Thursday 29 September 2022
10:00am to 13:05pm
The Lake House, Crosby Lakeside Adventure Centre,
Crosby Coastal Park, Cambridge Road, Waterloo,
Liverpool, L22 1RR

NHS
Cheshire and Merseyside

Meeting of the Integrated Care Board

Agenda

Chair: Raj Jain

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
10:00am	**Preliminary Business**			
ICB/9/22/01	Welcome, Introductions and Apologies	Chair	Verbal	-
ICB/9/22/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the Board Member Register of Interests)*	Chair	Verbal	-
ICB/9/22/03	Minutes of the previous meeting: • 4 August 2022.	Chair	Paper Approval	Page 4
ICB/8/22/04	Board Action and Decision Logs	Chair	Paper For note	Page 28
10:10am	**Standing Items**			
ICB/9/22/05	Report of the Chief Executive	GU	Paper For note	Page 32
ICB/9/22/06 **10:20am**	Report of the Place Director – Sefton	DB	Paper & Presentation For note	Page 59
ICB/9/22/07 **10:30am**	Resident Story	DB	Presentation For note	To be presented on day
10:35am	**ICB Business Items**			
ICB/9/22/08	Liverpool University Hospitals NHS Foundation Trust Clinical Services Reconfiguration Proposals	FL / AB	Paper For approval	Page 88
ICB/9/22/09 **10:55am**	Provider Collaborative Update	AM	Presentation For note	To be presented on day
ICB/9/22/10 **11:15am**	Assurance Process for Substantial Change	CW	Paper For note	Page 101
ICB/9/22/11 **11:35am**	Update on the Cheshire and Merseyside People Board	CSc / CS	Presentation For note	To be presented on day
ICB/9/22/12 **11:50am**	Developing the Cheshire and Merseyside Integrated Care Partnership	CW	Paper For note	Page 115
12:05pm	**ICB Key Update Reports**			
ICB/9/22/13	Cheshire & Merseyside System Month 5 Finance Report	CWi	Paper For noting	Page 123

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AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
	ICB Key Update Reports cont…			
ICB/9/22/14 **12:15pm**	Cheshire & Merseyside ICB Quality and Performance Report	AM / CD	Paper For noting	Page 142
ICB/9/22/15 **12:25pm**	Executive Director of Nursing & Care Report	CD	Paper For noting	Page 195
12:35pm	**Sub-Committee Reports**			
ICB/9/22/16	Report of the Chair of the ICB Audit Committee	NL	Paper For approval	Page 202
ICB/9/22/17	Report of the Chair of the ICB Quality and Performance Committee	TF	Paper For approval	Page 211
ICB/9/22/18	Report of the Chair of the ICB System Primary Care Committee	EM	Paper For approval	Page 285
12:50pm	**Other Formal Business**			
ICB/9/22/19	Responses to questions raised by Members of the Public in relation to items on the agenda	Chair	For noting	-
ICB/9/22/20	Closing remarks, review of the meeting and communications from it	Chair	Verbal For Agreement	- -
13.05pm	**CLOSE OF MEETING**			

Date and time of next meeting:
27 October 2022 - Crewe Lifestyle Centre, Everybody Health and Leisure, Moss Square, Crewe, CW1 2BB

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

13:05pm	**STAFF AWARDS**

Speakers

AB	Andrew Bibby, Director of Specialised Commissioning, NHS England
AH	Anthony Middleton, Director of Performance and Planning, C&M ICB
AM	Ann Marr OBE, Partner Member, C&M ICB
CD	Christine Douglas MBE, Director of Nursing and Care, C&M ICB
Csa	Christine Samosa, Chief People Officer, C&M ICB
CSc	Colin Scales, CEO, Bridgewater NHS Foundation NHS Trust
CWa	Clare Watson, Assistant Chief Executive, C&M ICB
CWi	Claire Wilson, Executive Director of Finance, C&M ICB
DB	Deborah Butcher, Place Director for Sefton, C&M ICB
EM	Erica Morriss, Non-Executive Director, C&M ICB
FL	Fiona Lemmens, Deputy Medical Director, C&M ICB
GU	Graham Urwin, Chief Executive, C&M ICB
NL	Neil Large, Non-Executive Director, C&M ICB
TF	Tony Foy, Non-Executive Director, C&M ICB

Meeting Quoracy arrangements:
Quorum for meetings of the Board will be a majority of members (eight), including:

- the Chair and Chief executive *(or their nominated Deputies)*
- at least one Executive Director *(in addition to the Chief Executive)*
- at least one Non-Exectuve Director
- at least one Partner Member; and
- at least one memebr who has a clinical qualification or background.

NHS
Cheshire and Merseyside

Cheshire & Merseyside Integrated Care Board Meeting

Held at Mercure Hotel, Linkway West, St Helens, Merseyside WA10 1NG

Thursday 4th August 2022 at 10.00 am

UNCONFIRMED Draft Minutes

ATTENDANCE		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB ***(voting member)***
Steven Broomhead	SBR	Partner Member, Chief Executive, Warrington Borough Council ***(voting member)***
Christine Douglas	CDO	Director of Nursing and Care, Cheshire & Merseyside ICB ***(voting member)***
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB ***(voting member)***
Adam Irvine	AIR	Partner Member, Chief Executive Officer, Community Pharmacy Cheshire & Wirral (CPCW) ***(voting member)***
Dr Fiona Lemmens	FLE	Regular Participant, Associate Medical Director, Cheshire & Merseyside ICB
Anthony Middleton	AMI	Regular Participant, Director of Performance and Improvement, Cheshire & Merseyside ICB
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside ICB ***(voting member)***
Neil Large	NLA	Non-Executive Director, Cheshire & Merseyside ICB ***(voting member)***
Ann Marr	AMA	Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust ***(voting member)***
Jayne Parkinson-Loftus	JPL	Regular Participant, Healthwatch St Helens
Prof Rowan Pritchard Jones	RPJ	Medical Director, Cheshire & Merseyside ICB ***(voting member)***
Dr Joe Rafferty	JRA	Partner Member, Chief Executive Officer, Mersey Care NHS Trust ***(voting member)***
Chris Samosa	CSA	Regular Participant, Director of People, Cheshire & Merseyside ICB
Graham Urwin	GUR	Chief Executive, Cheshire & Merseyside ICB ***(voting member)***
Clare Watson	CWA	Regular Participant, Assistant Chief Executive, Cheshire & Merseyside ICB
Claire Wilson	CWI	Chief Finance Officer, Cheshire & Merseyside ICB ***(voting member)***
Sally Yeoman	SYE	Regular Participant (nominated deputy), Voluntary Sector North West (VSNW) for Warren Escadale

Name	Initials	Role
In attendance		
Dr		
Carol Hill	CHI	Associate Director, Strategy, Integration and Partnerships – Liverpool Place
Claire Cullen	CC	Stroke Consultant, LUFHT
Helen Murphy	HM	Assistant Director of Integration, LUFHT
Mark Palethorpe	MPA	Place Director St Helens
Emma Lloyd	Clerk	Minute taker

Apologies		
Name	**Initials**	**Role**
Ian Ashworth	IA	Regular Participant, ChaMPs
Councillor Paul Cummins	PCU	Partner Member, Cabinet Member for Adult Social Care, Sefton Council ***(voting member)***
Warren Escadale	WES	Regular Participant Chief Executive, Voluntary Sector North West (VSNW)

Item	Discussion, Outcomes and Action Points	Action by
ICB/8/22/01	**Welcome, Introductions and Apologies:** Raj Jain (RJA), the Chair, introduced himself and informed those present that no fire alarm was expected and outlined the housekeeping rules in the event of an alarm. RJA welcomed the members of the public present at this meeting of the Integrated Care Board (ICB) for Cheshire and Merseyside. Thanks were expressed to St Helens for hosting the meeting today. RJA confirmed that the meeting will commence with a resident story and shared that the ICB is keen to hear directly from the people it serves. RJA expressed gratitude to Kim and Mike for sharing their story and confirmed that, as requested, this will not be filmed or live streamed. RJA informed the board members that questions will not be invited, but would ask that they keep Kim and Mike in mind when discussing this meeting's business Apologies were noted in respect of Louise Barry and Warren Escadale, and the Chair welcomed their nominated deputies. Apologies were also noted in respect of Councillor Paul Cummins. RJA also welcomed Christine Douglas (CDO), new Chief Nurse, to her first ICB meeting and expressed thanks to Marie Boles who has provided support in the interim. All members introduced themselves.	

	RJA reminded those present that this is a meeting held in public and confirmed that some public questions have been received in advance of the meeting. RJA confirmed that some of these questions will be addressed at the end of the meeting and although it will not be possible to address all of them today, all questions will be answered **Outcome:** Apologies were noted in respect of Louise Barry, Councillor Paul Cummins and Warren Escadale.	
ICB/8/22/02	**Declarations of Interest:** No declarations were raised in relation to the agenda for this meeting. **Outcome:** No declarations of interest were raised in relation to the agenda for this meeting	
ICB/8/22/03	**Minutes of the last meeting:** No comments were received in respect of the minutes from the ICB meeting held on 1st July 2022 and these were therefore approved as an accurate record of the meeting. **Outcome:** The Board approved the minutes from the Cheshire and Merseyside ICB meeting held on 1st July 2022.	
ICB/8/22/04	**Board Actions and Decision Logs:** A copy of the action and decision logs were provided to the Board prior to the meeting and RJA noted that there were no actions pertinent to this meeting's agenda. Questions/comments were invited:- • Steven Broomhead (SBR) raised a comment in relation to decision log ICB-DE-22-05, reservations and delegations. SBR asked whether the ICB is getting into a situation where local decision making at Place is being hampered by a lack of clarity around local delegations. SBR shared that whilst this is being raised on behalf of the Places in Cheshire, it is a system wide issue that needs to be addressed. SBR stated that it would be useful to speed up the process of securing clarity as it is starting to affect the 'business as usual'. ○ Graham Urwin (GUR) confirmed that 2022/23 was always going to be a year of transition and highlighted that, given the Legislation was late passing through parliament, together with the fact that the ICB was only established on 1st July 2022, it was important to have some stability.	

