Thursday 27 April 2023
09:00am-11:40am
Boardroom, The Department, Lewis's Building,
2 Renshaw Street, Liverpool, L1 2SA

NHS
Cheshire and Merseyside

Meeting of the Integrated Care Board

Agenda

Chair: Raj Jain

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

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
09:00am	**Preliminary Business**			
ICB/04/27/01	Welcome, Introductions and Apologies • confirmation of quoracy	Chair	Verbal	-
ICB/04/27/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the Board Member Register of Interests). Register of Interest available at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/*	Chair	Verbal	-
ICB/04/27/03	Minutes of the previous meeting: • 30 March 2023	Chair	Paper Approval	Page 3
ICB/04/27/04	Board Action Log	Chair	Paper For note	Page 25
ICB/04/27/05	Board Decision Log	Chair	Paper For note	Page 31
09:10am	**Standing Items**			
ICB/04/27/06	Chairs Announcements	Chair	Verbal	-
ICB/04/27/07	Report of the Chief Executive	GPU	Paper For note	Page 34
ICB/04/27/08	Resident / Staff Story	-	Presentation For note	-
09:30am	**ICB Key Update Reports**			
ICB/04/27/09	Executive Director of Nursing & Care Update Report	CDO	Paper For noting	Page 47
ICB/04/27/10 **09:40am**	Cheshire & Merseyside System Month 12 Finance Report	CWI	Paper For noting	Page 53
ICB/04/27/11 **09:50am**	Cheshire & Merseyside ICB Quality and Performance Update Report	AMI	Paper For noting	Page 69
10:00am	**ICB Business Items**			
ICB/04/27/12	Intelligence Into Action: Continued provision of ICS digital and data platforms	RPJ	Paper For approval	Page 121
ICB/04/27/13 **10:30am**	ICB Board Assurance Framework Quarter 1	CWA	Paper For approval	To follow
ICB/04/27/14 **10:45am**	NHS Cheshire and Merseyside ICS NHS Staff Survey 2022-23: Results and Actions	CSA	Paper & Presentation For noting & endorsement	Page 154

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
ICB/04/27/15 **11:05am**	Briefing on the national maternity and neonatal services delivery plan	CDO	Paper For Information	Page 175
11:15am	**Sub-Committee Reports**			
ICB/04/27/16	Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee	TFO	Paper For noting	Page 263
ICB/04/27/17 **11:20am**	Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee	TFO	Paper For noting	Page 270
ICB/04/27/18 **11:25am**	Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Resources Committee	EMO	Verbal For noting	-
11:30am	**Other Formal Business**			
ICB/04/27/19	Closing remarks, review of the meeting and communications from it	Chair	Verbal	-
11:40am	**CLOSE OF MEETING**			

Date and time of next meeting:
25 May 2023 09:00am Civic Center, Civic Way, Ellesmere Port, Cheshire, CH65 0AZ
A full schedule of meetings, locations, and further details on the work of the ICB can be found here: www.cheshireandmerseyside.nhs.uk

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

Speakers

AMI	Anthony Middleton, Director of Performance and Planning, C&M ICB
CDO	Christine Douglas MBE, Director of Nursing and Care, C&M ICB
CSA	Christine Samosa, Chief People Officer, C&M ICB
CWA	Clare Watson, Assistant Chief Executive, C&M ICB
CWI	Claire Wilson, Executive Director of Finance, C&M ICB
EMO	Erica Morriss, Non-Executive Director, C&M ICB
GPU	Graham Urwin, Chief Executive, C&M ICB
RPJ	Professor Rowan Pritchard-Jones, Medical Director, C&M ICB
TFO	Tony Foy, Non-Executive Director, C&M ICB

NHS
Cheshire and Merseyside

Integrated Care Board Meeting held in Public

Held at Boardroom, The Department, Lewis's Building,
2 Renshaw Street, Liverpool, L1 2SA
Thursday 30 March 2023
09.00am to 12.00pm

The Board meeting was recorded and available to watch at:
https://www.youtube.com/live/Bxnyg9FNE1w?feature=share

UNCONFIRMED Draft Minutes

MEMBERSHIP		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB **(voting member)**
Graham Urwin	GPU	Chief Executive, Cheshire & Merseyside ICB **(voting member)**
Claire Wilson	CWI	Executive Director of Finance, Cheshire & Merseyside ICB **(voting member)**
Christine Douglas MBE	CDO	Executive Director of Nursing and Care, Cheshire & Merseyside ICB **(voting member)**
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
Neil Large MBE	NLA	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
Hilary Garratt CBE	HGA	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
Ann Marr OBE	AMA	Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust **(voting member)** (up to item ICB/02/23/13)
Adam Irvine	AIR	Partner Member, Chief Executive Office, Community Pharmacy Cheshire and Wirral (CPCW**) (voting member)**
Dr Naomi Rankin	NRA	Partner Member, Primary Care (GP) Partner Member **(voting member)**
Prof. Steven Broomhead MBE	SBR	Partner Member, Chief Executive, Warrington Borough Council **(voting member)**
Councillor Paul Cummins	PCU	Partner Member, Cabinet Member for Adult Social Care, Sefton Council **(voting member)**
Prof. Joe Rafferty CBE	JRA	Partner Member, Chief Executive Office, Mersey Care NHS Trust, **(voting member)**
Prof. Rowan Pritchard-Jones	RPJ	Medical Director, Cheshire & Merseyside ICB **(voting member)**
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
IN ATTENDANCE		
Dr Fiona Lemmens	FLE	Associate Medical Director, Cheshire & Merseyside ICB **(Regular Participant)**

Christine Samosa	CSA	Director of People, Cheshire & Merseyside ICB **(Regular Participant)**
Clare Watson	CWA	Assistant Chief Executive, Cheshire & Merseyside ICB **(Regular Participant)**
Matthew Cunningham	MCU	Associate Director of Corporate Affairs & Governance / Company Secretary
Warren Escadale	WES	Chief Executive, Voluntary Sector North West **(Regular Participant)**
Louise Barry	LBA	Chief Executive, Healthwatch Cheshire
Prof. Ian Ashworth	IAS	Director of Public Health representative **(Regular Participant)**
John Llewellyn	JLL	Chief Digital Officer, ICB **(Regular Participant)**
Andy Thomas	ATH	Associate Director of Planning and Performance, ICB
Joanne Smith	JSM	PA to Associate Director of Quality & Improvement - St Helens (minutes)

APOLOGIES NOTED		
Anthony Middleton	AMI	Director of Performance and Improvement, Cheshire & Merseyside ICB **(Regular Participant)**

Item	Discussion, Outcomes and Action Points	Action by
09.00am	**Preliminary Business**	
ICB/03/30/01	**Welcome, Introductions and Apologies**	
	RJA welcomed all present at the meeting. Attendees were advised that this was a meeting held in public. Apologies were noted and recorded.	
ICB/03/30/02	**Declarations of Interest**	
	There were no declarations of interest made by Members that would materially or adversely impact on matters requiring discussion and decision on the items being considered at today's Board.	
ICB/03/30/03	**Minutes of the last meeting – 23rd February 2023**	
	Members reviewed the minutes of the meeting held on 23rd February 2023 and agreed that they were a true reflection of the discussions and decisions made subject to the following amendments: • ICB/02/23/12 - Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023 The action should read CSA to present staff survey results in April not CWA. Also, it was CSA that discussed the EDI report not CDO. **Action: make amendments to the February 2023 minutes** **The Integrated Care Board approved the minutes of ICB Board meeting of 23rd February 2023 subject to the agreed amendments.**	MCU
ICB/03/30/04	**Action Log**	
	The Board acknowledged the completed actions and updates provided in	

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	the document. RJA asked the officers in charge to ensure that any comments relating to time scales are not left blank, even though it is an ongoing programme, ensure there is some specificity to that. **The Integrated Care Board noted the Action Log.**	
ICB/03/30/05	**Decision Log**	
	Members reviewed the decision log and confirmed it was an accurate record of substantive decisions made by the Board to date. **The Integrated Care Board noted the Decision Log.**	
09.10am	**STANDING ITEMS**	
ICB/03/30/06	**Chairs Announcements**	
	None to report.	
ICB/03/30/07	**Report of the Chief Executive (Graham Urwin)**	
	GPU presented the Chief Executive Report to the Committee and commented on the following items: One of the Targets set by the government was to achieve no one waiting longer than 78 weeks by 31st March 2023. Unfortunately, this target was missed by around 80 patients, however we managed to clear 30,000 patients who would have breached that target during the last year, this is a phenomenal achievement. We have one of the smallest breaches to that target of any ICB. Two things happened that prevented us from hitting that target, the first being an independent sector provider not on our patch returned 2 patients to us that they could not treat, and they were returned late in the process. Also, the impact of the industrial action has reduced the capacity that we had to get as many patients through during the last month. RJA congratulated and thanked all providers on behalf of the board as this was an enormously challenging task and was a huge achievement despite the challenges. **Industrial Action** Pleased that an offer has been made to the majority of our staff side and now wait to see if this offer is accepted. Junior doctors talks with the government have commenced however, the planned industrial action in April will go ahead and will have significant impact on frontline delivery of health services. This industrial action will take place during staff annual leave and when there is an expectation that demand for health services will be higher due to the post easter weekend peak. Ambulance strikes caused public behaviour to change, and calls reduced, we have not successfully managed to get the same communication narrative to the public over the impact the junior doctor strikes will have on health services. Junior doctors do a large proportion of day-to-day work in the NHS and there will be significant consequences. There is a team at the ICB that are doing the emergency planning centrally to help and support all	

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	organisations that do their own emergency planning but there will be increased waiting times, cancellations, and deduction of services. RPJ confirmed that he has met with medical directors to plan the next round of industrial action for junior doctors. There is more concern and anxiety and therefore more effort has gone into making sure we keep everything as safe as can be for the public. The mutual aid offer is being put in place so organisations can support each other. RJA welcomed the idea of a learning event once the strikes are over and has asked RPJ to look into this. RJA confirmed that he was disappointed with the results from the public survey outcome report that was published this week that states that levels of satisfaction with NHS services was at an all-time low of 29%. However, the result was not unexpected given the challenges of the services. The public remain committed to the core principles of the NHS for example treatment on the basis of need is still at 92%. The outpouring of support continually seen from the public for NHS staff remains. **Changes to the GP Contract in 2023/24** The changes to the GP contract are a forerunner to the fact that the NHS are about to publish the primary care recovery plan. The primary care recovery plan will focus on access and satisfaction, this will be brought to the board and will outline some of the things we will be doing as a result of that. From 1st April 2023 we will take responsibility for NHS dentistry. CWI and the team are currently doing due diligence for the transfer of this function and responsibility into us, as part of these negotiations we know that the NHS dentistry budget will come to us with both spare capacity already bought from dentists and we will need to think how we can better utilise this and will also come with a budget underspend to allow us to make some tactical investments. A report will be brought to board setting out our plans of action for how we are going to improve this. NHS 75th birthday is coming up; we need to think how we appropriately celebrate and recognise the achievements of our staff and how we use this as an engagement opportunity. The message we need to get across is to reduce waiting times, addressing immediate access needs of patients is the thing that is going to change the patient satisfaction. NRA confirmed that the industrial action has had a massive impact on primary care, there are a significant amount of doctors in training who work in general practice. The secondary impact of transfer of workload, if appointments are cancelled etc the fall back is general practice therefore there is a big increase in staff stepping in to try to bridge the gap. There is no additional funding available to cover other staff. There is a general feeling of helplessness in primary care at the moment. RPJ confirmed that the meeting with medical directors did include primary care leadership and they understand the issues are across all services when industrial action comes into play. **Cheshire & Merseyside Integrated Care Board Quarter 3 Assurance** The sub committees of the board do an excellent job holding local NHS to account however, we also are held to account by NHSE on a quarterly	

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	basis. NHSE have categorised us as being System Oversight Framework (SOF) 3 in a 4-point scale with 1 being the best and 4 being the worst. All ICBs in the Northwest were put into this category. There are some things that will need to be in place for us to move up the ranking system, such as some improvements in delivery and improvements in the underlying financial position of the system. Furthermore, all parts of the systems need to move together, the SOF 4 organisation on our patch is a significant determiner in that rating and our desire to help and support that organisation to improve is in the whole systems collective interest. The letter from our quarterly review is published in the meeting pack. **ICB Running Cost Allowances** We must achieve a 30% reduction in running costs from the situation we inherited from former CCGs; however, this will be more than a 30% reduction as we will have to absorb costs of any pay award. For NHS trusts and frontline service providers the pay award will be fully funded, however, for ICB the expectation is that we will self-generate the funds to meet the pay award through further management of costs reductions. Significant savings have already been made from the removal of 9 CCG boards and the creation of just 1 board for the whole of Cheshire and Merseyside. Also, savings have already been made in how we have started to restructure the way we organise things. There are plans to make further savings around accommodation, there are a number of buildings that we lease office space in that are coming up for review. We will be co-locating with other public sector partners to reduce the overall running costs of the ICB and to support those partners. Keep in place a range of controls around internal establishments, vacancy control system in place, intending to run a voluntary redundancy scheme should we get approval from NHSE. Assurance will be given that we are on track to deliver those savings over a 2-year period. **Hewitt Review** The review has been delayed but is in the final phase of drafting. GPU is unable to discuss the findings and recommendations from the review at board today as it is not published yet. WES thanked RJA GPU for making sure that the VCSE sector was included in the Hewitt review. **ACTION: With regard to the suggestion of a learning event following the end of the industrial action RJA asked RPJ to look into this.** **The Integrated Care Board noted the contents of the report.**	RPJ
ICB/03/30/08	**Resident / Staff Story**	
	RPJ introduced a resident story which emphasised how early cancer screening can lead to better patient outcomes. This lung check health screening programme is being led in our region looking to identify patients who may have lung cancer without any symptoms. The screening programme is running nationally and has picked up 42% of our population who have been offered this screening. In Cheshire and Merseyside 73% of cancers are picked up at an early stage. The video told the story of a resident who was invited for a lung health	

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	check CT scan at Asda Car Park in Aintree, although the resident had no symptoms, he decided to attend for the lung health check which took 10 minutes in all. Shortly before Christmas the resident received a phone call to ask him to attend for an appointment to discuss the results. The resident was diagnosed with lung cancer at stage 1. He was able to have keyhole surgery as the cancer was caught so early and he did not have to undergo any chemotherapy. A few days after surgery he was feeling well, and eight weeks later he and his family went on holiday to Spain. The resident is one of 131 patients that have been detected early, this has not only improved his outcome, recovery and return to a normal life but also means that our resources are being used in the most thoughtful, sensible, effective, and efficient way for our patients and we continue to support this and take this as widely as possible for our population and communities. **The Integrated Care Board noted the video and extended its thanks to RPJ and the resident for sharing their experience.**	
09.30am	**ICB Key Update Reports**	
ICB/03/30/09	**Executive Director of Nursing & Care Update Report (Christine Douglas)**	
	CDO's report provided the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks, issues and highlights that have an impact on quality and safety within the Cheshire and Merseyside ICS footprint. CDO highlighted some of the current issues. **The Children & Young People's Beyond Conference** The annual conference took place on 7th March and was attended by 120 partners from across health, social care, voluntary and the independent sector. The event was opened by RJA who reaffirmed his commitment to ensure that the health and wellbeing of CYP in Cheshire and Merseyside is given parity with that of adults. The conference heard from a range of speakers including the Children's Commissioner for England. The conference concluded with a plenary session with a panel from our partner agencies who were asked challenging questions by children and young people in Cheshire and Merseyside as to the issues that mattered to them. It was a really good conference day that they will hopefully repeat annually. **The Serious Violence Duty** Following public consultation in July 2019 the government announced that it would bring forward legislation to introduce Serious Violence Duty on a range of specified authorities. The ICB has been identified as one of five specified authorities, that also include: • Police • Justice (including probation and youth offending teams) • Fire & Rescue • Local Authorities. The Duty requires the specified authorities to consult educational, prison and youth custody authorities for the area in preparation of their strategies. This will ensure relevant services work together to share information and	

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	allow them to collaborate and plan to reduce serious violence within our communities. By January 2024, the specified authorities mentioned must produce a Joint Strategic Needs Assessment, response plan and a method for impact and evaluation. As an ICB we are fully engaged with the work commissioned by the home office about assessing our readiness for maturity and for the delivery of its responsibilities. We have an identified member within our organisation who is taking the lead on this. There have been a series of workshops to discuss what this impact will be and the development of the Joint Strategic Needs Assessment. CSO confirmed that data has been gathered around how many young people who have undertaken work experience within health and social care have gone on to have a career in health, this is in partnership with colleagues in social care too not just health. SBR confirmed that there was an announcement in the recent budget that LEPs will cease to be funded by the government by 2024, which means they are in a transition plan now to move their functions. HGA stated that it is great that we are so involved in this and have made great early progress. The Serious Violence Duty also includes domestic violence and sexual assault, and it is so important to amplify the benefits not only for our population but the benefits for our staff. In relation to domestic violence the incidents are far higher for NHS staff than any other sector of the population. CDO confirmed that the transition period from childhood to adulthood is an area of issue but the beyond programme does focus on this area and further work needs to be done to ensure we make this a smooth transition to support out children and young people into adulthood. IAS gave positive feedback on the beyond work. A lot of leaders were speaking positive about beyond at the Healthcare Partnership Workshop. With regard to the serious violence issues and the impact on health, each of our community safety partnerships and drugs partnerships have done a lot of work on the Joint Strategic Needs Assessment and will be able to compliment the work going on here. TFO stated that the whole focus is getting the views of children and young people into our thinking, and this is an excellent opportunity to build on this to take it further and make good use of that intelligence. RJA confirmed that our new governance arrangements include a recommendation that it could be that we establish a new CYP Board to help us take forward some learning and best practice across the patch. **The Integrated Care Board noted the Executive Director of Nursing & Care Update Report.**	
ICB/03/30/10	**Cheshire & Merseyside System Month 11 Finance Report (Claire Wilson)**	
	The report updated the Board on the financial performance of Cheshire and Merseyside ICS (“the System”) for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g., Cash	

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	Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year. CWI highlighted that we continue to report that we will deliver a £30m deficit by the end of the year. There are a number of variances at individual organisational level within that but broadly it is a continuation of the position reported last month. We are close to year end and the focus over the last few weeks and months has been planning for next year within the overall operational planning process that the system has been pulling together. A formal report will be brought to the next board meeting once final plans have been submitted to the regulators. CWI highlighted the following which do have an impact on the planning process for next year. Delivering this year and reporting a full delivery of the efficiency target but are doing a big chunk of this non recurrently so using one off measures in order to get over the line this year. The total value of the one-off measures is around £160m a value that we need to recover next year. To reflect on the level of work in organisations across the system in March around the capital programme. This is a vital infrastructure investment going on across the system but there is still a lot of work to do to get to the place where we are fully investing the full £236m of our capital investment programme. We have spent £170m, in the final month of the year we have £70m left and are confident that this is on track to deliver. CWI confirmed that in this financial year around 80% of the budget was delegated to place directors. This does give place teams local autonomy as to how that spend can be utilised, however, they are given that delegation as an officer of our organisations, so this may not feel like full level of freedom is there. In the new financial year, we are looking to pool budget arrangements and legal framework such as section 75/65 agreements which remains our only way of delegating further to place. Therefore, we are asking individual places to work with place partners, what in scope services they would like to put within those pooled arrangements and then to further develop the section 75 agreements at place to enable that to happen. One of the issues is that £30m more than our current budgets have been committed to certain levels of spend, this is one of the key limitations of what might feel to be a lack of freedom at place, however, this is a lack of resource to make decisions with. There is no formal delegation process that exists other than section 75/65 agreements to a pooled budget. Arrangements have not really changed we just need to expand our use of them. Individual place teams determine what budgets they want to put into a section 65/75 agreement and then go through that process to do it, and that is how it is delegated. GPU confirmed that this report is a look back report. A look forward report will be dealt with in the private section today. GPU hears the comments about delegation from a number of sources. We need to get this right and we need to spend time on this in a detailed board workshop with other partners to work through. This is the first year of transition into the new ICB, it was the first year away from a covid funding regime back to a transitional regime. To have landed a £60b organisation with hardly any	

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	variance to plan across 18 organisations and the ICB itself was a huge task. CWI and the team have done a phenomenal job. Now we need to work on what is our operating model and way of working going forward. GPU confirmed that the outturn expenditure across all organisations in Cheshire and Merseyside on agency staff was £150m for this year. We need to drive this through our people board and partner collaboratives in finding a way of using our permanent assets and permanent recruitment and not paying the fees of external agencies. . **The Integrated Care Board noted the Cheshire & Merseyside System Month 11 Finance Report.**	
ICB/03/30/11	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	
	ATH provided an update on the Cheshire and Merseyside (C&M) ICB Quality and Performance Report. This included an overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care as well as a summary of key issues, impact, and mitigations. A number of key areas and risks were highlighted. **Urgent and Emergency Care** With regard to category 2 ambulance response time, there was a significant increase in waits for calls over the winter period, there is a marked improvement in this in January/February. Across most of the other metrics in UEC this is similar, such ambulance handovers which have also reduced. The pressure is still consistent with a winter scenario and March has had a resurgence of pressure and some of our trusts have seen the highest level of demand since December in March, which coincided with the industrial action that took place in March. The bed occupancy position remains static which is very high, and many trusts are operating at close to 100% occupancy and approximately 20% of acute beds are occupied by patients who no longer need to reside in hospital. **Mental Health & Learning Disabilities** Mental health inpatient beds are seeing high occupancy levels and as a result we are also seeing a slight increase in the number of out of area placements particularly in the Cheshire and Wirral area which are associated with the challenge in finding suitable inpatient mental health beds. **Elective Care & Diagnostics** The work that took place as part of clearing more than 30k patients from the waiting list to enable their treatment within 78 weeks, more than 3500 patients were transferred between providers in Cheshire and Merseyside through the mutual aid hub and this had a significant impact in terms of matching up with the patient demand and need with the capacity that was available. **Cancer** Referrals remain at a high level; we are seeing 30% higher referral levels than pre-covid. In the last 12 months over 156 thousand people have	

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	come through the 2-week referral route compared to just under 142 in the preceding 12-month period. **Primary Care** Referring to the pressure in primary care, the overall volume of appointments taking place in primary care is up on pre covid levels although now face to face appointments are around 95% of pre covid levels and telephone appointments have increased and enabled primary care to offer more appointments than pre covid. CSO informed the group that the data in the pack around sickness refers to September 2022, they receive updates on a weekly basis and look at trends such as which organisations are particularly high and discuss with HR Directors to understand if there are any underlying issues that we an support with. Also regularly share best practice and have had recent workshops around trusts with low levels of sickness absence and what they do that is most effective. GPU stated that this needs to be more systematic, what we are working through is a consistent approach to how we would deploy improvement resources within the system. We should also have a consistent sifting method as to what we prioritise for improvement. Getting the measurement right is the first important step and publicly using that measurement helps. We need to ensure that at every level we are able to introduce that element of peer review and mutual aid. We do have a small amount of internal improvement resource and we will target those places to where we have the greatest variation that has the greatest impact on health care and outcome. GPU stated that with regard to the Core20plus5 we have a range of 22 indicators that we intended to report through the HCP but can bring as an appendix to this board too. Many of the Core20plus5 indicators are longer term indicators with some big indicators around primary and secondary prevention that we should be attempting to influence now and would like. RJA confirmed that our relative performance compared to other ICBs in the Northwest has not improved as much as they have, yet we continue to invest and put a lot of time and attention. We will have an overview today with a deep dive in April, what we will hear in April is a far more place-based response to the information presented today in the private meeting. ATH confirmed that there is information in the public pack today which includes non-criteria to reside position with a more detailed presentation in the private board. GPU stated that the reason we have not had a place director presentation today is because we are now into a period of purdah for the elections to local councils that take place in early May. When we come to discuss the progress on non-criteria to reside, it would be wrong to debate this in public whilst we are in the purdah period and therefore, we will return to this in the private section. In due course this information will be out there to the public. **The Integrated Care Board noted the contents of the report and took**	

Item	Discussion, Outcomes and Action Points	Action by
	assurance on the actions contained. **ACTION:** **RPJ to bring forward proposals such as the intelligence into action so we can be clear how we are using the information around health inequalities to make a difference.** **Following the publication of the primary care recovery plan, AIR and NRA will think through a broader range of indicators and will get a collaborative view through Primary Care Committee to inform this board of a more holistic look at primary care.**	RPJ AIR/ NRA
10:00am	**ICB Business Items**	
ICB/03/30/12	**Northwest Specialised Commissioning Joint Working Agreement (Clare Watson)**	
	From April 2023 a joint working model with NHS England (NHSE) will be legally underpinned by a Joint Working Agreement and statutory Joint Committee between NHSE and the three Integrated Care Boards (ICBs) in the Northwest for the 59 specialised services that are appropriate for more integrated commissioning. This report sets out the scope and scale of services that have been identified as suitable and ready for joint working arrangements from April 2023. The report also describes the oversight and joint decision-making arrangements in Cheshire and Merseyside in 2023/24 as a stepping-stone to receiving full delegated commissioning responsibility for suitable services from next year including budgets and financial liabilities. The report also seeks approval from the Board to enter into a Joint Working Agreement with NHSE Northwest colleagues and other colleagues in the two ICBs, Greater Manchester and Lancashire & South Cumbria. Also details the progress to date of what we need to do to be ready to take on that full delegation from April next year. NHSE has approved plans to establish joint committees between its regions and multi ICB collaborations that will oversee and take commissioning decisions from 59 specialist services. This will coincide with the introduction of population-based budgets for these services and a move towards a new needs weighted allocation formula from next year. All finances, liability and contracting will remain with NHSE this year albeit overseen by the joint committee. A Joint Working Agreement has been developed nationally to underpin the joint working model and the proprieties of that are outlined in 1.2 of the report. CWA highlighted the introduction of the Northwest Specialised Services Committee which will go live in April with the first meeting taking place in June. The 2023/24 arrangements give ICBs greater involvement in the commissioning of specialised services which will help us learn, prepare, and develop ways of working before formally receiving delegation from April 2024 onwards. Commissioning responsibility for the other specialist services outside of the 59 will remain with NHSE in 2023/24. Some will be on a permanent	

Item	Discussion, Outcomes and Action Points	Action by
	basis, and some will be temporary and could be considered for further delegation to the ICBs in 2024 onwards. Section 2 details the criteria for the specialised services and the history behind NHSEs role as being the accountable commissioner of the specialist services. Section 2.4 to 2.6 detail the process that has taken place to arrive at the services in scope and they are outlined in appendix 4. The joint working arrangement formalises the governance required for the regional ICBs on finance, contracting and management data responsibilities, it also formalises where statutory functions will be jointly exercised in line with the NHS Care Act 2006. **Role of the NWSSC** This is outlined in 5.1. This will be a formal decision-making committee of the ICB, but as a joint committee, members will be acting on behalf of all four partners, the region and the 3 ICBs. Whilst work is undertaken to agree the terms of reference it has been proposed that we will organise engagement and awareness raising sessions for the board and members of the board who will become part of the joint committee. A draft template is included in appendix 2. **Readiness to operate under full delegation from April 2024 – due diligence process** Nationally the operating model for delegation in 2024 and beyond will require each region to identify an ICB to host the specialist commissioning team in its area. Agreement in principle is that NHS Lancashire and South Cumbria ICB will host. Throughout 2023/24 further work will continue to look at the operating model for the team and also our due diligence work. We have to complete a Pre-Delegation Assessment Framework (PDAF) to provide the necessary assurances to NHSE that we are ready to take on those services for delegation. The document will be submitted to NHSE in September 2023. We have a number of internal groups and working arrangements within Cheshire and Merseyside but also across the region with colleagues in the other ICBs. CWA will bring updates and reports to the board throughout the year**.** **ACTION: RJA asked CWA to set out a time frame for this board to understand how we will get some benefit out of this structural change.** **The Integrated Care Board:** **• noted the contents of the report** **• approve the ICB entering into a Joint Working Agreement and progressing the work to establish statutory joint committee arrangements with NHSE and NHS Greater Manchester and NHS Lancashire and South Cumbria ICBs for the 2023/24 period** **• approve delegating authority to the Assistant Chief Executive to sign the Joint Working Agreement on behalf of NHS Cheshire and Merseyside to enable these commissioning arrangements to 'go live' from April 2023**	CWA

Item	Discussion, Outcomes and Action Points	Action by
	• note that further engagement will be undertaken with members of the three ICB Boards in developing and agreeing the Joint Committee Terms of Reference.	
ICB/03/30/13	**2022-2023 Emergency Preparedness, Resilience and Response Core Standards Assurance Report**	
	The purpose of this report is to provide the Integrated Care Board (ICB) Executive Team with the self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and subsequent actions to improve compliance over the coming year. RJA took the report as read and confirmed that progress has been made and will continue to be made. **The Integrated Care Board noted the contents of the report.**	
ICB/03/30/14	**Cheshire and Merseyside People Board Update**	
	CSO presented to the board an update on the work of the People Board. Unfortunately, Colin Scales. Chair of the People Board was unable to present today with CSO. The terms of reference have been revised and agreed recognising that it is in that transition of being a subcommittee of Health Education England to being a system wide and more strategic group. Three sub committees have been created, one to look at our workforce supply for the future, one to look at workforce and operational planning, and one to look at our primary care workforce. Membership has been extended to include a social care provider, provider collaboratives, place representative, AHP representative and voluntary sector. Committed to making sure that all decisions are backed up with data and evidence. Our NHS workforce increased by 2.3% during the period of August to November last year and also seen a small increase in primary care of 28 WTE. At the same time there was an increase in the use of bank and agency staff and our turnover decreased slightly as did our sickness absence. Total available staffing increased slightly, and activity and performance improved against the 104 week waits and 52 week waits. Bank and agency staffing during this period equated to just over 10% of our total workforce. We are looking at our temporary staffing solutions and our approach to temporary staffing recognising that some staff do want the flexibility of working on the bank/agency. Trusts are looking to reduce their bank and agency spend but this group remains a key component of our workforce and collectively we are looking to develop a Cheshire and Merseyside approach to our temporary staffing. We monitor where those workforce increases are and looking at the data all of our staff groups saw an increase with some slight decreases in terms of bank work particularly around allied health professionals. Our vacancy and turnover rate also reduced but sickness levels remain a challenge. The sickness levels are considerable particularly around	

Item	Discussion, Outcomes and Action Points	Action by
	support to clinical staff and nursing midwifery, the main reasons for absence continue to be stress, anxiety, musculoskeletal absence and colds, flu, and general viral infections. The People Board does not just consider its NHS workforce but also considers the position in primary care and social care, there are still some pressures across both of our sectors. Both providers show the same trends, in that we have an aging workforce and the number of youngsters entering the sector remains around 5%. It is important for this group to look at the detail that we are required at a national level to fulfil. There are 10 key outcomes-based functions for every People Board, focusing on workforce planning, workforce supply, making sure we look after the staff we have in terms of their experience, their health and wellbeing, also that we have robust plans in terms of succession planning, talent management, and we have a workforce that is fit for the future. Workforce priorities have been refined and do reflect the 10 outcomes-based areas discussed. Against each of those 5 strategic areas there is a detailed action plan which will be monitored through the People Board. The People Board have timescales, milestones, and accountability for each of those. A number of work programmes have been agreed, such as a programme to look at the development of the ward-based nurse and recognise from a retention perspective this is an area where we tend to see the greatest levels of turnover. There is now a group looking at what we can do to improve retention, to understand the aspirations of those newly qualified nurses and to make sure we have a robust career framework for them. Also agreed a programme looking at new entry routes to midwifery careers exploring the trainee midwifery associate role. There is a programme to support the health and wellbeing of staff and funding has been secured to focus on domestic violence for our staff. This is a joint piece of work with trade union colleagues, and we have secured funding of £170k to support this. Workshop planned for May 2023 to consider the wider system workforce priorities recognising that the ICB will also assume significant responsibilities from Health Education England over the next few months. Continuing to work with colleagues in the development of place based social care workforce plans and are working with skills for care and our place directors to bring that back. Developing a data dashboard to share across all our providers the data that supports some of the workforce decisions but also quickly identifies where there is variation. AMA confirmed that there is an increase in staff and agency staff due to the increase in patients and the need for one-to-one care for some of those patients. HGA emphasised the need to amplify what makes people stay not just what makes people leave. Also, more nurses and midwives are being	

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	trained now but we are still not seeing that conversion into practice. We need to look into this and understand why these people are not converting into practice. Would like to see data in relation to do our staff generally, including board reflect the population we serve. CSO confirmed that they are looking into the need to have a proper integrated workforce and have therefore commissioned skills for care to support in developing the place based social care workforce data. In terms of diversity, we do not represent the population that we serve, we have got that data in terms of bands. In Cheshire and Merseyside, we attract a huge number of students but as low as 35% of them go on to have a career in our area. We know some reasons why students do not stay, and one is that it is difficult to get good quality and affordable housing in the area when they do qualify. In response HGAs question CDO confirmed that she is a member of the Consortium Board which look at nursing and midwifery, allied health professionals and how the universities work together with placement providers. CDO Acts as a conduit between the consortium through to the Directors of Nursing within our provider trust and they look at some of the issues CSO has discussed. NRA commented that with regard to the primary care graph, this is not quite as stark as it looks, if you have trained from school you have to be 25 to start GP training. Focusing on the 53% admin in general practice, they are the backbone, the first contact for patients, and the level of abuse they are receiving at the moment is causing them to leave. There is funding through networks to look at staff retention and recruitment and this needs to focus more on admin staff not just clinical staff. CSO confirmed that there are challenges around Health Visitors in that certain trusts have introduced an incentive to encourage staff to move from one provider to another. There is a programme from the mental health and learning disabilities & community collaborative that is focusing on those community staff. JRA stated that with regard to sickness relating to mental health trusts, some of this is probably actual injury to staff from patient violence. Need to discuss the long delays of transfer in mental health services. WES commented that this is a perfect opportunity to raise the lack of recruitment, lack of jobs, need to make this a core issue and a call to action with partners across Cheshire and Merseyside. RJA commented that this board is likely to have the single most important risk workforce. This was a fantastic presentation, and we need to think about the governance arrangements that enables us to do the assurance that this board needs to have on the important issue around workforce in that integrated way. We need to pick this up as we are thinking about governance arrangements for April. **The Integrated Care Board noted the content of the presentation.**	

Item	Discussion, Outcomes and Action Points	Action by
ICB/03/30/15	**NHS Cheshire and Merseyside ICB NHS Staff Survey results 2022-23: Results and Actions**	
	This paper (and supporting presentation) provides an overview of the ICB staff survey results for 2022. The results are presented against the 7 areas of the national People Promise and the key themes of staff engagement and morale. As an ICB and new organisation we felt it was necessary to participate in this survey. Nationally 37 ICBs took part in the survey. The response rate for NHS Cheshire and Merseyside was 65% and 172 staff also providing free text comments. The results were generally disappointing with ICB engagement score being at 6.72%. We did score positively with interpersonal relationships within teams including interactions within teams, kindness and understanding and handling of local disagreements. Also saw lower instances of discrimination, bullying and harassment and physical violence. Since the staff survey results have come out, we have been working with the staff engagement group to agree what our focus should be over the next 12 months to enable to receive better results. These include, celebration and recognition, health & wellbeing of staff, having effective appraisal schemes, making sure that staff have the capacity to do their job and making sure they are motivated at work and understand how the organisation works. We have established a working group to take forward the actions and also conducted a thematic review of the key themes and comments that staff made. We held a session on 15th March where we shared the results with staff and shared the presentation included in the pack. The staff ranked the areas they wanted us to focus on during the interactive session. We have a new staff engagement lead who has been meeting with staff across the whole organisation to understand their views and working with them to propose a new approach to staff engagement and involvement. A staff engagement group meeting took place on 29th March to review local feedback about what was well received, where there are still more concerns etc. Continue to test our approaches with staff and we are working collaboratively to share best practice and to improve the experience of all staff in the ICB. Will bring back reports of all trusts across Cheshire and Merseyside and look at where those areas of real strength are and where we can work collaboratively to make things better. EMO commented that it is really good that we are getting a good cascade across all the teams but need to work on how you personalise that, and what it means personally. HGA would like to know how we create safe spaces for people who do not feel comfortable engaging in the way this is set up. We need to look at spaces created for conversations, and we also need to be proactive in getting diverse representations.	

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	GPU commented that he is unhappy about the survey results and that this must be addressed. We need to change the way we engage with staff and learn from organisations that work with distributed staffing structures. GPU stated that this is a priority for us to address, and also seek some different learning on how we do this. **The Integrated Care Board noted the content of the report.**	
ICB/03/30/16	**Cheshire and Merseyside Cancer Alliance Update**	
	RPJ introduced John Hayes and Dr Chris Warburton from the Cancer Alliance who presented their report to the board. Cheshire & Merseyside Cancer Alliance brings together organisations, patients and others affected by cancer to drive improvements in clinical outcomes and patients' experience of the care and treatment they receive. The Alliance is funded by, and accountable to, the national cancer programme within NHS England. The Alliance is hosted by The Clatterbridge Cancer Centre NHS Foundation Trust on behalf of all Alliance partner organisations. Key responsibilities include: • Delivering NHS long term plan objectives for cancer including the ambition that by 2028 75% of cancers will be diagnosed at stages 1 and 2 • Reducing unwanted variation in care, access, patient experience and outcomes • Improving performance against cancer waiting time standards • Supporting innovation and safeguarding the long-term sustainability of cancer services. The Alliance is governed by a Board with a membership representing partner organisations across all geographical areas. Assurance is via the Board up to the national cancer programme in NHS England via the medical directorate of NHS England Northwest. The Alliance also reports into NHS Cheshire and Merseyside ICB and Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST). National priorities for 2023/24 are set out in the NHS Operational Planning Guidance and the 3 priorities are: • Continue to reduce the number of patients waiting over 62 days • Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancers are diagnosed or have cancer ruled out within 28 days • Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 An additional 3,000 new patients are being seen in cancer clinics every month, compared with three years ago, representing a 30% increase in capacity since the beginning of the COVID-19 pandemic.	

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	Although referral rates have increased by 30% since 2019/20, the conversion rate has only reduced slightly from 6.3% to 6.15%. The proportion of patients who begin their first cancer treatment is within 62 days of an urgent suspected cancer referral. Currently Managing a backlog of patients who are still under investigation beyond day 62. There was a rise in the numbers just before Christmas and have now seen a reduction of around 40% and are confident we can get this down further. One of the key challenges for Cheshire and Merseyside is to improve performance against the 28-day faster diagnosis standard. The national standard is set at 75% and we are at just over 61%, January is the latest published data and is the worst data we have seen. There are trajectories set and in year milestones that we are working towards. With regard to the four most common cancers, breast, lung, prostate and colorectal, breast remained relatively static, prostate has started to slightly improve, lung has had the biggest improvement which may be to do with the lung health check programme, colorectal has remained relatively static despite delays to the pathway due to high volumes of referrals. The Cancer Academy which was established in September 2022 and has worked very closely with People Board and Health Education England to develop this, now has over 700 registered users. This is a training and development resource specifically for cancer professionals and has been opened up to the whole country. We are wrapping this up as part of the National Health Education ACCEND Programme. **Targeted Lung Health Check Programme** This programme is offered to past and current smokers aged 55 to 74. Following a lung health assessment interview if they meet a certain criterion, they will be offered a low dose CT scan. This started with the areas with the worst lung cancer outcomes across Cheshire and Merseyside (Knowsley, Halton, and Liverpool) and is now currently being rolled out in St Helens and South Sefton with plans to roll out further in the next 12 months to Warrington, Wirral, Southport, and Formby. Over 80,000 invitations have been sent to date with 32,000 people attended a lung health check and 23,000 subsequently attended a low dose CT. There have been 131 lung cancers diagnosed to date, with approximately 75% at early stage and 35% of participants have accepted referral to smoking cessation services with a 49% quit rate at four weeks. **The Grail Study** This is a blood test which can detect circulating cancer DNA in the blood stream. The challenge with this test is whether it is going to pick up patients with early stage versus anybody with cancer that happens to be asymptomatic at the time. The study has now been rolled out across the country. The alliance have been working with the ICB on the most serious incidents that happen in cancer patients that are reported through STEISS. There is a potential that we are losing some learning there. Discussions have taken place with quality place leads to try to get a system together so that the	

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	cancer alliance are alerted when cancer serious incidents happen. They receive an anonymised report and decipher how we might learn from that and then spread that learning across Cheshire and Merseyside. FLE thanked the alliance for acknowledging the work that primary care puts into cancer referrals. FLE also wanted to acknowledge the work that GP Clinical Leads do at place, they educate, support general practice and quality improvement, they have contributed significantly. RJA commented that in a recent Northwest BAME assembly an issue about research was discussed. We know that with most research programmes not all populations are represented, and it would be good to understand what we are doing about this and inform the board. The health inequalities team and patient engagement experts within the cancer alliance are working with research organisations to reduce the barriers that individuals from any background may have in terms of consenting to join trials. Supporting them to completely review all of this and have things such as multi-lingual videos etc to make sure paperwork is not a barrier. GPU commented on the earlier patient video stating that the cancer alliance is a great asset, and they have our endorsement and support and asks that they keep pushing the boundaries. GPU quoted a sentence from the NHS Constitution "NHS works at the limits of science bringing the highest levels of human knowledge and skill to save lives and improve health". **The Integrated Care Board:** • **noted the contents of this report and ongoing efforts to improve operational performance and outcomes.** • **approved ongoing constructive conversations with colleagues at place and at corporate ICB around sustaining and embedding some of the improvements discussed.** • **noted that the alliance is keen to explore how it may support the ICB with its new commissioning duties for specialised cancer services which are to be delegated to the ICB from NHS England.**	
11:20am	**Sub-Committee Reports**	
ICB/03/30/17	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee (Tony F)**	
	The report provided assurance to the Board in regard to key issues, considerations, approvals and matters of escalation considered by the Quality and Performance Committee. Members were asked to take the report as read, however TFO highlighted the items listed below: **Quality and Performance Dashboard** Recognise the extension work in expanding and refining the dashboard making sure we see the right data and the right issues particularly focusing on risk and priorities for the ICB.	

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	Place Based Key Issues Report The Committee was presented with a report that detailed the work undertaken to secure quality improvement following the Rapid Quality Review of services for Cheshire and Wirral Partnership. **Infection Prevention & Control (IPC)** The committee was presented with its quarterly report into IPC governance and performance for the ICB and recognised the need refocus the work to deliver the right improvements. **Local Maternity and Neonatal System** The Committee was informed that Liverpool Women's Hospital had received an inspection by the Care Quality Commission and concerns were noted in relation to maternity triage and risk assessment provision. **Northwest Ambulance Service (NWAS) & System Pressures** Provided a detailed and challenging presentation in assessment of patient safety issues during the system pressures in January. They gave a high level of assurance that they are following through on every possible piece of learning from the potential for harm due to delays in ambulance response time. **The Integrated Care Board noted the contents of the report.**	
ICB/03/30/18	**Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Our Resources Committee**	
	The report provided assurance to the board on the adequacy of governance, risk management and internal control processes within the ICB. NLA confirmed that everything is on track with the annual accounts. **Supplier Set-Up Fraud & Anti-Fraud Interim Investigation Report** A sophisticated scam took place involving the hijacking of a supplier's email account. They have since been reviewed and received training and this should not happen again NLA confirmed that with regard to the tender waiver of £10m there were no concerns as a committee over this. **The Integrated Care Board noted the content of the report.**	
ICB/03/30/19	**Report of the Chair of the Cheshire & Merseyside ICB System Primary Care Committee (Erica Morriss)**	
	EMO confirmed that there is a good balance now across all of the four disciplines within primary care: GP, Pharmacy, Dentistry, and Ophthalmic. The focus on GP and community pharmacy are the challenges and opportunities we have discussed today. More so on dentistry and ophthalmic is that take on process. As a committee we are aware of access issues and need to look at how we maximise the spend and the how we maximise out the activity that is not met at the moment. This will	

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	all come together in the primary car strategic document that is being worked through. Had the first presentation from place on the primary care positives that have come from the development funding. Only 6 months in but some positive stories around practice resilience, retention, digital initiatives, social prescribing, and dementia working. Will report back in 6 months what the added value is and what we have achieved with this. **The Integrated Care Board noted the content of the report.**	
ICB/03/30/20	**Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Resources Committee (Emma Morris)**	
	EMO thanked everybody that has been involved with finance and also thanked ATH for his very helpful presentation. **The Integrated Care Board noted the content of the report.**	
ICB/03/30/21	**Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee (Clare Watson)**	
	CWA informed the board that the last committee was a really good meeting and asked the board to take the report as read. The key points are: • A more refreshed and robust governance around our transformation programme and activity and aligning those with the planning guidance and new prioritisation framework. • Supported funding for Q1 and Q2 from the transformation funding. • We will be introducing a more rigorous process for future funding around transformation programmes. RJA questioned the format of the report used for this type of committee and would like to follow this up with CWA outside of the meeting. **Action: RJA and CWA to meet to discuss format of Chairs Reports to Board** **The Integrated Care Board noted the content of the report.**	CWA / RJA
11:45am	**Other Formal Business**	
ICB/03/30/22	**Closing remarks, review of the meeting and communications from it (Raj Jain)**	
	RJA and CDO led the presentation of the National Chief Nursing Officer awards to the following colleagues: • Denise Roberts - Silver Award • Julie Tunney - Gold Award Denise was recognised for her outstanding performance that goes above and beyond her everyday role to provide excellent care, leadership and inspiration to colleagues and patients.	

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	Julie was also recognised for her outstanding performance and achievement. Julie is an exemplary nurse and a great role model for others and achieves high standards in clinical practice. The Chair thanked the Board for their participation in the meeting.	
	CLOSE OF MEETING	
Date, time, and location of Next Meeting:		
27 April 2023, 09:00am, The Boardroom, The Department, Lewis's Building, 2 Renshaw Street, Liverpool, L1 2SA		

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2023 - 2024

Updated: 17 April 2023

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-05	27/10/2022	**Continuous Glucose Monitoring Update**	Requested that in 12 months' time the Board be provided with a progress update.	Rowan Pritchard-Jones	01-Oct-2023	Added to the forward plan for October 2024	ONGOING
ICB-AC-22-06	27/10/2022	**Provider Collaborative Update**	Agreed that a strategic business case relating to increased delegation be brought to the Board for consideration.	Joe Rafferty	28-Nov-2022	Added to work plan for May 2023	ONGOING
ICB-AC-22-10	28/11/2022	**Cheshire & Merseyside System Month 7 Finance Report**	There was a need for a comprehensive provider organisational integrated performance report to be presented to the Board covering all challenges being faced by organisations. This would be provided in the new financial year.	Claire Wilson	April 2023	Added to work plan for May 2023	ONGOING
ICB-AC-22-11	28/11/2022	**Cheshire & Merseyside System Month 7 Finance Report**	In the absence of a comprehensice provider organisational integrated performance report, members would be sent dashboards that provided the wider financial position and workforce information.	Claire Wilson	Jan 2023		ONGOING
ICB-AC-22-13	28/11/2022	**ICB Equality, Diversity and Inclusion Update Report**	Members discussed how data collected via WRES, WDES, CORE20, EDS2 and other system would be used and shared with the Board. IAS agreed to bring a further report on Core20Plus to a future Board meeting in relation to this.	Ian Ashworth	TBC	Date to be confirmed when Director of Population Health starts with ICB	ONGOING
ICB-AC-22-14	28/11/2022	**Consensus on the Primary Secondary Care Interface**	RPJ confirmed that discharge medicines services were crucial for patients and a future paper would be required at Board to review	Rowen Pritchard-Jones	TBC	Has been added to the Board Forward Plan - date tbc	ONGOING
ICB-AC-22-15	28/11/2022	**Consensus on the Primary Secondary Care Interface**	An update report would then be presented to Board over the next 12 months	Rowen Pritchard-Jones	TBC	Has been added to the Board Forward Plan	ONGOING
ICB-AC-22-18	28/11/2022	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee**	The Primary Care Strategy. This would be presented to the Board in March 2023	Clare Watson	TBC	Awaiting national publication of Primary Care Recovery Plan. Added to work plan for May/June 2023	ONGOING
ICB-AC-22-20	26/01/2023	**NHS 2023/24 Priorities and Operational Planning Guidance**	That the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023 and as such there was a need for review by the ICB Executive Team and Provider Collaboratives. The final submissions would be presented to the Board for approval in March 2023	Clare Watson	March 2023	Added to work plan for March 2023	ONGOING

Action Log 2023 - 2024

Updated: 17 April 2023

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-21	26/01/2023	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**	The Committee had received an Urgent Care presentation and the intention was to return to the Board meeting in March with a full Urgent Care report	Anthony Middleton	March 2023	Added to work plan for May 2023	ONGOING
ICB-AC-22-22	26/01/2023	**Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee**	A programme reviewing the current transformational change activity occurring across the Cheshire and Merseyside system and the work to develop priorities, delivery, and governance approaches. A report relating to this would be presented to the Board at a future meeting	Clare Watson	March 2023	Added to work plan for May 2023	ONGOING
ICB-AC-22-23	02/03/2023	**Report of the Chief Executive**	CWA confirmed that a further report would be presented to the Board in March 2023 that would include the terms of reference for these new Committees	Clare Watson	01-Mar-2023	Added to work plan for April and May meetings 2023	ONGOING
ICB-AC-22-24	23/02/2023	**Cheshire & Merseyside System Month 10 Finance Report**	CSA/CDO to bring further information to the Board around non-contracted staff to allow for a better understanding of the issue	Christine Douglas	Not specified	Further information relating to bank and agency staff provided to the Board in March the People Board update	COMPLETED
ICB-AC-22-25	23/02/2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**	CWA to present on the results of the Staff Survey at the April Board meeting.	Clare Watson	April 2023	Update provided at March Board on ICB Staff and report on the April agenda	COMPLETED
ICB-AC-22-27	23/02/2023	**Cheshire & Merseyside ICB Risk Management**	The proposed format of the BAF and the final Risk Appetite document would be considered at the April 2023 Board meeting.	Matthew Cunningham	April 2023	Scheduled on April Board agenda 2023	ONGOING
ICB-AC-22-28	23/02/2023	**Cheshire & Merseyside ICB Prioritisation Framework**	CWA confirmed that that the Prioritisation Framework would be presented to the ICB Board in at its April 2023 meeting.	Clare Watson	April 2023	Date tbc	ONGOING
ICB-AC-22-29	23/02/2023	**Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB Update**	A further update report on delegated services would be presented to the Board in six months	Clare Watson	September 2023	Added to work plan for September 2023	ONGOING

Action Log 2023 - 2024

Updated: 17 April 2023

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-30	30/03/2023	**Report of the Chief Executive (Graham Urwin)**	With regard to the suggestion of a learning event following the end of the industrial action RJA asked RPJ to look into developing this.	Rowen Pritchard-Jones	date tbc	Action is still on-going	ONGOING
ICB-AC-22-31	30/03/2023	**Cheshire & Merseyside System Month 11 Finance Report (Claire Wilson)**	Overall operational planning process - A formal report would be brought to a subsequent board meeting once final plans have been submitted to the regulators.	Claire Wilson	date tbc		NEW
ICB-AC-22-32	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	With regard to the Core20plus5 there were a range of 22 indicators that would be reported through the HCP but could also be presented to this Board.	Andy Thomas	date tbc		NEW
ICB-AC-22-33	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	The ICB relative performance compared to other ICBs in the Northwest had not improved as much as they have, yet we continue to invest and put a lot of time and attention. Deep dive into this to be undertaken in April, place-based response to the information presented today in the private meeting. Further report to be brought back to the Board at a future meeting.	Andy Thomas	date tbc		NEW
ICB-AC-22-34	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	RPJ to bring forward proposals such as the intelligence into action so we can be clear how we are using the information around health inequalities to make a difference	Rowen Pritchard-Jones	April 2023	On the Board agenda for April. Therefore action completed	COMPLETED
ICB-AC-22-35	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	Following the publication of the primary care recovery plan, AIR and NRA will think through a broader range of indicators and will get a collaborative view through Primary Care Committee to inform this board of a more holistic look at primary care	Adam Irvine & Dr Naomi Rankin	tbc	National Primary Care Recovery Plan has not yet been published. Item can be combined with Board Action No ICB-AC-22-18 following consideration at SPCC.	COMPLETED
ICB-AC-22-36	30/03/2023	**Northwest Specialised Commissioning Joint Working Agreement (Clare Watson)**	RJA asked CWA to set out a time frame for this board to understand how we will get some benefit out of this structural change.	Clare Watson	tbc	CWA to provide an update at the May Board meeting	NEW
ICB-AC-22-37	30/03/2023	**Sub-Committee Reports**	RJA questioned the format of the report used for this type of committee and would like to follow this up with CWA outside of the meeting.	Raj Jain & Clare Watson	tbc	RJA, CWA and MCU to meet to review committee report format. Meeting to be arranged.	NEW

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-01	**01-Jul-22**	**ICB Constitution**	The following changes to the ICB constitution will be made:- 1) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 2) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 3) The wording of section 7.3 will be reviewed to ensure completeness. 4) The role of the local authority will be strengthened and added to the final version document prior to publication. 5) The principles in section 6.2.1 will be revised and updated subject to the approval of the Board.	Clare Watson	**27-Oct-22**	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map*	CLOSED
ICB-AC-22-02	**01-Jul-22**	**ICB Functions and Decision Map**	The diagram/wording on page 241 will be reviewed to make the link between the ICB and the Health and Wellbeing Boards clearer.	Claire Wilson	**27-Oct-22**	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map*	CLOSED
ICB-AC-22-03	**27-Oct-22**	**Cheshire & Merseyside System Month 6 Finance Report**	Requested CWA and CDO provide a Workforce Update at the next Board Meeting.	Claire Wilson	**28-Nov-22**	*Workforce Update report included within the Director of Nursing and Care Report*	CLOSED
ICB-AC-22-07	27/10/2022	**Winter Planning 2022-23**	Agreed that an updated position on winter resilience plans was reported to the Board at a future meeting	Anthony Middleton	28-Nov-2022	Winter Resilience Plan update report included on agenda for November 2022 meeting	CLOSED

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-08	28/11/2022	**Minutes of the previous meeting – 27 October 2022**	SBR questioned the minutes relating to item ICB/10/22/12 Provider Collaborative Update. He asked that the minute be changed to confirm that further discussions between JRA, SBR and GUR would take place but NOT that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration. RJA advised that his recollection was that the report had been requested. He confirmed that the recording of the meeting would be reviewed and confirmation of the agreed action be shared.	Raj Jain	Jan 2023	*Action completed*	CLOSED
ICB-AC-22-04	27/10/2022	**Executive Director of Nursing and Care Report - Recommendations within the Kirkup Report**	An independent investigation was commissioned in February 2022, reviewing 202 cases, evidence from family listening sessions, clinical records, interviews with clinical staff. Agreed to take the Kirkup recommendations to the Quality Committee for consideration.	Christine Douglas	28-Nov-2022		CLOSED
ICB-AC-22-09	28/11/2022	**Executive Director of Nursing & Care Report**	CDO confirmed that the C&M People Board was operational and that there was a need for robust plans to be developed to support this area of work. Early considerations included potential rostering issues and the introduction or continuation of flexible working arrangements Requested a report to January 2023 to describe if and how arrangements had been successful	Christine Douglas	Jan 2023	Update report on March Board	CLOSED
ICB-AC-22-12	28/11/2022	**Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton)**	RJA requested that the Cheshire and Merseyside Cancer Alliance be invited to the January 2023 meeting to explain its work programme	Rowan Pritchard-Jones	Jan 2023	Update report on March Board	CLOSED

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-16	28/11/2022	**Winter Planning 2022-2023 Update**	Requested that Cllr Louise Gittins, as Chair of the Cheshire and Merseyside Health and Care Partnership, receive a report on Place Based Winter Planning	Anthony Middleton	TBC	*Completed. Report circulated to Cllr Gittens*	CLOSED
ICB-AC-22-17	28/11/2022	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee**	An update on dentistry and optometry. A full formal report on dentistry would be presented to Board in February 2023.	Clare Watson	Feb 2023	Came to February Board	CLOSED
ICB-AC-22-19	23/01/2023	**Cheshire & Merseyside System Month 9 Finance Report**	GUR questioned the agency spend performance and outturn forecast. He asked how these figures compared to pre-pandemic levels and to performance against other ICS areas. CWA was asked to provide this information in future reports.	Claire Wilson	01-Feb-2023	CWI confirmed that the reports now included this information	CLOSED
ICB-AC-22-26	02/03/2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**	CWA confirmed that the following would be would be amended to reflect the conversation and forwarded to Members following the meeting for their approval: 'Empower and engage our leadership and workforce'. Needed to be more explicit to say addressing overall inequalities.	Clare Watson	March 2023	Amendments made and approved by Board members following the meeting	CLOSED

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2023 - 2024

NHS Cheshire and Merseyside

Updated: 17 April 2023

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

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2023 - 2024

NHS
Cheshire and Merseyside

Updated: 17 April 2023

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ICB-DE-22-10	04-Aug-2022	**Cheshire & Merseyside ICB Financial Plan/Budget**		1) The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. 2) The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	
ICB-DE-22-11	04-Aug-2022	**Cheshire & Merseyside System Month 3 (Quarter One) Finance Report**		The Board noted the Month 3 Financial Report.	
ICB-DE-22-12	04-Aug-2022	**Cheshire & Merseyside Month 3 (Quarter One) Performance Report**		The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB-DE-22-13	04-Aug-2022	**Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire**		The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB-DE-22-14	04-Aug-2022	**Virtual Wards – update on their expansion across Cheshire and Merseyside**		The Board noted the Virtual Wards update.	
ICB-DE-22-15	04-Aug-2022	**Responses to questions raised by Members of the Public in relation to items on the agenda**		The Board agreed to respond to all public questions raised prior to the August meeting.	
ICB-DE-22-16	29-Sep-2022	**Chief Executive Report**		1) The Board approved entering into the Sefton Partnership Board Collaboration Agreement 2) The Board approved the recommendation to delegate authority to the Chief Executive and the Assistant Chief Executive to sign off collaboration agreements or memorandum of understanding from other places noting that any arrangements requiring S75 or pooled budget agreements would be submitted to the ICB Board for approval.	
ICB-DE-22-17	29-Sep-2022	**Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal**		1) The Board approved the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation 2) The Board noted the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.	
ICB-DE-22-18	29-Sep-2022	**Developing the Cheshire and Merseyside Integrated Care Partnership (ICP)**		1) The Board approved the appointment of Louise Gittins as the designate Chair of the ICP 2) The Board approved the process for the appointment of a vice chair	
ICB-DE-22-19	29-Sep-2022	**Report of the Audit Committee Chair**		1) The Board approved the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee 2) The Board approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role 3) The Board approved ICB Information Governance Policies and statements / Privacy notices and their subsequent publication	
ICB-DE-22-20	29-Sep-2022	**Report of the Chair of the ICB Quality and Performance Committee**		The Board approved the proposed amendments to the revised Terms of Reference for the ICB Quality & Performance Committee	
ICB-DE-22-21	29-Sep-2022	**Report of the Chair of the ICB System Primary Care Committee**		The Board approved the proposed amendments to the Committees Terms of Reference subject to membership from LPS being included.	
ICB-DE-22-22	27-Oct-2022	**Chief Executive Report**		1) The Board noted the contents of the report. 2) The Board approved the recommendation change in the ICB's named Freedom to Speak Up Guardian.	
ICB-DE-22-23	27-Oct-2022	**Welcome to Cheshire East**		The Board noted the contents of the report and presentation.	
ICB-DE-22-24	27-Oct-2022	**Residents Story Update - Social prescribing**		The Board noted the presentation.	
ICB-DE-22-25	27-Oct-2022	**Cheshire & Merseyside System Month 6 Finance Report**		1) The Board noted the contents of this report in respect of the Month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. 2) The Board requested CWA and CDO provide a Workforce Update at the next Board Meeting.	
ICB-DE-22-26	27-Oct-2022	**Cheshire & Merseyside ICB Quality and Performance Report**		The Board noted the contents of the report and take assurance on the actions contained.	
ICB-DE-22-27	27-Oct-2022	**Executive Director of Nursing and Care Report**		1) Noted the content of the report. 2) Noted that CDO would be taking the Kirkup recommendations to the ICB Quality and Performance Committee for consideration. 3) Noted that a Workforce update will be provided within the next Director of Nursing and Care report to the Board Meeting.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2023 - 2024

NHS
Cheshire and Merseyside

Updated: 17 April 2023

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ICB-DE-22-28	27-Oct-2022	**Continuous Glucose Monitoring**		1) The Board approved the retirement of the current Cheshire & Merseyside Continuous Glucose Monitoring (CGM) policy, and 2) The Board approved the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28. 3) Requested that in 12 months' time the Board be provided with a progress update.	
ICB-DE-22-29	27-Oct-2022	**Provider Collaborative update**		1) Noted the content of the report. 2) Agreed that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration.	
ICB-DE-22-30	27-Oct-2022	**System Finance Assurance Report**		The Board noted the contents of the report and the development of the financial accountability framework.	
ICB-DE-22-31	27-Oct-2022	**Winter Planning 2022-23**		1) The Board noted the contents of this report for information. 2) The Board agreed that an updated position on winder resilience plans is reported to the Board at a future meeting	
ICB-DE-22-32	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee**		1) The Board noted the items covered by the Remuneration Committee. 2) The Board approved the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).	
ICB-DE-22-33	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**		The Board noted the contents of the report.	
ICB-DE-22-34	27-Oct-2022	**Report of the Cheshire & Merseyside Chair of the ICB Transformation Committee**		1) The Board noted the report 2) Approved the revised terms of reference attached to the paper.	

