07 March 2023
15.00pm – 17.00pm
Boardroom, The Department, Lewis's Building,
Renshaw Street, Liverpool, L3 5SB

Cheshire and Merseyside
Health and Care Partnership

Meeting of the Cheshire and Merseyside Health and Care Partnership

Agenda

Chair: Cllr Louise Gittins

AGENDA NO & TIME	ITEM		LEAD	ACTION / PURPOSE
15:00pm	**PART 1 (Informal): Workshop – HCP Priorities**			
HCP/01/23/01	Welcome, introduction to workshop and Ice breaker		LG	Verbal
HCP/01/23/02	**15:05**	Setting the scene – why are we here	LG/JG/NE	For Discussion
	15:20	Facilitated Workshop • Discussion – 40 mins • Feedback – 15 mins • Pledge – 5 mins		
	16:20	Summary and Next Steps		

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PACK PAGE NUMBER
16:30pm	**PART 2 (Formal): Business Items**			
HCP/01/23/03	Declarations of Interest *(HCP members are asked to declare if there are any declarations in relation to the agenda items)*	LG	Verbal	
HCP/01/23/04 16:30 – 16:35	Appointment of Joint Vice Chair – update	LG	Verbal	
HCP/01/23/05 16:35 – 16:45	Minutes of the last meeting – 17 January 2023	LG	Paper Approval	3
HCP/01/23/06 16:45 – 16:55	Actions from the last meeting, including update on progress	LG	Paper	16
HCP/01/23/7 16:55-17:00	Review of Meeting / Workshop	LG	For Discussion	
17:00pm	**Close of Meeting**			

Dates of future meetings:

Date	Time	Venue
9 May 2023	3:00 – 5:00	The Portal, Ellesmere Port Room G2 and 3
18 July 2023	3:00 – 5:00	The Boardroom, Lewis's Building, Liverpool
19 September 2023	3:00 – 5:00	The Portal, Ellesmere Port Room G2 and 3
14 November 2023	3:00 – 5:00	The Boardroom, Lewis's Building, Liverpool

Cheshire and Merseyside Health and Care Partnership Meeting

Meeting held online via MSTeams

UNCONFIRMED DRAFT Meeting Minutes
17th January 2023
3pm-5pm

MEMBERSHIP		
Name	**Initials**	**Role**
Cllr Louise Gittins	LGi	Chair of HCP, Leader of Cheshire West and Chester Council
Dr Raj Jain	RJa	Joint Vice Chair HCP, Chair of NHS Cheshire and Merseyside
Cllr Sam Corcoran	SCo	Leader of the Council, Cheshire East Council
Cllr Christine Bannon	CBa	Health Cabinet Member, Knowsley Council
Cllr Jane Corbett	JCo	Liverpool City Council
Cllr Marlene Quinn	MQu	St Helens Council
Cllr Ian Moncur	Imo	Chair of Health and Wellbeing Board/Cabinet member for Health and Wellbeing
Cllr Paul Warburton	PWa	Chair of Health and Wellbeing Board/Cabinet Member for Health and Adult Social Care, Warrington Council
Cllr Yvonne Nolan	YNo	Chair Adult Social Care and Public Health Committee, Wirral Council
Gareth Lee	GLe	Assistant Chief Constable, Cheshire Police
Jon Roy	JRo	Assistant Chief Constable, Merseyside Police
Alex Waller	Awa	Chief Fire Officer and Chief Executive, Cheshire Fire and Rescue
Phil Garrigan	PGa	Chief Fire Officer, Merseyside Fire and Rescue
Racheal Jones	RJo	CEO of One Knowsley, VCSE Representative for Liverpool City Region
Adam Irvine	Air	Chief Executive Officer, Community Pharmacy Cheshire and Wirral
Paul Warburton	PWr	Group Housing Director, Torus (Housing Association)
Isla Wilson	Iwi	Chair – Cheshire and Wirral Partnership NHS Foundation Trust, Provider Collaborative rep (trust in MH/LD/CS)
Dame Jo Williams	JWi	Chair of Alder Hey Children's NHS FT, Provider Collaborative rep (CMAST)
Ian Ashworth	IAs	Director of Public Health, Cheshire West and Chester Council
Margaret Jones	MJo	Director of Public Health, Sefton Council

Steve Park	Spa	Director of Growth, Warrington Borough Council
Anne Marie Lubanski	AML	Deputy Chief Executive and Strategic Director for Adults, Health and Homelessness, Liverpool City Council
Peter Broxton	PBr	Cheshire & Warrington LEP
Angela Simpson	ASi	Pro-Vice Chancellor/Executive Dean if the Faculty of Health and Social Care, University of Chester
Alison Cullen	ACu	VCFSE Rep, Cheshire and Warrington
Sarah Thwaites	STh	Healthwatch Liverpool
Carly Brown	CBr	Deputy Director of Children's Services
Lindsey Dawson	LDa	Head of Area, Skills for Care
Maxine Power	MPo	Director of Quality, Innovation, and Improvement, NWAS
Louise Barry	LBa	Chief Executive Officer, Healthwatch
IN ATTENDANCE		
Graham Urwin	GPu	Chief Executive, NHS Cheshire and Merseyside
Clare Watson	CWa	Assistant Chief Executive, NHS Cheshire and Merseyside
Claire Wilson	CWi	Director of Finance, NHS Cheshire and Merseyside
Matthew Cunningham	MCu	Associate Director of Corporate Affairs & Governance/Company Secretary, NHS Cheshire and Merseyside
Neil Evans	Nev	Associate Director of Strategy and Collaboration, NHS Cheshire and Merseyside, NHS Cheshire and Merseyside
Natalie Robinson	NRo	Associate Director of Programme Delivery and Assurance, NHS Cheshire and Merseyside
Chris Amery	Cam	Senior Corporate Communications Manager, NHS Cheshire and Merseyside

Apologies		
Name	**Initials**	**Role**
Professor Rowan Pritchard Jones	RPJ	Executive Medical Director, NHS Cheshire and Merseyside
Jane Parkinson Lofthouse	JPa	Healthwatch
Roy Jonathan Richard	RJR	Violent Reduction Partnership, Merseyside
Joanne Clague	JCl	North West Ambulance Service
Dr Raj Kumar	RKu	GP, Primary Care
Stephen Watson	SWa	Executive Director Place, Sefton Council
Prof Tom Walley	Twa	Associate Pro-Vice Chancellor for Clinical Research, University of Liverpool
Darren Mochrie	DMo	Chief Executive Officer, Northwest Ambulance Service
Karen Prior	KPr	Chief Executive Officer, Healthwatch representatives across C&M
Paul Mavers	PMa	Chief Executive Officer, Healthwatch representatives across C&M
Salman Desai	SDe	Deputy CEO/Director of Strategy, Partnerships & Transformation, Northwest Ambulance Service

Cllr Marie Wright	MWr	Chair of Health and Wellbeing Board/Cabinet member for Health and Wellbeing, Halton Borough Council

Item	Discussion, Outcomes and Action Points	Action by
HCP/11/22/01	**Welcome, Introductions and Apologies:** LGi welcomed everyone to the meeting she advised that today's meeting was being held on Teams due to the bad weather. LGi confirmed that the meeting would be filmed and recorded, the recording would be made available online at a later date. MQi requested that any future venues have a hard of hearing loop system available, she advised the Chair that if this were not available, she would need to have the option to join via Teams. LGi provided assurance that all venues that are used will be fully accessible. LGi confirmed that going forward a Chairs briefing will be provided after all future meetings. LGi highlighted that the Integrated Care Partnership Strategy cannot be approved until after the May elections when governance processes have been put in place. This will be for noting at today's meeting, a workshop will then take place in March for the group to review the strategy and share any feedback on this. LGi advised that going forward Milo Vassic from Halton will be the representative for all the Directors of Children's Services across the system, CBr will be deputising for him at today's meeting. CBr confirmed that she is attending today on behalf of the 9 Directors of Children's Services in Cheshire and Merseyside. Apologies were noted from Jane Parkinson Lofthouse from Healthwatch. Louise Barry and Sarah Thwaits attended on behalf of all the 9 Healthwatch areas in Cheshire and Merseyside. LGi reported that Cllr Frazer Lake is no longer the representative to Liverpool City Council. Cllr Jane Corbett will now represent Liverpool Council.	
HCP/11/22/02	**Declarations of Interest** There were no declarations of interest noted at this meeting	
HCP/11/22/03	**Minutes of the Last Meeting – 8 November 2022** The minutes from the last meeting on the 9th November were approved as an accurate record.	
HCP/11/22/04	**Actions from the last meeting including update on progress**	