	○ GUR also highlighted that it was important to recognise that there was a different funding regime throughout Covid and the government is now adjusting this back towards the pre-Covid funding regime. GUR informed the Board that the finance paper presented later in the meeting will clearly set out resources across the Places. GUR confirmed that one important thing on the list to do, is a producing a clear Scheme of Delegation with each of the Places. GUR shared that it is not decided which meeting this will come back to but confirmed that a formal paper will come back later this financial year. GUR also confirmed that the Board will have had the opportunity to see this before it is formally presented and it will be worked on collectively before a proposal is put forward. **Outcome:** The Board noted the action and decision logs following the meeting held on 1st July 2022.	
ICB/8/22/05	**Report of the Chair:** Raj Jain (RJA) shared that, last month, the Board received the last of previous iterations of the Health and Care Partnership Board. From 1st July 2022 onwards, it saw the creation of the ICB's sister committee, the Integrated Care Partnership Board (to be known as the Health and Care Board). RJA shared that time has been taken to review how this influential partnership board will operate, its purposes and how it will function. RJA shared that this review will be undertaken alongside partners and will make recommendations around the new format, purpose and functions, and how it will operate in the future. RJA highlighted that this committee will be a key engine for achieving the ICB's overall objectives. RJA highlighted that the partnership work will not be limited to the statutory organisations but will include wider partners from the voluntary sector across Cheshire and Merseyside. Comments and questions were invited with none raised. **Outcome:** The Board noted the report of the Chair.	
ICB/8/22/06	**Report of the Chief Executive:** A copy of the report was provided prior to the meeting. Graham Urwin (GUR) shared that he would like to take this opportunity to recognise the congoing and continued difficult operating environment, particularly for front line NHS staff. The ICB remains deeply proud and appreciative of these front-line health and care colleagues, who go above and beyond the call of duty as the NHS continues to manage pressures in the system . GUR shard that the NHS is still catching up with the backlog of work from Covid as well as the current day-to-day work.	

	GUR shared that some people would say the UK experienced the seventh wave of Covid during June and July and, not only did hospitals, GPs and other health care professional have to cope with this but they also had to cope with the additional burden and pressure caused by staffing issues due to staff absence. GUR highlighted that the NHS is a marvellous and significant institution but there is a need to recognise that it is under pressure and challenge, and these ICB meetings are being held in the context of this. GUR stated that anything the Board can do to support front line staff is fundamentally important. GUR shared that he does not intend to introduce every item within the CEO report and will expect that members have read the reports and will ask any challenge questions they feel appropriate. GUR shared the reports will highlight issues that are topical, which have been in local and national news, to acknowledge their existence and signal how the ICB is going to address them. An example of this is the GP survey, which is a significant report. A full report, lead by the Medical Director, will come back to the Board in the autumn, setting out the support for GPs in light of the survey findings, in particular those around access. GUR shared that reports will also outline issues that are a work in progress, to give the Board an opportunity to see what is happening, ask how they can find out more, how they can be involved and understand the checks and balances, rather than being involved just at the end when the recommendation comes through. GUR informed the Board that it will see, via the finance report, the volume of areas that the ICB is responsible for in terms of health and care and it will also be able to see the areas that they are not currently responsible for but will be from April 2023. Dentistry is an example and links to the patient story today. The ICB is not currently responsible for NHS dentistry in Cheshire and Merseyside but in April this will be transferring and it will be a big challenge from day one. GUR also highlighted that the ICB is not responsible for high end specialist services but they are likely to become responsible for some of these, if not all, and there will be a significant piece of due diligence work linked to this. GUR shared that there will be other items within his reports which have been brought for openness and transparency, to ensure that issues are put into the public domain through these ICB papers. GUR shared that, for example, there was an ask from the public to share the terms of reference that have been set for the Liverpool review and these are contained in the report for today's meeting. Questions and comments were invited:-	

	• Neil Large (NLA) noted that the objectives of the Liverpool review are extremely ambitious in terms of the clinical redesign and it refers to a revenue and capital perspective also. NLA felt that this work also has an ambitious timeframe and asked who has been commissioned to do the work and whether they are on target. ○ GUR confirmed that Carnall Farrar have been commissioned to undertake this review and they have held a starting meeting earlier this week. GUR shared that they have set out their methodology and a clear timeline which includes some contingency, however, the ICB is being very clear about the financial constraints associated with this review. It is therefore important that Carnall Farrar deliver on their commitments and the ICB holds them to account for this delivery. • Jayne Parkinson-Loftus (JPL) shared that she found it reassuring that responsibility for dental services is to be transferred to the ICB and will be dealt with at this level. JPL shared that Healthwatch agree that dental services is a significant issue and is being discussed on a daily basis. ○ GUR shared that, although the ICB will not take legal responsibility until 1st April 2023, it should use the period from now to then to: a) carry out due diligence, and b) understand all the information available; not just what is spent on these services but the wait times, numbers, barriers to access. This will enable the ICB to commence at the start with an improvement plan. ○ GUR highlighted that there will be no quick solutions, instead, the ICB will have to think about how to progressively improve this service month on month, year on year. • Dr Joe Rafferty (JRA) agreed that carrying out due diligence on transferring services between now and 1st April 2023 is a good idea but highlighted that there is the temptation to do just performance or financial due diligence. JRA asked whether GUR was planning on carrying out due diligence around a skills audit. ○ GUR shared his view that the due diligence process should be thorough and comprehensive, and it should not only take account of the skills of people delivering this service, but the skills of those that lead this work. ○ GUR highlighted that, currently, there are some specialised services that are managed at a North West level and some at a whole England level. GUR shared that he does not expect NHS England to delegate anything at a whole England level but confirmed that, when the ICB looks to take on North West issues, it will not want to take actions that denude its neighbouring areas. Therefore, the ICB will not only have to consider its own needs but those of the wider system.	

	○ GUR confirmed that a team of people will take the ICB through this work and it will consider how the Board and the input of partner members to influence this process. • Steven Broomhead (SBR) welcomed the fact that the report includes a section on the marmot community and the 22 beacon indicators. SBR stated that he would like the ICB to ask that all Places submit data to this Board yearly on what progress has been made against these indicators. ○ GUR agreed with SBR's recommendation and shared that much of the driver for this will be through the integrated care partnership where they will examine the detail from the beacon indicators. GUR shared that, currently, some indicators are measured quarterly and some annually but these will come back as part of the performance reporting to this board. No other questions or comments were raised. **Outcome:** The Board noted the Chief Executive's Report.	
ICB/8/22/07	**Report of the Place Director – St Helens:** Raj Jai (RJA) confirmed that he was delighted to welcome this item and shared that the ICB and ICP is made up of nine Places. Thanks were expressed to Mark Palethorpe (MPA) and St Helens Place for hosting the first visit and preparing their presentation. A copy of the presentation was provided prior to the meeting and MPA presented this to the Board. Questions:- • Tony Foy (TFO) noted that the 'Tartan Rug' table highlights two areas that have very different data to the others and asked whether St Helens Place is able to offer a brighter future for these two challenged areas by working in the localities rather than just working at a higher level. ○ MPA confirmed that the approach in St Helens has meant it has broken down the barriers that are seen locally as inhibiting progress for the local population. MPA shared, for example, that they have a working relationship with Torus Housing and therefore are able to work with partners and make a difference for the most deprived communities. ○ MPA also highlighted that if the residents see the NHS working together with partners in a joined up way, the patients will see the benefits. MPA shared that there is still a lot of work to do on this but in St Helens, they have a significant platform to work from.	

	• Raj Jain (RJA) noted the mention of listening and engaging in communities within the presentation and asked how MPA ensures that they work with communities and listen to their solutions as well as their priorities in a systematic and sustainable way. ○ MPA highlighted the importance of ensuring that the voice of the public gets into the room at meetings and provides challenge. This is in place at St Helens and use this to triangulate the work that they are doing. MPA confirmed that they constantly go back to the public and check via the stakeholder forum as well as through other groups. MPA shared that the key to locality work at a primary care level is around having daily conversations rather than monthly or quarterly engagements. MPA feels that St Helens are engaging rather than just writing the strategy and this is a constant way of working. • Steven Broomhead (SBR) noted that the NHS is relatively well funded and resourced compared to social care organisations who are working in what some would consider to be a national crisis. SBR asked, at a Place level, how St Helens will deal with this inequality in the allocation of resources. ○ MPA confirmed that he is realising this cannot be done alone and the benefit of having an integrated service locally is that there are no difficult discussions around continuing health care. MPA shared that integrated teams are in place and they are focussed on the resident. MPA noted that there is still more to be done around special educational needs and disability. ○ MPA confirmed that there is a challenge around the fair cost of care, the cap on care costs and the number of social workers needed to assess. In addition to this, there are the issues in schools and children coming into care need to be considered. Therefore, organisations need to look broader than their own side of the boundaries and look at how Places can support each other. MPA felt that there is an argument to suggest taking a mid-Mersey approach to certain issues will be beneficial for example. • Erica Morriss (EMO) noted the drive for equity and quality that was evident throughout the presentation, and asked what work is being done regarding the future workforce and giving hope to the young people of St Helens. ○ MPA agreed that the future workforce is an ongoing issue and this is not about funding, but rather the capacity. MPA shared that a bid was submitted around regeneration which included offers to local young people to provide opportunities beyond apprenticeships and build career pathways	

	○ MPA shared that another way St Helens is addressing this point is to review how it commissions services. If some services are commissioned on a larger scale, not only would economies of scale be achieved, but you will see consistency in practice and investment in the workforce which will help challenge the workforce issues. • Graham Urwin (GUR) shared that it is the ICB's intention to hold a meeting in public at each Place every year and he would like to acknowledge that St Helens' volunteered for the first one and have set the bar high. GUR noted that one thing we know we frequently get wrong is spending a lot of time talking about acute services and we don't give enough to mental health and the parity of esteem. GUR stated that it was good to see this ambition at the centre of the presentation and expressed thanks to MPA for making health and wellbeing the focus. • GUR shared that it is a privilege to be part of the system level looking at the full 2.7m population, but alongside this, there is the need to abhor and want to tackle variation as it cannot be the case that patients in one area get better access to services compared to another. • GUR felt that it was good to see that St Helens had set itself targets for improvement and had picked out key areas for improvement around reaching the North West average. GUR highlighted the need to be ambitious and consider whether the North West target is good enough for the population it serves and therefore asked whether there is anything, with the exception of further funding, that the Board can provide in terms of permissions or rules that will help Places go further and faster with their improvement plans. ○ MPA shared that it would be helpful to know that the ICB will adopt a pragmatic approach to supporting Place both when making requests for approval and seeking for forgiveness because an opportunity to collaborate has arisen and they have moved forward with something. MPA shared that in St Helens there are a number of wider partnerships which are keen to make a difference for the local population and the development of the integrated partnership piece is an important piece of work. • Prof Rowan Pritchard Jones (RPJ) shared he was pleased to see an emphasis on managing the healthy eating and obesity with young people and highlighted that tackling this now will potentially have a significant impact on the whole future population at a generational level. PRJ outlined the importance of engaging with social care and education in order to transform young people's approach to diet weight and exercise.	