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 April 2023

Chief Executive's Report (April 2023)

Agenda Item No	**ICB/04/23/07**
Report author & contact details	Graham Urwin, Chief Executive
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Graham Urwin, Chief Executive

Chief Executive's Report (April 2023)

Executive Summary	This report provides a summary of issues not otherwise covered in detail on the Board meeting agenda. This includes updates on: • Operational System Pressures • Industrial Action Update • Hewitt Review • All Age Continuing Healthcare Review • Annual Assessment of Integrated Care Board • Defence Employer Recognition Scheme • NIHR Network Update • Breathing Point' lung health website launched • Covid-19 Update • Eurovision 2023 • Decisions undertaken by the Executive Team.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	x				
Recommendation	**The Board is asked to:** • **note** the contents of the report.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
			x	x	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		x	x		
Management of Conflicts of Interest	None				
Next Steps	None				
Appendices	**Appendix One**	NHS England Letter regarding ICB Annual Assessment			

Chief Executives Report (April 2023)

1. Introduction

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

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

2. Operational System Pressures

2.1 Overall, the Cheshire and Merseyside system continues to operate just below the highest level of escalation (OPEL 3), with some of our Trusts - Southport and Ormskirk, Mid Cheshire, Wirral University Teaching Hospitals (all OPEL 2) and Alder Hey (OPEL 1) - achieving improved performance.

2.2 Levels of 'corridor care' were reduced throughout the week - the average number of patients being cared for on a corridor dropped to 26. This included just one Trust across Cheshire and Merseyside reporting corridor care on Saturday (15th April) - a positive sign for improved patient flow.

2.3 However, delays with mental health placements continue, due to occupancy levels and poor flow in and out of inpatient wards. By Monday (17th April), there were 13 patients awaiting mental health placements in acute trusts with a wait of more than 500 hours at Wirral and one of over 100 hours at East Cheshire.

2.4 As has been reported previously to the Board, nationally, Cheshire and Merseyside has been highlighted as an outlier due to the high proportion of patients with no criteria to reside (NCTR) currently occupying beds.

2.5 Representatives from NHS England, the Department of Health and Social Care, the Association of Directors of Adult Social Services, Local Government Association, and the Better Care Fund Programme Team .are set to visit Cheshire and Merseyside (April 24th and 25th) for an Integrated Discharge summit with NHS Trust Chief Executives, Directors of Social Care and NHS Cheshire and Merseyside.

2.6 The focus of the visit will be on leadership and culture and how joined up we are as a system. The team will want to see for themselves how integrated our discharge processes are and correlate this with our data. Flow into and through our hospitals will be of interest plus the numbers of NCTR and what we are doing to reduce these. Finally, place admission avoidance will form part of the key lines of enquiry to ensure a joined up approach across all of our nine places. Case studies will bring to life the work across out system focusing on NHS and Social

Care, and we will be able to provide them with an understanding of the challenges our Trusts are facing, and the actions being taken across the system.

2.7 I would like to put on record my thanks to Del Curtis (Place Director Cheshire West) and Mark Palethorpe (Place Director – St Helens) for taking a lead in coordinating the design and delivery of these visits. At the Board meeting on the 27 April, I will be able to provide an update on these visits.

3. Industrial Action Update

3.1 Junior Doctor members of the British Medical Association (BMA) joined a 96-hour walkout from 7am on Tuesday, 11 April to 7am on Saturday, 15 April. They were joined by members of the Hospital Consultants and Specialists Association (HCSA) and dental trainees who are members of the British Dental Association.

3.2 All Cheshire and Merseyside Trusts proactively and meticulously planned rotas for the week and, as such, no detrimental impact to flow or additional operational pressures were noted.

3.3 General Practice was also affected with GP Registrars in Training Practices taking Industrial Action. Surgeries were likely therefore running at reduced capacity, but no incidents have been escalated.

3.4 Additionally during this time the Grand National occurred at Aintree which brings considerable operational pressures to the Liverpool and surrounding area. Again, I would like to put on record my thanks to members of the Executive Team, ICB staff and all partners for working meticulously to ensure that as a system we were as prepared as best as we could be for the challenges faced during this time.

3.5 Board members are also no doubt aware that the Royal College of Nursing has signaled that members plan to join a 48-hour strike from 8pm on Sunday, April 30th. Detailed information about the impact of industrial action is published nationally here[1] with local information and advice available via the NHS Cheshire and Merseyside website.[2] As always the system will continue to work together to plan mitigations to the challenges presented by industrial action.

4. Hewitt Review

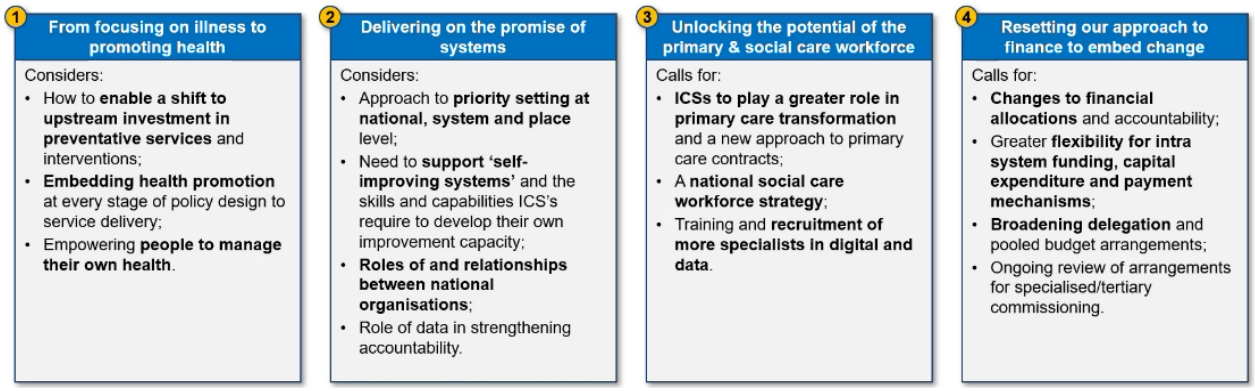
4.1 The Rt Hon Patricia Hewitt's independent review into how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed has been published.[3]

[1] https://www.england.nhs.uk/publication/preparedness-for-potential-industrial-action-in-the-nhs/
[2] https://www.cheshireandmerseyside.nhs.uk/posts/nhs-industrial-action/
[3] https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems

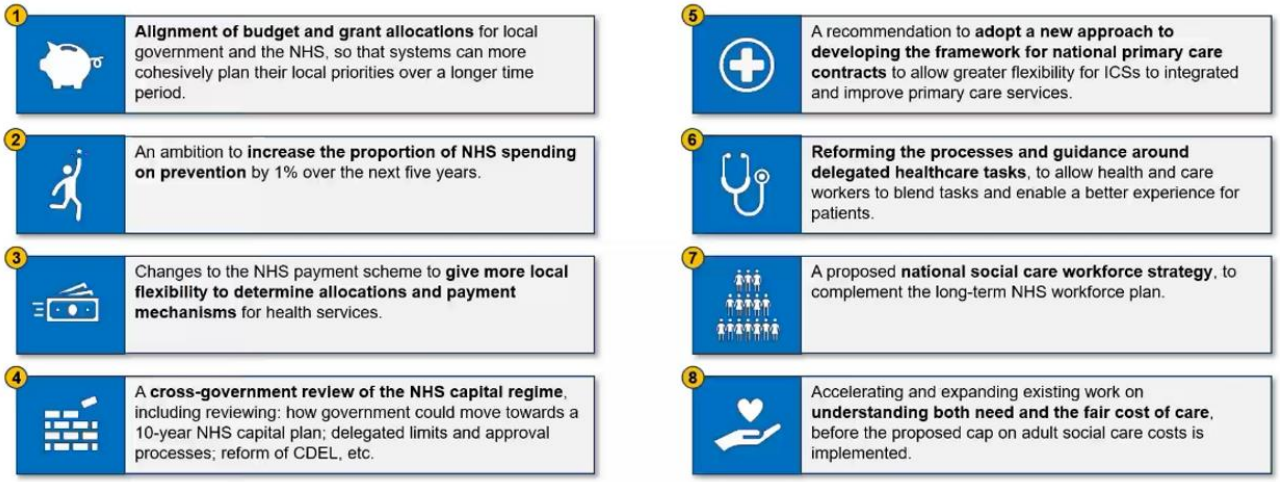
4.2 The review was conducted with significant engagement with leaders from across the health and care system and the report makes recommendations to maximise the opportunities ICSs bring to population health and wellbeing and provides a helpful overview of the issues hindering progress and placing burden on system players.

4.3 The report describes the opportunity presented by the introduction of ICSs and reinforces the need to embed collaboration and partnership working to address the challenges facing the health and care system. It sets out the Chairs conclusions on how organisations operating at national, regional and system level could work more effectively to enable ICS's to succeed.

4.4 The commentary is wide ranging, including 36 core recommendations. These recommendations are including within four main chapters:



4.5 There are various recommendations that would have implications for the NHS and wider government health policy if they were accepted and implemented. These include:



4.6 As we await the response from the Government to the findings and recommendations of the review, we will look to see how the recommendations could be adopted and implemented, where appropriate and where beneficial to the local system.

4.7 The Board will receive further updates regarding the Hewitt Review alongside further updates regarding the ICB governance and partnership review which the Board has been briefed on previously.

4.8 The Board may also be interested to read the summaries of the Hewitt Review report that have been published by the NHS Confederation[4] and NHS Providers.[5]

5. All Age Continuing Healthcare Review

5.1 The ICB is accountable for the fair and equitable distribution of All Age Continuing Health Care (AACC) funding against the assessed primary health needs of our residents. It is also accountable for the quality, safety and financial assurance of the continuing care provided. This area of provision is a significant area of financial cost, with significant budgeted overspend forecast, mainly due to increases in the cost of care rather than an increase in referrals.

5.2 Continuing Care assessment, and commissioning is delivered and led in each of the 9 places and currently there are broadly four different delivery models across Cheshire and Merseyside; with 'in house' clinical resource; outsourced commissioning support; local authority managed models and hybrid arrangements.

5.3 The ICB is currently undertaking a review of all delivery models in Cheshire and Merseyside to ensure that we have a delivery model that delivers on its statutory responsibilities in a way that is person centred, effective and efficient. The review includes some key principles that outline core elements of an ICB model that will be delivered within our nine places and those that will be delivered at scale.

5.4 The review proposals will be built upon current best practice locally and nationally, and this will enable us to develop a Cheshire and Merseyside model of AACC delivery that is designed to deliver, equity, consistency, value, and quality assurance whilst building upon the strength and best practice that currently exists in each place. The model of delivery will also support our strategic aims through addressing unwarranted variation of care at 'place', facilitating economies of scale and as a result continuing care is sustainable, affordable, and person centred.

5.5 Our plans for 2023-24 are:

- to have completed the second stage of review by June 2023
- development of an options appraisal for approval of a future model of delivery across the nine Places in Cheshire and Merseyside by August 2023
- to implement the new models of delivery by November 2023
- ongoing engagement with the Directors of Adult Social Services (DASS) to ensure we are working in partnership and plans are consistent, particularly in relation to those areas where care is joint funded.

[4] https://www.nhsconfed.org/publications/hewitt-review-what-you-need-know#:~:text=The%20Hewitt%20review%20proposes%20greater,their%20four%20main%20statutory%20purposes.
[5] https://nhsproviders.org/resources/briefings/on-the-day-briefing-the-hewitt-review

5.6 Further updates on this review will be brought back to the Board at future meetings.

6. Annual Assessment of Integrated Care Boards

6.1 The ICB has received correspondence from NHS England (Appendix A) regarding their duty to conduct an annual performance assessment of each ICB and publish a summary of these assessments. To provide an opportunity to appropriately reflect the findings of the Hewitt Review report and to engage further with ICB leaders NHS England have taken the decisions to delay the 2022/23 ICB annual assessment process until the second quarter of 2023/24.

6.2 NHS England will look to arrange to meet with ICB Chairs and Chief Executives during April and issue guidance on the 2022/23 ICB assessment process in May.

6.3 I will provide further updates on the annual assessment as and when further details have been agreed and communicated formally to the ICB.

7. Defence Employer Recognition Scheme (ERS)

7.1 The NHS Constitution for England (2015) states that the NHS will ensure that those in the armed forces, reservists, their families, and veterans are not disadvantaged. This is in line with the Armed Forces Covenant, of which we are signatories, which exists to redress the disadvantages that the armed forces community may face in comparison to other citizens, and to recognise sacrifices made.

7.2 As an employing organisation, staff that are employed, or potential staff coming in to the ICB, may face disadvantage due to their presence as an Armed Forces Community (AFC) member. That may be as a military parent, requiring leave at short notice, or a reservist needing additional leave annually to attend mandatory training camps.

7.3 The Defence Employer Recognition Scheme (ERS),[6] run by the Ministry of Defence, encourages employers to support defence and inspire others to do the same. The scheme encompasses bronze, silver, and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community, and align their values with the Armed Forces Covenant. The ICB successfully applied for bronze ERS, and at the time of applying for Bronze there was an aspiration to *go for gold!* and a commitment to apply for Silver in the next application window. At the Executive Team meeting on 6 April, it was agreed to submit an application to be considered for the silver award.

[6] https://www.gov.uk/government/publications/defence-employer-recognition-scheme/defence-employer-recognition-scheme

7.4 The ICB awaits a decision from the Ministry of Defence, expected during summer 2023. The aspiration of the ICB will then be to work towards gold accreditation in 2024.

8. NIHR Network Update

8.1 Significant progress has been made in the past 6 months regarding infrastructure to support ICS research. In October 2022, Sarah Fletcher was appointed as Senior Programme Manager for Cheshire and Merseyside ICS. We also now welcome Professor Terry Jones and Dr Greg Irving as Associate Medical Directors for Research for our ICS. In addition, to these important appointments, we have been named on two significant bids. Our application under NHS England's ICS Research Engagement Network Development (REND) programme was successful in late 2022, bringing in £100k to the region. ICS REND is a collaboration with colleagues at NHS Lancashire and South Cumbria Integrated Care System (as co-lead with Cheshire and Merseyside ICS), to work with two Voluntary and Community organisations across the North West Coast in developing two community-based research hubs, supported by NIHR colleagues at Clinical Research Network NWC and Applied Research Collaborative (ARC) NWC. It is hopeful that there will be a stage 2 for this project bringing more research opportunities to our ICS. The second bid, a response to NIHR's Capital Call for NIHR Infrastructure in November 2022, is requesting approximately £1.2m in funds under our ARC, to further develop place-based research infrastructure, namely through the development of primary care research hubs and a small fleet of mobile research units. It is hoped that the capital requested will assist researchers in reaching communities and vice versa, without the need for attendance in acute settings. The outcome of this bid is imminent.

8.2 CRN NWC has had a 6-month extension to its current hosting arrangements until 30th September 2024 due to unforeseen delays in the procurement process for RDN Coordinating Centre. The initial ambition was to transition and launch the Regional Research Delivery Networks (RRDNs) and the Research Delivery Network Coordinating Centre (RDNCC) at the same time. However, due to unforeseen delays in the approvals for the procurement of the RDNCC, the two competitions have become misaligned. As a result, the new RRDN contracts will commence from 1 October 2024. This extension will provide additional time for transition from LCRNs to RRDNs for current and future host organisations and our staff.

8.3 New hosting arrangements for Regional Research Delivery Networks (RRDNs) are still waiting to be announced. It is likely that any public dissemination is likely to be embargoed until the Autumn of this year to coincide with the revised timelines for RDNCC. However, we will of course try to keep you apprised of developments when we are able to do so.

9. Breathing Point' lung health website launched

9.1 I would also like to highlight another fantastic development delivered by system partners working together to help tackle lung disease – which is still the third biggest cause of death in the UK.

9.2 A new website has been launched that will offer people living with a lung condition advice, education, and guidance to manage their illness. Called Breathing Point (www.BreathingPoint.co.uk) it is aimed at supporting people in Cheshire and Merseyside and has been developed by the Innovation Agency, North West Coast Clinical Networks, and Liverpool Heart and Chest Hospital NHS Foundation Trust. To ensure the website is both accurate and relevant, it has been created in partnership with respiratory healthcare professionals, patients affected by lung conditions, and carers.

9.3 The new website will also help our GP's and healthcare professionals by bringing together a wide range of resources, making it easier to signpost patients to additional information about their condition. Several leading respiratory specialists from the North-West feature in videos that offer clear and simple advice in matters such as managing infections and flare-ups, advanced care and planning, and relaxation techniques.

9.4 As part of a wider move to what The Kings Fund called 'shared responsibility for health', support for people to manage their own health is being promoted through respiratory education. Breathing Point is the latest addition to the initiative and the website will help people living with a lung condition, as well as their families, friends, and carers, to better understand and manage their lung health.

10. Covid-19 Update

10.1 The phase 5 spring booster 2023 campaign started with vaccinations in care homes on 3 April 2023. The main programme of delivery commences on 17 April. Initial invitations for citizens eligible for the spring booster campaign will be rolled out gradually starting with those aged 85 or over and controlled by the national team. However, citizens who are eligible (those aged 75 and older, housebound, five-year-olds and the immunosuppressed) may book at any time through the National Booking Service (NBS) or via calling 119, be invited by Primary Care Networks (PCN) through local booking systems and can walk-in to sites registered on Grab a Jab.[7]

10.2 To date over 4,440 vaccinations have been delivered in care homes and more than 77 of our 490 care homes that are registered as older adult care homes with the CQC have been visited across Cheshire and Merseyside. This is great progress and an improved start on previous phases with careful attention being paid to lessons learned at both national and local level.

[7] https://www.nhs.uk/nhs-services/covid-19-services/covid-19-vaccination-services/find-a-walk-in-covid-19-vaccination-site/

10.3 The system also continues to see a small uptake of the evergreen offer. The latest position for Cheshire and Merseyside evergreen remains at almost 75% for first dose and 71.4% for second dose uptake compared with an uptake in the North West region of 73.1% and 69.4% respectively. In line with the Spring booster 2023 campaign, the evergreen offer will continue until the 30 June 2023.

10.4 The system plan for Spring 2023 is supported by a blend of community pharmacy, PCN and roving models and consists of 4 main hospital hubs, 31 PCNs and 51 Community Pharmacies. The Hospital hub network is reduced as healthcare workers are not part of this cohort, but the rest of the network provides sufficient capacity for the spring booster cohort and a spread of delivery models across seven days of the week across all places to enable local access.

10.5 The Living well buses continue to make excellent progress. As of 7 April, the buses have delivered over 420 clinics, over 11,100 covid vaccinations, over 6,540 MECC (Make Every Contact Count) discussions and over 12,250 health screenings. The team are now commencing their support for the mainspring booster programme from 17 April. Discussions are underway with Cheshire and Wirral Partnership NHS Foundation Trust to build on and develop the living well bus roving offer that was highly commended in the HSJ partnership awards, subject to funding.

11. Eurovision Song Contest 2023

11.1 As many of you are aware, Liverpool was successful in bidding to host Eurovision 2023. Eurovision takes place on 09 May 2023 and ahead of this the ICB has been working with system partners to prepare for this major event which will bring many thousands of people into the local area, and which will have an impact on local health and care services. Local partners are experienced in anticipating and mitigating the expected demands that a major event brings, and I would like to thank all staff who are part of the planning and who will be involved on the day in one capacity or another. There has been a call out to ICB staff, along with other partners, to also support the event by volunteering and I am confident that many of our staff have taken up this opportunity to be involved in the unique opportunity.

12. Decisions taken at the Executive Committee

12.1 Since the last Chief Executive report to the Board in March 2023, the following decisions have been made under the Executives' delegated authority at the Executive Committee. At each meeting of the Executive Team any conflicts of interest stated were noted and recorded within the minutes:

- **Corporate Estates & HQ Programme** – the Executive Team considered an update paper regarding the work underway looking at the existing corporate estates and leases and where efficiencies can be made. The Executive Team received projected reductions in costs over the next 3-4 years due to

downscaling in line with current plans. The Executive Team also received details regarding the work underway at No 1 Lakeside, Warrington and agreed to progress this as the designated HQ base of the ICB. Work is now progressing with regards arrangements for consulting with affected staff, development of communications to staff and public, the work required to the building at No 1 Lakeside, and the necessary work required to inform stakeholders and key contacts of the intended change.

- **Defence Employee Recognition Scheme (ERS**) – the Executive Team considered a paper regarding ERS and approved the submission for a Silver Award.
- **We Are One** – the Executive Team received and approved the recommendations within a paper outlining a new format for the delivery of the ICB Staff We Are One staff briefings.

12.2 Since the last meeting of the Board the Executive Team has continued to receive regular updates on the following:

- financial performance and progress towards developing the Financial Plan and submission to NHS England
- Quality issues identified across the system
- Industrial Action – plans and mitigation being put in place across the system.

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

- the ICB Senior Leadership Development Forum
- progress around the Mutually Agreed Resignation Scheme
- Non-Criteria to Reside data and the national discharge visits from NHS England and other agencies
- Neurodevelopment Pathways for Children and Young People
- Virtual Wards.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report (April 2023)

Appendix One: NHS England letter regarding ICB Annual Assessment

To:
- ICB chairs and chief executives

cc.
- National directors
- Regional directors
- Regional system and transformation directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

29 March 2023

Dear ICB chairs and chief executives (CEOs)

Annual assessment of Integrated Care Boards

NHS England has a statutory duty to conduct a performance assessment of each ICB with respect to each financial year and publish a summary of these assessments.

The NHS Oversight Framework outlines the approach NHS England will take to the inaugural annual assessment of ICB performance for 2022/23. We have been working with ICBs to develop more detailed guidance to support the assessment process, minimising additional burden while ensuring that the specific requirements set out in the Act are met.

As you know, the Chancellor of the Exchequer and the Secretary of State for Health and Social Care asked Rt Hon Patricia Hewitt to lead an Independent Review into how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed. The report is due to be published shortly.

To provide an opportunity to appropriately reflect the findings of the report and engage further with ICB leaders we have taken the decisions to delay the 2022/23 ICB annual assessment process until the second quarter of 2023/24.

We will arrange to meet with ICB Chairs and CEOs during April and issue guidance on the 2022/23 ICB assessment process in May. We will work with ICB leaders to consider the approach to annual assessment for future years as part of our wider review of the NHS Oversight Framework.

Yours sincerely,

Mark Cubbon
Chief Delivery Officer
NHS England

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 April 2023

Report of the Director of Nursing & Care's

Agenda Item No	ICB/04/27/09
Report author & contact details	Chris Douglas Director of Nursing & Care Kerry Lloyd – Deputy Director of Nursing & Care
Report approved by (sponsoring Director)	Chris Douglas – Executive Director of Nursing & Care
Responsible Officer to take actions forward	Kerry Lloyd – Deputy Director of Nursing & Care

Cheshire and Merseyside ICB
Integrated Care Board Meeting

Report of the Director of Nursing & Care's

Executive Summary	The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks, issues and highlights that have an impact on quality and safety within the Cheshire and Merseyside ICS footprint. The report will feature updates that include: • Industrial Action • Enhancing Health in Care Homes System Collaboration Event • Liberty Protection Safeguards • Continuing Health Care Objectives 23/24.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				
Recommendation	**The Board is asked to:** • Note the content of the report and request additional information / assurance as appropriate.				
Key issues	Preparation and planning have been ongoing since the first wave of industrial action (IA) in December 2022. The ICS established a governance framework that aligned to both national and regional architecture. Reducing the impact on the quality and safety during periods of IA continues to be a priority for ICS partners.				
Key risks	• the ongoing impact of IA has the potential to impact upon the quality and safety of services. • the ongoing quality impact of not meeting the CHC Objectives.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X	X	X	X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X	X	X	X	
Route to this meeting	Not Applicable				
Management of Conflicts of Interest	No conflict of interest identified				
Patient and Public Engagement	Not Applicable				
Equality, Diversity, and Inclusion	The nature and content of the paper does not require an Equalities Health Impact assessment (EHIA) to be undertaken.				
Health inequalities	Not Applicable				
Next Steps	Reporting will continue via the established governance routes.				
Appendices	None				

Report of the Director of Nursing & Care's

1. Executive Summary

1.1 The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks and issues impacting on quality and safety within the Cheshire and Merseyside ICS footprint.

1.2 The report will feature updates that include:

- Industrial Action
- Enhancing Health in Care Homes System Collaboration Event
- Liberty Protection Safeguards
- Continuing Health Care Objectives for 23/24.

2. Industrial Action

2.1 There have been ongoing periods of Industrial Action (IA) taking place throughout the month of April 2023, with the most significant taking place by The British Medical Association in relation to 'junior doctors' terms and conditions on the 11 April 2023 to the morning of 15 April, covering a 4-day period.

2.2 The Royal College of Nursing has signalled that members plan to join a 48-hour strike commencing from 8pm Sunday 30 April to 8pm Tuesday 2 May 2023. This will cover 14 provider organisations within the C&M ICS and cover all aspects of service provision. Unlike previous industrial action taken by nurses it is proposed that there will be no derogations for services such as emergency care, critical care, and cancer provision.

2.3 Preparation and planning have continued via the established clinical/workforce cell. The cell comprises Nursing, Human Resource and Medical senior leaders. The cell continues to meet on a regular basis, determined by intensity and frequency of IA and acts as a conduit for escalation and communication with ICS and regional partners.

2.4 The cell continues to gather insight and impact feedback from all affected organisations within C&M and has developed a tracker for oversight of any associated patient harm.

3. Enhancing health in Care Homes System Collaboration Event

3.1 An event was held in St Helens on Wednesday 19 April 2023 bringing together over 70 participants from a variety of agencies e.g., NHS England, ICB staff, Local Authority, Care Home Providers and Education, to consider the Enhancing Health in Care Home Model and look at how all agencies in Cheshire and Merseyside work together as a system to ensure we have capacity to play our part in supporting care homes.

3.3 The Enhanced Health in Care Homes Model (EHCH) moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, Voluntary, Community, and Social Enterprise (VCSE) sector and care home partners.

3.4 The NHS Long Term Plan (2019) contained a commitment as part of the Ageing Well Programme to roll out EHCH across England by 2024, commencing in 2020. This reflects an ambition for the NHS to strengthen its support for the people who live and work in and around care homes. This includes how Urgent Community Response is accessible to people living in a care home, increased support for nurses working in care homes through a national network, and the appointment of a chief advisor on care home nursing. Information will also be shared more easily and securely between the NHS and care homes, with NHS Mail now available to all care homes.

3.5 The awaited refresh of the implementation framework due imminently, is based on the original EHCH framework, published in 2016, and has been developed with a range of experts and partners. Care has been taken to expand EHCH without disrupting the elements of the original framework most likely to result in benefits for people living in care homes, such as continuity of care.

3.6 The challenges we are seeing in the care home sector include: -

- Inconsistency of wrap around and proactive support (i.e., accessing dietician, SALTS, mental health)
- Variance of EHICH offer across care homes (home rounds, medication reviews, MDTS etc)
- Difficulty in accessing clinical training to support increasing acuity of resident need
- Impact of current cost of living expenditure for providers in particular rising energy costs.
- Workforce attrition and high turnover of staff (due to burn out, moving to retail, other sectors etc)
- Difficult to recruit and retain nurses and registered managers
- High agency usage affecting care home costs and consistency of care
- Initiative fatigue -Ever increasing ‘asks’ from all parts of our system for care home improvement and transformation.

3.7 **The Impact for C&M:**

- Care home closures, suspensions and ‘closed to admissions’
- Financial pressure on system due to an increase in number of homes requesting ‘Top Up’ fees; and an increase in requests for additional 1-1 hours
- Increasing difficulty to commission high quality placements for complex needs

- Slight reduction in good and outstanding care homes from 80% to 76% (Oct 20-22)

- high levels of patients that do not meet the criteria to reside, awaiting placements in residential care settings: discharge pathways 2 and 3 remain the highest reasons for delayed discharge'
- Impact on wider system - under significant pressure with patient flow.

3.8 Cheshire and Merseyside ICS conducted a gap analysis in March 2023 on how each of the 9 Places have demonstrated achievement of the elements within the current framework and where we need to focus further attention. The outputs from the event will be used to inform the continuing work of the Care Homes Collaborative.

4. Liberty Protection Safeguards

4.1 The Government has set out its plans for adult social care reform in its publication of the Next steps to put People at the Heart of Care. To enable focus on these critical priorities, the Government has taken the decision to delay the implementation of the Liberty Protection Safeguards (LPS) beyond the life of this Parliament. This was one of a number of decisions taken as part of prioritising work on social care. More detail can be found on plans to reform and improve adult social care within the above publication.

4.2 It is recognised that this delay will be disappointing news for the people and organisations who have worked closely with us on the development of the LPS since the Mental Capacity (Amendment) Act was introduced in 2019.

4.3 During the LPS consultation, detailed feedback was received from stakeholders across the health and social care, voluntary and legal sectors, and the people affected by it. Many of those who responded to the consultation expressed support for the LPS and agreed that there is a need for a more streamlined and person-centred system. Though some responses to the consultation also suggested changes to the proposals in a number of ways which have been considered during the consultation analysis phase.

4.4 Although implementation of LPS has been delayed at this time, there is a plan to publish a summary of responses to the consultation in due course, which will set out further information about the feedback received at consultation phase and this update will be provided when the summary of responses is published.

4.5 In the meantime, the Deprivation of Liberty Safeguards remain an important system for authorising deprivations of liberty, and it is vital that health and social care providers continue to make applications in line with the Mental Capacity Act 2005 to ensure that the rights of those who may lack the relevant capacity are protected.

5. Continuing Health Care Objectives 2023/24

5.1 The current approach to NHS CHC assurance is to be retained for 2023/24 with continued focus on maintained and improved performance and delivery of the following key NHS CHC Assurance Standards:

- **28 Day Standard** – this assurance standard requires that ICBs and ICB Sub-Locations must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the ICB/ICB Sub-Location within 28 days from receipt of the Checklist (or other notification of potential eligibility).
- **28 Day Backlog** - ensure there are no referrals breaching 28 days by more than 12 weeks.
- **Location of Assessments** – this assurance standard requires that ICBs an ICB Sub-Locations must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting.

5.2 To support this, as with previous years, a national trajectory setting exercise will be undertaken for NHS CHC regional teams to work in conjunction with their ICB and ICB Sub-Location system leads to establish delivery plans for the NHS CHC Assurance Standards for Q1 to Q4 of 2023/24.

5.3 Given the current performance position, the trajectory setting exercise will continue to focus on the 28 day and 28-day backlog assurance standards, with continued oversight and monitoring of the Location of Assessment standard, as part of the overall assurance regime for 23/24, to ensure performance against this metric is maintained. The expectation is that the trajectory setting exercise will be rolled out in May 2023.

5.4 Formal 1:1 NHS CHC assurance meetings will be held between the national NHS CHC team and each NHS CHC regional lead on a quarterly basis for 23/24, with production of a Quarterly NHS CHC Assurance Executive Summary for the national NHS CHC SRO within NHS England and shared with Regional DoNs and Regional Chief Nurses following these meetings. Where required, assurance escalation is with the Regional DoNs.

6. Recommendations

6.1 The Board is asked to:

- **Note** the content of the report and request additional information/assurance as appropriate.

7. Officer contact details for more information:

Kerry Lloyd – Deputy Director of Nursing & Care
Kerry.lloyd@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 April 2023

Cheshire and Merseyside System Finance Report Month 12

Agenda Item No	ICB/04/27/10
Report author & contact details	Frankie Morris – Associate Director of Finance (Provider Assurance, Capital & Financial Strategy) Rebecca Tunstall – Associate Director of Finance (Planning & Reporting)
Report approved by (sponsoring Director)	Claire Wilson – Executive Director of Finance
Responsible Officer to take actions forward	Claire Wilson – Executive Director of Finance

Cheshire and Merseyside System Finance Report – Month 12

Executive Summary	This report updates the Board on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year. As at 31st March 2023 (Month 12), the ICS 'System' is reporting an aggregate deficit of £29.6m against a planned deficit of £30.3m resulting in a favourable variance for the year of £0.7m. This is an improvement of £4.2m on the position reported at month 11. The system has achieved the plan for the financial year.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				
Recommendation	**The Committee is asked to:** • **Note** the contents of this report in respect of the Month 12 ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.				
Key issues	The financial plan has been delivered for the year; however, delivery has been heavily reliant on non-recurrent measures. Continued focus on delivery of recurrent efficiencies will be critical in supporting the financial sustainability of our system in the future.				
Key risks	Outlined within the main paper.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X		X	X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
				X	
Route to this meeting	Papers previously discussed at ICB Finance, Investment and Resources Committee. Provider position will be presented to Cheshire and Merseyside Acute and Specialist Provider Collaborative in line with agreed reporting timetable.				
Management of Conflicts of Interest	No specific issues raised				
Patient and Public Engagement	Financial performance at both place and provider level will be subject to local public communications and engagement arrangements.				

NHS Cheshire and Merseyside Integrated Care Board Meeting

Equality, Diversity, and Inclusion	Efficiency Plans and Investment decisions will need to be subject to organisation level Equality Impact Assessments (EIA). This will be subject to internal audit review in line with locally agreed audit plans.
Health inequalities	Healthcare resource and investment decisions impact on health inequalities and so future place-based allocation decisions will be subject to EIA processes. Strong budget management and control is important to minimise areas of overspend which lead to an unplanned redistribution of resources.
Next Steps	Continued monitoring of financial forecasts for revenue and capital allocations. Further development of cost improvement plans and system wide efficiency opportunities. Development of financial strategy to support future financial sustainability.
Appendices	Appendices 1-5 gives details of the narrative in the main body of the report.

Cheshire and Merseyside System Finance Report – Month 12

Executive Summary

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

Financial performance for the period ending 31st March 2023

- The system is reporting an aggregate deficit of £29.6m against a planned deficit of £30.3m, resulting in a favourable variance of £0.7m for the year.
- This represents an improvement of £4.2m from the position last reported to the Board.
- Cost Improvement Plan performance has improved by £47.6m to £335.6m compared to planned efficiencies of £330.9m resulting in a favourable variance of £4.7m for the year.
- The system has delivered the financial position at the end of the year comprising a £42.4m deficit on the provider side, offset by a £12.7m surplus on combined CCG/ICB side.

The financial position for the year is set out in the table below and comprises a lower-than-plan surplus position of £6.9m for CCGs/ICB (compared to a plan profile value of £19.7m) and a deficit for NHS providers of £42.4m (compared to plan profile of £50.0m).

	2022/23		
	Plan £m	Actual £m	Variance £m
CCGs/ICB	19.7	12.8	(6.9)
Providers	(50.0)	(42.4)	7.6
Total System Surplus/(Deficit)	(30.3)	(29.6)	0.7

The £7.6m favourable variance to plan for providers offsets the £6.9m unfavourable variance for the ICB and this is due to the transfer of a planning gap taken into the ICB position on behalf of providers who could not deliver their share of an improvement target, but which is now being delivered as by the provider sector overall.

Capital

At the end of March 2023 Provider Capital spend was £237.5m, £641k above the ICB capital allocation of £236.9m. Primary Care Capital spend was £5.4m, £723k less than the allocation of £6.2m. In totality the ICB has slightly underspent; £100k against the overall capital allocation given.

System Finance Report to 31st March 2023 (Month 12)

Background

1) This report updates the ICB on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, and utilisation of available 'Capital' resources for the financial year.

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

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

4) At the end of quarter one and in all financial performance circumstances, CCGs have been deemed to have delivered a breakeven financial performance position through an adjusting resource allocation process for the Q1 period (from the full year ICB allocation) with any residual difference in Q1 performance (both favourable / adverse) being inherited by the ICB during Q2-4.As a result, the additional surplus above plan of £6.7m originally reported by CCGs has been transferred to the ICB.

Month 12 (March) Performance

ICB/CCG performance

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

6) The ICB has reported a surplus of £12.7m compared to an original planned surplus of £19.7m resulting in an adverse variance to plan of £6.9m as per the table below:

	2022/23 Plan £m	Actual £m	Variance £m	Variance %
System Revenue Resource Limit	**(4,583.0)**	**0.0**	**0.0**	
ICB Net Expenditure:				
Acute Services	2,410.2	2,409.7	0.5	0.0
Mental Health Services	425.7	433.9	(8.2)	(1.9)
Community Health Services	482.4	481.3	1.1	0.2
Continuing Care Services	227.1	243.1	(16.1)	(7.1)
Primary Care Services	474.0	485.0	(11.0)	(2.3)
Other Commissioned Services	12.4	12.2	0.2	1.5
Other Programme Services	55.6	51.7	3.8	6.9
Reserves / Contingencies	8.4	(1.6)	10.0	118.4
Delegated Primary Care Commissioning including:	420.2	413.4	6.7	1.6
a) Primary Medical Services	365.6	361.1	4.6	1.3
b) Pharmacy Services	54.5	52.4	2.1	3.9
ICB Running Costs	40.7	41.4	(0.7)	(1.8)
Total ICB Net Expenditure	**4,556.6**	**4,570.3**	**(13.6)**	(0.3)
Adjustment for Reimbursable Items				0.0
TOTAL ICB Surplus/(Deficit)	**26.4**	**12.8**	**(13.6)**	0.3
** NB - CCG Q1 Adjustment*	*(6.7)*	-	*6.7*	0.5
Adjusted Surplus/(Deficit)	**19.7**	**12.8**	**(6.9)**	(0.2)

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

   a. Mental Health - increased volume and value of packages of care, including out of area placements and non-contracted activity.
   b. Primary Care Services - overspend on prescribing partially offset by underspends on GPIT and investments.
   c. Community Services – overspend relating to independent sector contracts and community equipment services offset by underspends following a detailed review of place budgets.
   d. Continuing care - overspend relating to increases to volume and price for continuing care packages and funded nursing care. This is an area of significant focus and review by each place team.
   e. Reserves – mitigations secured to offset accepted planning risks.
   f. Delegated Pharmacy – underspend because of a reduction in transition fees for the remaining part of the year to cover the cost of the high uptake of the new advanced services.
   g. Efficiency savings are built into the position and are forecasting to achieve the planned position but a significant proportion of this is non-recurrently

delivered. This continues to be a key area of focus for place and corporate teams.

8) The £7.6m favourable variance to plan for providers offsets the £6.9m unfavourable variance for the ICB and this is due to the transfer of a planning gap taken into the ICB position on behalf of providers who could not deliver their share of an improvement target, but which is now being delivered as by the provider sector overall.

NHS Provider Performance

9) The table below summarises the combined NHS provider position to the end of March 2023 reflecting a year-to-date cumulative deficit position of 42.4m compared to a deficit plan of £50.0m. Further detail is provided in Appendix 2.

	2022/23		
	Plan	Actual	Variance
	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	4.6	7.5	2.8
Bridgewater Community Healthcare NHS Foundation Trust	0.0	1.1	1.1
Cheshire and Wirral Partnership NHS Foundation Trust	2.9	3.1	0.2
Countess of Chester Hospital NHS Foundation Trust	(3.1)	(20.6)	(17.6)
East Cheshire NHS Trust	(2.6)	(1.2)	1.4
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.3	4.1	1.8
Liverpool University Hospitals NHS Foundation Trust	(30.0)	(29.9)	0.1
Liverpool Women's NHS Foundation Trust	0.6	(1.6)	(2.2)
Mersey Care NHS Foundation Trust	5.7	16.9	11.2
Mid Cheshire Hospitals NHS Foundation Trust	(10.4)	(11.7)	(1.3)
Southport And Ormskirk Hospital NHS Trust	(14.2)	(13.7)	0.4
St Helens And Knowsley Teaching Hospitals NHS Trust	(4.9)	7.1	12.1
The Clatterbridge Cancer Centre NHS Foundation Trust	1.6	3.5	1.9
The Walton Centre NHS Foundation Trust	2.9	4.6	1.7
Warrington and Halton Teaching Hospitals NHS Foundation Tru	(6.1)	(5.4)	0.7
Wirral Community Health and Care NHS Foundation Trust	0.7	0.8	0.1
Wirral University Teaching Hospital NHS Foundation Trust	0.0	(6.8)	(6.8)
Total Providers Surplus/(Deficit)	**(50.0)**	**(42.4)**	**7.6**

10) 4 provider trusts as highlighted in paragraph 13 continue to report an adverse position resulting in an adverse position compared to plan of £27.9m.

11) Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£519.1m) and non-pay costs (£101.1m) offset set by favourable movements in Income (£607.3m) and

non-operating items (£13.9m) as per the table below. The significant variance on pay, compared to M11 reflects the additional costs of the pay award proposed shortly before year-end and the associated additional income from NHSE.

	2022/23 Plan £m	Actual £m	Variance £m	%
Total Income	(5,607)	(6,214)	607	(10.8)
Pay	3,633	4,152	(519)	(14.3)
Non Pay	1,927	2,028	(101)	(5.2)
Non Operating Items (excl gains on disposal)	97	77	20	21.0
Total Expenditure	5,657	6,256	(600)	(10.6)
Total Providers Surplus/(Deficit)	(50.0)	(42.4)	(7.6)	(15.3)

12) The Pay variance has increased significantly since month 11 due to the proposed pay award. Each provider has been supported with additional funding from NHSE.

13) Key pressures relate to underachievement on delivery of planned cost improvement programmes, rising inflation and operational pressures associated with continued provision of escalation bed capacity.

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

- **Countess of Chester NHS Foundation Trust**
  £20.6m deficit, £17.6m adverse variance to plan
  Key drivers are a high level of substantive vacancies resulting in high levels of agency and bank spend, increased energy costs, insourcing capacity and Waiting List Initiative (WLI) costs incurred to deliver elective recovery. CIP performance is behind plan, but being delivered non-recurrently, resulting in a future pressure.

- **Liverpool Women's NHS Foundation Trust**
  £1.6m deficit, £2.2m adverse variance to plan
  The variance is primarily driven by use of agency and premium rate staffing. This is due to high levels of sickness and national shortages of midwives and Obstetric consultants.

- **Mid Cheshire NHS Foundation Trust (MCHFT)**
  £11.7m deficit, £1.3m adverse variance to plan
  The Trust is experiencing increased unplanned demand, resulting additional escalation beds and a newly opened discharge lounge. Premium costs are being incurred to staff these additional areas, driving the overspends reported

against plan. CIP performance is behind plan and elective recovery is also behind pre-pandemic levels.

- **Wirral University Teaching Hospitals NHS Foundation Trust**
  Forecast £6.8m deficit, £6.8m adverse variance to plan
  The adverse variance to plan is as a result of 64 open escalation beds, use of corridor care in ED, increased energy costs and the Trust's underperformance in respect of recurrent CIP.

Provider Agency Costs

15) ICB Providers set a plan for agency spend of £113.3m, compared to actual spend in 2021/22 of £139.2m. The system is required to manage agency costs within budget and to demonstrate reduced reliance on agency staffing year on year.

16) Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency above £50k. In Month 12, agency spend is £156m (£42.7m above plan), equating to 3.76% of total pay. All Trusts except for Southport and Ormskirk and Mid-Cheshire reporting adverse positions to plan.

Efficiencies

ICB Efficiencies

17) The ICB has reported achievement of the planned efficiencies of £68.8m for the year.

18) The ICB has established a programme approach to identification, development and tracking of efficiencies and is a key area focus in respect of both this and future financial years and this has been a key area of focus in the recent place review meetings chaired by the ICB CEO.

Provider Efficiencies

19) Provider efficiency schemes have delivered efficiencies of £266.9m for the year compared to a plan of £262.2m. However, only £99.2m of this has been delivered recurrently (£167.7m non-recurrently) and this is a key risk to the underlying financial position of the system. The detail by provider is included in Appendix 4.

System Risks & Mitigations

20) The financial plan has been delivered for the year; however, delivery has been heavily reliant on non-recurrent measures. Continued focus on delivery of recurrent efficiencies will be critical in supporting the financial sustainability of our system in the future.

Provider Capital

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

22) At month 12, providers have spent £237.5m against a system allocation of £236.9m. Detail by provider is set out in Appendix 5.

23) The providers have overspent by £641k against the allocation, which is offset against the £723k underspend on the primary care allocation.

24) Key variances against original plans are as follows:

a. LUHFT underspend of £21.9m, following the allocation of additional PDC to support the New Hospital build and the release of the ICB reserve which was held by the Trust on behalf of the wider system.
b. Mid Cheshire overspend of £9.5m relates to additional RAAC work, which was approved by the national team and funded by via PDC.
c. Mersey Care underspend of £1m underspend is related to spend at the Whalley Site, which is now being carried out by Lancashire Care on their behalf.
d. Southport and Ormskirk £26m overspend is related to additional allocations associated with the 23/24 merger with St Helens and Knowsley Teaching Hospitals NHS Foundation Trust.

Primary Care Capital

25) The ICB's allocation of £6.2m is made up of a base allocation of £4.7m, additional winter allocation of £936k and a Falls grant of £543k

26) Spend at the end of the financial year equated to £5.4m, £723k less than the allocation, which has offset the provider overspend

27) The underspend is made up of £364k on GPIT and £360k on Improvement Grants, which did not complete before the end of the financial year.

28) In addition, an IFRS16 allowance of £537k has been allocated to the ICB for the Cunard Building Lease.

Strategic Capital

29) There are several Strategic Capital schemes, administered by NHS England, the main ones being:

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

30) The revenue consequences of these investments may pose a risk to provider financial positions if anticipated efficiencies are not delivered.

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

Recommendations

The Board is asked to:

- Note the contents of this report in respect of the month 12 financial position for both revenue and capital allocations within the 2022/23 financial year.

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Appendix 1

2022/23 plan submissions by CCG / NHS provider

	Plan £m
NHS HALTON CCG	(3.3)
NHS KNOWSLEY CCG	12.1
NHS SOUTH SEFTON CCG	(4.1)
NHS SOUTHPORT AND FORMBY CCG	(6.3)
NHS ST HELENS CCG	(1.9)
NHS WARRINGTON CCG	(2.3)
NHS WIRRAL CCG	7.5
NHS CHESHIRE CCG	(28.8)
NHS LIVERPOOL CCG	19.8
Total CCG	(7.4)
NHS LIVERPOOL CCG - as ICB Host	27.1
Total ICB Planned Surplus/(Deficit)	**19.7**

	Plan £m
Alder Hey Children's NHS Foundation Trust	4.6
Bridgewater Community Healthcare NHS Foundation Trust	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	2.9
Countess of Chester Hospital NHS Foundation Trust	(3.1)
East Cheshire NHS Trust	(2.6)
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.3
Liverpool University Hospitals NHS Foundation Trust	(30.0)
Liverpool Women's NHS Foundation Trust	0.6
Mersey Care NHS Foundation Trust	5.7
Mid Cheshire Hospitals NHS Foundation Trust	(10.4)
Southport And Ormskirk Hospital NHS Trust	(14.2)
St Helens And Knowsley Teaching Hospitals NHS Trust	(4.9)
The Clatterbridge Cancer Centre NHS Foundation Trust	1.6
The Walton Centre NHS Foundation Trust	2.9
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(6.1)
Wirral Community Health and Care NHS Foundation Trust	0.7
Wirral University Teaching Hospital NHS Foundation Trust	0.0
Total Provider Surplus/(Deficit)	**(50.0)**

Appendix 2

System Financial Position: Combined Year-to-date Financial Position by Organisation as at Month 12 (31st March 2023)

	2022/23		
	Plan £m	Actual £m	Variance £m
CCGs/ICB Surplus/(Deficit)	19.7	12.8	(6.9)
Alder Hey Children's NHS Foundation Trust	4.6	7.5	2.8
Bridgewater Community Healthcare NHS Foundation Trust	0.0	1.1	1.1
Cheshire and Wirral Partnership NHS Foundation Trust	2.9	3.1	0.2
Countess of Chester Hospital NHS Foundation Trust	(3.1)	(20.6)	(17.6)
East Cheshire NHS Trust	(2.6)	(1.2)	1.4
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.3	4.1	1.8
Liverpool University Hospitals NHS Foundation Trust	(30.0)	(29.9)	0.1
Liverpool Women's NHS Foundation Trust	0.6	(1.6)	(2.2)
Mersey Care NHS Foundation Trust	5.7	16.9	11.2
Mid Cheshire Hospitals NHS Foundation Trust	(10.4)	(11.7)	(1.3)
Southport And Ormskirk Hospital NHS Trust	(14.2)	(13.7)	0.4
St Helens And Knowsley Teaching Hospitals NHS Trust	(4.9)	7.1	12.1
The Clatterbridge Cancer Centre NHS Foundation Trust	1.6	3.5	1.9
The Walton Centre NHS Foundation Trust	2.9	4.6	1.7
Warrington and Halton Teaching Hospitals NHS Foundation Tru	(6.1)	(5.4)	0.7
Wirral Community Health and Care NHS Foundation Trust	0.7	0.8	0.1
Wirral University Teaching Hospital NHS Foundation Trust	0.0	(6.8)	(6.8)
Total Providers Surplus/(Deficit)	(50.0)	(42.4)	7.6
Total System Surplus/(Deficit)	(30.3)	(29.6)	0.7

Note: brackets denote deficit/overspend.