Item	Discussion, Outcomes and Action Points	Action by
	Identify opportunities for the Partnership to learn more about the purpose, governance, and structures of the ICB CWa agreed to present an update on this at the March 2023 meeting, she asked for volunteers to work with her on this. **Providing web access to the meeting for members of the public and ideas on how the partnership can engage effectively with the wider public** CWa confirmed that an ICB communication and engagement framework was published in July. An update on the framework will be presented at the ICB Board next week. CWa agreed that this would be shared with wider stakeholders and an update on this would be brought to this meeting in March 2023. **To invite a suitable education representative to the meeting** It was agreed that this action was complete. **To investigate the possibility of developing a central dashboard containing relevant data sources** IAs advised that a central dashboard has now been published and local Place leads should now access to this. It has now been agreed that a future session will be held on the fair employment charter. **How can this group explore widening the remit of the Fire Service Safe and Well check to meet the wider priorities of the cost of living and fuel poverty?** The fire service has now agreed to integrate cost of living and fuel poverty into their safe and well checks. AWa confirmed that during the safe and well checks literature from the local authorities is now shared with householders. Work is continuing to ensure that support is available for those who are most vulnerable. ACu noted that the voluntary sector is working closely with local authorities she asked can this information also be shared. MQu reported that job centre plus is doing a presentation at the Peoples Board they will be sharing all the figures for families in need in their area. On the 9th February the Town Hall in St Helen's will be open to the public they will be offering help to anyone who needs it. MQ clarified that this offer is also open to other districts. PGa noted that a lot of work is being done around the cost of living and safe and well. PGa agreed to invite the national Lead to a future meeting to give an update on what support the fire and rescue service offer. LGi agreed it would be useful to get an update on this she agreed to ensure that this is included on the forward plan. IAs provided assurance that work has also taken place linking in with the community pharmacy team to look at how they can cascade more wider information and advice. The medical director for the ICB is looking at doing some innovation work looking at high risk people and those	

Item	Discussion, Outcomes and Action Points	Action by
	residents with chronic obstructive pulmonary disease and children with asthma. CWa noted thanks to the voluntary sector for all the work they are doing she suggested it would be useful to get an update from them on their future plans. LGi agreed to ensure this is also added to the forward planner. **Can the Network of Social prescribers be used across the region to support the work around the cost of living /fuel poverty** LGi noted the importance of the role of social prescribing she suggested this is something that could be discussed at a future meeting, it was agreed that updates would be provided from both Liverpool and Knowsley. **To consider the possibility of developing a repository of innovation which can also be accessed by the public** LGi suggested this will link into the communications plan that will be reviewed at the next meeting. **Share website and contact details for the Zero Suicide website** It was noted that this action has now been closed. **To develop a comms plan for the HCP** It was agreed that this would be discussed at the next meeting. **To review meeting times and venues to ensure good public transport links** LGi confirmed that the next meeting will be held in Liverpool City Centre at the Lewis building. CBa asked have hybrid meetings been considered as an option to allow people to attend online if they are unable to get to a venue. LGi agreed that the whole technology around the meetings does need to be looked at. LGi asked the group to let her know if they have any thoughts on this and she agreed that this would be discussed at the next meeting.	
HCP/11/22/05	**Appointment of Joint Vice Chair Update** It was agreed at the last meeting that a representative from the community and voluntary sector would be appointed as Joint Vice Chair for this meeting. LGi confirmed that interviews are now being set up and it is hoped that by the March meeting a Joint Vice Chair will be in place.	
HCP/11/22/06	**Cheshire and Mersey HCP Draft Interim Strategy** LGi confirmed that this item is for noting she provided assurance that a detailed in-depth discussion on this will take place at the March meeting. NEv provided a summary of the paper and noted that originally it was agreed that this would be published at the end of December however it	

Item	Discussion, Outcomes and Action Points	Action by
	was later clarified that this was not mandatory. It was agreed by the ICP that further work would be done on this before it was published. The document describes the existing plans and strategies rather than presenting lots of new and alternative views. The document focuses on reducing health and equalities and building on all together fairer. Public engagement on this document has not yet been undertaken however colleagues from Healthwatch have shared some intelligence that they have gathered from the public. NE also noted that many of the documents that have been used to build the strategy have been developed though public engagement and co-produced. The document was shared in draft form at the start of December with a wide range of partners from across Cheshire and Merseyside feedback from this helped refine the document. One of the things that was updated was the vision and mission this now reflects living well for longer it also now shows that prevention is one of the key priorities. The core 20PLUS 5 set of health and inequality priorities for children and young people has now been embedded in the document. Although an impact assessment on the document has not yet been done this has been reviewed through the equality diversity and inclusion lens to ensure the language used and the content reflects those values and principles. NEv provided assurance that over the coming months a detailed impact assessment will be completed. Feedback has been received from the Cheshire and Mersey joint scrutiny committee this will help inform some of the detailed work that needs to be done. Work will take place with health and wellbeing boards and Places to use existing arrangements to talk about the strategy and plans. Work is also taking place with colleagues from the business intelligence teams across the system to look at the population health intelligence to help inform the priorities in the strategy. This will help with the development of an annual plan for next year that lets us concentrate on those priorities that will have the greatest impact on population health. NEv asked the group to share any feedback on the approach described in the paper as well as the content in the strategy. LGi thanked NEv for all the hard work he has done on this, she also thanked the scrutiny committee for their input into this. CBa raised concerns that although maternity services are referenced in the strategy there was no representation from maternity services at this	

Item	Discussion, Outcomes and Action Points	Action by
	meeting. CWa suggested that the provider collaborative (CMAST) should represent maternity services. CWa noted that the local authority and other partners are also in attendance she suggested that they could support any discussions around children's health and services. It was agreed that JWi would represent maternity services. JCo shared her feedback on the report and LGi agreed that this would be considered when the report was updated. RJR noted that the serious violence duty has now been published by the government. This places a specific duty on partners to collaborate to reduce serious violence. RJR asked how this duty will be met by the partnership and by the Board. LGi agreed to provide an update on this in March. RJR offered to support any development work around this. SCo noted concerns that the key message to tackle population health and promote good health may get lost in the 48-page report he also asked when will the finance strategy be produced. LGi agreed that this is a weighty document and agreed that work needs to take place to consider what the key priorities are. JCl asked can some thought be given to introducing some must doos over each year of the plan. LBi agreed that this is something that should be done. PWa thanked everyone for their input on the document he noted the importance of the adult social care and workforce sections that are included. PWa felt that there needs to be assurance that there is a workforce that is properly supported, educated, rewarded, and valued. It was agreed that the workforce element needs to be a priority. CWi advised that work is taking place on the NHS element of the financial strategy over the next couple of months however she felt that the wider financial strategy across the partnership will take longer. CWi suggested that an update on the process and timeframe on this should be brought back to this meeting. SCo asked for assurance that this strategy will be considered when budget setting for 23/24 is done. CWi confirmed that this will be considered when the budgets are set. CBa agreed that ensuring that there is correct financial support across the board and ensuring that there is a robust workforce needs to be a priority to ensure the services can be delivered. MQi felt that there needs to be a guarantee that the ICB will delegate finances down to Place once this has been done then work can take place at Place to integrate services. LGi agreed it is important that decisions can be made as a region.	

