Cheshire and Merseyside
Health and Care Partnership

Partnership Board
Wednesday 28th April 2021
15:00am to 17:00pm
Agenda

AGENDA NO.	ITEM	LEAD	ACTION
PB/21/25 15:00 - 15:04	Welcome, Introductions and Apologies	Alan Yates	Oral
PB/21/26 15:04 - 15:05	Declarations of Interest	All	Oral
PB/21/27 15:05 - 15:06	• Minutes of the last meeting 30th March 2021 • Minutes of Partnership Co-ordination Board – for review	Alan Yates (to note)	Paper Paper
PB/21/28 15:06 - 15:10	Chief Officer's Update	Jackie Bene	Oral
PB/21/29 15:10 – 15:15	Transformation Programmes Governance	Jackie Bene	Paper
PB/21/30 15:15 – 15:20	Transition of Partnership Co-ordination Group to a Partnership Development Advisory Group	Jackie Bene	Paper
PB/21/31 15:20 – 15:30	Preparing for the New Board	Alan Yates	Oral
PB/21/32 15:30 – 16:00	Rapid Health Needs Assessment for Cheshire and Merseyside	Eileen O'Meara / Sarah O'Brien	Paper
PB/21/33 16:00 – 16:05	Improving Health and Wellbeing in Cheshire and Merseyside Strategy	Sarah O'Brien	Paper (to note)
PB/21/34 16:05 – 16:10	MoU Status	Ben Vinter	Oral
PB/21/35 16:10 – 16:20	Draft Forward Plan	Ben Vinter	Paper
PB/21/36 16:20 – 16:35	End of 20/21 Year Finance Update	Keith Griffiths	Oral / Paper
PB/21/37 16:35 – 16:55	Update on ICS Development Programme	Sarah O'Brien	Oral
PB/21/38 16:55 – 17:00	Review of the meeting and communications from it	Alan Yates	Oral

Date and time of next meeting: Wednesday 25th May 2021, 15.00pm to 17.00pm

MEMBERSHIP – PARTNERSHIP BOARD

Chair
Alan Yates (AY) – Chair, Cheshire & Merseyside Health & Care Partnership

Executive Team
Jackie Bene (JB) – Chief Officer
Dave Sweeney (DS) – Implementation Director
Kieran Murphy (KM) – Clinical Lead
Marie Boles (MB) – Director of Nursing
Christine Hughes (CH) – Director of Communications & Engagement
Keith Griffiths (KG) – Director of Finance
Sarah O'Brien (SOB) – Director of Strategy & System Developemnt

Local Authorities
Professor Steven Broomhead (SBr) – Chief Executive, Warrington Borough Council
Kath O'Dwyer (KO) – Chief Executive, St Helens Council

Voluntary, Community and Social Enterprise (VCSE)
Warren Escadale (WE) – Chief Executive, Voluntary Sector North West

NHS Providers
Simon Barber (SBa) - Chief Executive, North West Boroughs Healthcare NHS FT
Ann Marr (AM) – Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust
Sheena Cumiskey (SC) – Chief Executive, Cheshire and Wirral Partnership NHS FT
Joe Rafferty (JR) – Chief Executive – Mersey Care NHS FT

NHS Commissioners
Mark Palethorpe (MPt) – Clinical Accountable Officer, NHS St Helens CCG
Jan Ledward (JL) – Chief Officer, NHS Liverpool CCG
Clare Watson (CW) - Chief Officer, Cheshire CCG

NHS North West
Linda Buckley (LB) – Director of Strategic Transformation and Locality Lead (C&M)

Advisory Members
Gerald Meehan (GM) – C&M Health and Care Partnership Advisor

NWAS

Daren Mochrie DM) - Chief Executive Officer

Primary Care

Dr Jonathan Griffiths (JG) - GP/Primary Care Advisor

Dr Raj Kumar (RK) - General Medical Practitioner - Eric Moore Partnership Medical Practice, Warrington and Clinical Director & Responsible Officer - NHS Digital

Public Health

Eileen O'Meara (EO) - C&M Population Health Clinical Lead/Director of Public Health and Public Protection Halton and Warrington LA

Cheshire and Merseyside Partnership Board

31st March 2021, 15.00-17.00

MS teams – Virtual

Present:

Alan Yates (AY)	Chair	Cheshire and Merseyside Health and Care Partnership HCP)
Keith Griffiths (KG)	Director of Finance	Cheshire and Merseyside Health and Care Partnership
Christine Hughes	Director of Communications and Engagement	Cheshire and Merseyside Health and Care Partnership
Gerald Meehan (GM)	Local Authority Advisor to the Executive Team	Cheshire and Merseyside Health and Care Partnership
Jackie Bene (JB)	Chief Officer	Cheshire and Merseyside Health and Care Partnership
Marie Boles (MB)	Director of Nursing (NHSI/E advisor to the Executive Team)	NHSE/I
Raj Kumar (RK)	GP Representative	Cheshire and Merseyside Health and Care Partnership
Steven Broomhead (SBr)	Chief Executive	Warrington Borough Council (present from 3.30)
Warren Escadale (WE)	Chief Executive	Voluntary Sector North West
Eileen O'Meara (EO'M)	C&M Population Health Clinical Lead & Director of Public Health and Public Protection	Cheshire and Merseyside Public Health Collaborative
Clare Watson (CW)	Accountable Officer	NHS Cheshire CCG
Sarah O'Brien (SO'B)	Executive Director of Strategy & System Development	Cheshire and Merseyside Health and Care Partnership
Linda Buckley (LB)	Director of Strategic Transformation, Locality Director (C&M)	NHSE/I
Maxine Power (MP)	Director of Quality, Innovation & Improvement	North West Ambulance Service (NWAS)
Dave Sweeney (DS)	Partnerships Lead	Cheshire and Merseyside Health and Care Partnership
Sheena Cumiskey (SC)	Chief Executive	Cheshire & Wirral Partnership Trust
Mark Palenthorpe (MPt)	Chief Officer	St Helens CCG
Fiona Taylor (FT) On behalf of Jan Ledward	Chief Officer	South Sefton CCG
Mark Bakewell (MBk)	Chief Finance Officer	Liverpool & Knowsley CCG
Kieran Murphy (KM)	Clinical Lead (NHSI/E advisor to the Executive Team)	NHSE/I

Kath O'Dwyer (KO'D)	Chief Executive	St Helens Council
Chris Somosa (CS)	Director of Workforce	C&M Health and Care Partnership

In attendance:

Jennefer Bennett (JB)	Executive Assistant	C&M Health & Care Partnership
Lisa Wainwright (LW)	Executive Assistant (minutes)	C&M Health & Care Partnership
Jonathan Griffiths (JG)	GP/Primary Care Advisor	C&M Health and Care Partnership
Ben Vinter (BV)	ICS Planning	C&M Health and Care Partnership
Faye Sefton (FS)	Digital Communications Manager	C&M Health and Care Partnership

Apologies:

Joe Rafferty (JR)	Chief Executive	Mersey Care NHS FT
Ann Marr (AM)	Chief Executive	St Helens & Knowsley Teaching Hospitals NHS FT
Jan Ledward (JL)	Chief Officer	NHS Liverpool CCG

Agenda No	Item	Action
PB/21/15	**Welcome, Introduction and Apologies**	**AY**
	AY welcomed the board members and apologies were noted as above.	
PB/21/16	**Declarations of Interest**	**AY**
	No declarations of interest were reported.	
PB/21/17	**Minutes of meetings**	**AY**
	The minutes of C&M Partnership Board meeting held on 24th February 2021 were accepted as true an accurate record of the meeting. AY noted there were some inconsistencies within the minutes in referring to the Partnership Coordination Group and Board, and confirmed that that this should be 'Group'. <u>Partnership Co-ordination Group</u> The minutes of the Partnership Coordination Group meetings contained within the meeting pack were noted for information purposes.	
PB/21/18	**Chief Officer Update**	**JB**

	JB reported that the Partnership would be officially designated an Integrated Care System from 1 April 2021, and that it was expected to become a statutory body from April 2022. Although the cell structure had not officially been stepped down to support the pandemic and recovery, work was ongoing to transition the existing hospital cell to a provider collaborative and the existing out of hospital cell to a Place collaborative. C&M had been particularly successful within the North West with the vaccination programme, which is a credit to the hard work of the all those involved. JB noted that there had been some positive collaboration across C&M to support the workforce, and there had been some good pieces of work undertaken, including the establishment of the Mental Health Hub to support workforce resilience. She added that the North West ADASS meeting had provided positive feedback on the integrated approach to the Peoples Plan for C&M. The planning guidance for 2021/22 had been received and a lot of extensive work was required to pull this together collaboratively and in ensuring that there was a strong inequalities reduction approach to the planning. The first draft was due to be submitted on 6 May 2021, and the Partnership Board will be updated on progress at the next meeting and be asked to provide formal approval of the plans prior to final submission.	
PB/21/19	**MOU Update**	**BV**
	BV referenced the paper which was contained within the meeting pack which provided the Board with an update on feedback from MoU adoption/agreement process to date. The Board were also asked to discuss their responses and next steps. It was noted that 19 positive responses had been received to date out of 37, and that a number of queries were raised by Liverpool City Council. Work will be undertaken to chase up the remaining responses. FT confirmed that she had responded on behalf of South Sefton and Formby. KO'D stated that she was aware that there had been some queries raised by Liverpool City Council and that she was happy to chase up a response from them if necessary. CW stated that a response had been sent from Cheshire but that she would confirm with BV. AY advised that he and the Board were content to have these CCG positions and support recorded via the minutes. MP raised a query about NWAS' involvement in the MOU. BV confirmed that NWAS had been omitted from the first draft of the MOU in error but had since been reinstated. DS commented that he felt that the MOU would be beneficial when working with Housing Associations. AY advised that the plan was for the new Partnership Board membership arrangements to come into effect from 1 June 2021 following the local authority government elections in early May. He described the approach for Trusts to establish their representation at the interim Partnership Board. It was important that the three constituencies were able to choose how they represented themselves as it was important that those representatives had the confidence of their constituency and had been identified by a consensual process. It was important that all formal members of the Partnership committed to the MoU before the end of April 2021 so that when the Interim Board commenced in	

	June it had the authority to operate under the aegis of the MoU. AY asked Board members to support all in their constituency to fulfil this expectation.	
PB/21/20	**Getting Under the Skin Research and BAME Action Plan**	**CS**
	CS referenced the Getting Under the Skin presentation contained within the meeting pack which was undertaken by Edna Boampong. She also presented the updated report on the C&M race equality, diversity and inclusion pledge and action plan which was also contained within the meeting pack. FT queried whether there had been a strategic focus on inter-racial relationships as she felt that there may be a danger of this being missed within regions of C&M which had fewer residents from ethnic minorities. RK advised that it was essential that race inequalities are considered during all of the system transformation programmes led by the ICS, and that it is important that the pledges are woven into this process and do not stand alone. He also noted there should be some consistency with the rest of the country in relation to the use of terminology and titles, and it was noted that the term race and ethnic minorities had replaced BAME. RK advised that he felt that there needed to be a sufficient network and leadership in place from both providers and community systems as part of the process, and he offered his support with this development. K'OD commented that it had been a really useful piece of research, and agreed that it was now time that actions were taken from it in order to address inequalities. E'OM advised the Board meeting that positive feedback on the research project had been received from Greater Manchester. She added that it was important that the research findings were utilised to address race inequalities both within the workforce and the community, and not just targeted for specific items such as vaccine hesitancy. SC agreed that it was a good piece of research and would be beneficial to utilise it to take forward future mental health programmes. She added that she also felt that it would be beneficial to consider how to help people from ethnic minorities feel more comfortable accessing services. CS commented that the research had been enlightening and would assist the partnership in a number of ways, including how to attract a more diverse workforce and to consider what barriers exist within local communities. CS responded to the Board's feedback, and confirmed that cabinet guidance had been received in relation to the appropriate use of terminology when referring to ethnic minorities, and this will be circulated out to all Trusts. She agreed that consideration needed to be given to inter-racial issues as well as ensuring that any system transformation was viewed through an 'inclusive lense'. In response to RK, CS confirmed that she would take executive lead for the action plan. It was proposed that the Partnership Board be provided with quarterly updates on the action plan.	
PB/21/21	**C&M HCP Strategy 2021 - 2025**	**JB/SOB**
	SO'B referenced the C&M HCP Strategy for 2021-25 which was contained in	

	the meeting pack. She explained that the strategy had been condensed from a previous 5 year strategy which was devised by Places in 2019 but was not published due to the pandemic. The strategy also included objectives set by NHSE following the impact of the pandemic, particularly in relation to inequalities and improving outcomes. The Partnership Board was asked for their approval of the strategy as a working document. EO'M advised that some of the terminology within the strategy would need to be updated as, for example, the term obesity had been replaced with healthy eating and reducing excess weight. She also proposed that the term CVD be used when referencing strokes and reducing deaths. EOM stated that it would also be beneficial to include additional outcomes for the reduction of alcohol unrelated to general medical diseases, including the reduction in domestic violence and criminal activity. SBr asked that there be reference made to Health and Wellbeing Boards within the strategy. SC asked that it be made clear that provider collaboration included mental health, learning disabilities and community services. KO'D asked that consideration be given to the connectivity of LEPs and combined authorities. FT commented that there needed to be more detail within the strategy in relation to quality standards. MB agreed that there should be stronger language used within the document in relation to quality and safety in the commentary. MP queried how the actions held within the strategy would be benchmarked. AY agreed that questions in relation to next steps were very valid and the executive team was attending to them. RK confirmed that patient safety sat at the heart of every transformational change and agreed that it would be beneficial to elaborate on this more within the strategy. MBk referred to the financial section, and commented that ensuring value for money and ensuring financial balance were not always connected. SO'B thanked Board members for the comments and suggestions and it was agreed that she would revise the document accordingly. The Board supported its publication after those revisions and subsequently reported to the next Partnership Board meeting in April 2021.	
PB/21/22	**Transformation Programmes Evaluation**	**JB/SOB**
	SO'B referred to the Transformation Programmes Evaluation paper which was contained within the meeting pack, and asked the Board for their approval with the recommendations contained. In summary, it was noted that all submissions received had been judged against the 4 criteria agreed by the Board, and that it had been judged that collaboration at scale and urgent and emergency care should no longer be supported by the HCP and the individual SROs had been informed. The next step would be for SO'B and JB to meet with the individual SROs in order to agree how much of the funding requested should be supported for each programme in order to then formalise the transformation programmes for 2021/22. A plan will then be shared at the next Partnership Board which will detail the	

	governance arrangements in place in order to ensure that the Partnership had full oversight of the transformation programmes it supported. In response to a query made by MBk, SO'B explained that it was likely that any financial costs in relation to Cancer will be funded by NHSE as part of the restoration and recovery plan. However, there will be some flexibility within the HCP's financial plans to provide financial support if necessary. LB reinforced that an elective recovery programme bid will be made to NHSE, but that a request for additional finances to the Partnership may be necessary if this was not successful. MBk advised that it would be beneficial to have further discussions with KG as to how non-recurrent funding could be made into something more sustainable in order to release funds for further investment. AY described how this process had been far more rigorous than in previous years with the development of criteria consistent with the purpose of the Partnership and with submissions against those criteria from the programmes. It was the intention to increasingly judge programmes by their return on investment. **The Partnership Board agreed to support the recommendations set within the Transformation Programmes Evaluation paper, and it was agreed that an update would be provided at the next Partnership Board meeting in April 2021.**	
PB/21/23	**Update on Marmot Work**	**EOM**
	EO'M presented the update on Marmot work slides which were contained within the meeting pack. The Board noted the update and were asked for any comments or queries. SO'B confirmed that Marmot had been linked in with academic partners from Edge Hill University, and arrangements will also be made for them to be linked in with Chester University. WE offered to provide links from the voluntary sector into any leadership groups established with a focus on inequalities. EO'M confirmed that this offer would be very welcome. AY commented that the national work undertaken by Marmot was central to the agenda for the partnership, and that many local partners had identified at the last Partnership Forum that they wished to work collaboratively in order to address inequalities.	
PB/21/24	**Review of the Meeting and Communications From It**	**AY**
	AY thanked members for their contribution and commented that the he felt that the meeting had been positive and had been assisted with good quality papers which had helped to stimulate an informed discussion. He added that it was planned that a programme of work would be developed for future board meetings in order to assist the partnership in working in a more disciplined and systematic way. CH confirmed that a summary of the partnership board meeting will be provided and circulated out for information. She added that hyperlinks in relation to the ethnic minorities' strategy will be circulated once the paper was finalised.	
	Date and Time of Next Meeting	

	Wednesday 28th April 2021 - Time: 15.00pm to 17.00pm	

C&M Partnership Co-ordination Group
Thursday 1st April 2021

Attendance

Name	Title
Jackie Bene (JB) – Chair	Chief Officer, Cheshire and Merseyside Partnership
Andrew Davies (AD)	Accountable Officer, NHS Warrington CCG and NHS Halton CCG
Clare Watson (CW)	Accountable Officer, NHS Cheshire CCG
Caroline Lees (CL)	Assistant Director, Urgent, Planned and Community Health, St. Helen's CCG
Tracy Jeffes (TJ)	Director of Place (South), NHS South Sefton CCG and NHS Southport & Formby CCG
Kath O'Dwyer (KO)	Chief Executive, St. Helen's Council
Jonathan Griffiths (JG)	Primary Care Advisor, Cheshire & Merseyside Partnership
Maxine Power (MP)	Director of Quality, Innovation and Improvement, North West Ambulance Service
Lucy Davies (LD)	Deputy Director, NHS Transformation Unit
Sophie Whitham (SW)	Associate Consultant, NHS Transformation Unit

Apologies

Name	Title
Joe Rafferty	Chief Executive, Mersey Care NHS FT
Dianne Johnson	Accountable Officer, NHS Knowsley CCG
Simon Banks	Accountable Officer, NHS Wirral CCG
Jan Ledward	Accountable Officer, NHS Liverpool CCG
Linda Buckley	Director of Strategic Transformation, NHS E/I
Eileen O'Meara	Director of Public Health and Public Protection for Halton and Warrington
Christine Hughes	Executive Director of Communications and Engagement, Cheshire and Merseyside Partnership
Sarah O'Brien	Executive Director of Strategy & System Development, Cheshire and Merseyside Partnership
Steven Broomhead	Chief Executive, Warrington Borough Council
Fiona Taylor	Accountable Officer, NHS South Sefton CCG and NHS Southport & Formby CCG
Mark Palethorpe	Accountable Officer, NHS St. Helens CCG

Minutes

1.	Welcome and introductions

The chair, Jackie Bene, opened the meeting.

No changes required to the minutes of the previous meeting.

2.	Minutes & action log

Action 037: ***SBr to determine how the learning from Warrington (as an early adopter of 111 First) can be shared across C&M.***

Learning to be shared at a future meeting. Action ongoing.

Action 068: ***CH to link with region to support regional communications regarding potential redundancies within CCGs.***

JB highlighted that this action was identified during early discussions. A decision was made to pause regional communications on this issue until further information is available. This was articulated in Connect to ensure people feel informed and included. Action closed.

Action 072: SO to distribute the commissioning slides presented by Mark Green to CCG AO's.

Slides sent to PCG members. Action closed.

3.	Current issues

- AD highlighted the limited information available regarding the finance, workforce, and staff side consultation timelines as CCG's transition to become part of the ICS. AD questioned what the anticipated process is for producing the System Development Plans and how information from the Places will be included.
- JB informed the group that Keith Griffiths is leading this work for the ICS and Neil Evans from Cheshire CCG. The requirement is for a Provider Collaborative and Out of Hospital (OOH) Cell approach. JB highlighted that the OOH Cell is transitioning to become more collaborative at Place. JB highlighted that a Development Plan was produced as part of the ICS designation process which provides much of the information required. Further development of the plan is required using the System Progression Tool and further input from Place. Ben Vinter is coordinating the production of this system development plan for the ICS.
- AD emphasised the importance of capturing the good work already happening at a Place level within these plans.
- JB informed the group she attended a Staff Side meeting regarding the CCG's transition. JB highlighted that there is an agreed way of working, although the information available remains limited. Further guidance on this issue is expected in June after a second reading of the bill in Parliament.
- AD highlighted a potential risk of individuals finding opportunities elsewhere which could leave the CCG's vulnerable to instability. AD suggested it would be helpful to have a system approach to this issue. AD emphasised that this risk is being tracked through the CCG Governing Bodies.
- JG highlighted the uncertainty for GP practices and PCN's around the GP COVID Capacity Extension Fund and prioritisation of those PCN's continuing the vaccination programme. JG

questioned who will make the decision around prioritisation of the additional funds ringfenced for GPs.

- CW confirmed that further clarity hasn't been provided on this issue.
- JB expressed her understanding that PCN's will have the opportunity to change their decision regarding the vaccination programme following the release of this new information. The money would be allocated to CCG's with decisions made locally.
- AD questioned whether a set of agreed principles for prioritisation could be developed and shared with the Primary Care Cell to ensure a standardised approach.
- CW emphasised that a consistent approach is required across the North West and suggested this issue is discussed further at the regional meeting further.
- KO informed the group that Mark Palethorpe has done a short article on why ICS's on a good idea for the Local Government Chronicle that will be published shortly.
- KO informed the group that the Cheshire and Mersey Local Authority Chief Executives have agreed to meet monthly primarily with a health and social care focus. This will include a representative from the DASS's group and one of the individuals in a joint appointment. JB and Sarah O'Brien have also been invited to this meeting.
- KO thanked JB for the invitation to join the Task and Finish sessions.

4.	Update on NW ICS Development Workforce Steering Group

- CW emphasised that limited information can be shared currently. This process relates to NHS staff specifically. Detailed further guidance is anticipated following the second reading of the bill in Parliament in June. CW highlighted that the HR principles are expected to be released in April.
- AD highlighted the need to comply with notice periods of up to 6 months.
- CW confirmed that notice periods have not been discussed yet. CW highlighted the need for further clarity on the meaning of 'below board level'.
- JB and Sarah O'Brien are meeting with Local Authority Chief Executives to keep them informed throughout this process. JB emphasised the importance of integrating at Place whilst following NHS HR processes.
- KO offered to support this engagement process between the ICS and Local Authority. KO discussed the integrated model adopted in St. Helens and emphasised the importance of adapting the approach taken to each Place.
- JB emphasised this is a journey towards integration at a system level and encouraged the sharing of ideas amongst PCG members.

5.	AOB

- JB informed the group that LD and SW have drafted a revised Terms of Reference for the PCG. They are meeting to discuss this in further detail next week.
- JB highlighted that the OOH Cell needs to transition to become the arrangements of the ICS. The current activities and production of formal reports for the region will continue. JB highlighted the Mental Health sub-cell as an example of how existing OOH Cell groups can transition to become a Mental Health Board/Alliance.
- JB emphasised the importance of the PCG not duplicating the work of the OOH Cell.
- JB highlighted that the Executive Meeting will develop into the NHS Body as described in the white paper. Further guidance is required.
- JB informed the group that an update around the PCG's purpose and membership and the OOH Cell will be brought to the next meeting (15/04/2021).

Summary of actions
No additional actions.

Cheshire and Merseyside
Health and Care Partnership

Today
06/04/2021

Cheshire & Merseyside Partnership Co-ordination Group – ACTION Log

Ref	Description of Issue/risk to be escalated	Raised by	Date raised	Date escalated	Escalated to	Response date	Response received/action taken	Status	Date Closed
037	SBr to determine how the learning from Warrington (as an early adopter of 111 First) can be shared across C&M.				Steven Broomhead	07/01/2021	0	Open	
020									
068	CH to link with region to support regional communications regarding potential workforce within CCGs.				Christine Hughes	01/04/2021	0	Closed	01/04/2021
021									
072	SO to distribute the commissioning slides presented by Mark Green to CCG AO's.				Sarah O'Brien	01/04/2021	0	Closed	01/04/2021
18/03/2021									

Cheshire & Merseyside Partnership Co-ordination Group – ESCALATION Log									

C&M Partnership Co-ordination Group
Thursday 15th April 2021

Attendance

Name	Title
Sarah O'Brien (SO) - Chair	Executive Director of Strategy & System Development, Cheshire and Merseyside Partnership
Clare Watson (CW)	Accountable Officer, NHS Cheshire CCG
Simon Banks (SB)	Accountable Officer, NHS Wirral CCG
Mark Palethorpe (MP)	Accountable Officer, NHS St. Helens CCG
Fiona Taylor (FT)	Accountable Officer, NHS South Sefton CCG and NHS Southport & Formby CCG
Michelle Creed (MC)	Chief Nurse, NHS Warrington CCG and NHS Halton CCG
Phillip Thomas (PT)	Assistant Chief Executive, NHS Knowsley CCG
Mark Bakewell (MB)	Chief Finance Officer, NHS Liverpool CCG
Deborah Butcher (DB)	Executive Director for Adult Health and Social Care, Sefton Council
Kath O'Dwyer (KO)	Chief Executive, St. Helen's Council
Christine Hughes (CH)	Executive Director of Communications and Engagement, Cheshire and Merseyside Partnership
Maxine Power (MP)	Director of Quality, Innovation and Improvement, North West Ambulance Service
Lucy Davies (LD)	Deputy Director, NHS Transformation Unit
Sophie Whitham (SW)	Associate Consultant, NHS Transformation Unit

Apologies

Name	Title
Jackie Bene	Chief Officer, Cheshire and Merseyside Partnership
Andrew Davies	Accountable Officer, NHS Warrington CCG and NHS Halton CCG
Joe Rafferty	Chief Executive, Mersey Care NHS FT
Steven Broomhead	Chief Executive, Warrington Borough Council
Dianne Johnson	Accountable Officer, NHS Knowsley CCG
Jan Ledward	Accountable Officer, NHS Liverpool CCG

Minutes

1.	Welcome and introductions

The chair, Sarah O'Brien, opened the meeting.

No changes required to the minutes of the previous meeting.

2.	Minutes & action log

Action 037: *SBr to determine how the learning from Warrington (as an early adopter of 111 First) can be shared across C&M.*

Learning to be shared at a future meeting. Action ongoing.

3.	Current issues

- No current issues were raised.

4.	**Transition to ICS Development Advisory Group**

- SO highlighted the ongoing discussion around the future of the Partnership Co-ordination Group (PCG). SO discussed the initial formation of the group in the context of the COVID-19 pandemic to provide connectivity and help address system-wide issues.
- SO discussed the proposal for the PCG to become the ICS Development Advisory Group. SO highlighted the need for this group and connectivity given the pace of change and timescales involved in working towards the ICS becoming a statutory body by April 2022. It would be an important method of engaging many parts of the system. The updated TOR proposes the new membership includes representation from every Place, the main NHS providers, the DASS group and continued representation from the Local Authorities, Voluntary Sector and Ambulance services. SO welcomed feedback on the proposed TOR from members.
- SO noted that there should be representation from the following providers: acute, community, mental health and specialist trust.
- PT highlighted the goal of the ICS to address health inequalities and questioned whether a Healthwatch representative would be a valuable addition to the group. PT suggested representatives from other sectors such as housing and quality could also add value.
- SO commented that group members are responsible for feeding back key discussion points from this meeting to the wider system. SO emphasised the importance of undertaking meaningful engagement with patients / residents at a place level.
- SB cautioned against the membership becoming too expansive. SB questioned whether there should also be a DCS representative in the group. SB emphasised the importance of distinguishing what should be discussed in this group opposed to elsewhere.
- KO offered to act as a conduit between the Housing Group which is supported by the Partnership and the ICS Development Advisory Group. KO agreed it would be valuable to have one Healthwatch representative. KO emphasised that there needs to be meaningful dialogue and co-production in every Place.
- KO emphasised that there needs to be a greater focus on the children's agenda. KO agreed to ask the DCS group whether they would like to be involved in this group.