Appendix 3

Agency spend: Current Performance and Forecast Outturn as at Month 12 (31st March 2023)

PROVIDER:	2022/23 Plan £m	2022/23 Actual £m	2022/23 Variance £m
Alder Hey Children's NHS Foundation Trust	0.0	(1.5)	(1.5)
Bridgewater Community Healthcare NHS Foundation Trust	(5.0)	(5.9)	(0.9)
Cheshire and Wirral Partnership NHS Foundation Trust	(3.1)	(8.0)	(4.9)
Countess of Chester Hospital NHS Foundation Trust	(8.4)	(18.0)	(9.5)
East Cheshire NHS Trust	(7.7)	(12.3)	(4.6)
Liverpool Heart and Chest Hospital NHS Foundation Trust	(0.7)	(1.2)	(0.5)
Liverpool University Hospitals NHS Foundation Trust	(12.2)	(15.5)	(3.3)
Liverpool Women's NHS Foundation Trust	(0.8)	(2.2)	(1.4)
Mersey Care NHS Foundation Trust	(17.7)	(20.7)	(3.0)
Mid Cheshire Hospitals NHS Foundation Trust	(21.0)	(20.6)	0.4
Southport And Ormskirk Hospital NHS Trust	(9.4)	(7.2)	2.2
St Helens And Knowsley Teaching Hospitals NHS Trust	(10.2)	(12.9)	(2.6)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	(1.8)	(1.8)
The Walton Centre NHS Foundation Trust	0.0	(0.3)	(0.3)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(10.2)	(15.4)	(5.1)
Wirral Community Health and Care NHS Foundation Trust	(1.7)	(2.7)	(1.0)
Wirral University Teaching Hospital NHS Foundation Trust	(5.0)	(9.9)	(4.8)
Total Providers Spend	**(113.3)**	**(156.0)**	**(42.7)**
as a proportion of Total Pay	3.12%	3.76%	

NHS Cheshire and Merseyside

Appendix 4

System Efficiencies: Current Performance and Forecast Outturn as at Month 12 (31st March 2023)

	2022/23 Plan £m	2022/23 Actual £m	2022/23 Variance £m
CCGs/ICB	68.8	68.8	0.0
	68.8	**68.8**	**0.0**
Providers:			
Alder Hey Children's NHS Foundation Trust	14.5	14.6	0.1
Bridgewater Community Healthcare NHS Foundation Trust	4.2	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	8.3	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	13.4	15.4	2.0
East Cheshire NHS Trust	5.5	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	4.9	6.0	1.1
Liverpool University Hospitals NHS Foundation Trust	75.0	77.8	2.8
Liverpool Women's NHS Foundation Trust	5.6	5.7	0.1
Mersey Care NHS Foundation Trust	22.8	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	16.8	16.3	(0.5)
Southport And Ormskirk Hospital NHS Trust	10.8	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	28.1	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	6.8	6.8	0.0
The Walton Centre NHS Foundation Trust	4.9	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation T	15.7	14.9	(0.9)
Wirral Community Health and Care NHS Foundation Trust	4.1	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	20.8	20.8	0.0
Total Providers	**262.2**	**266.9**	**4.7**
Total System	**331.0**	**335.6**	**4.7**

Recurrent/Non-recurrent split of Provider CIP delivery

2022/23	Recurrent Plan £m	Recurrent Actual £m	Recurrent Variance £m	Non Recurrent Plan £m	Non Recurrent Actual £m	Non Recurrent Variance £m	Total Plan £m	Total Actual £m	Total Variance £m
Alder Hey Children's NHS Foundation Trust	9.7	4.3	(5.4)	4.8	10.2	5.4	14.5	14.6	0.1
Bridgewater Community Healthcare NHS Foundation Trust	1.9	1.4	(0.5)	2.3	2.8	0.5	4.2	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	2.7	2.9	0.2	5.6	5.4	(0.2)	8.3	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	5.5	5.6	0.1	7.9	9.8	1.9	13.4	15.4	2.0
East Cheshire NHS Trust	3.5	2.0	(1.5)	2.0	3.5	1.5	5.5	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	3.9	3.4	(0.4)	1.0	2.5	1.5	4.9	6.0	1.1
Liverpool University Hospitals NHS Foundation Trust	32.0	11.1	(20.9)	43.0	66.7	23.7	75.0	77.8	2.8
Liverpool Women's NHS Foundation Trust	4.2	1.8	(2.4)	1.4	3.9	2.5	5.6	5.7	0.1
Mersey Care NHS Foundation Trust	15.6	15.3	(0.2)	7.2	7.4	0.2	22.8	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	7.1	6.1	(1.0)	9.7	10.2	0.6	16.8	16.3	(0.5)
Southport And Ormskirk Hospital NHS Trust	10.8	7.8	(3.0)	0.0	3.0	3.0	10.8	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	22.1	22.1	0.0	6.0	6.0	0.0	28.1	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	4.5	2.7	(1.8)	2.3	4.1	1.8	6.8	6.8	0.0
The Walton Centre NHS Foundation Trust	4.1	3.3	(0.8)	0.9	1.7	0.8	4.9	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	6.5	1.6	(4.9)	9.2	13.3	4.0	15.7	14.9	(0.9)
Wirral Community Health and Care NHS Foundation Trust	2.7	1.9	(0.8)	1.4	2.3	0.8	4.1	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	13.8	5.7	(8.1)	7.0	15.1	8.1	20.8	20.8	(0.0)
Total Providers	**150.5**	**99.2**	**(51.3)**	**111.7**	**167.7**	**56.0**	**262.2**	**266.9**	**4.7**

Note: brackets denote underdelivery

Appendix 5

Provider Capital: Current Performance and Forecast Outturn as at Month 12 (31st March 2023)

	2022/23 Charge against Capital Allocation (excluding IFRS 16 impact)		
	Plan £m	Actual £m	Variance £m
Alder Hey Children's NHS Foundation Trust	8.9	8.9	0.0
Bridgewater Community Healthcare NHS Foundation Trust	2.1	1.6	(0.5)
Cheshire and Wirral Partnership NHS Foundation Trust	2.6	2.5	(0.1)
Countess of Chester Hospital NHS Foundation Trust	19.9	19.6	(0.2)
East Cheshire NHS Trust	6.1	6.7	0.6
Liverpool Heart and Chest Hospital NHS Foundation Trust	11.3	11.4	0.1
Liverpool University Hospitals NHS Foundation Trust	62.6	40.7	(21.9)
Liverpool Women's NHS Foundation Trust	8.8	8.9	0.0
Mersey Care NHS Foundation Trust	11.1	10.3	(0.8)
Mid Cheshire Hospitals NHS Foundation Trust	29.0	38.6	9.5
Southport And Ormskirk Hospital NHS Trust	11.3	37.3	26.0
St Helens And Knowsley Teaching Hospitals NHS Trust	4.5	4.5	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	7.0	7.2	0.2
The Walton Centre NHS Foundation Trust	5.7	5.6	(0.2)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	12.5	12.4	(0.1)
Wirral Community Health and Care NHS Foundation Trust	9.4	9.4	0.0
Wirral University Teaching Hospital NHS Foundation Trust	11.9	11.9	0.0
Total Charge against System Operational Capital Plan	**224.8**	**237.5**	**12.7**
System Operational Capital Allocation	**236.9**		

Note: brackets denote underspend

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting Meeting

27 April 2023

Quality & Performance Report (April 2023)

Agenda Item No	ICB/04/27/11
Report author & contact details	Andy Thomas (contact details in body of report)
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Andy Thomas, Associate Director of Planning

Cheshire and Merseyside ICB Board Meeting

Quality and Performance Report (April 2023)

Executive Summary	The attached presentation provides on overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact, and mitigations.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** • **note** the contents of the report and take assurance on the actions contained.				
Key issues	• The urgent and emergency care system continues to experience significant and sometimes severe pressure across the whole of NHS Cheshire & Merseyside. • Significant reduction in backlogs for both elective and cancer care are to be welcomed.				
Key risks	• Impact on ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience. • Long waits for cancer and elective treatment could result in poor outcomes. • Workforce, encompassing recruitment, retention, skill mix/shortages, across health and social care.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
			X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		X			
Appendices	**Appendix One**	Performance Report			

Quality and Performance Report (April 2023)

1. Urgent Care

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

1.2 All acute hospitals across the system report daily against a nationally defined set of Operational Pressures Escalation Levels (OPEL). The majority of Trusts across C&M have been consistently reporting at OPEL 3 for an extended period during 2022 and into 2023. OPEL 3 is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'.

1.3 As winter pressures continued to build over the course of December and into January a total of six of Trusts across C&M declared the highest level of escalation, OPEL 4 on one or more occasions, with 15 separate declarations over this period.

1.4 Since mid-January most Trusts have continued to escalate predominantly at OPEL 3 or better, however increased pressure has been observed since late February and into March, with several further OPEL 4 declarations. Overall pressures are still consistent with a challenging winter situation as expected.

1.5 Category 2 ambulance call response times, which should be responded to within 18 minutes and includes serious presenting conditions including patients who may have had a stroke or are experiencing chest pain, deteriorated significantly in late 2022, reaching an average for December 2022 of 1 hour 53 minutes and 3 seconds.

1.6 Performance was particularly challenged in the early part of January also, but since this time there has been a significant improvement in response times, with the February 2023 mean response time at 28 minutes. However, it should be noted that performance in March has been more challenging, with NWAS reporting at its highest level of escalation on the 20th March.

1.7 Ambulance handover delays, both those between 30 and 60 minutes, and delays over 60 minutes rose significantly in December, and although improved, remain challenging with 1,445 such delays in February.

1.8 The delays in ambulance handovers at hospitals relate to overcrowding in emergency departments caused by a combination of high demand and insufficient bed capacity available within our hospitals to admit all those patients requiring a hospital bed.

1.9 These delays often lead to patients having to wait for a bed in the emergency department or on an assessment unit, as can be seen from high number of patients experiencing a delay of over 12 hours from the point of a decision to admit, which although improved from the peak in December, remains very high at 3,761.

1.10 The impact on ED of delays from decision to admit is crowding in department and in waiting areas and corridor care. In terms of corridor care, which is an indication of severe pressure in the urgent and emergency care pathway, whilst this is improved from the levels seen in December and early January, most acute Trusts with the exception of Alder Hey and specialist trusts, have had to care for patients on corridors during times of peak demand in order to release ambulance crews as rapidly as possible.

1.11 The majority of C&M acute Trusts with an Emergency Department continue to report bed occupancy in excess of 95%, typically in a range from 97%-100%, despite the opening of additional escalation beds. The lower occupancy levels reported in the performance tables reflect the inclusion of specialist Trusts.

1.12 Bed occupancy in adult mental health is also very high, running at or close to 100%, impacting on the ability of mental health trusts to accommodate patients who attend an acute emergency department and require admission. As is the case with acute care, a significant number of adult mental health beds are occupied by patients who are ready for discharge but are awaiting supported accommodation, care homes, nursing placements and further non-acute input.

1.13 Discharge figures remain too low - a seven day moving average of 361 discharges per day as at the end of March, against a target of 463.

1.14 Within acute Trusts, there continues to be a significant number of patients no longer meeting the criteria to reside in hospital. This has remined virtually unchanged since January, standing at 22.6% as at week commencing 13th March 2023. Within this there is significant variation across Trusts. The number of patients not meeting the criteria to reside within Trusts across Cheshire and Merseyside typically remains in excess of 1,000 on any given day with the majority awaiting packages of support to enable their discharge home.

1.15 Long length of stay is also a significant factor in the persistently high levels of bed occupancy. Patients with a length of stay over 21 days account for 28% of occupied beds.

1.16 In conjunction with the continued underlying level of COVID-19 occupancy, which increased in February and into March standing at approximately 7% of admitted patients as at mid-March, this in turn means that there are often insufficient beds to admit patients from the Emergency Department or direct admissions requiring beds.

1.17 Winter plans included additional national funding to open an additional 206 beds over the course of the winter, which were all opened ahead of schedule by the end of January 2023.

1.18 The ICB opened its System Control Centre (SCC) on 01 December in line with national guidance. The SCC operates daily, gathering intelligence and where possible brokering mutual aid across the system.

1.19 This has been augmented by a dedicated EPRR response to industrial action since December 2022, with an Incident Coordination Centre stood up alongside the SCC on industrial action days. Whilst some of the industrial action in December and January saw reductions in demand on the days of action, for the latest industrial action days most trusts saw an increase in attendances to their emergency departments with significant increases for St Helens and Knowsley and Southport & Ormskirk hospitals in particular who experienced the highest numbers of attendances since December 2022.

1.20 Place Directors are working closely with their respective Local Authorities to facilitate discharge. Given the extraordinary level of pressure this winter, this response has included a focus on increasing and then maintaining the run rate of hospital discharges every day and collectively increasing risk-based decisions about who can go home earlier with a lower package of care than might previously have been assessed.

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

2. Elective Care & Diagnostics

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

2.2. Patients waiting for long periods of time may experience a deterioration in their condition and may subsequently require more interventions. We are working hard to clear the longest waiting patients to reduce this risk.

2.3. The key priority for 2022/23 was to eliminate waits in excess of 78 weeks by the end of March 2023.

2.4. Whilst the total waiting list for elective care has been growing, Trusts have been making significant progress in reducing the numbers of patients waiting 78 weeks or longer.

2.5. At the time of the previous Board, it was reported verbally that due to a range of factors not all 78 week wait patients would have been cleared by the end of March and that approximately 80 capacity breaches could occur.

2.6. As at 3 weeks until the end of March deadline there were 1,557 patients waiting over 78 weeks to be cleared. Based on the most recent unpublished data, at year end there were 244 patients remaining, of which 79 were due to patient choice and 95 were due to complexity or the patient was unfit for treatment. The remaining 70 are classified as capacity breaches against the 78-week ambition. 74 patients out of 79 patients in the patient choice category have TCI dates, whilst 51 patients out of 95 patients in the complex/unfit category have TCI dates.

2.7. In the last 29 weeks Trusts have cleared 39,576 patients in this cohort and the mutual aid hub team have facilitated mutual aid for over 3,500 patients to expedite their treatment and / or appointments and support trusts with the long wait challenges.

2.8. The focus on long waits does not end at the end of March, and we continue to work with trusts through the mutual aid hub and meet weekly with each trust to review their waiting list and support with accessing all possible capacity (including diagnostics, independent sector, and sourcing capacity out of area) to clear the remaining patients and to focus on the next milestone, the elimination of waits in excess of 65 weeks by the end of March 2024.

2.9. The theatre utilisation programme continues, and each month an “opportunity pack” is produced to show where there are specialty-level opportunities to increase throughput.

2.10. A coaching programme is commencing in April to offer intensive training to Trust teams leading theatre improvement programmes to cascade the skills and knowledge around theatre improvement.

2.11. In terms of the total waiting list for elective care, this had been growing consistently, with referral to treatment clock starts consistently exceeding clock stops. However, over the last few months the gap between clock starts and stops has reduced, and growth has slowed slightly. This is also due in part to ongoing validation of waiting lists and reflects the work described above to clear long waits.

2.12. Elective recovery to pre pandemic levels is measured in terms of value-weighted elective activity compared to for access to the Elective Recovery Fund. By this measure, the latest published data for the month ending 31 December 2022, taken from Trust activity submitted via SUS puts Cheshire & Merseyside at 94.5% of 2019/20 spend value compared to 92.8% for the North West, and 95.4% for England.

2.13. For diagnostics, the national waiting target remains at <1% waiting over 6 weeks for a diagnostic test and zero 13+ week waiters with recovery targets of 95% of patients receiving a test by March 2025. Fast and accurate diagnosis is critical so that diseases are identified as early as possible so that patients have the best chance of recovery or living well with their condition.

2.14. A national activity target has been set at 120% of pre-pandemic levels, specifically 2019/20 activity baseline across a range of seven common diagnostic modalities.

2.15. Cheshire & Merseyside is at 137% as at December, compared to 116.4% for the NW region.

2.16. Due to winter pressures and industrial action, December and January saw diagnostic activity drop and waiting times increase for the first time in 2022/23. 75.1% of patients had been waiting 6 weeks or less in January, compared to 80% in November.

2.17. Services are being supported by the Cheshire and Merseyside Diagnostics Programme to deliver not just higher activity but also to reduce waste in the form of cancelled appointments and Did Not Attend (DNA) rates for patients across diagnostic tests which will also positively impact waiting times.

2.18. Trusts are increasing productivity using real time data monitoring in endoscopy and reducing echocardiography appointment slot times to the national standard which has allowed productivity to increase in some trusts by as much as 11%.

2.19. The programme has completed a piece of work to ensure that all surveillance patients (those with an existing diagnosis who require an annual check) are included within our waiting lists and so are not overlooked.

2.20. The opening of six Community Diagnostic Centres (CDCs) across Cheshire and Merseyside has resulted in activity growth and increased access for patients across the ICB footprint. We are providing the 3rd highest CDC activity levels in England. In 2022/23 activity is expected to outturn at circa 150,000 tests however in 2023/24 that is planned to rise to around 300,000 tests.

2.21. Cheshire and Merseyside Diagnostics Programme has plans in place for 3 further Community Diagnostic Centres (CDCs) to open in the first half of 2023.

2.22. This will provide a major boost to diagnostic activity levels and support the aim to increase activity further and reduce waiting times.

3. Cancer

3.1. High referral levels have resulted in more cancer patients being diagnosed and treated than in any previous year. Data suggest that the proportion of patients diagnosed with early-stage cancers has increased, which is positive.

3.2. However, although a greater number of patients have been seen and treated within target times, high volumes have meant that significant numbers of patients have experienced delays. The impact will continue to be monitored through patient experience surveys and clinical harm reviews.

3.3. A sharp and sustained rise in urgent suspected cancer referrals, capacity constraints experienced during each wave of COVID-19, alongside ongoing diagnostic backlogs and workforce constraints has resulted in the total cancer waiting list increasing considerably since 2019.

3.4. Urgent suspected cancer GP referrals continue on an upward trend. Year to date referrals are 130% of pre-pandemic baseline. January 2023 (latest published month) was 132.2% compared with 124.6% nationally.

3.5. More patients than ever continue to be seen and are being seen within target time. However, performance against the 14-day standard still remains below target at 76.9%, higher than the North West average of 75.1%, but short of the England performance of 80.3%.

3.6. 28-day faster diagnosis performance was 65.6% in December 2022 but dropped to 61.8% in January 2023. Increased referrals and a positive reduction of the over 62-day backlog (which in turn creates 28-day FDS breaches) impacted upon performance.

3.7. Lower GI cancer pathways are under significant pressure in most providers as a combined result of increased referrals and diagnostic capacity constraints. LGI referrals in 2022/23 YTD are 160% of pre-pandemic (2019) levels.

3.8. Lower GI pathways continue to be the focus of targeted support, primarily through the Alliance's faecal immunochemical testing (FIT) programme and the Endoscopy Network's improvement programme.

3.9. Similarly, a negative impact on performance was noted in January, with 31-day cancer performance dropping to 90.8% compared to 95.1% in December. The England performance also dropped significantly from 92.7% to 88.5%. Performance may have been impacted by industrial action and wider operational pressures in January, but remains better than the North West and England averages.

3.10. 62-day cancer performance saw a similar deterioration, dropping to 55.6% for Cheshire & Merseyside and 54.4% for England.

3.11. The number of patients waiting more than 62 days for a diagnosis or treatment (aka the over 62-day backlog) remains a concern but has improved by over 40% since the beginning of January 2023. The over 62-day cancer backlog stood at 1,444 as of 05 March 2023.

3.12. 3,000 additional cancer first appointments are being provided each month compared with 2019 to manage increased demand.

3.13. The Cancer Alliance is supporting improved efficiency and productivity with funding and project resources through the faster diagnosis programme.

3.14. Capital investments, training & education (in both primary and secondary care) and a pipeline of innovation are all building resilience and supporting recovery. However, significant further investment in the cancer workforce is required.

3.15. The key targets highlighted in the 2023/24 operational planning guidance, namely the 28-day faster diagnosis standard and the reduction of the over 62-day backlog, are both anticipated to be achieved by the end of Q4 2023/24 in line in the national expectation.

4. Mental Health & Learning Disabilities

4.1. Work is being undertaken to address VCSFE data flow issues for MH services for children and young people. A new Cheshire and Merseyside “Access Workstream” is being established to strengthen collaborative approaches to improving access and to drive delivery of the ICB level target.

4.2. Eating Disorder services for children and young people continue to receive referrals significantly above pre-COVID levels. Assessments are routinely available within four weeks of referral, with a small number of breaches due to appointment attendance.

4.3. The number of urgent referrals received is small, and compliance therefore reduces significantly in percentage terms when breaches occur. Alder Hey experienced one breach in quarter 3 as a result of family availability. Actions are being addressed to improve data quality issues for this indicator.

4.4. The 60% target for early intervention in psychosis treatment within 2 weeks was met during the reporting period following successful recruitment to vacant posts.

4.5. Talking Therapies (IAPT) access rates remain significantly below target with high numbers of vacancies being reported by some services.

4.6. Talking Therapies (IAPT) recovery rates have been achieved in 3 out of 9 Place areas with a further 2 close to achieving the 50% target. The Cheshire and Merseyside Talking Therapies Steering Group is collaboratively reviewing all metrics and data and sharing good practice to drive further improvement.

4.7. Access to NHS Talking Therapies (IAPT) within 6 weeks is being achieved at ICB level. However, further review is required for Sefton and Warrington as national data indicates that these areas are only achieving the 18-week target.

4.8. The number of out of area placement bed days increased to 1,200 in December 2022 as a result of continued high demand and delayed discharges. Patients from Cheshire and Wirral account for 1,190 of this activity with a further 10 days relating to Liverpool. Lack of supported housing, nursing homes and suitable community placements are the most significant reasons for delays.

4.9. A new NW region Escalation Framework for Adult MH will be piloted in Cheshire and Merseyside during April. The Escalation Framework does not replace local process, rather sets out that clear levels of escalation are defined and in place with clear roles and responsibilities for action at each level.

4.10. Continued progress is being made in implementing new integrated models of community care and further developing crisis models to improve patient flow.

4.11. In terms of annual health checks for people aged 14+ with a learning disability, the latest local data indicates a forecast outturn of 72.7% against the target of 75%. This comes with the caveat that it is unvalidated, unpublished data, but should give a good indication of final outturn, which if achieved would represent a slight improvement on the previous year.

4.12. Increased uptake in AHCs will improve patients' lives and forward health planning and will allow professionals to focus on the quality of the Health Checks being provided.

4.13. Across Cheshire and Merseyside, the Transforming Care Commissioners and teams continue to raise awareness of LD AHC's, and GP Practices who are not delivering against target are encouraged to begin with patients they did not see last year (outstanding AHCs continue to be targeted). Risk assessment tool is being encouraged to identify those patients who need face to face AHCs.

4.14. Most practices make at least 3 contacts with the patient to encourage them to come in. Contact is made in a variety of ways between phone, text messaging and easy read letters, recognising that patients can be challenging to reach or can fail to attend an agreed appointment.

4.15. Individual reasonable adjustments are provided where needed, with ongoing work to ensure individual needs are recorded and understood. To increase uptake of the LD Health check offer, it is widespread practice to send easy read letters to those patients who DNA or have not responded. Where possible, Health Facilitators follow up for non-attendance to understand why.

4.16. Flexible solutions have been sought in terms of location and provision of dedicated space for LD/Autism patients to better enable reasonable adjustments.

5. Primary Care

5.1. There are 355 GP Practices across Cheshire and Merseyside, looking after a population of 2.7 million people with the GP Practices grouped into 55 Primary Care Networks (PCNs) to deliver certain functions under the relevant national contracts.

5.2. GP practices were asked to focus on 'recovery and restoration' of general practice services, returning to pre-pandemic levels and scope of delivery as quickly as possible during 2022-23.

5.3. In relation to access, appointment activity remains higher than the same pre-pandemic period at 110.3% compared to 109.6% for England.

5.4. The mix of appointments across Cheshire & Merseyside however shows that face to face appointments, are overall slightly lower than pre pandemic but there has been a relative increase in telephone appointments.

5.5. Place/PCN and Practice level appointment data toolkit for Place is being rolled out from April 2023 to enable further granular analysis at Place level, noting comparable data for PCN and practice is only from August 22.

5.6. The ICB is awaiting publication of the National Access Recovery Plan which will give further targets and expectations nationally for primary care. It is anticipated that this will emphasise demand, capacity and access and therefore overall appointment availability.

5.7. Appointment data is reported and overseen at the System Primary Care Committee (bimonthly) where assurance is given on actions to support this at place and corporate level.

6. Summary/Recommendations

6.1. The Board is asked to:

- **note** the contents of the report and take assurance on the actions contained.

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 April 2023

Quality & Performance Report (April 2023)

Appendix One:
Performance Report

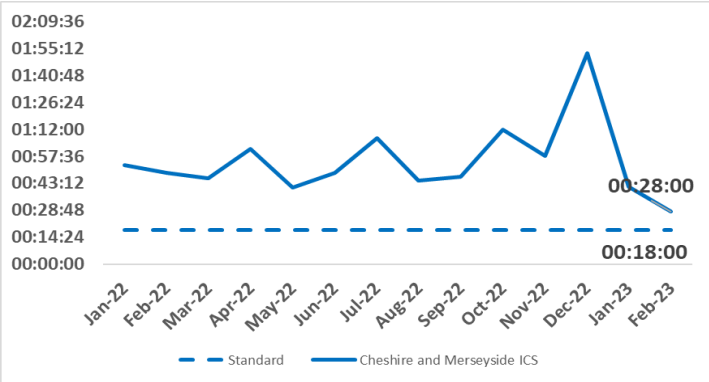
NHS
Cheshire and Merseyside

Performance Report

NHS
Cheshire and Merseyside

Section I: Urgent Care

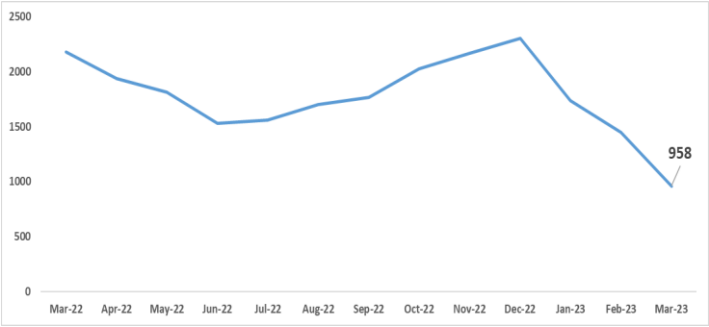
Ambulance Response times – Cat 2



Organisation	Dec-22	Jan-23	Feb-23
Cheshire & Merseyside	01:53:03	00:41:20	00:28:00
North West	01:12:11	00:29:17	00:22:36
England	01:18:57	00:32:06	00:32:20

North West & England figures published nationally, C&M figures from NWAS portal

Ambulance Arrival to handover 30 to 60 mins



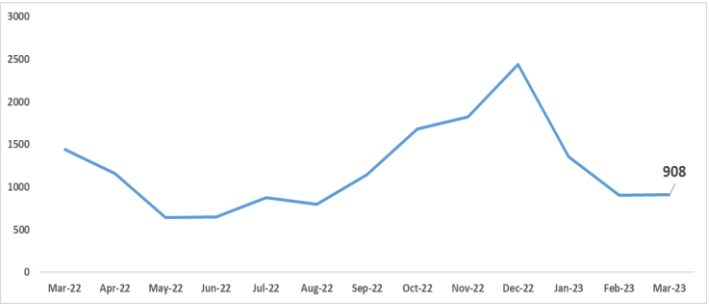
Organisation	Jan-23	Feb-23	Mar-23
Cheshire & Merseyside	1734	1445	958**
North West	5282	4333	3147
England	23919*	44734	18451***

*NW & England data published only from 16th January

** Locally available data only available until 19th March

*** National data only up to 12th March

Ambulance Arrival to handover >60 mins



Organisation	Jan-23	Feb-23	Mar-23
Cheshire & Merseyside	1356	904	908**
North West	3494	2124	2124
England	12380*	29739	13532***

*NW & England data published only from 16th January

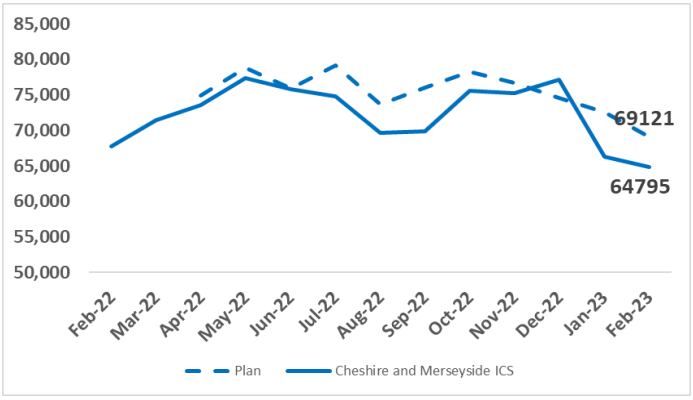
** Locally available data only available until 19th March

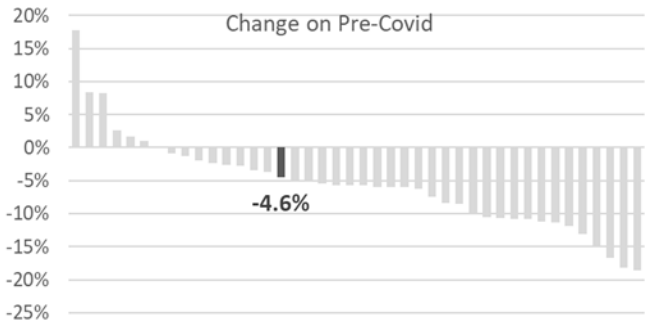
*** National data only up to 12th March

Mar 23**			
	Total measureable arrivals	>60 min arrival to handover	% attends over 60 mins
Liverpool University Hospitals (Aintree)	957	249	26%
Alder Hey	2	0	0%
Wirral University Teaching Hospital	458	139	30%
Countess of Chester	513	120	23%
Mid Cheshire Hospitals	467	12	3%
East Cheshire Hospitals	0	0	n/a
Liverpool University Hospitals (Royal)	731	216	30%
Southport & Ormskirk Hospital	596	46	8%
Warrington & Halton Hospital	765	80	10%
St Helens & Knowsley Hospital	330	46	14%

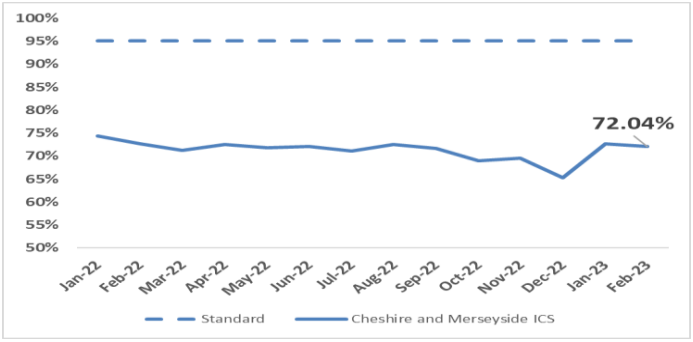
Section I: Urgent Care

A&E Attendances (Type 1)



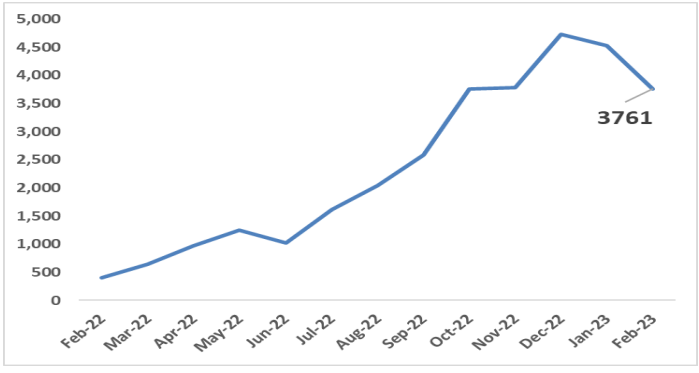


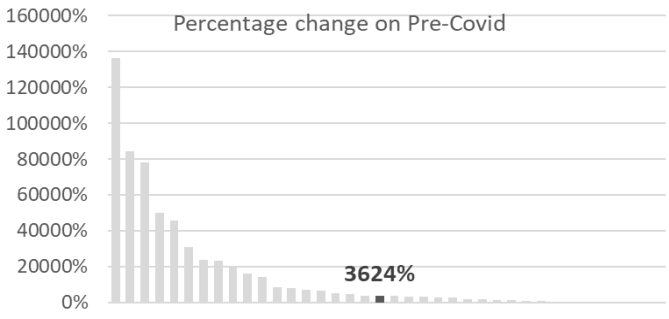
A&E 4 Hour Standard



Organisation	Dec-22	Jan-23	Feb-23
Cheshire & Merseyside	65.2%	72.7%	72.0%
North West	62.6%	69.9%	69.8%
England	68.2%	74.8%	74.0%

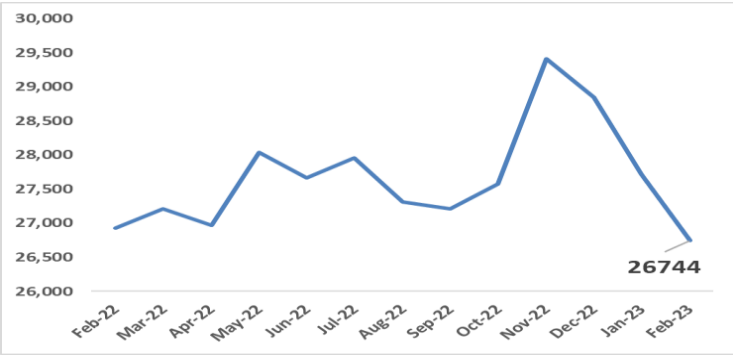
A&E 12 hour delays from decision to admit

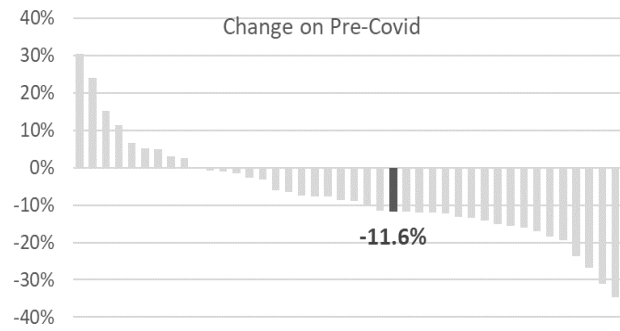




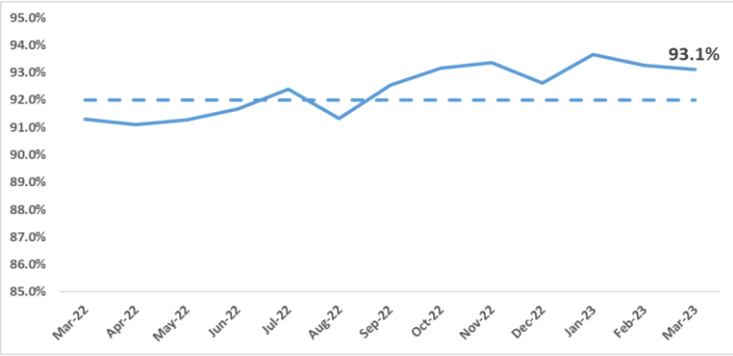
Section I: Urgent Care

Total Emergency admissions





Bed Occupancy General & Acute

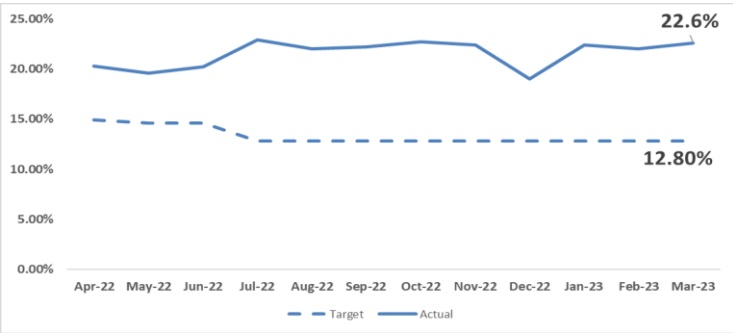


Organisation	Dec-22	Jan-23	Feb-23	Mar-23
Cheshire & Merseyside	92.6%	93.7%	93.3%	93.1%**
North West	93.3%	93.7%	93.2%	*
England	94.2%	94.3%	94.3%	*

* - National and regional figures published monthly in arrears

** - C&M data to 24th March

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



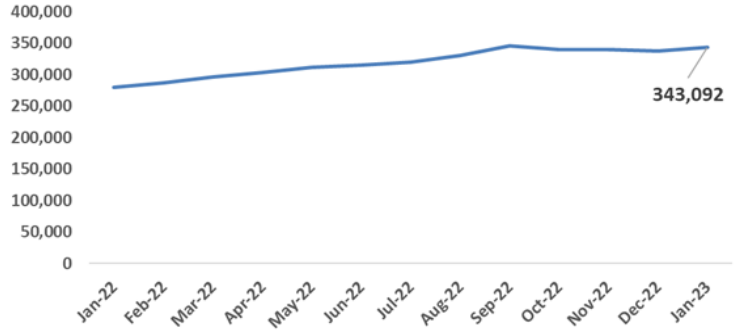
Organisation	Jan-23	Feb-23	Mar-23
Cheshire & Merseyside	22.4%	22.0%	22.6%*

* To Week Commencing 13/03/23

No longer meeting criteria to reside - Trust	02/04/2023
Countess of Chester Hospital	20.2%
East Cheshire Hospitals	16.6%
Liverpool University Hospitals	20.6%
Mid Cheshire Hospitals	15.7%
Southport & Ormskirk Hospital	12.8%
St Helens & Knowsley Hospital	17.2%
Warrington & Halton Hospital	27.0%
Wirral University Teaching Hospital	25.8%

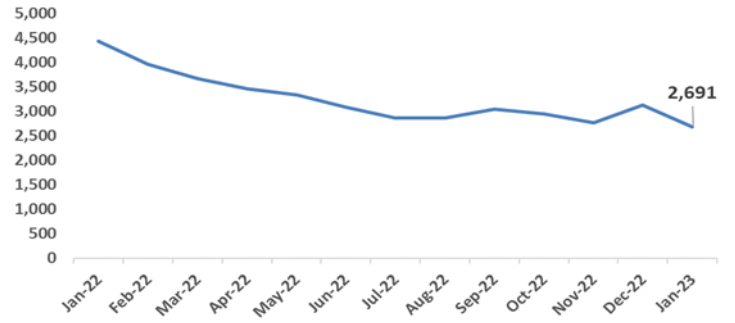
Section II: Planned Care

Total Waiting List Size



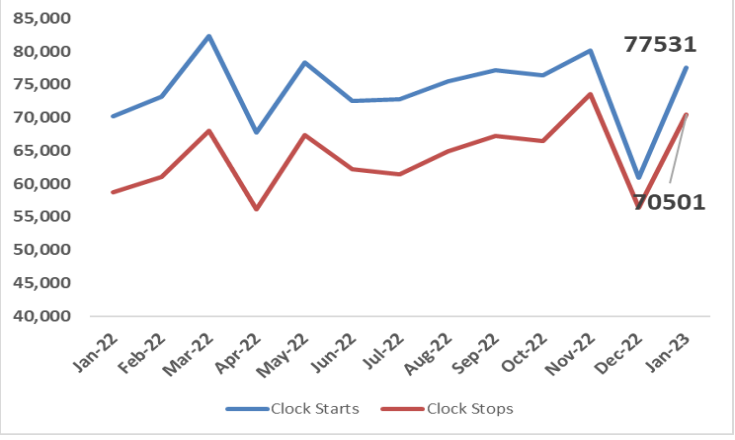
Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	339,619	336,835	343,092
North West	805,231	802,128	983,325
England	6,440,864	6,513,531	6,692,531

The number of people waiting 78 Weeks or more – Jan 23



Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	2768	3123	2691
North West	7357	8102	9738
England	40872	46335	41175

RTT – Clock Starts & Clock Stops

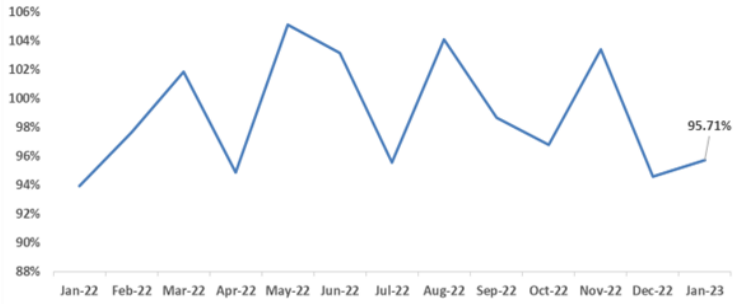


Cheshire & Merseyside	Nov-22	Dec-22	Jan-23
Clock Starts	80153	60931	77531
Clock Stops	73573	56349	70501

NB: Clock starts and clock stops for RTT treatment give a broad but not complete picture of additions and removals from the waiting list, as waiting lists are also subject to ongoing data validation.

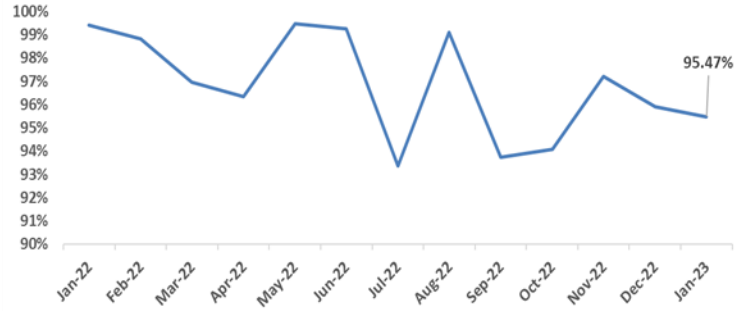
Section II: Planned Care

Outpatient First % of pre-COVID activity – Jan 23 (comparison with 2019/20)



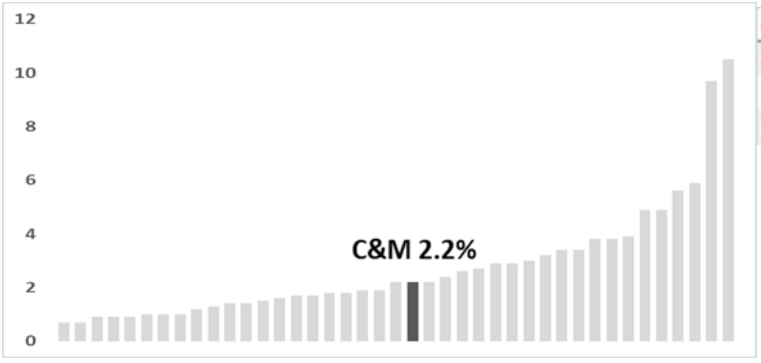
Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	103.41%	94.61%	95.71%
North West	93.14%	88.87%	94.28%
England	99.34%	95.07%	99.15%

Outpatient Follow-up % of pre-COVID activity – Jan 23 (comparison with 2019/20)



Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	97.21%	95.91%	95.47%
North West	94.88%	93.90%	96.93%
England	100.62%	98.83%	100.67%

Patient Initiated Follow-up (PIFU) ICS Benchmark – Jan 23

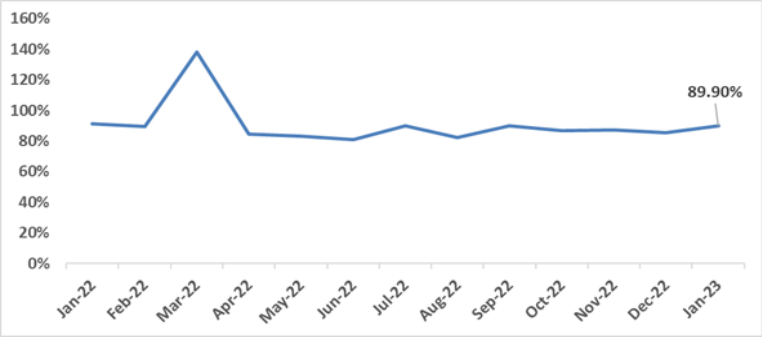


Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	1.8%	1.7%	2.2%
North West	1.5%	1.5%	1.7%
England	1.9%	2.0%	2.2%

NHS
Cheshire and Merseyside

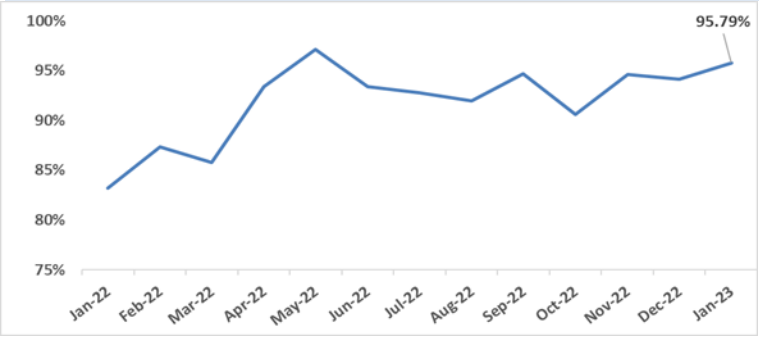
Section II: Planned Care

Elective inpatient admissions % of pre-COVID activity – Jan 23 (comparison with 2019/20)



Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	87.25%	85.63%	89.90%
North West	87.33%	92.26%	91.65%
England	82.76%	84.75%	82.39%

Day cases % of pre-COVID activity – Dec 22 (comparison with 2019/20)



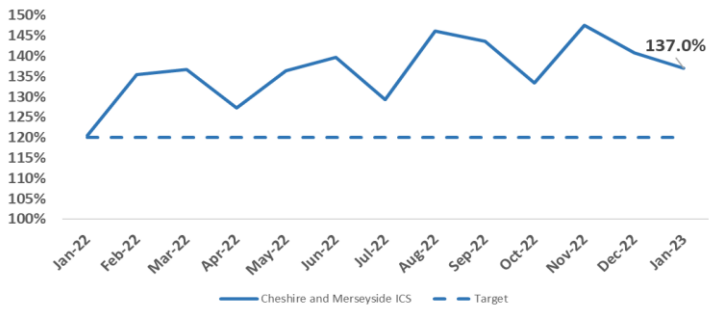
Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	94.58%	94.16%	95.79%
North West	90.92%	92.68%	94.12%
England	98.08%	97.39%	99.29%

Elective Recovery Fund – Value-weighted elective activity

SUS Value + A&G	30-Apr-22	31-May-22	30-Jun-22	31-Jul-22	31-Aug-22	30-Sep-22	31-Oct-22	30-Nov-22	31-Dec-22
North West	91.6%	94.3%	92.2%	93.0%	92.7%	90.5%	92.2%	92.7%	92.8%
LANCASHIRE AND SOUTH CUMBRIA ICB	*94.6%*	*99.4%*	*95.3%*	*97.7%*	*97.5%*	*98.7%*	*98.0%*	*95.8%*	*97.4%*
GREATER MANCHESTER ICB	*90.1%*	*89.7%*	*89.6%*	*89.5%*	*87.9%*	*82.6%*	*86.8%*	*87.5%*	*88.6%*
CHESHIRE AND MERSEYSIDE ICB	*91.4%*	*96.3%*	*93.0%*	*94.1%*	*95.0%*	*94.1%*	*94.4%*	*96.4%*	*94.5%*
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	*91.0%*	*96.5%*	*90.7%*	*94.1%*	*99.4%*	*96.7%*	*94.5%*	*99.8%*	*112.7%*
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	*94.5%*	*99.5%*	*98.1%*	*99.5%*	*101.3%*	*99.9%*	*96.5%*	*96.3%*	*90.3%*
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	*103.0%*	*109.4%*	*106.8%*	*101.7%*	*119.1%*	*106.2%*	*114.6%*	*96.5%*	*88.0%*
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	*97.6%*	*95.7%*	*99.6%*	*103.2%*	*92.6%*	*91.6%*	*102.0%*	*97.1%*	*96.2%*
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	*88.6%*	*98.2%*	*90.4%*	*84.8%*	*91.8%*	*91.3%*	*93.9%*	*96.3%*	*100.0%*
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	*89.9%*	*91.5%*	*89.6%*	*91.4%*	*89.7%*	*94.4%*	*87.5%*	*98.5%*	*89.4%*
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	*102.4%*	*105.0%*	*102.0%*	*104.6%*	*100.6%*	*100.7%*	*100.5%*	*100.3%*	*100.8%*
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	*97.9%*	*100.8%*	*92.0%*	*93.9%*	*95.8%*	*89.3%*	*100.6%*	*103.8%*	*90.3%*
THE WALTON CENTRE NHS FOUNDATION TRUST	*84.5%*	*111.6%*	*104.6%*	*107.8%*	*102.2%*	*104.5%*	*110.7%*	*112.4%*	*94.0%*
EAST CHESHIRE NHS TRUST	*72.2%*	*81.4%*	*80.0%*	*75.6%*	*84.4%*	*85.0%*	*85.9%*	*89.8%*	*99.0%*
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	*89.9%*	*85.5%*	*82.7%*	*83.8%*	*87.6%*	*83.3%*	*91.5%*	*90.6%*	*90.2%*
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	*89.3%*	*92.0%*	*89.6%*	*90.8%*	*89.4%*	*95.6%*	*97.2%*	*102.8%*	*92.5%*
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	*89.7%*	*96.2%*	*95.4%*	*93.4%*	*93.2%*	*91.4%*	*87.2%*	*87.5%*	*85.3%*
England	94.1%	96.8%	94.8%	95.5%	95.3%	96.4%	97.3%	96.6%	95.4%

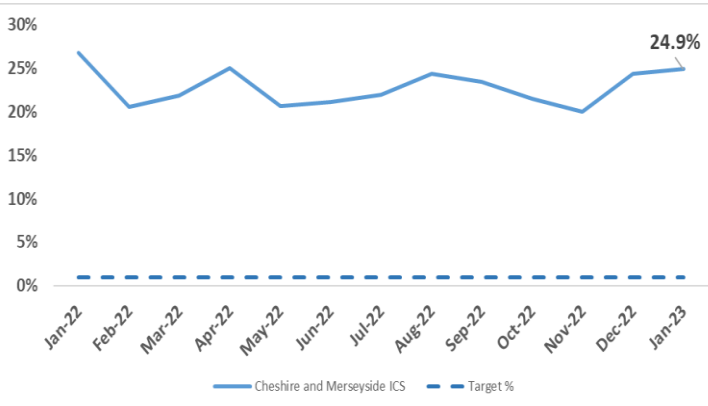
Section II: Planned Care

Diagnostic Activity: % of pre-COVID activity – Compared to same month in 2019



Organisation	Nov-22	Dec-22	Jan-23
Cheshire & Merseyside	147.5%	140.9%	137.0%
North West	109.7%	102.5%	116.4%

Diagnostic 6 week wait – objective no more than 1%

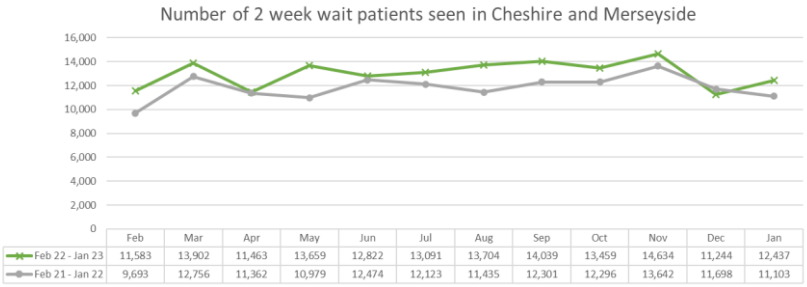


Organisation	Nov-22	Dec-22	Jan-23
Cheshire & Merseyside	20.0%	24.3%	24.9%
North West	22.7%	24.7%	30.0%
England	26.5%	31.5%	31.5%

NHS
Cheshire and Merseyside

Section III: Cancer Care

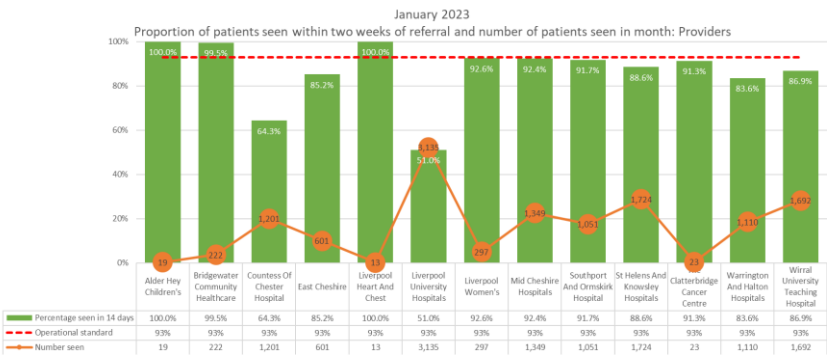
The number of 2 week wait pathway patients seen * *proxy for referrals*



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Feb 22 - Jan 23	11,583	13,902	11,463	13,659	12,822	13,091	13,704	14,039	13,459	14,634	11,244	12,437
Feb 21 - Jan 22	9,693	12,756	11,362	10,979	12,474	12,123	11,435	12,301	12,296	13,642	11,698	11,103

*Note: This metric shows numbers of patients seen in Cheshire & Merseyside, meaningful comparisons to numbers seen in the North West or England cannot be made.