Item	Discussion, Outcomes and Action Points	Action by
	GPu agreed that there needs to be clear delegation set out and people need to understand the level of influence and flexibility. LGi confirmed that further discussions on this will take place at the March meeting. LGi suggested it would be useful if colleagues could provide feedback from each of their own areas. The partnership noted the content of the draft interim strategy which outlines the interim approach as a partnership to identify and act on the objectives and priorities. LGi noted that the key priorities do need to be narrowed down. It was agreed that some actions on what needs to be achieved should be pulled together. A draft interim strategy document will be published on the Cheshire and Merseyside ICB website, this can also be published on each organisations own website this will help show a partnership approach and allow as much access and public engagement as possible. The NHS Cheshire and Merseyside ICB will be required to consider the prioritised areas identified within the draft interim strategy when they develop their ICB 5-year joint forward plan by June 2023. All health care partnership members must inform their own organisational plans using the strategy. The Partnership endorsed the suggested next steps within the paper with respect to refining the draft interim strategy in advance of the HCP approving a final strategy upon the formal establishment of the HCP as a statutory joint committee after the May elections. Work will take place to prioritise the areas contained in the draft interim strategy by reviewing population health, intelligence and reviewing and agreeing the priorities at a workshop in March. An HCP annual plan will be co-produced which details work programmes which will deliver the shared priorities and have clear and measurable outcomes. The work programme will recognise the response to the immediate service pressures as well as the longer-term objectives. **Decision: The partnership was happy to note and endorse the draft strategy.**	
HCP/11/22/07	**NHS Planning Guidance 2022/23** NEv shared a paper on the NHS planning guidance for 2023/24 for information and highlighted the following.	

Item	Discussion, Outcomes and Action Points	Action by
	The NHS planning guidance came out on the 23rd December and work is currently taking place to develop the Cheshire and Merseyside response to this. The 3 main areas are around recovering services and productivity, progress in delivering the long-term plan objectives and transforming the NHS. Three areas of recovery were highlighted in the NHS guidance these were: • Improving ambulance response and A&E waiting times • Reducing waits for elective care and cancer care and improving diagnostic testing for these • Primary care access The development of integrated care systems is also highlighted as a key priority. The integrated care board and its NHS provider Trusts are required to produce a joint forward plan however the guidance refers to this as the delivery plan for the system. NE suggested the document could be used to reflect the priorities in the strategy. All organisations are expected to be engaged in developing a joint forward plan. The joint forward plans will need to be reviewed annually. There is a requirement of integrated care boards to formally consult with health and wellbeing boards to ensure the final plan reflects the local priorities of the health and wellbeing boards. NE confirmed that there are 31 national measures these are the key objects that NHS England will monitor. NE confirmed that the forward plan must include the priorities within the Cheshire and Merseyside Health and Care Partnership Strategy as well as those 31 things that have been nationally identified as priorities. It also has to reflect local Place and wellbeing board strategies and priorities. MQu highlighted that Merseyside has some of the most deprived areas and health inequalities she queried will the 31 national priorities cover what is needed and if not, how will this be addressed. NE felt that all the priorities are relevant to our population however he agreed that a lot more additional things also need to be done on top of those compared to what is needed in other parts of the country. LGi suggested that the NHS targets could distract from the important work that is taking place she noted the importance of joining these together to ensure that we don't lose sight of objectives.	

Item	Discussion, Outcomes and Action Points	Action by
	MJo recognised that there are big inequalities across the patch about how people access services. It was agreed that these need to be linked to the marmot priorities. MJo suggested that there needs to be assurance that health inequalities are addressed. A planning group will take place tomorrow to work out the timeline NEv provided assurance that health and wellbeing boards will be involved as early as possible to ensure what is created is consistent with their views.	
HCP/11/22/08	**Workforce** LDa provided a workforce update focusing on adult social care and strategic workforce she highlighted the following. Skills for care are the strategic workforce planning and development body for adult social care in England. Skills for care have been a key delivery partner for the department of health and social care. They have influenced as well as delivered on activity on behalf of the sector. The vast majority of decision making around social care is done with elective members though local authorities or with citizens who may be in receipt of their own personal health and care budget. Adult social care is funded and purchased though a range of independent sector providers or from individuals with their own private wealth. The majority of care and support for adult social care comes from providers in the private, independent, and voluntary sector. Some of these will have a local authority or NHS commissioned contract however some will not. The directors of adult social care and adult social care commissioners will have an overview of the local market. There are currently 1.5m people working in adult social care which compares to 1.4m who work in the NHS this contributes 51.5b to the economy in England. It is estimated that there are around 17,900 organisations involved in providing or organising adult social care in England. This is delivered in a variety of different care providing locations. This equates to around 39,000 different locations, 69% of those locations are care quality commission regulated however the majority are made up of micro small enterprises. There are currently around 165,000 vacant posts in adult social care. There has been an increase of 55,000 since 2020/21 this is the equivalent of around a 52% increase. Around 63% of jobs are recruited from other roles within the sector which suggests that people move between employers.	

Item	Discussion, Outcomes and Action Points	Action by
	There are approximately 32,000 filled registered nurses' posts in adult social care and approximately 17,300 social worker jobs in local authorities. Regulated professionals follow higher education institute university learning pathways and it can take up to 3 years to develop a future social work workforce. This is something that needs to be taken into consideration when integrated workforce planning is being done. 28% of workers are aged 55 and over so consideration needs to be made on how this talent can be retained though flexible working. There are around 2100 organisations across 4900 provider locations in the Northwest and around 245,000 total posts of which 225 were filled. The data across Cheshire and Merseyside relates to workforce in the local authority and independent sector however there will also be induvial employers with their own budget as well as social care staff who work across health and social care. Looking at the projected number of people aged 65 and over It is expected that an additional 18,500 jobs will be needed in Cheshire and Merseyside by 2035. The framework provides a serious of recommendations around future models of care, the future workforce and future education across health and social care. By bringing together commissioners, directors and the private independent voluntary sector employers will ensure the framework can be embedded. The department of health and social care have supported a national recruitment campaign for care which is called made with care. This provides a range of social media resources for employers and local authorities to use to maximise national, regional, and local recruitment campaigns. Nationally work has taken place with the department of work and pensions to promote disability confidence to support those organisation and employers that are positive in their recruitment of people from under-represented groups. National events and events in the northwest have taken place looking at safe and fair recruitment. This looks at how employers can be supported to make informed safer recruitment decisions. Regionally the team have done some collaboration on the provider voice and supported the establishment of the carer academy toolkit. A top tips succession planning guide has been produced this will help establish a quality adult social care market.	

Item	Discussion, Outcomes and Action Points	Action by
	Joint working is taking place to look at integrated roles round delegated healthcare tasks, to look at career options and joint learning and development opportunities that can be supported at both Place and system level. LGi agreed that workforce is an ongoing challenge for everyone she felt that this is an area that needs some focus on to agree what can be done collectively. JWi asked how a new workforce will be created that will respond to an aging population that wants to live at home. LDa provided assurance that work has taken place to look at the way that people access and draw on care and support. LDa agreed that work needs to take place to look at joint learning and opportunities to ensure there is a greater understanding of health and social care roles. Work has taken place to look at some of the research. A deep dive analysis is being done to look at where the differences are each area and what can be done to improve these. LGi agreed that although it is important to do things at Place it is also important to do things together at a system level. CBa highlighted that people are working in care homes who are getting paid inappropriate pay. This needs to be looked at collectively from a regional point of view. There needs to be assurance that funding is in place to support this. YNo suggested that work should take place to look at hybrid working to make the most of an integrated workforce. LDa agreed this needs to be looked at as part of the planning. RJo asked what can be done on this footprint to support start ups and new entrants from the social sector. LGi agreed that this is something that should be looked at. MQu agreed that the wages in care is a problem she suggested until social care budgets are ringfenced for local authority there will always be a problem. ASi noted the importance of the development of workforce education and training plans locally. LDa agreed that work needs to take place to look at future models of care, future workforce, and future education needs. There also needs to be more opportunities for different routes into care. LDa provided assurance that these conversations are taking place with partners in the Northwest.	