Action 073: *KO to speak with DCS's and confirm whether a representative from this group is needed on the ICS Development Advisory Group.*

- KO supported the proposed key functions of the group.
- MP emphasised the importance of including the children's perspective in discussions and highlighted the ICS programme board which is currently being established. MP questioned whether there could be a targeted list of topics for the group to address to ensure efficiency and continually add value.
- CW highlighted the importance of ensuring appropriate membership and engagement which aligns with the existing groups and structures. CW supported the proposed key functions of the group.
- CH emphasised the importance of capturing the public voice through Healthwatch representation. CH discussed the HCP's communication plan which has been developed to actively engage with people on key issues relating to ICS development.
- DB supported the comments made by KO. DB offered to discuss who the representative from the DASS group could be with colleagues.
- MB suggested a workplan could be included in the TOR with key timelines for the advisory group.
- KO emphasised that detailed discussions should take place elsewhere and this group should provide an overseeing, advisory role.
- SO summarised that there was general agreement for the functions proposed in the TOR. The group reached a consensus that there should be a Healthwatch representative. SO confirmed that KO will pick up the issue of DCS representation with the DCS's. SO acknowledged the importance of connecting the advisory group with the Children's programme board.
- CW emphasised the importance of having an all age focus with regards to population health.
- SO highlighted the advisory group will focus on emerging ICS governance and architecture rather than pathways. SO discussed the Place lead role and proposed representation on the advisory group. SO confirmed there were no objections to inviting Place leads where the AO wasn't the Place lead e.g. from Cheshire West and Chester, Cheshire East, Halton and Sefton.
- KO highlighted that this reinforces the primacy of Place in developing the ICS.
- SO discussed the ICS Development Plan that has been submitted to NHSE/I. The System Development Tool produced by NHSE/I provides 6 clearly defined areas for the development of ICS's and is intended to be a self-assessment. The ICS Development Advisory Group could focus on these 6 themes and develop and discuss what should be included for each. The ICS Executive Team will oversee the Implementation Plan which has a greater level of detail. The advisory group will focus on the strategic discussions required.
- SO commented that Christine Samosa has identified the need to establish a small workforce task and finish group. The advisory group could receive updates if required.
- KO suggested the advisory board should review key project documents once and approve these. The group should then receive progress updates and exception reports following this initial review.
- SB supported the need to review key documents. SB highlighted the opportunity for development discussions around the role of Place lead. SB highlighted the importance of including an NHSE/I perspective in this group.
- MC suggested that having a succinct group doesn't allow for debate and discussion. MC highlighted the importance of this group in helping to develop the system architecture.
- SO confirmed the frequency of the meeting will remain the same. If there are limited agenda items, the meeting will be stood down as and when appropriate.
- DB highlighted the importance of connecting these discussions to the ongoing developments in Place around ICP's and identifying any interdependencies.

Action 074: *Bring revised TOR for ratification to the next Partnership Co-ordination Group meeting.*

5.	Update on NW ICS Development Workforce Steering Group

- CW provided the following updates from the NW ICS Development Workforce Steering Group:
  - There were helpful presentations with regards to the ICS people model and HR agenda.

- There were discussions around the posts in each ICS and which professional roles would be required. National guidance is anticipated on this issue.
- There is ongoing discussion around whether a new people function will be established within the ICS or whether existing expertise and capacity can be used.
- They are still waiting for HR principles and HR/OD framework.
- They have been asked to establish a separate reference group by the region and to start logging a formal risk register. This could be shared with the advisory group as part of the ongoing workforce update.

- SO highlighted that the region are also keeping a risk log. SO highlighted the complexity of determining where the people function should sit. This will be part of the scoping work required.
- CW confirmed that further HR information is required in June.
- FT emphasised the importance of having a transparent process for expressions of interest.
- SO highlighted the intention to write out to all CCG's and NHS regional staff, where appropriate, when there is an urgent workforce gap within the ICS that could be filled through a secondment.
- SB discussed the potential consequences of taking on HR within each system. SB questioned whether the HCP had received all the relevant workforce information that was requested.
- SO will confirm with Christine Samsoa what information is still outstanding.

Action 075: *SO to confirm with Christine Samosa what workforce information is still required from the Places.*

6.	AOB

- No other business raised.

Summary of actions

Action 073: *KO to speak with DCS's and confirm whether a representative from this group is needed on the ICS Development Advisory Group.*

Action 074: *Bring revised TOR for ratification to the next Partnership Co-ordination Group meeting.*

Action 075: *SO to confirm with Christine Samosa what workforce information is still required from the Places.*

Cheshire and Merseyside
Health and Care Partnership

Today
19/04/2021

Cheshire & Merseyside Partnership Co-ordination Group – ACTION Log

Meeting	Ref	Action Agreed	Owner(s)	Due date	Days to complete	Status	Date Closed	Comments
20 13/08/2020	037	SBr to determine how the learning from Warrington (as an early adopter of 111 First) can be shared across C&M.	Steven Broomhead	07/01/2021	0	Open		
36 15/04/2021	073	KO to speak with DCS's and confirm whether a representative from this group is needed on the ICS Development Advisory Group.	Kath O'Dwyer	29/04/2021	10	Open		
	074	Bring revised TOR for ratification to the next Partnership Co-ordination Group meeting.	Sarah O'Brien	29/04/2021	10	Open		
	075	SO to confirm with Christine Samosa what workforce information is still required from the Places.	Sarah O'Brien	29/04/2021	10	Open		

Cheshire and Merseyside
Health and Care Partnership

Cheshire & Merseyside Partnership Co-ordination Group – ESCALATION Log

Ref	Description of Issue/risk to be escalated	Raised by	Date raised	Date escalated	Escalated to	Response date	Response received/action taken	Status	Date Closed

Cheshire and Merseyside
Health and Care Partnership

Transformation Programmes Governance

Cheshire and Merseyside Health and Care Partnership

April 2020

Title	**C&M Health and Care Partnership Transformation Programmes Governance**
Author(s)	Lucy Davies
Version	V0.3
Target Audience	C&M Health and Care Partnership Board
Date of Issue	20/04/2021
Document Status (Draft/Final)	Final
Description	Provides an overview of the proposed governance for the Health and Care Partnership Transformation programmes

Document History:

Date	Version	Author	Notes
14/04/2021	0.1	Lucy Davies	Initial draft for review
20/04/2021	0.2	Lucy Davies	Inclusion of Natalia Armes feedback
20/04/2021	0.3	Lucy Davies	Inclusion of Sarah O'Brien feedback
Reviewed by:			Sarah O'Brien

Distribution

Version	Group or Individual	Date	Comments
0.1 (DRAFT)	Natalia Armes, PDO Director	14/04/2021	Initial draft for review and comment
0.2	Sarah O'Brien, Exec Director of Strategy & System Development	20/04/2021	Final draft for review and approval
0.3	C&M HCP Board	20/04/2021	Final

Contents

1. Introduction

The purpose of this document is to provide an overview of the proposed governance framework and approach for the 2021/22 transformation programmes to be sponsored or funded by the Cheshire and Merseyside Health and Care Partnership (C&M HCP).

A transformation programme review was undertaken by HCP Execs in March 2021 to ensure programmes met the below agreed criteria:

- Improving population health and healthcare including safety and quality improvement
- Tackling unequal outcomes and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

These programmes are not in place to disempower or duplicate local decision making, instead to focus on where progress can be made from taking a collective approach; to supplement the transformation taking place in the nine C&M local Places.

There are also several other regional-based Cheshire and Merseyside programmes which are sponsored or aligned with NHS England and Improvement (North West) with which these interact.

This document outlines how these programmes will be governed during 2021/22.

2. Proposed governance framework and approach

The proposed governance framework and approach utilises evidence-based methodology and builds on previous work across the HCP. The aim of the approach is to ensure robust assurance, clear reporting lines and provide visibility on transformation programme progress and risk escalation.

All transformation programmes will be accountable to the C&M HCP Transformation Programme Board which is described in more detail in section 3.

Figure 1 displays the programme lifecycle that all C&M transformation programmes will follow, setting clear expectations about the process. The programme lifecycle also lends itself to a gateway review process whereby all programmes will present progress at set points, seeking approval to continue from the Transformation Programme Board.

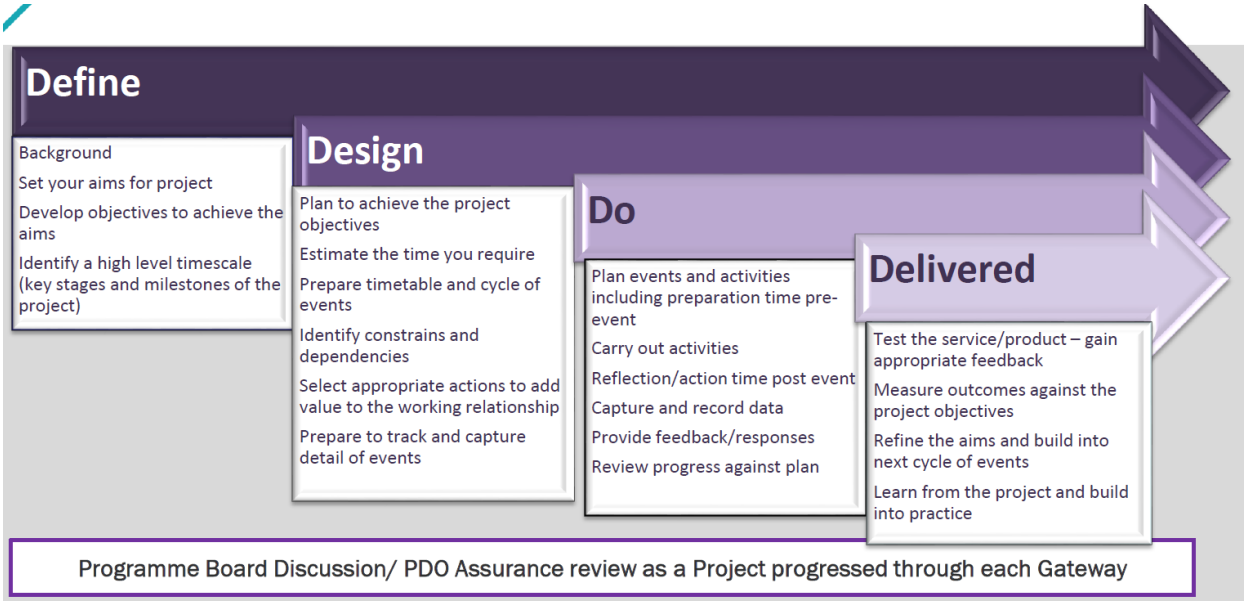


Figure 1: Programme lifecycle & gateways

In order to provide a robust but proportionate assurance approach, a suite of programme delivery documents have been produced. These will ensure all programmes follow a standard methodology and provide the required visibility to aid assurance and governance processes. Some of the key documents are highlighted below:

- Programme roles and expectations (detailed in Appendix A)
    - Senior Responsible Officer (SRO
    - HCP Senior Sponsors
    - Programme Director
    - Programme / Project Managers
    - Clinical Lead
- Monthly highlight reports to the Transformation Programme Board
- Bi-monthly summary highlight reports to the C&M HCP Board
- Assurance status reports

It is noted that HCP Senior Sponsors have already been assigned to the transformation programmes, details of which can be found in Appendix B.

For 2021/22 it is proposed that assurance processes are light touch and strike the balance between level and depth of reporting required, based on scale, risk, and complexity. The reporting processes will be led by each individual programme and rely on self-reporting, with oversight by the Transformation Programme Board (see section 3), HCP Senior Sponsor and the HCP Programme Delivery Office (PDO) as required. This framework will provide adequate visibility and opportunity for further action relating to programme delivery to be taken as required. It is recommended that this approach is reviewed to ensure if remains fit for purpose as the ICS continues to mature.

Further detail on the framework and approach is available upon request via Natalia Armes, PDO Director.

3. Transformation Programme Board

It is proposed that a Transformation Programme Board is created to operate as a strategic group. The Transformation Programme Board will be chaired by the C&M HCP Chief Officer and report into the HCP Board. Figure 2 depicts the governance and reporting structure.

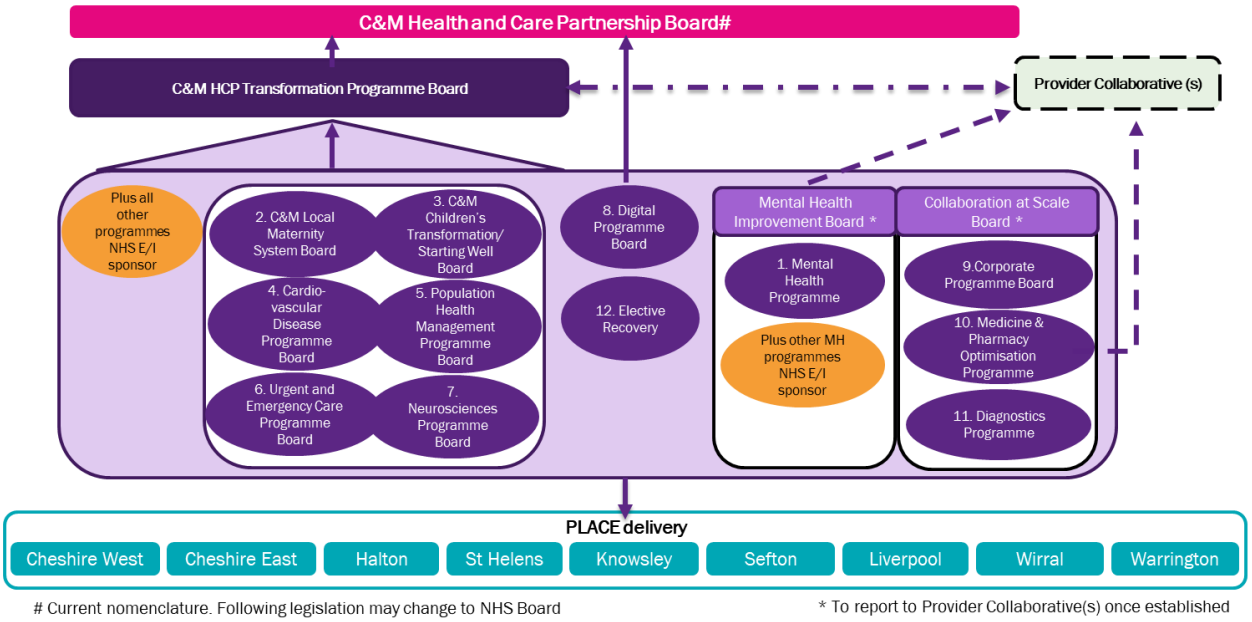


Figure 2: C&M Transformation Programme Board governance

The group will oversee all significant transformation programmes across Cheshire and Merseyside, including national programmes of transformation. It will direct and support an overarching programme to ensure that all interdependences are highlighted, approved projects are aligned with the HCP's vision and strategy and deliver the specified benefits such as achieving value for money and whilst sustaining quality and safety. In addition, it will ensure that all programmes are assessed to the agreed methodology and make recommendations as appropriate to the HCP Board.

The Programme Board will report bi-monthly to the HCP Board and is accountable to the HCP Board for discharging the responsibilities set out in the draft Terms of Reference – these can be found in Appendix C.

It is recommended that the first Programme Board is held in June to allow the programmes to fully mobilise before producing the first reports.

4. Alignment to NHSE programmes

It is clear that there are key transformation programmes across Cheshire and Merseyside programmes which are sponsored by or aligned to NHS England and Improvement (North West and National) programmes. Whilst some of these are standalone, others are very well connected or interlinked with transformation programmes or structures within ICS (e.g. mental health, maternity, children's, ageing well). As the HCP continues to mature as an ICS,

it is important to consider opportunities to align and harmonise arrangements where appropriate to ensure connectivity, efficiency and reduce duplication of effort. Figure 3 provides a high-level overview of these programmes.

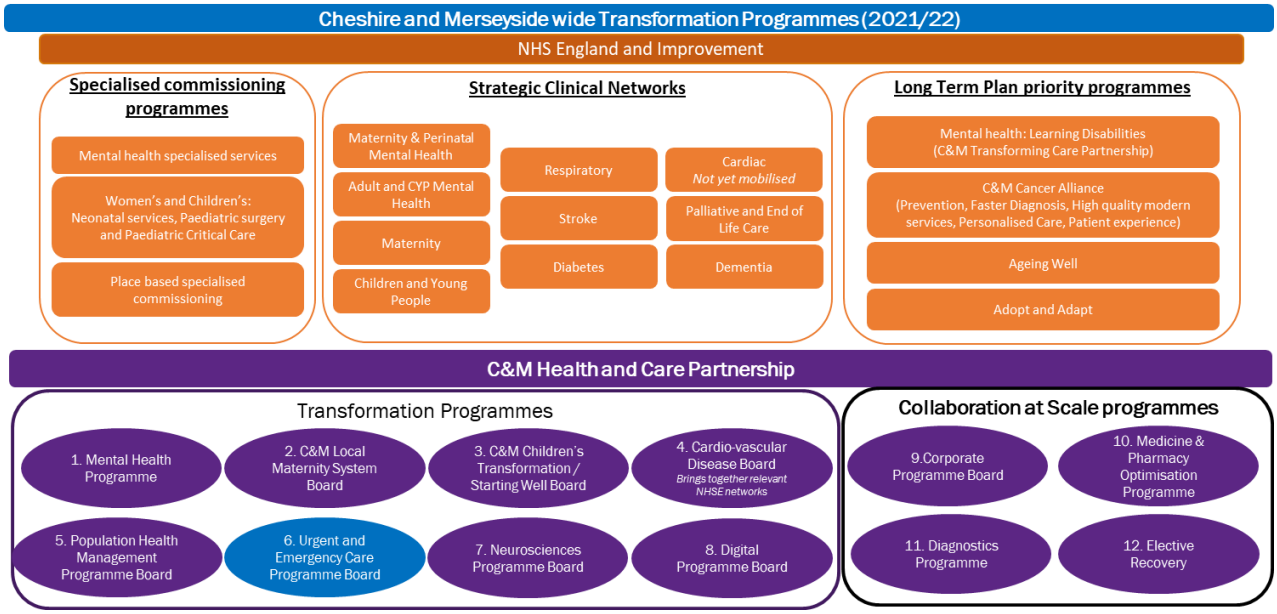


Figure 3: C&M-wide transformation programmes 2021/22

Please note that the Urgent and Emergency Care Programme Board is under review, awaiting NHSE/I feedback. It is anticipated the Programme Board will change its purpose and format to evolve into an overarching forum for A&E Delivery Boards.

Discussions with NHSE/I to date have indicated that the regional networks should be seen as a Cheshire & Merseyside resource to support transformation. NHSE/I are supportive of alignment around governance and would like to explore the opportunity to identify a C&M HCP Sponsor for each of their programmes in due course. This will require continued discussion and development as the ICS matures.

5. Recommendations

For the 2021/22 C&M HCP transformation programmes, the Board are asked to endorse and approve:

- The proposed governance framework and approach
- The draft terms of reference for the Transformation Programme Board and recommended start date of June for the first meeting

The Board are asked to note:

- the progress with work with NHSE/I programme alignment and the acknowledgement that this remains ongoing
- the need to review the assurance approach as the ICS matures

Appendices

Appendix A: Programme roles and expectations

Senior Responsible Officer (SRO)

The SRO is accountable for:

- Agreeing & setting priorities for the programme with the ICS Senior Sponsor
- Accountable for providing strategic direction and decision making for the programme
- Advocating, in the wider system & Partnership for the programme of work
- Agreeing and setting the programme performance management framework with the ICS Senior Sponsor and Programme Director, to include anticipated outcomes, impact, and KPI's/milestones to track programme delivery.
- Ensuring the programme achieves its overall objectives and delivers anticipated benefits
- Monitoring the progress of the programme
- Monitoring the key strategic risks facing the programme
- Reporting to HCP Programme Board & escalating issues as necessary and in a timely manner to the HCP Programme Board
- Ensuring Place is represented on the Programme and that work is disseminated and relevant to Place
- Maintaining the interface with key senior stakeholders, keeping them engaged and informed
- Ensuring coproduction and insight forms part of the programme
- Typically Chairs the Programme Board / other relevant meetings
- Accountable for the financial management of the programme

ICS Senior Sponsor

The ICS Senior sponsor is responsible for:

- Setting programme objectives & priorities with the SRO and offering appropriate support to the SRO as required
- Attending Programme Board meetings as required
- Maintaining ICS oversight of the programme and delivery against objectives
- Identification of linkages and interdependencies to wider programmes
- Agreeing and setting the programme performance management framework with the SRO and Programme Director, to include anticipated outcomes, impact and KPI's/milestones to track programme delivery.
- Attending HCP Programme Board
- Escalating issues to HCP Programme Board &/or Chief Officer as necessary and in a timely manner

Programme Director

The Programme Director is responsible for:

- Establishing programme governance arrangements and ensuring appropriate assurance is in place
- Accountable for the overall delivery of the project & day to day activity.

- Agreeing and setting the programme performance management framework with the SRO and ICS Senior Sponsor, to include anticipated outcomes, impact, and KPI's/milestones to track programme delivery.
- Tracks and drives performance against the key objectives and milestones of the project/programme.
- "Go to" person in the programme, facilitating access to staff and information. Participates in helping understand the programme of work and its current direction as well as participating in programme design.
- Ensure the programme is connected to other relevant ICS programmes, appropriate clinical networks, the 9 Places and any relevant NHSE sponsored programmes of work.
- Oversee, direct and manage the work of any project / programme support staff working on the programme
- Escalate as necessary any issues to the SRO
- Work across the ICS with system partners to develop and deliver programme objectives. Need to build and maintain effective, collaborative working with key stakeholders and where relevant regional and national colleagues
- Accountable for the operational management of the Programme.

Programme / Project Manager

Programme / project manager is responsible for:

- Supporting delivery of programme objectives by participating in: in service design, conduct detailed service analysis, set up meetings / workshops, identify subject matter experts, logistics, etc.
- Management of risks, issues and escalations as appropriate to Programme Director.
- Escalate issues to Programme Director
- Manage stakeholder engagement
- Act as a Project Manager to facilitate the change and maintain PMO paperwork, prepare reports etc
- As required undertake work to develop business case/service redesign.

Clinical Lead

Clinical lead is responsible for:

- Provides clinical advice, guidance and input to the project.
- Play an active role in any service redesign activity.
- Engages with other clinicians / professional groups and relevant networks to be able to bring a collective clinical view to the programme of work

Appendix B: HCP Senior Sponsors

Programme	HCP Senior Sponsor
1. Mental Health	Sarah O'Brien
2. C&M Local Maternity System Board	Christine Samosa
3. C&M Children's Transformation / Starting Well Board	Sarah O'Brien
4. Cardio-vascular Disease Programme Board	Christine Hughes
5. Population Health Management Board	Sarah O'Brien
6. Urgent & Emergency Care Programme Board*	TBC
7. Neurosciences Programme Board	Christine Hughes
8. Digital Programme Board	Sarah O'Brien
9. Corporate Programme Board	Keith Griffiths
10. Medicine & Pharmacy Optimisation Programme	Keith Griffiths
11. Diagnostics Programme	Christine Samosa

** Purpose and format of the Urgent & Emergency Care Programme Board is currently under review, awaiting NHSE/I discussion.*

Transformation Programme Board

DRAFT Terms of Reference

April 2021

Title	**Cheshire & Merseyside Health and Care Partnership Transformation Programme Board**
Author(s)	Lucy Davies
Version	V0.3
Target Audience	C&M HCP Board
Date of Issue	09/04/2021
Document Status (Draft/Final)	DRAFT
Description	This document describes the Terms of Reference for the Cheshire and Merseyside Health & Care Partnership Transformation Programme Board.

Document History:

Date	Version	Author	Notes
31/03/2021	0.1	Lucy Davies	First draft
01/04/2021	0.2	Lucy Davies	Inclusion of Natalia Armes amends
09/04/2021	0.3	Lucy Davies	Inclusion of Sarah O'Brien amends
Reviewed by:			Sarah O'Brien

Distribution

Version	Group or Individual	Date	Comments
0.1	Natalia Armes, PDO Director	31/03/2021	For first review
0.2	Sarah O'Brien, Executive Director of Strategy & Partnerships	09/04/2021	For review and comment
0.3	C&M HCP Board		For approval

Terms of Reference for the Cheshire and Merseyside Health and Care Partnership Transformation Programme Board

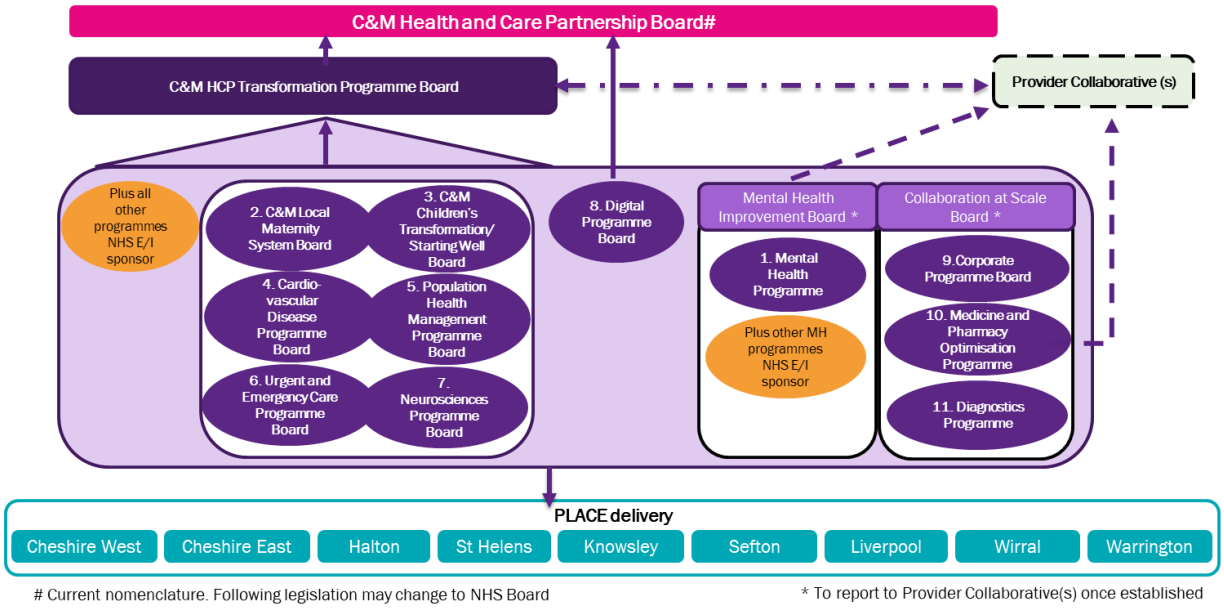
1. Purpose

The Programme Board operates as a strategic group and is chaired by the Cheshire and Merseyside Health and Care Partnership (C&M HCP) Chief Officer and reports into the HCP Board.

The group will oversee all significant transformation programmes across Cheshire and Merseyside, including national programmes of transformation. It will direct and support an overarching programme to ensure that all interdependences are highlighted, approved projects are aligned with the HCP's vision and strategy and deliver the specified benefits such as achieving value for money and whilst sustaining quality and safety. In addition, it will ensure that all programmes are assessed to the agreed methodology and make recommendations as appropriate to the HCP Board.

2. Governance

The revised structure for C&M HCP governance is shown below. The Transformation Programme Board will report directly to the HCP Board on a bi-monthly basis. The Provider Collaboratives are newly emerging and these groups will need to work together to ensure that discussions, assumptions and recommendations to the board are aligned



Current nomenclature. Following legislation may change to NHS Board

* To report to Provider Collaborative(s) once established

3. Accountability & Authority

The Programme Board reports bi-monthly to the HCP Board and is accountable to the HCP Board for discharging the responsibilities set out above. The Programme Board has the authority to challenge, approve, direct or stop projects.

4. Duties

The overarching duties of the Programme Board can be stated as follows:

- monitor the development, implementation and delivery of the HCP's transformation programmes
- provide assurance to the HCP Board that the programme plans are on track, to ensure achievement of pre-determined programme and project milestones
- ensuring alignment and eradication or foresee duplication across programmes
- ensure that all programmes are compliant with the 'Programme Assurance' framework.
- assure that the 'Programme Assurance' framework holds each work stream project responsible for developing a benefit realisation plan as well as identifying and mitigating potential risks to quality and service.
- monitor sustainability of programmes, and review regularly in order to ensure the programme is going to plan.
- review and escalate strategic programme risks as appropriate to the HCP Board
- ensure all plans and actions are aligned with the strategic direction of the Trust
- work holistically with the whole system, and in particular local authority where close working will be required to realise proposed changes

In practical terms, during its meetings, the Programme Board will:

- Receive and act upon, with timely decision making, the findings and recommendations within the assurance dashboard/highlight reporting summary provided by the PDO
- Provide projects with support and challenge – ensuring all agreed approaches are adhered to and that projects / programmes are well managed and align to the Trust Priorities
- Provide a holistic, outcome focussed approach identifying cross functional dependencies and opportunities.
- Ensure the achievability and the deliverability of projects by identifying any risks and mitigating actions at the earliest opportunity
- Evaluate and make recommendations to progress any new projects
- Be able to fundamentally challenge projects and recommend that they be paused, stopped or accelerated based on business cases / strategic fit
- Review specific projects and programmes and make recommendations to HCP Board as appropriate
- Provide governance for all projects and associated decisions made have taken account of 'due process' and efficient use of resources and assets
- Capture and share learning and knowledge, including tools developed to support the development of new delivery models.
- Act as an escalation point for the programmes to raise concerns about specific projects (e.g. Ability to resource)

5. Equality and Diversity

The Programme Board will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties

6. Membership

The Cheshire and Merseyside ICS Development Group will be chaired by Jackie Bene, Chief Officer, Cheshire and Merseyside Health and Care Partnership.