	RPJ asked whether these are groups that are coming closer to the NHS in terms of managing health and are they engaged in the same message. ○ MPA shared that work with younger children supporting early years hubs is key, to enable work with parents and young people now. MPA shared that this working is taking place in St Helens and they also work with education leaders at primary and secondary schools to ensure they are supporting young people but at the same time, not stigmatising them which can affect their engagement. MPA shared that this is carried out through the Active Live strategy which is supported by educational leaders. In addition, it is also included in the borough strategy which goes through to 2030 and is a measure within Ofsted inspections. No further comments or questions were raised and the Board expressed thanks again to Mark Palethorpe for the presentation. **Outcome:** The Board noted the report of the Place Director St Helens.	
ICB/8/22/08	**Report of the Remuneration Committee:** A copy of the report was provided prior to the meeting and Tony Foy (TFO), Chair of the committee, highlighted the following:- • The report provides an overview of the first committee meeting. It is for noting and to provide assurance of due process. • The committee had extensive discussions about the Very Senior Manager (VSM) pay framework and TFO informed the Board that was helpful to see the recommendation's adherence to the seven criteria points as this supported the committee to reach decisions using a consistent approach which ensured equitable decisions were made for all the VSMs involved. The committee agreed salaries within the national pay ranges and did not consider any salary in excess of the national recommendations. • The committee also considered those Place Directors who are joint appointments and remain employees of the local authority. The same criteria were applied, in order to reach decisions on their salaries. • The committee noted the need for a defined performance management framework and this work is to be concluded at a future meeting. • The retention of talent was discussed and the avoidance of compulsory redundancies through the management of change process. • The committee recognised we are in a period of considerable change for all staff and the broadening of the committee's role was welcomed.	

	No questions or comments were raised. **Outcome:** The Board noted the report of the Remuneration Committee.	
ICB/8/22/09	**Cheshire & Merseyside ICB Financial Plan/Budget:** A copy of the proposed ICB financial Plan and budget for 2022/23 was provided prior to the meeting and Claire Wilson (CWI) highlighted the focus for this agenda item is around the plan and delegations, and the wider discussion about risk can be picked up under the next agenda item. CWI following in relation to the first section of the report:- • The financial plan and budget for 2022/23 relates to both the system and the ICB. • The committee was asked to note that financial plan was submitted on behalf of the system in June and that was a combination of a number of months work across the system and the overall financial position included within the submission is an aggregation of 17 providers and 9 CCGs. • The planning process was overseen from an assurance and approvals perspective by the Health and Care Partnership and the systemwide finance committee. • The financial plan is brought for noting and support on the understanding that the submission occurred prior to the establishment of the ICB. • The paper sets out financial position for all parts of the system and includes a c£30m deficit for the year. Nationally there is a requirement for all systems to achieve a break-even position, but this deficit relates to the unavoidable costs of opening the new hospital in Liverpool in-year and this value has been understood and accepted by the NHS England national team. • The ICB is facing a financially challenged situation and the plans and targets set out in the plan are extremely challenging. • The Board is being asked to support the plan and note the submission of the financial plan. CWI highlighted the following in relation to the second section of the report:- • The report sets out how the ICB will delegate budgets to Place this year. • A pragmatic year 1 holding position has been adopted as the ICB continues to work on target operating models and how to work together across the system.	

	• A significant amount of the plan has been subject to a number of conversations locally and across the system prior to the establishment of the ICB as CCGs undertook their due diligence in advance of the 30th June.
	• The focus is around the plan and delegations, the wider discussion about risk can be picked up on the second paper.
	
	Questions and comments were invited:-
	
	• Tony Foy (TFO) asked about the robustness of the budgetary control processes in this complex ICB and Place situation.
	  ○ CWI shared that the CCGs had a number of measures to ensure robust budgetary control and these have been reviewed to create the financial control environment. CWI shared that this includes a series of delegations that will balance the need for autonomy and financial control.
	  ○ CWI noted the need for the ICB to continually review the processes in place to ensure it is not hampering local decision making and to ensure that decisions can be made smoothly and quickly.
	  ○ NHS England has required every organisation across the county an internal audit review its finance control system and CWI the need to ensure the ICB holds itself under high scrutiny. Therefore, a very early review of financial controls will be carried out and the outcome of this will be taken through the finance committee.
	
	• Neil Large (NLA) asked for timeframes around when the Board will be able to see the ICB budget so they can understand what they are accountable for.
	  ○ CWI shared that this is the first month of reporting and work is being done to develop a more comprehensive report going forward with the ICB input. Future reporting will include the detail around the ICB budget and the cost improvement plan (detailing running costs and challenges set to ensure value for money).
	
	• NLA noted that there is no contingency and asked how much of risk is this and whether the plan is based on actual levels of activity or expected levels of activity.
	  ○ CWI confirmed that this is a financial plan in a high challenging financial environment and the ICB has to respond to the changes in funding post-Covid.
	  ○ CWI shared that early discussions regarding the draft financial plan included a much larger expected deficit than the one presented today. The system has challenged itself to make the plan as ambitious as it can be and get back to a financially stable position. This does create a risk this requires close scrutiny throughout the year.	

	○ CWI confirmed that activity plans have been developed by individual providers in line with capacity planning and expected activity towards elective recovery. They have also provided estimates on non-elective and covid recovery. ○ CWI confirmed that contracts between ICB and NHS providers have been blocked for this year with some adjustments at the margin which will allow money to be moved around the system if there are significant changes. CWI highlighted that keeping track of activity will be very important to the ICB and providers collectively and whilst this is not a commissioning risk, the system is accountable for the financial position. CWI acknowledged the assumption that we will achieve 100% of the elective recovery funding and this is a risk; although the system did well in the early months of the year, June was a challenge due to covid. • NLA asked how realistic the Liverpool plan is, this given the 6% cost improvement programme (CIP) and a deficit position. ○ CWI confirmed that Liverpool University Hospitals Foundation Trust (LUFT) is one of the biggest provider organisations and also has a deficit. The ICB is working closely with them and they are being supported through a SOF4 arrangement and improvement programme. CWI confirmed that there is an independent financial review programme being carried out, in partnership with the organisation, to understand the drivers of the deficit and understand the financial strategy needed to be adopted to understand/harness the savings and opportunities of the new hospital build. • Steven Broomhead (SBR) noted the explanation on the deficit issues and shared that he welcomed the proposed 80% allocation to Place. SBR suggested that more monies could be delegated to Place over time. ○ CWI noted the comments around delegation and confirmed that the financial plan is the overall aggregation of a system plan as it stands now and work will continue around future delegations. • SBR also expressed concern around the lack of reserves in the plan and noted that inflation is in excess of 10% and there are significant workforce inflation costs. SBR shared that he recognises that the NHS is able to overspend whereas local authorities are not but asked whether the budget has the resources to meet the demands of inflationary pressures and the pressure on the system. ○ CWI shared her belief that there are no significant reserves even within providers. ○ CWI shared that the challenge for the ICB was whether to increase the cost improvement programme (CIP) to give a reserve, or whether to balance the risk throughout the year.	

	CWI highlighted that the level of CIP is higher than it has ever been (aggregate of 4.5%) and this in itself will be incredibly challenging. Some organisations are reporting a much higher CIP rate than the average contained within the plan. ○ CWI outlined the three components of cost improvement target and informed the Board that the ICB is required to review all investments to deal with the Covid response and meet the requirement to remove some of these measures. CWI confirmed that the removal of some of these is included within the plan. ○ CWI informed the Board that some areas will be able to make technical adjustments to support the financial position. These will be a one off and will not help the longer-term financial position. ○ CWI agrees that there is a level of risk and highlighted that collective work is needed to achieve this and as the ICB moves into next year, the focus will be on the level of non-recurrent savings as this will create a significant issue for next year. CWI confirmed that next year's financial strategy will need to be carefully thought out. ○ CWI confirmed that the financial plan includes inflation information as of June and has not been developed using an overinflated rate. CWI felt that the plan includes an element of realism in this regard. • Graham Urwin (GUR) highlighted that collaborative working with local partners is made more difficult by the fact that the NHS works within a different funding regime and one platform that we should build our success on is effective financial management and effective control of resources. There is a huge responsibility that comes with this and the ICB has a fundamental duty to the population it serves but also to the taxpayer. • Ann Marr (AMA) noted that one of the assumed resources is the Elective Recovery Fund (ERF) monies and highlighted that all organisations are desperate to take advantage of this fund by treating the patients, however, capacity is being consumed by the non-elective activity meaning that organisations cannot earn this funding because they can't free up beds to get the patients through. AMA highlighted that it is a shame the funding will be lost because we can not identify a better way to operate and would welcome discussion around to get into a better position to make use of this funding. ○ CWI confirmed that the ICB is anticipating receiving the full ERF which is a financial risk but understands the broader comment around how we maximum our rate of recovery and make use of this income.	

	○ CWI confirmed that she would welcome a representative from Cheshire and Merseyside Acute and Specialist Trust (CMAST) onto the Elective Recovery Group to review the opportunities we have available. ○ Raj Jain (RJA) also noted the recommendation to start working on the case to put forward to region and national around the current pressures and our inability to hit elective recovery targets. **Outcome:** The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. **Outcome:** The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	
ICB/8/22/10	**Cheshire & Merseyside System Month 3 (Quarter One) Finance Report:** A copy of the month 3 finance report was provided prior to the meeting and Claire Wilson (CWI) highlighted the following:- • The paper sets out financial position at the end of June 2022. This is a slightly unusual report as it is effectively reporting on the statutory organisation as they existed at the end of June; this includes the Clinical Commissioning Groups (CCGs) and providers in the system. • The CCG positions are now finalised and subject to audit. • The original financial plan included an overall planned deficient of £27m and we have delivered a position £1.6m better than this as of 30th June 2022. • The overall plan for the full year is £30m deficit and we are seeing £25.4m of this reported in Q1 which points to a back-ended risk. • There is an assumption that savings plans for individual organisations had developed plans based on a full year and therefore the savings will materialise in future months. Assurance will be provided to show that work is progressing at pace. • The report shows that, at Month 3, the deficit is centred around a small number of organisations. As the months go on, depending on their assumptions around CIP programmes, the risks are expected to materialise without corrective action. • The system financial recovery programme is being developed and will need further developing at pace. This will include how to hold organisations to account, how can the ICB support them and what decisions can we make across the system to expediate the cost saving programme.	

	• Peer review processes have been put into place for those organisations with deficit position. These processes have been clinically led. • Further discussions are planned around the additional financial controls that may be required to manage the in-year risk. This will include agency spend and what the local escalation processes look like. • There is a huge amount to do and considerable risk to deliver the proposed financial position but other Boards across the country will be having similar discussions to ensure that risks are being managed and holding us to account for delivery. Questions and comments were invited:- • Steven Broomhead (SBR) noted the small allocation capital budget and asked what the role of this Board is in relation to decisions on capital and how will this be reflected in the budget. o CWI confirmed that the NHS is very capital restrained. Cheshire and Merseyside are given a funding envelope and is able to determine how this is prioritised. CWI shared that half the capital element in the budget is controlled by Cheshire and Merseyside, and the other have is reserved for national processes. o CWI confirmed that the new hospital capital fund is a national programme with national criteria and the likelihood of one being in Cheshire and Merseyside is fairly low. • Jayne Parkinson-Loftus (JPL) expressed concern around the public's understanding of the savings and highlighted that, given the long waiting lists etc, it is hard to assure patients that savings of over £68m will not have an impact on their care. o Graham Urwin (GUR) confirmed that the NHS was given whatever funding it required to get through Covid and it therefore did not operate with a budget. This money is not being given back, however, budgets are slowly being brought back down to pre-pandemic levels. GUR confirmed that it will never get back to that level because of the inflation each year, but they are starting to reduce the funding for dealing with the difficult operating environment of Covid. GUR shared that the ICB feel that this is happening too soon but that is the decision of the government. o GUR stated that, in terms of the elective recovery fund, if we can do the work there is no current limit to how much we can claim, but we are restrained by capacity we have and the workforce. If there are spaces on wards and theatres and the staffing is in place then the money will be available. This is the operational challenge the NHS is working under.	