Item	Discussion, Outcomes and Action Points	Action by
	PWa noted that in Warrington work is taking place to look at apprenticeships for social workers. PWa noted that staff need to be valued and paid appropriately. Staff need to be incentivised to want to work in the care sector. JCo agreed that money needs to be ringfenced to pay decent wages, there needs to be in work training and clear progression routes to ensure people want to go into social care and stay. LDa agreed it is important to have clear career progression articulated to them she also noted the importance of having a good work life balance. LGi agreed to consider how some of this discussion can be taken forward.	
HCP/11/22/09	**HCP Forward Plan** LGi confirmed that the following items need to be included on the forward plan: • There needs to be some input from the community and voluntary sector about the work they are doing • The strategy will be reviewed at the March meeting • Consideration needs to be made on what should be achieved in the first year of the plan – workforce needs to be one of the top priorities LGi asked for any further items for the forward plan to be sent to her. CBa agreed that workforce needs to be one of the priorities she suggested that everyone should come together collectively to campaign for better pay for the workforce. CBa suggested that agency payments also need to be reviewed. **Action: Committee members to send any items for inclusion on the forward plan of the HCP.**	
Date of Next Meeting: 07.03.23		

End of Meeting

HCP Action Log						
Action No	Meeting Date	Action	Owner	Due Date	Status	Update / Notes
1	08.11.22	To identify opportunities for the Partnership to learn more about the purpose, governance, and structures of the ICB	Clare Watson	01/01/2023	Open	Clare Watson to provide an update at the March 2023 meeting
2	08.11.22	To provide web access to the meeting for members of the public and to ask the group for their ideas on how this Partnership can engage effectively with the wider public	Maria Austin	01/02/2023	Ongoing	Meetings planned to be live streamed from May meeting onwards
3	08.11.22	To invite a suitable Education representative to the meeting	Natalie Robinson	01/12/2022	Closed	Education representative identified
4	08.11.22	To investigate the possibility of developing a central dashboard containing relevant data sources	Ian Ashworth	01/03/2023	Closed	IAs advised that a central dashboard has now been published and local Place leads should now access to this. It has now been agreed that a future session will be held on the fair employment charter.
5	08.11.22	How can this group explore widening the remit of the Fire Service Safe and Well check to meet the wider priorities of the Cost of Living and Fuel poverty?	All/Business Intelligence	01/01/2023	Open	
6	08.11.22	Can we use the network of social prescribers across the region to support the work around cost of living/fuel poverty?	PCN network	01/01/2023	Ongoing	Representatives from Liverpool and Knowsley to be invited to a future meeting to provide an update
7	08.11.22	To consider the possibility of developing a repository of innovation which can also be accessed by the public	Natalie Robinson	01/03/2023	Open	To be considered as part of the development of the HCP Communication Plan
8	08.11.22	To share website and contact details for the Zero Suicide website	Natalie Robinson	01/01/2023	Closed	
8	08.11.22	To develop a comms plan for the HCP	Maria Austin	01/01/2023	Open	Update to be provided at the Mach 2023 meeting
9	08.11.22	To review meeting times and venues to ensure good public transport links	Natalie Robinson	01/01/2023	Open	Dates and venues have been set. Venues to be kept under review
10	17.01.22	Committee members to send any items for inclusion on the forward plan of the HCP to the Chair	Natalie Robinson	01/03/2023	Open	

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Cheshire and Merseyside
Health and Care Partnership

Cheshire and Merseyside Health and Care Partnership (ICP) Interim Strategy

Summary

2023-2028

Who We Are – the Cheshire and Merseyside Health and Care Partnership

The Cheshire and Merseyside Health and Care Partnership (ICP) represents the coming together of health services, the local authority, and vital systems partners from across our region.

The partnership is a statutory body, collectively working to improve the health outcomes of the 2.7 million people living across Cheshire and Merseyside. A core responsibility of the partnership is to jointly to assess the health, public health and social care needs of Cheshire and Merseyside, and generate a five-year strategy that addresses these needs.

Our Health and Care Partnership

Our Integrated Care Board

Our 9 Local Authorities

17 NHS Providers

North West Ambulance Service

Our Police Service

Our Fire & Rescue Service

Voluntary, Community, Faith & Social Enterprise Sector

Education

Local Enterprise Partnerships

55 Primary Care Networks

355 General Practices

2 Provider Collaboratives

Social Care Providers

Children's Services

Public Health

Carers

Housing

HealthWatch

What Challenges Do We Face – Our Population Health Profile

There are long standing social, economic and health inequalities across Cheshire and Merseyside, with levels of deprivation and health outcomes in many communities worse than the national average. There are pockets of deprivation across every one of the nine Places across Cheshire and Merseyside, which has a direct impact on long term health outcomes. Key populations health facts:

- 35% of our population are deprived and 26% of our children live in poverty
- Deaths due to heart disease, cancer, respiratory conditions, and alcohol and drugs are higher than the England average. People in the most deprived area can live 15 years less than those in wealthier areas.
- The number of Looked After Children is 47% higher than the England average

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How Are We Going To Address Them – Our Health and Care Partnership Strategy

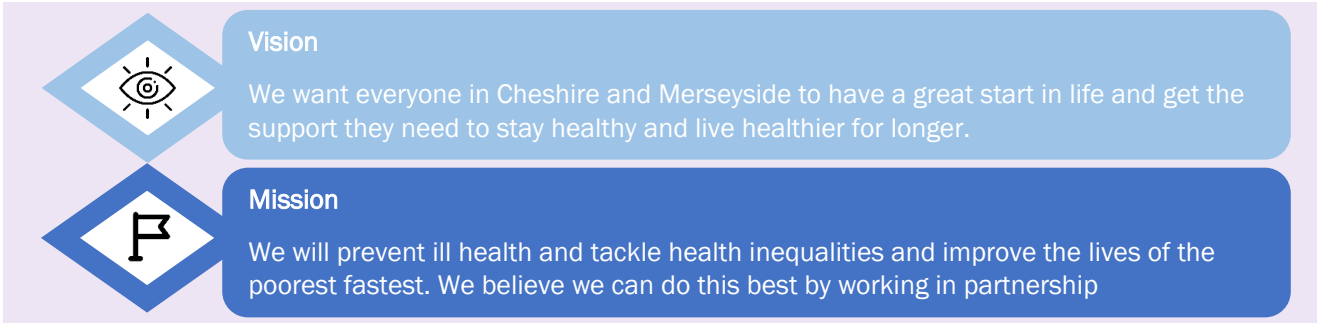
This document is a summary of our interim draft Health and Care Partnership Strategy. Our interim document represents the start of our journey towards developing a fully fledged strategy, ready for approval by the new Statutory Joint Committee, once it is formed later on in 2023.

This strategy is aligned to, and builds on, a number of other Cheshire and Merseyside-based strategies and national guidance:

- Our Place Plans
- Health & Wellbeing Strategies
- Place and System Leve People Plans
- The Health and Care Act 2022
- Our Workforce Strategy
- NHSE Guidance for Integrated Care Systems

Our Partnership's Vision, Mission, and Strategic Objectives

Our Health and Care Partnership Strategy is guided by our vision, mission and four core objectives:



As the focus of our interim draft Health and Care Partnership Strategy is themed around our four strategic objectives, this summary document focuses on the commitments set out within these four core areas. The joint achievement of our shared commitments will in turn support us to collectively deliver our vision and succeed in our mission.

The full version of the interim draft Health and Care Partnership Strategy can be found here.

1: Tackling health inequalities in outcomes, experiences and access

We will:

- Give every child the best start in life, enabled to maximise their capabilities
- Create fair employment and good work for all
- Ensure a healthy standard of living for all, with sustainable communities
- Strengthen the role of health prevention.
- Tackle racism, discrimination and their outcomes

All Together Fairer

Our region understands the importance of reducing health inequalities. In 2019, health and care leaders across Cheshire and Merseyside outlined their collective commitment to tackling health inequalities by agreeing to become a "Marmot Community".

Further to this in 2021, the ICP commissioned the landmark 'All Together Fairer' report, informed by Prof Sir Michael Marmot, which sets out the actions required for us to build a fairer, healthier Cheshire and Merseyside.

Our partnership fully endorses the reports recommended actions, and commits to:

1. Increasing and making equitable funding for social determinants of health and prevention
2. Strengthening partnerships for health equity
3. Creating stronger leadership and workforce for health equity
4. Co-creating interventions and actions within communities
5. Strengthening the role of business and the economic sector in reducing health inequalities
6. Extending social value and anchor organisations across the NHS, public services and local authorities
7. Developing social determinant of health in all policies

In addition to implementing the above, our region will also utilise our agreed set of local Marmot 'Beacon Indicators' to monitor the impact of our actions on social determinants of health.

