpool Hospital for complex gynaecology operations.

The biggest safety issue is not being on the same site as other services who provide surgical and medical support. If not addressed, the avoidable risk for women who require co-located services will continue to grow as co-morbidities and complexity of cases increase. There are worries that staffing will worsen, and services will become more difficult to staff safely. The way in which some services are currently arranged means that national care standards are not met, if not addressed there is a risk that services will be lost from Liverpool.

Although issues around women's hospital services in Liverpool have been discussed in the past, this is a new process, focussed on the problems as they stand today. The purpose of the clinical case for change is to set out the key risks and challenges facing hospital gynaecology and maternity services in Liverpool. In May 2024, 70 people including clinicians, managers and people with lived experience, attended an event to discuss the draft case for change. The draft case for change was then shared with NHS partners and wider stakeholders to seek their support and gain their feedback, the final draft reflects the feedback received.

Diagnostic capacity is still required for the patients of Liverpool, Liverpool Women's Hospital is an excellent building to provide this service from. The ICB are committed to NHS delivered services being delivered from the Crown Street site. There are no plans to discuss any other services going in to this site.

If approved, next steps will be a six week public engagement, called Improving Hospital Gynaecology and Maternity Services in Liverpool which will launch on 15th October 2024. Views on the case for change will be gathered, asking what is missing from the case for change, for experiences on the care they have received and what they want from services in the future. The public will not be asked about proposals for the solution. There will be online and printed material explaining the case for change, a questionnaire and a number of engagement events both online and in person, in Liverpool, Sefton and Knowsley and at different times of the day. Funding is being provided to voluntary sector organisations to engage directly with specific groups. All feedback will be submitted into a report which will be published early in 2025 to inform the next stages of the programme.

A lived experience panel has been established who have met twice; 30% of the women are from a non-white background, it is hoped for engagement with a broader representation as possible. A virtual reference group and a dedicated website have been set up. Design work will be commenced taking onboard feedback received from the engagement period. Phase 2 will be mid-2025 looking in detail at the design, talking to clinical colleagues and the lived experience panel about potential solutions to the problem. This will then go to options appraisal and detailed modelling.

For Board to discharge their duties, an equalities analysis has been undertaken. The case for change has been taken through NHS England's assurance process who have accepted and approved the case for change, meaning continuation into the next phase. The case for change has been taken through the clinical senate for an independent clinical review. The Women's Services Committee signed off plans for engagement.

The Board discussed –

- The emotion behind any NHS change, and public views being expressed in future board reports.
- Personal experiences of Board members and the care they received at Liverpool Women's Hospital, and providing the best possible care for the women of Liverpool.
- There is no intention of introducing any more private provision into the NHS locally, including at the Crown Street site.
- Concerns about the future of Liverpool Women's Hospital if changes are not made.
- The specialist focus on maternity and gynaecology services provided in a place that puts women and children first. The unique status of the Crown Street site for people of the city of Liverpool.
- Positive options for consultation as soon as practical.
- Paying tribute to staff at Liverpool Women's Hospital who work to deliver the best care possible and to resolve and mitigate may risks identified in the case for change.
- NHS England and ICB releasing additional investment if required, to address the risks identified in the case for change.
- Retaining the confidence of the public about the ICB's and the NHS's intentions.
- Retaining the name of Liverpool Women's Hospital within the configuration of services is important for the community.

- Liverpool City Council look forward to contributing and supporting a successful consultation process and will work with the NHS to make sure all of the communities in Liverpool are fully engaged.
- Ensuring that during the engagement process those women and communities who are most disadvantaged, are actively sought out.
- Commitment to developing futureproofing of services understanding what the women of Liverpool need in the future, with a clear emphasis through the lived experience panel, that coproduction will be integral to the process of identifying what is required in the future.

The Board -

- Approved the final draft case for change.
- Approved the commencement of a six-week period of public engagement on the case for change alongside the additions of co-production.

Any Other Business

ICB/10/24/05 – Closing Remarks

The Chair thanked Board members for their continued contributions and support.