The following table contains the Transformation Programme Board membership.

Programme Board Role	Name	Title
Chair	Jackie Bene	Chief Officer, C&M HCP
HCP Executive representative - strategy	Sarah O'Brien	Executive Director of Strategy & System Development, C&M HCP
HCP Executive representative - finance	Keith Griffiths	Director of Finance, C&M HCP
Programme Delivery Office	Natalia Armes	Programme Delivery Office Director, C&M HCP
XXX SRO		
XXX SRO		
XXX SRO		
XXX SRO		
XXX SRO		
XXX SRO		
XXX SRO		
NHSE/I Programmes representative		
Provider Collaborative Board representative		
Programme Board Support	Michael Lester	Project Support C&M PDO

Other colleagues across C&M may be invited to attend on an ad hoc basis to present papers or to advise the Programme Board.

7. Quoracy and frequency

A quorum will be XXX members / XX% and must include the Chair or nominated Deputy Chair. The Programme Board will meet on a monthly basis.

If a Programme Board member is not available a formal nominated deputy for that individual should attend the meeting instead. Every effort will be made to ensure the presence of the appropriate representation at a meeting, but should this prove operationally difficult, alternative means of securing all members' opinions will be undertaken, particularly prior to a recommendation being made.

8. Reporting

Formal highlight assurance reporting and escalation will be through the Cheshire and Merseyside HCP Partnership Board.

The Group will feedback to the Cheshire and Merseyside health and care system through co-ordinated strategic communications.

9. Administration

The Chair of the Board will be responsible for agreeing the agenda, which will be circulated together with supporting papers at least 3 working days (or two plus a weekend) prior to the Programme Board, unless there are exceptional circumstances authorised by the Chair.

A log of agreed actions and decisions will be taken from each meeting and shared within 2 working days of the meeting.

The ICS Development Group will be administered by the C&M PDO. The point of contact is Michael Lester via c&m.pdo@miaa.nhs.uk .

10. Review

The Terms of Reference will be reviewed in October 2021 and April 2022 to ensure that the arrangements remain appropriate and reflect the ICS statutory infrastructure.

ICS Development Advisory Group

Proposed Terms of Reference

Report To:	**Cheshire & Merseyside Health & Care Partnership Board**
Date of Report:	20/04/2021
Report Author(s):	Sarah O'Brien
Purpose:	**This report details the proposed terms of reference for the ICS Development Advisory Group. This group will evolve from the C&M Partnership Co-ordination Group which was established during the pandemic response in 2020.** **The purpose of the Cheshire and Merseyside ICS Development Advisory Group is to provide advice about the activities required for the Cheshire and Merseyside Health and Care Partnership to become a statutory ICS by April 2022 and the development of the ICS implementation plan.**
Recommendation(s):	The Board is asked to approve the proposed terms of reference and creation of the ICS Development Advisory Group

Cheshire and Merseyside
Health and Care Partnership

Cheshire & Merseyside ICS Development Advisory Group

DRAFT Terms of Reference

Title	**Cheshire & Merseyside ICS Development Advisory Group**
Author(s)	Lucy Davies, Sophie Whitham
Version	V0.3
Target Audience	C&M Partnership Co-ordination Group
Date of Issue	16.04.2021
Document Status (Draft/Final)	DRAFT
Description	This document describes the Terms of Reference for the Cheshire and Merseyside ICS Development Advisory Group.

Document History:			
Date	**Version**	**Author**	**Notes**
19/03/2021	0.1	Lucy Davies, Sophie Whitham	First draft
09/04/2021	0.2	Lucy Davies	Amends to include feedback from Jackie Bene and Sarah O'Brien
16/04/2021	0.3	Lucy Davies, Sophie Whitham	Amends to include feedback from Partnership Co-ordination Group
19/04/2021	0.4	Lucy Davies	Amends to include feedback from Jackie Bene and Sarah O'Brien
Reviewed by:			Jackie Bene and Sarah O'Brien

Distribution			
Version	**Group or Individual**	**Date**	**Comments**
0.1	Jackie Bene Sarah O'Brien	25/03/2021	First draft of TOR shared to gain feedback.
0.2	Partnership Co-ordination Group	09/04/2021	Draft ToR shared with PCG to gain feedback.
0.3	Jackie Bene Sarah O'Brien	16/04/2021	Next iteration for review
0.4	Partnership Co-ordination Group	22/04/2021	Final draft for ratification

Terms of Reference for the Cheshire and Merseyside ICS Development Advisory Group

1. Purpose

The purpose of the Cheshire and Merseyside **ICS Development Advisory Group** is to provide advice about the activities required for the Cheshire and Merseyside Health and Care Partnership to become a statutory ICS by April 2022 and the development of the ICS implementation plan.

The statutory ICS in Cheshire and Merseyside will be made up of an **ICS NHS Body** and a separate **ICS Health & Care Partnership** (NHS, local government, and partners). In summary, the ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs.

The ICS Development Advisory Group will be time-limited to provide advice to the establishment of these two entities and the development of the ICS implementation plan.

2. Background

The Integration and Innovation White Paper (February 2021) outlines the legislative proposals for health and care reform to be implemented in 2022. It is anticipated that the C&M Health and Care Partnership Board will remain and there will be an additional statutory ICS NHS Body.

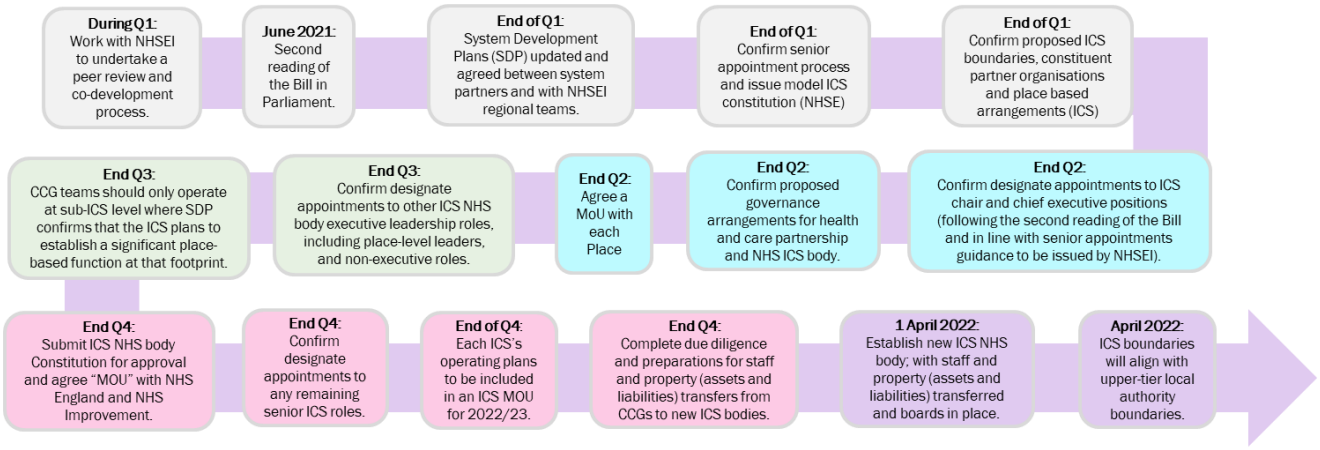
A statutory ICS NHS Body which will:

- be responsible for the **day to day running** of the ICS, and NHS planning and allocation decisions.
- take on the **commissioning functions** of the CCGs and some of those of NHS England within its boundaries, as well as CCG's responsibilities in relation to Oversight and Scrutiny Committees.
- have a **unitary board**, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body.
    - the board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and Mental Health Trusts, and non-executives.
    - NHSE will publish further guidance on how Boards should be constituted, including how chairs and representatives should be appointed.
- be responsible for:
    - developing a plan to address the health needs of the system;
    - setting out the strategic direction for the system; and
    - explaining the plans for both capital and revenue spending for the NHS bodies in the system

A statutory ICS Health and Care Partnership which will:

- be made up of a **wider group of organisations** than the ICS NHS Body
- **promote partnership** arrangements, and developing a **plan to address the health, social care and public health needs** of their system. Each ICS NHS Body and local authority would have to have regard to this plan.
- be used by NHS and Local Authority Partners as a **forum for agreeing co-ordinated action and alignment of funding** on key issues, and this may be particularly useful in the early stages of ICS formation

ICS Development Timeline



Source: NHS England and NHS Improvement. *2021/22 priorities and operational planning guidance: Implementation guidance.* Available from: Report template - NHSI website (england.nhs.uk)

The above diagram illustrates the key milestones for the implementation of ICS statutory arrangements as outlined by NHS England and NHS Improvement in the *2021/22 Priorities and Operational Planning guidance* paper. The ICS Development Advisory Group will support the ICS along this journey through the functions identified below as and when appropriate.

3. Key functions of the ICS Development Advisory Group

- Provide connectivity and help to foster collaboration between NHS organisations (both ICSs and providers), local authorities and other partners.
- Act as an **advisory** group in the development of effective ICS decision-making processes and governance structures.
- Act as an **advisory** group to determine how the ICS allocation functions can be aligned with Place.
- Provide advice and support to the completion of the ICS System Development Tool where necessary.
- Provide a co-ordinated escalation route for system wide issues.
- Support ad-hoc activities as required to meet April 2022 deadline.

4. Membership

The Cheshire and Merseyside ICS Development Advisory Group will be chaired by Jackie Bene, Chief Officer, Cheshire and Merseyside Health and Care Partnership.

Membership of the group is to include:

- ICS representation
- Provider representation
- CCG representation
- Local Authority representation from Cheshire, and from Merseyside
- NHSE/I representation
- Voluntary sector representation
- Healthwatch representation

The following table contains the proposed membership of the Partnership Co-ordination Group. Further revision may be required.

Role	Name	Title
Chair		Chief Officer, C&M HCP
ICS representative / Deputy Chair		Executive Director of Strategy & Partnerships, C&M HCP
Provider representative - acute		TBC
Provider representative – mental health		TBC
Provider representative – specialist trust		TBC
Provider representative – community		Community Provider Representative
Provider representative		Director of Quality, Innovation and Improvement, North West Ambulance Service
CCG representative		Accountable Officer, NHS Cheshire CCG
CCG representative		Accountable Officer, NHS Liverpool CCG
CCG representative		Accountable Officer, NHS St. Helens CCG
CCG representative		Accountable Officer, NHS Wirral CCG
CCG representative		Accountable Officer, Halton and Warrington CCGs
CCG representative		Accountable Officer, South Sefton and Southport and Formby CCGs
CCG representative		Accountable Officer, Knowsley CCG
Place lead – Cheshire West		Deputy Chief Executive – Health and Wellbeing, Cheshire West and Chester Council
Place lead - Cheshire East		Chief Executive, Cheshire East Council
Place lead - Halton		Chief Executive, Halton Borough Council
Place lead – Sefton		Executive Director for Adult Health and Social Care, Sefton Council
Local Authority representative for Cheshire		Chief Executive, Warrington Borough Council
Local Authority representative for Merseyside		Chief Executive, St. Helens Council
C&M DASS representative		TBC
C&M DPH representative		TBC

Role	Name	Title
C&M DCS representative (tentative)		*TBC*
Primary care representative		Primary Care Advisor, C&M HCP
Primary Care Forum Representative		TBC
Voluntary Sector Representative		Chief Executive, Voluntary Sector North West
Healthwatch representative		TBC
NHSE/I representative		TBC
C&M Strategic Communications		Executive Director of Communications and Engagement, C&M HCP
Support		Deputy Director, NHS Transformation Unit
Support		Associate Consultant, NHS Transformation Unit

5. Quoracy

The Group will take a task and finish approach, and therefore the meetings will be determined by the agenda and the work plan as this develops. Ultimately the Chair will set requirements (and therefore quoracy) for attendance based on each agenda.

If a Group member is not available a formal nominated deputy for that individual should attend the meeting instead. Every effort will be made to ensure the presence of the appropriate representation at a meeting, but should this prove operationally difficult, alternative means of securing all members' opinions will be undertaken, particularly prior to a recommendation being made.

6. Reporting

For relevant issues, formal reporting and escalation will be through the Cheshire and Merseyside HCP Partnership Board.

The Group will feedback to the Cheshire and Merseyside health and care system through co-ordinated strategic communications.

7. Frequency and duration of meetings

The Group will meet bi-weekly for a 1.5-hour session. In the instance there are limited agenda items for discussion, the meeting will be stood down.

8. Administration

The ICS Development Advisory Group will be administered by the NHS Transformation Unit. The point of contact is sophie.whitham1@nhs.net).

A log of agreed actions and decisions will be taken from each meeting and shared within 2 working days of the meeting.

9. Review

These Terms of Reference will be reviewed after three months to ensure that the arrangements remain appropriate.

Rapid health needs assessment for Cheshire and Merseyside

Reader information	
Authors	Dr Matthew Atkinson and Sharon McAteer
Contributors	Steve Knuckey
Director of Public Health Lead and reviewer.	Eileen O'Meara
Number of pages	39
Date release	April 2021
Description	The document provides an overview of the latest available health data across Cheshire & Merseyside, describing the overarching health needs facing the sub-region. It describes current life expectancy trends and the drivers for this as well as for the Health Care Partnership priorities.
Contact	Matthew.Atkinson@halton.gov.uk
Related documents	PHE Health Inequalities data pack for Cheshire & Merseyside STP, January 2020 Liverpool John Moores University & Champs Health Profiles for Liverpool City Region and Cheshire & Warrington for: Children and Young People Older People Vulnerable Populations

Executive Summary

This is a desktop update of the health needs of the Cheshire and Merseyside area undertaken for the Cheshire & Merseyside Health & Care Partnership.

Our population of 2.5 million people over 9 local authority and CCG areas is varied, with Liverpool having a younger population and areas in Cheshire being less deprived on the whole. However, each local authority has significant variation within it. Life expectancy is 78.4 for men and 81.9 for women, both lower than the England average.

Specific wards are identified, where death rates are particularly high, or emergency hospital presentations are higher than would be expected for the level of deprivation experienced. The latter are listed as “priority” wards.

Much of the inequality in mortality within Cheshire & Merseyside and between Cheshire & Merseyside and England can be accounted for through heart disease, stroke, lung and other cancers and chronic respiratory conditions such as COPD. Many of these deaths are considered avoidable, either preventable through public health action, or amenable to health care. Smoking remains a key contributor to the avoidable deaths in the region and to the inequalities within it.

Updated high level data is presented covering many of our priority areas and each shows variation across the region. Our more deprived boroughs tend to have increased exposure to health risks and poorer health outcomes. These inequalities are seen from childhood and specific issues are discussed, including obesity.

At the time of writing, we have had nearly 190,000 cases of COVID-19 across the region and this is broken down over time and by area. The impact of COVID on other health outcomes is discussed in the relevant section.

COVID-19 has led to massive disruption to service delivery and placed a huge strain on our staff and communities. However, it has also accelerated the development of remote delivery and helped build on our partnerships to make big changes rapidly. We must take care to capture and build on these benefits.

We should target the causes of avoidable mortality and poor health outcomes with a focus on the reduction of health inequalities and by targeting those localities with the greatest need.

Contents

1. Introduction

This report is a rapid high-level health needs assessment for Cheshire and Merseyside. We examine the major causes of death and disability and review available data for our region as it relates to our established priorities. We include the impact of COVID-19 but also take a wider view to look beyond the pandemic and focus our efforts where they'll have the greatest benefit.

1.1 Objectives

- Use available data to update the causes of poor health and death in our region.
- Highlight inequalities in health outcomes and life expectancy
- Recommend further bespoke analysis on key topics
- Discuss future priority areas as we move beyond the acute phase of the COVID-19 pandemic.

1.2 Methods

This was primarily a desktop exercise using publicly available data. PHE Fingertips was the primary source and data presented is from here unless stated.

Charts have been presented with local authority / CCG areas in the same order where possible (rather than ranking each measure), to aid following a specific area through the report.

ONS data was used for demographics and additional cause of death information was gathered from the Global Burden of Disease study. Extracts from a bespoke report for the Partnership on health inequalities and priority wards for action are also presented.

The NHS RightCare "Where to Look" STP level pack was reviewed but was published in 2019 using data from 2017 to 2018 and so has not been included in this rapid update.

2. Our population

Cheshire & Merseyside Health & Care Partnership comprises 9 local authorities and 9 CCGs.

All are coterminous apart from:

- Cheshire CCG covers the local authorities of Cheshire East and Cheshire West and Chester.
- Sefton local authority is split into South Sefton CCG and Southport and Formby CCG

It has a total population of just under 2.5 million people.

It is more deprived than England as a whole, although there are significant differences in health outcomes and life chances within the region.

2.1 Population structure

The Office for National Statistics (ONS) puts the Cheshire & Merseyside resident population at an estimated 2,496,557 people. Liverpool has the largest single population and Halton the smallest.

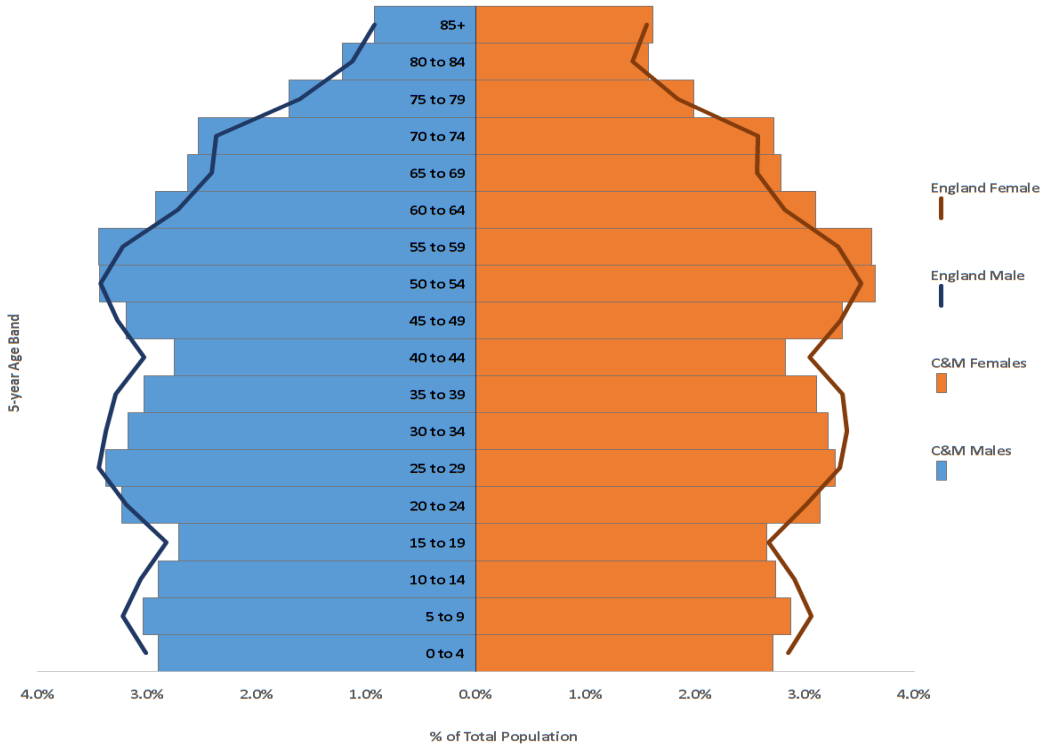
Figure 1: Population age breakdown, 2019 mid-year estimate

Age	0 to 17	18 to 24	25 to 49	50 to 64	65 to 74	75+
Cheshire East	20.1%	6.2%	29.0%	21.7%	12.2%	10.8%
Cheshire West and Chester	20.0%	7.6%	29.8%	20.9%	11.7%	9.9%
Halton	22.2%	7.4%	31.8%	20.1%	11.0%	7.4%
Knowsley	22.4%	8.1%	31.3%	20.9%	9.6%	7.7%
Liverpool	19.3%	13.8%	35.1%	17.0%	8.1%	6.6%
Sefton	19.6%	6.8%	28.3%	21.8%	12.0%	11.5%
St. Helens	20.4%	7.3%	31.5%	20.2%	11.4%	9.2%
Warrington	21.1%	7.0%	32.4%	20.6%	10.3%	8.6%
Wirral	20.8%	6.9%	29.5%	20.9%	11.8%	10.1%
Cheshire & Merseyside	20.3%	8.4%	31.1%	20.2%	10.8%	9.2%
England	21.4%	8.4%	32.8%	19.0%	9.9%	8.5%

Source: ONS via Nomis

The proportions in each age group are fairly similar in each local authority apart from Liverpool which has a higher proportion of its population in the 18-24 age group and slightly lower proportions in the 50 and over age categories. Sefton and Cheshire East have the highest proportion of those aged 75 and over, with the percentage in this age group lowest in Liverpool, Halton and Knowsley. It is similar to England although it does have slightly lower percentages in the younger age bands and slightly higher percentages from age 50-54.

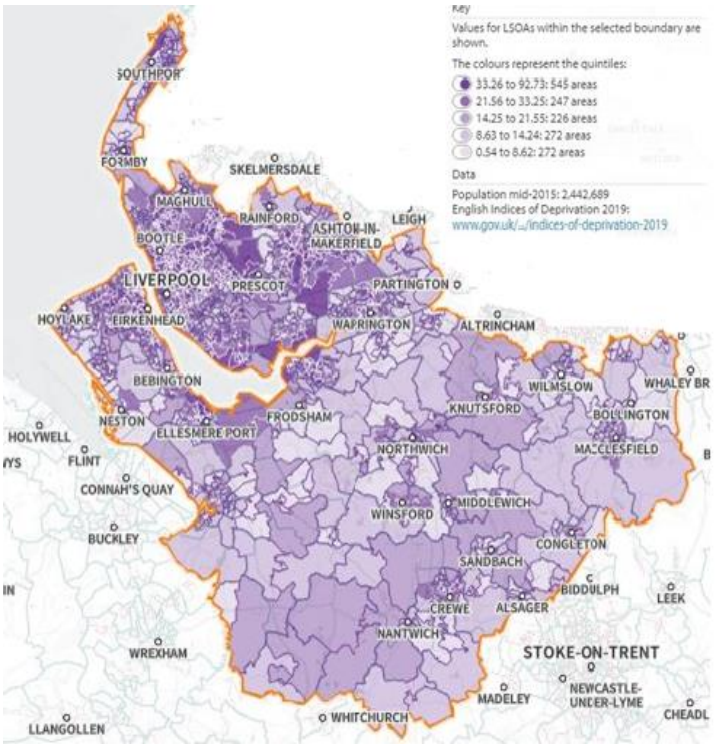
Figure 2 - Proportion of total population in each broad age band, 2019 mid-year estimates (C&M v England)



2.2 Deprivation

Deprivation scores are only available for the old CCG boundaries i.e. the 4 CCGs that now make up Cheshire CCG. Whilst the area is much more deprived than England as a whole, using the national Index of Multiple Deprivation (IMD), 2019, 6 CCGs have scores lower than England and 6 are higher. Even within CCGs practice deprivation scores vary considerably.

Figure 3: Index of Multiple deprivation by lower super output area (LSOA) and CCG scores, 2019



Overall IMD 2019 scores per CCG (most deprived to least deprived CCG area)

(range of IMD scores of practices in CCG)

- England 21.7
- Cheshire & Merseyside 28.1

- Knowsley 43.0 (range 59.2-25.7)
- Liverpool 42.4 (range 68.7-16.9)
- South Sefton 32.6 (range 59.3-11.7)
- Halton 32.3 (range 45.0-17.6)
- St. Helens 31.5 (range 45.7-13.1)
- Wirral 29.6 (range 58.6-9.8)
- Southport & Formby 19.4 (range 31.3-9.4)
- Vale Royal 19.2 (range 30-9-12.6)
- Warrington 18.9 (range 36.4-7.1)
- West Cheshire 17.6 (range 38.9-7.1)
- South Cheshire 17.0 (range 27.7-9.2)
- Eastern Cheshire 12.2 (range 17.5-4.6)

Source: PHE SHAPE tool; IMD scores via Ministry of Housing, Communities and Local Government

3. Priority wards

Whilst poor health outcomes are known to be associated with deprivation, some areas have higher levels of hospital admissions and emergency presentations than those with similar levels of deprivation. In 2020 these ward areas were identified in a report to the partnership.[1]

The report highlighted that the Partnership area had no "exemplar" wards – areas where the number of emergency admissions for chronic ambulatory care and urgent care sensitive conditions were significantly below what might be expected in the top quintile of deprivation. However, many of our more deprived wards were designated as "priority" wards, where the rates of emergency admissions were higher than peer areas:

[1] Health inequalities and Covid-19, report by John Brittain and Professor Chris Bentley

Figure 4 - "Priority" wards by CCG area[1]

NHS CCG area	Number of priority wards	Total number of wards in CCG
Halton	11	21
Knowsley	11	15
South Cheshire	3	
South Sefton	7	13
St Helens	6	16
Vale Royal	2	10
Warrington	4	22
West Cheshire	4	36
Wirral	9	22
Liverpool	19	30

The North West has the most priority wards of any English region and Cheshire & Merseyside is the STP area with the most priority wards in England.
A range of tools for assessing and supporting these wards at local level are provided in the report.

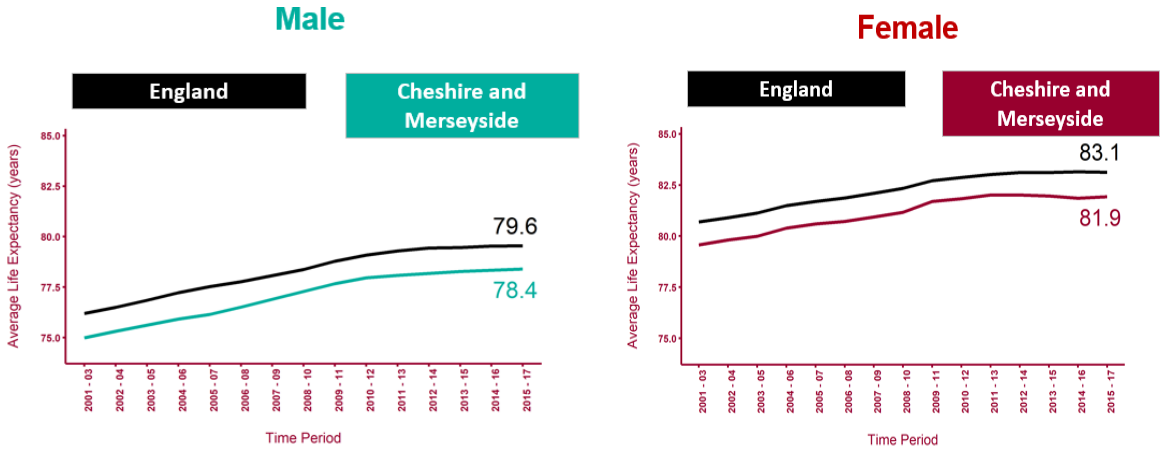
4. Life expectancy and mortality

4.1 Overall trends

2011 marked a turning point in long-term mortality trends in England, with improvements stalling for the first time in 20 years. The emergence of COVID-19 in 2020 will have significant implications for life expectancy.

Healthy life expectancy[2] has also increased, but not as much as life expectancy, so more years are spent in poor health. This gap tends to be wider in the most deprived groups.

Figure 5 - Life expectancy in England and Cheshire & Merseyside



Source: PHE Health Inequalities STP pack

The graphs above demonstrate that for both men and women, life expectancy is below the England average for those living in Cheshire & Merseyside. Not only is this persistent inequality worrying but it masks inequalities across the sub-region and within the sub region.