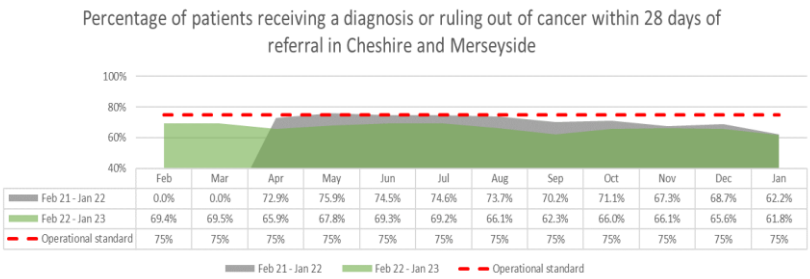
% of patients who waited for less than 14 days to be seen after referral



	Alder Hey Children's	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Women's	Mid Cheshire Hospitals	Southport And Ormskirk Hospital	St Helens And Knowsley Hospitals	Clatterbridge Cancer Centre	Warrington And Halton Hospitals	Wirral University Teaching Hospital
Percentage seen in 14 days	100.0%	99.5%	64.3%	85.2%	100.0%	51.0%	92.6%	92.4%	91.7%	88.6%	91.3%	83.6%	86.9%
Operational standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Number seen	19	222	1,201	601	13	3,135	297	1,349	1,051	1,724	23	1,110	1,692

Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	77.5%	76.8%	76.9%
North West	74.9%	75.1%	73.8%
England	78.8%	80.3%	81.8%

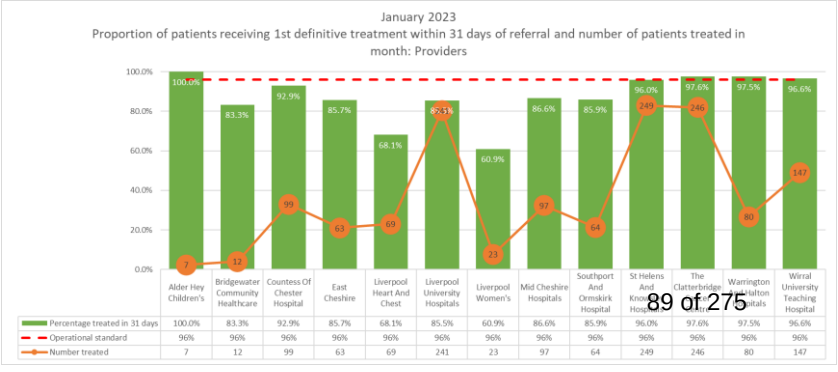
% of patients receiving a diagnosis or ruling out of cancer within 28 days of referral



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Feb 21 - Jan 22	0.0%	0.0%	72.9%	75.9%	74.5%	74.6%	73.7%	70.2%	71.1%	67.3%	68.7%	62.2%
Feb 22 - Jan 23	69.4%	69.5%	65.9%	67.8%	69.3%	69.2%	66.1%	62.3%	66.0%	66.1%	65.6%	61.8%
Operational standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	66.1%	65.6%	61.8%
North West	64.4%	66.2%	63.7%
England	69.7%	70.7%	67.0%

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

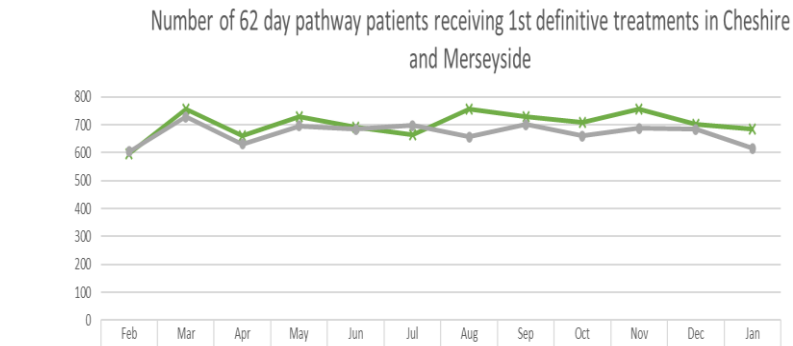


	Alder Hey Children's	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Women's	Mid Cheshire Hospitals	Southport And Ormskirk Hospital	St Helens And Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington And Halton Hospitals	Wirral University Teaching Hospital
Percentage treated in 31 days	100.0%	83.3%	92.9%	85.7%	68.1%	85.5%	60.9%	86.6%	85.9%	96.0%	97.6%	97.5%	96.6%
Operational standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Number treated	7	12	99	63	69	241	23	97	64	249	246	80	147

Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	94.0%	95.1%	90.8%
North West	92.9%	93.6%	88.3%
England	91.6%	92.7%	88.5%

Section III: Cancer Care

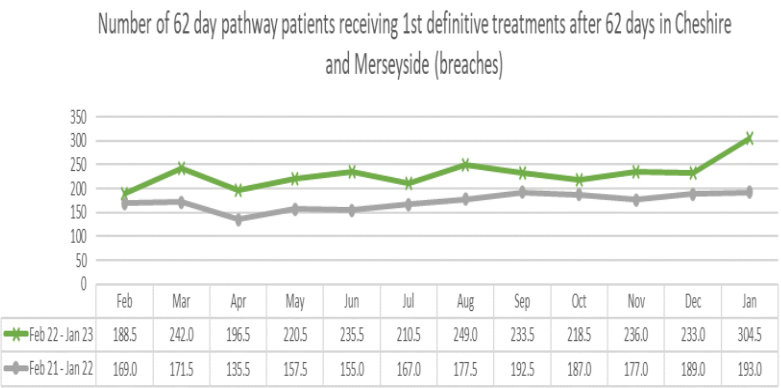
Number of patients receiving treatment for cancer treatment by their GP waiting on 62 day pathway



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Feb 22 - Jan 23	595.5	755.0	661.5	728.0	691.0	665.5	755.5	730.5	710.0	757.5	702.5	685.0
Feb 21 - Jan 22	604.5	728.0	631.5	697.0	684.0	698.5	657.0	701.0	660.0	687.0	684.5	616.5

*Note: This metric shows numbers of patients seen in Cheshire & Merseyside, meaningful comparisons to numbers seen in the North West or England cannot be made.

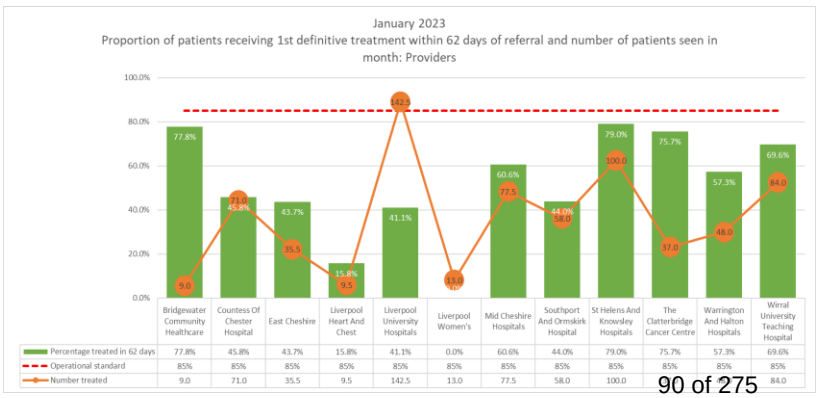
% Patients referred for cancer treatment by their GP waiting more than 62 days for treatment to start



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Feb 22 - Jan 23	188.5	242.0	196.5	220.5	235.5	210.5	249.0	233.5	218.5	236.0	233.0	304.5
Feb 21 - Jan 22	169.0	171.5	135.5	157.5	155.0	167.0	177.5	192.5	187.0	177.0	189.0	193.0

Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	68.8%	66.8%	55.5%
North West	63.1%	63.4%	54.2%
England	61.0%	61.8%	54.4%

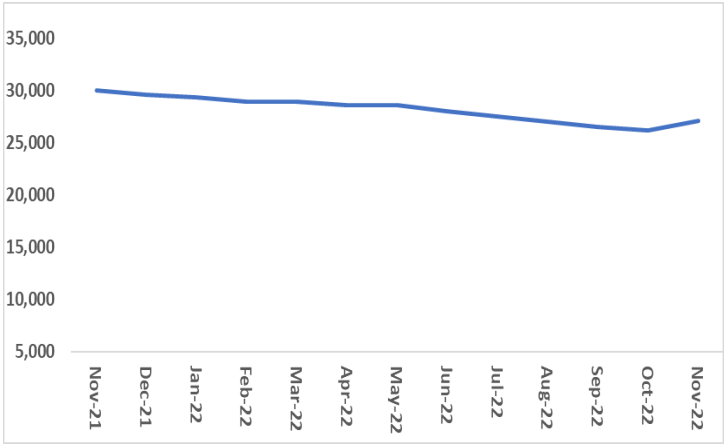
% Patients referred for cancer treatment by their GP waiting more than 62 days for treatment to start - Providers



	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Women's	Mid Cheshire Hospitals	Southport And Ormskirk Hospital	St Helens And Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington And Halton Hospitals	Wirral University Teaching Hospital
Percentage treated in 62 days	77.8%	45.8%	43.7%	15.8%	41.1%	0.0%	60.6%	44.0%	79.0%	75.7%	57.3%	69.6%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	9.0	71.0	35.5	9.5	142.5	13.0	77.5	58.0	100.0	37.0	48.0	84.0

Section IV: Mental Health

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

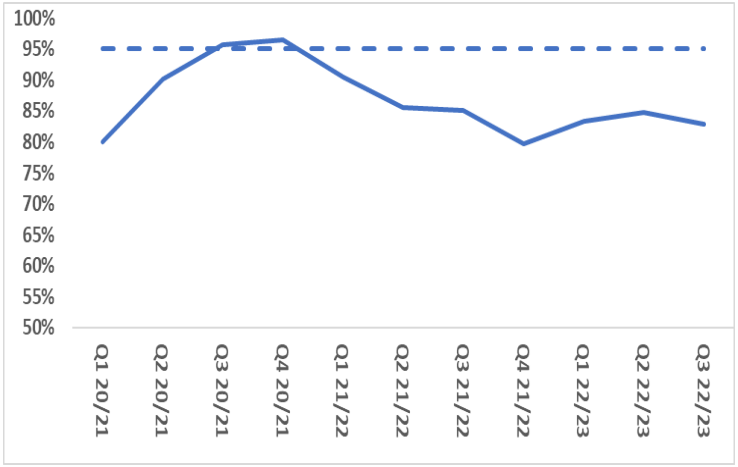


Organisation		Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	-		26,190	27,050
North West	-		93,075	95,100
England		697,350	701,658	708,939

source: NHS futures core data pack

A cyber incident affected NHSE ability to process national level data from August 22 onwards, national level data cannot be considered an accurate reflection of activity. NHS Digital has produced estimates for the affected months

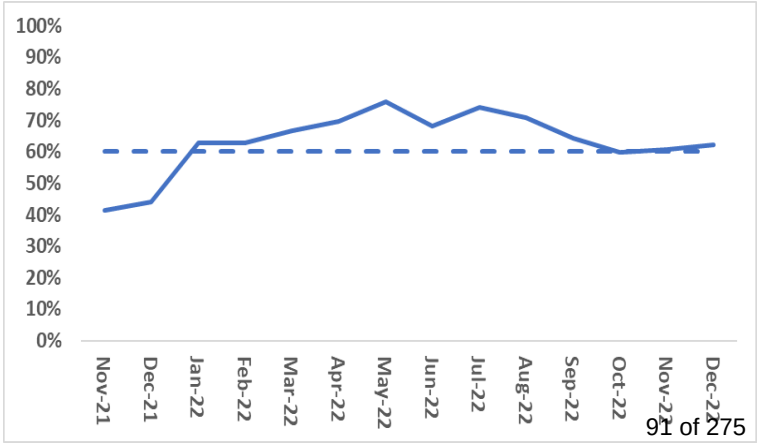
% of children and young people with eating disorders seen within 1 week (Urgent): *rolling 12 months



Organisation	Q1 22/23	Q2 22/23	Q3 22/23
Cheshire and Merseyside	83.3%	84.80%	82.80%
North West	84.6% -		86.80%
England	68.1%	67.10%	77.50%
* 12 months to end of quarter			

A cyber incident affected NHSE ability to process national level data from August 22 onwards, national level data cannot be considered an accurate reflection of activity. NHS Digital has produced estimates for the affected months

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

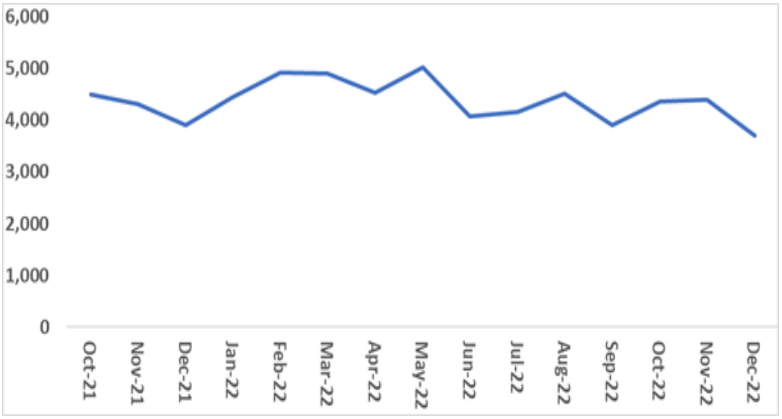


Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	59.40%	60.70%	62.10%
North West	62.30%	65.10%	68.10%
England	72.20%	72.20%	72.10%

This metric is impacted by the Mersey Care data issue in Jan 23 data MHDS submission

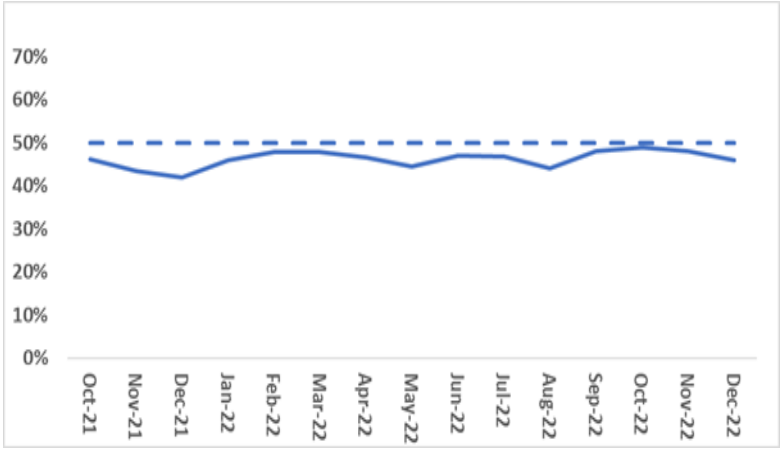
Section IV: Mental Health

IAPT access: No of people entering NHS funded treatment



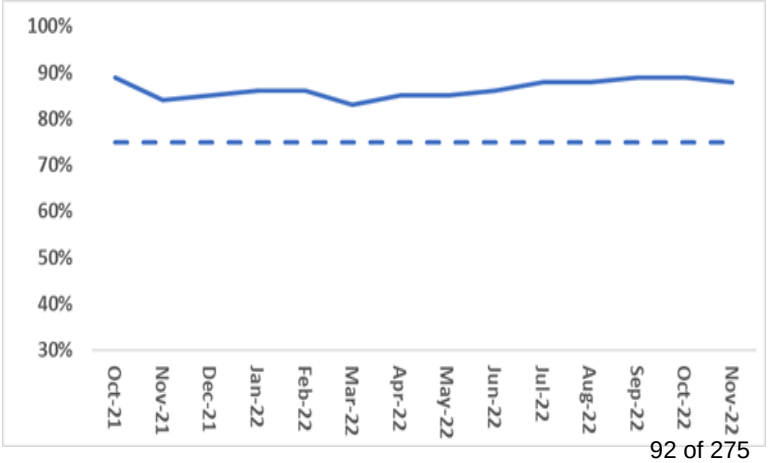
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	4,360	4,395	3,710
North West	14,625	15,025	10,760
England	102,971	113,385	81,501
source: NHS futures core data pack			

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



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	49.0%	48.0%	46.0%
North West	47.0%	48.0%	47.0%
England	49.2%	49.5%	48.9%

IAPT 6 week waits: * % finished treatment in the reporting period who had first treatment within 6 weeks



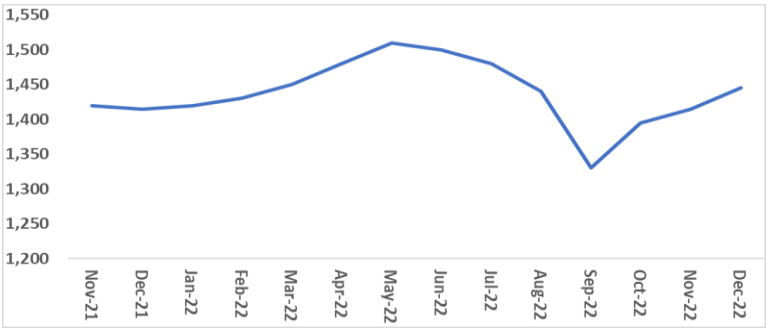
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	89.0%	88.0%	89.0%
North West	82.0%	81.0%	81.0%
England	89.2%	89.1%	89.7%

**source : NHS futures MH Core Data Pack*

NHS
Cheshire and Merseyside

Section IV: Mental Health

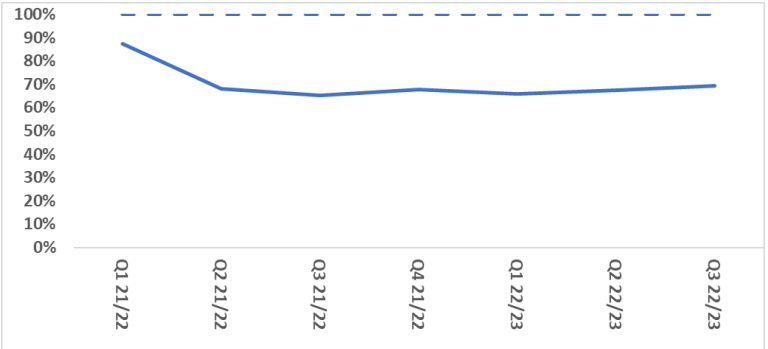
No of women accessing specialist community perinatal mental health services *rolling 12 months



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	1,395	1,415	1,445
North West	5,600	5,655	5,710
England	45,245	45,475	45,560

This metric is impacted by the Mersey Care data issue in Jan 23 MHDS data submission

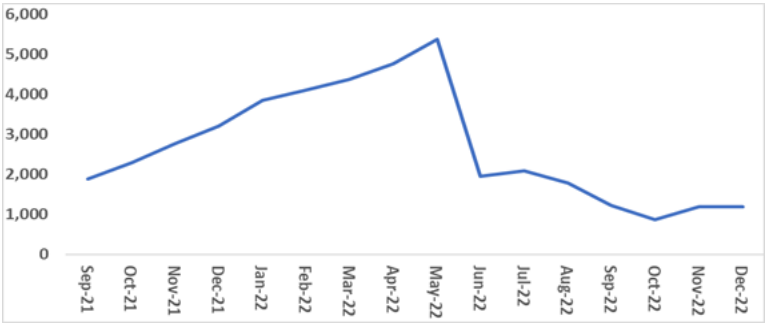
Physical health checks for people with severe mental illness



Organisation	Q1 22/23	Q2 22/23	Q3 22/23
Cheshire and Merseyside	65.9%	67.6%	69.3%
North West	73.2%	73.9%	74.7%
England	73.2%	74.5%	76.5%

** metric calculation has changed in line with SOF definition – denominator is LTP indicative trajectory (weighted share of national LTP ambition 22/23*

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

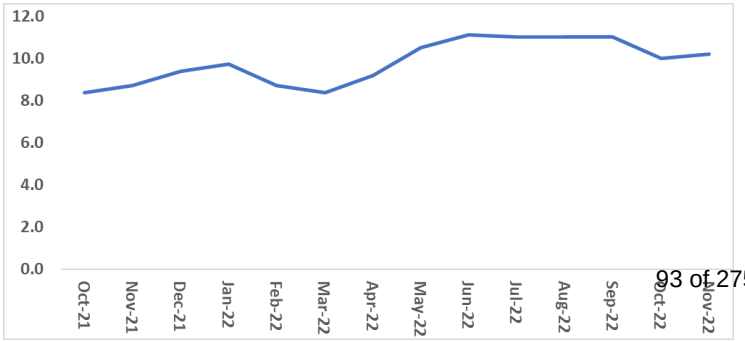


Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	865	1,190	1,200
North West	4,876	5,780	6,500
England	57,255	60,205	56,305
source: NHS futures OAP report or			

Source: NHS futures OAP report

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

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



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	-	10.00	10.20
North West	-	10.90	10.80
England	8.70	8.50	8.90

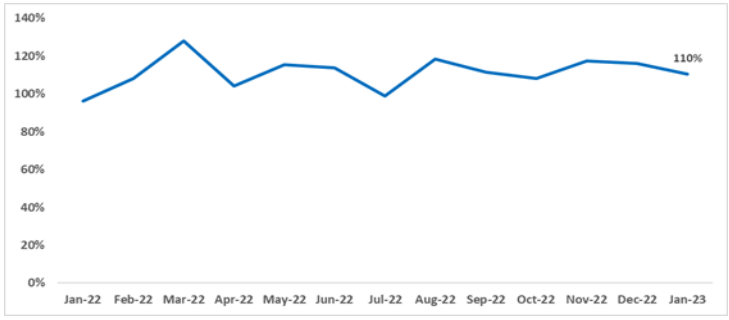
rolling qtr (MH core data pack)

A cyber incident affected NHSE ability to process national level data from August 22 onwards, national level data cannot be considered an accurate reflection of activity

This metric is impacted by the Mersey Care data issue in Jan 23 data MHDS submission

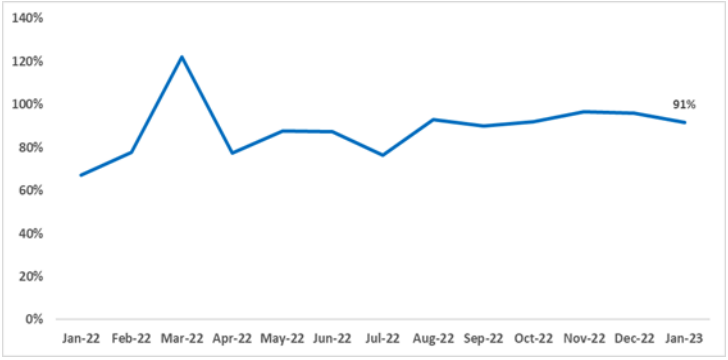
Section V: Primary Care

Total appointments delivered against pre-covid baseline



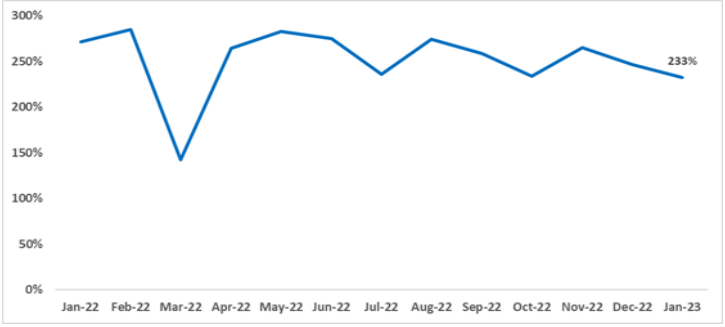
Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	117.4%	116.2%	110.3%
North West	120.0%	118.6%	112.8%
England	118.1%	114.8%	109.6%

Face to Face appointments delivered against pre covid baseline



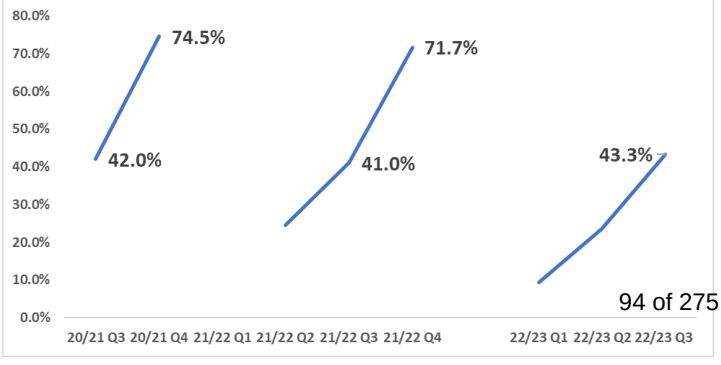
Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	96.5%	95.7%	91.4%
North West	100.9%	99.8%	95.7%
England	100.3%	97.3%	94.0%

Telephone appointments delivered against pre-covid baseline



Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	264.9%	246.3%	232.6%
North West	294.2%	276.0%	261.8%
England	239.5%	228.5%	215.6%

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

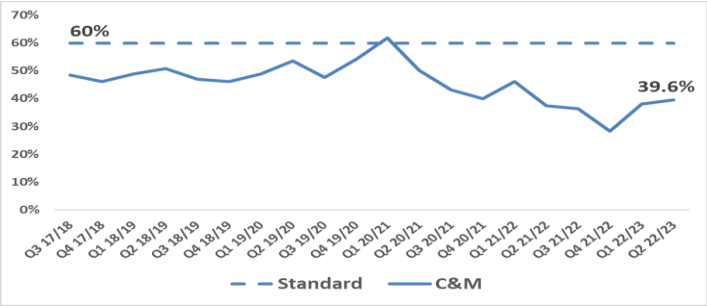


Organisation	Q1 22/23	Q2 22/23	Q3 22/23
Cheshire & Merseyside	9.4%	23.6%	43.3%
North West	9.3%	24.1%	44.8%
England	10.4%	26.0%	46.0%

NHS
Cheshire and Merseyside

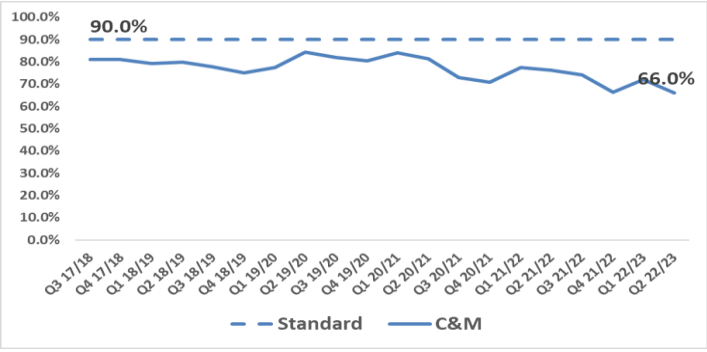
Section VI: Quality Care

Admitted to stroke unit <4 hours



Organisation	Q4 21/22	Q1 22/23	Q2 22/23
Cheshire & Merseyside	28.2%	37.9%	39.6%
North West	36.3%	40.6%	39.9%
England	38.2%	38.6%	37.9%

Spent >90% of time on stroke unit

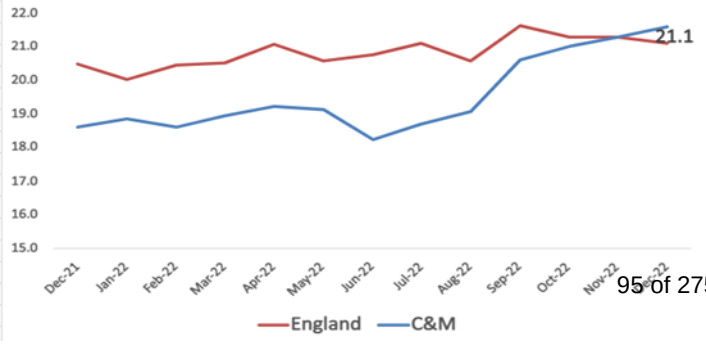


Organisation	Q4 21/22	Q1 22/23	Q2 22/23
Cheshire & Merseyside	66.3%	71.9%	66.0%
North West	68.2%	75.0%	72.5%
England	73.1%	74.2%	75.8%

C.Difficile (Hospital Onset)

Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	22.9	23.7	24.6
North West	26.0	27.3	27.0
England	18.8	19.3	18.9

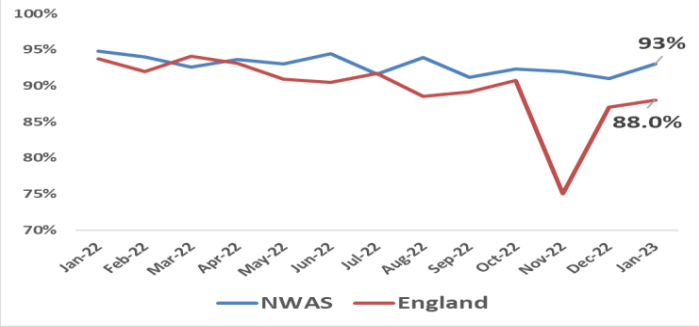
E.Coli (Hospital Onset)



Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	21.0	21.3	21.6
North West	22.7	23.2	23.0
England	21.3	21.3	21.1

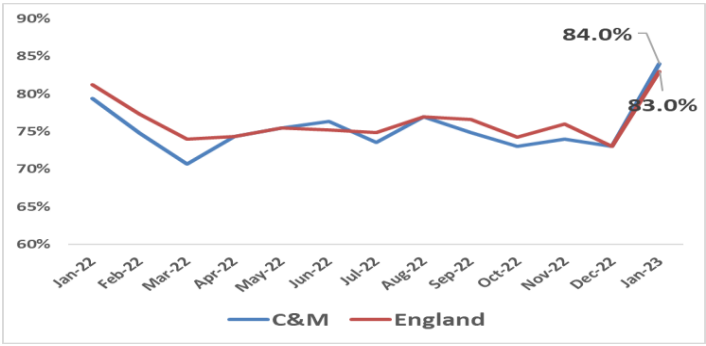
Section VI: Quality Care

Friends & Family – Ambulance Service



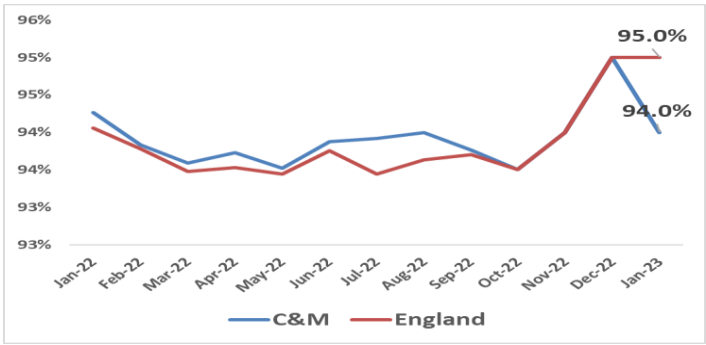
Organisation	Nov-22	Dec-22	Jan-23
NWAS	92.00%	91.00%	93.00%
England	75.00%	87.00%	88.00%

Friends & Family score – A&E



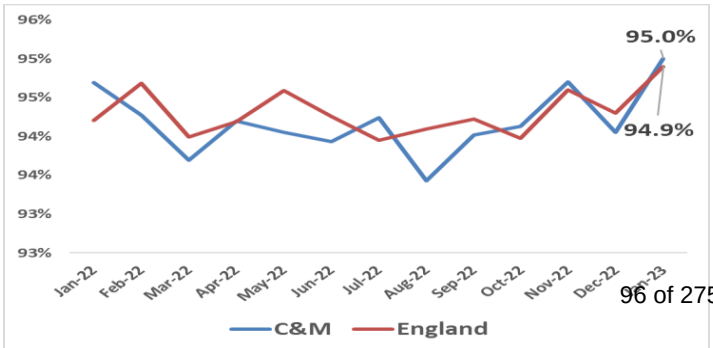
Organisation	Nov-22	Dec-22	Jan-23
Cheshire & Merseyside	74.0%	73.0%	84.0%
North West	74.0%	73.4%	83.2%
England	76.0%	73.0%	83.0%

Friends & Family score – Outpatient



Organisation	Nov-22	Dec-22	Jan-23
Cheshire & Merseyside	94.0%	95.0%	94.0%
North West	93.6%	94.1%	94.2%
England	94.0%	95.0%	95.0%

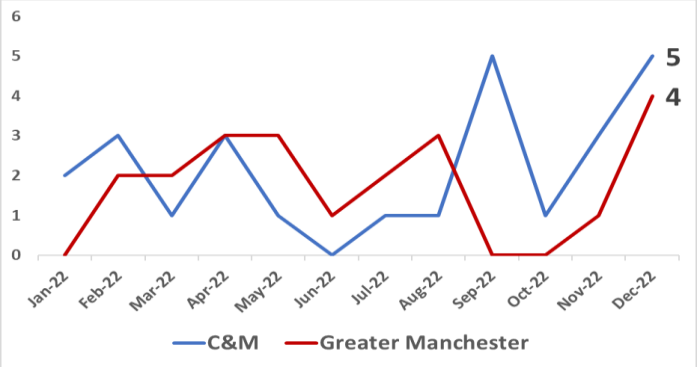
Friends & Family score – Inpatient

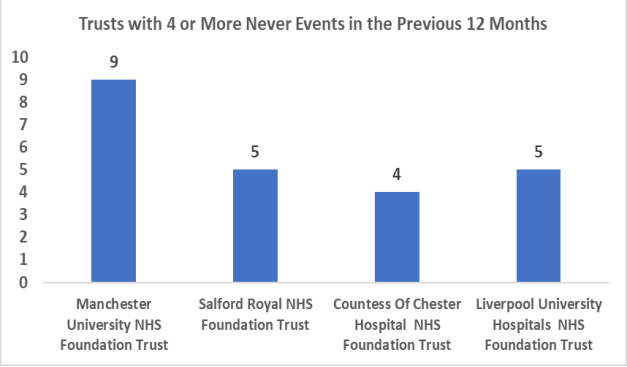


Organisation	Nov-22	Dec-22	Jan-23
Cheshire & Merseyside	94.7%	94.1%	95.0%
North West	93.6%	93.8%	94.2%
England	94.6%	94.3%	94.9%

Section VI: Quality Care

Never Events





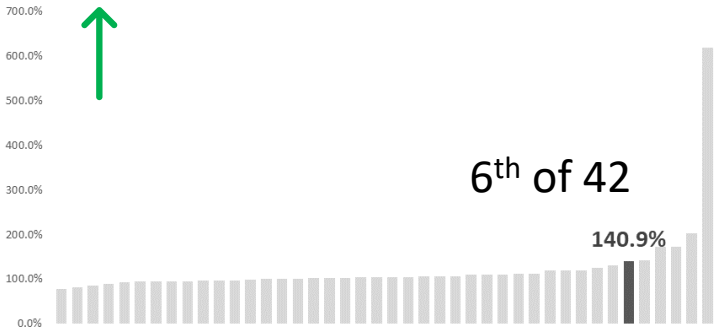
Deterioration since July 22

Improvement since July 22

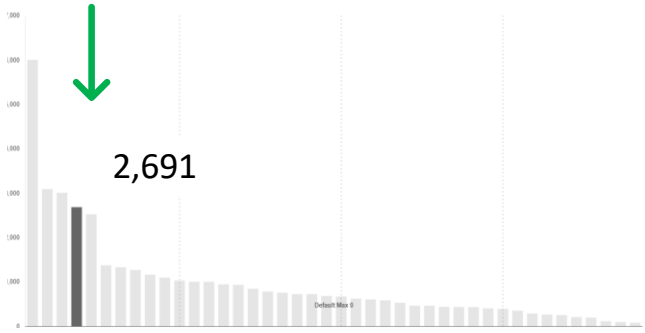
NHS Cheshire and Merseyside

ICB – National Performance Ambition Metrics

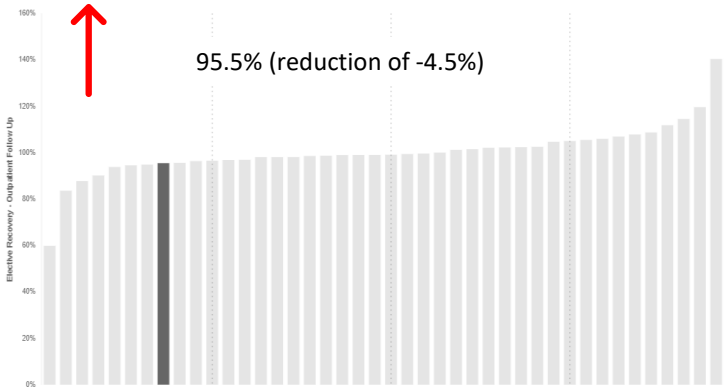
Increase diagnostic activity to 120% pre-pandemic levels



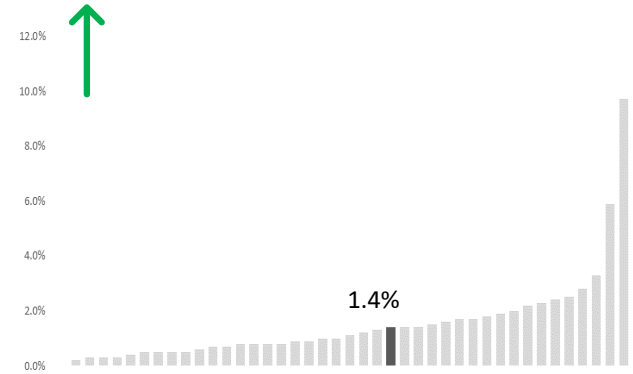
Eliminate 78 week waiters by the end of March 2023



-25% reduction in outpatient follow up attendances

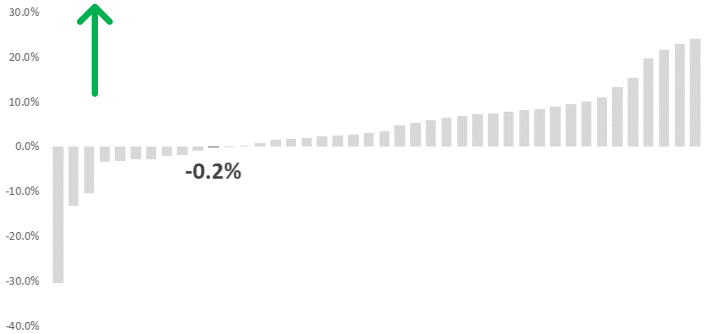


5% of outpatient attendances to convert to PIFU pathways

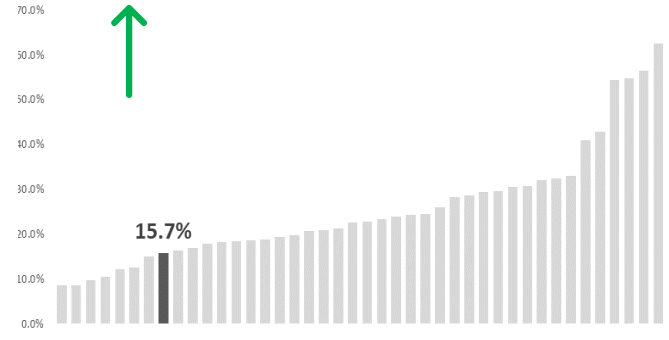


10% more patients to complete treatment through a combination of completed pathways (4% via clock stops and 6% via Advice & Guidance deflections)

Clock stops



Advice & Guidance



Deterioration since July 22

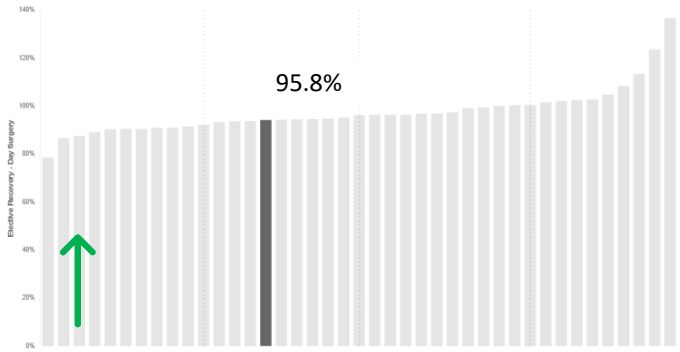
Improvement since July 22

NHS Cheshire and Merseyside

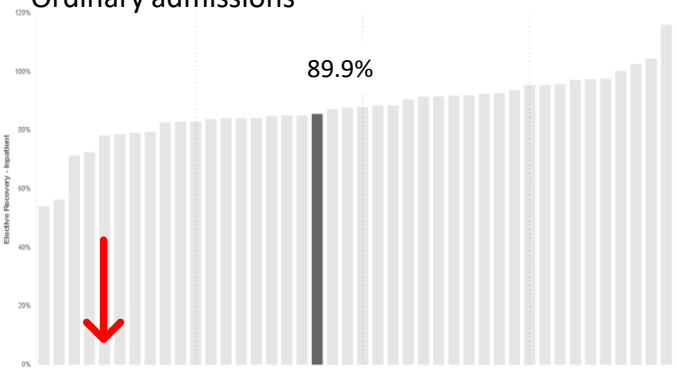
ICB – National Performance Ambition Metrics

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

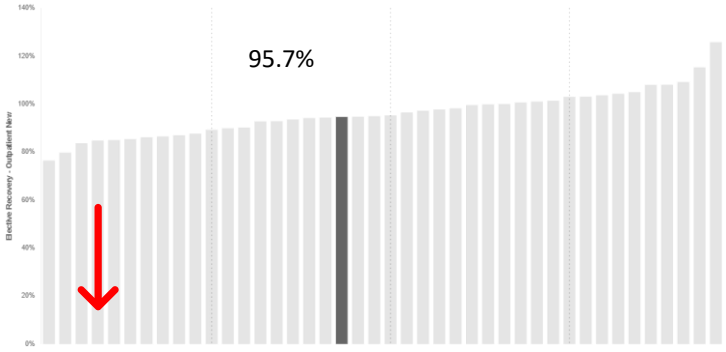
Day case



Ordinary admissions



Outpatient new



Deterioration since July 22

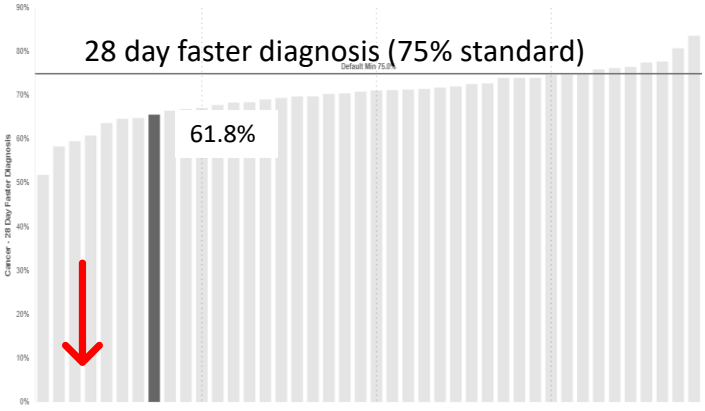
Improvement since July 22

NHS Cheshire and Merseyside

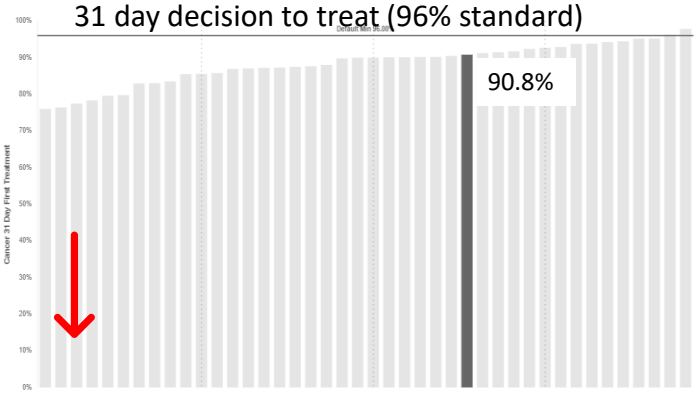
ICB – National Performance Ambition Metrics

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

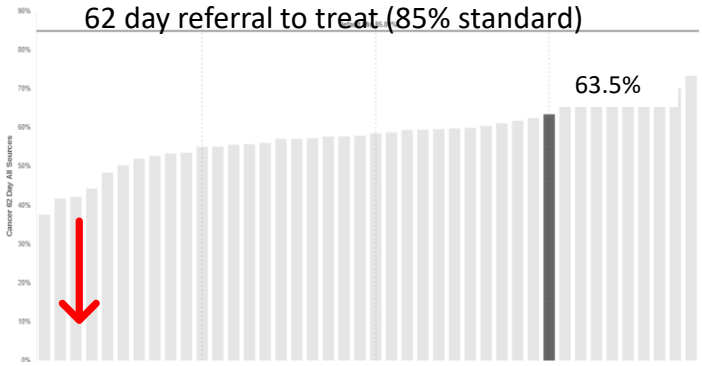
28 day faster diagnosis (75% standard)



31 day decision to treat (96% standard)



62 day referral to treat (85% standard)



NHS
Cheshire and Merseyside

Appendix 2 – Provider Summaries

NHS
Cheshire and Merseyside

Warrington & Halton Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**66.6%**
A&E Attendances All	Mar 23	-	10,454
Breast Feeding Initiation	Dec 22	70.0%	**58.8%**
C.difficile (Hospital Onset)	Jan 23	13.00	**24.6**
Cancelled Operations	Q3 22/23	0.65%	0.2%
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	75.0%
Cancer 2 Week Wait	Feb 23	93.00%	**89.0%**
Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	**75.0%**
Cancer 31 Day First Treatment	Feb 23	96.00%	98.4%
Cancer 62 Day Classic	Feb 23	85.00%	**58.1%**
Day Surgery Activity	Feb 23	-	2,060
Diagnostics - 6 Week Standard	Feb 23	1.00%	**21.5%**
E.coli (All Cases)	Jan 23	-	111.6
Elective Inpatient Activity	Feb 23	-	265
Mixed Sex Accommodation Breaches	Feb 23	0	**6**
MRSA (All Cases)	Jan 23	-	2.6
MSSA (All Cases)	Jan 23	-	34.8
Outpatient Follow Up Activity	Feb 23	-	27,240
Outpatient New Activity	Feb 23	-	7,660
Outpatient Total Activity	Feb 23	-	34,900
RTT 104 Week Breach	Feb 23	0	**1**
RTT 52 Week Breach	Feb 23	0	**1,415**
RTT 78 Week Breach	Feb 23	0	**170**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**57.6%**
RTT Total Incompletes	Feb 23	-	29,604
Sickness Absence Rate	Nov 22	4.00%	**5.8%**
Staff Recommend Care	Q3 22/23	80.00%	**55.8%**
Summary Hospital Mortality Indicator	Nov 22	100.00	99.5

NHS
Cheshire and Merseyside

Wirral University Teaching Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**65.1%**
A&E Attendances All	Mar 23	-	10,873
Breast Feeding Initiation	Dec 22	70.0%	**47.7%**
C.difficile (Hospital Onset)	Jan 23	13.00	**46.2**
Cancelled Operations	Q3 22/23	0.65%	**0.9%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	79.8%
Cancer 2 Week Wait	Feb 23	93.00%	**82.7%**
Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	**-**
Cancer 31 Day First Treatment	Feb 23	96.00%	**92.7%**
Cancer 62 Day Classic	Feb 23	85.00%	**69.3%**
Day Surgery Activity	Feb 23	-	3,860
Diagnostics - 6 Week Standard	Feb 23	1.00%	**9.7%**
E.coli (All Cases)	Jan 23	-	92.0
Elective Inpatient Activity	Feb 23	-	585
Mixed Sex Accommodation Breaches	Feb 23	0	**1**
MRSA (All Cases)	Jan 23	-	1.5
MSSA (All Cases)	Jan 23	-	25.6
Outpatient Follow Up Activity	Feb 23	-	30,040
Outpatient New Activity	Feb 23	-	10,930
Outpatient Total Activity	Feb 23	-	40,970
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	**1,280**
RTT 78 Week Breach	Feb 23	0	**66**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**58.5%**
RTT Total Incompletes	Feb 23	-	40,039
Sickness Absence Rate	Nov 22	4.00%	**6.5%**
Staff Recommend Care	Q3 22/23	80.00%	**62.1%**
Summary Hospital Mortality Indicator	Nov 22	100.00	**107.4**

NHS
Cheshire and Merseyside

St Helens & Knowsley Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**63.8%**
A&E Attendances All	Mar 23	-	14,642
Breast Feeding Initiation	Dec 22	70.0%	**49.1%**
C.difficile (Hospital Onset)	Jan 23	13.00	**14.4**
Cancelled Operations	Q3 22/23	0.65%	**1.0%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	**73.3%**
Cancer 2 Week Wait	Feb 23	93.00%	**89.3%**
Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	94.5%
Cancer 31 Day First Treatment	Feb 23	96.00%	97.7%
Cancer 62 Day Classic	Feb 23	85.00%	**77.8%**
Day Surgery Activity	Feb 23	-	3,810
Diagnostics - 6 Week Standard	Feb 23	1.00%	**27.4%**
E.coli (All Cases)	Jan 23	-	91.4
Elective Inpatient Activity	Feb 23	-	440
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	1.1
MSSA (All Cases)	Jan 23	-	39.8
Outpatient Follow Up Activity	Feb 23	-	29,230
Outpatient New Activity	Feb 23	-	14,240
Outpatient Total Activity	Feb 23	-	43,470
RTT 104 Week Breach	Feb 23	0	**1**
RTT 52 Week Breach	Feb 23	0	**2,360**
RTT 78 Week Breach	Feb 23	0	**345**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**62.1%**
RTT Total Incompletes	Feb 23	-	45,492
Sickness Absence Rate	Nov 22	4.00%	3.5%
Staff Recommend Care	Q3 22/23	80.00%	**77.6%**
Summary Hospital Mortality Indicator	Nov 22	100.00	**102.5**

NHS
Cheshire and Merseyside

Mid Cheshire Hospitals Summary

The trust have reported no patients waiting over 104 weeks for the second month. Despite more activity in most diagnostic modalities in 2022 compared to pre-pandemic, the backlog has increased slightly. Performance against the majority of Cancer targets for the trust remain above England and Cheshire & Merseyside averages.

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**60.0%**
A&E Attendances All	Mar 23	-	9,721
Breast Feeding Initiation	Dec 22	70.0%	70.2%
C.difficile (Hospital Onset)	Jan 23	13.00	**17.5**
Cancelled Operations	Q3 22/23	0.65%	**1.2%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	**71.4%**
Cancer 2 Week Wait	Feb 23	93.00%	**85.9%**
Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	**81.4%**
Cancer 31 Day First Treatment	Feb 23	96.00%	**92.2%**
Cancer 62 Day Classic	Feb 23	85.00%	**70.6%**
Day Surgery Activity	Feb 23	-	2,025
Diagnostics - 6 Week Standard	Feb 23	1.00%	**25.7%**
E.coli (All Cases)	Jan 23	-	103.6
Elective Inpatient Activity	Feb 23	-	220
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	2.1
MSSA (All Cases)	Jan 23	-	32.0
Outpatient Follow Up Activity	Feb 23	-	16,705
Outpatient New Activity	Feb 23	-	7,680
Outpatient Total Activity	Feb 23	-	24,385
RTT 104 Week Breach	Feb 23	0	**1**
RTT 52 Week Breach	Feb 23	0	**1,698**
RTT 78 Week Breach	Feb 23	0	**73**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**58.8%**
RTT Total Incompletes	Feb 23	-	37,651
Sickness Absence Rate	Nov 22	4.00%	**5.5%**
Staff Recommend Care	Q3 22/23	80.00%	**67.1%**
Summary Hospital Mortality Indicator	Nov 22	100.00	95.2

NHS
Cheshire and Merseyside

Liverpool University Hospitals Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**68.3%**
A&E Attendances All	Mar 23	-	26,150
C.difficile (Hospital Onset)	Jan 23	13.00	**25.5**
Cancelled Operations	Q3 22/23	0.65%	**1.2%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	**62.1%**
Cancer 2 Week Wait	Feb 23	93.00%	**68.2%**
Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	**37.0%**
Cancer 31 Day First Treatment	Feb 23	96.00%	**88.9%**
Cancer 62 Day Classic	Feb 23	85.00%	**48.6%**
Day Surgery Activity	Feb 23	-	7,040
Diagnostics - 6 Week Standard	Feb 23	1.00%	**15.7%**
E.coli (All Cases)	Jan 23	-	117.2
Elective Inpatient Activity	Feb 23	-	1,200
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	2.0
MSSA (All Cases)	Jan 23	-	36.0
Outpatient Follow Up Activity	Feb 23	-	54,975
Outpatient New Activity	Feb 23	-	26,780
Outpatient Total Activity	Feb 23	-	81,755
RTT 104 Week Breach	Feb 23	0	**21**
RTT 52 Week Breach	Feb 23	0	**6,264**
RTT 78 Week Breach	Feb 23	0	**453**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**50.6%**
RTT Total Incompletes	Feb 23	-	78,169
Sickness Absence Rate	Nov 22	4.00%	**6.9%**
Staff Recommend Care	Q3 22/23	80.00%	**56.0%**
Summary Hospital Mortality Indicator	Nov 22	100.00	**103.2**

NHS
Cheshire and Merseyside

East Cheshire Hospitals Summary

Significant progress continues with the utilisation of Independent Sector capacity, specifically within Gastroenterology, ENT, General Surgery and T&O specialties and some theatre lists are being converted to support long waiting patients. The cancer 62 day performance has seen a continuation of challenged performance. This is multi-factorial with the main impacts being the challenges of complex diagnostic pathways, delays in radiology as well as the reporting of histology.

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**54.4%**
A&E Attendances All	Mar 23	-	4,150
C.difficile (Hospital Onset)	Jan 23	13.00	**13.5**
Cancelled Operations	Q3 22/23	0.65%	0.3%
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	**67.5%**
Cancer 2 Week Wait	Feb 23	93.00%	**81.8%**
Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	**43.6%**
Cancer 31 Day First Treatment	Feb 23	96.00%	100%
Cancer 62 Day Classic	Feb 23	85.00%	**54.2%**
Day Surgery Activity	Feb 23	-	880
Diagnostics - 6 Week Standard	Feb 23	1.00%	**9.7%**
E.coli (All Cases)	Jan 23	-	124.1
Elective Inpatient Activity	Feb 23	-	95
Mixed Sex Accommodation Breaches	Feb 23	0	**3**
MRSA (All Cases)	Jan 23	-	3.4
MSSA (All Cases)	Jan 23	-	44.8
Outpatient Follow Up Activity	Feb 23	-	5,420
Outpatient New Activity	Feb 23	-	3,885
Outpatient Total Activity	Feb 23	-	9,305
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	**215**
RTT 78 Week Breach	Feb 23	0	**6**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**62.9%**
RTT Total Incompletes	Feb 23	-	11,731
Sickness Absence Rate	Nov 22	4.00%	**5.8%**
Staff Recommend Care	Q3 22/23	80.00%	**62.6%**
Summary Hospital Mortality Indicator	Nov 22	100.00	**115.7**

NHS
Cheshire and Merseyside

Countess of Chester Hospital Summary

The trust upgraded from an outdated electronic patient record (EPR) system to a new EPR system in 2021. Data issues have impacted on availability of data and the trust's ability to manage waiting lists effectively, leading to poor performance across the majority of areas.
Issue: Data, once migrated from the old system, was not visible on the new system, leading to ongoing use of manual records.
Action: Detailed validation of patient records across every service and all points of delivery (POD), eg Out Patients, Inpatients etc. commenced in November 2021 and is expected to be completed by December 2022.
Mitigation: As at September 2022 validation of Diagnostic data is almost complete and good progress has been made on validating RTT, particularly Open Pathways. In addition there is notable improvements to TCI data and Outpatient Follow Ups (FUPs). The trust are also working with NHS digital to ensure data from the new system is loading accurately onto the "Spine".
For cancer the trust have implemented a process/pathway review, leadership restructure and overhaul of operational reporting governance.