CLOSE OF MEETING

Date of Next Meeting:

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

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2023 - 2025

Updated: **21.11.2024**

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	Update in November CEX Report 2024	COMPLETED	Board is asked to approve closure of action
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	tbc		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	Q&P Committee have approved a number of changes to the Integrated Performance Report as part of a structured expansion to the overall report, future iteration will look to include other metrics subject to data quality, availability and clear objective	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	Deferred to January 2025 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	CO and TF have met and agreed to ensure that there is a Patient Safety sub-section of the iCBs Clinical Strategy	COMPLETED	Board is asked to approve closure of action
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	On the November 2024 Board Agenda	COMPLETED	Board is asked to approve closure of action

Action Log 2023 - 2025

Updated: **21.11.2024**

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	Incorporated into the report to November 2024 Board	COMPLETED	Board is asked to approve closure of action
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	Jan-25	Annual Reporting cycle being developed.	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 January 2025 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	Answers to be circulated to Board members following November 2024 meeting	ONGOING	
ICB- AC-21-65	26/09/2024	**Report of the ICB Chief Executive**	The Medical Director to discuss under 18's being members of the Data into Action Patient Advisory Group to input into public advisory work at the Data into Action Board, and report to the ICB Chair.	RPJ	Nov-24	Update sent to the ICB Chair from RPJ	COMPLETED	Board is asked to approve closure of action
ICB-AC-21-66	26/09/2024	**Report of the ICB Director of Nursing and Care**	Alison Lee to bring a detailed recovery report on All Age Continuing Health Care to a future Board.	AL	Jan-25		ONGOING	
ICB-AC-21-67	26/09/2024	**Report of the ICB Director of Nursing and Care**	A full report on All Age Continuing Health Care at the Finance Investment and Resource Committee meeting taking place in October 2024 and update to be brought to November Board meeting	CD	Nov-24	Summary contained within FIRC Chairs Report to November Board	COMPLETED	Board is asked to approve closure of action
ICB-AC-21-68	26/09/2024	**NHS Cheshire and Merseyside Finance Report Month 4**	The Director of Finance to provide an update to Tony Foy on the pressure of £7.7m in the prescribing budget and issues with no cheaper stock options.	CWI	Nov-24	Deep dive undertaken at FIRC around prescribing which provided further detail	COMPLETED	Board is asked to approve closure of action

Action Log 2023 - 2025

Updated: **21.11.2024**

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-21-69	26/09/2024	**Highlight Report of the Chair of the ICB Quality and Performance Committee**	The Director of Nursing to pick up patient feedback and experience not being explicit in the Oversight exit criteria with Trish Bennett outside of the Board meeting.	CDO	Nov-24	Meeting to be arranged	ONGOING	
ICB-AC-21-70	26/09/2024	**Highlight Report of the Chair of the ICB Children and Young Peoples Committee**	The Chair asked for the ICB to do some work on further understanding the pros and cons on whether we should use people who leave care, as a protected characteristic in the same way that statutory protected characteristics are used. Chris Samosa to bring an update to a future Board meeting	CSA	Jan-25	Work has been undertaken and an update will come to Board in January 2025	ONGOING	
ICB-AC-21-71	26/09/2024	**Cheshire and Merseyside Urgent and Emergency Care Improvement Programme Update**	Anthony Middleton to explore patient experience and quality as a part of sentinal metrics.	AMI	Jan-25	Q&P Committee have approved a number of changes to the Integrated Performance Report as part of a structured expansion to the overall report, future iteration will look to include other metrics subject to data quality, availability and clear objective	ONGOING	
ICB-AC-21-72	26/09/2024	**Cheshire and Merseyside Children and Young Peoples Elective Wait Recovery; Accelerated Delivery Proposal**	Cheshire and Merseyside Children and Young Peoples Elective Wait Recovery; Accelerated Delivery Proposal to be discussed at November 2024 meeting with further updates from AMI	AMI	Nov-24	Moved to January 2025 meeting	ONGOING	

Meeting of the Board of NHS Cheshire and Merseyside

28 November 2024

Agenda Item No: ICB/11/24/28

Confirmed Minutes of ICB Committees

Click on the links below to access the minutes:

- Finance, Investment and Our Resources Committee – October 2024 (**CLICK HERE**)
- Health and Care Partnership – July 2024 (**CLICK HERE**)
- Quality and Performance Committee – September 2024 (**CLICK HERE**)
- Quality and Performance Committee – October 2024 (**CLICK HERE**)
- Women's Hospital Services In Liverpool Committee – 2024 (**CLICK HERE**)
- Strategy & Transformation Committee – September 2024 (**CLICK HERE**)
- System Primary Care Committee – 2024 (**CLICK HERE**)