[2] Healthy life expectancy is an estimate of the number of years lived in 'very good' or 'good' general health, based on how individuals perceive their general health. Disability-free life expectancy is an estimate of the number of years lived without a long-lasting physical or mental health condition that limits daily activities

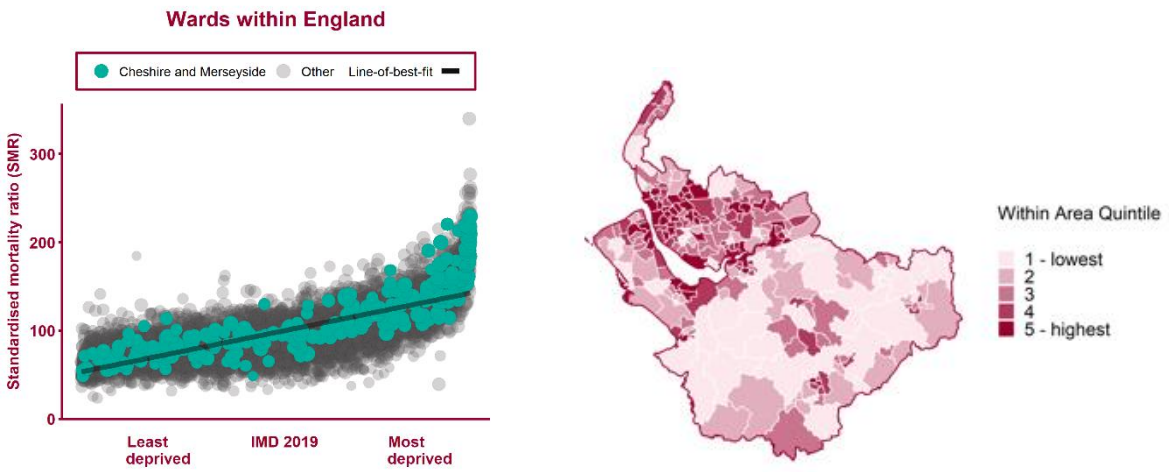
Figure 6 - Key life expectancy indicators, local authorities in Cheshire & Merseyside (2017-19)

Indicator	Period	England	C&M	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St. Helens	Warrington	Wirral
Life expectancy at birth (Female) New data	2017 - 19	83.4	-	84.1	83.3	81.7	80.5	80.4	82.9	81.2	82.8	82.3
Life expectancy at birth (Male) New data	2017 - 19	79.8	-	80.3	80.1	77.4	76.8	76.6	78.9	77.8	79.0	78.5
Healthy life expectancy at birth (Female)	2016 - 18	63.9	-	69.8	66.3	57.5	59.1	57.8	62.4	59.3	64.0	63.7
Healthy life expectancy at birth (Male)	2016 - 18	63.4	-	66.5	65.4	59.5	58.3	60.7	64.0	59.2	64.7	61.4
Inequality in life expectancy at birth (Female) New data	2017 - 19	7.6	-	7.3	8.8	8.5	9.2	9.8	11.8	8.8	7.2	11.1
Inequality in life expectancy at birth (Male) New data	2017 - 19	9.4	-	8.9	10.6	9.9	9.9	10.2	12.5	11.7	9.7	13.0

4.2 What is driving the differences?

Levels of deprivation impact on death rates, both in C&M and generally across England. This can be seen by the chart showing all-cause mortality under age 75 by ward. Those more deprived wards have the higher overall death rates. The map shows there is also significant variation across Cheshire and Merseyside.

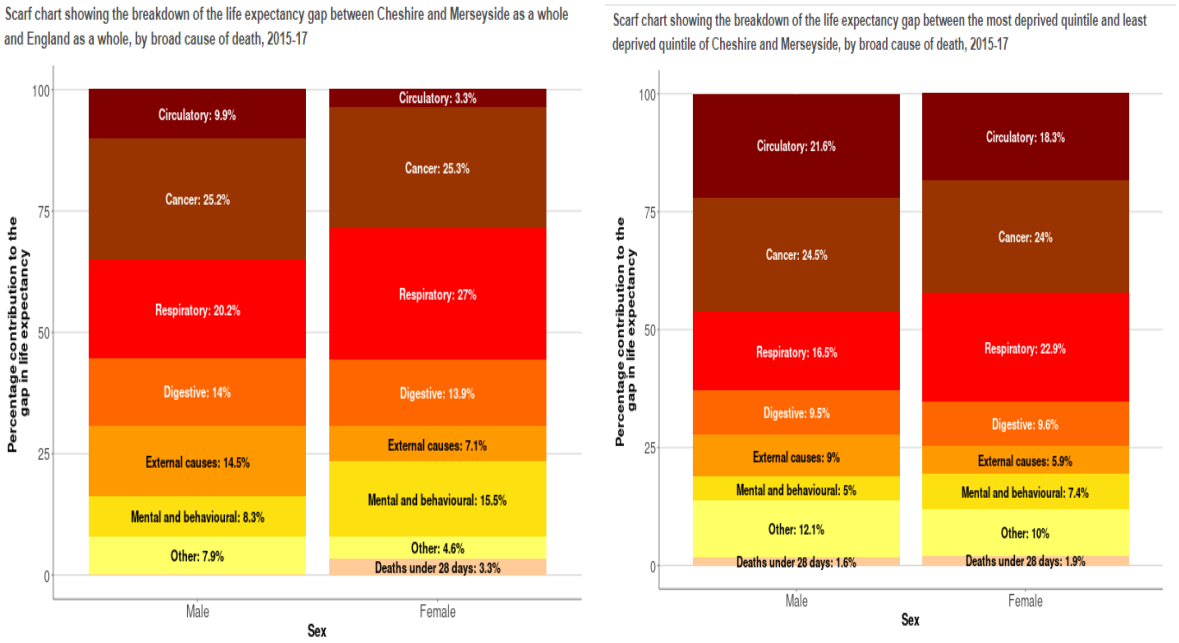
Figure 7- Deaths from all causes, under 75 years (2013 - 17)



Source: PHE Health Inequalities STP pack

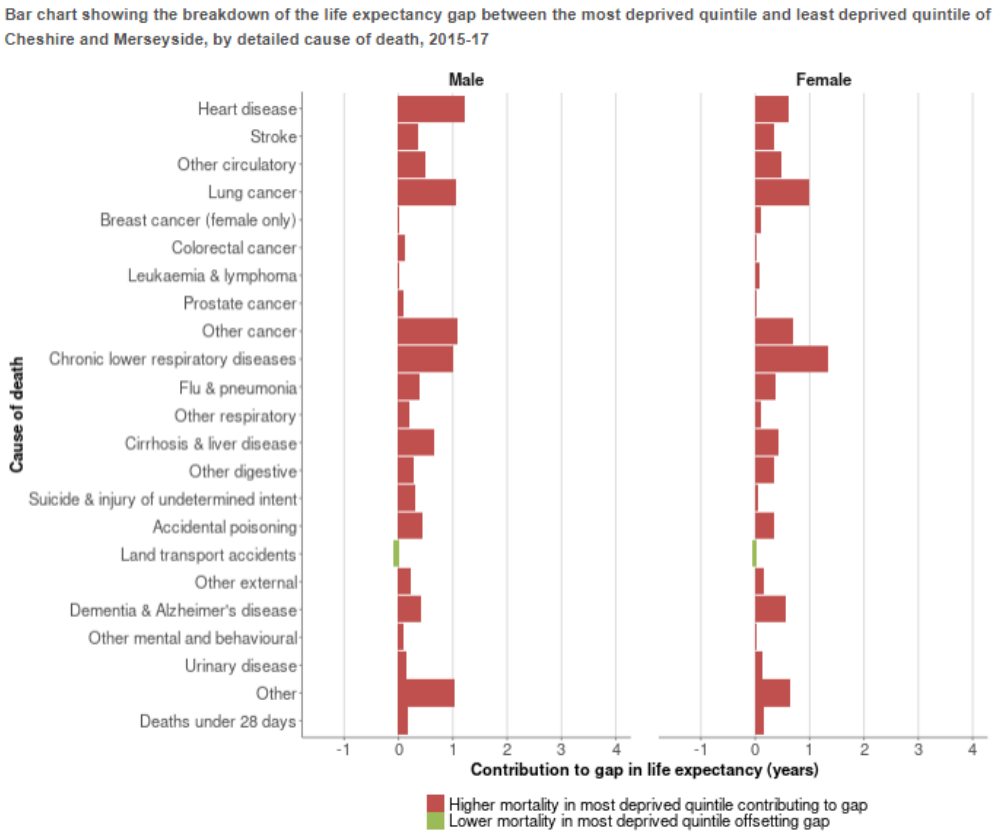
A number of causes account for the majority of the difference, with heart disease, cancers, respiratory and digestive diseases accounting for just over 69% (69.3% males and 69.5% females) of the difference compared to England and over 72% (72.1% males and 74.8% females) when comparing the most and least deprived quintiles across Cheshire & Merseyside

Figure 8 - Causes of the gap in life expectancy between Cheshire & Merseyside and England (left) and within Cheshire and Merseyside (right)



Looking at more detailed breakdown of these disease categories it is heart disease and stroke, lung cancer and other cancers, chronic lower respiratory disease and cirrhosis and liver disease that account for the gap locally.

Figure 9 - Detailed breakdown of the causes of life expectancy gap across Cheshire & Merseyside, 2015-17



Source: Public Health England based on ONS death registration data and mid year population estimates, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2015

5. Changing causes of death

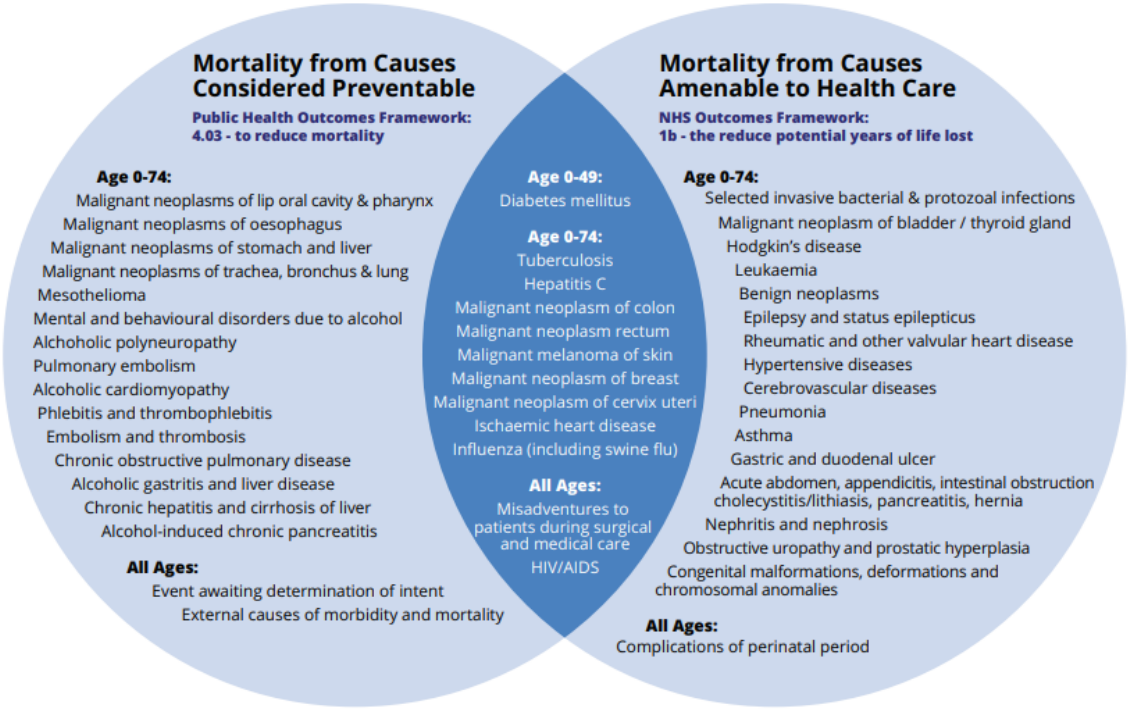
Data from the Global Burden of Disease study (2019) showed that in the North West of England, ischaemic heart disease remains our leading cause of death and is now followed by chronic obstructive pulmonary disease (COPD)[3]. These are the leading causes of death and disability combined, followed by low back pain. Lung cancer and stroke are the next leading causes to death and disability.

Many of these deaths are considered **avoidable**, deaths that could be avoided through prevention or treatment, either:

- **Preventable mortality** - Where most or all deaths from a particular cause could be avoided by public health interventions or changes to an individual's environment or behaviour. This could mean through action on smoking or alcohol, the types of food on sale locally, improvements to road safety or prevention of suicide.
- **Amenable / treatable mortality** - Where most or all deaths from a particular cause could be avoided through good quality healthcare. These deaths might be prevented if services are easily accessible and effectively diagnose and treat conditions in all groups.

[3] http://www.healthdata.org/united-kingdom-england-north-west-england

Figure 10 – Example causative conditions for preventable and amenable / treatable mortality



The full list of causes of death considered preventable and treatable used by the ONS was published by the OECD and Eurostat in 2019[4].

England had an overall age-standardised rate of avoidable mortality of 220.9 deaths per 100,000 people in 2019. Improvements have been slowing in the second decade of the century.

[4] http://www.oecd.org/health/health-systems/Avoidable-mortality-2019-Joint-OECD-Eurostat-List-preventable-treatable-causes-of-death.pdf

5.1. Preventable deaths in Cheshire and Merseyside

Figure 11 - Age-standardised preventable mortality rates by local authorities in England, between 2001 to 2003 and 2017 to 2019 - females[5]

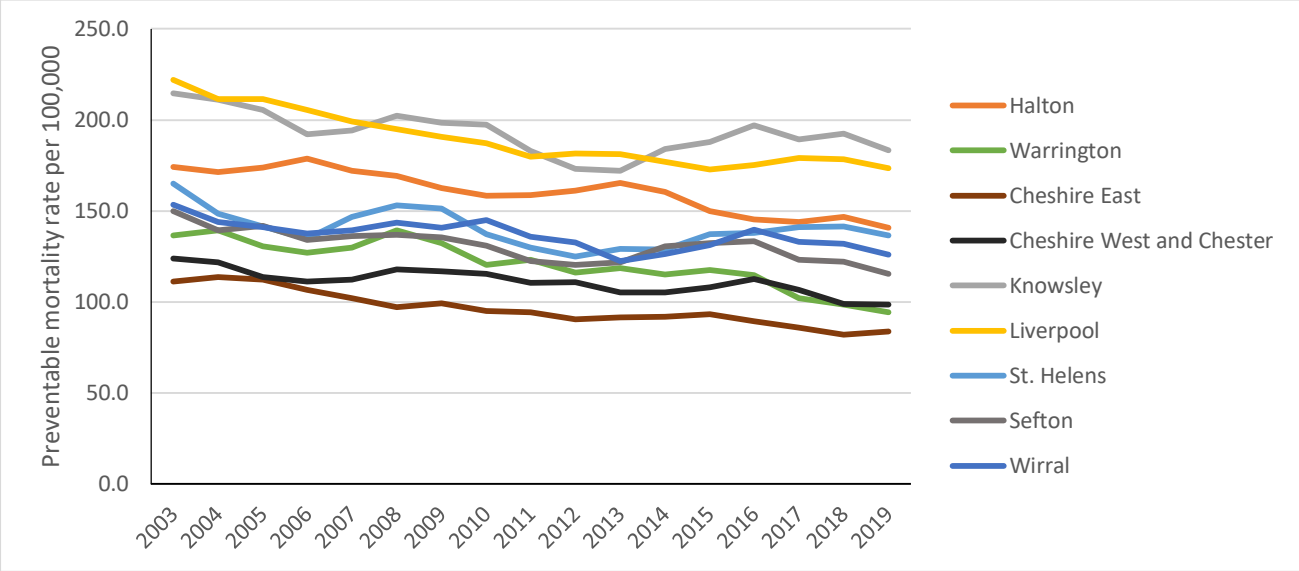
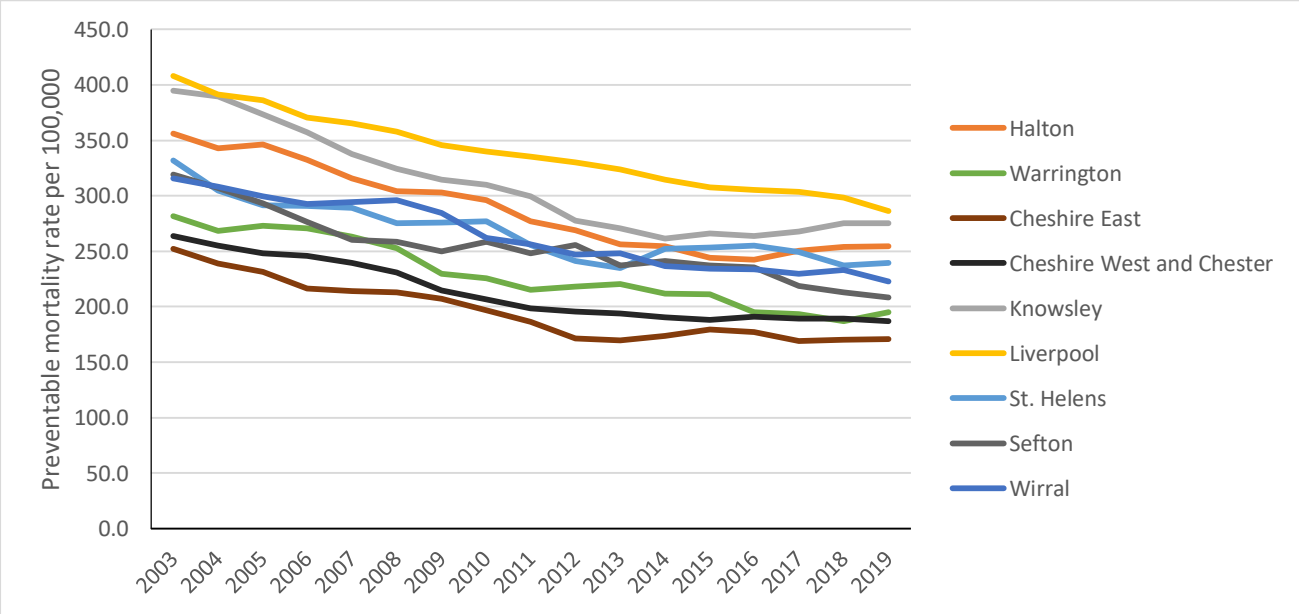


Figure 12 - Age-standardised preventable mortality rates by local authorities in England, between 2001 to 2003 and 2017 to 2019 - males



5 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2019

5.2. Amenable / treatable deaths in Cheshire and Merseyside

Figure 13 - Age-standardised treatable mortality rates by Clinical Commissioning Groups in England, 2001 to 2019 - females

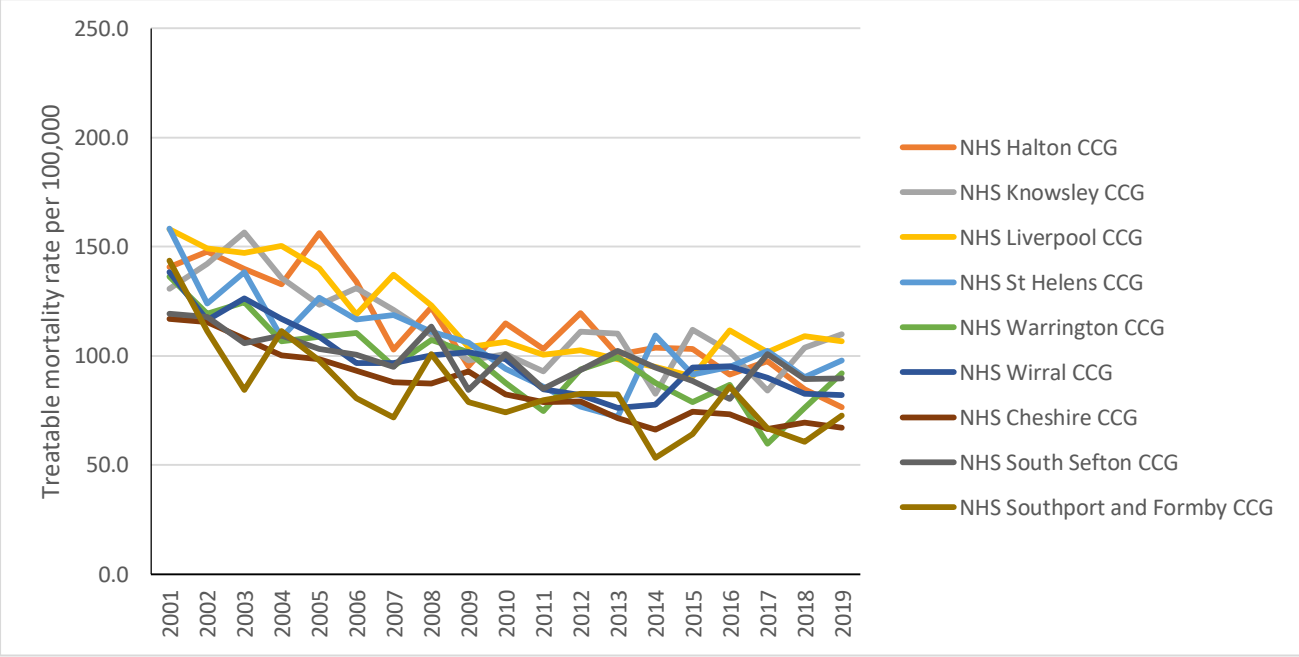
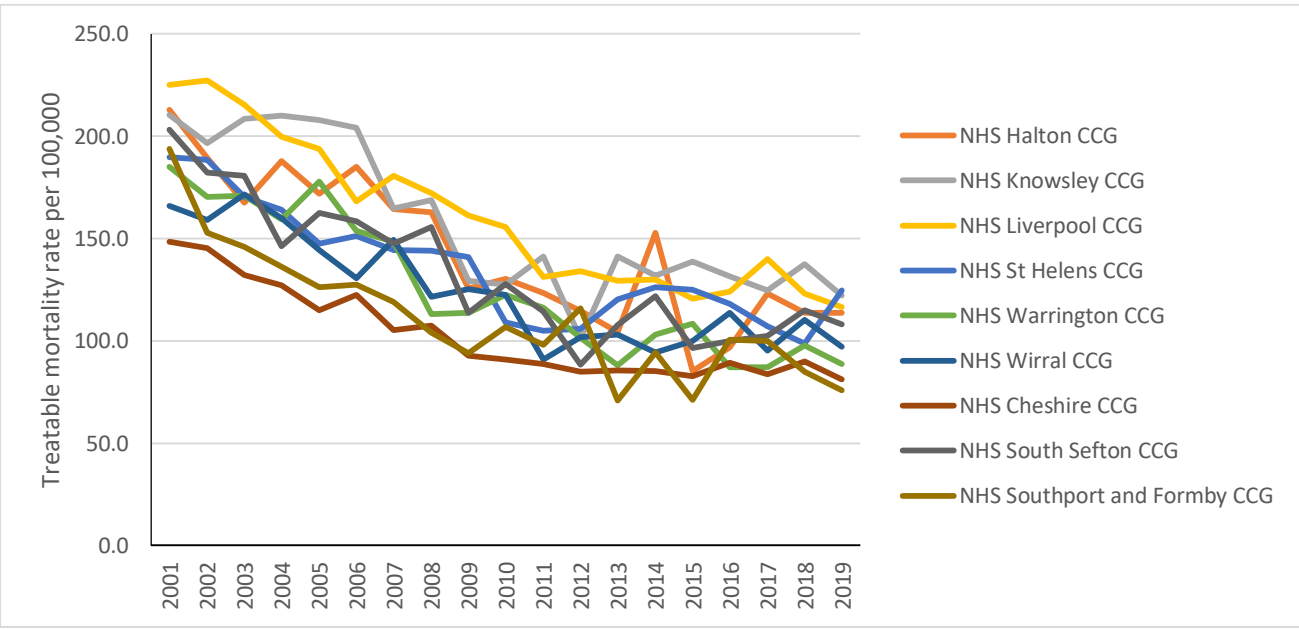


Figure 14 - Age-standardised treatable mortality rates by Clinical Commissioning Groups in England, 2001 to 2019 - males



Rates of amenable/treatable mortality have been improving in Cheshire and Merseyside (with a greater improvement seen in men) over the past twenty years.

Though rates of avoidable mortality do differ between our areas within Cheshire and Merseyside, inequalities between wards within these areas will be much greater. Local authorities who have undertaken this analysis have found that rates of avoidable deaths in their most deprived wards can be more than double those in their least deprived wards.

Our local ward areas with the highest mortality rates and those most affected by premature mortality can be found in **Appendix 2.**

Figure 15 - Changes in causes of death in the North West[3]

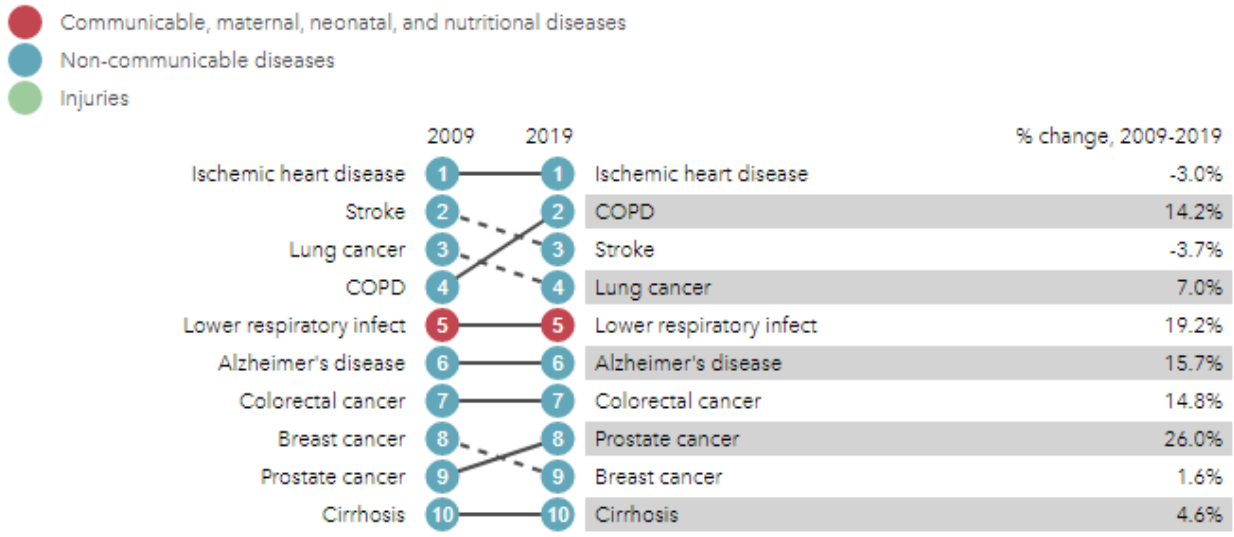
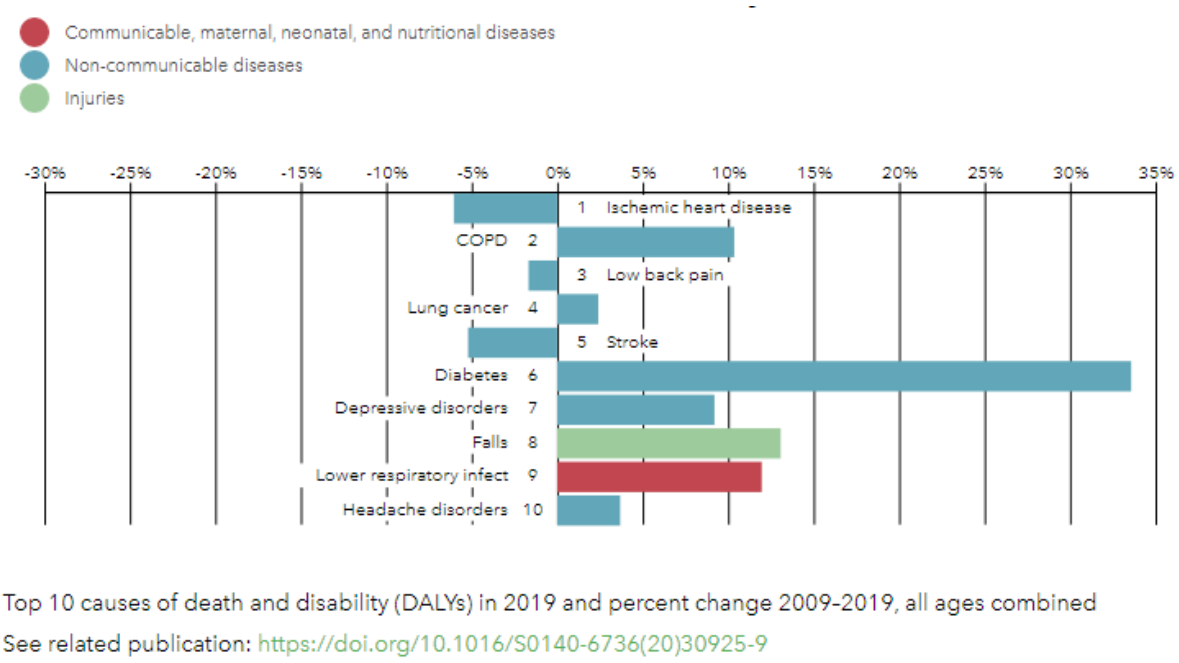


Figure 16 - Changes in cause of death and disability combined in North West[3]



6. Child Health

In October 2020 The Public Health Institute at Liverpool John Moores University published two child health profiles under commission from the Cheshire & Merseyside Public Health Collaborative, Champs.

Split across a child and young people's life course they found overall children in the Liverpool City Region (LCR) had a poorer start in life compared to the North West and especially the England average experience. This poor start carried through the life course for the majority of indicators considered within early years, primary and secondary school years. For Cheshire & Warrington the picture was more mixed. Generally children had a better than average start in life, although for Warrington levels of lone parent families and looked after children are higher than the national average, although child poverty is the second lowest in the North West.