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**56.8%**
A&E Attendances All	Mar 23	-	6,760
Breast Feeding Initiation	Dec 22	70.0%	**64.3%**
C.difficile (Hospital Onset)	Jan 23	13.00	**38.1**
Cancelled Operations	Q3 22/23	0.65%	**0.8%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	**73.7%**
Cancer 2 Week Wait	Feb 23	93.00%	**63.0%**
Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	**-**
Cancer 31 Day First Treatment	Feb 23	96.00%	96.9%
Cancer 62 Day Classic	Feb 23	85.00%	**58.5%**
Day Surgery Activity	Feb 23	-	2,300
Diagnostics - 6 Week Standard	Feb 23	1.00%	**17.7%**
E.coli (All Cases)	Jan 23	-	108.4
Elective Inpatient Activity	Feb 23	-	260
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	2.0
MSSA (All Cases)	Jan 23	-	43.3
Outpatient Follow Up Activity	Feb 23	-	22,950
Outpatient New Activity	Feb 23	-	8,950
Outpatient Total Activity	Feb 23	-	31,900
RTT 104 Week Breach	Feb 23	0	**2**
RTT 52 Week Breach	Feb 23	0	**2,492**
RTT 78 Week Breach	Feb 23	0	**137**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**46.5%**
RTT Total Incompletes	Feb 23	-	35,479
Sickness Absence Rate	Nov 22	4.00%	**5.1%**
Staff Recommend Care	Q3 21	80.00%	**46.7%**
Summary Hospital Mortality Indicator	Nov 22	100.00	99.9

NHS
Cheshire and Merseyside

Southport & Ormskirk Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**73.7%**
A&E Attendances All	Mar 23	-	10,466
Breast Feeding Initiation	Dec 22	70.0%	**53.3%**
C.difficile (Hospital Onset)	Jan 23	13.00	**28.1**
Cancelled Operations	Q3 22/23	0.65%	**1.7%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	75.0%
Cancer 2 Week Wait	Feb 23	93.00%	93.6%
Cancer 2 Week Wait Breast Symptomatic	Feb 23	93.0%	-
Cancer 31 Day First Treatment	Feb 23	96.00%	**92.4%**
Cancer 62 Day Classic	Feb 23	85.00%	**50.5%**
Day Surgery Activity	Feb 23	-	1,705
Diagnostics - 6 Week Standard	Feb 23	1.00%	**18.7%**
E.coli (All Cases)	Jan 23	-	135.0
Elective Inpatient Activity	Feb 23	-	170
Mixed Sex Accommodation Breaches	Feb 23	0	**3**
MRSA (All Cases)	Jan 23	-	0.7
MSSA (All Cases)	Jan 23	-	51.3
Outpatient Follow Up Activity	Feb 23	-	13,860
Outpatient New Activity	Feb 23	-	5,265
Outpatient Total Activity	Feb 23	-	19,125
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	**198**
RTT 78 Week Breach	Feb 23	0	**2**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**62.8%**
RTT Total Incompletes	Feb 23	-	18,211
Sickness Absence Rate	Nov 22	4.00%	**6.9%**
Staff Recommend Care	Q3 22/23	80.00%	**51.2%**
Summary Hospital Mortality Indicator	Nov 22	100.00	**102.2**

NHS
Cheshire and Merseyside

Liverpool Women's Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**84.1%**
A&E Attendances All	Mar 23	-	1,413
Breast Feeding Initiation	Dec 22	70.0%	**68.4%**
C.difficile (Hospital Onset)	Jan 23	13.00	0.0
Cancelled Operations	Q3 22/23	0.65%	**1.6%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	**53.5%**
Cancer 2 Week Wait	Feb 23	93.00%	**91.7%**
Cancer 31 Day First Treatment	Feb 23	96.00%	**65.2%**
Cancer 62 Day Classic	Feb 23	85.00%	**16.0%**
Day Surgery Activity	Feb 23	-	470
Diagnostics - 6 Week Standard	Feb 23	1.00%	**7.6%**
E.coli (All Cases)	Jan 23	-	49.6
Elective Inpatient Activity	Feb 23	-	115
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	0.0
MSSA (All Cases)	Jan 23	-	7.1
Outpatient Follow Up Activity	Feb 23	-	7,245
Outpatient New Activity	Feb 23	-	4,920
Outpatient Total Activity	Feb 23	-	12,165
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	**2,128**
RTT 78 Week Breach	Feb 23	0	**143**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**42.1%**
RTT Total Incompletes	Feb 23	-	17,709
Sickness Absence Rate	Nov 22	4.00%	**7.3%**
Staff Recommend Care	Q3 22/23	80.00%	**71.6%**

NHS
Cheshire and Merseyside

Liverpool Heart & Chest Hospital Summary

Key Performance Indicator	Period	Target	
C.difficile (Hospital Onset)	Jan 23	13.00	3.9
Cancelled Operations	Q3 22/23	0.65%	**4.1%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	**45.5%**
Cancer 2 Week Wait	Feb 23	93.00%	100%
Cancer 31 Day First Treatment	Feb 23	96.00%	**86.2%**
Cancer 62 Day Classic	Feb 23	85.00%	**33.3%**
Day Surgery Activity	Feb 23	-	360
Diagnostics - 6 Week Standard	Feb 23	1.00%	0.7%
E.coli (All Cases)	Jan 23	-	11.6
Elective Inpatient Activity	Feb 23	-	330
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	0.0
MSSA (All Cases)	Jan 23	-	23.2
Outpatient Follow Up Activity	Feb 23	-	4,420
Outpatient New Activity	Feb 23	-	2,370
Outpatient Total Activity	Feb 23	-	6,790
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	**49**
RTT 78 Week Breach	Feb 23	0	**8**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**73.2%**
RTT Total Incompletes	Feb 23	-	4,938
Sickness Absence Rate	Nov 22	4.00%	**5.4%**
Staff Recommend Care	Q3 22/23	80.00%	90.6%

NHS
Cheshire and Merseyside

Alder Hey Hospital Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	**77.7%**
A&E Attendances All	Mar 23	-	6,049
C.difficile (Hospital Onset)	Jan 23	13.00	0.0
Cancelled Operations	Q3 22/23	0.65%	**1.4%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	100%
Cancer 2 Week Wait	Feb 23	93.00%	100%
Cancer 31 Day First Treatment	Feb 23	96.00%	100%
Cancer 62 Day Classic	Feb 23	85.00%	100%
Day Surgery Activity	Feb 23	-	1,635
Diagnostics - 6 Week Standard	Feb 23	1.00%	**24.5%**
E.coli (All Cases)	Jan 23	-	44.7
Elective Inpatient Activity	Feb 23	-	370
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	0.0
MSSA (All Cases)	Jan 23	-	29.8
Outpatient Follow Up Activity	Feb 23	-	16,115
Outpatient New Activity	Feb 23	-	5,835
Outpatient Total Activity	Feb 23	-	21,950
RTT 104 Week Breach	Feb 23	0	**4**
RTT 52 Week Breach	Feb 23	0	**578**
RTT 78 Week Breach	Feb 23	0	**26**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**54.9%**
RTT Total Incompletes	Feb 23	-	23,812
Sickness Absence Rate	Nov 22	4.00%	**6.7%**
Staff Recommend Care	Q3 22/23	80.00%	86.4%

NHS
Cheshire and Merseyside

The Walton Centre Summary

Key Performance Indicator	Period	Target	
C.difficile (Hospital Onset)	Jan 23	13.00	**15.5**
Cancelled Operations	Q3 22/23	0.65%	**3.3%**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	-
Cancer 2 Week Wait	Feb 23	93.00%	-
Cancer 31 Day First Treatment	Feb 23	96.00%	-
Cancer 62 Day Classic	Feb 23	85.00%	**0.0%**
Day Surgery Activity	Feb 23	-	910
Diagnostics - 6 Week Standard	Feb 23	1.00%	0.7%
E.coli (All Cases)	Jan 23	-	31.0
Elective Inpatient Activity	Feb 23	-	270
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	0.0
MSSA (All Cases)	Jan 23	-	28.8
Outpatient Follow Up Activity	Feb 23	-	7,875
Outpatient New Activity	Feb 23	-	3,870
Outpatient Total Activity	Feb 23	-	11,745
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	**59**
RTT 78 Week Breach	Feb 23	0	**1**
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**75.9%**
RTT Total Incompletes	Feb 23	-	12,201
Sickness Absence Rate	Nov 22	4.00%	**6.2%**
Staff Recommend Care	Q3 22/23	80.00%	86.5%

NHS
Cheshire and Merseyside

The Clatterbridge Cancer Centre Summary

Key Performance Indicator	Period	Target	
C.difficile (Hospital Onset)	Jan 23	13.00	**36.9**
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	100%
Cancer 2 Week Wait	Feb 23	93.00%	100%
Cancer 31 Day First Treatment	Feb 23	96.00%	98.6%
Cancer 62 Day Classic	Feb 23	85.00%	87.5%
Day Surgery Activity	Feb 23	-	240
Diagnostics - 6 Week Standard	Feb 23	1.00%	0.0%
E.coli (All Cases)	Jan 23	-	134.2
Elective Inpatient Activity	Feb 23	-	80
Mixed Sex Accommodation Breaches	Feb 23	0	0
MRSA (All Cases)	Jan 23	-	0.0
MSSA (All Cases)	Jan 23	-	70.5
Outpatient Follow Up Activity	Feb 23	-	38,690
Outpatient New Activity	Feb 23	-	1,410
Outpatient Total Activity	Feb 23	-	40,100
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	0
RTT 78 Week Breach	Feb 23	0	0
RTT Incomplete 18 Week Standard	Feb 23	92.00%	97.4%
RTT Total Incompletes	Feb 23	-	841
Sickness Absence Rate	Nov 22	4.00%	**5.4%**
Staff Recommend Care	Q3 22/23	80.00%	85.4%

NHS
Cheshire and Merseyside

Cheshire & Wirral Partnership Summary

Key Performance Indicator	Period	Target	
Day Surgery Activity	Feb 23	-	-
EIP Open Referrals Waited < 2 Weeks	Feb 23	60.00%	-
EIP Open Referrals Waiting < 2 Weeks	Feb 23	75.00%	**3.1%**
Elective Inpatient Activity	Feb 23	-	-
IAPT Face to Face	Jan 23	-	13%
IAPT Incomplete Waiting under 18 weeks	Jan 23	95.0%	**78.2%**
IAPT Incomplete Waiting under 6 weeks	Jan 23	75.0%	**63.0%**
IAPT Referrals	Jan 23	-	1,080
IAPT Referrals Entered Treatment	Jan 23	-	825
IAPT Waited Less Than 18 Weeks	Jan 23	95.0%	98.9%
IAPT Waited Less Than 6 Weeks	Jan 23	75.0%	94.5%
Mixed Sex Accommodation Breaches	Feb 23	0	0
Outpatient Follow Up Activity	Feb 23	-	-
Outpatient New Activity	Feb 23	-	-
Sickness Absence Rate	Nov 22	4.00%	**6.7%**
Staff Recommend Care	Q3 22/23	80.00%	**70.6%**

NHS
Cheshire and Merseyside

Mersey Care Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	97.8%
A&E Attendances All	Mar 23	-	12,501
Day Surgery Activity	Feb 23	-	-
EIP Open Referrals Waited < 2 Weeks	Feb 23	60.00%	**57.1%**
EIP Open Referrals Waiting < 2 Weeks	Feb 23	75.00%	**42.9%**
Elective Inpatient Activity	Feb 23	-	-
IAPT Face to Face	Jan 23	-	-
IAPT Incomplete Waiting under 18 weeks	Jan 23	95.0%	98.9%
IAPT Incomplete Waiting under 6 weeks	Jan 23	75.0%	97.3%
IAPT Referrals	Jan 23	-	2,950
IAPT Referrals Entered Treatment	Jan 23	-	2,110
IAPT Waited Less Than 18 Weeks	Jan 23	95.0%	99.5%
IAPT Waited Less Than 6 Weeks	Jan 23	75.0%	96.8%
Mixed Sex Accommodation Breaches	Feb 23	0	0
Outpatient Follow Up Activity	Feb 23	-	-
Outpatient New Activity	Feb 23	-	-
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	0
RTT 78 Week Breach	Feb 23	0	0
RTT Incomplete 18 Week Standard	Feb 23	92.00%	97.7%
RTT Total Incompletes	Feb 23	-	44
Sickness Absence Rate	Nov 22	4.00%	**8.2%**
Staff Recommend Care	Q3 22/23	80.00%	**66.8%**

NHS
Cheshire and Merseyside

Wirral Community Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	95.4%
A&E Attendances All	Mar 23	-	4,591
Cancer 31 Day First Treatment	Feb 23	96.00%	-
Cancer 62 Day Classic	Feb 23	85.00%	-
Diagnostics - 6 Week Standard	Feb 23	1.00%	**29.2%**
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	0
RTT 78 Week Breach	Feb 23	0	0
RTT Incomplete 18 Week Standard	Feb 23	92.00%	100%
RTT Total Incompletes	Feb 23	-	118
Sickness Absence Rate	Nov 22	4.00%	**7.2%**
Staff Recommend Care	Q3 22/23	80.00%	**71.6%**

NHS
Cheshire and Merseyside

Bridgewater Community Healthcare Summary

Key Performance Indicator	Period	Target	
A&E - 4 Hour Standard	Mar 23	95.00%	98.1%
A&E Attendances All	Mar 23	-	3,481
Cancer - 28 Day Faster Diagnosis	Feb 23	75.0%	91.0%
Cancer 2 Week Wait	Feb 23	93.00%	98.2%
Cancer 31 Day First Treatment	Feb 23	96.00%	100%
Cancer 62 Day Classic	Feb 23	85.00%	**62.5%**
Day Surgery Activity	Feb 23	-	0
Diagnostics - 6 Week Standard	Feb 23	1.00%	**2.6%**
Elective Inpatient Activity	Feb 23	-	0
IAPT Incomplete Waiting under 18 weeks	Jan 23	95.0%	-
IAPT Incomplete Waiting under 6 weeks	Jan 23	75.0%	-
IAPT Referrals	Jan 23	-	-
IAPT Referrals Entered Treatment	Jan 23	-	-
IAPT Waited Less Than 18 Weeks	Jan 23	95.0%	-
IAPT Waited Less Than 6 Weeks	Jan 23	75.0%	-
Mixed Sex Accommodation Breaches	Feb 23	0	-
Outpatient Follow Up Activity	Feb 23	-	6,770
Outpatient New Activity	Feb 23	-	1,780
RTT 104 Week Breach	Feb 23	0	0
RTT 52 Week Breach	Feb 23	0	0
RTT 78 Week Breach	Feb 23	0	0
RTT Incomplete 18 Week Standard	Feb 23	92.00%	**41.5%**
RTT Total Incompletes	Feb 23	-	2,632
Sickness Absence Rate	Nov 22	4.00%	**6.1%**
Staff Recommend Care	Q3 22/23	80.00%	**79.3%**

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C&M Place Summary:

Feb 23 System Oversight Framework publication

			SubICB								
NHS OF Metric Name Full	Aggregation Source	Period	NHS CHESHIRE (SUB ICB LOCATION) (27D)	NHS HALTON (SUB ICB LOCATION) (01F)	NHS KNOWSLEY (SUB ICB LOCATION) (01J)	NHS LIVERPOOL (SUB ICB LOCATION) (99A)	NHS SOUTH SEFTON (SUB ICB LOCATION) (01T)	NHS SOUTHPORT AND FORMBY (SUB ICB LOCATION) (01V)	NHS ST HELENS (SUB ICB LOCATION) (01X)	NHS WARRINGTON (SUB ICB LOCATION) (02E)	NHS WIRRAL (SUB ICB LOCATION) (12F)
S009a: Total patients waiting more than 52 weeks to start consultant led treatment	SubICB	2022 11	6,966	899	1,864	7,059	2,907	565	1,025	1,421	1,515
S009b: Total patients waiting more than 78 weeks to start consultant led treatment	SubICB	2022 11	611	126	262	900	385	69	143	183	89
S009c: Total patients waiting more than 104 weeks to start consultant led treatment	SubICB	2022 11	27	0	2	11	6	1	2	4	3
S010a: Total patients treated for cancer compared with the same point in 2019/20	SubICB	2022 11		139%	157.9%	88.1%	85.2%	99.2%	93.2%	114.7%	115.4%
S012a: Proportion of patients meeting the faster cancer diagnosis standard	SubICB	2022 11	63.2%	72.7%	66.8%	58.8%	63.8%	67.9%	68%	71.3%	73.5%
S013a: Diagnostic activity levels: Imaging	SubICB	2022 11	112.1%	109.4%	102.3%	108.3%	104.5%	107.3%	104.4%	102.4%	102.6%
S013b: Diagnostic activity levels: Physiological measurement	SubICB	2022 11	77.8%	78%	92%	85.8%	81.9%	119.2%	90.7%	69.1%	78.8%
S013c: Diagnostic activity levels: Endoscopy	SubICB	2022 11	75.3%	119.7%	144%	118.9%	88%	163.4%	118.9%	124.6%	105%
S013d: Diagnostic activity levels: Total	SubICB	2022 11	105.5%	107.3%	103.7%	106.9%	100.5%	112.4%	103.8%	100.4%	99.5%
S031a: Rate of personalised care interventions	SubICB	22-23 Q2	57.5 per 1,000	21.03 per 1,000	52.99 per 1,000	87.44 per 1,000	40.44 per 1,000	26.15 per 1,000	43.76 per 1,000	68.05 per 1,000	63.44 per 1,000
S032a: Personal health budgets	SubICB	22-23 Q1	0.61 per 1,000	1.57 per 1,000	0.97 per 1,000	0.41 per 1,000	0.54 per 1,000	0.71 per 1,000	12.85 per 1,000	1.02 per 1,000	0.45 per 1,000
S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	SubICB	2022 11	10	2	0	11	2	0	1	3	6
S041a: Clostridium difficile infection rate	SubICB	2022 11	126.8%	132.4%	98%	102.9%	110.2%	89.6%	68.6%	158.7%	155.3%
S042a: E. coli bloodstream infection rate	SubICB	2022 11	110.6%	98.9%	137.1%	127.1%	114.5%	113.1%	100.7%	119%	129.3%
S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	SubICB	Nov 2021 - Oct 2022	89%	109.2%	107.8%	104.9%	113.7%	95%	111.2%	89.8%	107.6%
S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	Nov 2021 - Oct 2022	7.5%	6.74%	7.43%	8.28%	8.93%	9.21%	6.1%	6.53%	10.6%
S046a: Population vaccination coverage: MMR for two doses (5 year olds)	SubICB	22-23 Q1	91.5%	93.4%	78%	75.3%	83.1%	90.6%	89.2%	91.4%	89.2%
S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	SubICB	2022 10	72.4%	68.9%	56%	59.7%	62.4%	74.9%	64.6%	67.1%	68.8%
S050a: Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	SubICB	21-22 Q4	75.5%	71.6%	72%	64.4%	69.5%	73.3%	72.5%	74.3%	72.8%
S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	SubICB	2021-22	88.4%	90.7%	91.6%	89%	88.9%	89.5%	90.7%	90.9%	90.6%
S053b: % of hypertension patients who are treated to target as per NICE guidance	SubICB	2021-22	60.7%	57.1%	53.6%	57.3%	52.3%	62.8%	58.1%	58%	57.7%
S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	SubICB	22-23 Q1	56.9%	58.8%	59.9%	60.8%	58.9%	51.6%	58%	54.9%	59.2%
S055a: Number GP referrals to NHS Digital weight management services per 100k population	SubICB	22-23 Q2	114.2 per 100,000	86.2 per 100,000	76.3 per 100,000	124.3 per 100,000	40.9 per 100,000	133 per 100,000	69.3 per 100,000	62.9 per 100,000	24.9 per 100,000
S081a: Access rate for IAPT services	SubICB	22-23 Q2	61.6%	61.7%	56.6%	49.7%	45.9%	49%	75.6%	56.5%	71.7%
S086a: Inappropriate adult acute mental health placement out of area placement bed days	SubICB	Aug 2022 - Oct 2022	640	0	0	35	0	0	0	0	190
S105a: Proportion of patients discharged from hospital to their usual place of residence	SubICB	2022 11	89.7%	95.5%	94.5%	94%	94.6%	92%	92.8%	94.9%	92.8%
S115a: Proportion of diabetes patients that have received all eight diabetes care processes	SubICB	21-22 Q4	42.9%	28.5%	31.8%	42.9%	32.4%	47.2%	26.9%	27.3%	30.9%

Rank Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile

NHS
Cheshire and Merseyside

ICB – Provider SOF Segments

Updated 17th March 2023

Trust	Segment	Change from October 22
Liverpool Heart and Chest Hospital NHS Foundation Trust	1	↔
The Walton Centre NHS Foundation Trust	1	↔
Alder Hey Children's NHS Foundation Trust	2	↔
Bridgewater Community Healthcare NHS Foundation Trust	2	↔
Cheshire and Wirral Partnership NHS Foundation Trust	2	↑
Mersey Care NHS Foundation Trust	2	↔
Mid-Cheshire Hospital NHS Foundation Trust	2	↔
North West Ambulance Service NHS Trust	2	↔
Southport and Ormskirk Hospital NHS Trust	2	↔
St Helens and Knowsley Teaching Hospitals NHS Trust	2	↔
Warrington and Halton Teaching Hospitals NHS Foundation Trust	2	↔
Wirral Community Health and Care NHS Foundation Trust	2	↔
Clatterbridge Cancer Centre NHS Foundation Trust	2	↔
Countess of Chester NHS Foundation Trust	3	↔
East Cheshire NHS Trust	3	↔
Liverpool Women's Hospital NHS Foundation Trust	3	↔
Wirral University Teaching Hospital NHS Foundation Trust	3	↔
Liverpool University Hospitals NHS Foundation Trust	4	↔

https://www.england.nhs.uk/publication/nhs-oversight-framework-segmentation/

Key

Segment 1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities
Segment 2	Plans that have the support of system partners in place to address areas of challenge.Targeted support may be required to address specific identified issues
Segment 3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)
Segment 4	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 April 2023

Intelligence into Action: Continued provision of ICS digital and data platforms

Agenda Item No	ICB/04/27/12
Report author & contact details	Jim Hughes, CIPHA SRO / Lesley Kitchen, Programme Head, Shared and Person Held Records / Helen Duckworth, Head of Business Intelligence, John Llewellyn CDIO
Report approved by (sponsoring Director)	Prof. Rowan Pritchard-Jones, Executive Medical Director
Responsible Officer to take actions forward	John Llewellyn, Chief Digital Information Officer

NHS Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board

Intelligence into Action: Continued provision of ICS digital and data platforms

Executive Summary	This paper seeks funding support for continued provisioning of: • the existing ICS population health and data platform with associated tooling and expert resources: • the integrated C2Ai PTL tool across the 10 acute trusts, supporting risk-adjusted triage and prioritisation of the Patient Treatment List (PTL). • and associated shared care record over a transition period of two years. Each ICB has an obligation to provide a population health analytics capability to support its key objectives around improving outcomes in population health and health care and tackling inequalities in outcomes, experience, and access. Cheshire and Merseyside has developed a capability in this area which is considered one of the exemplars across the national health and care system will potentially be used by NHS England's Digital Maturity Programme as a blueprint for other ICS's . The capability is a key asset for Cheshire and Merseyside and is demonstrating very encouraging results from currently live initiatives but requires ongoing funding to sustain that momentum and further develop our expertise and capacity in this area. It clarifies the national position around future Digital Funding which does not include any future provision for these capabilities. The paper provides the costs to continue with current arrangements post March 2023 and seeks approval to continue to fund existing capabilities, whilst linking to a rationalisation and consolidation of shared record capabilities into a single ICS wide solution. An initial desktop review of BI/PHM systems was conducted in February 2023 and a more detailed consultative process will be conducted with system stakeholders during 2023 to agree a simplified analytics platform and an associated resource and governance model to support wider system access to the Population Health Analytics assets provided by the ICB. The paper also outlines an indicative future governance which formalises relationships with Academia and ensures the ongoing Intelligence into Action Programme is informed by Population Health and transformation priorities of the system and is equally accessible by provide organisations, collaboratives and all our places. The paper and associated investment was considered at the March 2023 meeting of the Finance, Investment and Resources Committee which **recommended** the **approval of option 2: the allocation of funds to continue the population health platform tooling and associated analytic and transformation resources for the next 2 financial years.**

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

Recommendation

The Board is asked to approve :

- The allocation of funds to support option 2, which will allow for:
  - the continued provision of the existing population health and data platform and associated shared care record over a transition period of two years.
  - the continued provision of the integrated (within CIPHA) C2Ai PTL tool across the 10 acute Trusts to support risk-adjusted triage and prioritisation of the Patient Treatment List (PTL).

During the transition period, through the offices of the Chief Digital Information Officer and Director of Performance and Planning, there will be a rationalisation of the digital and data platforms and alignment of the digital and data architecture to wider, national initiatives such as the Federated Data Platform (FDP), Sub-National (NW) Secure data Environments (SDE) and national record sharing initiatives.

Key issues

The CIPHA contract runs to end March 2025 but funds for contract and associated System P and C2Ai programmes expired in March 2023.

Key risks

National Digital Funding for 23/24 onwards does not include any specific allocation for shared records or population health analytics or AI functionality.

Without ongoing support for this platform and associated analytics and transformation capability, the ICS's ability to deliver precision evidence based interventions to address specific population health challenges and rebalance health inequalities will be significantly reduced – This risk is articulated on the Board Assurance Framework (Risk P2).

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

Route to this meeting

- **ICB Corporate Directors (Feb , March 2023)**
- **ICB Clinical Informatics Advisory Group (Feb 2023)-** The Group considered the progress so far in developing the ICC's capability in this area . There was consistent clinical support for the concept and an ask that the capability be developed further and mainstreamed as a core asset for stakeholders across the system to use to answer their specific use cases. The Group formally supported the proposal and welcomed the planned work to develop an associated governance and pipeline process to "democratise" access to the service and develop greater insight on behalf of system stakeholders.
- **Finance, Investment and Resources Committee Part A (March 2023)** – the committee considered the proposals and agreed that the capability

	described was a priority for ongoing support. They considered that all the capabilities described were currently being funded within the C&M system so this did not represent a "new additional" request for investment. The committee also noted: • the planned work to reduce other existing spend on analytics platforms through rationalisation during 2023/24 and • the opportunities for revenue generation which the ongoing development of the data assets represented. A commercial model is under development to ensure revenue flows back to the ICB as a result of secondary use of data curated in this platform
Management of Conflicts of Interest	The paper and recommendations do not represent any known conflicts of interest for the board
Patient and Public Engagement	The collaborative approach amongst the ICB and wider system partners which underpins this initiative, includes dedicated resource from the LCR Civic Data Cooperative, enabling a sustained and sustainable approach to patient and public engagement. An ongoing and transparent dialogue will be maintained to ensure public confidence in data stewardship and increased public involvement in prioritisation of transformation effort.
Equality, Diversity, and Inclusion	A formal Equality Impact Assessment has not yet been undertaken on the platform, tools and capabilities described in the paper, however the principles of the approach are entirely consistent with the need to deliver intelligence on a whole population basis. The approach delivers dashboards or reports that explicitly address and identify inequalities to ensure that those cohorts or individuals identified are positively affected through the interventions suggested by the evidence.
Health inequalities	This paper describes the core capabilities around which the ICB will generate actionable insights on which to based prioritized action to reduce health inequalities across the populations served.
Next Steps	Procurement of ongoing C2Ai services as part of the platform capabilities. Establish new governance to support system use of capability, managed pipeline of analytics requests and prioritize against agreed priorities. – Agree a work plan for 2023/24 and reporting regime to track benefits and bring back through ICB Governance
Appendices	**Appendix One – key points from national policy, strategy and guidance relating to population health management tools and shared care records.** **Appendix Two – Cheshire and Merseyside Digital and Data Strategy** **Appendix Three - Cheshire and Merseyside BI/pop health management systems review (desktop exercise)**

Intelligence into Action: Continued provision of ICS digital and data platforms

1. Executive Summary

1.1 This paper seeks funding support for continued provisioning of:

- the existing ICS population health and data platform with associated tooling and expert resources:
- the integrated C2Ai PTL tool across the 10 acute trusts, supporting risk-adjusted triage and prioritisation of the Patient Treatment List (PTL); and
- associated shared care record over a transition period of two years.

1.2 Each ICB has an obligation to provide a population health analytics capability to support its key objectives around improving outcomes in population health and health care and tackling inequalities in outcomes, experience and access and Cheshire and Merseyside has developed a capability in this area which is considered one of the exemplars across the national health and care system will potentially be used by NHS England's Digital Maturity Programme as a blueprint for other ICS's . The capability is a key asset for C&M and is demonstrating very encouraging results from currently live initiatives but requires ongoing funding to sustain that momentum and further develop our expertise and capacity in this area.

1.3 The capability developed is based on multi-agency collaboration with significant academic leadership, resource, and investment (£circa 6m value in equivalent resources), working alongside other agencies across C&M. The ambition is to build on this foundational work into a learning Health System at Scale, where we apply computational technologies to drive insight from our routinely collected data and improve care for individual patients based on knowledge generated by research. The learning from the pandemic response in C&M is applied directly into this model where research focused on local evidence gaps is giving us the basis for precision interventions.

1.4 The commitment to this collaborative approach is further evidenced by the appointment of Professor Iain Buchan, Associate Pro Vice Chancellor for Innovation and Chair of Public Health and Clinical Informatics at University of Liverpool to the role of Associate Medical Director for Health Intelligence in the ICB

1.5 The Analytics capability described in the paper has been instrumental to Cheshire and Merseyside's COVID response and is now providing valuable insight to help target our recovery response.

1.6 The Combined Intelligence for Population Health Action (CIPHA) saved many lives and livelihoods in the COVID-19 pandemic by standing up a persistent longitudinal care record in 90 days and using it to coordinate rapid actions across all NHS, local government, and national public health organisations across Cheshire & Merseyside. Having near-real time data linked across COVID-19 tests, GP records, and hospital admissions, linked to social and administrative public health data, allowed our region to host the world's first voluntary mass testing for people without COVID-19 symptoms, which reduced hospitalisation by at least a quarter (https://www.bmj.com/content/379/bmj-2022-071374) and enabled earlier reopening of our regional economy.

1.7 CIPHA enabled rapid evaluation and smarter implementation of many pandemic responses, including: NHS and emergency service staff testing, saving thousands of worker days from being wasted in quarantine; better targeted vaccination campaigns; and one of the most agile, large scale uses of telecare to support the vulnerable at home. Over a thousand NHS staff now use CIPHA dashboards to monitor services and to identify patients in particular risk groups, to accelerate preventive actions such as medicines optimisation, vaccination reminders, social care reviews, better discharge planning etc. As a result of CIPHA the ICB can now move much faster in producing insights from linked data for multiple purposes, spanning commissioning, quality management, direct care, public health measures and action-research (where the NHS problem holder pulls in academic analytic capability as required). Through CIPHA, as an actionable insights engine, agnostic of the underlying technology platforms, the ICB can now reduce duplication in platforms and processes.

1.8 CIPHA also links population health management to care workflow in one system, helping change analytic cultures from description to action, for example from describing inequalities in waiting lists to programming equity into managing them. CIPHA positions Cheshire and Merseyside to lead national responses to the Hewett Review's call for more preventive, intelligence led, AI-augmented health systems.

1.9 The original CIPHA capability has been augmented using the C2Ai solution to allow us to understand waiting lists at individual patient risk level, provide bespoke pre operative care and as a result reduce length of stay (**ave. 2.6 days**), reduce complications **(13% risk of chest infection to 0%)** reduce costs (**ave £1100 per patient**) and improve patient outcome.

1.10 A critical aspect of this work is maintaining patient confidence in use of personal data. The intelligence into Action programme has a very strong track record in information governance and public engagement. Our rigour around appropriate data handling is demonstrated in the results of NHS England's review of ICB compliance with risk stratification control published in March 2023. The audit which tested each ICB's level of established controls put in place to manage the use of patient identifiable data (under section 251b exemption) demonstrated a high level of control with C&M raked **second** nationally on a range of compliance measures.

1.11 The paper outlines funding requirements over the next two years to allow us to maintain momentum in this critical area of ICB strategy. Over that period, there will be a detailed review of shared records provision across our places and a rationalisation of the digital and data architecture and alignment to wider, national architectures such as the Federated Data Platform (FDP) and national record sharing initiatives.

1.12 Approval of this continued investment will allow the ICB to remains at the forefront of Intelligence drive action for population health and managing inequalities whilst the underpinning architecture is further rationalised.

2. Background, scope, and context

2.1 The contract with Graphnet which provides the technical platform and associated tools (e.g.- PowerBI) for CIPHA is not funded beyond March 2023. Additionally, key resources, such as the C2Ai PTL tool, to support 'Intelligence into Action' and enable transformation are also not funded beyond March 2023. If this is not urgently addressed the ICS will lose capabilities that are key to both current operational and strategic priorities.

2.2 The Graphnet contract provides the means:

- to fulfil the ICS objective of evidence-based population health transformation (dashboards supporting priority areas and SystemP).
- to connect the ICS's data platform to the national Federated Data Platform (FDP) as per national guidance.
- to be the data platform that contributes to the North West Secure Data Environment (SDE) for research, as per national guidance and of which CM ICS is a contributing partner
- to advance the ICS's Shared Care Record, as per national guidance.

2.1 **Funding to date - ICS data platform (CIPHA),SystemP and the C2Ai PTL tool**

2020/21	NHSx COVID pandemic emergency funding in full (£5m)
2021/22	National funding (Health Service Led Investment) plus NHSx COVID pandemic recovery funding through funded CIPHA expansion programme for additional specialist analytical resource and tools (£3.2m)
2021/22	National NHS England elective recovery funding to support initial C2Ai pilot at three trusts (£100k) NHSx elective recovery funding to extend pilot to all C&M acute trusts, include prehabilitation/pre-surgical clinical optimisation and to embed into CIPHA (£0.5m)
2022/23	CM STP (ICS) funded through cost pressure (£2.5m) (this will be offset at year end by circa 750K from current budgets) plus NHSx COVID pandemic recovery funded CIPHA expansion procgramme for additional specialist analytical resource and tools (£0.7m)
2022/23	CM STP (ICS) SystemP (£0.4m)

2.2 Summary to date of C&M ICS investment:

- £1.75m over three years C&M investment in CIPHA (not including capital charges)
- £0.4m one year C&M investment in SystemP.

2.3 **Shared Care Records.** National funding streams (GDE, LHCRE, and ShCR) have been used over several years (2018–2022). This was complemented with some place-based investments, but these have not been consistent across the ICS. This model will need to be revisited in due course (as part of the rationalisation of digital and data platforms) in order to ensure fairness across all nine of the ICS's Places.

2.4 **Current architecture.** The technology landscape for population health management and shared care records in Cheshire and Merseyside is complex. The current architecture arises from previous investments and collaborations. Different tools with different functionalities are used in different parts of the System. Local tools sit alongside System-wide capabilities, and both sit alongside national capabilities.

2.5 Population health management and shared care records have commonalities in their sources of data, but historic arrangements have driven a sub-optimal technical architecture when requirements are considered 'in the whole'. This is a not an unusual situation, and Cheshire and Merseyside ICS is not alone in facing these challenges.

2.6 The following diagram (Figure One) is a highly simplified representation of the existing technical architecture for PHM and shared care records in the ICS. The diagram illustrates the main platforms / solutions that are in use, and highlights where similar activities occur in multiple places. The diagram also highlights the areas of the architecture and support which are included in the scope of this investment case (shown within the red dashed boxes) and this scope is described in the following section of the document.

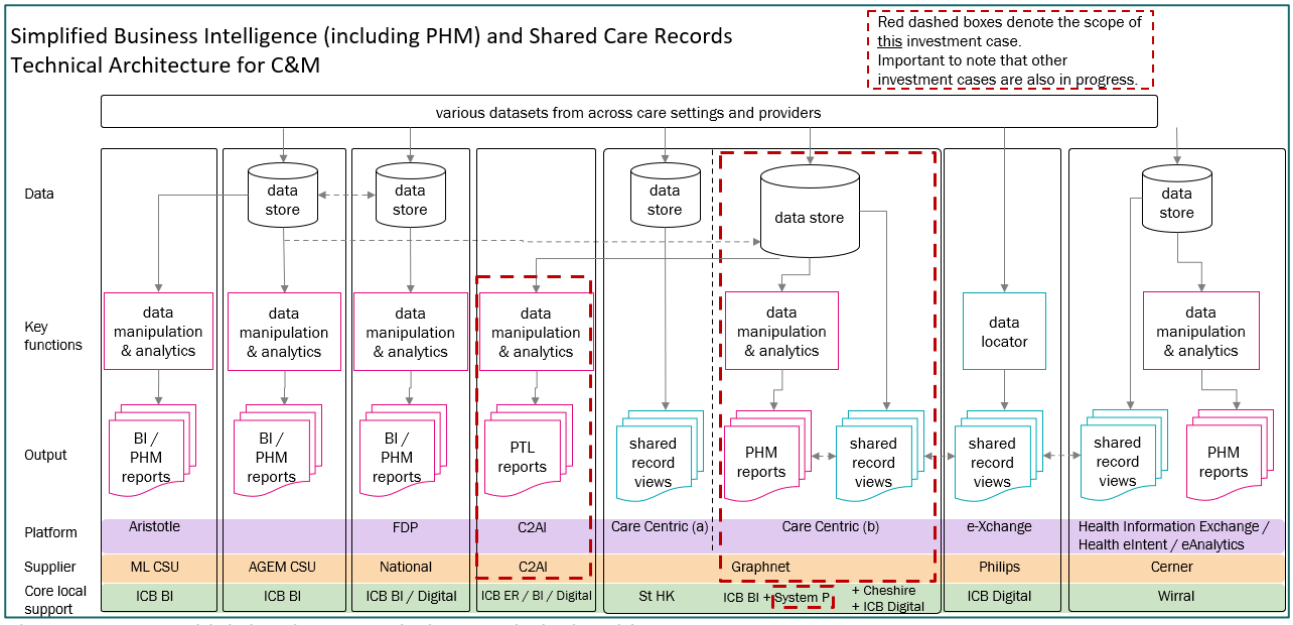
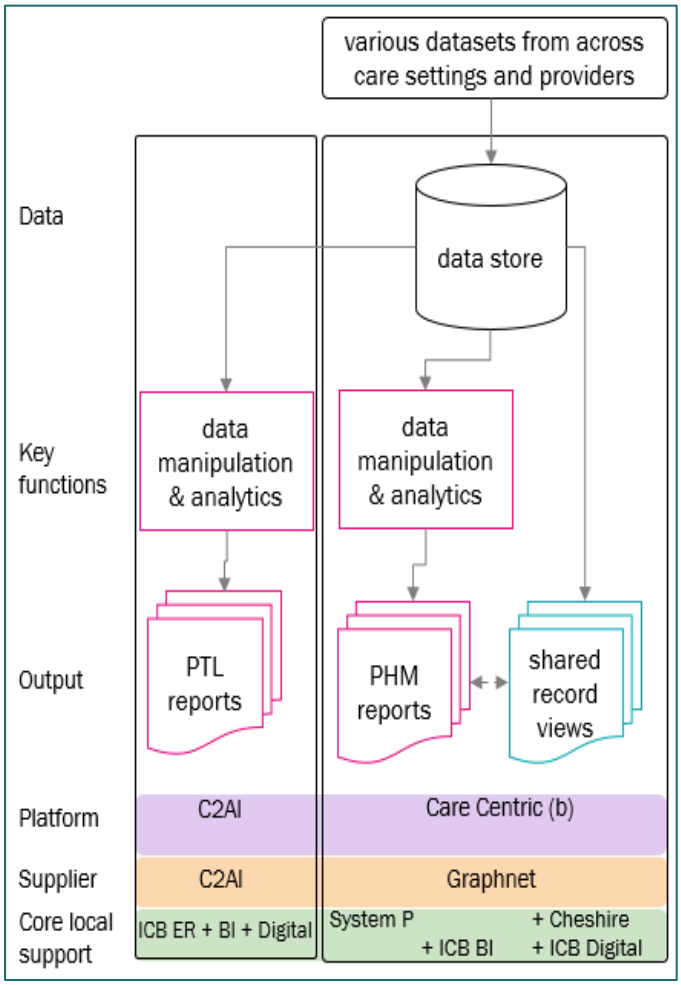


Figure 1 - current high-level PHM and ShCR technical architecture

2.7 Scope of this investment case



The scope of this investment case is:

- Continuing the provision of the Graphnet CareCentric platform which is a solution for ICS-wide PHM and shared care records.
- Securing resources for System P to continue Insight into Action and transformation enablement.
- The continued provision of the C2Ai PTL tool integrated within CIPHA across the 10 acute Trusts, supporting risk-adjusted triage and prioritisation of the Patient Treatment List (PTL).

It is vital to note that that although this investment case does not incorporate the ICB digital team members who provide support to both PHM data flows and shared records, there is a clear dependency on these personnel (and other resources) for ongoing implementation, business-as-usual (BAU), and transformation enablement. Other discussions are taking place (led through the Chief Digital Officer) with further investment cases being developed as appropriate.

2.8 Referring back to the wider technical picture (Figure One), additional work is required to rationalise this and align it to broader architectures such as the Federated Data Platform (FDP) and national record sharing initiatives. The complex landscape, with its many interdependencies, dictates that this rationalisation is a longer-term piece of work, so it is proposed that the in-scope investments will create space for a transitionary period through which the Chief Digital Officer's office can develop and advance its medium- and longer-term strategic architecture.

2.9 **Alignment to policy and strategy.** For several years national policy, strategy, and guidance has provided the context and a strong rationale for investment in digital and data platforms for population health management and shared care records. Table One lists key national documents. The specifics of how these align with this investment case can be found in Appendix One.

Table One

January 2019	**NHS Long Term Plan**
• Plan to accelerate the redesign of patient care.	
August 2021	**What Good Looks Like**
• Framework to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely.	
December 2021	**2022/23 priorities and operational planning guidance**
• Priorities for the year ahead.	
February 2022	**Health & social care integration: joining up care for people, places and populations**
• White paper setting out measures to make integrated health and social care a universal reality.	
June 2022	**Data Saves Lives**
• Secretary of State's strategy for how data will be used to improve the health and care of the population in a safe, trusted and transparent way.	
June 2022	**A plan for digital health and social care**
• Consolidates the different national digital goals and investments into a single action plan.	
December 2022	**2023/24 priorities and operational planning guidance**
• Priorities for the year ahead.	
December 2022	**Secure Data Environments for NHS health and social care data**
• Policy guidelines and intentions for the use of SDEs.	
December 2022	**Guidance on developing the joint forward plan**
• Supporting ICBs and partners to develop 5-year JFPs	
January 2023	**Hewitt review**
• Independent review into oversight and governance of ICSs.	

Figure 2 - Summary of key national documents

2.10 At an ICS level, this investment case aligns with the Cheshire and Merseyside Digital and Data Strategy which was endorsed by the ICB in November 2022. This strategy reiterates the key role digital and data platforms have in turning 'intelligence into action'. Population health management platforms and shared care records are fundamental aspects in delivering digital and data goals:

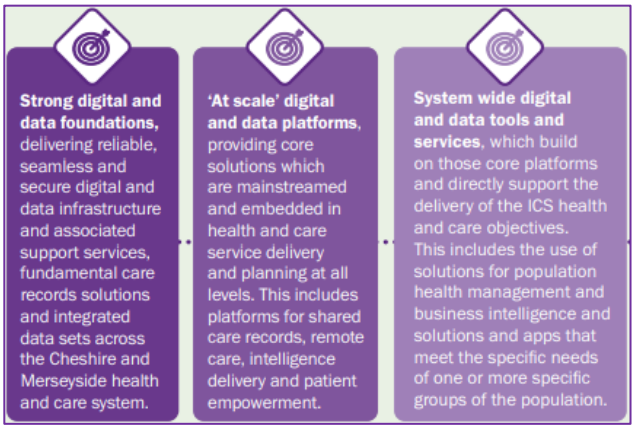


Figure 3 - key aspects of the C&M Digital and Data Strategy

2.11 Further details on the ICS digital and data strategy can be found in Appendix Two. There are also many transformation programmes and major schemes of work emerging within the ICS which have a significant reliance on the platforms in scope of this investment case. Examples include:

- ***Clinical Pathways Programme –*** the proposed orthopedics surgery operating model promotes working across boundaries, and the same will apply to other specialties which adopt an elective-hub model. Currently, workarounds are in place to access and update records for these patients, but these are not scalable and electronic interfaces such as shared records are a key enabler for future arrangements.
- ***Elective Recovery*** – the C2Ai PTL tool enables clinicians to efficiently prioritize patients based upon their individual clinical risk factors. This reduces clinical risk and enables the physiological optimisation of patients prior to surgery, positively impacting recovery time and length of stay. It also enables suitable patients to be selected for high volume, low complexity (HVLC) surgical lists and for NHS treatment in the independent sector. The tool has also shown positive impact on consultant and administration time and has demonstrably narrowed health inequalities.
- ***Anticipatory Care*** – an individual's wishes for treatment and the future can be made visible to all, relevant, health and care professionals through a shared record platform.
- ***Place-based review of digital and data platform options*** – for example, Healthy Wirral Partners has an opportunity to review the mechanisms for sharing and aggregating patient/client records in the light of developments at a Cheshire and Merseyside level, and a breakpoint in the local contract for the systems currently used.
- In the area of ***Population Health Management (PHM)*** - the programmes for Elective Restoration, Urgent and Emergency Care, Community, Mental Health, CVD and Respiratory are all supported by a set of PHM applications that enable understanding of the epidemiology of populations; benchmarking of areas where process and outcomes can be improved; and identification of cohorts at risk of certain outcomes, with re-identification for proactive direct care. These applications (summarised in Figure Five) support, for example, waiting list management and identification of those at risk of fuel poverty.

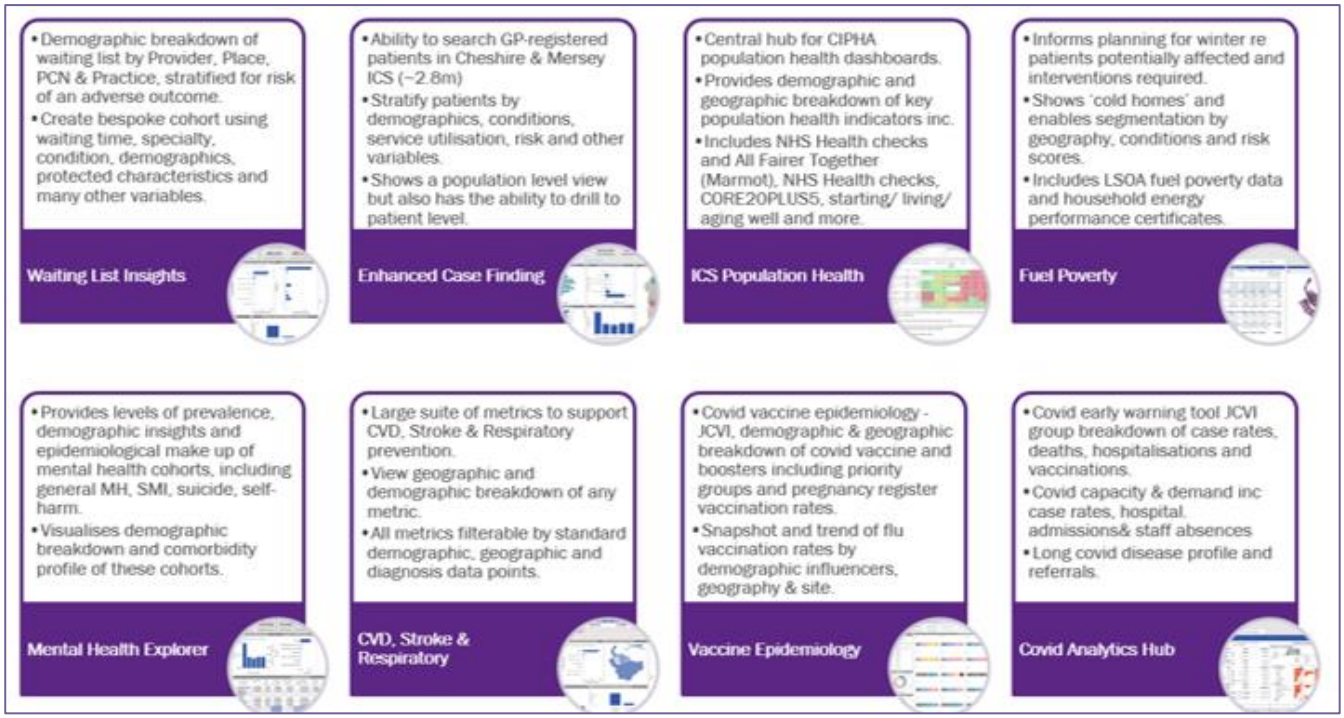


Figure 4 - overview of core CIPHA applications

3. Investment requirement and implementation plan

3.1 **Funding requirement.** At the end of March 2023 national funding ends, and the funding required for the continued provision of the population health platform (CIPHA) and the C2Ai PTL tool falls to the ICB. The total funding requirement requested for 23/24 is £5.31m.

3.2 There are three core elements to the costs – (a) Graphnet, (b) Cheshire and Merseyside transformation (System P), and (c) C2Ai PTL tool – which are detailed below.

3.3 It is also vital to note that that although this investment case does not incorporate the ICB digital team members who provide support to both PHM data flows and shared records, there is a clear dependency on these personnel (and other resources) for ongoing implementation, business-as-usual (BAU), and transformation enablement. Other discussions are taking place (led through the Chief Digital Officer) with further investment cases being developed as appropriate.

- Graphnet (note - all figures exclude any capital charges from previous national funding.)

	2023/24 £(m)	**2024/25 £(m)**
Licenses *	2.4	2.4
Johns Hopkins	0.26	0.26
Power BI	0.6	0.6
Services	0.44	0.44
Total	***3.7***	***3.7 + inflation uplift***

- Cheshire and Merseyside transformation (System P)

	2023/24 £
Programme Director	25,000
Director of Analytics	25,000
Project support	40,000
Transformational project management – Complex Lives	75,000
Transformational project management – F&D	75,000
Transformational project management – Multimorbidity	150,000
Non-pay budget for infrastructure, training events	30,000
Evaluations of Models of Care	80,000
Total	**500,000**

- C2Ai tool integrated with CIPHA across the 10 acute Trusts supporting risk-adjusted triage and prioritisation of the Patient Treatment List (PTL). The following pricing is proposed for Cheshire and Merseyside, that recognises the collaborative working relationship and support from the region through a significant discount to national pricing:

Component	Additional remarks	Units	List Price (per unit)	Total with discount (ICS-wide)
1. PTL Risk stratification tool	Annual license fee with weekly/ daily updated analysis and automated data input from Trust upload to C2-Ai and download of PTL analysis back to Trust.	10	£100,000 p.a.	£800,000 p.a.
2. Observatory	Monthly risk adjusted clinical outcomes analysis inclusive of SDoH and ICU capacity.	10	£100,000 p.a.	£150,000 p.a.
3. Integration	Integration with shared care record CIPHA	1	Waived	N/A
4. Implementation	To April 30th 2024	1		£160,000
Total				**£1,110,000**

3.4 The full specification of the C2AI work is given in Appendix Three.

3.5 **Cost recovery model.** Cheshire and Merseyside already has a strong record of direct cost avoidance and cost recovery in these areas. The first two years of the CIPHA programme (build, licensing, technology, and programme costs) were met

through national funding. In year 3 CIPHA license costs were met by the ICB at £2.4m with £750K recovered from national funding.

3.6 Several routes are being pursued to minimise the financial costs associated with population health management and shared care records. During 2023/24 it is proposed that some costs may be recovered directly, whilst other avenues avoid and potentially reduce costs overall.

- **Direct cost recovery:** The CIPHA programme currently grants access to data for circa 15 research projects per year, and this number is expected to grow over the coming years. Many of those projects are already funded and it is proposed to introduce a model for subscription / usage for data access. The model has not yet been developed and will take its principles from the North West Secure Data Environment where the charge per project will be based on project size. If an average cost were applied of £20K then the recovery would be £300K per year.

- **Other Income Generating Opportunities:** – examples where the existence of the CIPHA platform is a significant factor in attracting other related funding:
  - Health Foundation Data Lab income of £500k for period 2023/24 to 2025/26
  - NW SDE funding into Cheshire and Merseyside ICB to develop CIPHA capability for research circa £500K for each of the next two years
  - Alignment to the Federated Data Platform (FDP) where costs are met through national procurement.
  - Evidence from the NHS England review of C2Ai
    - 125 bed-days freed up per 1,000 patients on PTL.
    - 8% reduction in emergency admissions
    - 100% reduction in avoidable cancellation rate (60% to 0% rejection rate by independent sector)

- **Technical architecture / platform rationalisation** – as described in part 1, the technical architecture associated with PHM is complex and holds significant potential for rationalisation and associated cost efficiencies. Various factors will affect the timing of changes but a shift towards a more strategic architecture model would incorporate potential savings from rationalisation across:
  - the four existing shared records platforms.
  - the various BI / PHM tools / platforms. An initial desktop exercise was conducted in February 2023, and this is presented in Appendix 3: this further review will be conducted with wider Place and Provider stakeholders.
  - the combined data needs of PHM / BI and shared records; reducing duplicate data flows and data management.

3.7 **Implementation approach / high level roadmap**. If approved, this investment will provide the stability required for key digital and data platforms in the short-term. It will also provide a transition period of two years; allowing PHM and shared care records platforms / architecture to be rationalised through the officer of the Chief Digital Officer. The following bullets summarise the key activities to be taken

forward. Full plans will be developed, and the Digital Transformation and Clinical Improvement Assurance Board will be kept appraised of progress:

- Continue to support transformation, via enhancements to population health management delivered through the CIPHA platform.
- Revisit the options for deploying the Graphnet licenses for an ICS longitudinal shared care record.
- Explore and address the local variation in funding models for shared care records across the ICS.
- Develop a future (2025 and beyond) target operating model for digital and data platforms incorporating PHM and shared care record requirements. This will involve consultation across ICS stakeholders; continuing to work with national and regional teams to understand and influence national / sub-national digital and data infrastructure design and availability; and engagement with suppliers, academia, and others to understand and influence market developments.

3.8 **Governance.** This work falls under the stewardship of the Chief Digital Officer and, as such, will link through the Digital Transformation and Improvement Programmes line to the Digital Transformation and Clinical Improvement Assurance Board.