NHS Prevention Pledge

Working in tandem with our Cheshire and Merseyside Marmot Community Programme, is the NHS Prevention Pledge. This pledge comprises of 14 core component, across a number of cross-cutting prevention themes, taking a system-wide approach to promoting wellbeing and tackling health inequalities.

Although a number of our NHS Trusts have adopted the pledge, we are committed to ensure that all of our Trusts adopt the pledge in full. In doing so, we aim to ensure that the reduction of health inequalities features as a key priority across all our Trusts corporate strategies. In the future we also hope to expand the pledge to providers across our wider health and care system.

Cost of Living Pressures

An individual's physical home environment is closely related to their health outcomes. For example, living in a cold home, being frequently exposed to damp, and living in cramped households can exacerbate a wide range of physical and mental health conditions. With the cost of living rising significantly, many individuals will be faced with mounting financial pressures and may no longer be able to afford basic necessities.

Our partnership is committed to addressing the impact of cost-of-living pressures by working to reduce deprivation and income inequality, sharing good practice across our nine Places, jointly improving housing quality and energy efficiency and addressing local health needs via NHS interventions.

2: Improve population health and healthcare

We will:

- Deliver the Core20PLUS5 priorities, providing safe and accessible services
- Improve early cancer diagnosis, and our dementia and mental health services
- Improve patient satisfaction with primary care access, & reduce elective/ emergency waits
- Reduce deaths from cardiovascular disease, suicide and domestic abuse

Core20PLUS5
Our region supports the national Core20PLUS5 approach to population health. This approach can be broken down into three parts:

Core20 – this is the most deprived 20% of the population, for us this is >900,000 people.

PLUS – this represents the population groups that are experiencing poorer-than-average health outcomes.

5 – these are the key clinical areas which require accelerated improvement:

- **Maternity**: we will ensure continuity of care is guaranteed for all people most at risk in pregnancy, accelerate preventative programmes for under-represented groups, and support the delivery of national priorities.
- **Severe Mental Illness (SMI):** we will ensure annual health checks for 60% of people living with SMI.
- **Chronic Respiratory Disease:** we will implement 4 pathways to improve the speed/accuracy of diagnosis and the quality of care, support smoking cessation, improve access to pulmonary rehab, and improve the uptake of Covid, flu and pneumonia vaccines.
- **Early Cancer Diagnosis**: we will implement new preventative initiatives, support primary care with the early cancer diagnosis agenda, reduce cancer waiting times, invest in cancer staff skills and education, reduce unwarranted variation and reduce health inequalities for vulnerable communities.
- **Cardiovascular Disease (CVD):** we will have diagnosed and treated 25% of those with familial hypercholesterolaemia by 2024. By 2029 we will have detected at >85% of those with Atrial Fibrillation & anticoagulated 90% of those at risk of stroke. We will have diagnosed and begun treating >80% of those with high blood pressure, provided more people with a CVD risk assessment, and ensured those at highest risk are treated with statins.

Beyond the five clinical priorities identified by the CORE20PLUS5 approach, our partnership has also committed to a number of key actions within the following health, care and corporate areas.

Children and Young People (CYP)
We will create a joint 3 year CYP strategy, listening to the needs of children and young people to co-create solutions that work for them. We will deliver the ambition of the national Family Hubs and Start for Life programme, and use the CORE20PLUS5 approach. We will also establish a multi-agency meeting in each of our Places to support children in crisis and develop a model for CYP 'safe places' as an alternative to hospital care.

Learning Disability and Autism (LD&A)
We will work to reduce the number of people in specialist in-patient and continue to develop effective, integrated community services for LD&A. We will reduce wait times and ensure more people received LD&A annual health checks and assessments. By 2028 we will reduce the life expectancy gap for people with a learning disability and/or autism by at least 20%

Carers
A new system-wide Carers Partnership Group for Cheshire and Merseyside has been established, supported by the NHSE national / regional carers team. Our partnership will identify and support carers through several interventions, such as carers passports and enhanced out-of-hours contingency planning.

Mental Wellbeing / Health and Suicide Prevention
We have an established Mental Health Programme, and a long-standing public health collaborative 'CHAMPS'. Building on this, we will utilise our population health intelligence to better understand local needs and gaps. We will also use innovative commissioning of community base schemes such as art therapy, continue to roll out new mental health roles.
We also have a new Suicide Prevention strategy, with a vision to eliminate suicide for our community. By implementing our strategy, we will improve suicide risk awareness and prevention, build suicide prevention capability within our staff, and support our Mental Health Trusts to implement safer care standards.

Reduction of harm from alcohol
We will support prevention, detection and early intervention for people at risk of harm from alcohol. We will also work to develop an intelligent liver function test for all GPs to access, and we will ensure that people transitioning from hospital to the community on an alcohol pathway will wait no more than 7 days to be seen.

Reducing Obesity and Physical Activity
We are addressing obesity in our region through the Food Active programme, and the Strategic Overweight and Obesity programme. We also support our Places to develop opportunities to use physical activity as a way of improving population health. Our system aims to empower 150,000 people to become more active by 2026.

Dementia and End of Life (EoL) Care
Rates of dementia in our region are higher than average. We will improve the quality of dementia care by exceeding the national diagnosis rate standard, offering personalised care, and providing support to carers.

We will also continue to ensure that when a person reaches the end of their life that they are supported to die well, with dignity, in their preferred place, supported by the people important to them. We will also raise public awareness of EoL care, so our communities are confident and willing to support each other through loss.

Personalised Care and Adult Social Care
We will use methods like make every contact count to embed discussions on health into day-to-day conversation, we will use social prescribing to enable self-management, and support the use of Personal Budgets.

We will improve access to Home Care and Extra Care Housing to reduce reliance on residential and nursing homes. We will increase capacity in the care market and workforce by making it an attractive place to work.

Data and Digital
We have an innovative Digital and Data Strategy in place. It is our mission to be the most digitally advanced and data driven ICS in England by 2025. To achieve this, we will build strong digital and data foundations, level up our infrastructure, deliver 'at scale' platforms such as shared care records, and develop system-wide BI services.

Research and Innovation
Our population has been poorly served by research opportunities in the past. We are working to rectify this by establishing a Cheshire and Merseyside Research Development Hub, creating a network of research champions, deliver annual learning events, and contributing to the development of a North West Secure Data Environment.

Health Protection
We will use our assets to assure the effectiveness of our health protection approaches and clarify any catch-up activity that is required. We will also develop a view of common health protection risks, shared mitigation plans and review our health protection arrangements to analyse and identify opportunities to strengthen clinical pathways for prevention.

3: Enhancing quality, productivity, and value for money

We will:

- Develop a financial strategy focused on reducing inequality and prioritising prevention
- Plan, design and deliver services at scale to drive quality and efficiency
- Maximise cost reduction by collaborating at scale, & developing whole system approaches
- Develop an approach to research and innovation across our partnership

Quality Assurance and Improvement
Our system supports and aligns with the key requirements of quality oversight, as set out by the National Quality Board (NQB) in its 'Shared Commitment to Quality' guidance. We will ensure the fundamental standards of quality are delivered, continually improve the quality of services, and achieve the highest regulatory standards. We will also further develop our approach to reciprocal and meaningful engagement with service users, and agree shared quality assurance and improvement actions through our System Quality Group.

Access to Dentistry, General Practice and NHS Diagnostic Tests
Several factors have led to challenges in accessing NHS Dentistry. To improve access in our region, we will invest in an Advice Triage Helpline service, and work with partners to develop an oral health improvement strategy.
To improve GP access, we will support our Primary Care Networks (PCNs) in addressing workforce challenges and growing teams through the Additional Roles Reimbursement Scheme (ARRS).
To improves access to diagnostics, we will work to achieve the 6 week wait target by 2025, deliver 120% of pre-pandemic levels of activity by 2023, reduce clinically inappropriate demand, and utilise digital solutions.

Community Pharmacy
We will develop new commissioning models that expand the range of service and capacity within Community Pharmacy, in order to improve access. We will also enable our population to have access to services directly ensuring services are integrated into our local models and pathways.