	○ Raj Jain (RJA) confirmed that all of the ICB's provider organisations will do a quality and safety impact assessment and these will be reviewed this through the Medical Director and the medical team to ensure that there are no productivity and safety issues. • Neil Large (NLA) accepted that this is a year of 'getting through', but asked about the strategy that moves the ICB forward, in particular:- a) when will the impact on equalities will be seen? b) when will there be a change of pace in terms of targets for Places? c) Cheshire has a £6.9m deficit and would like to understand whether this is around fair share issues. When will we ensure that Places have a fair share process? d) NLA also noted the poor record in relation to the better payment fund. ○ GUR confirmed that Clare Watson will be preparing a 5-year plan for the system and this will be signed off by the Board no later than March next year. This plan will be underpinned by quality, digital, workforce and financial strategies. ○ CWI confirmed that work continues to take place to identify where there are blockages in the plan are and will report to the board every month. **Outcome:** The Board noted the Month 3 Financial Report.	
ICB/8/22/11	**Cheshire & Merseyside Month 3 (Quarter One) Performance Report:** A copy of the Month 3 Performance Report was provided prior to the meeting and Anthony Middleton (AMI) highlighted the following:- • This is a developing reporting process and it is intended to integrate quality, finance and performance into one report pack in future months. • The report follows some key indicators but does not cover all of them. next month's report will bring some detail of targets and objectives from this year's planning guidance. • Urgent care – there is pressure across all centres. A&E attendances are used as a barometer of pressure and we know we are approximately 7% up on expected rate. GP appointments are also up by 7% and occupancy rates are very high. AMI highlighted that we are experiencing ongoing waves of covid and at one point in June/July, 9% of all bed stock was being managed for covid patients. We are in a really challenging position. • Workforce challenges – these challenges are being seen across the board. Recovery work in the social care workforce sector is showing signs of improvement.	

	• The data shows the consequences of long terms stay in A&E. • Ambulance response times - the data clearly shows the attempts by the North West Ambulance Service (NWAS) to address responses times to Cat 1 and 2 cases, even if this means that the response times for Cat 4 is longer. • Recovery – the system is having some success in reaching pre-pandemic levels but there are still challenges around non-elective numbers having an impact on elective and day cases. We are at 103% of elective outpatient pre-covid levels and are seeing a lot of outpatient follow up attendances being patient lead rather than via six month follow-up appointments which is having a positive impact and providing more capacity to tackle waiting times. The latest objective for backlogs was highlighted and AMI confirmed that the ICB was able to report 0% of over 2 year wait lists at the end of July. It will continue to work towards the objective of eliminating 78 week waits by the end of March 2023. • Cancer – activity levels were maintained throughout covid but there was a reduction in referrals. A surge in referrals has been seen and hospitals are performing 109% of treatments compared to pre-pandemic levels but there are significant backlogs to address. These are coming down slowly and wait lists are twice the pre-pandemic levels. Cancer patients are tracked and treatments will be brought forward and adjusted deepening on clinical need and in the context of the overall backlog. The cancer network has worked together by allowing waiting lists to be shared to allow patients to move between sites to enable them to receive treatment. We will work towards a move to this model completely rather than tracking patients by site. Questions and comments were invited:- • Adam Irvine (AIR) expressed disappointment that the report only covers general practice within primary care and does not include dentistry, ophthalmology or pharmacy. AIR asked whether future reporting could include these areas and confirmed that he was willing to support with this. ○ AMI confirmed that work is being done to incorporate the other areas into the data and confirmed that he would welcome AIR's involvement to support this work. • Dr Joe Rafferty (JRA) noted that there was no reference to mental health, learning disability or community services within the report and shared that the highest instances of mental health issues are seen within this ICS area. JRA shared his view that, by taking so long to put this data into our matrix, we are institutionally stigmatising patients with metal health issues.	

	JRA felt that this was not the intention but highlighted the need to move forward rapidly on this and suggested that a number of indicators could be selected and measured as this will give an indication of performance in these areas. . o AMI agreed with JRA's comments and confirmed that inclusion of mental health, learning disability and community services is part of the development of the overall paper. AMI confirmed that, even in the current operational planning round, there was only one indictor relating to mental health alongside 40 or 50 for the acute sector. **Outcome:** The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB/8/22/12	**Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire:** A copy of the paper on the Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire was provided prior to the meeting. Dr Fiona Lemmens (FLE) highlighted the following:- • The paper has been brough for a decision, building on conversation at the Shadow ICB meetings. • The Board welcomed Dr Claire Cullen (CCU), stroke consultant, and Carol Hill (CHI), Director of Strategy at Liverpool Place and SRO on the Stroke programme. • Governance - Section 8 provides details of the extensive process over a protracted length of time, since 2015. The programme was protracted in part due to Covid. The process has been accelerated over the past five months due to concerns around sustainability of stroke services at Ormskirk and Southport and this challenge has been met by a very collaborative approach. The programme has now reached the point of asking for decision and we have final OSC meeting is scheduled for September. On 27th July, Lancashire and South Cumbria ICB supported the paper with some caveats. They also want to be involved in the next phases of the work to ensure this mobilises safely but continues to develop as planned. • Outcomes – In June, the ICB asked how we will know we are making a difference. In response to this, a local dashboard has been produced and the data looks promising. • Finance – the original pre-consultation business case was carried out five years ago and, in hindsight, had some gaps around assumptions. This was carried out during pre-covid times and were are now existing in a very different environment.	

There is a lot of learning from this exercise for future pre-business cases, including the need to carry out horizon scanning. The stroke process will be used as an example. The changes in costs are due to two key areas: i) the changes to diagnostics, and ii) the staffing situation is completely different.

Questions and comments were invited:-

- Claire Wilson (CWI) shared that the paper shows an annual cost of just over £7m compared to pre-consultation cost of c£2.8m and confirmed that a number of review meetings have been held with wider financial and clinical colleagues to understand this. CWI highlighted that this is a significant investment and there is a need to be clear that this is the right model and it has value. CWI confirmed that £2m has been found from the ICB budget to support the in-year costs but more work is needed over coming weeks and months to determine the annual costs and ensure this is a value for money model. CWI shared that she was conscious that, clinically, this has to happen in September to support the clinical risk and is therefore supportive of the case subject to further work on affordability in the long term.

- Ann Marr (AMA) asked whether the Board is approving the principle of a hyper acute centre or whether it is supporting the business case with the figures included it. AMA confirmed that she would welcome the scrutiny of costs and stated that the additional patients will be from Southport which, under payment by results (PBR), would yield around c£1m. AMA also pointed out that there will be some drift into Whiston from the Royal and this is a capacity issue which has not been mentioned in the paper. AMA highlighted that there are some areas of shared population outside Liverpool and there is therefore a need to consider the wider area when making decisions.
  - It was confirmed that the request is to approve the mobilisation of phase one and the recommendations within the business case, with the caveat that further work across the system is required, including financial work.
  - FLE confirmed that modelling work is being done on patient flow and confirmed that this was also a comment from Lancashire and South Cumbria ICB.
  - Dr Claire Cullen (CCU) highlighted that it is not straight forward to say we are taking in an additional number of patients, this is also creating a gold standard of service for the people of North Mersey which requires additional funding for staffing to meet national standards, as well as investment in radiology and the national imaging pathway. CCU welcomed the continual review of outcomes and felt that they would expect to see an improvement in snap performance in September but the full benefits will not be seen until further down the line.

	○ CCU highlighted that one of the key drivers has been around thrombectomy. The rates for thrombectomy are well below the 10% we should be aiming for. CCU shared that, across the North West, thrombectomy rates were 1.8% last financial year and in LUFT were around 2.5%. CCU shared that in 3 years LUFT has gone from 6 patients receiving a thrombectomy to 41 and this shows a rapid regional improvement. Therefore, when patients are able to go to the new site with the latest imaging, it will have a significant impact. • Neil Large (NLA) confirmed that the clinical case is strong but felt that the move from a £2.8m business case to £7m was a concern, particularly in terms of the planning behind the business case. NLA felt that the ICB needs to work through some principles around developing business cases, looking at today and the future horizon to capture the advancements. ○ FLE agreed with the comment and shared that this is the reason she has committed to using this case as a 'lessons learnt' exercise. Covid has had an impact in this case but agrees with the point around horizon scanning. • AMA confirmed that she was pleased to see the drive to reach a gold standard service but highlighted the need for this to be available to the whole of Cheshire and Merseyside, not just North Mersey, as the ICB is responsible for all areas. AMA agreed with the points around thrombectomy but felt that access to specialised services was better the closer to Liverpool you are. ○ FLE agreed with AMA's comments and confirmed that the Cheshire & Merseyside stroke network is addressing this through their work plan. • Raj Jain (RJA) agreed that the clinical and patient case is strong and the aim for a gold standard service is essential, however, RJA expressed concern around whether the decision made today may have an unstoppable impact on the financial plan. ○ CWI confirmed that, if the Board approves the full business case now, it does not preclude the system reviewing the business case and pulling costs out of it at a future point but highlighted that the decision is around whether the Board is comfortable with that given the substantial differential. ○ RJA shared his view that it is normally extremely difficult to stop something once it has been approved and whilst we do not want to stop it, there are significant costs involved. ○ Graham Urwin (GUR) shared that as we come out of the Covid funding regime, we are moving into a system where it is necessary to constrain its costs in a collaborative way. We therefore need to determine whether the additional cost is real and then who pays for this.	

	○ GUR outlined the expectation that there is already a level of financial support in the system for the acute sector in Liverpool, and there is also an expectation that they will support this. This will be subject to the review in Liverpool. GUR's view was therefore, that the Board should be approving the clinical case but making it clear that this will be continually reviewed and decisions will be made around how much of this cost should be absorbed within the funds that have already been given to LUFT along with the notion of peer review to make sure that this is right and fair. **Outcome:** The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB/8/22/13	**Virtual Wards – update on their expansion across Cheshire and Merseyside:** A copy of the paper was provided prior to the meeting and Raj Jain (RJA) invited any comments or questions. • RJA asked why progress is not being made quicker and further than outlined in the report. ○ Anthony Middleton (AMI) confirmed that there is a need to review the current occupancy of virtual wards to understand the lessons learned before work can progress at pace. **Outcome:** The Board noted the Virtual Wards update.	
ICB/8/22/14	**Responses to questions raised by Members of the Public in relation to items on the agenda:** The Chair reminded those present that, due to the number of questions received, they would only deal with a few during the meeting but that all questions would be answered following the meeting. • *Q. Would the Board consider taking positive and urgent action to inform people on NHS waiting lists that they have a choice of where they are treated and that by travelling what maybe a short distance their waiting time could be reduced?* ○ Anthony Middleton (AMI) confirmed that is the next phase of transformational progress. Part of elective programme will be to get this information and share this with the public.	