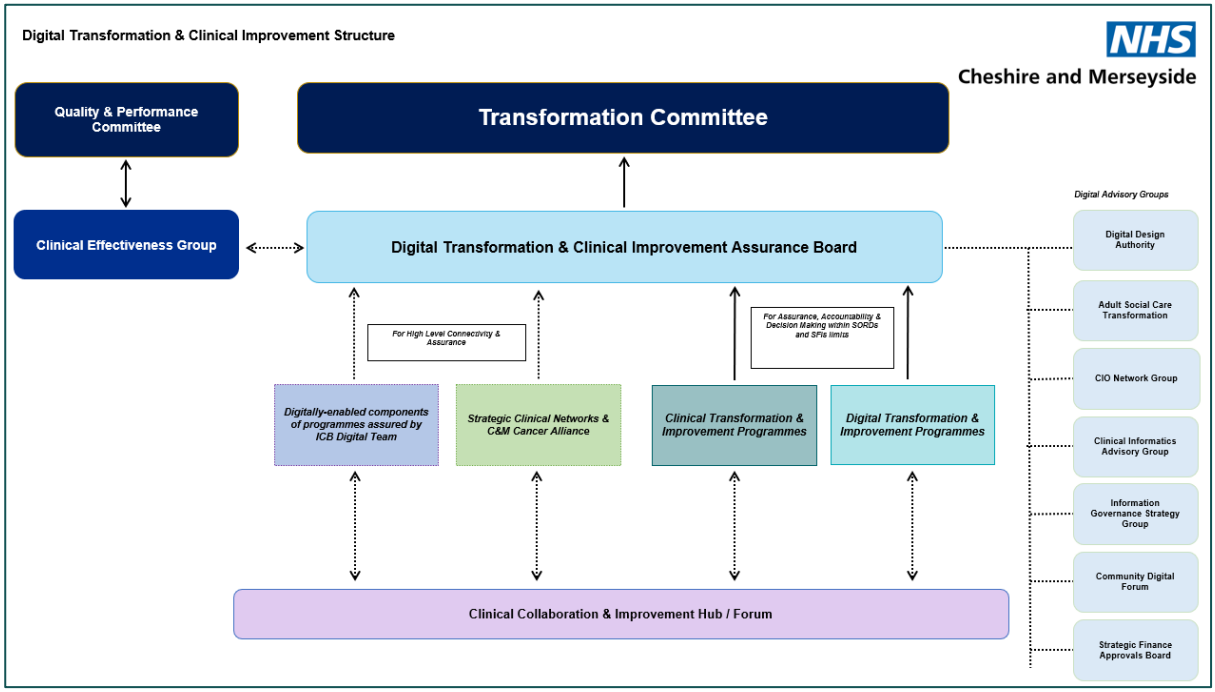


Figure 5 - Governance arrangements

3.9 **Establishment of an Intelligence into Action Programme.** Building on the deliverables that CIPHA brought in delivering and agile response to pandemic the next step is to create formal Intelligence into Action programme as the basis for a learning health system. It will bring together the population health management teams and technologies in the ICB together with the data scientists and engineers from different disciplines under the University of Liverpool Civic Health Innovation Lab (CHIL) and other health and care professionals from all health and care provider organisations. Through a common purpose and shared objectives, the

Intelligence into Action programme will seek to improve the health and well-being of the population through the optimal use of an integrated data set, tools, methodologies, and associated actions.

3.10 The partnership with the University of Liverpool, CHIL, will focus activity through three workstreams: Data-intensive Discovery, AI for Patient and Population Care, and Civic Data and Digital Trust. These will deliver translational data science and engineering aligned to the University strategic priorities and aligned to the ambition in the ICB Digital and Data strategy and the ICB operational plan.

3.11 Intelligence into Action programme scope. The programme provides a governance that will optimise the use of resources currently deployed in Cheshire and Merseyside and in academia that are concerned with the use of data to develop actionable intelligence and evidence to support health and care decision making for planning purposes and for direct care. The programme at maturity will inform the planning round and provide the evidence base for transformation. The primary data management platform is a combination of the Graphnet Care Centric deployment (CIPHA) and the AGEM CSU Data Management Environment. Other data sources will be added as the programme develops.

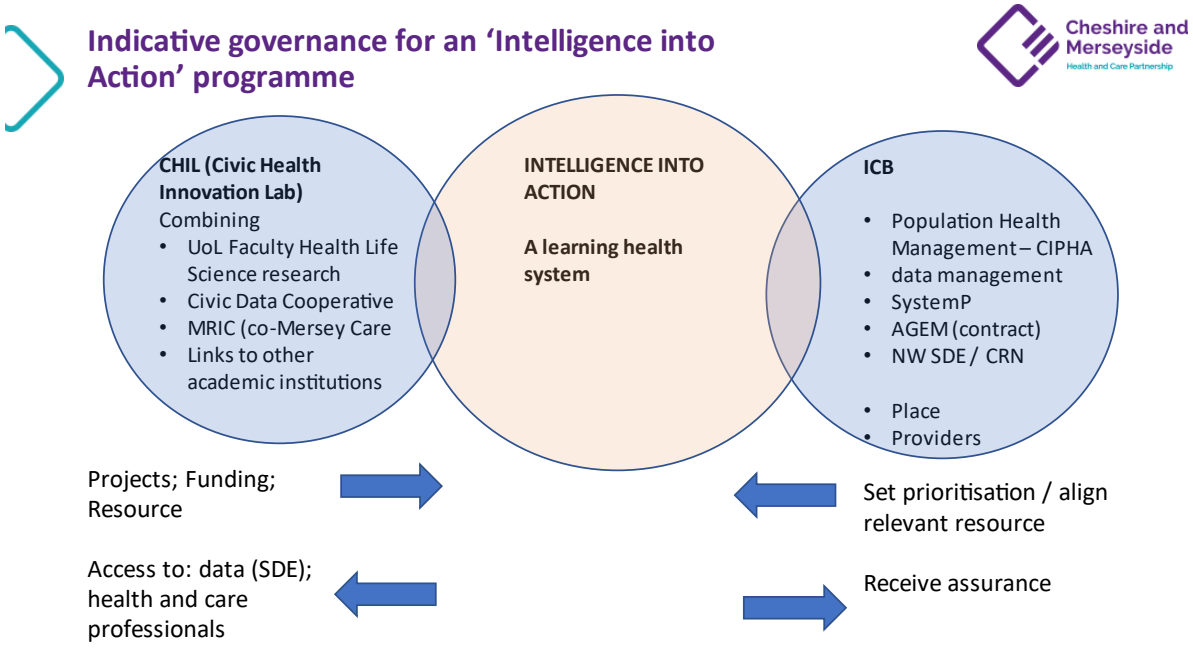
3.12 The programme workplan will be driven by

- Population Health Board (Core20PLUS5)
- Transformation Programmes.

3.13 The programme will support:

- Provider Collaboratives
- Places
- NHS and care providers.

3.14 The programme will provide dashboards and reports and insights on its workplan. The programme will support transformation but will not deliver the transformational change.



4. Benefits and Risks

4.1 **Benefits.** The benefits arising from the adoption of population health management tools and shared care records are well documented. At a high level they align to the Triple Aim and include:

- Better outcomes and experience for individuals due to information sharing and well-informed decisions.
- Better outcomes and better equality for populations due to interventions and resources being more appropriately targeted in the population.
- Better productivity for health and care providers due to time savings, less repetition, and less duplication.
- Better broader social and economic development due to the ICS's reputation as a leader in these fields.

4.2 There are many existing examples of the value already realised in Cheshire and Merseyside through the adoption of PHM and shared care records. Benefits of provision of the CIPHA integrated C2Ai PTL tool based on an NHS England evaluation:

- 125 bed-days freed up per 1,000 patients on PTL
- 8% reduction in emergency admissions
- 100% reduction in avoidable cancellation rate (60% to 0% rejection rate by independent sector)
- 27% reduction in long-waiters and highest urgency patients (within 6 weeks of deployment)
- Overall, an estimated 15% increase in PTL throughput and >60 times return on investment.

4.3 In addition, the continued provision of the C2Ai PTL tool enables the ICB to meet its statutory duty as outlined in the 23/24 NHS planning guidance, 'Improving NHS patient care, outcomes and experience can only be achieved by embedding innovation and research in everyday practice. ICBs have a statutory duty to facilitate or otherwise promote research and the use of evidence obtained from research and to promote innovation, for example AI and machine learning which is driving efficiency and enabling earlier diagnosis.'

4.4 Population Health Management examples:

- *"Directors of Public Health are sincerely thankful for all your hard work in establishing CIPHA. It is an amazing achievement and the speed in which the Platform was set up [within three months], in the most challenging of circumstances, is truly outstanding and a testament to all involved. You've enabled DsPH, PH teams and strategic groups within the LRFs across C&M to have access to data that helps to inform their planning and understanding of the pandemic, which has been key for managing our System's response to this crisis and will be equally instrumental in driving our COVID recovery moving forward."* **Director of Public Health, Liverpool City Council**

- *"CIPHA very quickly developed in a matter of weeks from a mere concept to a practical tool which can help inform key decisions when responding to Covid-19. It is enabling us to predict the pressures clinical teams will be placed under during the coming weeks, and better inform decisions about the surge capacity that needs to be put in place. Casemix data can help us understand how internationally identified trends, such as vitamin D status, the effects of social deprivation and frailty, impact patients in our local area."* ***Chief Clinical Information Officer, St Helens & Knowsley Teaching Hospitals***

- *In November 2021, the CIPHA programme supported asymptomatic mass COVID testing in Liverpool. The economic benefit to Liverpool City region was estimated to be £0.5bn over the following 3 months as Liverpool City was moved from 'Tier 3 measures' to 'Tier 2 measures'.*

Shared Records examples:

"Saves time ringing GP surgeries and being kept on hold. Also reduces number of faxes / emails for information." Dementia Care Navigator

"Saves time! Allows quick access to admission and discharge summaries." Allied Health Professional

"Freed up time for more efficient clinical caseload management." Consultant Psychiatrist

"Allows more informed clinical decision making." Advanced Clinical Practitioner

"Benefits in having access to other Trust's hospital letters, medications and investigations. Information from other specialties with regards to medication changes is beneficial." Pharmacist

4.5 **Risks.** The key risks associated with this work are:

Risks	Mitigations
It is not possible, or it takes longer than anticipated, to rationalise Cheshire and Merseyside's technical architecture for PHM and shared care records.	Parallel investment in the ICS Digital and Data team to ensure appropriate expertise and capacity. Close alignment with ICS-wide transformation priorities and programmes and continued stakeholder engagement.
The medium- and long-term costs associated with a rationalised technical architecture are unaffordable.	Market engagement and exploration of commercial models; robust, ongoing benefits analysis; and alignment with national funding and architecture offers.
Cost recovery is not possible.	Development of the proposed cost recovery model in conjunction with System-wide and national partners and stakeholders.
There is limited adoption of PHM insights and shared records.	Close alignment with ICS-wide transformation priorities and clinical improvement programmes.

5. Options

Option 1 - do not fund the Graphnet contract, C2Ai and System P transform enablers beyond March 2023
This option significantly adversely affects the ICS's ability to meet its own operational and strategic objectives and priorities. The ICS will not be able to deliver against the national planning guidance. It will affect the ICS's advanced reputation for population health management and its ability to attract to the region, and to exploit, leading research and innovation.

Option 2 – fund the Graphnet contract, C2Ai and System P transform enablers to the end of 2024/25
This option retains vital platforms and capabilities supporting the ICS to fulfil key ICS and national objectives. It also allows Cheshire and Merseyside to further build on its national reputation as a leader in this area. Under this option the system can avail itself of the opportunity to adopt all of the offered tools and methods which enable 'insight-into-action' through a combined population health and shared record platform as articulated in the endorsed digital and data strategy. It would allow population health management to link more readily to direct care allowing, for example: an intelligence into action-based approach to winter planning; improved anticipatory discharge; medicines management; front door avoidance; addressing fuel poverty; targeted vaccine delivery; and management of acute trust PTL.

	2023/24 £m	2024/25 £m
Graphnet, Plus Tooling	3.7	3.7 (plus inflation uplift)
C2Ai (inc Specialist Support)	1.1	1.1
System P	0.5	0.5
Capital Charges	0.575	0.575
Total Cost	5.875	5.875

6. Recommendation

6.1 **The Board is asked to:**

- **approve** the recommendation of the Finance, Investment and Resources Committee – support for Option 2.

Appendix One – key points from national policy, strategy and guidance relating to population health management tools and shared care records

NHS Long Term Plan – January 2019.
https://www.longtermplan.nhs.uk/

Key points from Chapter 5: Digitally-enabled care will go mainstream across the NHS:

- Ensure that clinicians can access and interact with patient records and care plans wherever they are.
- Use decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition.
- Use predictive techniques to support local health systems to plan care for populations.
- Link clinical, genomic, and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical research, and publish, as open data, aggregate metrics about NHS performance and services.

What Good Looks Like – August 2021.
https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/

Key points for Integrated Care Systems:

Ensure Smart Foundations

- Drive organisations towards 'simplification of the infrastructure' by sharing and considering consolidation of spending, strategies, and contracts.
- Lead the delivery and development of an ICS-wide shared care record (ShCR) which adheres to the Professional Records Standard Body's (PRSB) Core Information Standard.

Healthy Populations

- Lead the delivery and development of an ICS-wide intelligence platform with a fully linked, longitudinal dataset (including primary, secondary, mental health, social care, and community data) to enable population segmentation, risk stratification and population health management.
- Use data and analytics to redesign care pathways and promote wellbeing, prevention, and independence (for example, identifying patients for whom remote monitoring is appropriate).
- Create integrated care models for at risk population groups, using data and analytics to optimise the use of local resources and ensure seamless coordination across care settings.
- Ensure that local ICS and place-based decision-making forums, including PCN multi-disciplinary teams, have access to timely population health insight and analytical support.
- Make data available to support clinical trials, real-world evidencing, and AI tool development.
- Drive ICS digital and data innovation through collaborations with academia, industry, and other partners.

2022/23 priorities and operational planning guidance – December 2021.
https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf

D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge

- Ensure providers of community health services, including ICS-commissioned independent provider, can access the Local Care Shared Record as a priority in 2022/23, to enable urgent care response and virtual wards.

G: Continue to develop our approach to population health management, prevent ill-health and address inequalities

- ICSs will drive the shift to population health, targeting interventions at those groups most at risk, supporting health prevention as well as treatment.
- The safe and effective use of patient data is key to this. Systems are asked to develop plans by June 2022 to put in place the systems, skills and data safeguards that will act as the foundation for this. By April 2023, every system should have in place the technical capability required for population health management, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities. Systems are encouraged to work together to share data and analytic capabilities.

H: Exploit the potential of digital technologies to transform the delivery of care and patient outcomes

- A digitised, interoperable, and connected health and care system is a key enabler of delivering more effective, integrated care. Systems are asked to ensure that:
    - by March 2023, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to national exchange by March 2024. Standards will be published to support this.
    - local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by March 2023, and that all social care providers can connect within six months of them having an operational digital social care record system.

Health & social care integration: joining up care for people, places, and populations – February 2022.
https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

4) Digital and data

- Health and adult social care providers within an ICS must reach a minimum level of digital maturity, and these providers should be connected to a shared care record. This will ensure each ICS has a functional and single health and adult social care record for each citizen by 2024, with work underway to enable full access for the person, their approved caregivers and care team to view and contribute to.
- Data to support an understanding of population health, including unmet need and disparities, should be fully shared across NHS and local authority organisations, to allow ‘place boards’ or equivalents, and ICSs to plan, commission and deliver shared outcomes, including public health and prevention services.
- Each ICS will implement a population health platform with care coordination functionality that uses joined up data to support planning, proactive population health management and precision public health by 2025.
- 4.3 People will move seamlessly between health and care settings because people and those supporting their health and care, including both professionals and unpaid carers, will be able to see and contribute to their care record and care plans.

- 4.4 They can be assured that they will not become lost in the gaps between services, either experiencing long delays or with risk factors that should be proactively managed, because data is joined up and everyone who needs it can access it.
- 4.10 Basic shared care records are now in place in all but one ICS. However, we must ensure that shared care records cover the entirety of a person's life and include both health and care, which they currently do not. For adult social care, we will ensure that within 6 months of providers having an operational digital social care record in place, they are able to connect to their local Shared Care Record, enabling staff to appropriately access and contribute to the record. We will also reinforce the use of the NHS number universally across social care to support this. Work is also underway to enable citizens to be able to access and contribute to their shared care records, building on successes to date.

Data Saves Lives – June 2022
https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data

Many key points. See document.

A plan for digital health and social care – June 2022
https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care

Many key points. See document.

2023/24 priorities and operational planning guidance – December 2022.
https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf

- The long-term sustainability of health and social care also depends on having the right digital foundations. NHS England will continue to work with systems to level up digital infrastructure and drive greater connectivity.
- NHS England will: Procure a Federated Data Platform, available to all ICSs, with nationally developed functionality including tools to help maximise capacity, reduce waiting lists and co-ordinate care.
- 'Improving NHS patient care, outcomes and experience can only be achieved by embedding innovation and research in everyday practice. ICBs have a statutory duty to facilitate or otherwise promote research and the use of evidence obtained from research and to promote innovation, **for example AI and machine learning which is driving efficiency and enabling earlier diagnosis.**'

Secure data environments for NHS health and social care data – policy guidelines – December 2022
https://www.gov.uk/government/publications/secure-data-environment-policy-guidelines/secure-data-environment-for-nhs-health-and-social-care-data-policy-guidelines

Many key points. See document.

Guidance on developing the Joint Forward Plan – December 2022
https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf

Recommended content includes:

- Digital and data - Steps to increase digital maturity and ensure a core level of infrastructure, digitisation, and skills. These actions should contribute to meeting the ambition of a digitised, interoperable, and connected health and care system as a key enabler to deliver more effective, integrated care. This could include reducing digital inequity and inequalities and supporting net zero objectives.

- Population Health Management – The approach to supporting implementation of more preventative and personalised care models driven through data and analytical techniques such as population segmentation and financial demand modelling. This could include: developing approaches to better understand and anticipate population needs and outcomes (including health inequalities); using population health management approaches to understand future demand and financial risk; support redesign of integrated service models based on the needs of different groups; and putting in place the underpinning infrastructure and capability to support these approaches.

Hewitt Review – Letter from Rt Hon Patricia Hewitt to stakeholders – January 2023

"Enabling timely, relevant, high-quality and transparent data: we recognize that timely, relevant, high-quality and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. Good data, used well, can generate actionable insights into outcomes and the drivers of inequalities, as well as productivity, quality, and safety. ICSs should focus on enabling data sharing and digital innovation that supports real-time service improvement, Of course, effective data can also enable greater accountability, a learning culture and research, although simply doing this through uncoordinated data requests can create unnecessary administrative burdens rather than improvements. NHS England, working in collaboration with DHSC and local government (including through DLUHC, the LGA and CCN) have a key role to play. By defining standards on data taxonomy and services' interoperability, and coordinating data request to the system, they can create the conditions for wider transformation."

NHS Cheshire and Merseyside Integrated Care Board

Appendix Two – Cheshire and Merseyside Digital and Data Strategy

https://www.cheshireandmerseyside.nhs.uk/about/digital-and-data-strategy/

Appendix 3 Cheshire and Merseyside BI/pop health management systems review (desktop exercise)

1. Introduction

The following document outlines the current business intelligence systems commissioned across Cheshire and Mersey ICB. For each system it outlines the following:-

- History of commissioning decisions
- Current contract value
- Supplier
- Contract length
- Product Catalogue
- Usage statistics

To note:

- National systems are not included in this document
- A standardised view of usage metrics for comparison needs to be developed. Also, a better understanding of user views and user stories could supplement usage statistics to inform future commissioning decisions
- This is a desktop exercise and requires fuller stakeholder engagement on current and planned usage with Place and Providers

2. Summary of contracts and functionality

Supplier	Value	Provision	Status
MLCSU	£650k	- Aristotle Portal with Business Intelligence reporting including performance, population health and risk stratification - Analytical service of ~12 WTE to face C&M ICB priorities	NHS England Protected Service
Graphnet (CIPHA Platform)	£3.7m	BI Associated Provision - Linked datasets and associated data management for population health and shared care record - Front end reporting layer for population health - Consultancy for development of population health analytics - BI tooling e.g., John Hopkins Risk stratification etc. Other Provision - Linked datasets for a shared care record - Front end layer for shared care record (currently implemented in Cheshire and St Helen's)	Graphnet contracted until March 2025 22/23 cost pressure for ICB partly offset 23/24 and 24/25 subject to investment case decision currently with Exec
QlikSense	£137k	- Front end reporting software deployed in Cheshire Place	Contracted until 31st December 2023

Microsoft Power BI	~£50k	- Front end reporting software deployed across the ICB (Previously separate Liverpool/Wirral CCG tenancy's that have now been merged into one)	Contracted until x
Public View	£250k*	- Front end visualisation of all National Performance reporting data in the form of dashboard, trend, SPC, Benchmarking etc. - Ability to upload local data and KPI's - ICB and Provider View of performance and quality	Contracted until 31st March 2022 with option to extend (funding identified)

*This is for an ICB and Provider Licences. ICB licence is £60k, Provider Licences are £30k each, £250k reflects a discounted price if purchase for the whole ICS.

With the exception of Public View, the above front-end solutions are supported by data from the core data management service for the ICB which is contracted from Arden and GEM CSU and detailed below

AGCSU	£1.2m	- Data Management of Direct Access database - Onboarding and management of local and national data flows - Feeding data flows for front end solutions described in table 1	NHS England Protected Service

3. Detailed Service area descriptions

3.1 Arden and GEM CSU Data Management Service

History

In the formation of CCG's and CSU's in 2012, NHS England made a decision to procure data management services separately to other elements of Business Intelligence, those being front end visualisation tools and analytical services. AGEM CSU was appointed as the data management service for all C&M CCG's. Whilst AGEM provide front end tooling and analytical services for other ICB's, they only provide Data Management to C&M.

Product Catalogue

AGEM data store is not a front-end solution. They provide a cloud-based Azure Data Management Environment (DME) accessed via SQL Studio. The ICB and increasingly other ICS organisations access this to produce analytics. They also provide a data management service for the data in that environment.

The Data Assets in this environment are the National NHS Digital data flows such as SUS; several local data flows such as C&M Criteria to Reside Dataset and PLICS costing data; and the data flows that Graphnet hold to populate the C&M population health/shared care record solution, for example primary care data.

The North West is a phase 1 Secure Data Environment (SDE), a programme of significant resource aimed at mobilising data for research. The DME provided by AGEM is the C&M ICB

C&M offer into this north-west platform. GM have a similar service and set up.

Usage

The DME is core part of the ICB data provision and is accessed daily by all ICB Analytical employees. The Information Governance is now in place that ICS Partners can also access the data. Providers, Local Authorities and Academic partners are increasingly gaining access to undertake work across the ICB via applying to the C&M Data Access and Asset Group, established since 2019.

3.2 Midlands and Lancashire CSU: Aristotle

History

In the formation of CCG's and CSU's in 2012, NHS England made a decision to procure data management services separately to other elements of Business intelligence. Front end visualisation tools and analytical services were procured as part of a wider LOT including other non-BI services. AGEM did not bid for the business and MLCSU were appointed to provide those BI services.

The delivery of MLCSU services across the CCGs that constitute C&M ICB today was different. The below table describes that difference. This has been the formal arrangement for MLCSU services until the ICB was formed on 1st July 2022. Informally, since mid-2020, MLCSU have worked to be more agile in their services across the wider ICB without the need for extra renumeration post COVID. The legacy decisions of CCG's have led to different front-end solutions to be in play across the ICB in 2023.

Liverpool CCG	Aristotle (Access/Training/new developments) and Statutory Returns
Sefton CCG	Aristotle (Access/Training/new developments) and Statutory Returns
Knowsley CCG	Aristotle, statutory returns, prescribing, risk stratification support and some analytical services regarding performance reporting
S Helen's CCG	Aristotle (Access/Training/new developments), Statutory Returns, prescribing, risk stratification support and analytical services
Warrington CCG	Aristotle, statutory returns, prescribing, risk stratification support and analytical services
Halton CCG	Aristotle, statutory returns, prescribing, risk stratification support and analytical services
Wirral CCG	No Services PCN access to Aristotle for IIF Report Statutory Returns (not all)
Cheshire CCG	Aristotle (Only PCN access to IIF Report), statutory returns and prescribing. However,

	they pulled out of the contract end March 2020

Product Catalogue

- IG Compliant Secure Role Based Access; Highly skilled and responsive BI Development team; 400+ Online Reports, 5000+ User access accounts
- Population Health Management, Health Inequalities, Risk Stratification, Covid Specialist, OTiS Urgent Care, Mental Health, Primary & Secondary Care, Performance, Quality, Bespoke developments
- Utilising both Open Source and Proprietary software
- Intuitive visualisation utilising Power BI, Tableau, SSRS, Data Cubes
- Analyst Server Environment supporting deep dive analytics and data science(not utilized due to Arden and GEM data management
- 1000+ Metrics and KPIs (performance, quality, etc.) managed in bespoke environment enabling multiple uses
- Dedicated Training and Support Desk function
- Routine and mandatory data collection (Dedicated BI Operations team)
- Clinical system linkage

Analytical service of ~10.62 WTE to face C&M ICB priorities

Aristotle_XI_Summary Product Slide_230

Usage

262 Individual users accessed reports, 3,827 reports viewed by users. 45.3% reports viewed by GP & PCN users. 35.1% reports viewed by ICB & ICB partners, Liverpool, Halton & Warrington have accessed the most reports with Sefton, Knowsley & St Helens not far behind. Low usage for Wirral and Cheshire. 19.6% reports viewed by CSU aligned users. Most popular reports viewed are GP and PCN Primary Care Dashboard; Health Inequalities Dashboard; PCN Profile Report; A&E Attendances & Admissions; PCN Network DES & IIF Dashboard 2022-23; Population Segmentation & Covid Risk Segmentation Tool; RTT – Commissioner

3.3 Graphnet (CIPHA Platform)

History

At the start of the COVID pandemic in 2019 NHS X agreed to fund a business case for introduction of a population health management solution across C&M. Graphnet was selected as a supplier and commissioned at pace to implement patient level linked datasets and analytics to support COVID management. Post pandemic the purpose of the platform has been extended to include non-covid related population health analytics. The platform is also a shared care record, currently implemented in Cheshire and St Helen's. An investment case is with the ICB for consideration for future funding.

Product Catalogue

The graphnet platform (CIPHA) predominantly focusses on the provision of analytics to support Population Health Management, allowing for key insights into the epidemiology of segmented cohorts of the population. There are risk stratification tools available and the ability to re-identify individuals for the purposes of direct care.

CIPHA Core Applications v1.0.pd

Usage

There are 657 users across C&M that have an account. 200 of these have logged on at least three times in that last 3 months. The user groups that are most active are the BI team itself; Public Health analysts in Local Authorities; clinical teams in some Acute Providers, Mersey Care and some Place based PCN's to proactively manage patients for direct care; Programme leads at the ICB to monitor Population Health metrics.

3.4 Place Based Solutions

Power BI

In 2012 Wirral CCG did not purchase any service from MLCSU and in housed their Business Intelligence and Portal provision. They have a mature platform that utilises Power BI as a technology for its front end. The data source is AGEM DME.

Liverpool also procured Power BI licencing and began development of in-house automated reporting in 2019. In development of the ICB TO, a decision was made in 2022 to amalgamate the Power BI licences for Wirral and Liverpool into one ICB tenancy, which now exists. Saving ~50k for the system.

Product Catalogue

The Liverpool Place Power BI Service is currently published on the Wirral Place tenancy. It contains 37 reports covering Contracting, System Performance, Mental Health, ND, LD & SEND, and Physical Health (vaccinations, Enhanced Health in Care Homes etc.)

The Wirral Place Power BI Solution contains ~42 dashboards and ~250 reports.

Usage
Between the two systems there are 843 users. More specific information has been requested on how many regular users there are.

For the Liverpool element the reports are available to 80 users in Liverpool Place and 53 external users (access to external users is more tightly managed). The external users are mainly from LUHFT and Mersey Care, but there are also users in General Practice, Liverpool City Council, Voluntary Sector providers, and other C&M Places.

QlikSense
In 2020 Cheshire CCG pulled out of the MLCSU contract and implement an in-house portal. The solution uses QLIK software as its front end with data from AGEM DME.

Product Catalogue
Cheshire host 126 apps in QlikSense, covering work areas such as Finance, Primary Care, Performance and Urgent Care, as well as specific programmes, such as Thriving and Prevention and Living Well for Longer.

The Cheshire BI team are in the process of reviewing the current dashboard position and are aiming to reduce this offering to around 34 high-priority and 27 medium priority core dashboards, which represents the majority of current data provision.

Usage
There are 295 users who have accessed the QlikSense platform in the past 12 months, excluding the BI team. In the past 90 days there have been requests for access from 46 new users.

Users are primarily located in Cheshire Place, care communities and local authorities, but there are also some registered users at CWP, local Acutes, MLCSU and voluntary sector organisations as well.

There is a maximum of around 25 people accessing Qlik per day, excluding BI. These users have generated 4,707 sessions with QlikSense over the past year, and 1,128 sessions in the past 90 days. The majority of users (around 90%) have a basic level of access. These users have collectively accessed QlikSense for a total of 802 hours in the past year, 200 hours in the past 90 days and 85 hours in the past month, as Qlik usage has increased since last Autumn.

Public View

History

Until Autumn 2021 the HCP did not have a C&M wide Business Intelligence solution (Aristotle was not implemented ICB wide), any analytical support or leadership. In Autumn 2021 the HCP exec team approved the commissioning of a performance solution called Public View. The solution was a 'quick fix' to have a succinct view of performance data across the ICB and providers in time for the ICB formation deadline in March 2022 (subsequently moved to July 2022). The intention was for this to bridge the gap to Aristotle metrics engine which was in development and to become prime source of performance information. Three provider trusts were actively looking at procuring Public View themselves at this time. Funding was secured from national elective restoration TIF funds that awarded money for visualisation of performance across systems. The system was procured for the ICB and all C&M providers at a cost of £250k. An ICB licence alone costs £60k and a provider licence alone cost £30k.

Product Catalogue

Public View displays all performance metrics is a succinct set of dashboarding, showing benchmarks, trend, SPC, RAG. It has functionality for end users to create bespoke board reporting dashboard to report performance.

Public_View_Brochure.pdf

Usage

Within the BI function, Public View allows quicker access to visualisations of performance data that currently make up about 50% of the current ICB board report. These visualisations can be created from other sources with more processing time as it is not automated. Public View is utilised by non-BI user groups specifically in Cheshire, some programmes at the ICB and also 6 C&M provider trusts use it to monitor performance.

4. Short Term rationalisation if the BI Solutions

Place based structures have been re-organised so that data management activities are now centralised into an ICB Data Management Team that will go live on 1st April 2023.
The power BI instances for Liverpool and Wirral have been merged into one tenancy that will be managed y the ICB data management team. Whilst some efficiencies have been made to date, this team will have the capacity to accelerate the work to make efficiencies in the reporting done, the processing and software used to process and visualise the data.

A reporting audit has commenced to understand a) what can be automated that is still manually processed and b) where there is duplication in the automated reports what can be stopped. A work plan will be prioritised for 2023 from this process.

Power BI, is the dominant user interface in place across the ICB and also where the most skills lie within the ICB Business Intelligence function to develop and run reporting. Careful discussions have commenced with Cheshire Place to migrate (and rationalise) the QlikSence reporting into Power BI. Assurances will need to be given that there will be no loss of service or functionality in this transition.

A more in-depth review of BI systems is required in 2023 that includes stakeholder engagement and workshops.

February 2023

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 April 2023

Cheshire and Merseyside Staff Survey 2022: Results & Actions

Agenda Item No	ICB/04/27/14
Report author & contact details	Paul Martin – Head of HR Paul.martin@cheshireandmerseyside.nhs.uk Suzanne Burrage, Head of Staff Experience, Engagement and Wellbeing (internal) Suzanne.burrage@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director)	Chris Samosa, Chief People Officer
Responsible Officer to take actions forward	Paul Martin / Christine Samosa

NHS
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Cheshire and Merseyside Staff Survey 2022: Results & Actions

Executive Summary	This paper (and supporting presentation) provides an overview of the staff survey results for 2022 for all NHS organisations in Cheshire and Merseyside. The results are presented against the 7 areas of the national People Promise and the key themes of staff engagement and morale. The presentation also provides a high-level overview of the staff engagement scores for organisations across the Cheshire & Merseyside system with identification in movement from the previous survey year. Organisations are currently sharing their own results and developing localised action plans in line with staff feedback. In Cheshire and Merseyside, we have some of the best performing Trusts and will be able to share best practice and provide support to increase performance.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				X
Recommendation	**The Board is asked to:** • **note** the staff survey results and **endorse** the actions taken to review and respond to the Staff Survey results 2022.				
Key issues	The Cheshire and Merseyside NHS staff survey results are detailed in the attached presentation (Appendix One). At a high level, 39,540 staff (45.5%) completed the survey across Cheshire and Merseyside and staff engagement scores range from 6.4 to 7.6 with 7.6 being the highest nationally. Generally, Cheshire and Merseyside organisations scored at or above the national average in most areas, however performance has remained static since 2021 and we have not seen significant improvement in results				
Key risks	Poor results in the staff survey impact on staff morale and our ability to attract and retain staff . In addition, the reputation of the NHS as a model employer is impacted.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
			X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
Route to this meeting	Staff survey results were embargoed until 09 March 2023 but will now have been considered by Trust People Committees and Boards where action plans to improve performance will be considered. Staff side involvement in the development of action plans is critical and consideration of these will have taken place in Trust level consultation and negotiation forums and at Social Partnership Forum				

Management of Conflicts of Interest	No conflicts of interest identified.	
Patient and Public Engagement	Not applicable to the content of this paper.	
Equality, Diversity, and Inclusion	The Nature of this paper as a position statement on the results of the staff survey does not require an Equalities Health Impact Assessment (EHIA) to be undertaken.	
Health inequalities	Not Applicable to the contents of this paper.	
Next Steps	• Sharing of the report with Cheshire and Merseyside HRD's/ CPO's • Identification of potential collaborative working opportunities • Sharing best practice session facilitated by Deputy HRD's.	
Appendices	**APPENDIX ONE**	"Staff Survey Results 2022"

Cheshire and Merseyside Staff Survey 2022: Results & Actions

1. Executive Summary

1.1 This paper (and supporting presentation) provides an overview of the staff survey results for 2022. The results are presented against the 7 areas of the national People Promise and the key themes of staff engagement and morale.

1.2 The presentation provides a high-level overview of the staff engagement scores for organisations across the Cheshire & Merseyside system with identification in movement from the previous survey year. Organisations are currently sharing their own results and developing localised action plans in line with staff feedback.

2. Background

2.1 The national Staff Survey was undertaken during the period September to November 2022 and follows an agreed national format with questions aligned to areas of the People Promise and the themes of staff engagement and morale.

2.2 Over 30,500 staff completed the survey across 17 organisations in Cheshire and Merseyside , which is a 45.5% response rate.

3. Staff Survey Results and Action Areas

3.1 The staff survey is broken down into the following areas of the People Promise:

- **We are compassionate and inclusive (score 7.3).** This score has been stable since 2021 and was 0.1 above the national average.

There has been improvements in three of the four sub themes, with a significant difference of +1.4 in the number of people who felt that their organisation respects individual differences. Of the 17 organisations in Cheshire and Merseyside, 8 have improved across this theme, 4 have stayed the same. Compassionate Leadership and Inclusion have seen improvement in all questions, whereas Compassionate Culture has seen a reduction in the majority of questions. Of interest is the increase in the number of people who said that they have experienced discrimination by service users in the past 12 months. This increased by 0.8% since 2021

- **We are recognised and rewarded (score 5.8).** This score declined by 0.2 since 2021 and scored the same as the national average.

This theme has been affected by the deterioration of those who are satisfied with their pay, which has declined by 9.1%. On average across the country, responses to satisfaction with pay has fallen approximately 10%. Of the organisations within

the Cheshire and Merseyside system, two improved whilst eight declined. This theme also focuses on recognition and value; the results indicate improvements when focused on colleagues and line managers but less so from an organisational perspective where there has been a decline of 0.1.

- **We each have a voice that counts (score 6.8).** This score has been stable since 2021. This score was 0.1% above the national average.

This theme explores levels of autonomy and control and raising concerns. People across Cheshire and Merseyside report that they feel more able to make suggestions about improvements in their workplace and are more involved in change which affects them. However, the highest change in this theme relates to raising concerns about clinical practice which has dropped 1.5%

- **We are safe and healthy 6.1** This score has been stable since 2021. This score was 0.2 above the national average. There are many improvements within this theme, for example, the pressure felt by colleagues and the impact that this has on their health. More people are willing to report experience of bullying, harassment, and physical violence and this is reflected in the increased scores of numbers of people who report that this is their experience. Burnout, which has been an area of concern has improved, though this is not reflected in time available for family.

- **We are always learning** 5.2 This score has been stable since 2021 and scored below the national average by 0.2)

Whilst this is the only theme that has scored below the national average, there has been significant improvement in all areas. All organisations apart from three improved and one stayed the same.

- **We work flexibly (score 6.1).** Stable since 2021 this scored the same as the national average.

  Support for work life balance has improved and people feel more able to discuss flexible working within their line manager. However, over 45% of people feel unable to ask about flexible working or feel that their organisation is supporting their work life balance which equates to approximately 17,000 people.

- **We are a team (score 6.7).** -This score has been stable since 2021 and scored the same as the national average

  Team working across the Cheshire and Merseyside system has improved by significant amounts, people report that they meet to discuss the team's effectiveness, have shared objectives, and are supported by their line managers, though improvements spread beyond this. The only area identified for improvement is understanding of each other's role.

- **Staff engagement 6.9** This score has been stable since 2021 and this scored above the national average by 0.1.

  The Engagement theme, explores motivation, involvement and advocacy and is identified as having a direct correlation to patient safety. Reviewing organisational performance, Acute Trusts have fared less well in their results than other types of organisation. In addition, whilst motivation and involvement have shown areas of improvement, the sub theme of advocacy has fallen, 3.2% less people would be happy with the standard of care provided by their organisation and 1% less would recommend their organisation as a place to work, lastly less people (0.6%) believe that care of patients / service users is their organisation's top priority.

- **Morale (score 5.8).** This score has been stable since 2021 and scored above the national average by 0.1.

  Morale explores, work pressure, commitment to stay and stressors. CM achieved a score above the national average and 7 organisations saw improvements in this theme, whilst 5 remained the same. The biggest improvement is line manager support; more people report that they will continue to work in the organisation, however, work pressure and clarity on roles and responsibilities are areas for improvement.

4. Reviewing the Results and Developing the Action Areas

4.1 Following the initial sharing of our results we will be sharing the report with HR Directors/ Chief People Officers at their network meeting on 16th April.

4.2 A best practice sharing and learning session will be arranged to ensure that those Trusts who have performed well can share their experiences and initiatives with peers and agree how best to support those organisations who have more challenging results.

4.3 The results will also be shared with the Cheshire and Merseyside Social partnership forum to ensure that staff side colleagues are aware of the Cheshire and Merseyside results.

5. Recommendations

5.1 The Board is asked to:

- note the Cheshire and Merseyside results and endorse the actions taken to review, disseminate and respond to the Staff Survey results 2022.

6. Officer contact details for more information

Please contact Paul Martin, Head of Workforce Programme or Christine Samosa, CPO
Paul.martin@cheshireandmerseyside.nhs.uk
Christine.samosa@cheshireandmerseyside.nhs.uk

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 April 2023

Appendix One:

Cheshire and Merseyside Staff Survey 2022: Results & Actions

NHS
Cheshire and Merseyside

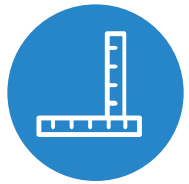
Integrated Care Board Meeting
Staff Survey Results 2022

Background To The Survey/Methodology

Background

NHS
Cheshire and Merseyside

National Annual Staff Survey – supported by People Pulse



Used by NHS England, and by CQC, to judge and assess Trust performance

.

Definite correlations between staff engagement, patient experience and patient outcomes

Survey content – stable since 2021

Content wrapped around People Promise & Staff Engagement/Moral e scores

Methodology

NHS
Cheshire and Merseyside

Online Survey

Survey fieldwork undertaken between Sept/Nov 2022

.

Multiple reminders to staff

.

Sample designed to ensure good statistical comparability between organisations and good statistical comparability over time

Comparability within organisations less robust, unless additional samples are used

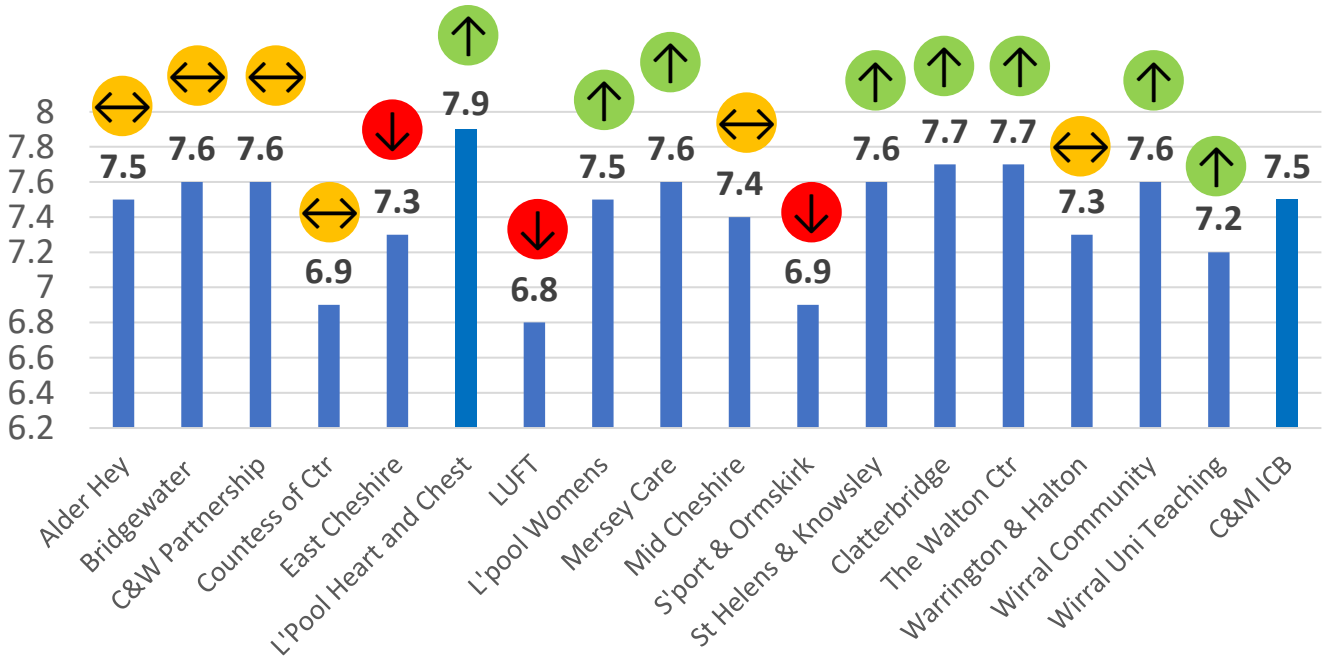
Organisations work with independent survey providers

Cheshire and Merseyside's response rate was 45.5% compared to average of 44.7%

Cheshire & Merseyside Trust Scores

Cheshire and Merseyside

People Promise: We Are Compassionate and Inclusive



System View:

2022 7.3 **2021** 7.3

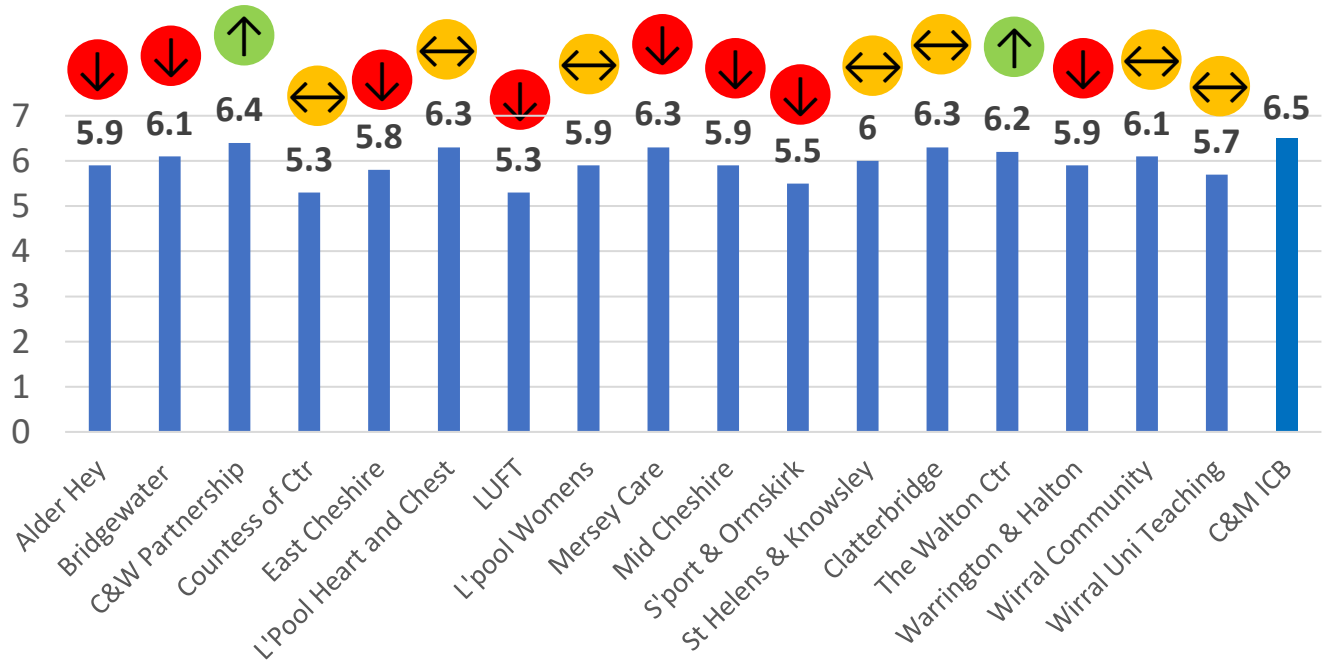
We are compassionate and inclusive is made up of three separate scores:

- Compassionate culture which declined from 7.2 to 7.1
- Compassionate leadership which improved from 6.9 – 7.00
- Diversity and equality which remained the same
- Inclusivity which improved from 6.9 to 7.00

Change since last survey

Cheshire and Merseyside

People Promise: We Are Recognised and Rewarded



System View:

2022 5.8 **2021** 6.0

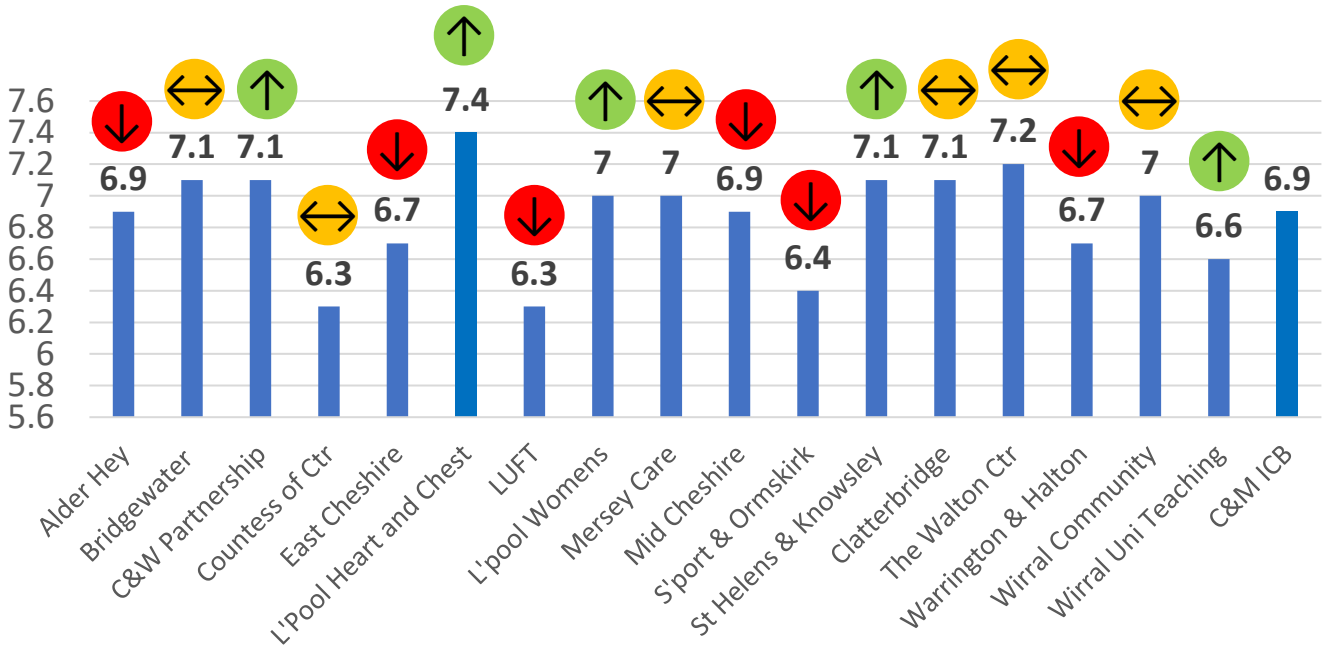
We are recognised and rewarded does not have separate sub scores and across CM there was a .2% drop from the 2021 survey.

The decrease was seen across the majority of age groups (except 66+) and nearly all professional groups excluding (social care and wider healthcare professions)

Change since last survey

Cheshire and Merseyside

People Promise: We Each Have a Voice That Counts



System View:

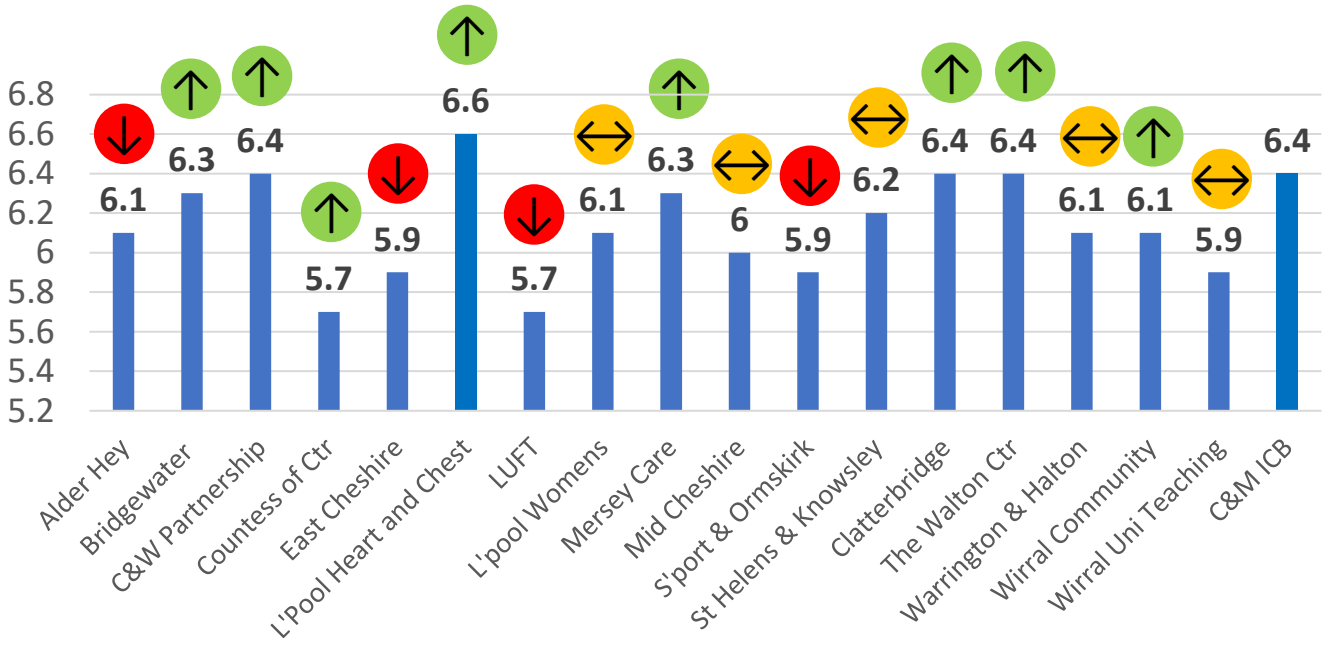
2022 6.8 **2021** 6.8

This theme looks at autonomy and raising concerns. For the autonomy sub score across CM the rate has not changed however the rate for raising concerns has fallen from 6.7 to 6.6

Change since last survey

Cheshire and Merseyside

People Promise: We Are Safe and Healthy



System View:

2022 6.1 **2021** 6.1

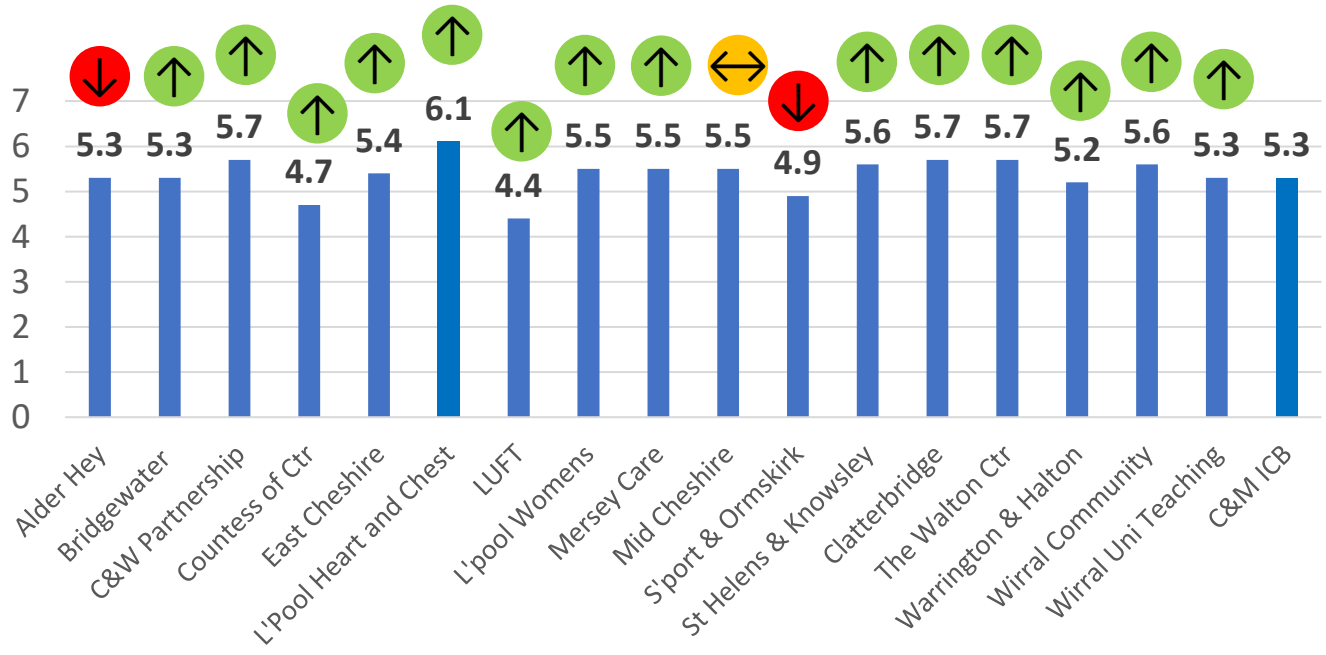
Across all three sub groups in this theme CM have remained stable. The themes are:

- Burnout
- Health and safety climate
- Negative experiences

Change since last survey

Cheshire and Merseyside

People Promise: We Are Always Learning



System View:

2022 5.2 **2021** 5.1

5.2 5.1

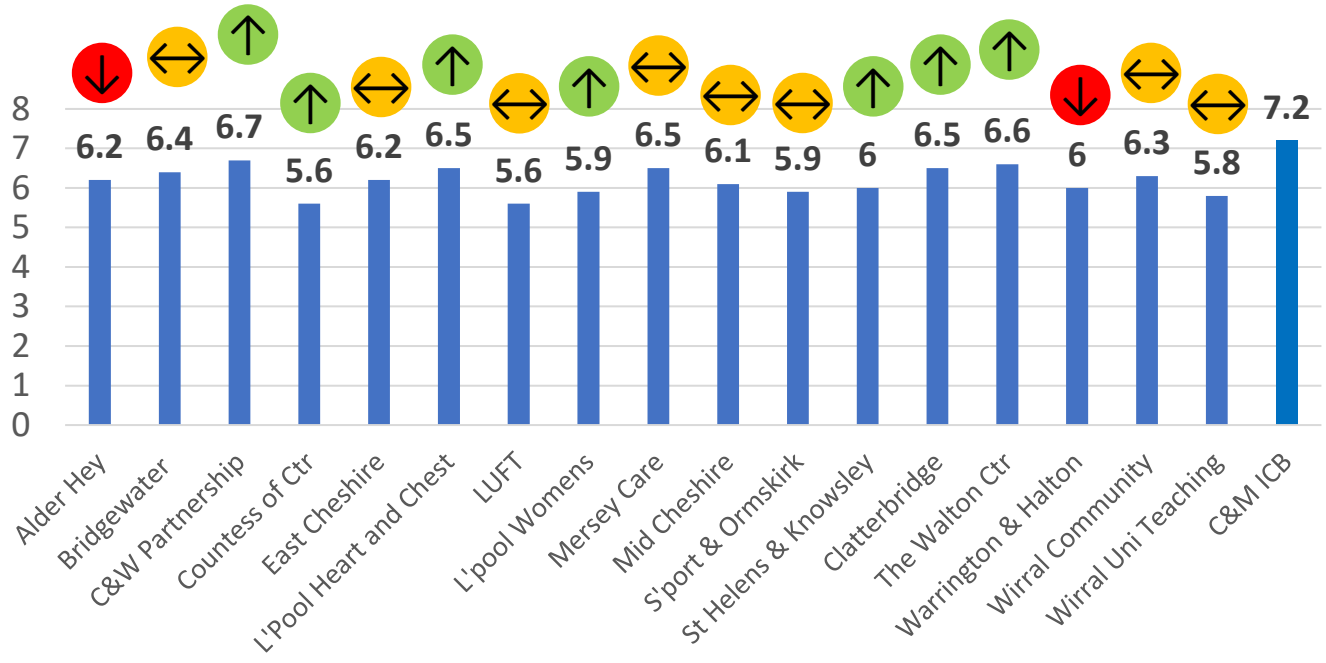
This theme was one of two which improved overall by .1%.