Elective Care Recovery and Transformation Programme (ERTP) and Clinical Pathways Programme (CPP)
Our ERTP work was established to support the recovery of activity levels back to pre-Covid. The programme will complete a harms review of those waiting a long period and support waiting well initiatives. We will eliminate waits of >104 weeks, establish more elective hubs, and aim for top decile performance.
Our CPP work is focused on transformation of clinical pathways for the long term, to improve the resilience of smaller Trusts, and to consolidate pathways where this provides better outcomes.

Admissions Avoidance
We know that we have higher rates of hospital admissions than our peers. We will support admission avoidance by reviewing how we currently work and share ways of working across the system, by supporting a business intelligence model that tracks capacity and demand, and developing a shared workforce development plan.

Workforce
We will meaningfully improve working conditions to end our reliance on agencies, upskill and re-skill staff to work in new roles, promote staff health and wellbeing, enable culturally competent ways of working, develop leadership and talent management, and work as system partners to develop a social care academy.

Finance
Cheshire and Merseyside Health and Care partners have combined budgets of £4.4bn meaning we are a significant part of the local economy, in terms of employment and procurement of services. Our ICS will develop its system-wide financial strategy in the first half of 2023, and which will support our ambitious system plans and longer-term financial sustainability. The strategy will include an allocation approach to determine how we will best use resources to support reducing inequalities, and financial mechanisms to support integration.

4: Helping the NHS to support broader social and economic development

We will:

- Embed our commitment to social value
- Develop as an Anchor Institution/ System
- Promote involvement in regional initiatives to support our communities
- Implement school programmes aimed at improving mental wellbeing, and inspire young people to consider careers in health and social care
- Work with Local Enterprise Partnerships to connect our system with local business.

Anchor Institution

The term 'anchor institution' refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve.

As a partnership we are a significant part of our local economy, including in terms of as employers, purchasers from the local supply chain, as well as being embedded in our communities. As an Anchor Institution/ System we will sign up to the relevant fair employment charters for our region, and commit to providing the real living wage. We have also pledged to employ and purchase locally in the first instance.

We will measure and evidence the progress we make from becoming an Anchor System, and we will develop an Anchor Network Progression Framework to help our organisations self-assess their own ambitions.

Social Value

Our definition of Social Value is: the good that we can achieve within our communities, related to environmental, economic and social factors.

As one of a group of Social Value Accelerator Sites across the UK, we are dedicated to exploring and learning more about how social value can practically and effectively be embedded at scale.

We will work together across our sector to achieve social value outcomes, foster innovation, and reduce avoidable inequalities. We will continue to protect our health and social care services, give a voice to our local communities, embed social value across the entire commissioning cycle, and create real opportunities for social innovation in our region.

Our Green Plan

Climate change poses a threat to our health as well as our planet. Across our organisations, we are committed to achieving net zero by 2040 (or earlier).

To achieve this we are transforming the way we use tech to provide health and care, we are decarbonising estates and enhancing sustainable food in our hospitals. We are working to reduce the environmental impact of our products and we are phasing out single use plastics.

We have already achieved:

- Installation of >300 solar panels at Wirral Community Health
- Reducing the use of nitrous oxide by approx. 443 tonnes of CO2
- Introduced cycle to work scheme
- Introduced reusable theatre gowns, saving 23 tonnes of carbon dioxide emissions and £22,000 which has been reinvested into patient care.

We will build on these successes and continue to work with partners to achieve our aims.

Developing our Strategy

We recognise that as we develop, in the coming months and years, we will need to develop and refine the content of our strategy to reflect our progress.

This development will be both in terms of working with our communities to reassess our priorities, and working to mature our relationships as partners. These developments will support us to identify increasingly integrated and innovative solutions to deliver our key shared objectives.

During 2023 we will focus on a number of key activities to further develop this strategy;

- Connect more effectively with our communities to ensure that our Place and Health and Care Partnership plans continue to reflect what is truly important to our people.
- Develop a Prioritisation Framework that ensures our annual plans will focus our resources in a way that delivers the greatest benefit to our population
- Co-produce detailed work programmes with measurable outcomes to ensure we deliver on our shared priorities. The work programmes will recognise the need to respond to our immediate service pressures, as well as our longer-term objectives.
- Agree how we will measure and report on these outcomes, so we are assured of the progress we are making and able to effectively communicate this progress to our population
- Produce a summary version of our strategy and annual plan for our citizens, which provides a clear and concise description of our strategic priorities
- Formalise the arrangements of the Health and Care Partnership as a Statutory Joint Committee to oversee finalising this strategy and subsequently delivery against it.
- Develop a system financial strategy that supports delivery of this Health and Care Partnership strategy.

Cheshire and Merseyside
Health and Care Partnership

Emerging Priority Themes for CMHCP in 2023/24

March 2023

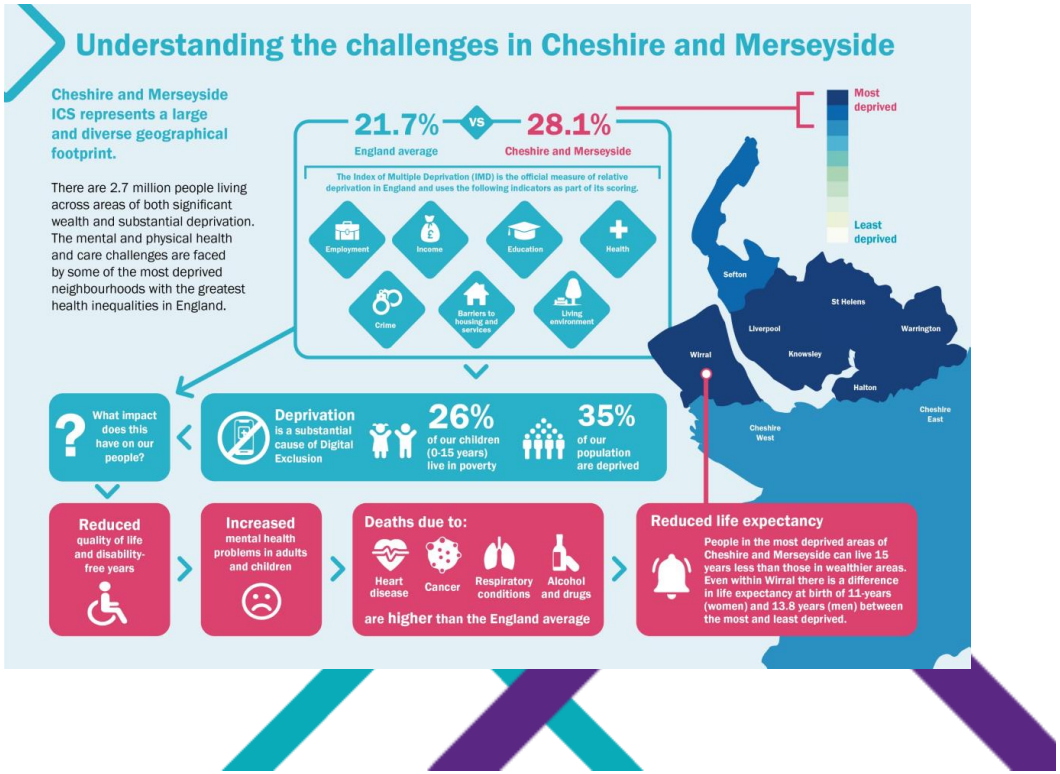
Executive Summary

Background

In developing the draft Interim Cheshire and Merseyside Health and Care Partnership (CMHCP) Strategy, it has been recognised that the vast breadth and volume of areas of focus of the strategy presents a risk, and it is more likely that we will improve outcomes by focussing our greatest effort on the highest priorities.

CMHCP partners supported further work to identify our highest priorities, allowing the potential to focus our resources on a smaller number of areas whilst still having a significant impact on the health of our population by making more significant progress in these prioritised areas.

Initial discussions took place between the Cheshire and Merseyside Directors of Public Health and members of the Integrated Care Board, and a task and finish type approach was established to develop a standard approach and gain a consensus on our greatest priorities.