Rates of hospital admissions are significantly higher for LCR as a whole compared to England across various stages of childhood for asthma and unintentional injuries. There are exceptions, for example in Wirral, admissions for unintentional injuries are the lowest in the NW, similar to the national average. In Warrington, rates of hospital admission for asthma amongst children and young people are significantly lower than the England average and the lowest across the NW. However, all three authorities in Cheshire and Warrington have significantly higher rates of admissions caused by unintentional and deliberate injuries.

Vaccination uptake (for both Dtap /IPV /Hib vaccination aged 2yrs, and MMR vaccination - 2 doses aged 5yrs, 2018/19) was overall better than the England average in all but two local authorities across Cheshire & Merseyside. Where it was not, the rates were statistically similar.

Primary school is a significant milestone and presents a key opportunity for tackling health and social inequalities faced by some children in LCR. Overall, LCR compares significantly worse to the national average on each of the primary school indicators. For example **Halton, Knowsley, Liverpool, Sefton** and **Wirral have worse percentage of school readiness**, levels in **Cheshire East, Cheshire West & Chester** and **St. Helens** are similar to the national average, with only **Warrington** having significantly better levels of school readiness.

Progression to secondary school gives new opportunities and choices for many children and young people. It is essential that children are supported with positive environments and opportunities to grow in to confident and healthy young adults. Except for chlamydia detection in 15 to 24yrs olds, which are significantly better, Cheshire & Merseyside as a whole compares significantly worse to the national average on each of the selected indicators relating to adolescents and young adults, although at a local authority level the pattern is more mixed, generally with indicators being worse in LCR than in Cheshire & Warrington.

The details with accompanying data can be found at:

https://www.ljmu.ac.uk/~/media/phi-reports/pdf/2020-08-children-and-yp-health-wb-profile-liverpool-city-region.pdf

and

https://www.ljmu.ac.uk/~/media/phi-reports/pdf/2020-08-children-and-yp-health-wb-profile-cheshire-and-warrington.pdf

Other key indicators

A third of deaths in children and young people (0-19) in the UK are considered avoidable[5].

Our infant mortality rate is comparable to the England average, with Liverpool as the only local authority area having a statistically significant higher infant mortality rate than England[10].

As discussed in the **Zero suicide and improved mental wellbeing** section later in this report, children and young people are a recognised priority group for suicide prevention. 60% of young people who died from suicide had been in contact with specialist children's services in one recent national study[13]. COVID-19 has

meant massive disruption to young people's lives and introduced new pressures, which may increase the risk of suicide. However, suicide was already rising in 10-24 year olds in England.

Alcohol-related admissions in children and young people are higher than the England average – see **Harm to children and young people** section of this report.

Excess weight in children and young people

Data from the National Childhood Measurement Programme show that Cheshire and Merseyside has a significantly higher prevalence of excess weight than England in both reception-age children and in those at year 6. Halton, Knowsley, St. Helens and Liverpool are worse than the England average at both ages, with Sefton worse at year 6.

Overweight children and adolescents are around 5 times more likely to become obese adults than those who are not obese[6].

Education of children and parents will have a marginal impact on these rates. The government updated their childhood obesity action plan in 2017, with measures such as the soft drinks levy, product reformulation, improved labelling and help for school sports[7]. Much of the actions needed are at national level, especially those that limit the acceptability, availability and affordability of unhealthy and high calorie food and drinks. However, local organisations can do much to make the healthy choice the easy choice and to increase access to physical activity in our schools and in our communities.

Reception: Prevalence of obesity (including severe obesity) 2019/20

Area	Recent Trend	Count	Value
England	↑	39,404	9.9
C&M	↑	1,105	11.3*
Halton	→	160	14.3*
Knowsley	→	155	13.8*
St. Helens	→	165	12.1*
Liverpool	→	270	11.6*
Sefton	→	90	10.0*
Wirral	→	135	9.5*
Warrington	→	130	8.5*
Cheshire East	–	-	*
Cheshire West and Chester	–	-	*

2019/20 data is not published for Cheshire East or for Cheshire West and Chester but the prevalence of obesity at reception in 2018/19 was 9.1% in both areas.

6

https://pubmed.ncbi.nlm.nih.gov/26696565/#:~:text=Obese%20children%20and%20adolescents%20were,be%20obese%20over%20age%2030.

7 https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action/childhood-obesity-a-plan-for-action

Year 6: Prevalence of obesity (including severe obesity) 2019/20

Area	Recent Trend	Count	Value
England	↑	103,362	21.0
C&M	↑	3,845	23.7*
Knowsley	→	350	27.2*
St. Helens	→	415	25.8
Liverpool	→	1,195	25.7
Halton	→	275	25.7*
Sefton	→	630	22.7
Wirral	→	700	20.7
Warrington	→	280	18.7*
Cheshire East	–	-	*
Cheshire West and Chester	–	-	*

2019/20 data is not published for Cheshire East or for Cheshire West and Chester but the prevalence of obesity at year 6 in 2018/19 were 17.9% and 19.4% respectively.

7. Smoking

Tobacco remains the leading cause of death and disability in the North West, contributing to cardiovascular disease and stroke, COPD, lung and other cancers[3].

Smoking prevalence amongst young people is unknown at a local level. Nationally, survey data shows around 5-6% of 15 year olds are regular or occasional smokers (Smoking, Drinking and Drug Use Among Young People in England, SDD survey 2018).[8] There has been a significant reduction from 2004 when 21% of 15 year olds identified themselves as regular smokers.

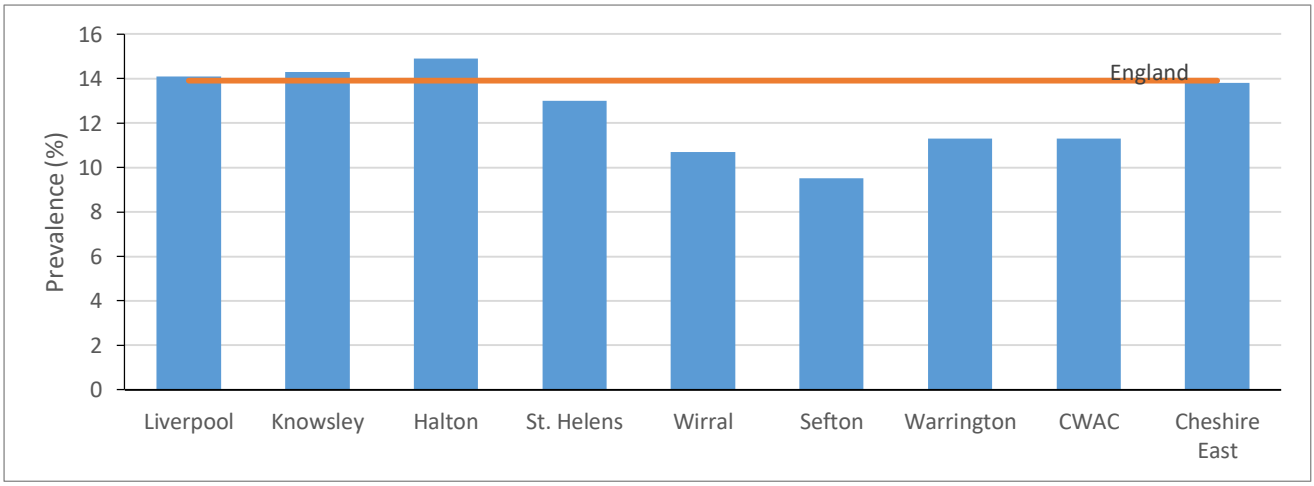
Estimates from the 2019 Annual Population Survey suggested that[9]:

- In the UK, 15.9% of men smoked compared with 12.5% of women.
- Those aged 25 to 34 years had the highest proportion of current smokers (19.0%).
- In the UK, around 1 in 4 (23.4%) people in routine and manual occupations smoked, this is around 2.5 times higher than people in managerial and professional occupations (9.3%).
- In Great Britain, more than half (52.7%) of people aged 16 years and above who currently smoked said they wanted to quit

[8] Note that the Smoking Drinking and Drug Use Survey 2020 fieldwork was cancelled due to the coronavirus (COVID-19) pandemic. It will now go ahead Autumn 2021.

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019

Figure 17 - Smoking prevalence in adults - current smokers (APS) 2019[10]



These data suggest that many of our areas are now at or below the England average. QOF data suggests that some of our CCG areas are significantly above the England average, but this information may be less reliable.

Of concern is the widening inequality in smoking behaviour, both nationally and locally. In some of our boroughs, residents are four times as likely to smoke if they are in routine and manual occupations, compared to those in managerial and professional occupations.

Quintiles: Best Worst Not applicable

Recent trends: – Could not be calculated; No significant change; Increasing; Decreasing

Smoking prevalence in adults (18-64) - socio-economic gap in current smokers (APS) 2019

Area	Recent Trend	Count	Value
England	–	-	2.46
C&M	–	-	-
Warrington	–	-	4.22
Cheshire West and Chester	–	-	4.07
St. Helens	–	-	3.85
Sefton	–	-	3.52
Cheshire East	–	-	3.37
Wirral	–	-	3.20
Liverpool	–	-	3.10
Knowsley	–	-	2.21
Halton	–	-	2.21

Also, most of the region has higher rates of maternal smoking at time of delivery than England.

[10] https://fingertips.phe.org.uk/

Compared with benchmark: Better Similar Worse Not compared

Smoking status at time of delivery New data 2019/20

Area	Recent Trend	Count	Value
England	↓	58,834	10.4
Cheshire and Merseyside	↓	3,062	12.5*
NHS St Helens CCG	→	302	16.4
NHS Vale Royal CCG	→	160	16.3
NHS South Cheshire CCG	→	270	15.6
NHS Halton CCG	→	204	15.3
NHS Knowsley CCG	↓	285	15.3
NHS Wirral CCG	→	372	12.5
NHS Liverpool CCG	↓	686	12.4
NHS South Sefton CCG	→	178	12.0
NHS Warrington CCG	→	208	10.3
NHS West Cheshire CCG	→	215	9.6
NHS Southport And Formby CCG	→	77	8.7
NHS Eastern Cheshire CCG	→	105	6.3

While our rates seem to be improving, smoking remains a major cause of morbidity and mortality in the region and those in routine and manual occupations are much more likely to be exposed. However, most smokers want to quit and we must continue to support them to do so.

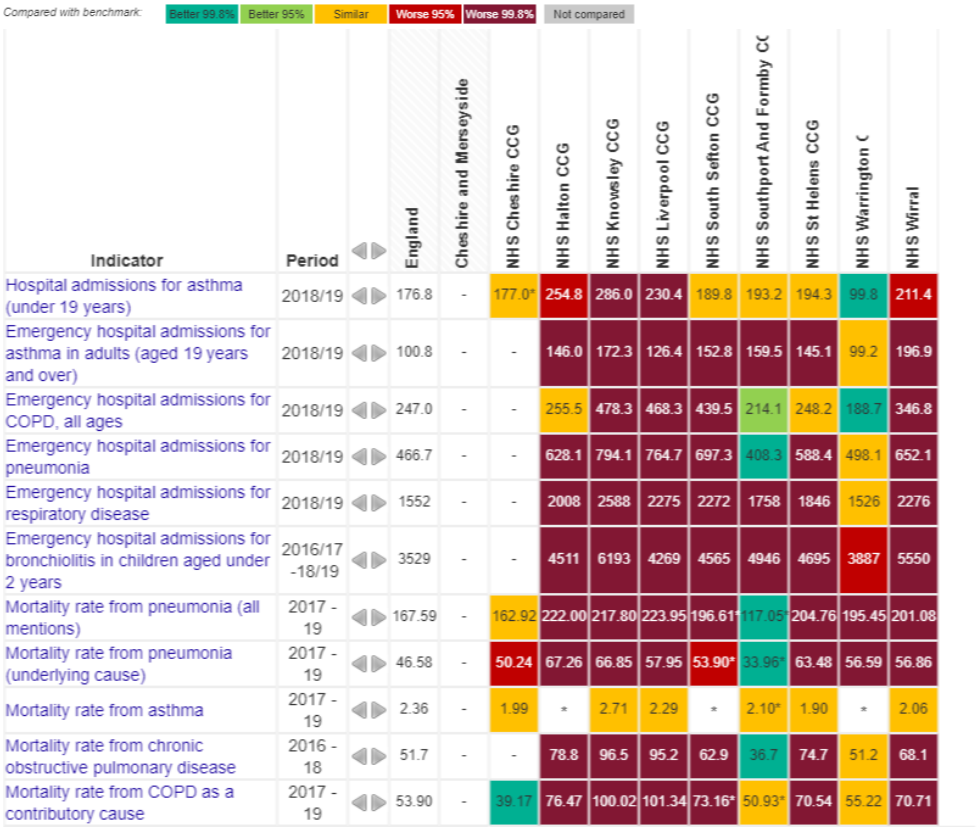
Smokers that manage to quit reduce their lifetime health and social care costs by 48% and the biggest short-term savings come from helping those in contact with the NHS to stop smoking. Delivering assessment, very brief advice (VBA) and referral during every patient episode in secondary care would increase quit rates and be cost-saving within 5 years.[11]

8. Respiratory health

COPD (usually related to smoking) is a major cause of premature death and disability in our region and many of our local areas experience higher mortality rates from COPD than the England average. For asthma, though mortality rates are similar to England, our residents are more likely to be admitted to hospital as an emergency, suggesting poorer access to preventative, primary and urgent care to reduce the need for these presentations. Our infants and young children are also more likely to be admitted as an emergency with bronchiolitis, which could reflect greater exposure to the causative viruses or to second hand smoke or poor housing conditions.

[11] https://www.gov.uk/government/publications/local-health-and-care-planning-menu-of-preventativeinterventions

Figure 18 - Comparison to England benchmark for a range of respiratory indicators[10]



Compared with benchmark: Better 99.8% | Better 95% | Similar | Worse 95% | Worse 99.8% | Not compared

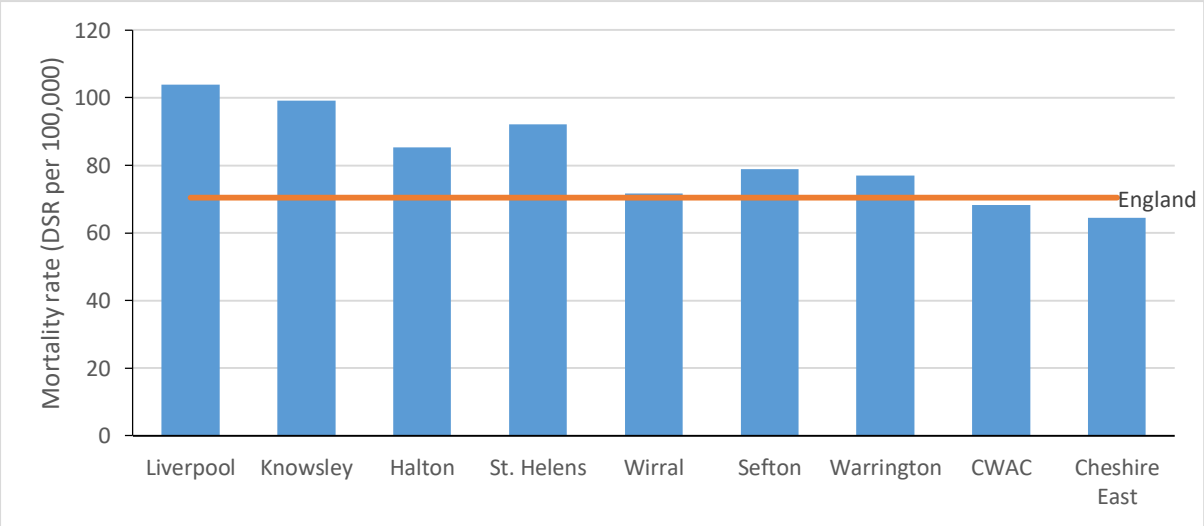
Indicator	Period	England	Cheshire and Merseyside	NHS Cheshire CCG	NHS Halton CCG	NHS Knowsley CCG	NHS Liverpool CCG	NHS South Sefton CCG	NHS Southport And Formby CC	NHS St Helens CCG	NHS Warrington C	NHS Wirral
Hospital admissions for asthma (under 19 years)	2018/19	176.8	-	177.0*	254.8	286.0	230.4	189.8	193.2	194.3	99.8	211.4
Emergency hospital admissions for asthma in adults (aged 19 years and over)	2018/19	100.8	-	-	146.0	172.3	126.4	152.8	159.5	145.1	99.2	196.9
Emergency hospital admissions for COPD, all ages	2018/19	247.0	-	-	255.5	478.3	468.3	439.5	214.1	248.2	188.7	346.8
Emergency hospital admissions for pneumonia	2018/19	466.7	-	-	628.1	794.1	764.7	697.3	408.3	588.4	498.1	652.1
Emergency hospital admissions for respiratory disease	2018/19	1552	-	-	2008	2588	2275	2272	1758	1846	1526	2276
Emergency hospital admissions for bronchiolitis in children aged under 2 years	2016/17 -18/19	3529	-	-	4511	6193	4269	4565	4946	4695	3887	5550
Mortality rate from pneumonia (all mentions)	2017 - 19	167.59	-	162.92	222.00	217.80	223.95	196.61*	117.05*	204.76	195.45	201.08
Mortality rate from pneumonia (underlying cause)	2017 - 19	46.58	-	50.24	67.26	66.85	57.95	53.90*	33.96*	63.48	56.59	56.86
Mortality rate from asthma	2017 - 19	2.36	-	1.99	*	2.71	2.29	*	2.10*	1.90	*	2.06
Mortality rate from chronic obstructive pulmonary disease	2016 - 18	51.7	-	-	78.8	96.5	95.2	62.9	36.7	74.7	51.2	68.1
Mortality rate from COPD as a contributory cause	2017 - 19	53.90	-	39.17	76.47	100.02	101.34	73.16*	50.93*	70.54	55.22	70.71

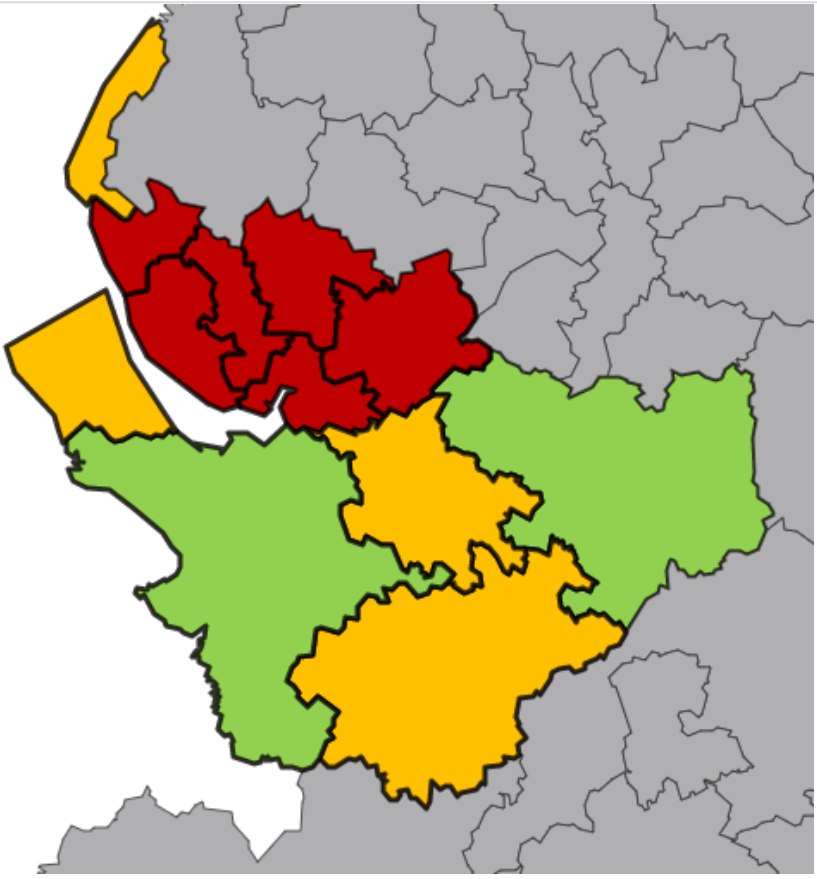
Action on smoking is key to reducing deaths from respiratory conditions, but people also need access to the pneumococcal and influenza vaccines and proactive and personalised care. COVID-19 will be considered separately but we have seen that many of the actions taken to limit its spread have been effective in reducing the spread of other respiratory pathogens and consideration should be given to these in the future.

9. Cardiovascular disease

Many of our local areas have more deaths from cardiovascular disease than England overall and ischaemic heart disease is the leading cause of death in the North West.

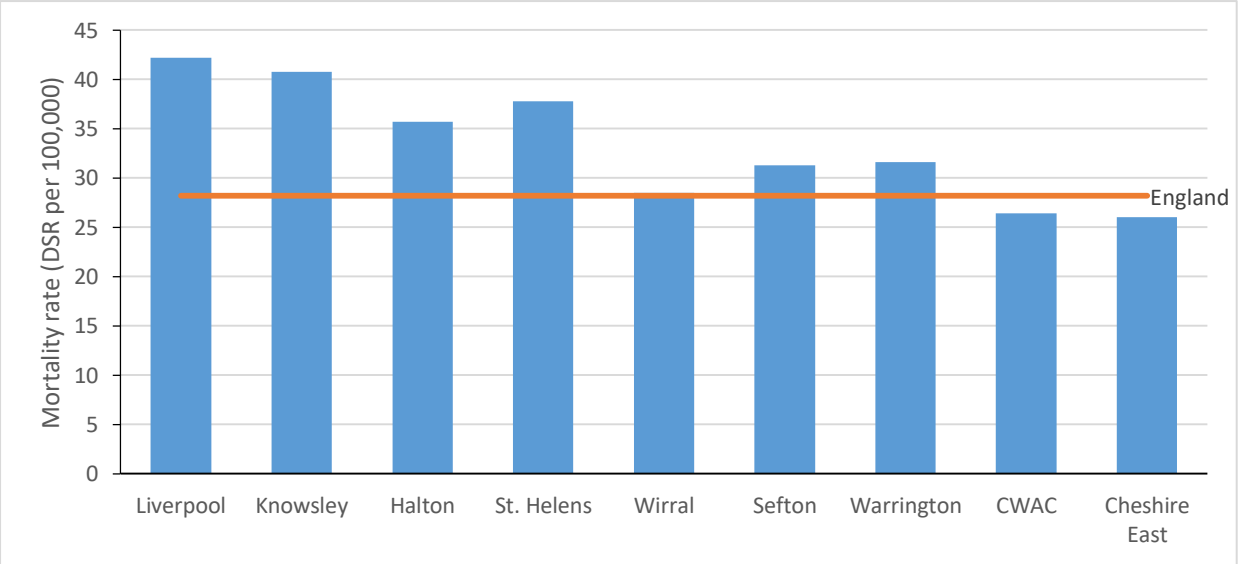
Figure 19 - Under 75 mortality from all CVD (DSR per 100,000) by local authority versus England (2017-19)[10]





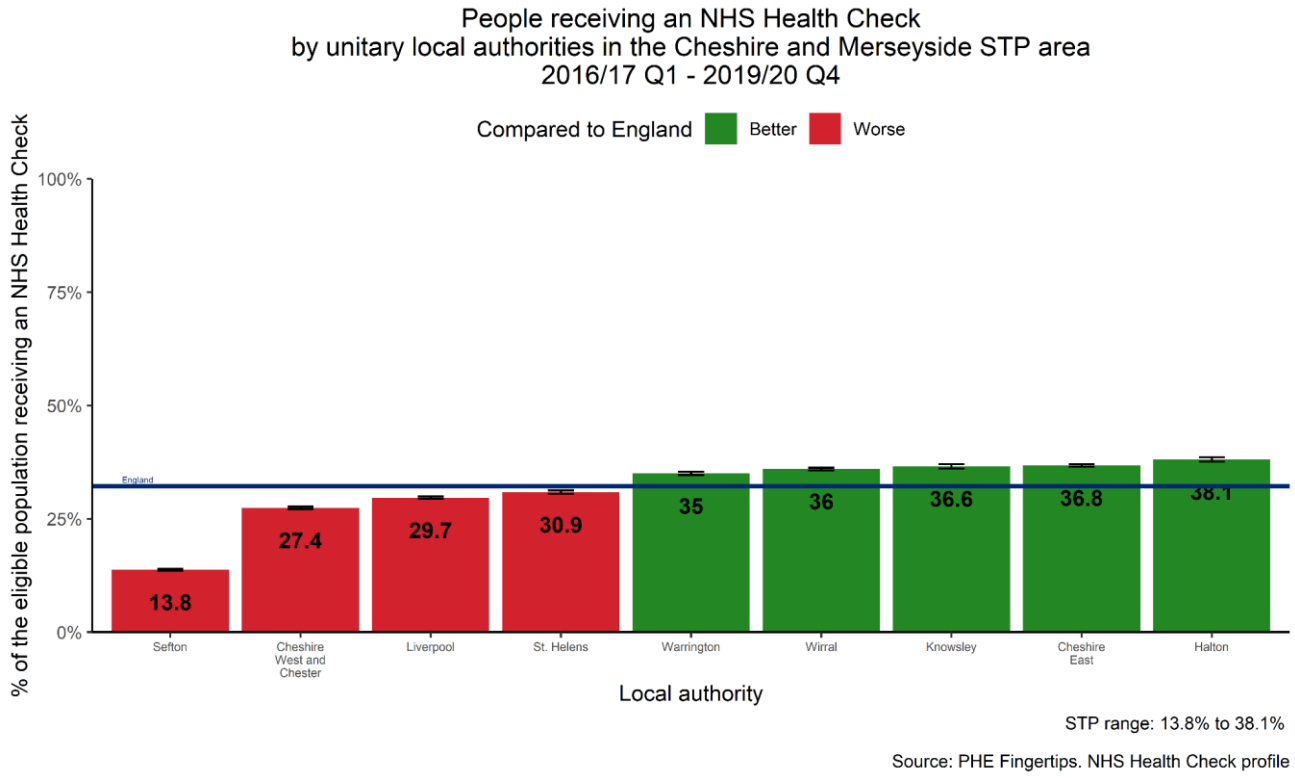
A very similar picture was seen for deaths from preventable CVD across our region.

Figure 20 - Under 75 mortality from preventable (2019 def) CVD (DSR per 100,000) by local authority versus England (2017-19)



NHS Health Check

This programme has faced significant disruption due to the COVID-19 pandemic but much of the data is from before 2020. Though some of our areas are at or better than the England average, the majority of our eligible residents are still missing out on this assessment.



Cheshire and Merseyside CVD Board

The British Cardiovascular Society set out principles for a seamlessly integrated system of care, from preventative and community care to tertiary diagnostics and treatments, with a focus on outcomes and a reduction in inequalities. Though our figures have improved significantly, CVD still represents the greatest opportunity for averting adverse outcomes and deaths (such as from heart attacks and strokes). The

programme is data driven and will use observational reports from the Getting It Right First Time (GIRFT) programme to minimise unwarranted variations in care.

Though COVID has impacted services and led to poorer outcomes in those with chronic conditions, it has accelerated a shift to remote care and coordinated primary care networks. Exemplar community models have been shared across the region and there is a plan to support the development of a Cardiac Collaborative across Cheshire and Merseyside.