- *Q. The Performance report doesn't have 52 and 18 week figures - are these available?*
  - AMI confirmed the focus has been on 78-week waits, but the 52 and 19 week figures are available and will be included in future reports to the Board and can be published.

- *Q. Does the Service Specification require Carnall Farrar to reach a conclusion compatible with the Introduction, or are they free to reject the assertions and perspective of the One Liverpool Strategy?*
  - Graham Urwin (GUR) confirmed that rather than starting from nothing, the review is taking what has been done to date and accelerating/developing this. GUR confirmed that the reviewers have been appointed through a robust process and if they feel there are fundamental flaws with how we are working now, GUR would expect them to bring this to the ICB to be discussed and agree an appropriate pathway.

- Q. The sole mention of the Ockenden Report in the Cheshire & Merseyside ICB Board papers is (p92) the planned allocation of £3.731mn "Ockenden Funding" out of an ICB total of £5.697bn, which amounts to 0.065% of total allocation.
  Question:
  a) What will the Cheshire & Merseyside Ockenden Funding be spent on?
  b) How will the ICB ensure that maternity finance and staffing speedily reaches the levels envisaged in the Ockenden Report, thereby ensuring safer and happier birth experiences. and much improved maternity staff retention?
  c) How will the Cheshire and Merseyside ICS Board ensure maternity finance and staffing speedily reaches the levels envisaged in the Ockendon report, and in the report of the Parliamentary select committee's report "The safety of Maternity services in England" thereby ensuring safer and happier birth experiences. and much improved maternity staff retention?
  d) What measures from the ICB report will help improve the life expectancy of babies under one year of age in this area?
  - Christine Douglas (CDO) confirmed that the Local Maternity Neonatal System (LMNS) will provide assurance to the ICB on the totality of the Ockenden agenda. The LMNS has identified the formula for the allocation of funds to providers and it will monitor and provide assurances that the funds are being used to meet the objectives. CDO also confirmed that the system quality group for the ICB will be reviewing all matters that relate to Ockenden and these have been timetabled within their scheduled meetings.

	Raj Jain (RJA) confirmed that all members of the public who submitted questions will receive a response. **Outcome:** The Board will respond to all public questions raised prior to the August meeting.	
ICB/8/22/15	**Any Other Business:** There was no other business.	
ICB/22/11	**Review of the meeting and communications from it:** Raj Jain (RJA), Chair, highlighted that this has been the first meeting with a wholesome agenda that covers the work we are setting out to achieve. The Board are aware that the meetings are a work in progress and we know that there are certain areas of the remit that we will see more of in due course. The ICB will periodically review the effectiveness of this Board. Thanks were expressed to the presenters at this meeting, with particular thanks to Mark Palethorpe. The Board has discussed a number of important matters and will work with the comms team to ensure these are reflected on the website. Thanks were expressed to the members of public for attending and highlighted the importance of their attendance as it brings the items discussed to life.	

Date of Next Meeting: 29th September 2022, 10.00 am to 12.30 pm

End of Meeting

CHESHIRE MERSEYSIDE INTEGRATED CARE BOARD

Action Log 2022-23

Updated: 4th August 2022

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-01	01-Jul-2022	**ICB Constitution**	The following changes to the ICB constitution will be made:- 1) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 2) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 3) The wording of section 7.3 will be reviewed to ensure completeness. 4) The role of the local authority will be strengthened and added to the final version document prior to publication. 5) The principles in section 6.2.1 will be revised and updated subject to the approval of the Board.	Clare Watson	27-Oct-2022	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map*	COMPLETED
ICB-AC-22-02	01-Jul-2022	**ICB Functions and Decision Map**	The diagram/wording on page 241 will be reviewed to make the link between the ICB and the Health and Wellbeing Boards clearer.	Claire Wilson	27-Oct-2022	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map*	COMPLETED

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

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Decision Log 2022 - 2023

Updated: 4th August 2022

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-01	01-Jul-2022	**ICB Appointments (Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Executive Members of the Integrated Care Board:- 1) Claire Wilson, Director of Finance; 2) Professor Rowan Pritchard Jones, Medical Director 3) Christine Douglas MBE, Director of Nursing and Care.. They also agreed that Marie Boles, Interim Director of Nursing and Care, will fulfil this position until the substantive postholder commences.	
ICB-DE-22-02	01-Jul-2022	**ICB Appointments (Non-Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Non-Executive Members of the Integrated Care Board:- Neil Large MBE, Tony Foy and Erica Morriss.	
ICB-DE-22-03	01-Jul-2022	**ICB Appointments (Partner Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Partner Members of the Integrated Care Board:- Ann Marr OBE and Dr Joe Rafferty CBE.	
ICB-DE-22-04	01-Jul-2022	**ICB Constitution**		The Integrated Care Board approved:- 1) The NHS Cheshire and Merseyside Constitution subject to some agreed updates (see action plan ref: ICB-AC-22-01 for details). 2) The Standards of Business Conduct of NHS Cheshire and Merseyside. 3) The Draft Public Engagement/Empowerment Framework of NHS Cheshire and Merseyside. 4) The Draft Policy for Public Involvement of NHS Cheshire and Merseyside.	
ICB-DE-22-05	01-Jul-2022	**Scheme of Reservation and Delegation**		The Integrated Care Board approved:- 1) The Scheme of Reservation and Delegation of NHS Cheshire and Merseyside. 2) The Functions and Decisions Map of NHS Cheshire and Merseyside. 3) The Standing Financial Instructions of NHS Cheshire and Merseyside. 4) The Operational Limits of NHS Cheshire and Merseyside.	
ICB-DE-22-06	01-Jul-2022	**ICB Committees**		The Integrated Care Board approved:- 1) The core governance structure for NHS Cheshire and Merseyside. 2) The terms of reference of the ICB's committees. It also noted the following:- i) The proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board. ii) The receipt of Place based s75 agreements which govern defined relationships with and between specified local authorities and the ICB in each of the 9 Places.	
ICB-DE-22-07	01-Jul-2022	**ICB Roles**		The Integrated Care Board agreed the lead NHS Cheshire and Merseyside roles and portfolios for named individuals, noting that the Medical Director will be the SIRO and the Executive Director of Nursing and Care will be the Caldicott Guardian.	
ICB-DE-22-08	01-Jul-2022	**ICB Policies Approach and Governance**		The Integrated Care Board:- 1) Noted the contractual HR policies that will transfer to the ICB alongside the transferring staff from former organisations. 2) Endorsed the decision to adopt NHS Cheshire CCG's suit of policies as the ICB policy suite from 1st July 2022. 3) Agreed to establish a task and finish group to set out a proposed policy review process, using the committee structure for policy approval. 4) Noted the intention to develop a single suite of commissioning policies to support an equitable and consistent approach across Cheshire and Merseyside.	
ICB-DE-22-09	01-Jul-2022	**Shadow ICB Finance Committee Minutes Approval**		The Board agreed that the minutes of the Cheshire and Merseyside Shadow ICB Finance Committee held on 30th June 2022 can be submitted to the first meeting of the ICB's established Finance, Investment and Our Resources Committee.	
ICB-DE-22-10	04-Aug-2022	**Cheshire & Merseyside ICB Financial Plan/Budget**		1) The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. 2) The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	

CHESHIRE AND MERSEYSIDE
INTEGRATED CARE BOARD

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Decision Log 2022 - 2023

Updated: 4th August 2022

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-11	04-Aug-2022	**Cheshire & Merseyside System Month 3 (Quarter One) Finance Report**		The Board noted the Month 3 Financial Report.	
ICB-DE-22-12	04-Aug-2022	**Cheshire & Merseyside Month 3 (Quarter One) Performance Report**		The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB-DE-22-13	04-Aug-2022	**Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire**		The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB-DE-22-14	04-Aug-2022	**Virtual Wards – update on their expansion across Cheshire and Merseyside**		The Board noted the Virtual Wards update.	
ICB-DE-22-15	04-Aug-2022	**Responses to questions raised by Members of the Public in relation to items on the agenda**		The Board agreed to respond to all public questions raised prior to the August meeting.	

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report

29 September 2022

Agenda Item No	ICB/9/22/**05**
Report author & contact details	Graham Urwin, Chief Executive
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Graham Urwin, Chief Executive

NHS Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report (September 2022)

Executive Summary	This report provides a summary of issues not otherwise covered in detail on the Board meeting agenda. This includes updates on: • Specialised commissioning • Place Based Collaboration Agreements • Autumn Covid-19 Booster Update • ICP Strategy Development Update • CCG Annual Reports and Accounts and AGM 2021-22 • Freedom to Speak Up Month • C&M Adult Social Care Report • Clatterbridge Elective Hub TIF scheme.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X			
Recommendation	**The Board is asked to:** • **note** the contents of the report • **approve** entering into the Sefton Partnership Board Collaboration Agreement • **approve** the recommendation regarding approval of entering into collaborative Place Based Partnership arrangements.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X		X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
Management of Conflicts of Interest	No				
Next Steps	None				
Appendices	Appendix A				
	Appendix B	Sefton Partnership Board Collaboration Agreement			

Chief Executives Report (September 2022)

1. Introduction

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

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

2. Government announcement around the NHS – 'Our Plan for Patients'

2.1 At the time of publishing this report the Government have published their policy paper 'Our Plan for Patients'. This can be found at: https://www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients. I will take the opportunity to verbally update the Board on this announcement at the September meeting with regards its implications to the NHS in Cheshire and Merseyside.

3. Specialised Commissioning Update

3.1 NHS England (NHSE) and Cheshire and Merseyside ICB (C&MICB) are working in partnership to develop the Pre-Delegation Assessment Framework (PDAF), the document the ICB submits to NHSE to take on delegation of specialised services. We are in the process of considering the service segmentation rationale (single or multi ICB footprint), intelligence profiling the 65 services and understanding the finance and governance arrangements for these services to be delegated. The PDAF will inform decisions around:

- ICS agreement to proposed Service segmentation
- ICS readiness to take on these services – from April 2023 or April 2024
- ICS oversight/governance (clinical and financial) tailored to meet population health need, addressing health inequalities to optimise whole system pathway access and quality assured service pathways delivering good outcomes and patient experience.