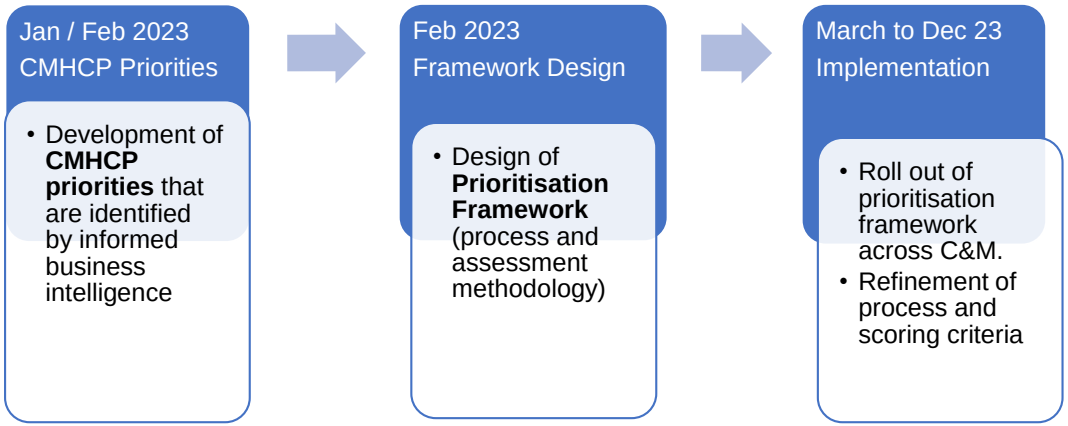


Our approach to understanding priorities

Two workstreams have been established:

The CMHCP Priorities Group focussed on reviewing the latest available intelligence in relation to population health, health inequalities quality and access with the aim of identifying those areas which should be prioritised within the interim CMHCP Strategy.

The Prioritisation Framework Group focussed on developing a prioritisation framework which can be applied to the plans for the five-year period of the strategy but with an immediate focus on 2023-24.



Emerging priorities for 2023/24

Cheshire and Merseyside
Health and Care Partnership

Condition / Theme

- CVD
- Cancer
- Respiratory
- Mental Health
- Falls
- Children and Young People and Maternity

Quality, Access and Experience

- Waiting Times for Urgent and Planned Care
- Access to GPs, Dentists, Mental Health Support and Social Care support

System P Segmentation

- Complex Lives
- Frailty and Dementia

Tobacco

Alcohol

Obesity and Physical Health

Vaccination

Prevention Cross Cutting Priorities

Conclusions and Recommendations

We have considered a range of data sources in order to better understand emerging priorities in C&M. The results of this work conclude that there are four key groups of priorities to consider:

1. **Condition / Theme** - 3 conditions emerging as key – CVD, Cancer and Respiratory. And 3 further themes around Falls, Mental Health and CYP and Maternity. This intelligence has been gathered through looking at 4 key data sources, and there is consensus across these that these are priority areas for C&M
2. **Quality, Access and Experience** – 3 further priorities emerging around waiting times, access and patient experience. Within the analysis indicators, we looked at areas of concern, waiting times across both urgent and planned care were poor, and this was backed up by Healthwatch intelligence, as well as adding in concerns around access to services – GPs, Dentists, Mental Health Support and Social Care.
3. **System P segmentation –** System P have identified the importance of segmenting people around common sets of needs rather than being single disease focussed. We need to weave this approach into the focussed disease areas to complement each other. When we identify someone with CVD risk factors, we consider if they are part of a prioritised segment and consider the range of interventions that fit with this, interventions would be holistic and reduce their disease risk.
4. **Prevention cross cutting priorities** - if C&M do not consider population health as a whole, we will not reduce the demand on services in the future. The four cross cutting priorities identified will have a direct impact on the disease priorities, and interventions that reduce harmful behaviour around tobacco, alcohol, healthy diet and physical activity will lead to reduced health inequality and a healthier population. Vaccinations are a must in terms of health protection.

If we prioritise interventions against the key priorities that have been identified through this analysis, it is likely that there will be a bigger impact on reducing health inequalities and improving health and wellbeing health outcomes for the population of C&M.

What we looked at

The data sources considered (1)

	Description	Rationale
Life Expectancy Inequalities	Life expectancy and cause of death data	There is a 9.5 yr inequality gap in C&M, we need to understand the diseases that most contribute to this gap in order to reduce this.
Global Burdon of Disease	The Global Burden of Disease (GBD) is a tool that provides a comprehensive picture of mortality and disability.	The tool quantifies health loss from hundreds of diseases, injuries, and risk factors, and a report generated to understand the top ten disease burdens in terms of Disability Adjusted Life Years (DALYs) for the selected geography.
PHE Fingertips data	Fingertips is a large public health data collection. Data is organised into themed profiles.	These interactive, localised profiles are a rich source of indicators across a range of health and wellbeing themes, helping us to understand where we perform poorly against national and regional averages.
RightCare	RightCare aims to support health and care systems to improve care quality, population health and system sustainability. Resources produced include data packs and toolkits.	RightCare data is presented in packs that allows local health and care systems and places to consider information from across whole pathways of care. and identify the greatest opportunities for improvement in both spend and health and care outcomes.

The data sources considered (2)

	Description	Rationale
Quality and Access data	A number of data sources used to consider national performance indicators, constitutional standards and system outcome framework metrics.	Considering this data enables us to understand areas of concern and underachieving performance metrics. Outliers have been identified by; • National outlier (top 10 worse performing ICB) • Local ICB outlier • Significant under achievement against standard
Healthwatch	The Health and Care Partnership Interim Strategy Contains a section called "Listening to you – the Healthwatch Perspective".	The data in the HCP strategy is an account of people's experiences in accessing healthcare across C&M and is an important to perspective to consider in terms of our priorities.
System P	System P is a whole system approach to addressing multiagency, multisector challenges that negatively impact population health and will deliver transformational change in service provision through collaborative working.	The programme uses Bridges to Health segmentation methodology, which has been endorsed by NHS England. Segmentation aims to categorise the population according to health status, health care needs and priorities. This methodology identifies groups of people who share characteristics that influence the way they interact with health and care services.

What we found

Mapping data source by emerging priority

The table summarises how the data source maps to the emerging priorities. The table gives an indication of the consensus between data sources. For example CVD and Respiratory emerging as a priority across all data sources we looked at.

Data Source	Emerging Priority – Condition / Theme					
	CVD	Cancer	Respiratory	Falls	Mental Health	CYP and Maternity
Life Expectancy Inequalities	☑	☑	☑			
Global Burden of Disease	☑		☑	☑	☑	
Fingertips (C&M level)	☑	☑	☑	☑	☑	☑
Fingertips (Place level)	☑	☑	☑	☑	☑	☑
RightCare	☑	☑	☑			

Quality, access and public / patient experience

Different priorities started to emerge as we looked at quality and access performance measures and when we considered patient voice through the Healthwatch intelligence in the HCP interim strategy.

The Quality and Access analysis looked at metrics across a number of different data sources - National performance indicators, Constitutional standards, and System Outcome Framework metrics. Outliers were then identified if C&M were in the top 10 worst performing nationally, if C&M were a local ICB outlier, or if there was significant under achievement against a standard. Indicators were considered across Planned Care, Urgent Care, Cancer, Mental Health, Primary Care and Quality.

When we then considered the Healthwatch intelligence contained in the HCP Interim strategy, this supported the data, and offered another perspective, particularly on Access to services.

Data Source	Emerging Priority – Quality, Access and Patient Voice		
	Waiting Times for Urgent and Planned Care	Access to GPs, Dentists, Mental Health Support and Social Care support	Quality and Patient Experience
Quality Performance Indicators	☑	☑	☑
Healthwatch	☑	☑	☑

Key findings for other data sources

System P data challenges our thinking around priorities because it is not a system that looks a diseases, it is a segmentation tool that looks at different segments of the population using Bridges to Health segmentation methodology.

Two segments have been prioritised in C&M – these are **Complex Lives** and **Frailty and Dementia**, with a third segment (Long Term Conditions) also identified for consideration in a future stage of the work..

It is also likely that by prioritising these segments, there is a higher prevalence of social deprivation, health inequalities, housing issues, social care issues. The methodology forces us to look by person, rather than by condition as it is also likely that an individual will be in multiple segments.