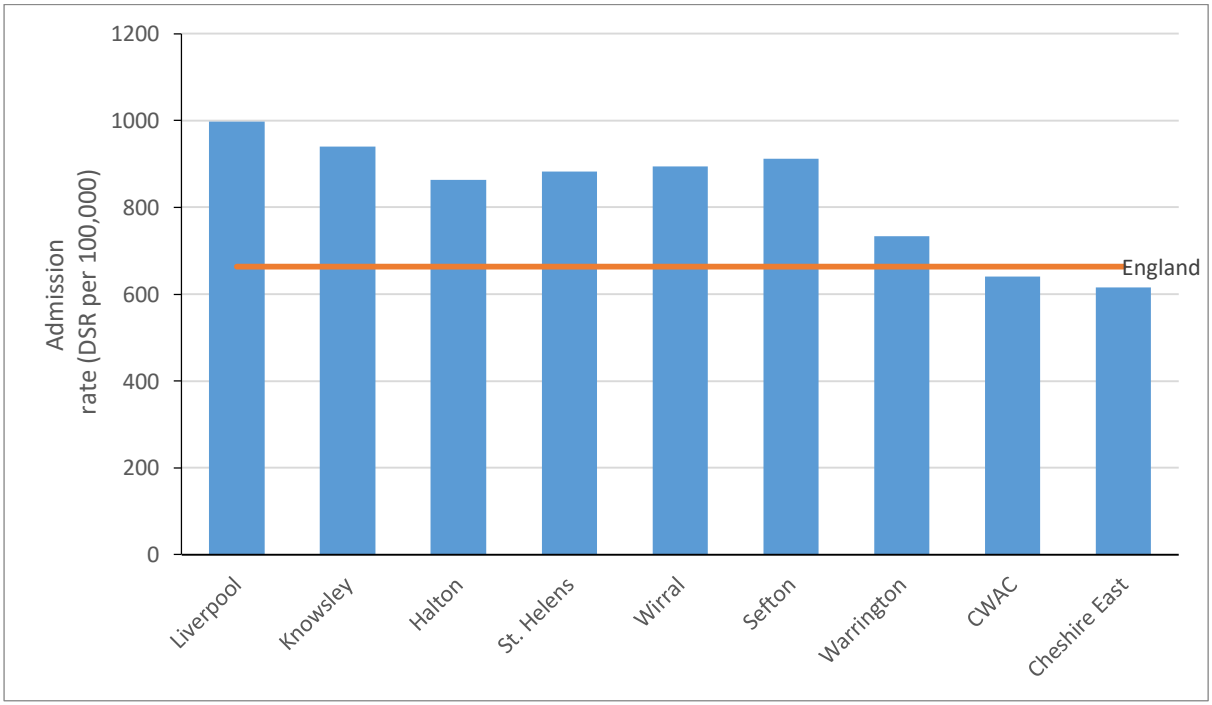
A detailed review of the data and profiles for each of our areas has been presented to the board. PHE's LKIS team have prepared an updated detailed review of cardiovascular data for presentation to the board. This will show that whilst our mortality for CHD has been falling, it is an improving picture in Cheshire that has driven this change and that significant inequalities remain across the region.

HCP Population Board Programme activity

- Develop & scale up remote and digitally- enabled CVD prevention pathways in primary care (e.g. home blood pressure monitoring)
- Empower self-care for CVD risk factor patients
- Promote health and wellbeing to reduce population CVD risk
- Raise awareness of key CVD prevention messages
- Reduce associated inequalities through multifaceted and targeted approaches

10. No harm from alcohol

Figure 21 - Admission episodes for alcohol-related conditions (Narrow) (DSR per 100,000) 2018-19[10]



Only Cheshire West and Chester and Cheshire East have admission rates that are at or below England levels. This narrow measure shows more direct harm from alcohol but it clearly has wider health implications and is a major contributor to CVD, cancers and other avoidable morbidity and mortality (see Error! Reference ource not found.). Health data will mask the huge impact has on our families, communities and economy.

Our night-time economy has been severely affected by COVID-19 but off-sales alcohol has remained available throughout the pandemic and home drinking may mask the scale of the problem. Reducing the

harm from alcohol relies on national policy (pricing, availability), local action (licensing, campaigns), widespread support (identification and brief advice in health and other settings) and specific services.

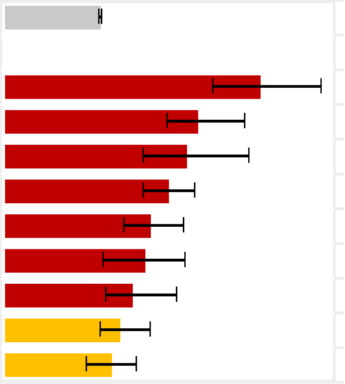
On average, for every 8 people who receive a brief intervention, 1 will reduce their drinking to safer levels and if this is implemented systematically, there is great potential to reduce population-level harm.[12]

Harm to children and young people

Outside of Cheshire East and Cheshire West & Chester, all of our areas have more alcohol-related hospital admissions in children and young people than the England average.

Figure 22 - Admission episodes for alcohol-specific conditions - Under 18s, 2017/18 to 19/20, Crude rate per 100,000

Area	Recent Trend	Count	Value
England	–	10,986	30.7
C&M	–	-	-
St. Helens	–	90	81.6
Sefton	–	100	62.0
Halton	–	50	58.3
Liverpool	–	150	52.7
Wirral	–	95	46.9
Knowsley	–	45	44.9
Warrington	–	55	41.2
Cheshire East	–	85	37.0
Cheshire West and Chester	–	70	34.3



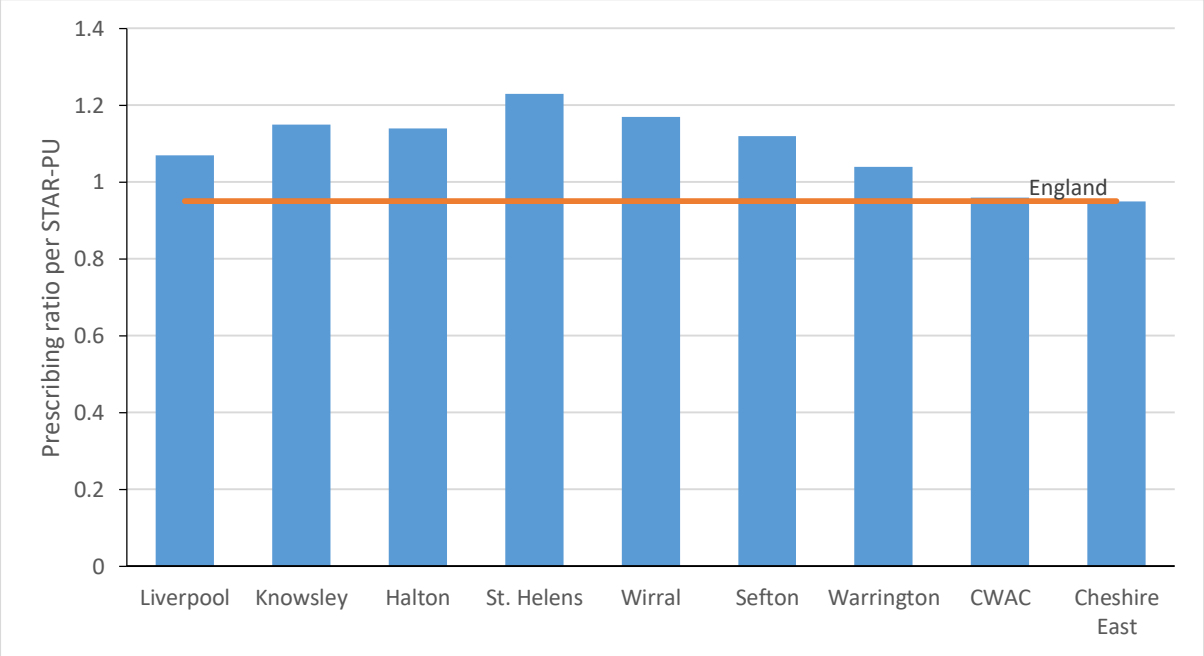
Population health programme activity

- Alcohol competency skills audit
- Intervention and brief advice programme

[12] http://www.nwph.net

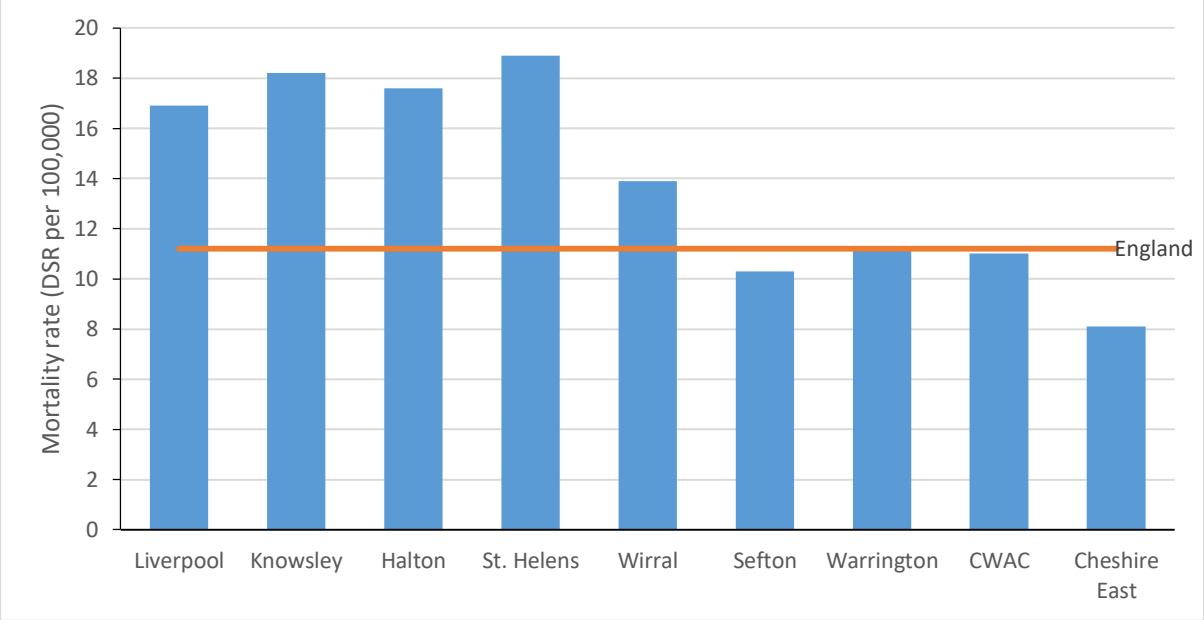
11. Reducing antimicrobial resistance

Figure 23 - Adjusted antibiotic prescribing in primary care by the NHS (Indirectly standardised ratio per STAR-PU) 2019[10]



There is a complex relationship between infections, symptoms, healthcare access and prescribing behaviour and so it is not easy to say that prescribing is inappropriate. Some of our areas experience higher mortality due to communicable diseases and the prevention of infection continues to be an important aspect of antimicrobial stewardship.

Figure 24 - Mortality rate from a range of specified communicable diseases, including influenza (DSR per 100,000) 2017-19



The Partnership's activity in this programme is set out in the AMR action plan.

12. Zero suicide and improved mental wellbeing

The NHS Long Term Plan makes suicide prevention a priority and specific funding for suicide prevention and suicide bereavement services has been agreed[13]. There is an updated Cross-Government Suicide Prevention Workplan with new actions in the context of COVID-19.

COVID-19 has placed a strain on our mental health, but the pandemic came at a time when suicide rates were already rising in England and Wales. In 2018, the age-standardised suicide rate was the highest it had been since 2004[14].

These groups were previously identified as particularly vulnerable and agreed as priority groups for suicide prevention activity nationally[13]:

- Middle-aged men
- People who self-harm
- Children and young people.
- People with mental illness.

COVID-19 will have exacerbated existing risk factors and also introduced new ones such as job loss, debt, bereavement, loneliness or social isolation.

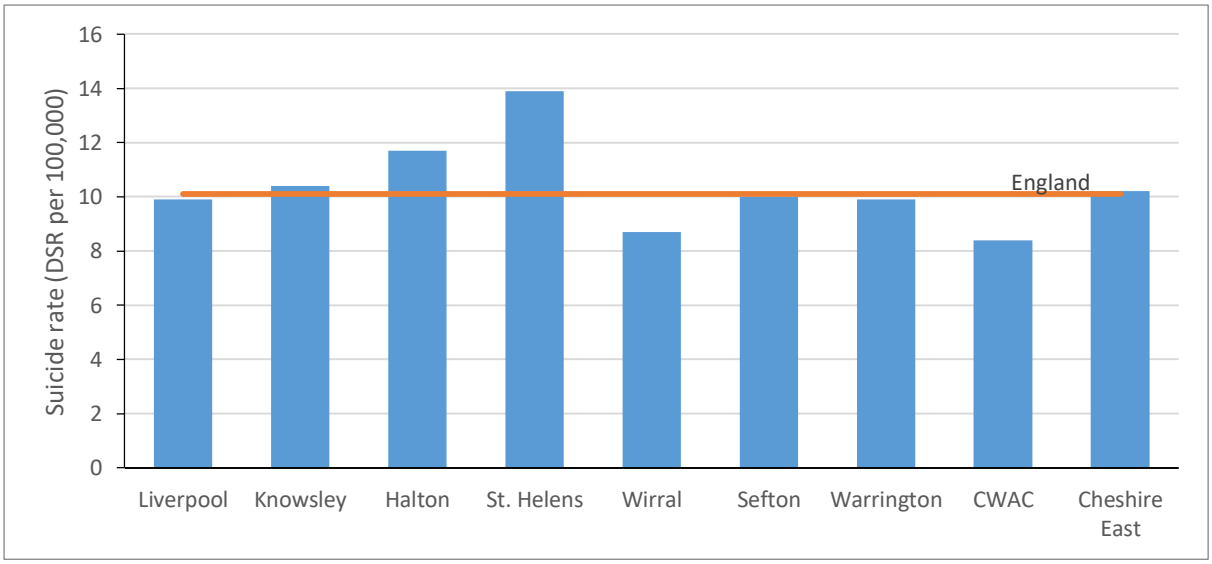
Figure 25 - Hospital admissions for mental health conditions, 2019/20, Crude rate per 100,000

Area	Recent Trend	Count	Value
England	↑	10,756	89.5
C&M	→	715	140.9*
Wirral	↑	145	214.8
Halton	→	50	173.8
Sefton	→	90	166.5
St. Helens	→	55	149.2
Cheshire East	→	115	148.8
Knowsley	→	50	147.9
Warrington	→	55	123.9
Cheshire West and Chester	→	70	102.0
Liverpool	→	85	88.5

[13] https://www.gov.uk/government/publications/suicide-prevention-in-england-fifth-progress-report

[14] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/recenttrendsinsuicidedeathoccurrencesinenglandandwalesbetween2001and2018/2020-12-08

Figure 26 - Suicide rate (DSR per 100,000) 2017-19[10]

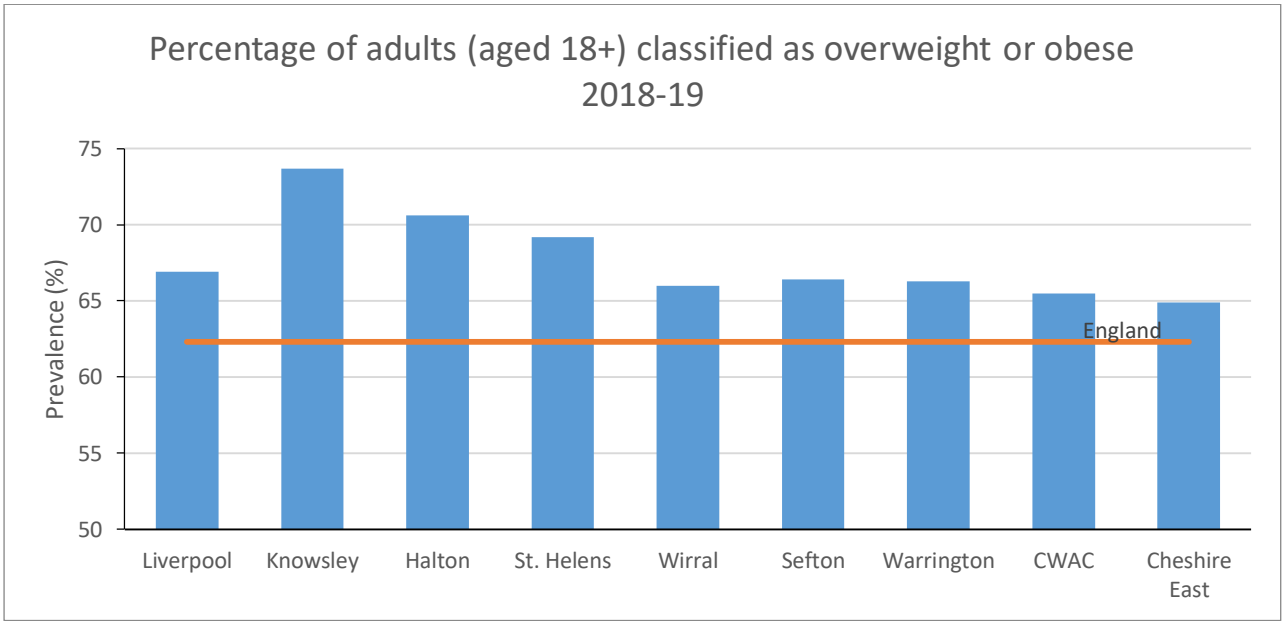


Population Health Programme activity

- Continue to undertake weekly Real Time Surveillance
- Community Response Planning and Intelligence
- Support After Suicide /Amparo
- Develop and implement a Mental Wellbeing/Suicide Prevention campaign
- Management of Suicide Prevention contracts
- Review of Middle Aged Men Programmes
- Commissioning Bereavement Support
- Refresh of CM NO MORE Strategy
- Website development to host information for public and professionals
- NHSE/I Primary Care Pilot

13. Increasing physical activity

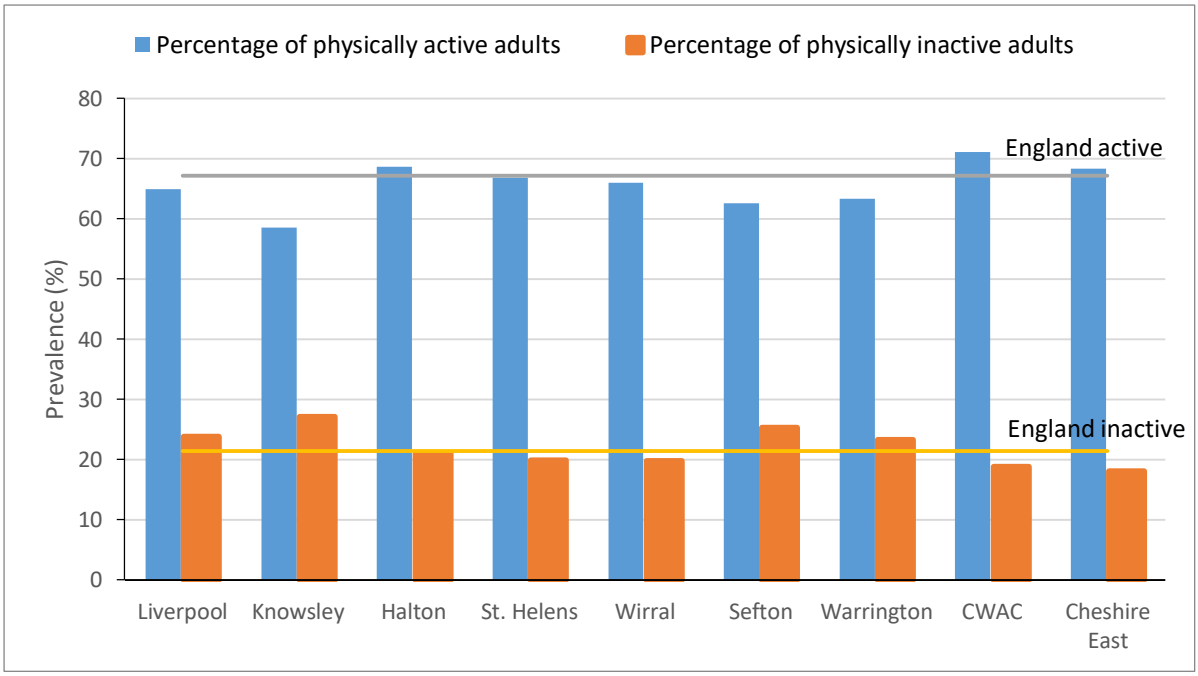
Figure 27 - Percentage of adults (aged 18+) classified as overweight or obese 2018-19[10]



Overweight and obesity is related to access to and uptake of a healthy diet as well as exercise and other health factors. All of our areas have higher levels of obesity than the England average. Obesity in children is discussed above - **Excess weight in children and young people**

We have seen that those with obesity are particularly vulnerable to COVID-19 with many intensive care admissions and deaths being in those who are overweight or obese. Lockdowns and local restrictions may have increased sedentary behaviour, but we have also seen increased uptake of walking and cycling. Many cycling infrastructure projects have proven very popular and we should do all we can to encourage the uptake of active transport as well as activity for leisure.

Figure 28 - Percentage of physically active versus inactive adults (2018-19)[10]

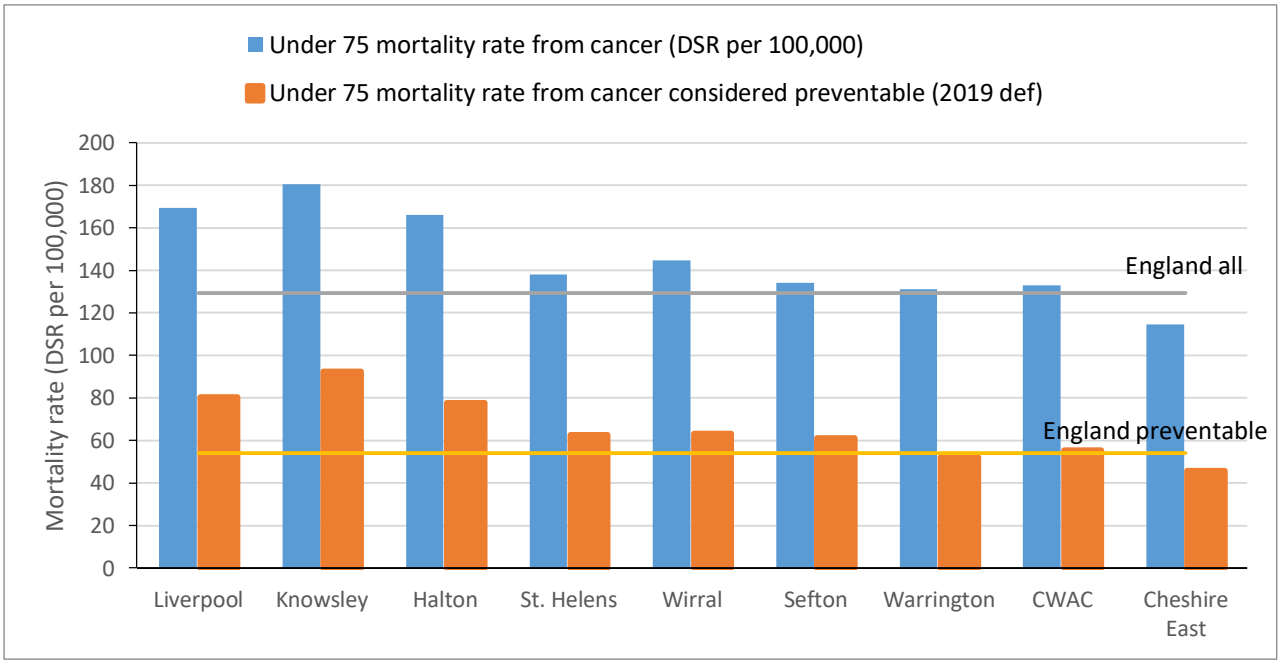


Population Health programme activity:

- Physical activity. Development of Framework/Implementation and comms plan Early Years (0-11)
- Workplace, Health and Social Care.

14. Cancer

Figure 29 - Under 75 mortality rate from cancer (All versus preventable) 2017-19[10]



Overall, our cancer figures are better in our less deprived areas, with fewer premature deaths and a higher uptake in our cancer screening programmes. However, there will also be significant inequality within each

region. Screening data is often available at practice level and it is likely that there is an opportunity to save lives if variation is eliminated within and between our areas.

We may see an impact of COVID in several aspects of cancer care, from increased exposure to risk factors (home drinking, sedentary behaviour), to delayed diagnosis through late presentation or missed screening opportunities, to delays to treatment such as through the postponement of surgery or urgent care.

Figure 30 - Cancer screening coverage - breast and bowel cancer (2020)[10]

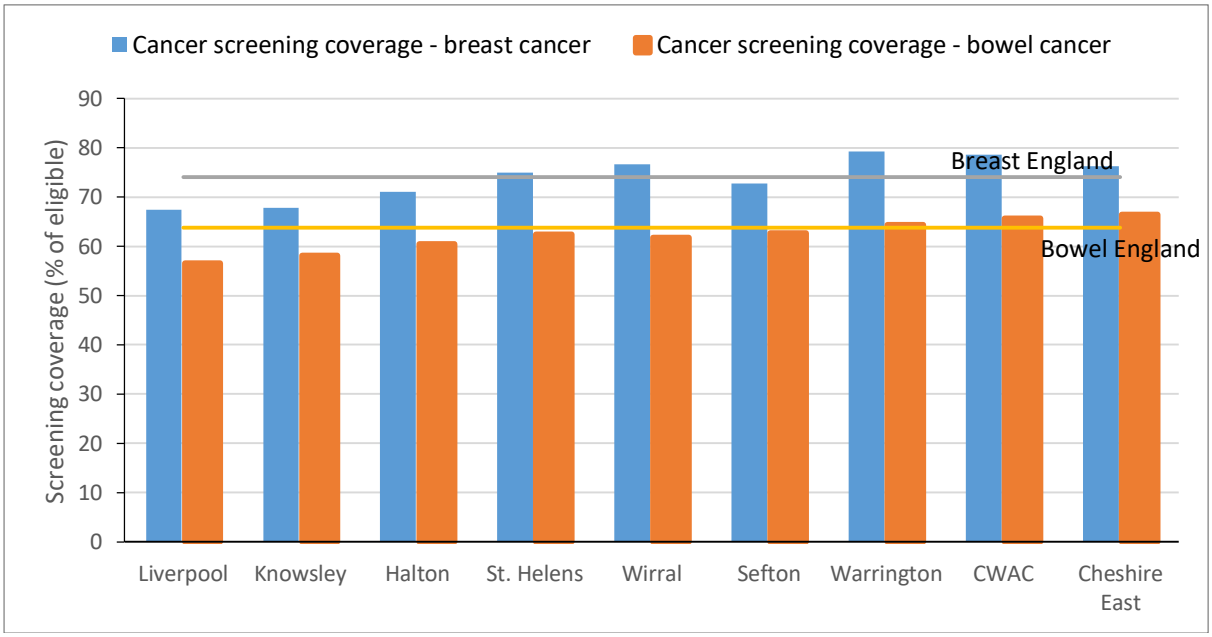
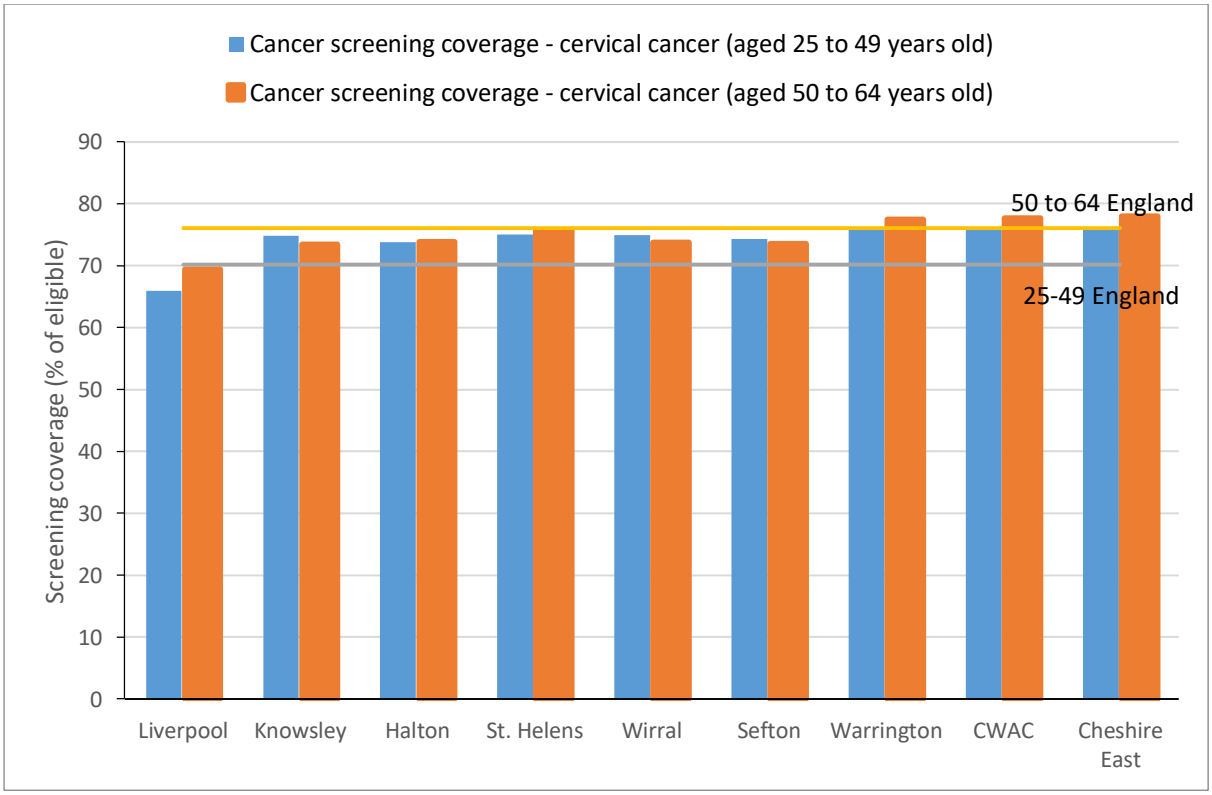


Figure 31 - Cervical screening coverage 2020[10]



Population health programme activity

- Implement 8 WTE Cancer Screening Coordinators for breast and bowel screening
- Develop training toolkit for frontline community staff to educate and influence cancer outcomes of local population for breast, bowel and cervical cancer
- Develop cervical text message reminder service with Primary Care Networks

Cheshire and Merseyside Cancer Alliance priority areas:

- Prevention
- Faster Diagnosis
- High Quality Modern Services Programme Work
- Patient Experience
- Personalised Care

15. COVID-19: The Pandemic Curve over the last year

(note: as a fast moving issue, this section aims to provide a picture of the pandemic across Cheshire and Merseyside. It does not aim to provide the up-to-the-day data available via the CIPHA dashboards and other sources)

Coronavirus disease 2019 (**COVID-19**) is a contagious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The first case was identified in Wuhan, China, in December 2019. The disease has since spread worldwide, leading to an ongoing pandemic.