2.2 In delivering this work, further national guidance and documentation is awaited:

- final National PDAF template
- national and local workforce perspective mainly due to organisational reform, holidays and unplanned national events impacting on the breadth of information and evidence available to support ICB decision making in line with the C&MICB Board timeframe.
- the work from a national, regional and ICB level requires much consideration to provide assurance on governance around decision making patient experience and outcomes in care are not compromised.

2.3 Discussions are ongoing within NHSE as to what the submission deadlines will be for the Specialised Services PDAF, expectations are that this will be delayed by a couple of weeks. Based on our current understanding of the likely submission date, we are planning that a final draft PDAF submission will be considered by the Board at its meeting on the 27 October 2022 at the earliest.

3. Approval of Place Based Collaboration Agreements

3.1 All nine places in Cheshire and Merseyside have some form of collaborative arrangements in place outlining their partnership arrangements and/or intent to work in partnership at Place. These have been captured in Committee / Board Terms of Reference, and other associated documents (i.e., Memorandum of Understanding (MOUs)). For those Places that have had their Partnership Committee/Board TORs and associated documents approved/endorsed by their respective CCGs prior to 1 July 2022, the ICB has in effect inherited that agreement/position.

3.2 As it currently stands the Place Based Partnership Committees / Boards are – legally – collaborative forums – where decisions undertaken at these forums are done so via the authority delegated to the individuals who form the membership rather than the Committee itself having formal delegated authority. For ICB functions/resources, decisions would be enacted through the authority delegated to ICB Place Directors (and other ICB staff) who form the membership of that forum, and whose authority is outlined within the ICB Scheme of Reservation and Delegation (SORD).[1]

3.3 For those Places who are still due to have their main Place Based Committee / Board TORs approved/supported by the ICB or who will require approval or amendments to any existing TORs, the ICB SORD currently indicates that the ICB Board is responsible for approval.

3.4 **Appendix A** provides an example of one such Collaboration Agreement for the Sefton Partnership Board. The Board is being asked today to approve the ICB being a signatory on this Agreement.

Recommendation:	The Board is asked to approve the ICB entering into the Sefton Partnership Board Collaboration Agreement.

3.5 To enable greater flexibility and timeliness to help support the development of Place Based Arrangements during this year of stability and transition, it is being proposed that whilst such Committees or Boards which underpin the arrangements remain as consultative forums as outlined in 3.2, that the authority to approve entering into such agreements (including approval of TORs for Places Based Committees) on behalf of the ICB is delegated to the Chief Executive and Assistant Chief Executive. Any approval of such arrangements will be reported back to the Board via the Chief Executive Report.

[1] https://www.cheshireandmerseyside.nhs.uk/media/lxdfkwlk/cm-sord.pdf page 20, Section 9 Partnership, Joint or Collaborative Working

3.6 To confirm, as the ICB progresses with developing and agreeing delegations to Place, any decisions with regards formal delegation to Place of ICB functions, resource / funding and decision-making authority to Place (via or by such Place Committees) will come directly to the Board for approval.

Recommendation: The Board is asked to approve the delegation of authority to the ICB Chief Executive and Assistant Chief Executive to approve entering into collaborative arrangements with Places, as outlined in paragraph 3.5.

4. Autumn 2022 COVID-19 Booster Programme Update

4.1 The Autumn booster offer is now under way for Cheshire and Merseyside which started on 5 September with a focus on our most vulnerable population. Our first week saw Care home residents, staff and housebound vaccinated using the Moderna Bivalent vaccine with over 200 care homes visited. Over 90% of Care homes have a booked visit in the coming weeks of the programme.

4.2 Primary Care, Community pharmacy and Hospital Hub sites are now vaccinating our older population, along with health and social care staff and people who are immunosuppressed. As of Monday 19 Sept, the Cheshire and Merseyside programme has delivered just under 60,000 boosters whilst delivering just over 4,000 primary doses as part of the evergreen offer. Shortly, people aged 50 and over will be invited to get their vaccination through the national booking system.[2]

4.3 We are enhancing the Cheshire and Mersey offer this Autumn through the Living Well service (offered by Cheshire Wirral Partnership) which is a system wide offer, directed by Place to target hard to reach, seldom heard groups to offer the autumn booster and evergreen offer. Following a successful evaluation of Living Well over the summer, this service works in partnership to provide hyper local intervention primarily targeting the most deprived 20% of the population, Inclusion health groups, Maternity, Severe mental illness, Chronic respiratory disease, Early cancer diagnosis and hypertension case finding. This includes physical and mental health checks alongside provision of social advice, guidance, and signposting, for example around food insecurity, poverty, and personal finances. Living Well is being formally evaluated by the University of Chester as well as locally, working with place leads to measure impact on reducing health inequalities across Cheshire and Merseyside.

[2] https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/book-coronavirus-vaccination/

5. CCG Annual General Meeting and CCG Annual Reports 2021 - 2022 publication

5.1 Clinical Commissioning Groups (CCGs) were required to publish their Annual Report and Accounts online by 30 September of each year, i.e., within 6 months of last day of reporting period. As CCGs were disestablished on the 1 July 2022 and their websites largely closed or archived (in Cheshire and Merseyside all websites have been archived but are still available to view) the Annual Report and Accounts for the 2021-22 period still need to be made available.

5.2 Ordinarily, the CCG would be required to hold an Annual General Meeting (AGM) at which the Annual Report is presented, again within the 6-month period of last day of reporting period. However, as 2022/23 is a year of transition, guidance from NHS England has stated that in order to discharge this duty that the ICB can present the CCG Annual report(s) and Accounts at a public board meeting in lieu of a CCG AGM.

5.3 None of the former CCGs within Cheshire and Merseyside have held an AGM for the 2021-22 period. As such we are bringing to the attention of the Board, and public, today of all the Annual Report and Accounts 2021-22 of all the former Cheshire and Merseyside CCGs via: https://www.cheshireandmerseyside.nhs.uk/latest/reports/, thereby discharging the duty required of the ICB.

6. Integrated Care Partnership Strategy Development Update

6.1 On 29 July 2022 guidance was issued by the Department of Health and Social Care requiring Integrated Care Partnerships (ICP) to have published an interim strategy by December 2022.[3] This would be informed by Place Health and Wellbeing Boards' Joint Strategic Needs Assessments (JSNA) alongside any additional research or available data to build a holistic understanding of the Cheshire and Merseyside populations' health and care needs. The aim of the ICP Strategy is to focus on activity that will be delivered at a Cheshire and Merseyside system (or cross-system) level, while Joint Local Health and Wellbeing Strategies (JLHWSs) should focus on what can be delivered at 'place' and in communities.

6.2 The guidance outlines that on the basis this is an interim Strategy the guidance expects ICPs will need to consider revising their strategy when they receive a new JSNA, and to work with HWBs, local authorities and ICBs to align the timelines of their strategies with the additional requirement for the Integrated Care Board to produce a five-year joint forward plan, which will also be required to be produced by April 2023. Whilst the national guidance in relation to "The ICB Five Year Joint Forward Plan" is yet to be released it will contain the ICB plans to implement the ICP Strategy, alongside other nationally determined priorities driven from the NHS Mandate, NHS Long Term Plan and Operational Planning Guidance.

[3] Guidance on the preparation of integrated care strategies - GOV.UK (www.gov.uk)

6.3 The guidance goes on to outline some key areas to consider when producing the strategy, including personalised care; addressing disparities in health and social care; population health and prevention; health protection; babies, children, young people and their families, and healthy ageing; workforce; research and innovation; health-related services; and data and information sharing. Within Cheshire and Merseyside, we have previously developed key priorities, through a Health and Care Partnership Strategy[4] and undertaken further targeted work on several areas such as Health Inequalities. This work helps to provide much of the content of a strategy and allows us to articulate our local priorities.

6.4 Over the coming months, in developing the ICP Strategy we will include additional local priorities areas, such as our green plan, social value, anchor institutions, finance and estates optimisation. In agreeing our ICP Strategy we will engage to consider key areas which may have become priorities since developing our previous strategy, such as responding to the impact of the covid pandemic and the cost-of-living pressures being experienced in our communities.

6.5 The guidance reinforces that ICPs should engage effectively in developing the ICP strategy; including with local Healthwatch organisations; local people and communities; providers of health and social care services; the voluntary, community, and social enterprise (VCSE) sector; local authority and ICB leaders; and wider organisations and partnerships to ensure a wide range of people are able to engage and input into the production of the strategy. Development of a comprehensive engagement plan will be at the heart of the process, including our Health and Wellbeing Board partners and communities.

7. Clatterbridge Elective Hub TIF scheme

7.1 In September 2021, NHS England announced that there would be £700 million in national funding made available through the Targeted Investment Fund (TIF), to support schemes that promote recovery from the COVID-19 pandemic, as part of its operational planning guidance. Systems were asked to work with NHS England and NHS Improvement regional teams to put together proposals.

7.2 The largest scheme awarded Phase One TIF funding in the North West was the £11.6m Cheshire and Merseyside Surgical Centre, Clatterbridge, delivered by Wirral University Teaching hospital, and which has created two elective theatres and which will be able treat an additional 3,000 patients a year. This project has been delivered to budget and is due to go live in the autumn.

7.3 In early September the ICB was informed that Clatterbridge had been successful in securing additional Phase 2 TIF funding that would be used to develop two more modular theatres and a state of the art recovery facility for system use on that site. These additional theatres will help to deliver an additional 4,000 elective cases per year and 17,000 ophthalmic outpatient procedures.

[4] https://www.cheshireandmerseysidepartnership.co.uk/wp-content/uploads/2021/04/Strategy-Document-Final-June-2021.pdf

8. Freedom to Speak Up

8.1 The Month of October is 'Speak Up Month' which is a national awareness campaign run by the National Guardians Office.[5] Speak Up Month is an opportunity to raise awareness of how much the NHS values speaking up. The campaign this month focusses on the impact Freedom to Speak Up can bring for safety, civility, and inclusion.

8.3 Throughout October the ICB will be raising awareness of the campaign through its staff communications and social media outlets. I encourage Board members to find out more by looking at the National Guardians Office website at: https://nationalguardian.org.uk/.

[5] https://nationalguardian.org.uk/

DATE **2022**

1. NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

2. SEFTON METROPOLITAN BOROUGH COUNCIL

3. MERSEY CARE NHS FOUNDATION TRUST

4. SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST

5. LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

6. ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST

7. HEALTHWATCH SEFTON

8. SOUTHPORT AND FORMBY PRIMARY CARE NETWORK

9. SOUTH SEFTON PRIMARY CARE NETWORK

10. SEFTON COUNCIL FOR VOLUNTARY SERVICE

11. ONE VISION HOUSING

COLLABORATION AGREEMENT FOR

SEFTON PARTNERSHIP

No	Date	Version Number	Author
1	October	1	Hill Dickinson
2	June 2022	2	Ellie Moulton, Debbie Fairclough, Stephen Williams, David McCullough
3	July	3	Debbie Fairclough, reflecting feedback from the task and finish group

Sefton Partnership
PROJECT MANAGEMENT OFFICE

CONTENTS

Executive summary: collaboration agreement for the Sefton Partnership

This agreement provides an overarching framework for the place-based partnership approach to integrated health, care and wellbeing in Sefton, known as the Sefton Partnership.