Data Source	Emerging Priority – System P	
	Complex Lives	Frailty and Dementia
System P	☑	☑

How Cross Cutting themes relate to emerging theme / condition priorities

Disease priority and indicators	CVD	Cancer	Respiratory	Falls	Mental Health	CYP and Maternity
Tobacco						
Alcohol						
Obesity and Physical Activity						
Vaccinations						

Whilst these four priorities are considered ‘cross cutting’, this table also aims to show how strongly each of them map against emerging condition / theme priorities.

The detail of what we found

Life Expectancy Inequalities

Disease priority and indicators	CVD	Cancer	Respiratory
Life expectancy inequalities (top 3 causes males/female)	Heart disease contributes to life expectancy health inequalities for males	Lung cancer contributes most to life expectancy inequalities males and females Other cancer contributes to female Life expectancy inequalities	Chronic lower respiratory contributes to life expectancy inequalities for males females

Global Burden of Disease Inequalities

Disease priority and indicators	CVD	Respiratory	Falls	Mental Health
Global Burden of Disease top 10 highest causes of Disability Adjusted Life Years	Heart Disease top contributor to Disability Adjusted Life Years (DALYS	COPD and Lower respiratory significant contributor to DALYS	Falls significant contributor to DALYs	Depressive disorders a significant contributor to DALYs

Fingertips (top down – analysis by ICB)

NHS
Cheshire and Merseyside

Disease priority and indicators	CVD	Cancer	Respiratory	Falls	Mental Health	Children and young people and maternity
C&M Fingertips indicators below England	National Child Measurement Programme 5 indicators Smoking Prevalence 2 indicators	Smoking Prevalence 2 indicators	Smoking Prevalence 2 indicators			Hospital demand in children and young people 5 indicators (includes A&E attendance 0-4 yrs, emergency admissions 0-4yrs, hospital admissions due to injuries 0-14yrs) National Child Measurement Programme 5 indicators

Liver Disease indicators highlight cross cutting theme around alcohol (4 outlier indicators relate to mortality and 5 to admissions around liver disease)

* Not all indicators on Fingertips are currently available at ICS geographies.

Fingertips (bottom up – analysis by place)

NHS
Cheshire and Merseyside

CVD	Cancer	Respiratory	Falls
AAA screening (9/9 areas below England Under 75 CVD (6 areas above England) Smoking status at time of delivery (6/9 above England)	Population vaccination coverage: HPV one dose (12 to 13 year old (9/9 areas below England) Cancer screening coverage: breast cancer (8/9 areas below England) Cancer screening coverage: cervical cancer (aged 50 to 64 years old) (7/9 below England) Cancer screening coverage: bowel cancer (7/9 below England) Smoking status at time of delivery (6/9 above England) Smoking	Smoking status at time of delivery (6/9 below England) Flu (2 to 3 years old) (7/9 below England) Flu (primary school aged children) (7/9 below England Population vaccination coverage: Flu (at risk individuals) (6/9 below England)	Over 85 and over 65 emergency admissions (9/9 areas higher than England) 65-79 emergency hospital admissions (7/9 areas above England

Mental Health	Vaccinations	Children and young people and maternity
Emergency Hospital Admissions for Intentional Self-Harm (9/9 areas above England) Admissions for unintentional and deliberate injuries in children 0-14 (8/9 areas above England QOF Depression highest proportion for ICB	HPV one dose (12 to 13 year old) (9/9 below England) DTaP and IPV booster (5 years) (8/9 below England) MMR for two doses (5 years old) (8/9 below England) Flu (2 to 3 years old) (7/9 below England) HPV vaccination coverage for two doses (13 to 14 years old) (7/9 below England) Flu (primary school aged children) (7/9 below England) Dtap IPV Hib (2 years old) (7/9 below England) Population vaccination coverage: PPV (6/9 below England) Population vaccination coverage: Flu (at risk individuals) (6/9 below England) Population vaccination coverage: PCV (6/9 below England	Vaccination coverage (see vaccinations) Smoking status at time of delivery (6/9 below England) Emergency Hospital Admissions for Intentional Self-Harm (9/9 areas above England) Admissions for unintentional and deliberate injuries in children 0-14 (8/9 areas above England Breastfeeding initiation (8/9 areas below England) School readiness at the end of Reception (language) (6/9 areas below England Pupil absence (6/9 areas below England) Breastfeeding prevalence at 6-8 weeks after birth (6/9 areas below England) Smoking status at time of delivery (6/9 areas below England) Reception: Prevalence of overweight (including obesity) (6/9 areas below England)

**Alcohol related admissions may also impact across these areas where 8/9 Places have high rates*

RightCare

Cheshire and Merseyside Health and Care Partnership

CVD	Cancer	Respiratory
Circulatory 2nd biggest opportunity to save on elective Circulatory opportunities for none elective savings Under 75 CVD worse than peers	Cancer opportunity to save on elective spend	Largest opportunity to save on non elective spend Under 75 mortality higher than peers

There are large opportunities in terms of elective spend, non-elective spend and bed day savings for Respiratory, GI, Circulation and GU.

For elective:

Genitourinary is the largest opportunity at £4.3m, up from £3.3m pre-COVID

Circulation is the second largest opportunity at £3.1m, down from £5.6m pre-COVID

Gastro has seen a large reduction, down from £8m to £2.7m. Cheshire alone reduced by c. £3m

For non-elective:

Respiratory is the largest NEL spend opportunity at £8.4m, followed by Gastrointestinal at £7.1m.

Circulation has an opportunity of £4.8m, up from £3.3m pre-COVID

GU has increased from £1.3m to £4m, driven by Wirral.

Under 75 mortality rate is higher than demographic peers for Respiratory, Stroke and CVD and liver disease.

Quality and Access

Waiting Times for Urgent and Planned Care	Access to GP's, Dentists, MH and SC Support	Quality and Patient Experience
Urgent Care: 4 hour – Type 1 Ambulance – cat 3 and 4 response times A&E – DTA to admission – 12 hour waits Stroke – 90% of stay on Stroke unit Planned Care: Referral to Treatment – long waits Diagnostics – cystography Cancer – 2 week wait and faster diagnosis	Primary Care – numbers of GP appointments; number of direct care staff MH – health checks	Quality – care hours per patient; total antibiotic prescribing; hospital onset c.difficile infections

Healthwatch

Cheshire and Merseyside Health and Care Partnership

Waiting Times for Urgent and Planned Care	Access to GP's, Dentists, MH and SC Support	Quality and Patient Experience
Elective Care - long waits impacting on quality of life, mental health. Poor communication of waits. **Access to Urgent care** not easy - all pathways Person centred **discharge from Hospital** Processes - inconsistencies - not always due to lack of social care availability, poor communication with patients	**Access to a GP** - difficulties in how they can communicate - accessing appointments, lack of choice now e.g. telephone and online consultations. Lack of face to face options? **Access to a Dentist** - unable to register or access appointments, missed appointments (during covid), access out of area resulting in higher travel costs, long waits leading to later diagnosis of serious conditions e.g cancer Access to **Mental Health support** (including children, impact of covid and cost of living) Accessing **Social Care** support	**Communication** with service users/carers **Lack of learning** from complaints, concerns and compliments

System P

Complex Lives	Frailty and Dementia
This segment is for adults who have a physical and mental health condition alongside other key issues such as homeless, addictions, care leavers. • Breadth of issues and challenges this segment covers • Opportunity to look at multiple prevention and pathway developments via a different lens • Huge inequity experienced by this segment • Relatively small cohort but large system impact	People in this segment will have increasing vulnerability from frailty and/or forms of dementia. • Relevant to all places across C&M • Will draw out similarities and differences between different areas and cohorts • System impact has potential to be significant • Health and care data linkages will cover much of this segment activity • Managing the effects of pandemic – affected

System P data challenges our thinking around priorities because it is not a system that looks a diseases, it is a segmentation tool that looks at different segments of the population using Bridges to Health segmentation methodology.

Two segments have been prioritised in C&M – these are **Complex Lives** and **Frailty and Dementia**, with a third segment (**Long Term Conditions**) also identified for consideration in a further stage.

It is also likely that by prioritising these segments, there is a higher prevalence of social deprivation, health inequalities, housing issues, social care issues. The methodology forces us to look by person, rather than by condition as it is also likely that an individual will be in multiple segments.