Symptoms of COVID-19 are variable, but often include fever, cough, fatigue, breathing difficulties, and loss of smell and taste. Symptoms begin one to fourteen days after exposure to the virus. Of those people who develop noticeable symptoms, most (81%) develop mild to moderate symptoms (up to mild pneumonia), while 14% develop severe symptoms, and 5% suffer critical symptoms (respiratory failure, shock, or multiorgan dysfunction). At least a third of the people who are infected with the virus remain asymptomatic and do not develop noticeable symptoms at any point in time, but they still can spread the disease.[15][16] Some people continue to experience a range of effects—known as long COVID—for months after recovery, and damage to organs has been observed. Multi-year studies are underway to further investigate the long-term effects of the disease. The virus that causes COVID-19 spreads mainly when an infected person is in close contact with another person.

The first cases of Covid-19 appeared in early January 2020 in a couple of Cheshire & Merseyside areas. Cases had been detected in all 9 local authorities by 13th March 2020.

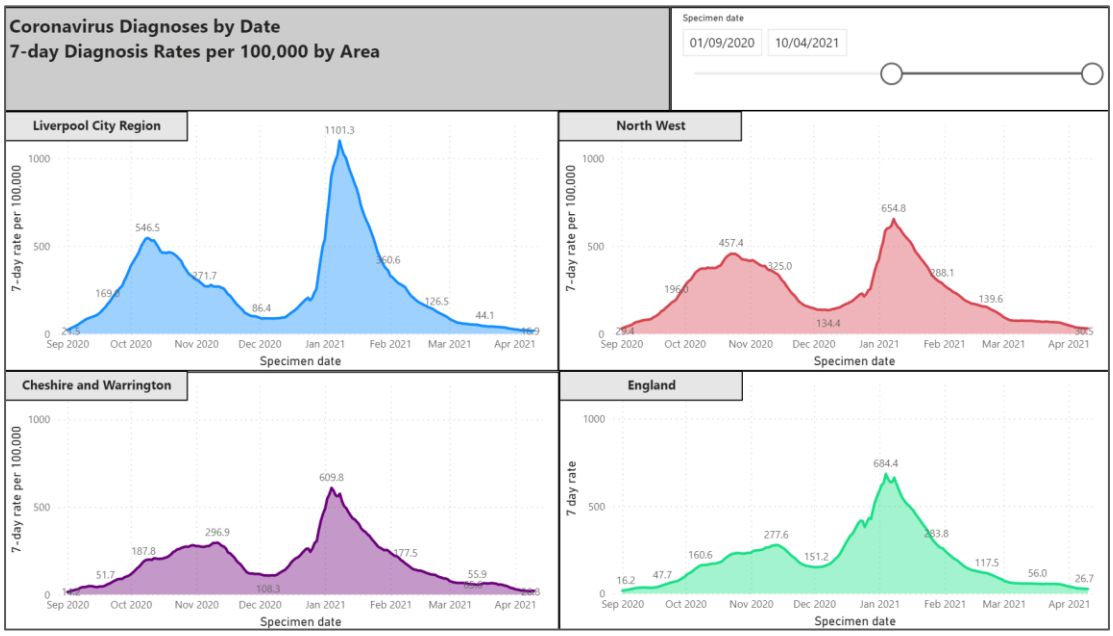
Initially most testing occurred in NHS and care home settings – known as Pillar 1 cases – so it is not possible to accurately assess case rates across the whole of the pandemic. After an initial peak in April, the impacts of national lockdown positively affected rates and hospital admissions. However, the easing of lockdown, opening up of the economy including hospitality, and subsequent increase in social mixing resulted in increasing number of positive cases from August 2020. Restrictions were imposed and strengthened across the sub-region in October so when the second national lockdown was announced commencing 5 November cases had already started to fall locally. However, from the beginning of December, with more workplaces open and Christmas festivities on the horizon cases began to rise sharply. There had also been a new variant

1. *Oran, Daniel P.; Topol, Eric J. (22 January 2021). "The Proportion of SARS-CoV-2 Infections That Are Asymptomatic". Annals of Internal Medicine: M20-6976. doi:10.7326/M20-6976. ISSN 0003-4819. PMC 7839426. PMID 33481642.*

16 *"Transmission of COVID-19". European Centre for Disease Prevention and Control.*

of the virus detected, known as the Kent variant, which was much more transmissible. These two factors created the environment for the highest case rates seen during the year, peaking at the end of the first week in January 2021.

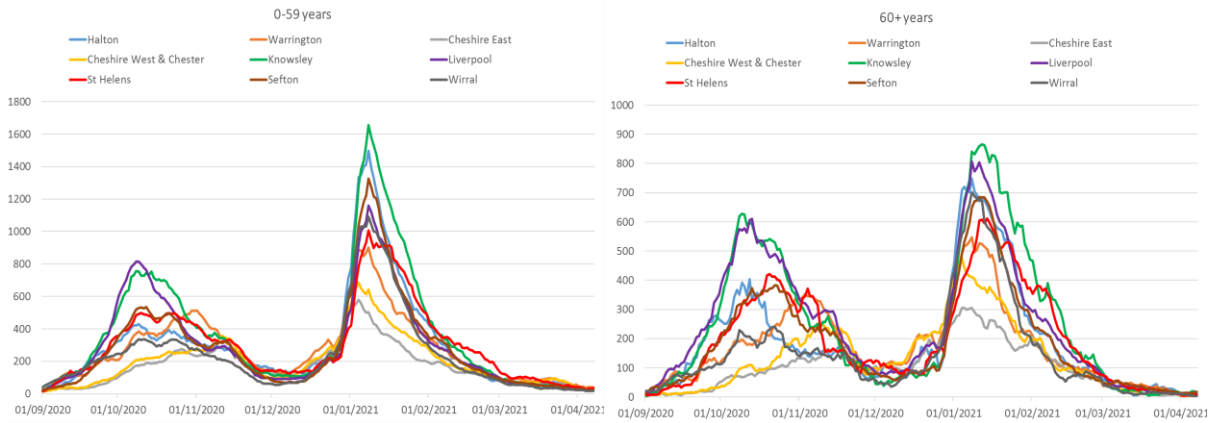
Figure 32: New cases, 7-day rolling rate per 100,000 population



Source: PHE Situational Awareness Explorer portal

Cases amongst those aged 0-59 years have been higher than those aged 60+ reflecting shielding and mobility e.g. young people having to attend school and those of working age who have continued to work outside the home. The waves have followed the same pattern as for all age, although the rates have consistently been lower in the 60+ age group.

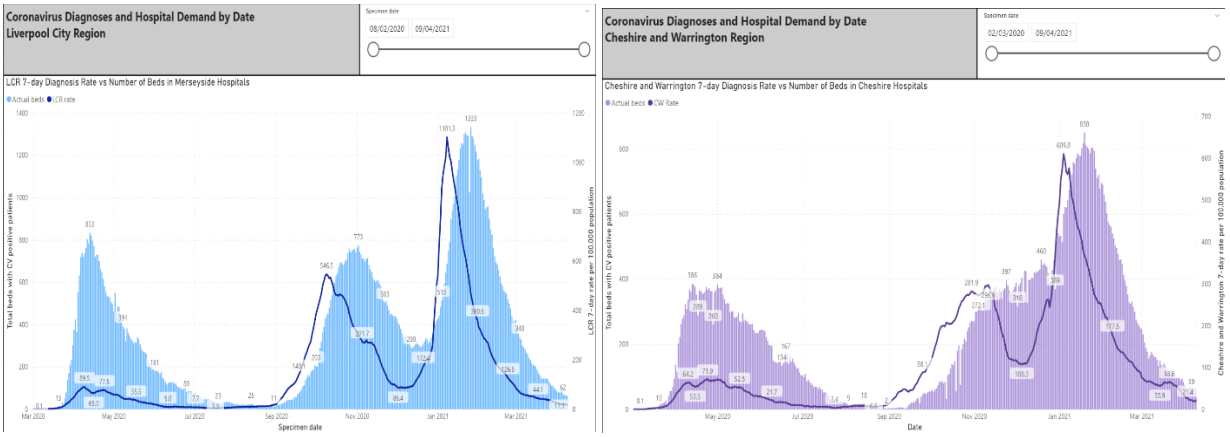
Figure 33: 7-day rolling rates per 100,000, aged 0-59 and 60+, September 2020 onwards



Source: PHE via coronavirusdata.gov.uk

Hospital admissions tend to follow behind cases by a week or two. As with cases there have been three waves of admissions to hospital across Cheshire & Merseyside where the person being admitted tested positive for Covid-19. The latest peak (mid to late January depending on the individual hospital Trust) has now decreased with only 3 new admissions per day of a person diagnosed positive for Covid-19 and only 5 new inpatient diagnoses. Only 1.92% of occupied hospital beds are for people with Covid-19. HDU/ICU beds occupied by a person with Civud-19 have also fallen..

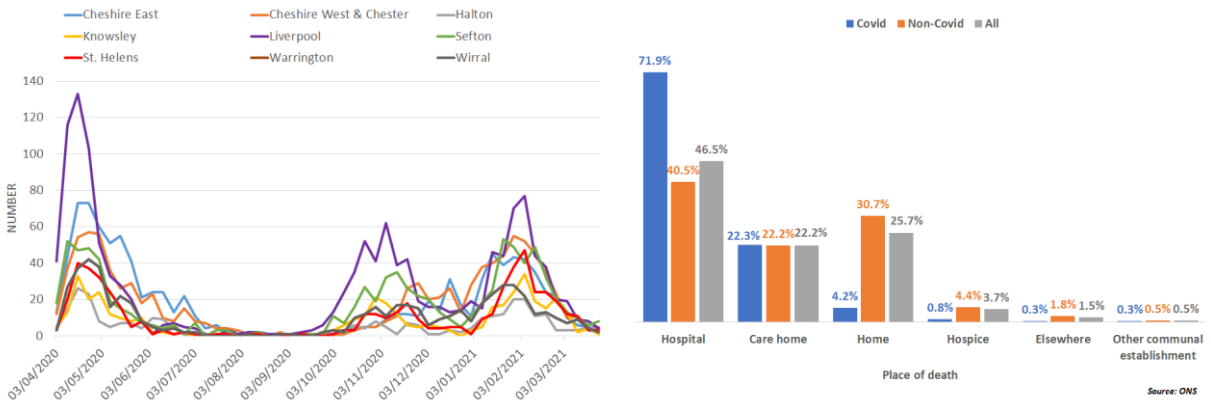
Figure 34: Trend in hospital admissions



Source: Hospital daily sitreps via NHS England and cases via PHE

Whilst the majority of people recover from the disease within a week or two, with only a small proportion becoming ill enough to need hospital care, a proportion of these together with frail older people living in care homes have died from the disease. Whilst coding early on in the pandemic may have resulted in a level of under estimation we know for definite that 7,003 people have died of the disease. The third wave saw a rise to 356 deaths per week n early February to 31 week of 26 March. A higher proportion of deaths due to Covid-19 occur in hospital compared to non-Covid deaths. Like hospital admissions there is a lag between the peak number of cases and the peak in deaths. Deaths, which had risen sharply are now in single figures per week in all local authority areas.

Figure 35: Trend in deaths a proportion of deaths by place of death, Cheshire & Merseyside, week 1 2020 to week 5 2021

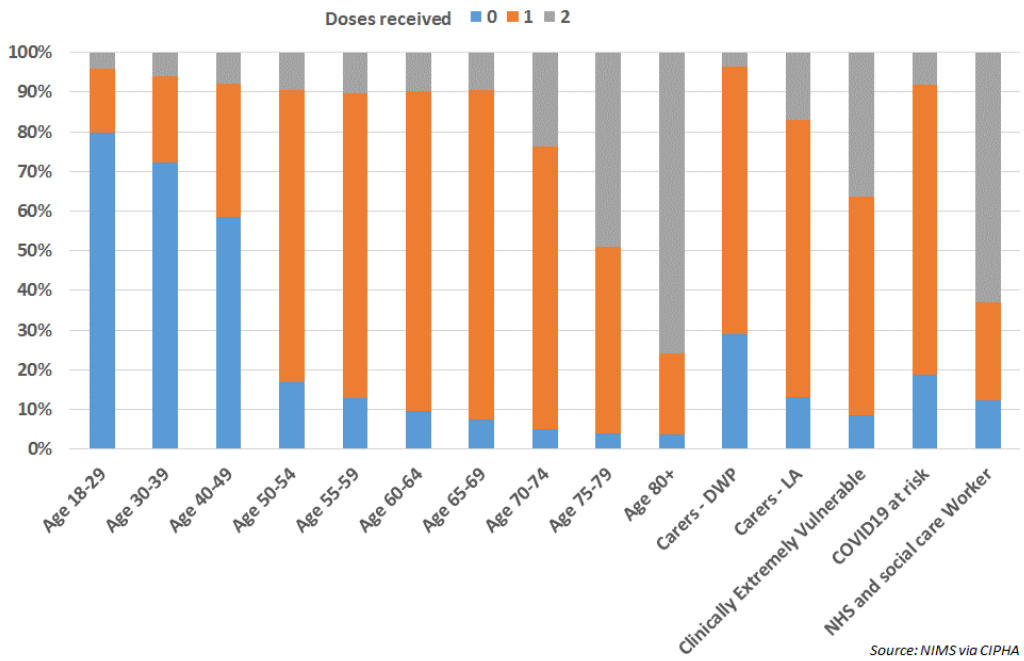


Source: Office for National Statistics

One of the most important pharmacological interventions in assist in bringing rates down and helping us to recover from the pandemic is the introduction is mass vaccination. Using Joint Committee on Vaccination and Immunisation (JCVI) categories, vaccination started with the most vulnerable based on age plus health and care workers and has now been extended to Clinically Extremely Vulnerable regardless of age plus all

over the age of 50 (recently extended to 40 year olds). Uptake has been extremely good, especially in the oldest age groups. Lower uptake in younger age groups to date is partially a reflection that the programme has only recently been opened up to those age 50+ and now 40+. Two doses of the vaccine are recommended with a 10-12 week gap between first and second dose. Therefore, apart from the oldest group, few in the other priority groups will have reached their second dose window and this is reflected in the data.

Figure 36: Vaccination uptake by JCVI priority groups, no dose, 1 dose and 2 doses



Population health activity

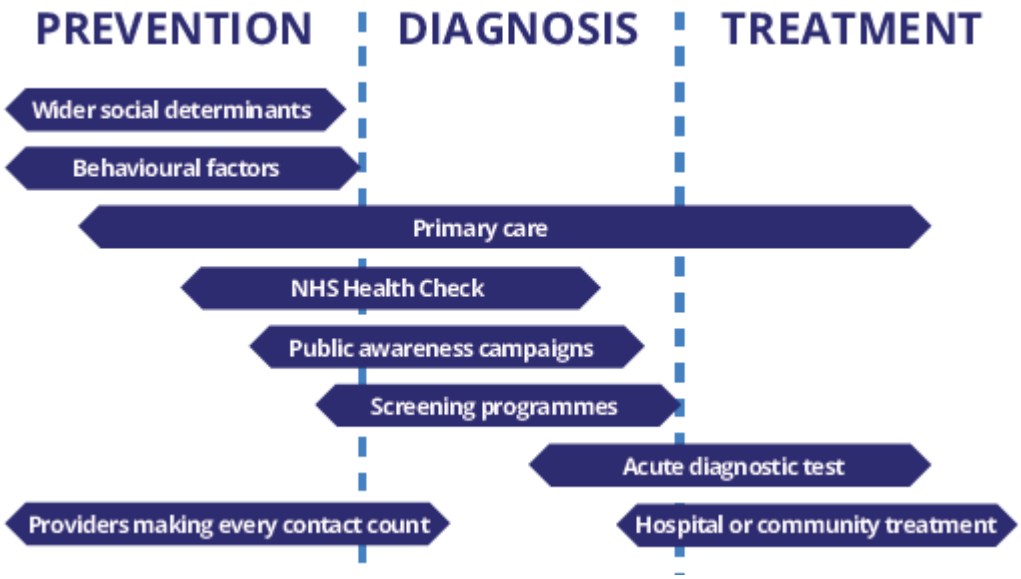
- Strategic Leadership. Ensure effective governance structures to deliver good outcomes, system consistency and alignment, risk management, quality assurance. via CM DsPH Leadership/Board
- Contact Tracing System/Hub. Develop an integrated system to case finding and contact tracing with local places, Public Health England and the National TT Team overseen by the CM CT Strategic Programme Board
- Contact tracing workforce. Develop a training framework and programme to enable a trained, supervised workforce (short and long term), together with surge capacity and mutual aid system.
- Communications and engagement. Deliver strong, clear and consistent communication for the public, workforce and system to supplement national messages
- Data Flows and Analytics.
- Ensure a cohesive approach to data and intelligence so that CM is able to identify hotspots/monitor cases/outcomes and trigger thresholds
- Case Management System. Implement a robust and resilient Case Management System that allow information capture at C&M and local level to help track/manage local cases and outbreak
- Policy and Guidance. Shared CM outbreak management framework. Supporting effective scenario planning/pathways and protocols
- Testing and Vaccination. Ensure strategic connectivity to national policy and CM strategy to ensure adequate, responsive targeted testing capacity and vaccinations are deployed

- Supporting programmes direct and indirect impact (Marmot/CVD/Mental wellbeing and Suicide Prevention/Alcohol/Cancer Screening)

16. Areas of opportunity

This report has taken a high level view of the health of Cheshire and Merseyside's population but there are many groups and conditions that have not been examined in detail. For each condition contributing to poor health and wellbeing, we can consider how illness can be prevented, diagnosed early and managed proactively, with early intervention closer to the person the priority.

Figure 37 - Domains of intervention, reproduced from Living Well for Longer (DoH, 2013)



Each programme is considering how the system needs to function to ensure a joined-up and person-centred patient experience and to achieve the left-shift to more proactive care.

In doing so, we should consider how we move to a system of population health management: The organisation of and accountability for the **health** and **healthcare needs** of defined groups of people utilising **proactive** strategies and interventions that are **coordinated, engaging, clinically meaningful, cost effective** and **safe**.

This will allow us to deliver on: the IHI Triple Aim of Population Health, which here has been expanded to five aims.

Figure 38 - the IHI Triple Aim of Population Health (often expanded to five key aims)

COVID-19 has led to massive disruption to service delivery and placed a huge strain on our staff and communities. However, it has also accelerated the development of remote delivery and helped build on our partnerships to make big changes quickly. We must take care to capture and build on these benefits.

Potential aims

Target the causes of avoidable mortality with action on smoking, poor diet, sedentary lifestyles and alcohol; ensure high uptake of vaccinations and screening programmes; embed prevention in all health and social care activity and make services accessible to all.

System-wide action is needed. The greatest gains are made when expertise impacts across organisational boundaries and we take coordinated action to improve care.

Those populations at the highest risk of experiencing poor health outcomes may need increased investment and service provision. Health inequalities should not just be seen as an input or as a measure of need but as an outcome, something that every service has an opportunity and responsibility to improve. We have presented wards with higher levels of premature deaths and those with more emergency hospital admissions than might be expected for their levels of deprivation. These “priority” wards should be addressed when planning services and interventions.

Every contact with services is an opportunity to support quitting smoking, improving diet, increasing exercise and reducing alcohol. This activity should be part of service planning. Investing here can show real savings to local health and social care system resources in just a few years.

Care pathways for causes of avoidable mortality should be examined to ensure all opportunities for improvement are realized and comparisons with comparable areas can help find places to focus.

As a system, we must honestly appraise the impacts of our services on health inequalities. We should question whether we have the same expectations for the health of those living in our most deprived areas as those in our most affluent.

17. Dissemination and next steps

Paper to be shared with the Cheshire & Merseyside Health & Care Partnership Board. Accompanying slide deck will be developed.

Comments will be requested.

Programmes to continue deeper dives into data and find areas of opportunity at both system-wide and small area level, focusing on those localities that have been identified as experiencing the most harm.

Consider refreshing priorities based on our causes of avoidable deaths across the region – bespoke analysis may be required using cause of death data. For example, avoidable mortality rates can be calculated at ward level to identify areas experiencing the most avoidable harm, where public health interventions or healthcare service improvement might give the greatest benefits.

Planning is underway for the creation of Cheshire and Merseyside population health dashboard, which will allow leaders to see areas of priority and progress.

Appendix 1 – Priority ward table for Cheshire and Merseyside

Figure 39 - Priority Wards: Cheshire and Merseyside STP[1]

2019 CCG code	2019 CCG name	Status	2019 ward name	2019 ward code
01F	NHS Halton CCG	Priority	Appleton	E05001577
		Priority	Broadheath	E05001580
		Priority	Ditton	E05001583
		Priority	Grange	E05001585
		Priority	Halton Lea	E05001588
		Priority	Hough Green	E05001591
		Priority	Kingsway	E05001592
		Priority	Mersey	E05001593
		Priority	Norton South	E05001595
		Priority	Riverside	E05001596
		Priority	Windmill Hill	E05001597
01J	NHS Knowsley CCG	Priority	Cherryfield	E05010935
		Priority	Halewood South	E05010937
		Priority	Northwood	E05010938
		Priority	Page Moss	E05010939
		Priority	Prescot North	E05010940
		Priority	Prescot South	E05010941
		Priority	Shevington	E05010943
		Priority	St Gabriels	E05010944
		Priority	St Michaels	E05010945
		Priority	Stockbridge	E05010946
		Priority	Whitefield	E05010949
01R	NHS South Cheshire CCG	Priority	Crewe Central	E05008620
		Priority	Crewe South	E05008624
		Priority	Crewe St Barnabas	E05008623
01T	NHS South Sefton CCG	Priority	Church	E05000936
		Priority	Derby	E05000937
		Priority	Ford	E05000939
		Priority	Linacre	E05000942
		Priority	Litherland	E05000943
		Priority	Netherton and Orrell	E05000947
		Priority	St Oswald	E05000951
01X	NHS St Helens CCG	Priority	Bold	E05000918
		Priority	Earlestown	E05000919
		Priority	Parr	E05000924
		Priority	Thatto Heath	E05000928
		Priority	Town Centre	E05000929
		Priority	West Park	E05000930
02D	NHS Vale Royal CCG	Priority	Northwich Witton	E05012231
		Priority	Winsford Dene	E05012248
02E	NHS Warrington CCG	Priority	Bewsey and Whitecross	E05011025
		Priority	Fairfield and Howley	E05011030
		Priority	Orford	E05011038
		Priority	Poplars and Hulme	E05011040
02F	NHS West Cheshire CCG	Priority	Blacon	E05012209
		Priority	Neston	E05012226
		Priority	Westminster	E05012244
		Priority	Wolverham	E05012253
12F	NHS Wirral CCG	Priority	Bidston and St James	E05000955
		Priority	Birkenhead and Tranmere	E05000956
		Priority	Bromborough	E05000957
		Priority	Claughton	E05000959
		Priority	Leasowe and Moreton East	E05000964
		Priority	Liscard	E05000965
		Priority	Rock Ferry	E05000971
		Priority	Seacombe	E05000972
		Priority	Upton	E05000973
99A	NHS Liverpool CCG	Priority	Anfield	E05000887
		Priority	Belle Vale	E05000888
		Priority	Clubmoor	E05000892
		Priority	County	E05000893
		Priority	Croxteth	E05000895
		Priority	Everton	E05000896
		Priority	Fazakerley	E05000897
		Priority	Kensington and Fairfield	E05000899
		Priority	Kirkdale	E05000900
		Priority	Knotty Ash	E05000901
		Priority	Norris Green	E05000903
		Priority	Old Swan	E05000904
		Priority	Princes Park	E05000906
		Priority	Riverside	E05000907
		Priority	Speke-Garston	E05000909
		Priority	Tuebrook and Stoneycroft	E05000910
		Priority	Warbreck	E05000911
		Priority	Wavertree	E05000912
		Priority	Yew Tree	E05000915

Appendix 2: Mortality by ward

Figure 40: All cause mortality under 75 (2013-17), electoral wards across Cheshire & Merseyside in the worst area quintile