The arrangements set out build on the existing integrated governance structures between health and care partners in Sefton. They are intended to broaden the partnership to include key partners such as Primary Care Networks and further develop the established place-based integrated working arrangements between the partners for the benefit of the Sefton population.

This agreement is designed to work alongside existing contractual and partnership arrangements for the delivery of care, support and community services via the NHS and Council to the extent such services are within the scope of the agreement. The agreement is not intended to be legally binding.

The partners intend to work together under the governance framework set out in this agreement to develop the Sefton Partnership and may potentially in future include requirements in relation to population health outcomes, risk/gain share, financial and contract management requirements, as may be agreed between the partners.

The partners will review progress made and the terms of this agreement at six monthly intervals from 1 July 2022 and may agree to vary the agreement to reflect developments. Notwithstanding this, the partners may review and amend the terms of this agreement at any time.

DATE: 2022

This collaboration agreement (the **agreement**) is made between:

1. **NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD** of Regatta Place, Brunswick Business Park, Summers Lane, Liverpool L2 4BL

2. **SEFTON METROPOLITAN BOROUGH COUNCIL** of Bootle Town Hall Oriel Road, Bootle, L20 7AE (the "**Council**");

3. **MERSEY CARE NHS FOUNDATION TRUST** of V7 Building, Kings Business Park, Prescot L34 1PJ ("**MCFT**");

4. **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST** of Southport And Formby District General Hospital, Town Lane, Kew, Southport PR8 6PN ("**S&OHT**");

5. **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** of Prescot Street, Liverpool, Merseyside, L7 8XP ("**LUHFT**");

6. **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST** of Eaton Road, Liverpool L12 2AP ("**AHCFT**");

7. **HEALTHWATCH SEFTON** Suite 3B, North Wing, Burlington House, Crosby Road North, Waterloo L22 0LG ("**Healthwatch**").

8. **SOUTHPORT AND FORMBY PRIMARY CARE NETWORK ("Primary Care Networks/ PCNs")** 12 Church Street, Southport, Merseyside, PR9 0QT

9. **SOUTH SEFTON PRIMARY CARE NETWORK ("Primary Care Networks/ PCNs")** G03-G07 Biz Hub, 36 Canal Street, Bootle, L20 8AH

10. **SEFTON COUNCIL FOR VOLUNTARY SERVICE ("CVS")** Suite 3B, 3rd Floor, North Wing, Burlington House, Crosby Road North, Waterloo, L22 0LG

11. **ONE VISION HOUSING** Heysham Road , Bootle , L30 6UR

together referred to in this agreement as the "**partners**".

The ICB and the Council (in its role as commissioner of social care and public health services) are together referred to in this agreement as the "**commissioners**

MCFT, S&OHT, LUHFT, AHCFT, Healthwatch, Sefton Council for Voluntary service, Primary Care, One Vision Housing and the Council (in its role as provider of social care and locality services, whether directly or through contracting arrangements with third party providers) are together referred to in this agreement as the "**providers**".

Background.

a) The NHS Long Term Plan was published in January 2019 and provided a vision of health and care joined up locally around population needs, the experience of Social Care and Health collectively responding to covid further compounded the need to achieve this. Subsequently on the 11th February 2021 a White Paper was published as a response to the 2020 NHS England Consultation - Integrating care: Next steps to building strong and effective integrated care systems across England **"Health and social care integration: joining up care for people, places and populations"**[1] (the "**White Paper**") it set out the key components of an integrated care system ("**ICS**"). The Bill has since moved through parliament and received Royal Assent in April, which will see it take affect from the 1st July 2022.

b) The Health and Care Act is designed to promote integration of Health and Care System focused on health of the population not patients. It obligates us to operate Health and Care seamlessly without artificial silos. Integrated Care Systems (ICS) will be funded to support Health outcomes in their area and held to account by CQC. ICS's will deliver the best possible care through dynamic partnerships between the NHS and Local Authorities. They will use collective resources to address the most complex heath issues, with enhanced assurance frameworks for Social Care to support improved outcomes and experiences.

c) This agreement sets out the values, principles, and shared ambition of the partners in supporting the further development of place-based health and care provision for the people of Sefton using a population health management approach, building on the progress achieved by the partners to date. The partner organisations under this agreement include HealthWatch Sefton, Primary Care Networks, One Vision Housing and Sefton CVS recognising both the vital role of wider cross-sector partners and the central role primary care will play in moving towards a population health management approach for Sefton.

d) The partners will focus on priority programmes in line with a life-course approach and work towards achieving specific outcomes as per the Health & Wellbeing Strategy and the proposed Marmot "beacon indicators" for Cheshire & Merseyside that are set out in "All Together Fairer". Further priority programmes may be identified by the partners during the term of this agreement as required to further the collaborative work of the partners for the benefit of the population of Sefton.

e) The partnership acknowledge that the Council has a dual role within the Sefton health and care system as both a commissioner of social care and public health services but also as a provider of social care and locality services either through direct delivery or through contracts with third party providers. In its role as commissioner of social care

[1] *Health and Social Care Integration: joining up care for people, places and populations* (Health and social care integration: joining up care for people, places and populations)

services the Council will work in conjunction with the C&M ICB/ICB and in its role as a provider of social care services the Council will work in conjunction with the providers. The Council recognises the need to and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified and managed.

f) This agreement is intended to work alongside:
   a. the services contracts between the C&M ICB and the providers and between the Council and the providers; and
   b. the Section 75 agreement between the C&M ICB and the Council.

1. INTRODUCTION

1.1 The partners have agreed to work together on behalf of the people of Sefton to develop the Sefton Partnership through which to identify and respond to the health and care needs of the Sefton population, and deliver integrated health, support and community care to develop and ultimately deliver improved health and care outcomes for the people of Sefton.

1.2 This agreement sets out the key terms that the partners have agreed, including:

1.2.1 the vision of the partners, and key objectives for the development and delivery of integrated services in Sefton;

1.2.2 the key principles that the partners will comply with in working together;

1.2.3 the governance structures underpinning the Sefton Partnership and

1.2.4 A place plan will be developed for 2022/23, which the partners will work together to implement once that has been agreed.

1.3 partners agree to work together in good faith and understand that this agreement shall not be legally binding. The partners each enter into this agreement intending to honour all of their respective obligations.

1.4 Each of the providers has one or more individual services contracts (or where appropriate combined services contracts) with the C&M ICB or the Council. This agreement will work alongside these services contracts and the Section 75 agreement as appropriate.

1.5 Each of the commissioners and the providers agree to work together in a collaborative and integrated way on a Best for Sefton basis and the services contracts set out how the providers provide services to the Population. This agreement is not intended to conflict with or take precedence over the terms of the services contracts unless expressly agreed by the partners in writing.

This agreement is not intended to override or replace the independent statutory and regulatory duties that each partner has, and each partner remains responsible for ensuring that they comply with such duties.

Each partner acknowledges and confirms that as at the date of this agreement, it has obtained all necessary authorisations to enter into this agreement and that its own organisational leadership body has approved the terms of this agreement.

2. THE VISION

2.1 The overarching vision for the partnership as per the borough's Health & Wellbeing Strategy, and local NHS five-year plan Sefton 2gether, is as follows:

A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future.

Our ambitions for Start Well are:

- Education and training will enable every young person to unlock the door to more choices and opportunities
- Every child will achieve the best start in their first 1001 days
- Every child and young person will have a successful transition to adulthood, including young carers, and children with special educational needs and disabilities for whom transition extends to 25 years.

Our ambitions for Live Well are:

- Health, care and wellbeing services across the wider system will work together to support individuals, carers, families, and communities
- The wider system has a strong role in prevention, early intervention, health equity, and integrated care so that access and support is available where needed
- Everyone has a fulfilling role which can support their needs, with opportunities to contribute, learn and progress

Our ambitions for Age Well are:

- Older people will stay active, connected and involved by being part of strong communities in which they are important.
- As people grow older, they will be provided with support, tailored to their needs which respects their dignity and individual preferences, including in relation to caring responsibilities.
- Our communities and the built environment will meet the needs of people as they get older, through age and disability friendly towns, communities, services, housing and transport.

Our All Age ambition is that:

- The places where we live will make it easy to be healthy and happy, support our physical and mental health, with opportunities for better health and wellbeing on our doorstep, where social connections are encouraged across all generations.

3. THE OBJECTIVES

The partners have agreed to work together and to perform their duties under this agreement in order to improve population health and reduce health inequalities across Sefton.

The partners will aim to achieve the following outcomes identified in the Sefton Health & Wellbeing Strategy as well as contribute to the proposed "Marmot beacon indicators" as set out in the All Together Fairer report for Cheshire & Merseyside:

3.1

- Education and training will enable every young person to unlock the door to more choices and opportunities
- Every child will achieve the best start in their first 1001 days
- Every child and young person will have a successful transition to adulthood, including young carers, and children with special educational needs and disabilities for whom transition extends to 25 years.
- Everyone will have a fulfilling role which can support their needs
- The wider system will have a strong role in prevention and early intervention
- Older people will stay active, connected and involved by being part of strong communities in which they are important.
- As people grow older, they will be provided with support, tailored to their needs which respects their dignity and individual preferences, including in relation to caring responsibilities.
- Our communities and the built environment will meet the needs of people as they get older, through age and disability friendly towns, communities, services, housing, and transport.
- The places where we live will make it easy to be healthy and happy, with opportunities for better health and wellbeing on our doorstep

3.2 The partners acknowledge that they will have to make decisions together in order for the Sefton Partnership to work effectively. The partners agree that they will work together and make decisions on a Best for Sefton basis in order to achieve the outcomes.

4. THE PRINCIPLES

4.1 The principles underpin the delivery of the partners' obligations under this agreement and set out key factors for a successful relationship between the partners.

4.2 The partners agree that the success of the Sefton Partnership will depend on their ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the planning, provision and use of community assets and services across the partners.

4.3 The partners will work together in good faith and will:

4.3.1 Work together to deliver a single vision through a focused set of priorities to reduce the unacceptable gap in health and wellbeing inequalities

4.3.2 Work to achieve financial sustainability by working to create the conditions to guarantee the most efficient, effective and value for money based use of public resources in Sefton.

4.3.3 Deliver person centred services informed by the voice of experts by experience through commitment to codesign, coproduction and listening at all levels to our owners – the people that need Care and Support.

4.3.4 Commit to acting ethically at all times with the ultimate interest of the citizen held at the heart of what we do. This is to be achieved through openness, honesty, transparency and constructive challenge.