Both appraisals and development improved each by .1%

Change since last survey

Cheshire and Merseyside

People Promise: We Work Flexibly



System View:

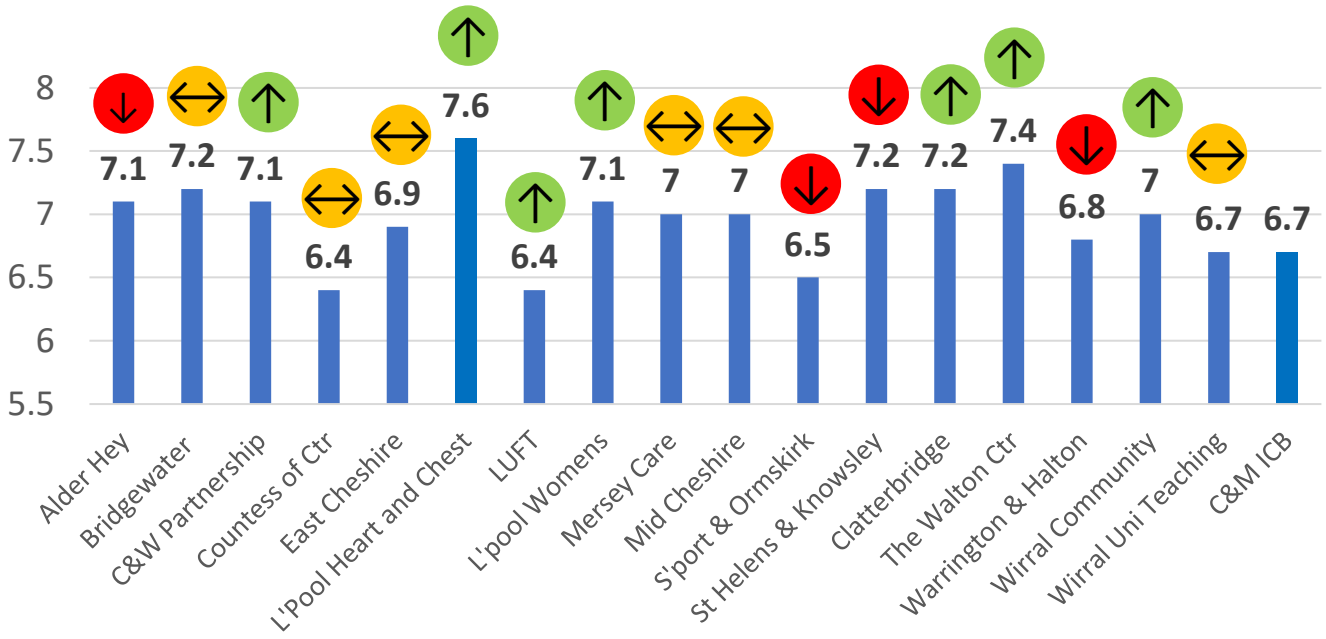
2022 6.1 **2021** 6.1

Of the two subgroups of We Work Flexibly, one, Flexible working remained stable whilst the second Support for Work Life Balance saw an improvement of .1%

Change since last survey

Cheshire and Merseyside

People Promise: Staff Engagement



System View:

2022 6.9 **2021** 6.9

Staff Engagement has decreased in 2020 from 7.00 to 6.9 in 2022

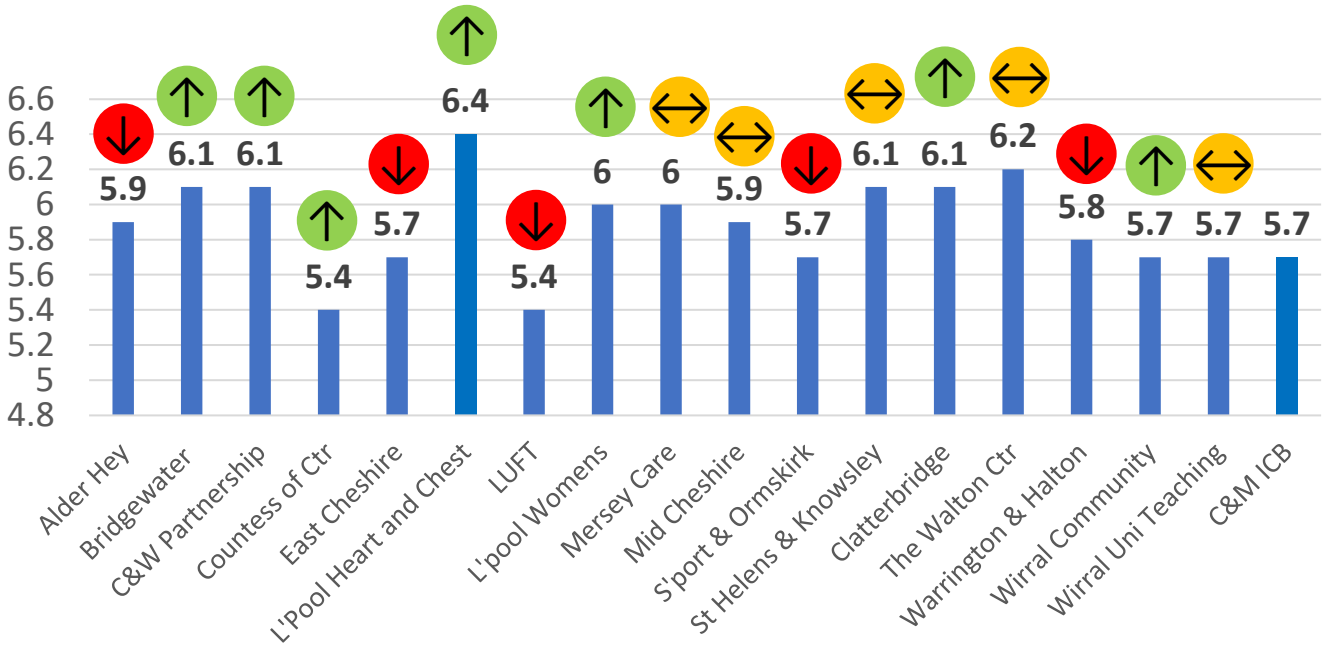
There are three sub groups in this theme:

- Advocacy which has fallen over the last three years from 7.3, 6.9 and 6.8
- Involvement fell by .1 in 2021 and recovered by that amount in 2022
- Motivation fell from 7.3 after 2020 to 7.0 where it remained in the 2022 survey results

Change since last survey

Cheshire and Merseyside

People Promise: Morale



System View:

2022 5.8 **2021** 5.8

Morale fell from 6.2 in 2020 to 5.8 in 2021 where it has remained stable.
The three sub scores are
Stressors which fell from 2020 6.5 to 6.4
Thinking about leaving which fell from 6.4 in 2020 to 6.0 in 2021 where it has remained stable
Work pressure which fell from 5.7 in 2020 to 5.1

Change since last survey

NHS
Cheshire and Merseyside

Questions

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

27 April 2023

NHS England's three-year delivery plan for maternity and neonatal services

Agenda Item No	ICB/04/27/15
Report author & contact details	Catherine McLennan Programme Director LMNS
Report approved by (sponsoring Director)	Christine Douglas
Responsible Officer to take actions forward	Catherine McLennan Programme Director LMNS

NHS England's three-year delivery plan for maternity and neonatal services

Executive Summary	NHS England published a three year delivery plan for maternity and neonatal services on 30th March 2023 following several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup, This three-year plan brings together the key objectives maternity and neonatal services, and systems that support them, are asked to deliver against over the next three years. NHS England developed the new delivery plan in consultation with service users, healthcare staff, trust leaders and other stakeholders, as well as with the Independent Working Group on maternity chaired by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCOG). This consultation has supported NHS England to triage and review the actions remaining from the Ockenden and Kirkup reports as well as existing NHS England plans for maternity. The report sets out the twelve priority objectives for NHS Trusts and systems for the next three years, across four themes: 1. Listening to women and families with compassion 2. Supporting the workforce 3. Developing and sustaining a culture of safety 4. Meeting and improving standards and structures. The Cheshire and Merseyside Local Maternity and Neonatal System (LMNS) has undertaken an initial gap analysis in response to the plan, which will be reviewed in more depth and an action plan developed with more detail

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

Recommendation	**The Board is asked** • **note** the content of the report • **note** the actions being taken by the LMNS and next steps.
Key issues	Within the body of the report.
Key risks	-

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

Route to this meeting	This paper is also being discussed at the ICBs Liverpool Women's Sub Committee meeting on Tuesday 25 April 2023.

Cheshire and Merseyside ICB
Integrated Care Board Meeting

Management of Conflicts of Interest	N/A	
Patient and Public Engagement	NO	
Equality, Diversity, and Inclusion	NO	
Health inequalities	YES	
Next Steps	Following consideration of this paper it will be presented to the Cheshire and Merseyside LMNS Assurance Board. Further updates on actions will be presented to the Cheshire and Merseyside ICB Quality & Performance Committee.	
Appendices	**Appendix One**	The Three Year Delivery Plan
	Appendix Two	LMNS Gap Analysis

NHS England's three-year delivery plan for maternity and neonatal services

1. Background

1.1 NHS England published a three year delivery plan for maternity and neonatal services on 30th March 2023 (Appendix One). Following several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup,

1.2 This three-year plan brings together the key objectives maternity and neonatal services, and systems that support them, are asked to deliver against over the next three years.

1.3 NHS England developed the new delivery plan in consultation with service users, healthcare staff, trust leaders and other stakeholders, as well as with the Independent Working Group on maternity chaired by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCOG). This consultation has supported NHS England to triage and review the actions remaining from the Ockenden and Kirkup reports as well as existing NHS England plans for maternity.

1.4 The report sets out the twelve priority objectives for trusts and systems for the next three years, across four themes:

- **Listening to women and families with compassion**
- **Supporting the workforce**
- **Developing and sustaining a culture of safety**
- **Meeting and improving standards and structures.**

1.5 The LMNS has undertaken an initial gap analysis in response to the plan, which will be reviewed in more depth and an action plan developed with more detail. (Appendix Two).

2. Theme 1: Listening to and working with women and families with compassion

2.1 The plan identifies listening and responding to women and families as an essential component of safe and high-quality care: the importance of listening emerged strongly from both the Ockenden and Kirkup reports.

2.2 **Theme 1 - Objective 1: 'Care that is personalised'**
All women to receive compassionate personalised care based on an ongoing dialogue between women and families and their clinicians. NHS England and ICBs also have actions under this objective, with NHS England in particular committing to actions including:

- Producing standardised information to support the delivery of personalised care and aid decision-making
- Extending the national support offer for services who have not achieved UNICEF BFI accreditation or equivalent
- Creating a new patient-reported experience measure for maternity services by 2025.

2.3 Trusts are asked to:

- Provide maternity and neonatal staff with time, training, tools, and information to deliver personalised care
- Undertake regular audits of personalised care, including seeking feedback from women and parents, and acting on the findings
- Consider how to achieve midwifery continuity of carer in line with safe staffing principles
- Achieve the UNICEF UK Baby Friendly Initiative (BFI) standards on infant feeding, or equivalent, by 2027.

Theme 1: Objective 1	ICBs responsibilities	Suggested Evidence	Comments
'Care that is personalised'	Commission for and monitor implementation of personalised care for every woman. https://www.england.nhs.uk/wp-content/uploads/2021/03/B0423-personalised-care-and-support-planning-guidance-for-lms.pdf	Feedback on personalised care gathered via MNVPs from a wide range of service users.	LMNS engagement team and clinical team will continue to work closely with people from local communities and MNVPs to get feedback and input from a wide range of women and families. All maternity / neonatal units have bereavement facilities, but they are currently located within the Maternity / neonatal units. This plan requires that compassionate and high-quality care for bereaved families **including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units, and this will need to be developed.** 7 day / week Bereavement services are a requirement of Ockenden and there is variation in this currently across Providers. There is variation in infant feeding support

Theme 1: Objective 1	ICBs responsibilities	Suggested Evidence	Comments
			and Trusts are being supported to achieve BFI status.
	Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.	Perinatal pelvic health services and perinatal mental health services are in place.	LMNS leading Perinatal Pelvic Health Programme (in progress). There is still variation in service provision. Maternal Mental Health Silver Birch Service in place.
	Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care	The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.	Perinatal Mental Health Silver Birch implemented and audit of referrals and outcomes in place. Bereavement support is also offered although there is variation in bereavement support across C+M.

2.4 **Theme 1 - Objective 2: 'Improve equity for mothers and babies**

NHS England will in turn provide support for the implementation of Local Maternity and Neonatal System equity plans and pilot and evaluate new service models designed to reduce inequalities. Trusts are asked to:

- Pay particular attention to health inequalities in providing services, for example facilitating informed decision-making in areas of inequalities and ensuring access to interpreter services.
- Monitor differences in outcomes and experiences for women and babies from different backgrounds and make changes in response.

Theme 1: Objective 2 Improve equity for mothers and babies	ICBs responsibilities	Suggested Evidence / Progress	Comments
	Continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational	Equity and Equality plan developed and is in place.	LMNS to review progress and actions not yet started due to resource and where necessary present Business Case to ICB for

Theme 1: Objective 2 Improve equity for mothers and babies	ICBs responsibilities	Suggested Evidence / Progress	Comments
	boundaries (23/24)		support.
	Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.	LMNS to review MVNP representation and support the commissioning of MNVPS to reflect ethnic diversity and facilitate outreach to those women not engaged. All MVNP action plans reviewed by the LMNS in 2022.	LMNS to monitor delivery against MVNP action plans, particularly for ethnicity and under-represented groups and those living in areas of deprivation and with multiple disadvantage (Wider determinants of Health). Equity and Engagement Forum will meet quarterly starting Q1 23/24 to ensure women and families from ethnic backgrounds, under-represented groups and those living in areas of deprivation and with multiple disadvantage voices are heard and acted on.

2.5 **Theme 1 - Objective 3: 'Work with service users to improve care'**
The three-year plan acknowledges that co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it.

2.6 The plan recommends that this is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users. MNVPs need to listen to and reflect the views of local communities including bereaved families and all groups.

Theme 1 Objective 3 Work with service users to improve care	ICB Responsibilities	LMNS Progress	Comments
	Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.	LMNS has an Engagement Team which works with community and service users' groups as well as MNVPs play key role in co-production e.g. bid for new role of Senior Independent Advocate.	LMNS will review all engagement and role of service users in co-design and co-production and current MNVP activity in line with these recommendations.
	Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.	LMNS has been working with Place and Trusts to ensure all MVNPs are renumerated.	LMNS to review for consistency of role, activity, representation and renumeration by ICB.
	Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.	LMNS has reviewed and signed off MNVP action plans in 2022.	MVNP action plans to be reviewed and signed off for 2023 and annually thereafter.

2.7 **Measuring impact:** NHS England will monitor progress using:
- Indicators from CQC's maternity survey to monitor progress
- Indicators from Perinatal mental health services
- Proportion of services achieving UNICEF BFI accreditation.

2.8 **Theme 2 - Objective 4: Growing, 'Retaining and Supporting our Workforce'**
NHS England acknowledges that the ambitions of the three-year plan "can only be delivered by skilled teams with sufficient capacity and capability" and that currently services do not have the staff they need.

2.9 Objective four is to grow the workforce, and asks trusts to:
- Undertake regular local workforce planning, and to meet staffing establishment levels set by Birthrate Plus by 2027/28
- Develop and implement local plans to fill vacancies, including specific support for newly qualified staff and returners
- Provide additional administrative support.

Theme 2 Objective 4: Growing, Retaining and Supporting our Workforce	ICB Responsibilities	LMNS Comments
	Commission and fund safe staffing across their system. Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).	LMNS commissioned Birthrate plus reports for all 7 Providers in 2021/22. Midwifery staffing review undertaken by the LMNS using the Birth rate Plus reports and current establishments. LMNS supports GOLD a weekly meeting that review staffing and clinical activity in collaboration with all Providers. Electronic daily sitrep report now available monthly and quarterly which also shows delays in care (Induction of labour, elective caesarean section, and Triage breaches) linked to staffing, and reasons for staffing concerns. Vacancy and sickness and absence rates are monitored across C+M.
	Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.	This is a new requirement LMNS to develop a plan to address this in 23/24. The LMNS sits on Cheshire & Mersey Acute & Specialist Trusts provider collaborative (CMAST) on addressing midwifery workforce challenges. The seven workstream are Preregistration capacity including RN / RM conversion; International Recruitment; Return to Practice; Recruitment and Retention; Band 5 Standardised Preceptorship programme; Advanced Clinical Practice; Maternity Support Worker workforce. There is now Bi monthly Cheshire and Merseyside workforce data now available to aid workforce. reporting and monitoring although there is a two-month time lag.

Theme 2 Objective 4: Growing, Retaining and Supporting our Workforce	ICB Responsibilities	LMNS Comments
		The CMAST workstream is focused on five key themes: • Supply • Stability • Experience/Culture • Training/Development/Talent • Agility CMST priority areas are Nursing • Midwifery • HCAs • Elective Recovery Workforce • Programme Established and prospective task and finish groups include: • Pre-registration capacity – including RN/RM conversion • International Recruitment including CM standardized IR recruitment program • Return to Practice (RTP) • Recruitment and retention (Pastoral care) • CM Band 5 standardized preceptorship Programme • Advanced Clinical Practice (Midwifery) • MSW workforce (Implementation of MSW Framework) International Recruitment: IR remains ongoing, presently 26 IR recruited midwives will be joining the CM midwifery team, from countries including, Botswana, Zambia, and Jamaica. 5 out of 7 providers within CM have IR midwives recruited, with one additional provider joining in phase 2. It is hoped that funded support for IR will be maintained in

Theme 2 Objective 4: Growing, Retaining and Supporting our Workforce	ICB Responsibilities	LMNS Comments
		phase 2 and IR recruitment to increase by 30% in 2023/2024. A social media campaign is underway within CM LMNS regarding IR and successful recruited and settled IR midwives have been approached to be part of the campaign (pipeline).
	Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements.	LMNS has worked with HEE and HIE to maximise quality student placements. LMNS has facilitated student placements in the social sector. **Pre-registration capacity:** The LMNs has taken an active role in combination with local HEI and HEE to review student midwife capacity within the region, to support both providers and HEI to increase pre-registration midwifery capacity, It is supporting conversations around joint and shared students, which will increase placement opportunity therefore increasing the student midwife capacity, discussions are ongoing with local HEI's in how we can use the opportunity of Midwifery Continuity of care team midwifery to also review student capacity and student placement opportunity. Further discussions regarding RN to RM conversion places and the potential of increasing places within CM are in progress. (pipeline)

2.10 **Theme 2 Objective 5: 'Value and retain the workforce'**
NHS England has committed to

- Providing funding for a retention midwife in every maternity unit during 2023/24, with ICBs providing this thereafter
- Providing funding to establish neonatal nurse quality and governance roles in trusts
- Strengthening neonatal clinical leadership at the national level.

2.11 Trusts are asked to take the following actions:

- Develop a retention improvement action plan to address local retention issues
- Reduce workforce inequalities and create an anti-racist workplace by acting on principles set out in combatting racial discrimination resources
- Identifying and addressing issues highlighted in student and trainee feedback surveys
- Offering newly registered midwives a preceptorship programme and providing mentors for newly appointed band 7 and 8 midwives
- Carry out succession planning and ensuring that the leadership pipeline represents the ethnic background of the workforce.

Theme 2 Objective 5 Share best practice for retention and staff support.	ICBs Responsibilities	LMNS Comments / Progress
	Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.	There is regional representation on the GOLD meeting and staffing concerns and challenges have been highlighted there previously and addressed nationally. (For instance, Covid restrictions and delays in accessing testing and results impacting during pandemic on staffing).

2.12 **Theme 2 Objective 6: 'Invest in skills'**
All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development.

2.13 NHS England's proposed actions include:

- Refreshing the curriculum for maternity support workers and supporting the implementation of the maternity support worker (MSW) competency, education, and career development framework
- Developing leadership role descriptors for obstetricians by summer 2023
- Establishing a national training route for obstetric physicians.

2.14 Trusts are asked to:

- Undertake an annual training needs analysis and make training available in line with the core competency framework
- Ensure obstetricians and neonatal medical staff have appropriate clinical supervision in line with RCOG and British Association of Perinatal Medicine (BAPM) guidance
- Ensure locum medical staff covering middle grade obstetric rotas for two weeks or less possess an RCOG certificate of eligibility.
- Progress against these objectives will be measured by national surveys including the NHS Staff Survey and the GMC training survey, along with workforce data.

Theme 2 Objective 6	ICB Evidence	Comments
	Progress against workforce, retention, succession, and training plans.	CMAST Workforce Group established seven workstreams in place: Workshop held on 9th December with Chief People Officers to review and confirm priority areas for the CMAST workforce programme **MSW workforce (Implementation of MSW Framework)** Realising the potential of the Maternity Support Worker Workforce across the Cheshire and Merseyside LMNS region Assurance has been confirmed by the HOMS/DOMS that all MSW's are correctly coded within ESR (information and assurance requested for regional return) Focus groups have commenced within the CM MSW workforce to understand the challenges, and gain feedback regarding JD's, job roles, differences in community vs acute care, all this information is being fed back into both the LMNS Equity program and the HEE/regionally funded MSW workstream.
	Local staff feedback mechanisms.	WHaM Workforce Survey 2022 was carried across all staff groups in maternity neonatal services. Findings were fed into the CMST workstream.

Theme 2 Objective 6	ICB Evidence	Comments
	Progress against the nursing and midwifery high impact retention interventions. https://www.england.nhs.uk/wp-content/uploads/2022/07/B1711_Retaining-our-nursing-and-midwifery-colleagues-13-July-2022.pdf	There are nationally funded Midwifery retention roles in place in C+M Providers. **Band 5 Preceptorship Program to aid retention on qualification.** Work has begun to standardize band 5 preceptorship Programme within C&M, currently developing a digital APP which will allow midwives to access training and complete competency-based assessments in 'real time' on the wards and community settings. Standardization of the band 5 preceptorship Programme will allow for a moveable and transferable midwifery workforce across the CM providers, it will also answer the questions raised regarding training and preceptorship and support in the recent Ockendon review and Ockendon essential actions, a task and finish group chaired by a HOM/Dom has been developed. The regional HEE team is supporting this work.

2.15 **Theme 3 Objective 7: 'Developing and sustaining a culture of safety, learning and support'**
This theme focuses on cultural issues identified in the Kirkup report including teamworking, professionalism, compassion, listening, and learning. It sets out objectives related to developing a safety culture, learning, and improving, and support and oversight with an ambition that all staff working in maternity and neonatal services:

- Are supported to work with professionalism, kindness, compassion, and respect
- Are psychologically safe to voice their thoughts and are open to constructive challenge
- Receive constructive appraisals and support with their development
- Work, learn and train together as a multi-disciplinary team.

2.16 Trusts are asked to

- Ensure maternity and neonatal leads have the time, training and development and lines of accountability to focus on developing a safety culture
- Support senior leaders to engage in national leadership programmes offered by NHS England by April 2024
- At board level, reviewing an implementation plan to improve and sustain culture, aligned with freedom to speak up (FTSU)
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns.

- Ensure staff have access to FTSU training modules and a Guardian who can support them to speak up.

Theme 3 Objective 7 Developing and sustaining a culture of safety, learning and support	ICB Responsibilities	LMNS comments
	Monitor the impact of work to improve culture and provide additional support when needed.	SCORE cultural staff survey is part of the leadership programme and Trusts participating in waves. TBC
	Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.	LMNS has hosted 2 MDT learning events in 2022. Clinical Network hosts six monthly Safety Summits. A further event being planned for June regarding 3-year delivery plan. The LMNS funded bespoke leadership programmes for Heads of Midwifery and Aspiring Heads of Midwifery 2022 to support existing staff and create a succession planning pipeline in roles which are hard to recruit to but essential for quality care.

2.17 **Theme 3 Objective 8: 'Learning and improving'**

This sets an ambition that services will respond effectively when safety incidents occur. Trusts are required to:

- Establish and maintain effective and compassionate processes to respond to families who experience harm or raise concerns, in line with the principles of duty of candour and including a single point of contact
- Respond effectively and openly to patient safety incidents using the patient safety incident response framework (PSIRF)
- Acting on outcomes data, staff feedback, clinical audits, and other sources of information to
- learn from where things do not go well, as well as understanding 'what good looks like'
- Giving adequate time and formal structures to review and share learning and implement resulting actions
- Consider culture, ethnicity and language factors when responding to incidents.

Theme 3 Objective 8 'Learning and improving'	ICB Responsibilities	LMNS Comments
	Share learning and good practice across all trusts in the ICS.	Quality Surveillance and Safety Group (QSSG) is in place and shares good practice and learning across providers. Examples include Coroners 27 a letter which highlighted need for rapid access to blood transfusion in neonatal resuscitation. The case was shared, and the recommendations sent to all providers to ensure all complied. Cases for learning are part of the agenda. The Maternal Medicine network, Preterm network also feed into this group and share learning widely across the system. The LMNS are creating a forum where learning from clinical incidents and SIs can be shared, and improvement and learning can be rapidly shared. The LMNS has a preterm network in place which is sharing good practice and supporting learning. The LMNS has supported the development of the Maternal Medicine Network. The LMNS were part of the development of the escalation and divert policy across the North West. The electronic sitrep is linked to this and uses the same OPEL categories.
	Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.	This is currently in transition and there is variation across the system. PLACE is leading its implementation. The Single Maternity SI panel has met for a year. Themes are being look at and will be shared across the system. The LMNS needs to work closely with PLACE to understand its role

Theme 3 Objective 8 'Learning and improving'	ICB Responsibilities	LMNS Comments
		in the future implementation of PSIRF

2.18 **Theme 4 Objective 9: 'Support and Oversight'**

NHS England acknowledges that it is difficult to measure cultural improvement, and therefore will focus on the feedback of frontline staff as recorded by the NHS Staff Survey and other national surveys. Trusts are asked to:

- Regularly review the quality of maternity and neonatal services, supported by the perinatal quality surveillance model and national maternity dashboard at a minimum
- Appointing an executive and non-executive maternity and neonatal board safety champion
- Involving the maternity and neonatal voice partnership in developing the trust's complaints process
- Listen to and act on feedback from staff at board level, in line with FTSU guidance.

Theme 3 Objective 9 Support and Oversight	ICB responsibilities	LMNS comments
	Commission services that enable safe, equitable, and personalised maternity care for the local population.	LMNS to share in depth knowledge and expertise from service reviews of maternity and neonatal care to support ICB commissioning decisions and model of care.
	Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.	PQSM is monitored through QSSG at the IMNS. Neonatal care is monitored through the neonatal Operational Delivery Network. The Director of NODN sits on QSSG and the LMNS Assurance Board.
	Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.	GOLD and Sitrep are examples of collaborative working which brings a range of staffing and quality care metrics together and they are shared with Providers and the QSSG. Triage Improvements has been identified as an LMNS/ICB priority. The first Triage Improvement meeting with representatives from an all Providers and NWAS is planned for 24th April 2022.

2.19 **Theme 4 Objective 10: 'Standards to ensure best practice'**
This theme acknowledges the need for consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities. This requires the development of clear standards and structures to support the delivery of the plan, including

- clinical best practice
- the provision of high-quality data
- effective digital tools.
- developing new best practice.

2.20 NHS England commits to:

- Supporting the integration of MEWS, NEWTT-2, and other tools with existing digital maternity information systems by autumn 2024
- Providing support to capital projects to increase and align neonatal cot capacity in 2023/24 and 2024/25
- Conducting a national maternity and neonatal infrastructure compliance survey to determine the level of investment needed for the maternity and neonatal estate.
- Trusts are asked to:
- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024
- adopt the national MEWS and NEWTT-2 tools by March 2025, which will be updated by NHS England
- Regularly review and act on key local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality
- Ensure staff are enabled to deliver care in line with evidence-based guidelines including NICE
- Complete the national maternity self-assessment tool and use the findings to inform improvement plans.

Theme 4 Objective 10: Standards to ensure best practice	ICBS Responsibilities	LMNS Comments
	Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle (SBL).	Process to be confirmed but it will build on current policies and standardised processes for SBL and other guidelines and policies.
	Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme.	LMNS oversaw the assurance of the assurance process for declaration in 2022. This wording marks a significant shift to the LMNS being assured of content. Process to be determined for 2023. Regular monthly 1-1 meetings and joint meetings were scheduled with Trusts to offer support. Determine process for assurance of content of the assurance of Trust submission for MIS. Bi - monthly 1-1 meetings established and monthly all

Theme 4 Objective 10: Standards to ensure best practice	ICBS Responsibilities	LMNS Comments
		provider meetings to be established.
	Monitor and support trusts to implement national standards.	LMNS Assurance role and regular review meetings to inform support, training, and QI
	Commission care with due regard to NICE guidelines.	See comments re NICE above.

2.21 **Theme 4 Objective 11: 'Data to inform learning'**
NHS England commits to several actions including convening a taskforce to progress the Kirkup report recommendation for a maternity and neonatal early warning system, to report by autumn 2023. Trusts are asked to:

- review available data to identify and address areas of concern in maternity services, including inequalities
- ensure high-quality submissions to the maternity services data set and report incidents as appropriate to NHS Resolution, Healthcare Safety Investigation Branch (HSIB) and the national perinatal epidemiology unit.

Theme 4 Objective 11 Data to inform learning	ICB Responsibilities	LMNS Comments
	Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.	LMNS will work closely with providers and digital teams and escalate concerns within the ICB
	Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.	Benchmark with other LMNs

2.22 **Theme 4 Objective 12: 'Make better use of digital technology in maternity and neonatal services'**
This relates to using digital technology in maternity and neonatal services. NHS England sets out several supporting actions including:

- Setting out the specification for a complaint EPR, including maternity, by March 2024
- Publishing a refreshed digital maternity record standard and maternity services data set standard by March 2024
- Incorporating pregnancy-related data and features into the NHS App.

2.23 Trusts are asked to:

- Develop and begin implementation of a digital maternity strategy and roadmap in line with NHS England's 'What good looks like framework' framework

- Where not being managed by the ICB, procure an EPR which complies with national specifications, including the digital maternity record standard and maternity services data set
- Include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set in neonatal module specifications.

Theme 4 Objective 12 'Make better use of digital technology in maternity and neonatal services'	ICB Responsibilities	ICB Evidence
	Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.	Support regional digital maternity leadership networks. LMNS shared role and priorities with ICB Digital workstream
	Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.	Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle. Develop standardised digital personalised care plans.

2.24 In addition, the following will support the implementation of the 3-year plan ambitions:
- An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.
- The Maternity Incentive Scheme

2.25 **Care Quality Commission Role**
The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance. All the themes will also be considered by CQC as part of their inspection criteria.

2.26 Success measures for this theme include existing key outcome measures for safety: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after births, and preterm births – monitored nationally by ethnicity and deprivation. Latest data for Quarter 3 shows that Cheshire and Merseyside are doing better than the national average for these outcomes. NHS England will also use other metrics including the local implementation of version 3 of the Saving Babies' Lives Care Bundle and periodic digital maturity assessments of trusts.

3. LMNS Actions / Next Steps

3.1 The LMNS will continue to develop the 3-year Plan for Maternity and Neonatal Services (March 2023) gap analysis to inform the action plan and key performance indicators for 2023/24, 2024/25 and 2025/26.

3.2 The LMNS are hosting a Learning and Development Event in June 2023 (date to be confirmed) with key stakeholders to co-produce the LMNS action plan.

3.3 The LMNS 'Equity and Engagement Forum' will meet quarterly starting Q1 23/24 to ensure women and families from ethnic backgrounds, under-represented groups and those living in areas of deprivation and with multiple disadvantage voices are heard and acted on and are represented in the 3-year Delivery Plan for maternity and neonatal services LMNS action plan.

4. Recommendations

4.1 **The ICB Board are asked to:**

- Note the content of the report
- Note the actions being taken by the LMNS and next steps.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Appendix One:
NHS England's three-year delivery plan for maternity and neonatal services

NHS England

Three year delivery plan for maternity and neonatal services

March 2023

Contents

Summary

With this plan we aim to make care safer, more personalised, and more equitable, by:

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Supporting our workforce to develop their skills and capacity to provide high-quality care.

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide “PSIRF” approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting and improving standards and structures that underpin our national ambition.

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new “MEWS” and “NEWTT-2” tools by 2025.
- In 2023, NHS England’s new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Introduction

1. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. We are grateful to the many people and organisations that have shared what needs to be done including NHS staff, Donna Ockenden, Dr Bill Kirkup, and organisations representing families. Most importantly, we would like to thank those using maternity and neonatal services for informing this plan. While the birth of a baby represents the happiest moment of many people's lives, some families have experienced unacceptable care, trauma, and loss, and with incredible bravery have rightly challenged the NHS to improve.

2. The summary above sets out the benefits we expect to deliver for families through this plan. This will continue to require the dedication of everyone working in NHS maternity and neonatal services in England, who work tirelessly to support families and improve care. Most women have a positive experience of NHS maternity and neonatal services, and outcomes have improved with over 900 more families welcoming a healthy baby each year compared to 2010.

3. But we must acknowledge that there are times when the care we provide is not as good as we want it to be. Recent independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford and by Dr Bill Kirkup on maternity and neonatal services in East Kent, and previously Morecambe Bay, set out many examples of poor care over years. We know that families from some groups, especially ethnic minorities, have had particularly poor experiences. We must work together to change this, and this plan sets out how we will do this.

4. In preparing this plan we have listened to what you have to say. We know all staff want women and babies to be at the centre of care, and with so many improvement initiatives it can be difficult to know what to prioritise. We know gaps in staffing mean those who provide care do not always have time to learn and improve, and on occasion, struggle to provide care to the highest standards. We have heard that some people feel disempowered by negative team cultures and a lack of strong leadership.

5. For the next three years, we are asking services to concentrate on **four high level themes**. Please take some time to consider these themes, what they mean to you and to the women and babies you care for. Working together, we can make a real difference.

Responsibilities

6. This plan sets out what we need to have in place, and responsibilities for each part of the NHS:

   - Trusts are the main operational unit of maternity services in the NHS and the employer of most staff. Trust boards have a statutory duty to ensure the safety of care, including ensuring staff have the resources they need.
   - Integrated care boards (ICBs) commission most maternity services. Each ICB will be a partner in an integrated care system (ICS). ICSs are a partnership of organisations that plan and deliver joined up health and care services. The local maternity and neonatal system (LMNS) is the maternity and neonatal arm of the ICS. ICBs commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision-making.
   - NHS England provides national leadership for the NHS in England. NHS England operates through regional teams which are responsible for relationships with individual ICBs. NHS England has statutory responsibility for commissioning neonatal services, through regional specialised commissioning teams and operational delivery networks (ODNs).

7. It is everyone's responsibility to provide or support high quality care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate concerns. We have sought to improve our approach to quality surveillance at trust, ICS, regional, and national level. This involves bringing together all relevant partners at each level to facilitate robust understanding and action, informed by shared and accurate information. Some trusts need additional support to improve – this is provided through the Maternity Safety Support Programme (MSSP), which aligns with the overall NHS Oversight Framework and tiered support, so that support for maternity and neonatal care forms part of a wider response where needed.

What you told us

8. We could not develop this delivery plan without talking to people who use, work in, lead, or have an interest in these services. We want to thank everyone who shared their views to inform this plan. We held 50 meetings reaching over 1,000 attendees, including 191 service users, 419 workforce members, 329 leaders of services, systems, and regions, and 106 stakeholders. We additionally received 2,128 responses to our survey from 782 service users, 1,133 workforce members, 105 leaders, and 108 stakeholders.

9. While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services. The information in this plan also applies to these individuals; particularly the principles described in Theme 1.

10. While each of the groups who helped inform this plan had different areas they gave greatest importance to, there was clear agreement on what the plan's focus should be. This consensus has shaped the four themes, and the objectives within each of these.

11. The most consistent priority among those using and providing services was safe care. Delivering safe care remains central to this delivery plan.

    "Safe, compassionate care, which allows you the confidence to speak up and be listened to if something is not right." (Service user)

    "We need to take action and make a pledge to improve the safety of every maternity service in England." (Leader)

12. You told us how important improving equity and equality is. We have a dedicated objective on improving equity.

    "Those that are most vulnerable should be enabled to have a strong voice within maternity care provision." (Stakeholder)

13. You told us that we need to be clear about who is responsible for doing what, and to bring the asks of services and systems into one place. This delivery plan sets out clear responsibilities and measures of success across services and systems.

    “One clear plan that looks to encompasses the recommendations from various reports such as Better Births, Ockenden, Kirkup.” (Workforce member)

Listening to and working with women and families with compassion

14. You told us that personalised care supports safety, makes women feel valued, and avoids families needing to re-tell their story – who they are or what they need. You told us it is important to join up care across maternity and neonatal pathways.

    “To be treated as an individual human being.” (Service user)

    “Consistency! I saw so many different people I had to tell them my 'story' every time.” (Service user)

    “Being fully informed without judgement on pros and cons of all care offered.” (Service user)

    “Listening to the families using the care and embedding their voices along all pathway.” (Leader)

    “Supporting parents to be actively involved in the care of their baby on the neonatal unit (family integrated care).” (Service users)

Growing, retaining, and supporting our workforce

15. You told us that there needs to be enough staff in services, with the time and training to support their effectiveness as well as to protect their wellbeing.

    “Safe staffing that will then provide safe and personalised care.” (Leader)

    “Enough staffing to feel supported, safe and provide care when it is needed.” (Service user)

    “Adequate staff with the appropriate training working in the right environment. Having the time and resources to listen to women and their families.” (Workforce member)

Developing and sustaining a culture of safety, learning, and support

16. You told us that there needs to be a positive culture and leadership in services. Staff need to be free to speak up, in an environment that learns from experiences and incidents and does so with compassion.

    “Listening, learning and facing up to failings.” (Stakeholder)

"Confidence in the care provider, trust, integrity and honesty if mistakes occur." (Leader)

"Leadership training to enable managers to better manage teams and support them." (Workforce member)

"Psychological safety at work and teams that work together with a shared vision and a foundation of kindness." (Stakeholder)

Standards and structures that underpin safer, more personalised, and more equitable care

17. You told us that we need to improve our data collection to help oversight and improvement, among other important standards and infrastructure. Our fourth theme focuses on these crucial elements that support the other themes.

"Notes to be available to all staff when required rather than just to one person." (Service user)

"Delivering high quality, evidence-based care in a local environment for service users." (Workforce member)

"Improved data collection and IT systems - joined up maternity and neonatal electronic patient record systems which are user friendly and accessible." (Workforce member)

"Organisational transparency and providing in depth data to provide meaningful data that can be used to prevent as well as respond to trends and themes." (Leader)

Theme 1: Listening to and working with women and families with compassion

1.1 Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities. Better Births identified that "women wanted to be listened to about what they want for themselves and their baby, and to be taken seriously when they raise concerns". The Ockenden report into maternity services at Shrewsbury and Telford described how families who raised concerns "were brushed aside, ignored and not listened to". This section sets out actions for personalised care, improving equity, and working with service users.

1.2 Key commitments for women and families include:

Empowering staff to ensure that all women are offered personalised care and support plans as part of their care.

Ensuring pregnant women and new mothers have access to pelvic health services in every area of England by 2024 to identify, prevent, and treat common pelvic floor problems.

Rolling out perinatal mental health services to improve the availability of this specialist care.

Investing to ensure the availability of bereavement services 7 days a week by the end of 2023/24 for women and families who sadly experience loss.

Funding to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.

Implementing local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality.

Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Objective 1: Care that is personalised

1.3 Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs. This information can be included in each personalised care and support plan to help ensure that service users do not have to repeat their story. While many women and babies experience excellent personalised care (CQC, 2023), it is clear from independent reports that not all do.

1.4 Our ambition is:

- Women experience care that is always kind and compassionate. They are listened and responded to.
- Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected.
- All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.
- Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination.
- Women have clear choices, supported by unbiased information and evidence-based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Re:Birth report, and is co-produced.
- All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and fetal medicine networks, and neonatal care, when needed.
- Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8

weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies.

- Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.
- Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units.

How we will make this happen

1.5 It is the responsibility of trusts to:

- Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.
- Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.
- Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.
- Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.

1.6 It is the responsibility of integrated care boards (ICBs) to:

- Commission for and monitor implementation of personalised care for every woman.
- Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.
- Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care.

1.7 NHS England will:

- Work with service users and other partners to produce standardised information to aid decision-making, focusing on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour, and pain relief.

- Extend the national support offer to the 38 maternity services yet to achieve UNICEF BFI accreditation or an equivalent initiative.
- Publish national postnatal care guidance by the end of 2023, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.
- In Spring 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.
- Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.
- By March 2024, act on findings from the evaluation of independent senior advocate pilots as set out in the interim Ockenden report.
- Invest to ensure availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.

Objective 2: Improve equity for mothers and babies

1.8 Significant health inequalities exist in maternity and neonatal care in England. For example, outcomes for women and babies from minority ethnic groups are worse than for white women, and outcomes for those living in the most deprived areas are worse than for those in the least deprived (MBRRACE-UK, 2022). Though we know NHS staff want to provide the best care to every woman and baby, a National Institute for Health and Care Research funded study found that “multiple structural and other biases exist in UK maternity care”. (Knight, M et al, 2021).

The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived areas.

1.9 Our ambition is:

- To reduce inequalities for all in access, experience, and outcomes.
- Targeted support where health inequalities exist in line with the principles of proportionate universalism.
- Services listen to and work with women from all backgrounds to improve access, plan, and deliver personalised care. Maternity and neonatal voice partnerships

ensure all groups are heard, including those most at risk of experiencing health inequalities.

- The NHS collaborates with local authority services, other public sector organisations, and a wide range of private and voluntary sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022).

How we will make this happen:

1.10 It is the responsibility of trusts to:

- Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.
- Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.

1.11 It is the responsibility of ICBs to:

- During 2023/24, continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries.
- Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.

1.12 NHS England will:

- Provide regional and national support for the implementation of LMNS equity and equality action plans.
- Pilot and evaluate new service models designed to reduce inequalities, including enhanced midwifery continuity of carer, and from 2023, culturally sensitive genetics services for couples practising close relative marriage in high need areas.
- Continue to work with the Maternity Disparities Taskforce to explore disparities in maternity care and identify how to improve outcomes.

- In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services.

Objective 3: Work with service users to improve care

1.18 Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users.

1.19 Our ambition is:

- MNVPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.
- MNVPs have strategic influence and are embedded in decision-making.
- MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.

1.20 In addition, neonatal parental advisory groups represent service user experience as part of operational delivery networks.

How we will make this happen:

1.21 It is the responsibility of trusts to:

- Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.

1.22 It is the responsibility of ICBs to:

- Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
- Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.
- Ensure service user representatives are members of the local maternity and neonatal system board.

1.23 NHS England will:

- Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.
- Through operational delivery networks, support parent representation in the governance of neonatal services.
- Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement.

Determining success for Theme 1

1.24 We will determine overall success by listening to women and their families:

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. They will be aggregated at trust, ICB, and national levels and at national level analysed by ethnicity and deprivation.
- We will use these progress measures:
  - Perinatal pelvic health services and perinatal mental health services are in place.
  - The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.
  - The proportion of maternity and neonatal services with UNICEF BFI accreditation.
- Evidence which ICBs can use includes:
  - Feedback on personalised care gathered via MNVPs from a wide range of service users.
  - Local evidence of working with women and families to improve services, including co-production.
- Relevant regulation and incentivisation includes:
  - The CQC will continue to consider compassionate and personalised care as key lines of enquiry during inspections.
  - The NHS Resolution CNST Maternity incentive scheme which encourages the use of MNVPs.

Case Study: Seeking Sanctuary Clinic - to enhance the maternity care of anyone seeking sanctuary

The Seeking Sanctuary Clinic, hosted in Berkshire West, is a specialist maternity clinic developed in 2021 from co-production between Royal Berkshire NHS Foundation Trust maternity team, and Berkshire West public health team, to enhance the maternity care of anyone seeking sanctuary such as refugees, asylum seekers, those fleeing conflict, undocumented migrants and people who have been trafficked.

This is a 'one stop shop' style clinic held in a children's centre, delivered in two-hour sessions held every two months, aimed specifically for these families, in addition to their usual antenatal and postnatal care. The barriers to access and inequalities that these families may be experiencing are removed where possible. For example, women are able to bring their partners and children with them, there are interpreters booked for every language in attendance, refreshments are provided and transport is available to support people to get to the clinic.

There are many health care professionals and voluntary organisations that come together at the clinic including midwifery and obstetrics. There is also accessible antenatal education with New Directions, sexual health, health visiting, a tuberculosis service, health in pregnancy advisors, Compass Recovery College (mental health and wellbeing support), Reading Refugee Support and Reading Voluntary Action.

The clinic is ever evolving, and additional professionals and organisations are invited to sessions to meet the bespoke needs of the group. Local charity The Cowshed donated to the clinic enabling each family that attends to be provided a ready-made birth bag to assist them on their journey.

The local Maternity Voices Partnership also attends to offer feedback sessions for these groups. While the project is in an initial evaluation phase, feedback so far has been very positive from service users, with more than fifty families supported so far, predominantly from Afghanistan, Syria, and Ukraine.

Theme 2: Growing, retaining, and supporting our workforce

2.1 The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to. We need to change that. The plan is informed by the best available evidence, including the QMNC framework which underpins the NMC midwifery standards. This theme sets out three areas of action for maternity and neonatal staffing: continuing to grow our workforce; valuing and retaining our workforce; and investing in skills.

2.2 Key commitments for women and families include:

NHS services will ensure the right numbers of the right staff are available to provide the best care for women and babies through regular local workforce planning, including trusts meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.

Implementing staff retention improvement action plans to identify and address local retention issues. During 2023/24, retention midwives will be funded in every maternity unit.

Supporting the retention and recruitment of staff caring for babies in neonatal units by continuing to invest in education and workforce leads.

Providing a core competency framework that will inform local mandatory training programmes to ensure that the skills relevant to staff's roles are kept up to date.

Objective 4: Grow our workforce

2.3 The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and

psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements.

2.4 Established midwifery posts have increased by over 2,000 WTE since March 2021, with obstetric consultant posts and maternity support worker posts each increasing by around 400 WTE since April 2021. For neonatal services, we have invested to establish over 550 new neonatal nurses, care-coordinators, and workforce and education leads, and have committed to funding 130 WTE new allied health professional and over 40 WTE new psychologist posts.

2.5 Our ambition is for:

- Workforce capacity to grow as quickly as possible to meet local needs.
- Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training, absence, and leave.
- Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning.

How we will make this happen

2.6 It is the responsibility of trusts to:

- Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

2.7 It is the responsibility of ICBs to:

- Commission and fund safe staffing across their system.
- Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).

- Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.
- Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements.

2.8 NHS England will:

- Assist trusts and regions with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing.
- Boost midwifery workforce supply across undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment.
- Increase medical training places across obstetrics and gynaecology and anaesthetics, to expand the consultant workforce in maternity services.
- Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care.

Objective 5: Value and retain our workforce

2.9 Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. A growing number of staff who leave are aged under 55 and do so for reasons other than retirement. Some staff groups, including ethnic minority staff, are more likely to report negative experiences of working in NHS maternity and neonatal services. We need to do more to improve the experience of all our staff, to retain them within the NHS.

2.10 Our ambition is:

- Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.
- All staff are included and have equality of opportunity.

- A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination.

How we will make this happen

2.11 The NHS Long Term Plan and NHS People Plan set out how improving the experience of our NHS people will encourage them to stay with us for longer.

2.12 It is the responsibility of trusts to:

- Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.
- Implement equity and equality plan actions to reduce workforce inequalities.
- Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.
- Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.
- Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.
- Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

2.13 It is the responsibility of ICBs to:

- Share best practice for retention and staff support.
- Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.

2.14 NHS England will:

- Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter.
- Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.
- In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance.

- In 2023/24, strengthen neonatal clinical leadership with a national clinical director for neonatal and national neonatal nurse lead.
- Continue to address workforce inequalities through the Workforce Race Equality Standard.
- Provide national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local services.
- By July 2023, develop a safe clinical learning environment charter for trusts; by April 2024, develop models for coaching; and, by October 2024, embed a framework to support the standards of supervision and assessment for midwifery students. These initiatives will help to ensure high quality clinical placements for those training to be midwives.

Objective 6: Invest in skills

2.15 Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes, yet unwarranted variation in training and competency assessment currently exists, especially for temporary staff (for example, Stulberg et al, 2020, McCulloch et al, 2008).

2.16 Our ambition is:

- All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development.
- All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards.
- Training is multi-disciplinary wherever practical to optimise teamworking.

How we will make this happen

2.17 It is the responsibility of trusts to:

- Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.

- Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.
- Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.

2.18 NHS England will:

- Refresh the curriculum for maternity support workers (MSWs) by June 2023.
- Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.
- Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development.
- Establish a sustainable national route for the training of obstetric physicians, to support the development of maternal medicine networks.
- Work with royal colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.
- Through action set out above to grow the workforce, help to address pressures on backfill for training.

Determining success for Theme 2

2.19 We will determine overall success by listening to staff:

- Our outcome measures for this theme will be the NHS Staff Survey, the National Education and Training Survey, and the GMC national training survey.
- Our progress measures will be:
  - Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.
  - In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists.

  - To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.

- Evidence that ICBs can use includes:
  - Progress against workforce, retention, succession, and training plans.
  - Local staff feedback mechanisms.
  - Progress against the nursing and midwifery high impact retention interventions.
- Relevant regulation and incentivisation includes:
  - The CQC inspection criteria includes key lines of enquiry around staff skills, knowledge, experience, and opportunities for development.
  - The NHS Resolution CNST maternity incentive scheme incentivises trusts to evidence that training in accordance with the core competency framework is in place.

Case study: One stop obstetric ambulatory service

The Chelsea and Westminster Hospital NHS Foundation Trust cares for approximately 5,500 maternity patients per year. The maternity team identified common themes in complaints about their service, including delays in receiving care and long waits for obstetric or scan reviews. The team felt they could improve triage management, patient experience and care, through a truly multidisciplinary approach so set up a ‘one stop’ service since January 2021.

The team recognised a key cause of delay within the department was delays in obstetric reviews. They were able to increase consultant presence and recruit a clinical fellow with obstetric ultrasound training to work solely in the triage department for five mornings a week, to deliver a ‘see and treat’ set up, comparable to the way emergency departments are run.

The triage team also includes midwives and maternity support workers, who greet attendees, perform initial observations and a dedicated receptionist who enables clinicians to focus on care rather than administrative tasks. Some midwives have developed professionally to perform tasks that are usually undertaken by obstetricians, such as prescribing and performing presentation scans.

From October 2022 to February 2023 the service has had on average 850 visits per month, with around 100 ultrasound scans performed. The department answers approximately 2,500 phone calls per month, with one midwife allocated to answer phone calls each day to triage and support women.

Improvements in the new obstetric ambulatory service triage system mean the department works more efficiently and safely with staff feeling better supported. Waiting times have been reduced, with 80-95% of women seen within 15 minutes of arrival which exceeds the national KPI (within 30 minutes) for maternity triage services. Feedback from women has also been increasingly positive. The team are exploring future opportunities to expand the service hours and increase the scope of midwifery and maternity support workers, supporting the team’s development and dynamic skillset.