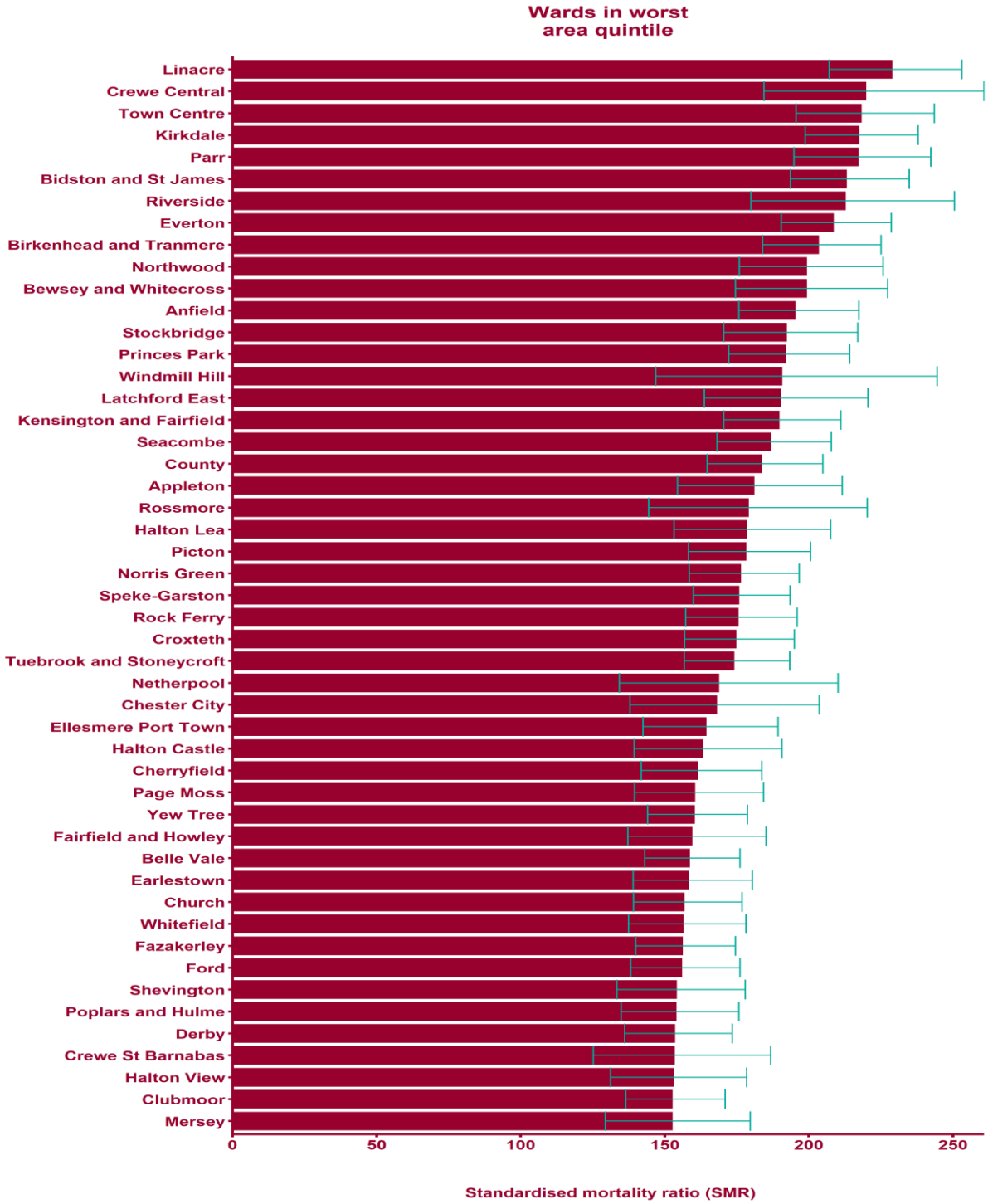
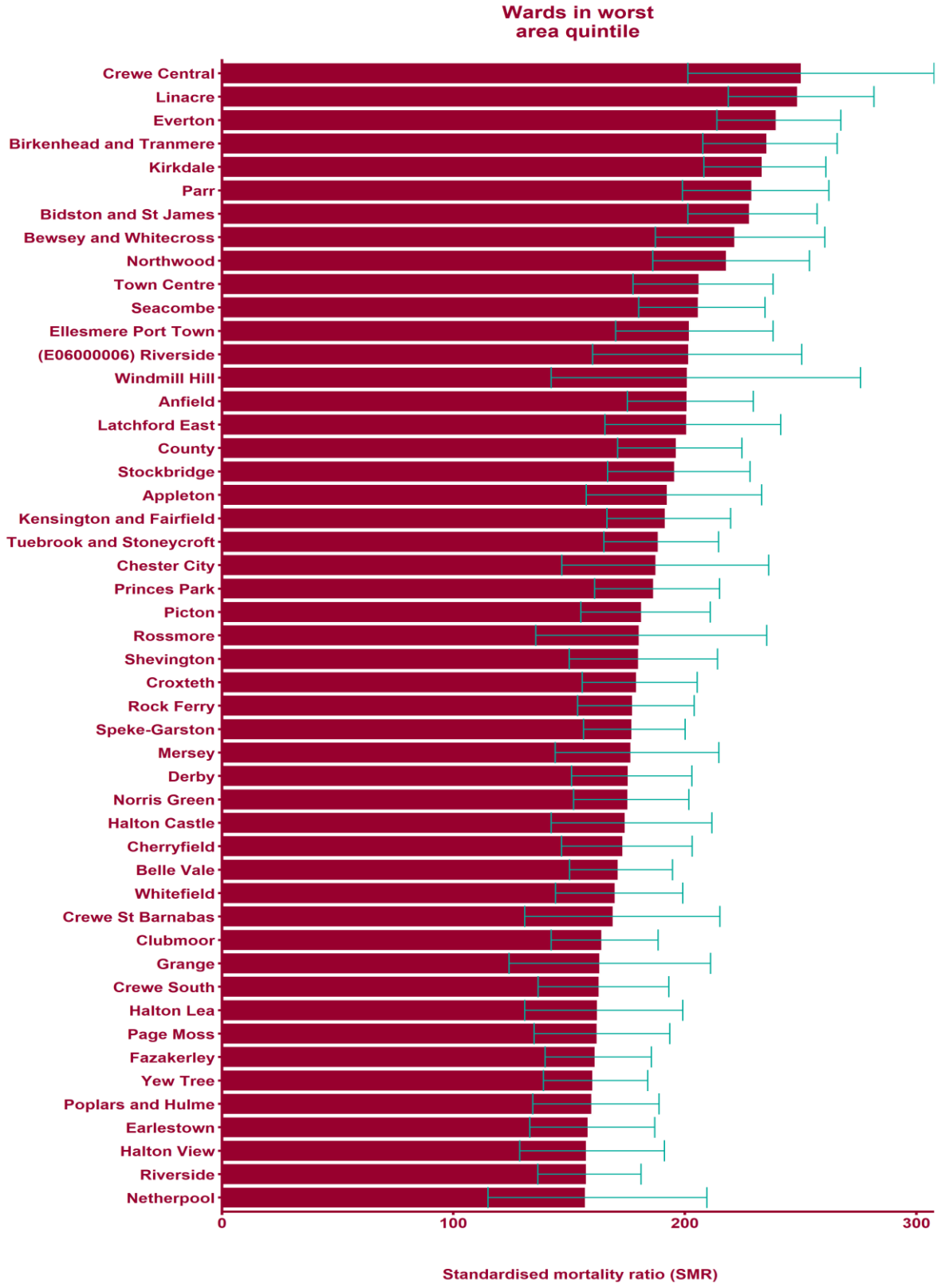


Figure 41: Deaths from causes considered preventable, all ages (2013 - 17)



Cheshire and Merseyside
Health and Care Partnership

Improving Health and Wellbeing in Cheshire and Merseyside

Strategy 2021-2025

Introduction

The NHS Long Term Plan published in 2019 called for health and care to be more joined up locally to meet people's needs. Since then, ICSs (Integrated Care Systems) have developed across England as a vehicle for the NHS to work in partnership with local councils and other key stakeholders to take collective responsibility for improving the health and wellbeing of the population, co-ordinating services together and managing resources collectively. Cheshire and Merseyside was designated an ICS by NHS England in April 2021.

Cheshire and Merseyside is one of the largest ICSs with a population of 2.6 million people living across a large and diverse geographical footprint. The ICS brings together nine 'Places' coterminous with individual local authority boundaries, 19 NHS Provider Trusts and 51 Primary Care Networks. There are many underlying population health challenges in the region; for example in Liverpool City Region 44% of the population live in the top 20% most deprived areas in England, 26% children (0-15 years) live in poverty and compared to England average, the region performs significantly worse for premature cancer, Cardiovascular disease (CVD) and respiratory deaths.

Whilst the levels of deprivation are not as high in Cheshire, there are stark pockets of deprivation and health outcomes for some long-term conditions, and alcohol and self-harm are worse than the England average. Demand for health and care services in the region is very high and growing (exacerbated by the impact of the Coronavirus pandemic). Our services are not sustainable without a different approach in how we work together, and a shift in focus away from the treatment of illness to one of prevention and wellbeing.

Equality, diversity and inclusion is part of everything we do and we have made a series of pledges to address race equality. After an extensive project to gain insight into our ethnic communities we now have a deeper understanding of them and their needs. This will inform our decisions and developments.

Our Vision

We want everyone in Cheshire and Merseyside to have a great start in life, and get the support they need to stay healthy and live longer.

Our Mission

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

In the pages that follow, we set out our strategic objectives and associated aspirations that will enable us to achieve our vision and mission over the next five years. They are derived from NHS England's stated purpose for ICSs and joint working with our partners to identify the key areas for focus if we are to reduce health inequalities and improve lives.

Our Strategic objectives

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

Our Partners

Local Authorities

Cheshire East Council

Cheshire West and Chester

HALTON BOROUGH COUNCIL

Knowsley Council

Liverpool City Council

St.Helens Council

Sefton Council

WARRINGTON Borough Council

WIRRAL

Clinical commissioning groups (CCGs)

NHS

- Cheshire
- Halton
- Knowsley
- Liverpool
- St Helens
- South Sefton
- Southport and Formby
- Warrington
- Wirral

Providers

NHS

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

NHS North West Ambulance Service NHS Trust

- North West Ambulance Service NHS Trust

Voluntary sector organisations

VSNW healthwatch

- Voluntary Sector North West
- Healthwatch

Identifying Our Five Year Aspirations

Prior to the Coronavirus Pandemic, we engaged extensively across our partnership to understand the key health and wellbeing issues that are;

Common to our nine places

Supported by population health data

Relevant to the Long Term Plan

We wanted to understand the big issues we need to address to improve health and reverse the widening gaps in life expectancy between the poorest and wealthiest in our population. Stroke, suicide, alcohol related harm and death from violent crime were all identified for targeted whole system action, together with better access to services (eg cancer) in deprived communities.

Since the review, the Coronavirus Pandemic has presented the biggest challenge for population health since the NHS was created and we know that it has hit our most vulnerable communities hardest. If we do not tackle the impact of COVID there is a real risk of an irreversible deepening of poverty and health inequity across Cheshire and Merseyside. Therefore, our aspirations also focus on addressing the issues most affected by the pandemic.

Strategic Objective 1

Improve population health and healthcare

Five Year Aspirations:

We will:

- Reduce deaths from cardiovascular disease, suicide and domestic abuse
- Reduce levels of obesity
- Reduce harm from alcohol
- Provide high quality, safe services
- Provide support to all those experiencing ‘long covid’
- Provide integrated, high quality, mental health and wellbeing services for all people requiring support from low levels of intervention to crisis management and inpatient care.
- Underpin improvements in health and healthcare with Research and Innovation by supporting collaboration between Cheshire and Merseyside academic partners, and making them a key part of our ICS health and care partnership.

Strategic Objective 2

Tackling Unequal Outcomes and Access

Five Year Aspirations:

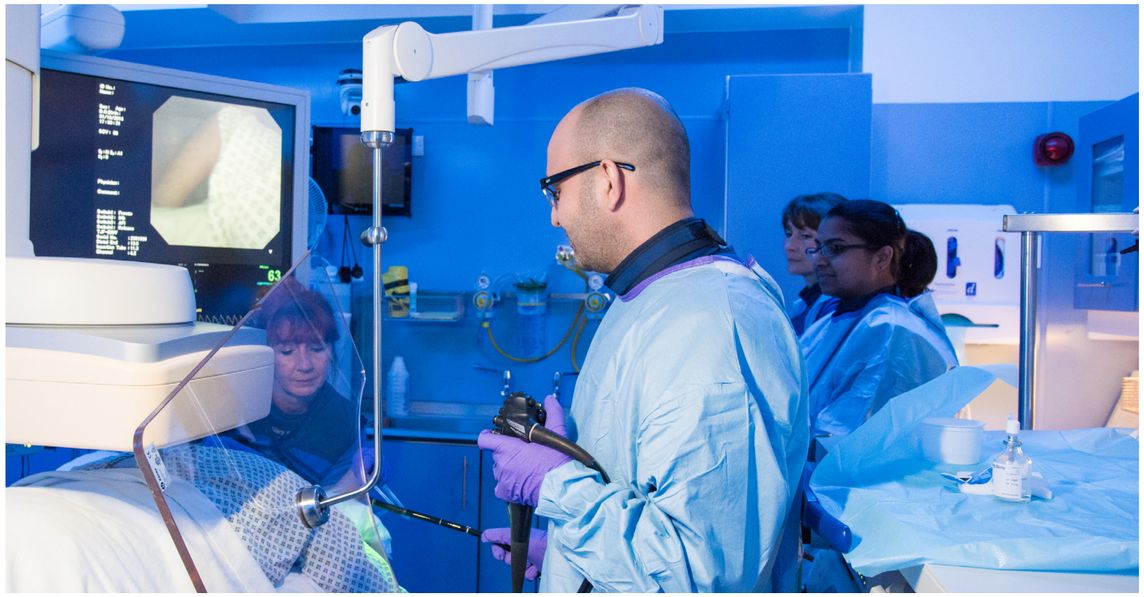
We will:

- Develop Integrated Care Partnerships in all nine places. They will support communities and individuals to be 'resilient and healthy' and access appropriate, timely support within their communities. Health and Wellbeing Boards are integral to our places and provide strategic oversight for local effectiveness. ICPs will link with Health and Wellbeing Boards and work in Place to tackle the wider socio-economic causes of poor health and inequality.
- Establish Provider Collaboratives (system wide and at Place) who will work together to reduce variation in access to services (for all our residents), reduce long waiting times and improve quality of healthcare, alongside rapid recovery of healthcare services as the pandemic eases.
- Implement a system of population health measurement that will enable us to target and tackle our key challenges in our most vulnerable communities. This will help us:

1. Reduce the life expectancy gap in the most deprived communities, in children and those with mental health conditions and help people live extra years in good health.
2. Improve early diagnosis, treatment and outcome rates for cancer
3. Improve waiting times for children and adult mental health services
4. Target those with chronic diseases so they access services especially those in our most deprived areas.
5. Reduce the impact of poor health and deprivation on educational achievement.

Strategic Objective 3

Enhancing productivity and value for money



Five Year Aspirations:

We will:

- Prioritise making greater resources available to prevention and well-being services
- Plan, design and deliver services at scale (where appropriate) to drive better quality, improved effectiveness and efficiency
- Maximise opportunities to reduce costs by procuring and collaborating on corporate functions at scale
- Develop whole system plans to address workforce shortages and maximise collaborative workforce opportunities
- Secure value for money
- Achieve financial balance across the ICS
- Develop a whole system Estates Strategy.

Strategic Objective 4

Helping the NHS to support broader social and economic development

Five Year Aspirations:

We will:

- Embed a commitment to social value in all our partner organisations
- Establish the NHS as a key Anchor institution in Cheshire and Merseyside, offering significant employment opportunities for local people
- ICS will be involved in regional initiatives to develop economy and support communities in Cheshire and Merseyside
- Develop a programme in schools to support mental wellbeing of young people and inspire a career in health and social care
- Work with Local Economic Partnerships to connect the NHS and our partners with business and enterprise.

Achieving our Objectives & Aspirations

Partnership is key, and working together, our ultimate goal is to improve the health and wellbeing of the population ensuring there is high quality, joined up care as close to people's homes as possible. Drawing on the expertise and resources available in our voluntary sector, and with the support of our local politicians, local authorities, businesses, schools and other key stakeholders, we can secure the economic growth needed to positively impact on health and wellbeing. We know that achieving our ambitions will be much harder because of Covid-19, but that has also shown that together, we are better. Our learning from the pandemic response will enhance our ability to serve our communities, especially our most vulnerable residents.

'Place' – the primacy of place is absolute and the nine local areas in our system are the key to our aspirations. Each of our nine Places will form an integrated local partnership (ICP) linked closely with Health and Wellbeing Boards, to deliver on their own local plans, and support work across Cheshire and Merseyside. The focus in each Place will be on health inequalities, outcomes and access, and partners will collaborate to ensure a high standard of care locally and strategies to address inequalities. These nine Integrated Care Partnerships (ICPs) will connect the NHS and health, care and prevention services to local businesses, schools, housing, police, fire and other partners to support local work on economic development and community safety and resilience.

Our NHS and third sector providers will also work collaboratively to deliver joined up care focusing on equal access for our most deprived communities. Transformation programmes, including national programmes linked to the NHS Long Term Plan, will support delivery of our aspirations and we will work closely with local academic partners to ensure our approaches are evidenced based and can demonstrate impact.

Many Local Authority partners have signed up to the Marmot Community approach to improving population health and we will work with this framework and with other public health specialists and local population health academics so our mission to improve the lives of the poorest fastest is realised. Health and wellbeing for individuals is much more than the absence of disease and the NHS alone can't address or fix this. We must build a healthy society with resilient communities and our commitment is to work in partnership to achieve this.

Key Enablers:

Below are some of the key enablers to help us meet our objectives and aspirations.

Legislative change during 2021-22 will facilitate integration and collaboration within ICSs and reduce competition and regulation that currently 'blocks' some elements of partnership working. These changes will support us to work effectively as a system and within each Place for better healthcare and improved population health within our finite resources.

1. Digital Transformation: we will have a robust digital transformation strategy to build on the digital innovation achieved during the pandemic and implement a shared care record across Cheshire and Merseyside.

2. Population Health Platform: we will build on and embed the use of real time population health data and analytics at both system level and Place to drive the focus on population health and care strategies.

3. Provider Collaboratives: we will establish provider collaboratives to ensure consistent high quality standards across our NHS providers. Our hospitals, mental health and community service providers will work together to address waiting times and access.

4. Place Based Integrated Care Partnerships: Each of our nine places will have effective ICPs to ensure local services (primary care, social care, community & mental health) are joined up and supporting people to manage their own wellbeing.

5. Strategic Workforce Planning: As an ICS we will secure a whole system overview of workforce challenges across all sectors and implement strategies to ensure we are growing and supporting the workforce of the future, Cheshire and Merseyside will be a great, innovative place to work.

6. Service design & transformation: we will change the way we design and transform (commission) services where the approach focuses on improved outcomes and great health care across the population and addresses unwarranted variation. Our transformation programmes will support and influence how we design services.

7. Research & Innovation: we will utilise the strength of our academic and innovation partners to embed a culture of learning, research and innovation across the system.

8. Communication & Engagement: we will communicate effectively and inclusively with all our partners and the public and we will engage and co-produce services with our local population. We will use the insight gained from 'Getting Under the Skin' to help us reach specific, seldom heard groups.

Next Steps

Across Cheshire and Merseyside there are high indices of deprivation, significant complexity amongst our population and deeply rooted inequalities of access and outcomes. As part of our journey to become an ICS we have built strong partnerships and there is now system-wide recognition and will for a step change in how we work together and integrate services. We will use our Vision, Mission, Strategic Objectives and Aspirations to underpin all our work, including engagement with local people. Our next step is to develop metrics for each of our aspirations so that progress can be properly monitored with oversight through our Partnership Board, which includes elected members to ensure democratic accountability.

Cheshire and Merseyside
Health and Care Partnership

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Health and Care Partnership Board Draft Forward Plan

Item for discussion

Report To:	**Cheshire and Merseyside Health and Care Partnership Board**
Date of Report:	28/04/21
Report Author(s):	Ben Vinter
Purpose:	Provide the Board with: • A draft Board Forward Plan to support discussion • Engage the Board in discussion on the structure, approach and next steps
Recommendation(s):	The Board is asked to: A. Provide any feedback on structure or content of its forward work programme B. Discuss and agree any appropriate next steps

I. Context

The draft HCP Board Forward Plan has been developed to provide a structure for engagement with the Board on its focus and approach over the coming year of transition.

While it is recognised that the membership of the Board is expected to change in the coming months both current and future memberships will have valid perspectives and experience to share on the scope of the Board's work. It is also probable that, during the year ahead, the scope of the Board's work will change from one ICS Board (as now) to reflect government thinking and anticipated NHSE guidance focusing on NHS and Partnership portfolios.

II. Structure of the work to date

The presentation aims to explore these issues through a number of stages or views:

1. The developing scope and architecture of an ICS – potential remits for a Partnership Board and an NHS Board
2. An initial architecture
    a. Grounding these potential areas of focus in the traditional remit of a Board
    b. Grounding the remit of a Board with the expected remit of an ICS

3. Proposals for the focus of Board meetings during the upcoming transition period
    a. Potential standing items and frequency
    b. Draft forward plan for a Board during combined phase
4. Draft proposals for areas of focus of a Partnership Board during an anticipated period of shadow operation

III. Recommendations

The Board is asked to:

A. Provide any feedback on structure or content of its forward work programme
B. Discuss and agree any appropriate next steps

Cheshire and Merseyside
Health and Care Partnership

Partnership Board Work Plan

Draft for discussion - April 2021

Government Intentions: The White Paper

‘The NHS and local authorities will be given a duty to collaborate with each other.

We will also bring forward measures for statutory integrated care systems (ICSs). These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body.

The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems’ health, public health, and social care needs’

Potential Responsibilities of ICS Partnership Board / NHS Board

Cheshire and Merseyside
Health and Care Partnership

ICS Health and Care Partnership	NHS ICS Board
Strategy	
Integrating health, care and public health planning	Strategic Health Planning
Reducing inequalities	Health intelligence
Prevention	
Population health intelligence	
Sustainability and Corporate Social Responsibility	
Regeneration and public realm	
Governance	
Shared / aligned funding arrangements	System finances, pooled funding and control total
Partnership approach to health and wellbeing pan sector programmes	Strategic Commissioning
Pan sector efficiency initiatives	System Performance
Voluntary, Community and Faith Sector delivery	Capital and Infrastructure
Integrated care risks	NHS Estate
	NHS programmes and initiatives
	Delegations (inc Place / Collaborative Reporting) – Delivery – Finances – Employment – Accountability to OSC / HWB – Quality and safety – Clinical engagement
	Statutory Compliance
	NHS Joint Commissioning (with NHSE)
	Responsibilities delegated from NHSE
	Risk management
Culture	
Improving lives through partnership	Communicate and engage on health planning
C&M People Plan	NHS C&M People Plan
Innovation	
Voluntary, Community and Faith Sector engagement and contribution	
Public engagement	
Social and Community Value	

Purpose of ICS and a Board : The White Paper

Integrating care: Next steps to building strong and effective integrated care systems across England describes the role of ICSs in the delivery of integration to serve four fundamental purposes:

a. Improving population health and healthcare (Strategy)

b. Tackling unequal outcomes and access (Strategy)

c. Enhancing productivity and value for money (Governance & Culture)

d. Helping the NHS to support broader social and economic development (Strategy)

Potential Partnership Board themes & frequency – during transition period

Cheshire and Merseyside Health and Care Partnership

Monthly

- CEOs update and Partnership coordination activities
- Update from relevant ICS Development Priority workstream and/or decision e.g system plan or JCCG programmes
- Focus on sharing learning from Place / Provider initiatives (from September)
- ICS Financial Position (developing arrangements and awareness)
- Update from NHS Board – when established or in shadow form (from Q3)
- Programmes update (alternate months)

Quarterly

- ICS Development Plan review
- ICS foundations – decisions on key transition milestones
- Strategy led deep – dive / theme discussion
- Equalities lens e.g Equity of Recovery
- System wide innovation - case study sharing best practice
- Corporate Social Responsibility focus: Sustainability, social value and anchor institutions,
- Wider determinants of health focus

Bi-annual

- Risk
- Estates and infrastructure
- Quality overview
- Staff Survey and action plan
- Equalities action plan

Key:
- Strategy
- Governance
- Culture

Potential Partnership Board items – recognising transitional year
Combined Dual Function Phase 1

Cheshire and Merseyside Health and Care Partnership

May

- Joint Committee of CCGs – development and work plan
- Places and Place Forum Update
- ICS Functional location
- Provider Collaboration – emerging thoughts
- ICS Planning Submission – NHSE
- Primary Care Network Forum – Establishment Update

June

- NHSE guidance ICS – NHS, PvCv, Place VCS
- Digital Strategy / Review
- ICS Development Plan – refresh
- CCG Annual Report - headlines / highlights
- HWB Priorities

July

- Initial plans for the establishment of ICS NHS Bodies and Health and Care Partnerships
- People Plan Action Plan
- ICS Regional Peer Review – ICS Development
- NHSE Best Practice Engaging People and Communities – implications for places and the ICS
- JSNAs

August – will there be an August meeting?

- ICS Financial Frameworks briefing inc Delegation and Contracts
- Marmot and Population Health Intelligence
- Getting under the skin research and BAME action plan
- ICS Terms of References – establishing ICS governance
- Provider Collaboration Proposals
- Updates on NHSE guidance ICS – Place V2

September

- Programmes Update
- Place MoUs
- Arrangements for ICS NHS and HCP Board

Potential Partnership Board items – recognising transitional year
Shadow Partnership Function Phase 2

Cheshire and Merseyside Health and Care Partnership

October

- Anticipated shadow working arrangements
- Approaches to engaging with the public and engagement activities 21/22 and 22/23
- Determining our key metrics

November

- ICS Delegations
- Contracting for 22/23
- Investment Priorities 22/23

December

- Workforce Planning
- Emerging Place Priorities

January

- ICS Planning 22/23
- Estates Planning and Regeneration alignment

February

- ICS objectives
- Anchor institutions and capitalising on social value
- Programmes Update

March

- CCG Handover and Closure to ICS and/or NHSE
- Staff Survey Action Plan/s
- Getting under the skin research and BAME action plan

Cheshire and Merseyside
Health and Care Partnership

Finance Report to 31 March 2021

Keith Griffiths

22 April 2021

Finance report to 31st March 2021

1. Introduction

1.1. This report summarises the financial performance of the Cheshire & Merseyside Health and Care Partnership (HCP) for the second half of 2020/21 (i.e. H2 20/21), covering the 6 months to 31st March 2021. This specifically covers:

- HCP Running Costs (i.e. 'corporate' functions);
- the individual Transformation Programmes managed on a system-wide basis; and
- the COVID-19 Mass Vaccination programme across Cheshire & Merseyside.

1.2. As regards the aggregate financial performance of CCG and Provider organisations within the Cheshire and Merseyside health system, Appendix 1 presents that a net overspend of £11.0m was delivered against the financial envelope for H2 2020/21, after the adoption of agreed year-end strategies to optimise the System's resources into 2021/22. Individual organisational positions are still subject to required regulatory and audit processes and therefore finalised outturns will be reported to the Partnership Board in May 2021.

2. Overview of financial performance

2.1. At the meeting on 26th August 2020, the Partnership Board approved a Plan for H2 20/21 with a maximum value to £7,406k (depending on the specific options of transformation programmes agreed), comprising the CCG 2.0% top-slice and Provider contributions. This resource was further augmented by £1,710k slippage in respect of 2019/20 expenditure commitments and £500k from the H2 20/21 System envelope which was retained as a system contingency linked to the pandemic response.

2.2. In terms of the outturn for H2 20/21, the HCP remained within these approved resources, delivering a surplus of £1,634k (excluding the £546k underspend against the Mass Vaccinations programme). Table 1 below summarises this position. This surplus was subsequently used to support achievement of the System's year-end financial strategy (see Section 3).

Table 1: Overview of performance against 2020/21 System budget

	2020/21 Budget £000s	2020/21 Outturn £000s	2020/21 Variance £000s
Total Income	(9,636.5)	(9,702.0)	(65.5)
HCP Running Costs *	4,258.6	4,263.4	4.8
Programme Costs	4,640.4	3,804.9	(835.5)
(Surplus)/Deficit	**(737.5)**	**(1,633.8)**	**(896.3)**
Mass Vaccs**	0.0	(546.0)	(546.0)

* Incorporates COVID Testing programmes

** Budget reflects net income and expenditure offset position i.e. gross expenditure of £905k matched by income and allocations. Any underspend in 2020/21 is to be carried forward to support the programme in 2021/22.

2.3. In respect of the underspend on the system's Transformation Programmes, the main components are as follows:

Table 2: Summary of Programme budget underspend for 2020/21

		£000s
2.3.1.	Cancer Alliance –2019/20 slippage no longer required	(84.0)
2.3.2.	Corporate Collaboration of Scale – reduction in scale of Programme for 2020/21	(309.0)
2.3.3.	Ageing Well – slipped to 2020/21 due to programme hiatus	(137.0)
2.3.4.	2020/21 HSLI revenue consequences not transacted	(200.0)
2.3.5.	Neuro Rehab	(31.0)
2.3.6.	Other underspends	(74.5)
Total Programme variance (under)/overspend		**(835.5)**

2.4. Of these, only items 2.3.3 – 2.3.5 represent commitments which potentially need to be re-provided for within 2021/22.

2.5. With regard to the Mass Vaccination and Testing programmes, income and allocations received in-year have been underspent by £546k. This is being carried forward to support the ongoing Covid vaccination programme within 2021/22.

3. Year-end system financial management strategy

3.1. The financial business for CCG requires that any overspend incurred in one year is recovered via a reduction in resources available to that CCG in the subsequent period. Provider organisations are not subject to similar requirements.

3.2. As part of the financial strategy to maximise resources available to the system in the first half of 2021/22 (i.e. H1 21/22) therefore, a decision was taken in conjunction with CCG and Provider Finance Directors to ensure that all CCGs achieved breakeven at the end of 2020/21, via support from both the HCP and Providers (on a sub-systems basis). Appendix 1 summarises the outcome of this strategy.

3.3. The HCP initially allocated £11.0m of retained H2 20/21 System monies and in-year underspends to support achievement of CCG year-breakeven positions. Of these, the Mass Vaccinations underspend (£546k) and funding for Enhanced Occupational Health & Wellbeing Pilots (£2,550k) would need to be specifically re-provided in 2021/22, and are therefore a charge against resources for H1 21/22.

3.4. Following this, further allocations (amounting to £4.8m) were received by the HCP towards the year-end, enabling further distribution so as to ensure achievement of an optimum system-wide financial position. The majority of this second distribution is required to be re-provided during H1 21/22 in respect of specific commitments.

3.5. At the HCP's encouragement, agreements were reached between Providers and CCGs within each of the four sub-systems (i.e. Cheshire, North Mersey, Mid Mersey and Wirral) to cover the corresponding residual CCG deficits (i.e. after application of the HCP contribution). The HCP wishes to commend Provider and CCG colleagues for collaborating to successful deliver a financial strategy will be provide system-wide benefit in 2021/22.

4. Recommendations

4.1. The Partnership Board is asked to note the contents of this report.

Appendix 1

Cheshire & Merseyside health system: Financial outturn positions for 2020/21 (provisional subject to review and audit

	£m
Aggregate of individual Provider (deficit)/surplus positions	(11.8)
Aggregate of individual CCG (deficit)/surplus positions	0.8
Net overall System (deficit)/surplus position for 2020/21	**(11.0)**

Notes:

1. The strategy to achieve CCG breakeven effectively avoids the 'clawback' of commissioner overspends/deficits in the subsequent financial year. This requirement does not apply to Provider overspends/deficits.

2. Individual organisational positions are presently subject to review and finalisation by NHSE/I and external audit and are therefore not provided at this time. However, no further material movement is envisaged.

3. The respective CCG and Provider positions reflect the year-end financial strategy adopted to enable the Cheshire and Merseyside health system to attain the most advantageous financial position entering into 2021/22.

4. Provider positions are after national funding specifically for additional annual leave obligations arising, and non-NHS income lost, as a direct consequence of the pandemic response.