Theme 3: Developing and sustaining a culture of safety, learning, and support

3.1 An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. We want everyone to experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the Kirkup report stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning. This theme sets out actions in three areas: developing and sustaining a positive safety culture for everyone; learning and improving; and support and oversight.

3.2 Key commitments for women and families include:

> Supporting staff to work with professionalism, kindness, compassion, and respect. Leaders will empower their teams to do this, with practical guidance and training through the perinatal culture and leadership programme by 2024.
>
> Implementing an NHS-wide approach in 2023 for all incidents to support families with a compassionate response, and to ensure learning.
>
> Listening and acting upon issues raised by staff or service users through Freedom to Speak Up (FTSU) Guardians, the complaints process, or maternity and neonatal voices partnerships (MNVPs).

Objective 7: Develop a positive safety culture

3.3 Culture is everyone's responsibility and key to enabling cultural change is compassionate, diverse, and inclusive leadership in maternity and neonatal services and beyond.

3.4 Our ambition is:

- All staff working in and overseeing maternity and neonatal services:
  - Are supported to work with professionalism, kindness, compassion, and respect.

  - Are psychologically safe to voice their thoughts and are open to constructive challenge.
  - Receive constructive appraisals and support with their development.
  - Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.
- Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.
- There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'.
- Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.
- Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.
- Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief.

How we will make this happen

3.5 It is the responsibility of trusts to:

- Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.
- Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.
- At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.
- Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.

3.6 It is the responsibility of ICBs to:

- Monitor the impact of work to improve culture and provide additional support when needed.
- Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.

3.7 NHS England will:

- By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.

Objective 8: Learning and improving

3.8 Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and improvement approach, from teams to ICBs.

3.9 Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services.

3.10 The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria. The responsibilities for trusts and ICBs set out below, also apply to these, or any other external investigations.

How we will make this happen

3.11 It is the responsibility of trusts to:

- Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust.
- Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.
- Respond effectively and openly to patient safety incidents using PSIRF.

- Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.
- Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.
- Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).

3.12 It is the responsibility of ICBs to:

- Share learning and good practice across all trusts in the ICS.
- Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.

3.13 NHS England will:

- Throughout 2023, support the transition to PSIRF through national learning events.
- Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.

Objective 9: Support and oversight

3.14 While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise.

3.15 Our ambition is:

- Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate.
- Well led services, with additional resources channelled to where they are most needed.
- Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.

How we will make this happen

3.16 It is the responsibility of trusts to:

- Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.
- Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.
- Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.
- Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.
- At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.

3.17 It is the responsibility of ICBs to:

- Commission services that enable safe, equitable, and personalised maternity care for the local population.
- Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.
- Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.

3.18 NHS England will:

- Through our regional teams, listen to the local NHS and through our national governance listen to frontline staff voices and continue to work RCOG, RCM, BAPM, and others.
- Continue to work closely with national bodies, ICBs, and trusts to address issues escalated to national level.
- Provide nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP).
- Work to align the MSSP with the NHS oversight framework, improve alignment with the recovery support programme, and evaluate the programme by March 2024.
- During 2023/24, test the extent to which the PQSM has been effectively implemented.

- By March 2024, provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.

Determining success for Theme 3

3.19 Achieving meaningful changes in culture will take time and progress measures are difficult to identify and can have unintended consequences. We will primarily determine overall success by listening to the people who use and work in frontline services.

3.20 Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.

- The evidence ICBs can use across maternity and neonatal services includes:
  - Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture.
  - Whether trust boards regularly share and act on learning.
  - Staff feedback on how incidents and issues of concern are managed.
- Relevant regulation includes:
  - The CQC will continue to consider whether a trust has a learning and responsive culture, strong leadership, and robust governance.

Case study: NFaST - Neonatal Families and Staff Together, supporting neonatal units to become more emotionally supportive environments

In 2021, the North West Neonatal Operational Delivery Network commissioned Spoons, a Greater Manchester-based charity specialising in neonatal family support, to research how their neonatal units could become more emotionally supportive environments for service users and staff.

The project worked with 13 neonatal units and a 28-family focus group, collecting data from more than 260 parents and 250 staff members, exploring their emotional needs. The project identified that the experience of neonatal care has a profound long-term impact on parents and their infants. In turn, the experience of working on a neonatal unit is emotionally challenging and can have significant impact on a staff member's individual wellbeing.

Volunteer peer supporters, who had personal experience of neonatal care, were trained for the units. Psychological training was provided to 100 staff across four neonatal units, including doctors, nurses, and support staff. Reflective practice group sessions were led by a clinical psychologist, to help the teams collaborate and understand each other and the needs of their babies and families better.

The pool of volunteer peer supporters continues to grow, and additional peer support training has been commissioned, with a model of ongoing supervision in development. This project demonstrates the power of true collaboration between the NHS, service users and third sector partners.

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

4.1 To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow. In many areas this is already in place; this plan does not seek to introduce new standards, extra reporting, or change structures, but to ensure that these enablers are consistently implemented to support care.

4.2 Key commitments for women and families include:

Making care safer by consistently implementing best practice, including:

- By 2024, an updated version of the updated Saving Babies Lives Care Bundle – a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- By 2025, the national maternity early warning score and updated newborn early warning trigger and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed.

In 2023, NHS England's new taskforce will report on how data can be used as an early warning system to detect safety issues within maternity and neonatal services, enabling action to address any issues sooner.

By 2024, the NHS will publish refreshed data and recording standards that allow us to collect more meaningful standardised data that can then be used to improve care.

Supporting the roll out electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.

Objective 10: Standards to ensure best practice

4.3 Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. However, the Ockenden report found that many women cared for at the trust were not offered care in line with best clinical practice. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care. Additionally, the Kirkup report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.

4.4 Nationally defined best practice already exists, including:

- The Saving Babies Lives Care Bundle, a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- The national maternity early warning score (MEWS)and updated newborn early warning trigger and track (NEWTT-2) tools to improve the detection and care of unwell mothers and babies, enabling timely escalation of care.
- NICE guidance, which sets out the evidence based best practice in maternity and neonatal care.

4.5 Our ambition is:

- Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities.
- Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice care.
- Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance.
- Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines.
- Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies.

How we will make this happen

4.6 It is the responsibility of trusts to:

- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.
- Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.
- Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.
- Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.

4.7 It is the responsibility of ICBs to:

- Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.
- Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme.
- Monitor and support trusts to implement national standards.
- Commission care with due regard to NICE guidelines.

4.8 NHS England will:

- Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration.
- Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.
- Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.
- Over the next 3 years, undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England.
- Continue to learn from research and evaluation as set out in the National Maternity Research Plan available on the FutureNHS platform.

Objective 11: Data to inform learning

4.9 The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects.

4.10 Our ambition is:

- Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.
- Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports.
- The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work.

How we will make this happen

4.11 It is the responsibility of trusts to:

- Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.
- Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.

4.12 It is the responsibility of ICBs to:

- Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.

4.13 NHS England will:

- At a regional level, understand any variation in outcomes and support local providers to address identified issues.
- Convene a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.

- Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.

Objective 12: Make better use of digital technology in maternity and neonatal services

4.14 Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR). Most neonatal units use the same electronic product, which is designed for neonatal data capture, though some trusts and neonatal units are considering how to improve neonatal alignment with maternity and paediatrics as part of their EPR roll out.

4.15 Our ambition is:

- Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them.
- All clinicians are supported to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, secure networks, and training.
- Organisations enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices.

How we will make this happen

4.16 It is the responsibility of trusts to:

- Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework.
- Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop.

- Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.

4.17 It is the responsibility of ICBs to:

- Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.
- Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.
- Support regional digital maternity leadership networks.

4.18 NHS England will:

- Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.
- Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024.
- Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership.
- Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.
- Develop facets of a digital personal child health record with service user-facing tools to support neonatal and early years health by March 2025.

Determining success for Theme 4

4.19 We will determine overall success by focusing on clinical outcomes:

- Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. We will monitor these measures nationally by ethnicity and deprivation.
- The progress measures we will use are:
  - Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.
  - Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care.

  - The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.
  - A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.
- The evidence that ICBs can use includes:
  - Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle.
  - An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.
  - Progress against locally planned improvements.
- Relevant regulation and incentivisation includes:
  - The NHS Resolution CNST maternity incentive scheme supports trusts to provide safer maternity services through incentivising compliance with 10 safety actions.
  - The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.

Case Study: Ask A Midwife - using social media to communicate with service users

Ask A Midwife (AAM) is a social media messaging service managed by midwives, which empowers service users to make timely and informed decisions about their maternity care. AAM is coordinated centrally to ensure consistency of delivery and messaging by the Humber and North Yorkshire local maternity and neonatal system (LMNS), and four acute trusts are now working collaboratively to offer the service via Facebook, Instagram, and email.

The service is staffed by trust midwives who have a dual role in supporting the AAM service on a part-time basis alongside their clinical work. Questions from women and families range from pregnancy, birthing options, appointments, and the care of a new-born baby.

More than 94% of queries can be answered immediately and midwives can refer women to other health professionals and support organisations where required. The service routinely averages 800 queries per month, with more than 8,500 queries answered overall in 2022 and 508 onward referrals to health professionals, maternity units, NHS 111, and pharmacies. Patient confidentiality is conducted in the same way as telephone queries would be in a hospital, but the usual ways of contacting the hospital maternity team, such as by phone, are also available.

The service also allows the LMNS to cascade timely public health updates for pregnant women, including communications around vaccinations, perinatal mental health, postnatal care, and infant feeding. For example, when the AAM team saw an increase in messages around winter viruses they responded by posting self-help information.

AAM is promoted through Maternity Voices Partnership groups, with printed postcards and posters distributed in maternity settings, Children's Centres, through direct referral by midwives, and attendance at community outreach events, such as one in Spring 2023 specifically for people from the Romanian and Polish community.

Support available to staff, trusts, and systems

The maternity hub on the FutureNHS platform has relevant material for each theme.

Theme 1: Listening to and working with women and families with compassion

- Personalised care and support planning guidance and the Personalised Care Institute
- Equity and Equality guidance for Local Maternity and Neonatal Systems
- NHS statutory guidance for working in partnership with people & communities
- National maternity voices partnership toolkit
- Service specification for care of pregnant and post-natal women in detained settings
- Delivering Midwifery Continuity of Carer at full scale
- Maternal medicine network national service specification

Theme 2: Growing, retaining, and supporting our workforce

- Nursing and midwifery retention self-assessment tool
- National preceptorship framework
- Advanced Clinical Practice: capability framework for midwifery
- RCOG advice and guidance on workforce planning and flexibility
- A 'how to' guide and templates to reflect the Core Competency Framework

Theme 3: Developing and sustaining a culture of safety, learning, and support

- Maternity and Neonatal Safety Champions toolkit
- NHS national freedom to speak up policy and guidance

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

- Support for quality improvement through patient safety collaboratives
- The Maternity self-assessment tool
- The recommendations register
- NICE guidance
- Saving Babies Lives Care Bundle
- An MSDS guidance hub
- For digital health there is Digital Maternity Leaders training course and the Shuri Network brings together women from minority ethnic groups

Acknowledgements

This plan has been developed with contributions from clinical leaders within NHS England and a wide range of partners, including but not limited to:

- The Independent Working Group, chaired by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. Members include:
  - British Association of Perinatal Medicine
  - Royal College of Paediatrics and Child Health
  - Royal College of Anaesthetists
  - Obstetric Anaesthetists Association
  - Society of Radiographers
  - Care Quality Commission
  - The Department of Health and Social Care
  - Health Education England
  - Service user voice representatives.

- Hearing from around 3,000 people via events and a survey. This included:
  - People who use maternity and neonatal services
  - National and regional service user voice representatives
  - Frontline professionals, including midwives, obstetricians, and neonatal colleagues
  - Integrated care boards
  - NHS England regional teams
  - Voluntary, community, and social enterprise organisations
  - National Guardian's Office
  - National stakeholders.

We remain committed to working closely with partners as we deliver this plan. Thank you to all the individuals and organisations who have shared their time, expertise, and experience so far.

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This publication can be made available in a number of alternative formats on request.

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS England's three-year delivery plan for maternity and neonatal services

Appendix Two: LMNS Gap Analysis

3 year delivery Plan Maternity and Neonatal Services Gap Analysis Introduction

This Gap analysis is provisional and has been undertaken to give the ICB a pre-emptive understanding of the LMNS position. LMNS intends to engage with Stakeholders to ensure a full gap analysis and co-production of the action plan that will accompany this delivery plan.

The LMNS intends to engage with Stakeholders including women and families, Providers, Charities and others to ensure a full gap analysis and co-production of the action plan that will accompany this gap analysis and the delivery plan.
The action plan will span a 3 year cycle in line with this being a 3 year action plan.

Theme 1 Objective 1	Care that is Personalised	Ambition	Measures	LMNS Progress / Comments	Actions
		Women experience care that is always kind and compassionate. They are listened and responded to.	Indicators of women's experience of care from the **Care Quality Commission (CQC) maternity survey.** Aggregated at trust, ICB, and national levels (at national level analysed by ethnicity and deprivation).	CQC Womens Survey 2022 publishes January 2023. MCHT in top 6 nationally. STHK in bottom 7 nationally. All other Providers not consistently better. MCHT in top six nationally 'better than expected' (2021 no provider was consistently better). All providers completed attribution exercise so reports are available for antenatal and postnatal care as well as labour and birth. **Strengths:** 2 of 7 Trusts showed improvement with no decreases (MCHT & S+O); Feeding your baby – MCHT was top; WUHT better nationally; Staff Caring for you – MCHT better; Antenatal check ups WHH and S+O improved from worse to same. Care at home after birth LWH improved to same. Weaknesses: STHK 10 Questions (in Bottom 7 nationally) and COCH 5 Questions. Antenatal check ups COCH & WUHT worse than expected. Care in Hospital after birth LWH & STHK somewhat worse; LWH benchmark worse than expected for care at home after birth nationally; Need for more support for Mental Health COCH; WHH; Medical history not available at antenatal check-ups STHK; S+O; MCHT	Survey results shared at LMNS Assurance Board 3rd February 2023. Trusts that fell into the yellow areas to produce a SMART action plan developed with the MVP chair and local engagement network and share it with their Trust Board and the LMNS by end Q2 2023 – recommendation for discussion at 3. Request MCHT and their MVP Chair present their work and insights at the LMNS Meetings with providers. All providers to develop quality improvement plans working closely with the Maternity Voices Partnership and user representatives to improve satisfaction with maternity services based on their own individual reports. Engage MVP leads and other user representatives including LMNS engagement team to support shared learning and improvement. Independent Senior Advocate role being recruited to – providing additional support to families in COCH and S+O to be made aware of survey results when in post. Staffing oversight continue to QSSG and LMNS Board including reporting on delays in care.
		Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected.		LMNS are scoping a education and competency framework for the delivery of PCP within providers	
		All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.		Plans for enhanced continuity of carer pilot teams for 22/23 reviewed by National team, proposed teams revised by providers. First wave of funding for enhanced CoC active teams confirmed by National team for LWH, WHH & WUTH. Linking with family hubs partnership group and connecting with developing estates planning, next meeting January 2023. Funding requirements for CoC lead posts at all providers reviewed and updated and has been agreed by LMNS until 31st March 2022. Monthly meeting continue to support leads and focus on providing MCoC as the default model of care for all women. Planning wrap around services available and required to include in enhanced model across C&M. Linking with 'Best for baby too' improvement collaborative. Training developed for peer support On going monthly reporting on % women on MCoC pathway.	Planning and development of peer support volunteers, service speculation complete, in collaboration with Health inequalities lead and Koala. Service proposal sent to HoMs. Plans to visit providers in areas where the Enhances Continuity of Carer (ECoC) is proposed to support the individual needs and the implementation of the model. Continuous support for all providers with building blocks to aim to provide MCoC to all women as the default model and report any concerns identified to LMNS. Monthly meetings continue and on going plans to improve CoC. Working with engagement team to support enhanced model and centering pregnancy. LMNS collaborating with regional and National team regarding next steps for each provider. Evaluating MCoC active teams – model, staffing, booked on, receipt of.
		Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination.		**Smoke free Pregnancy**: All maternity providers within Cheshire & Merseyside are now working towards implementing new regional smokefree pathways and in-house models of care to ensure women, and their families, can access support and treatment for tobacco dependency as per the NHSE LTP recommendations. Ongoing LMNS support has been provided to ensure each provider within Cheshire & Merseyside has been provided with the necessary information and funding streams to embed these new models of care. A 'Trust Implementation Support Pack', containing a number of both locally developed documents and National papers, was shared with each Head of Midwifery in February 2023. Screening and vaccination programme further details to be confirmed. LMNS led and continues to support the Covid vaccination programme across C+M.	All maternity providers within Cheshire & Merseyside are anticipated to 'go live' with these new services in Q1 and Q2 of 23/24, with Southport & Ormskirk and Warrington & Halton to 'go live' in April 2023. Ongoing support will be provided for sites to achieve all the elements of the 'fully established' checklist.
		Women have clear choices, supported by unbiased information and evidence- based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Re:Birth report, and is co-produced.		Trusts monitor compliance with NICE guidelines. All Trusts have access to interpreter services. There is variation in co-production. QR codes are in use for access to alternative languages.	LMNS will map existing practices and develop action plan to support Trusts and MVPs in co-production.

		All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and fetal medicine networks, and neonatal care, when needed.		Specialist Community Perinatal Mental Health Services : Liverpool, St Helens and Knowsley and Wirral and Cheshire are live and report their data to NHS England. Target – at least 66,000 with moderate to severe mental health (This number includes MMHS) women accessing support by 2023/24. Maternity Outreach Clinics in all STPs/ICSs by 2023/24 [following a piloting phase in select sites commencing in 2020/21] Silver birch MMHS hub pilot commenced 7th March 2022, Liverpool 11th March 2022 and St Helens and Knowsley 23rd March 2022. We went live across Cheshire and Merseyside 26th August 2022. Offering both psychology and midwifery support to date we have received 500 referrals – Trajectory 2% of women seen of birth population 28,000. We have exceeded this unable to provide figures this is provided to MMHS data set. Cheshire and Merseyside have 2.0 WTE midwives within the MMHS – challenges to provide equity across the patch. 6 PSW – lived experiences. 4 therapist- 2 psychologists – 1.0 wte AND 0.8 wte Neonatal Coordinator process of recruiting to support PSW within NICU units across Cheshire and Merseyside with recruitment, training and supervision in order for support to provide to parents within the NICU settings Specialist midwives: – Warrington – 1 midwife - 2605 deliveries Arrowe Park – 2 part time midwives with – 2975 deliveries Leighton – 1 – 3080 mid Cheshire COC- 1 – 2325 deliveries LWH – 1 and 0.6 wte awaiting commencement of a further midwife 0.6 wte– 7465 deliveries Southport and Ormskirk - 1 midwife 0.8 – 2290 deliveries Whiston – 1.0 midwife – 3885 deliveries .	
		Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8 weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies.		LMNS exploring linking midwifery care to the 6 week postnatal check with Health Visiting.	
		Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.		TBC from LWL	
		Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units.		All Providers have bereavement facilities but are co-located within maternity/neonatal units.	LMNS to scope current provision.
Theme 1 Objective 1	**Care that is Personalised**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.		LMNS are scoping a education and competency framework for the delivery of PCP within providers	
		Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.		LMNS have completed an in-depth gap analysis and audit of compliance against the principals set out in delivering PSCP, this was taken to our LMNSAB for sign off and are now planning with MVP chairs and LMNS engagement team to refresh our evidence of women's views on accessing and support within maternity services – this will include neonatal families in this engagement piece, via the ODN and our new jointly LMNS/Merseycare funded peer supporter neonatal role.	
		Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.		LMNS planning to review midwifery staffing as a system with the new NHS E MCOC staffing tool	

		Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027 https://www.unicef.org.uk/babyfriendly/accreditation/	The proportion of maternity and neonatal services with UNICEF BFI accreditation.	The LMNS has dedicated infant feeding working group which includes community and neonatal from the ODN we are presently requesting ICB support to participate in the 'Better Breastfeeding programme' which is a system ICB led infant feeding strategy, we are supporting providers within CM to achieve accreditation or reaccreditation for BFI . an we add in that the LMNS Has funded all maternity trusts and neonatal with BFI accreditation. All NW Trusts continue to work towards Neonatal BFI with all 3 LMS having funded the initial training. All units have now registered their intent to achieve and at least stage 1 accreditation is now being funded by all 3 LMS this year. The ODN will continue to support units as they progress, but a lot of the work required needs to be completed at unit level.	
Theme 1 Objective 1	**Care that is Personalised**	**ICBs responsibilities**	**Suggested Evidence**	**LMN Progress / Comments**	**Actions**
		Commission for and monitor implementation of personalised care for every womanhttps://www.england.nhs.uk/wp-content/uploads/2021/03/B0423-personalised-care-and-support-planning-guidance-for-lms.pdf	Feedback on personalised care gathered via MNVPs from a wide range of service users.	LMNS engagement team and clinical team will continue to work closely with people from local communities and MNVPs to get feedback and input from a wide range of women and families. All maternity / neonatal units have bereavement facilities, but they are currently located within the Maternity / neonatal units. This plan requires that compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units, and this will need to be developed. 7 day / week Bereavement services are a requirement of Ockenden and there is variation in this currently across Providers. There is variation in infant feeding support and Trusts are being supported to achieve BFI status.	
		Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.	Perinatal pelvic health services and perinatal mental health services are in place.	LMNS leading Perinatal Pelvic Health Programme (in progress). There is still variation in service provision. Perinatal Mental Health Silver Birch is in place.	
		Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care	The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.	Perinatal Mental Health Silver Birch implemented and audit of referrals and outcomes in place. Bereavement support is also offered although there is variation in bereavement support across C+M.	
Theme 1 Objective 2	**Improve equity for mothers and babies**	**Ambition**	**Measures**	**LMNS Progress / Comments**	**Actions**
		To reduce inequalities for all in access, experience, and outcomes.	Indicators of women's experience of care from the **Care Quality Commission (CQC) maternity survey.** Aggregated at trust, ICB, and national levels (at national level analysed by ethnicity and deprivation).		
		Targeted support where health inequalities exist in line with the principles of proportionate universalism.		Enhanced Midwifery Continuity of Carer Models in place and being supported buy LMNS. Plans for enhanced continuity of carer pilot teams for 22/23 reviewed by National team, proposed teams revised by providers. First wave of funding for enhanced CoC active teams confirmed by National team for LWH, WHH & WUTH. Linking with family hubs partnership group and connecting with developing estates planning, next meeting January 2023.	

		Services listen to and work with women from all backgrounds to improve access, plan, and deliver personalised care. Maternity and neonatal voice partnerships		6 of 7 Providers in C+M have MVP Chairs funded and in post. 1 Provider STHK currently does not have an MVP Chair. This has been raised as a concern with STHK and the LMNS Assurance Board. 1 Provider (LWH) has recruited User representative directly which could impact on independence. LMNS successful in bid for Independent Senior Advocate Role to support women and families who experience an adverse event during pregnancy and childbirth. Currently out to advert.	Continue to work closely with MVNP and continue to support independent funding for the post. Recruit to Senior Independent Advocate Role.
		The NHS collaborates with local authority services, other public sector organisations, and a wide range of private and voluntary sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england		Equity and Equality Plan in place to address inequalities.	LMNS to monitor delivery against MVNP action plans, particularly for ethnicity and under-represented groups and those living in areas of deprivation and with multiple disadvantage (Wider determinants of Health). Equity and Engagement Forum will meet quarterly starting Q1 23/24 to ensure women and families from ethnic backgrounds, under-represented groups and those living in areas of deprivation and with multiple disadvantage voices are heard and acted on.
Theme 1 Objective 2	**Improve equity for mothers and babies**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.		Access to Interpreter services in Emergency Departments has been identified as a problem for pregnant and postnatal care. This has been escalated to the ICB and is on the QSSG risk register.	LMNS to ask Director of Nursing lead to take this issue to the Directors of Nursing Group. To continue to be monitored through the QSSG.
		Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.		Equity and Equality plan developed and is in place.	LMNS to review progress and actions not yet started due to resource and where necessary present Business Case to ICB for support.
Theme 1 Objective 2	**Improve equity for mothers and babies**	**ICBs responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries (23/24)		Equity and Equality plan developed and is in place.	
		Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.		LMNS to review MVNP representation and support the commissioning of MNVPS to reflect ethnic diversity and facilitate outreach to those women not engaged. All MVNP action plans reviewed by the LMNS in 2022.	LMNS to monitor delivery against MVNP action plans, particularly for ethnicity and under-represented groups and those living in areas of deprivation and with multiple disadvantage (Wider determinants of Health). Equity and Engagement Forum will meet quarterly starting Q1 23/24 to ensure women and families from ethnic backgrounds, under-represented groups and those living in areas of deprivation and with multiple disadvantage voices are heard and acted on.
Theme 1 Objective 3	**Work with service users to improve care**	**Ambition**	**Measures**	**LMNS Progress / Comments**	**Actions**

		Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users.		LMNS has an Engagement Team which works with community and service users groups as well as MNVPs play key role in co-production e.g. bid for new role of Senior Independent Advocate.	
		MNVPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		LMNS Engagement team in place.	
		MNVPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		LMNS had lead link for MVNP across C + M until March 23, This role is being reviewed to ensure strategic links with LMNS. LMNS supports the MNVP being independently funded to ensure they have maximum impact. Some Providers include MNVP in the Maternity Safety Champion meetings as best practice.	LMNS to support and monitor MNVP in all providers being part of the Maternity Safety Champion meetings / walkarounds.
Theme 1 Objective 3	**Work with service users to improve care**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.		LMNS has been supportive of this within the remit they have had previously.	
Theme 1 Objective 3	**Work with service users to improve care**	**ICB Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.		LMNS has an Engagement Team which works with community and service users groups as well as MNVPs play key role in co-production e.g. bid for new role of Senior Independent Advocate. LMNS has been working closely with the MNVP Chairs and other user representation.	LMNS will review all engagement and role of service users in co-design and co-production and current MNVP activity in line with these recommendations. LMNS will review current MVP activity in line with these recommendations.
		Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.		LMNS has been working with Place and Trusts to ensure all MVNPs are renumerated.	LMNS to review for consistency of role, activity, representation and renumeration by ICB.
		Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.		LMNS has reviewed and signed off MNVP action plans in 2022.	MVNP action plans to be reviewed and signed off for 2023 and annually thereafter.
		Ensure service user representatives are members of the local maternity and neonatal system board		Nicky Lyons who is Patient Safety Lead and User representative sits on LMNS Assurance Board.	LMNS to consider recruiting a further user representative.

Theme 2 Objective 4	Growing, Retaining and Supporting our Workforce	Ambition	NHSE Measures	LMNS Progress / Comments	Actions
		Workforce capacity to grow as quickly as possible to meet local needs.	Outcome Measures : NHS staff Survey; National education and training survey; GMC national survey	LMNS workforce collaboration with 7 workstreams The 7 workstream are Preregistration capacity including RN / RM conversion; International Recruitment; Return to Practice; Recruitment and Retention; Band 5 Standardised Preceptorship programme; Advanced Clinical Practice; Maternity Support Worker workforce. There is now Bi monthly Cheshire and Merseyside workforce data now available to aid workforce reporting and monitoring although there is a two-month time lag.	All CMAST workstreams are delivering against the objectives set. LMNS will continue to work closely with CMAST and report progress through LMNS Assurance Board and ICB.
		Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training, absence, and leave.	Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data	Birthrate plus; BAPM guidelines and RCOG guidance including RCOG guideline on management of locums, are used to inform and evaluate staffing. All providers have evaluated their training uplift based on Ockenden recommendations.	LMNS will revisit the staffing guidelines and establishments in 2023/24.
		Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning.		CMAST as discussed above is aligning with these	LMNS will continue to link with national and regional sources to ensure alignment.
Theme 2 Objective 4	**Growing, Retaining and Supporting our Workforce**	**Trust Responsibilities**	**NHSE Measures**	**LMNS Progress / Comments**	**Actions**
		Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.	In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists. To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.	LMNS will review the annual census. LMNS monitors sickness and absence through the Sitrep and GOLD meetings. LMNS will link with the CMAST workstreams to monitor, recruitment, retention and succession planning and role development.	
		Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.	Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.		
		Provide administrative support to free up pressured clinical time.		LMNS care co-ordinator role planned to support midwifery teams working in enhanced midwifery Continuity of Carer models.	

Theme 2 Objective 4	Growing, Retaining and Supporting our Workforce	ICB Responsibilities	NHSE Measures	LMNS Progress / Comments	Actions
		Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).	To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.	LMNS supports GOLD a weekly meeting that review staffing and clinical activity in collaboration with all Providers. Electronic daily sitrep report now available monthly and quarterly which also shows delays in care (Induction of labour, elective caesarean section and Triage breaches) likely linked to staffing, and reasons for staffing concerns. Vacancy and sickness and absence rates are monitored across C+M.	
		Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.		This is a new requirement. LMNS commissioned Birthrate plus reports for all 7 Providers in 2021/22. Midwifery staffing review undertaken by the LMNS using the Birth rate Plus reports and current establishments. LMNS supports GOLD a weekly meeting that review staffing and clinical activity in collaboration with all Providers. Electronic daily sitrep report now available monthly and quarterly which also shows delays in care (Induction of labour, elective caesarean section and Triage breaches) linked to staffing, and reasons for staffing concerns. Vacancy and sickness and absence rates are monitored across C+M. This is a new requirement LMNS to develop a plan to address this in 23/24. The LMNS sits on Cheshire & Mersey Acute & Specialist Trusts provider collaborative (CMAST) on addressing midwifery workforce challenges. The seven workstream are Preregistration capacity including RN / RM conversion; International Recruitment; Return to Practice; Recruitment and Retention; Band 5 Standardised Preceptorship programme; Advanced Clinical Practice; Maternity Support Worker workforce. There is now Bi monthly Cheshire and Merseyside workforce data now available to aid workforce. reporting and monitoring although there is a two-month time lag. The CMAST workstream is focused on five key themes: •Supply •Stability •Experience/Culture	LMNS to develop a plan to address this in 23/24.

		Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements.		LMNS has worked with HEE and HIE to maximise quality student placements. LMNS has facilitated student placements in the social sector. LMNS has worked with HEE and HIE to maximise quality student placements. LMNS has facilitated student placements in the social sector. Pre-registration capacity: The LMNs has taken an active role in combination with local HEI and HEE to review student midwife capacity within the region, to support both providers and HEI to increase pre-registration midwifery capacity, It is supporting conversations around joint and shared students, which will increase placement opportunity therefore increasing the student midwife capacity, discussions are ongoing with local HEI's in how we can use the opportunity of Midwifery Continuity of care team midwifery to also review student capacity and student placement opportunity. Further discussions regarding RN to RM conversion places and the potential of increasing places within CM are in progress. (pipeline)	Continue to work with CMAST workstreams and report progress to LMNS Assurance Board and ICB escalating concerns if required.
Objective 5	**Value and retain the workforce**	**Ambition**	**NHSE Measures**		**Actions**
		Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience	**To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale**		
		All staff are included and have equality of opportunity.		The LMNS carried out a workforce survey of staff views and experiences in 2022. The findings have been passed to the workforce work programme to be incorporated into that programme.	
		A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination.			
Theme 2 Objective 5	**Value and retain the workforce**	**Trust Responsibilities**	**NHSE Measures**	**LMNS Progress / Comments**	**Actions**
		Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.	To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale	LMNS do this through sitrep and HEE workforce data base. They have also met Providers with Reginal teams to look at the PWR data and ensure that is accurate for workforce monitoring going forward.	
		Implement equity and equality plan actions to reduce workforce inequalities.			
		Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.			

		Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.			
		Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.		Nationally funded Retention Midwives are in place in 3 providers and early indications are that they have a positive impact on retention.	The LMNS will monitor progress against this as part of the Ockenden requirements. LMNS monthly review meetings are in place.
		Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.		The LMNS funded bespoke leadership programmes for Heads of Midwifery and Aspiring Heads of Midwifery 2022.	
Theme 2 Objective 5	**Value and retain the workforce**	**ICBs Responsibilities**	**NHSE Measures**	**LMNS Progress / Comments**	**Actions**
		Share best practice for retention and staff support.		There are nationally funded Midwifery retention roles in place in C+M Providers.	LMNS to explore further the impact of these roles and whether further support available to other Providers.
		Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.		There is regional representation on the GOLD meeting and staffing concerns and challenges have been highlighted there previously and addressed nationally. (For instance Covid restrictions and delays in accessing testing and results impacting during pandemic on staffing)	
Theme 2 Objective 6	**Invest in skills**	**Ambition**	**Measures**	**LMNS Progress / Comments**	**Actions**
		All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development.	Progress against workforce, retention, succession, and training plans.	LMNS monitoring staffing in electronic sitrep have highlighted that specialist midwives and midwifery managers are being used to fill rota shortages and delivering direct clinical care, so not always able to function in the role they are trained and employed to do. Ultimately this could impact on quality of care.	LMNS Electronic sitrep reports go direct to Providers. LMNS to follow up Provider responses to Sitrep.
		All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards.			
		Training is multi-disciplinary wherever practical to optimise teamworking.		This is a requirement of MIS and is monitored by Trusts and the lMNS.	
Theme 2 Objective 6	**Invest in skills**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.		LMNS has developed Training Needs Analysis templated which covers all Core Competency training and miss requirements which providers use to ensure they deliver appropriate care. This is monitored by the Trusts and needed as evidence for Maternity Incentive Scheme (MIS) and Clinical Negligence Scheme for Trusts (CNST) payments.	The LMNS will review TNA once MIS year 5 released expected April 2023. The requirement is for a 3 year rolling programme with local cases included.

		Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.		LMNS have confirmed as part of Maternity Incentive Scheme year 4 that all Providers are compliant or have an action plan to meet compliance.	LMNS to continue to monitor progress against action plans.
		Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums		LMNS have informed providers through WHaM operational Group that compliance with this is required.	LMNS to work with providers to understand current position and develop action plan to ensure all providers are compliant.
Theme 2 Objective 6	**Invest in skills**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
	ICB Evidence	Progress against workforce, retention, succession, and training plans.		CMAST Workforce Group established seven workstreams in place: Workshop held on 9th December with Chief People Officers to review and confirm priority areas for the CMAST workforce programme **MSW workforce (Implementation of MSW Framework)** Realising the potential of the Maternity Support Worker Workforce across the Cheshire and Merseyside LMNS region Assurance has been confirmed by the HOMS/DOMS that all MSW's are correctly coded within ESR (information and assurance requested for regional return) Focus groups have commenced within the CM MSW workforce to understand the challenges, and gain feedback regarding JD's, job roles, differences in community vs acute care, all this information is being fed back into both the LMNS Equity program and the HEE/regionally funded MSW workstream.	
		Local staff feedback mechanisms.		WHaM Workforce Survey 2022 was carried across all staff groups in maternity and neonatal services. Findings were fed into the CMST workstream.	

		Progress against the nursing and midwifery high impact retention interventions. Https://www.england.nhs.uk/wp-content/uploads/2022/07/B1711_Retaining-our-nursing-and-midwifery-colleagues-13-July-2022.pdf		There are nationally funded Midwifery retention roles in place in C+M Providers. Band 5 Preceptorship Program to aid retention on qualification. Work has begun to standardize band 5 preceptorship Programme within C&M, currently developing a digital APP which will allow midwives to access training and complete competency-based assessments in 'real time' on the wards and community settings. Standardization of the band 5 preceptorship Programme will allow for a moveable and transferable midwifery workforce across the CM providers, it will also answer the questions raised regarding training and preceptorship and support in the recent Ockendon review and Ockendon essential actions, a task and finish group chaired by a HOM/Dom has been developed. The regional HEE team is supporting this work.	

Theme 3 Objective 7	Developing and sustaining a culture of safety, learning, and support	Ambition	Measures	LMNS Progress / Comments	Actions
	Develop a positive safety culture (Maternity and Neonatal Services)	Staff are supported to work with professionalism, kindness, compassion, and respect.	NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey		
		Staff are psychologically safe to voice their thoughts and are open to constructive challenge.	NHSE will primarily determine overall success by listening to the people who use and work in frontline services.		
		Staff receive constructive appraisals and support with their development.			
		Staff work, learn and train together as a multi-disciplinary team across maternity and neonatal care			
		Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.			
		There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'.	Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture.		
		Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.			

		Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.	Staff feedback on how incidents and issues of concern are managed.		
		Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief.	Staff feedback on how incidents and issues of concern are managed.		
Theme 3 Objective 7	**Developing and sustaining a culture of safety, learning, and support**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		·Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.			
		Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.		COCH team are participating in national leadership Quad training and WUTH to follow in second wave.	
		At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.			
		Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.			

		Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.			
Theme 3 Objective 7	**Developing and sustaining a culture of safety, learning, and support**	**ICB Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Monitor the impact of work to improve culture and provide additional support when needed.		SCORE cultural staff survey is part of the leadership programme and Trusts participating in waves.	LMNS to confirm when the SCORE survey will be occurring in all Providers with NHSE, and scope alternative measures and potential Improvement Programme for culture.
		Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.		LMNS has hosted 2 MDT learning events in 2022. Clinical Network hosts six monthly Safety Summits. A further event being planned for June regarding 3-year delivery plan. The LMNS funded bespoke leadership programmes for Heads of Midwifery and Aspiring Heads of Midwifery 2022 to support existing staff and create a succession planning pipeline in roles which are hard to recruit to but essential for quality care.	LMNS to host stakeholder minimum 3 events per year.
Theme 3 Objective 8	**Learning and improving**	**Ambition**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Staff working in maternity and neonatal services have an appreciation and understanding of ‘what good looks like.' Staff must actively learn from when things go well and when they do not. To do this, we need a continuous learning and improvement approach, from teams to ICBs.			

		Patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services.		PSIRF in process of being implemented across C+M.	
		The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria.		HSIB investigates cases. Currently feedback to direct to organisations.	LMNS to explore HSIB feedback as a system.
Theme 3 Objective 8	**Learning and improving**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust.			
		Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.			
		Respond effectively and openly to patient safety incidents using PSIRF.			
		Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.		NODN Director sits on the Quality Safety and Surveillance Group and LMNS Assurance Board.	
Theme 3 Objective 8	**Learning and improving**	**ICB Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**

		Share learning and good practice across all trusts in the ICS.		Quality Surveillance and Safety Group (QSSG) is in place and shares good practice and learning across providers. Examples include Coroners 27 a letter which highlighted need for rapid access to blood transfusion in neonatal resuscitation. The case was shared, and the recommendations sent to all providers to ensure all complied. Cases for learning are part of the agenda. The Maternal Medicine network, Preterm network also feed into this group and share learning widely across the system. The LMNS are creating a forum where learning from clinical incidents and SIs can be shared, and improvement and learning can be rapidly shared. The LMNS has a preterm network in place which is sharing good practice and supporting learning. The LMNS has supported the development of the Maternal Medicine Network. The LMNS were part of the development of the escalation and divert policy across the North West. The electronic sitrep is linked to this and uses the same OPEL categories.	LMNS to use shared learning at engagement events. Maintain inclusive response to learning from adverse events and best practice. Also to use networks such as preterm birth and maternal medicine networks (and emerging networks to share learning).
		Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.		This is currently in transition and there is variation across the system. Its implementation is being led by PLACE. The Single Maternity SI panel has met for a year. Themes are being look at and will be shared across the system.	LMNS to work closely with PLACE and Providers to support the implementation and learning across the system.
Theme 3 Objective 9	**Support and Oversight**	**Ambition**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate.		The QSSG meets bi monthly to oversee the PQSM.	

		Well led services, with additional resources channelled to where they are most needed.			
		Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.			
Theme 3 Objective 9	**Support and Oversight**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.			
		Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.			
		Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.		LMNS have list of appointed of the Maternity and Neonatal safety champions.	LMNS to monitor this annually. LMNS to explore with Providers how this happens.
		Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.			
		At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.			
Theme 3 Objective 9	**Support and Oversight**	**ICB responsibilities**	**Evidence**	**LMNS Progress / Comments**	**Actions**

		Commission services that enable safe, equitable, and personalised maternity care for the local population.		LMNS to share in depth knowledge and expertise from service reviews of maternity and neonatal care to support ICB commissioning decisions and model of care.	LMNS to review the knowledge from service reviews.
		Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.		PQSM is monitored through QSSG at the lMNS. Neonatal care is monitored through the neonatal Operational Delivery Network. The Director of NODN sits on QSSG and the LMNS Assurance Board.	QSSG will continue to meet bi-monthly
		Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.		GOLD and Sitrep are examples of collaborative working which brings a range of staffing and quality care metrics together and they are shared with Providers and the QSSG. Triage Improvements has been identified as an LMNS/ICB priority. The first Triage Improvement meeting with representatives from a all Providers and NWAS is planned for 24th April 2022.	LMNS to explore how sitrep reporting can be better integrated into the current reporting structures to maximise their potential for learning. Triage Task and Finish Group being established. Draft terms of reference in place and meetings scheduled.

Theme 4 Objective 10	Standards to ensure best practice	Ambition	Measures	LMNS Progress / Comments	Actions
		Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities.	1. Outcome measures for this theme are those of our existing safety ambition: **maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births.** NHSE will monitor these measures nationally by ethnicity and deprivation. 2. –**Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care**. 3.The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (**ATAIN**) programme	The LMNS monitors these through the QSSG and LMNS Assurance Board in alliance with NODN.	
		Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice care.		TBC	
		Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance.		Where trusts are not NICE compliant there is a process for them to declare why not locally.	? LMNS should ask Trusts which NICE guidance they are declaring non compliance with
		Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines.			
		Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies.		All NNU have a clear designation of level of care. The units do work across the system to optimise capacity through GOLD and the neonatal network.	
Theme 4 Objective 10	**Standards to ensure best practice**	**Trusts responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and	Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.	This will be part of MIS and monitored through that process and the QSSG.	
		Adopt NEWT tool by March 2025		TBC	
		Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.		PMRT	
		Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.		See above	

		Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.		LMNS asked for the national self assessment tool completion.	LMNS to review and refresh national assessment tool completion by Providers.
Theme 4 Objective 10	**Standards to ensure best practice**	**ICBS Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.		Process to be confirmed but it will build on current policies and standardised processes for SBL and other guidelines and policies.	
		Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme.		LMNS oversaw the assurance of the assurance process for declaration in 2022. This wording marks a significant shift to the LMNS being assured of content. Process to be determined for 2023. Regular monthly 1-1 meetings and joint meetings were scheduled with Trusts to offer support. Determine process for assurance of content of the assurance of Trust submission for MIS. Bi - monthly 1-1 meetings established and monthly all provider meetings to be established.	Determine process for assurance of content of the assurance of Trust submission for MIS. Bi - monthly 1-1 meetings established and monthly all provider meetings to be established.
		Monitor and support trusts to implement national standards.		LMNS Assurance role and regular review meetings to inform support, training, and QI	
		Commission care with due regard to NICE guidelines.		See comments re NICE above.	Need process to ensure adherent to NICE guidance - note CTG interpretation concerns.
Theme 4 Objective 11	**Data to inform learning**	**Ambition**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.		MSDS will be feeding regional dashboard available from April 23.	
		Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports.		Heat map has been developed regionally.	
Theme 4 Objective 11	**Data to inform learning**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work.			LMNS do we need an analyst to pull this together - it is a big job?

		Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.			
Theme 4 Objective 11	**Data to inform learning**	**ICB Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.		LMNS will work closely with providers and digital teams and escalate concerns within the ICB	
		Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.		Benchmark with other LMNs	
Theme 4 Objective 12	**Make better use of digital technology in maternity and neonatal services**	**Ambition**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them.	– A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.	Badgernet provides this facility. LMNS aware that WHH have badgernet. STHK; MCHT and COCH currently in procurement for new IT system. ICB support requested to encourage one system. TBC	
		All clinicians are supported to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, secure networks, and training.			
Theme 4 Objective 12	**Make better use of digital technology in maternity and neonatal services**	**Trust Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Organisations enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices.			
		Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework.		All providers have a digital strategy signed off by the ICB November 2023.	

		Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop.		see comments above re Badgernet.	
Theme 4 Objective 12	**Make better use of digital technology in maternity and neonatal services**	**ICB Responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.		TBC - digital team	
		Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.		TBC - digital team	
Theme 4 Objective 12	**Make better use of digital technology in maternity and neonatal services**	**ICB evidence**	**Measures**	**LMNS Progress / Comments**	**Actions**
		Support regional digital maternity leadership networks.		TBC - digital team	
		Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle.			
Theme 4 Objective 12	**Make better use of digital technology in maternity and neonatal services**	**Regulation responsibilities**	**Measures**	**LMNS Progress / Comments**	**Actions**
		An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.			
		Maternity Incentive Scheme		LMNS supported year 4 MIS submission successfully.	LMNS will support LMNBS year 5 submission with full Business Schedule.
		The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.			

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Quality & Performance Committee Chair

27 April 2023

Agenda No	ICB/04/27/16
Report author & contact details	Kerry Lloyd, Deputy Director of Nursing & Care kerry.lloyd@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director/ Chair)	Tony Foy, Chair
Responsible Officer to take actions forward	Kerry Lloyd, Deputy Director of Nursing & Care

Cheshire and Merseyside ICB Board Meeting

Report of the Quality & Performance Committee Chair

Executive Summary	The purpose of this report is to provide assurance to the C&M Integrated Care Board in regard to key issues, considerations, approvals and matters of escalation considered by the C&M ICB Quality & Performance Committee in securing continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centered, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X	X		
Recommendation	**The Board is asked to:** • Section 2 note the content • Section 3 note the content and the issues considered by the Committee and actions taken. • Section 4 Consider the matters escalated to the ICB Board				
Key issues	Noted in the body of report.				
Key risks	Noted in the body of report.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X	X	X	X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X	X	X	X	
Management of Conflicts of Interest	No conflicts of interest declared at the Committee.				
Next Steps	Noted in the body of report.				
Appendices	None				

Report of the Quality & Performance Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Quality & Performance Committee	The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable, and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues. In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties: • Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); and • Adult safeguarding and carers (the Care Act 2014).	Tony Foy

2. Meetings held and Summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
23/03/06	16/03/23	**Place Based Quality Reporting:** The committee received the monthly place-based quality report that included assurance in relation to: MSI Choices UK, a provider of termination of pregnancy services and a description of a related incident concerning a Lancashire patient being treated in Southport & Ormksirk Hospital. The incident has been reported through the Serious Incident Framework and will be overseen by the Greater Manchester ICB as this provider falls within their footprint. The committee was also assured in relation to the incident involving paediatric audiology services in Warrington & Halton Hospital and subsequently, Bridgewater Trust. Both organisations are working collaboratively with regional and national colleagues to ensure that those children involved are reviewed, with individual communications now completed to inform affected families of the incident itself and associated actions taken. The committee were also updated in relation to the ongoing work involving independent providers of mental health services in Warrington Place. The committee was informed of the positive outcome of the CQC inspection at St Mary's Hospital, where the overall inspection rating improved from 'Requires Improvement' to 'Good'.
23/03/07	16/03/23	**Risk Register** The committee received a paper which provided assurance as to the ongoing development of the corporate risk register for quality. The committee was satisfied in relation to the transfer of legacy risks and the aggregation of those risks pertaining to quality into consolidated approach and endorsed the approach being taken in relation to new and emerging risks.
23/03/08	16/03/23	**Performance Report** The committee received its monthly report that described the levels of performance in key areas across the C&M system. The committee heard how ongoing industrial action had affected elective recovery work and how that has impacted on the national target to ensure that no patient waited more than 78 weeks for an intervention by 31st March 2023, and despite best efforts the ICB may narrowly miss that target.

Decision Log Ref No.	Meeting Date	Issues considered
		The committee was updated in relation to mental health demand and how this demand is affecting occupancy levels across the system. This in turn has impacted upon the numbers of patient being placed out of area, the committee was informed that this would be a focus for the April 2023 System Quality Group and a report would be brought back to the subsequent committee in relation to action being taken. The committee discussed the ongoing issue in relation to the increased Summary Hospital Mortality Indicator at East Cheshire Trust. The ICB Medical Director reported being in liaison with the Trust Medical Director and is supporting them in better use of triangulated intelligence in ensuring the right actions are being taken. It was agreed that a more detailed report would be brought to a subsequent committee by the Medical Director, outlining the ICB approach to mortality oversight more generally.
23/03/09	16/03/23	**Enhanced Health in Care Homes (EHCH) & Quality Improvement** The committee was updated in relation to the work that has occurred following the November 2022 System Quality Group. EHCH was established in 2020, and a further gap analysis was undertaken in Feb/Mar 2023 at place-based level as to progress against each of the EHCH domains. Good progress was made across all places, there were some nuances, and further work is required to better understand what is happening in relation to end of life/dementia. A workshop is proposed in April 2023 for care home leads, Local Authority, general practice leads, urgent care leads, Healthwatch and CQC, to discuss safe discharge and admission avoidance. The EHCH Regional Lead is expected to refresh the framework. The purpose is to take stock and bring people together as a system. This will not replace work at place, it will continue with its cross-cutting approach and will be brought back to System Quality Group in May 2023 for sign off.
23/03/10	16/03/23	**Patient Experience** The committee received its quarterly update report that described the ongoing work to develop the complaints policy and the activity in relation to complaints, concerns, and MP enquiries. The committee also heard how that from July 2023, the ICB would take on responsibilities for Pharmacy, Optometry and Dentistry and the challenges that would be involved in ensuring that the ICB is able to respond in a timely way to these additional demands.

Decision Log Ref No.	Meeting Date	Issues considered
		The committee was informed of the thematic analysis that was undertaken to ensure the appropriate actions and learning are taken from complaints received and actions taken regarding specific outlier areas.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
-	-	-

4. Issues for 4. Escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
23/03/05	16/03/23	The committee received its monthly report from the Local Maternity & Neonatal System. The committee was appraised of the strategic and ongoing risks and issues affecting maternity services and in particular, their attention was drawn to the impact of workforce shortages that are playing out both nationally and locally. The committee was informed how the LMNS were working with CMAST and LPC to ensure that actions were being taken to address recruitment and retention issues where local action is needed. The committee was also informed about the work underway at Liverpool Women's Hospital following inspection in January 2023. Liverpool Women's Hospital had an unannounced CQC visit week commencing 31st January 2023, where triage, delays in IOL and staffing challenges were identified. The regional Chief Midwife and the ICB carried out a site visit following the CQC visit, with an action plan in place. The CQC followed this with a Trust wide 'Well-Led' inspection in February 2023The committee was informed that there is input from both ICB, LMNS and regional partners to oversee and ensure improvements are made.

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date		Recommendation from the Committee
-	-	-	-

6. Recommendations

6.1 **The ICB Board is asked to:**

- Section 2 - note the content
- Section 3 - note the content and the issues considered by the Committee and actions taken.
- Section 4 - Consider the matters escalated to the ICB Board regarding Maternity Services.

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Remuneration Committee Chair

27 April 2023

Agenda Item No	ICB/04/27/17
Report author & contact details	Matthew Cunningham, matthew.cunningham@nhs.net
Report approved by (sponsoring Director/ Chair)	Tony Foy, Chair of the Remuneration Committee
Responsible Officer(s) to take actions forward	Chris Samosa, Chief People Officer Matthew Cunningham, Associate Director of Corporate Affairs and Governance

Report of the Remuneration Committee Chair

Executive Summary	The Remuneration Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 22 March 2023. The meeting was quorate and able to undertake the business of the Committee. Declarations of interest were noted where applicable. Main items considered at the meetings included: • Proposals for the remuneration of the ICB Director of Population Health and the interim Place Director for Liverpool • ICB Mutually Agreed Resignation Scheme. The meeting of the 22 March 2023 also considered confidential, employee specific matters. The next meeting of the Committee is scheduled to be held on 20 June 2023.

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

Recommendation	**The Board is asked to:** • **note** the items covered by the Remuneration Committee at its meeting on the 22 March 2023 • **note** the decisions made by the Committee.

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

Management of Conflicts of Interest	Declarations of Interest were recorded in relation to those staff present at the meeting who could be in scope of the ICBs MARS Scheme. Whilst the content of the Chairs report does relate to some individuals on the ICB Board and those in attendance, the Committee has already made the decision (where applicable) and as such Board members and attendees in potential scope of the MARS scheme are not conflicted by being informed of the discussion at the April 2023 Board meeting.
Next Steps	n/a
Appendices	n/a

Report of the Remuneration Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Remuneration Committee (Statutory Committee)	The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary the committee is required to: • confirm the ICB pay policy including adoption of any national or local pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors. 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 Directors, including but not limited to termination payments. The Committee's duties are as follows: For the Chief Executive, Directors, and other Very Senior Managers: • determine all aspects of remuneration including but not limited to salary, • determine arrangements for termination of employment and other contractual terms and non-contractual terms. 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. For Non-Executive Directors (NEDs):	Tony Foy, ICB Non-Executive Member

Committee	Principal role of the committee	Chair
	• determine the ICB remuneration policy (including the adoption of pay frameworks) • oversee contractual arrangements. Additional functions that the ICB has chosen to include in the scope of the committee include: • functions in relation to nomination and appointment of (some or all) Board members through convening an ICB Appointments Panel • functions in relation to performance review/ oversight for directors/senior managers • succession planning for the Board • assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR) • board development which maybe progressed through a discreet working group.	

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision /Action Log Ref No.	Meeting Date	Issues considered
	22.03.23	**ICB Mutually Agreed Resignation Scheme** The Committee received a paper that provided members with an update on the proposed introduction of a Mutually Agreed Resignation Scheme (MARS) for the ICB during 2023-2024. The Remuneration Committee was asked to note that an application for approval of the NHS Cheshire & Merseyside MARS has been made to NHSE and a decision is expected early in April 2023. Should the scheme be approved, the ICB intended to launch MARS to eligible employees during April, with those leaving via MARS doing so, no later than the end of July 2023. **The Committee noted the update report and requested further detail be brought back to the Committee regarding process, numbers, and costings.**

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision /Action Log Ref No.	Meeting Date	Issues considered
	22.03.23	**Remuneration of the ICB Director of Population Health and the interim Place Director for Liverpool**. The Committee considered a report that provided the committee with the proposed annual remuneration for the individual who will be undertaking the ICB Director of Population Health position, and the individual appointed to be the Interim Liverpool Place Director. The Committee received assurance that the remuneration rates recommended for approval had been informed by national guidance and were consistent with the remuneration rates and ranges previously agreed by the Committee for other ICB VSM positions. **The Committee approved the recommended annual remuneration for the ICB Director of Population Health and the Interim Place Director for Liverpool, namely:** • **Director of Population Health – approval of an annual remuneration of £120,000. Approval also received to take individual's previous NHS and Local Authority service into account for the purpose of determining annual leave, sick pay, paternity leave and redundancy.** • **Interim Place Director for Liverpool – approval an annual remuneration of £140,000.**

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision /Action Log Ref No.	Meeting Date	Issue for escalation
-	-	-

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision / Action Log Ref No.	Meeting Date	Recommendation from the Committee
-	-	-

6. Recommendations

6.1 **The ICB Board is asked to:**

- **note** the items covered by the Remuneration Committee at its meeting on the 22 March 2023
- **note** the decisions made by the Committee.