4.3.5 To build on what we learnt during COVID – the power of acting as one, being risk enabled, outcome focused, and solution driven to solve our 'wicked problems'

4.3.6 Invest in innovative and creative services that bring best practice to Sefton and offer digital solution that bring maximum impact and solutions to our citizens

4.3.7 Ensure that all that we do is informed by a population health framework that enables shared, collective data to ensure that residents are getting the best possible care and support – in the right place at the right time

(Together these are the "**principles**").

5. RESOLVING DISPUTES AND DISAGREEMENTS

5.1 The partners agree to adopt a systematic approach to problem resolution which recognises the objectives (section 3) and the principles (section 4) above and which:

5.1.1 seeks solutions without apportioning blame;

5.1.2 is based on mutually beneficial outcomes;

5.1.3 treats providers and the commissioners as equal parties in the dispute resolution process; and

5.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

5.2 If a problem, issue, concern or complaint comes to the attention of a partner in relation to the objectives, principles or any matter in this agreement and is appropriate for resolution between the commissioners and the providers such partner shall notify the other partners and the partners each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion within 20 operational days of such matter being notified.

5.3 If any partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this agreement (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this agreement) the receiving partner will liaise with the Sefton Partnership board as to the contents of any response before a response is issued.

6. TRANSPARENCY

Subject to compliance with the Law and contractual obligations of confidentiality, the partners will provide to each other all information that is reasonably required in order to deliver the priority programmes and implement the Sefton Place Delivery Plan (once it has been agreed an signed off) in line with the objectives.

7. OBLIGATIONS AND ROLES OF THE PARTNERS

7.1 Each of the partners acknowledges and confirms that:

7.1.1 it remains responsible for performing its obligations in accordance with the service contracts to which it is a party;

7.1.2 it will be separately and solely liable to the relevant counterparty or counterparties under its own services contracts;

7.1.3 it remains responsible for its own compliance with all relevant regulatory requirements and remains accountable to its board/cabinet and all applicable regulatory bodies; and

7.1.4 it will work collaboratively with the other partners to develop the Sefton Partnership approach for the priority programmes and implement the Sefton Partnership place plan.

8. SEFTON PARTNERSHIP GOVERNANCE

8.1 The partners must communicate with each other and all relevant staff in a clear, direct and timely manner. In addition to the partners' own board, cabinet or other relevant committee, which shall remain accountable for the exercise of each of the partners' respective functions, the governance structure for the Sefton Partnership will comprise: the Sefton Partnership board and any established sub-groups; and the Sefton Health and Wellbeing Board.

8.2 It has now been confirmed that substantive delegations to place will not occur during the remainder of 2022/23 therefore the Sefton Partnership board will operate as a collaborative forum and will be responsible for making recommendations on strategic policy matters relevant to the place partnership.

Sefton Partnership board

8.3 The board is the forum responsible for:

8.3.1 overseeing the partnership arrangements under this agreement.

8.3.2 reporting to the Health and Wellbeing Board and Cheshire and Merseyside Integrated Care Board on progress against delivering the Health & Wellbeing Strategy for Sefton and supporting the development and implementation of a place delivery plan; and

8.3.3 working with:

(a) national stakeholders (including NHS England and NHS Improvement); and

(b) the Cheshire & Merseyside Integrated Care System

to communicate the views of the partners and updates/progress reports on matters relating to integrated care in Sefton.

8.4 The Sefton Partnership board will act in accordance with its terms of reference.

8.5 The chair of the partnership will mirror that of the Health and Wellbeing Board and be the Sefton representative on the Cheshire and Merseyside Integrated Care Partnership. The deputy chair of the partnership will be a GP lead clinician from within Sefton. The chairing arrangements shall be reviewed on a bi-annual basis.

8.6 Each partner must ensure that its appointed members or attendees of the Sefton Partnership Board (or their appointed deputies/alternatives) attend all of the meetings of the relevant group and participate fully and exercise their rights on a Best for Sefton basis and in accordance with the agreed principles

8.7 The partners will communicate with each other clearly, directly and in a timely manner to ensure that the partners (and their representatives) present at the Sefton Partnership board are able to participate in discussions and/or represent their nominating organisations to enable effective and timely consensus recommendations to be made to a relevant board.

8.8 The partners will review and develop the governance arrangements for the Sefton Partnership during 2022/23 to strengthen arrangements and create frameworks for potential joint decision-making between the partners, such review to include consideration of developing a joint committee structure between the partners in line with the relevant provisions of the Health and Care Act 2022. This will be subject to approval by the relevant bodies.

Sefton Health and Wellbeing Board

8.9 The Sefton Health and Wellbeing Board is a committee of the Council, charged with promoting greater health and social care integration in Sefton. The Health and Wellbeing Board will receive reports from the Sefton Partnership Board as to the development of the partnership arrangements under this agreement and progress against the Health & Wellbeing Strategy.

9. CONFLICTS OF INTEREST

9.1 The partners will:

9.1.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this agreement or the operation of the Sefton Partnership Board, and the committees/forums or groups that operate below immediately upon becoming aware of the conflict of interest whether that conflict concerns the partner, or any person employed or retained by them for or in connection with the performance of this agreement;

9.1.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this agreement (without the prior consent of the other partners) before they participate in any decision in respect of that matter; and

10. CHARGES AND LIABILITIES

10.1 The partners will continue to be paid in accordance with the mechanism set out in their respective services contracts.

10.2 The partners have not agreed as at the commencement date to share risk or reward. However, the partners will work together in time to develop system financial principles, including the potential development of risk/reward sharing mechanisms.

10.3 The partners' respective responsibilities and liabilities in the event that things go wrong with the services will be allocated under their respective services contracts and not this agreement.

11. CONFIDENTIALITY AND INFORMATION SHARING

11.1 Each partner shall keep confidential all confidential information that it receives from the other partners except to the extent that such confidential information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a partner to this agreement.

11.2 To the extent that any confidential information is covered or protected by legal privilege, then disclosing such confidential information to any partner or otherwise permitting disclosure of such confidential information does not constitute a waiver of privilege or of any other rights which a partner may have in respect of such confidential information.

11.3 The partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 11 (*Confidentiality and Information Sharing*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this agreement.

11.4 Nothing in this Clause 11 (*Confidentiality and Information Sharing*) will affect any of the partners' regulatory or statutory obligations.

11.5 The partners acknowledge that they are each subject to the requirements of the FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that each partner is able to comply with their statutory obligations.

12. DURATION AND REVIEW

12.1 This agreement shall take effect on the Commencement Date and will continue in full force and effect unless and until terminated in accordance with the terms of this agreement.

The partners will review progress made and the terms of this agreement at six monthly intervals from 1 July 2022 and may agree to vary the agreement to reflect developments. Notwithstanding this, the partners may review and amend the terms of this agreement at any time in accordance with Clause **Error! Reference source not found.** (*Variations)*

13. VARIATIONS

Any variation to this agreement shall not be effective unless set out in writing and signed by or on behalf of the partners.

This agreement has been entered into on the date stated at the beginning of it.

Signed by [insert]

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

.....

[ ]

Signed by [insert]

for and on behalf of **SEFTON METROPOLITAN BOROUGH COUNCIL** .....

[ ]

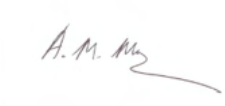
Signed by Joe Rafferty, CEO

for and on behalf of **MERSEY CARE NHS FOUNDATION TRUST**

1st August 2022

Signed by Ann Marr OBE, CEO

for and on behalf of **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**



10th August 2022

Signed by James Sumner, CEO

for and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

29th July 2022

Signed by [insert]

for and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST** .....

[ ]

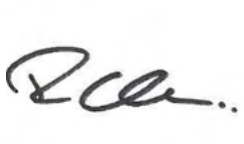
Signed by Diane Blair

for and on behalf of **HEALTHWATCH SEFTON**

9th September 2022

Signed by Dr Robert Caudwell, Clinical Director

for and on behalf of **[SOUTHPORT & FORMBY PRIMARY CARE PARTNER]**



5th August 2022

Signed by Dr Craig Gillespie, Clinical Director

for and on behalf of **[SOUTH SEFTON PRIMARY CARE PARTNER]**

7th August 2022

Signed by Angela White OBE, CEO

for and on behalf of **[SEFTON COUNCIL FOR VOLUNTARY SERVICE]**

11th August 2022

Signed by [insert]

for and on behalf of [**ONE VISION HOUSING**]

.....

[ ]

SCHEDULE 1

Definitions and interpretation

1. The following words and phrases have the following meanings:

Agreement	this agreement incorporating the Schedules.
Best for Sefton	the achievement of the Vision and Objectives for the Sefton population on the basis of the principles.
Claims	any claims, actions, demands, fines or proceedings.
Commencement date	the date entered on page one (1) of this agreement.
Confidential information	the provisions of this agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this agreement.

Dispute	any dispute arising between two or more of the partners in connection with this agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in section 5
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act.
ICB	Cheshire & Merseyside Integrated Care Board.
Sefton Partnership	The place based arrangement for care and support.
ICS	Integrated Care System.
Insolvency	(as may be applicable to each partner) a partner taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business.
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code.
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time.
Objectives	the objectives for the Sefton Partnership set out in Clause 3.
Operational Days	a day other than a Saturday, Sunday or bank holiday in England.
Population	the population of Sefton covered by each of the commissioners.
Principles	the principles for the Sefton Partnership set out in Clause 7.3.

Priority Programmes	the programmes which will set out the key priority areas and populations which are to be the focus of joint working between the partners.
Section 75 agreement	the agreement relating to 2022/23 entered into by the commissioners under section 75 of the National Health service Act 2006 to commission the services listed in the Schedules to that agreement.
Service Users	people within the Sefton population served by the commissioners and who are in receipt of the services.
Services	the services provided, or to be provided, by each Provider to service Users pursuant to its respective services Contract.
Services Contract	a contract entered into by one of the C&M ICB or the Council and a Provider for the provision of services, and references to a services Contract include all or any one of those contracts as the context requires.

NHS
Cheshire and Merseyside

Integrated Care Board Report

Place Director Report – St Helens

NHS
Cheshire and Merseyside

Cheshire and Merseyside Integrated Care Board Meeting

Date of meeting:	29 September 2022	
Agenda Item No:		
Report title:	Place Director Report - Sefton	
Report Author & Contact Details:	Deborah Butcher, place director	
Report approved by:		

Purpose and any action required	**Decision/ Approve** →		**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	X

Committee/Advisory Group previously presented
N/A

Executive Summary and key points for discussion

Purpose of this paper

Each host Place is required to produce a Place Director's Report for consideration by the Cheshire and Merseyside Integrated care Board.

Executive summary

The Sefton Place Director report aims to provide an overview of the following:

1. A brief history of Sefton
2. The Sefton integration journey
3. Sefton place plan vision and priorities
4. Key challenges for Sefton 2022/23
5. A summary of the Sefton Place director objectives
6. Describing the Sefton inequalities agenda
7. Engaging with people and communities within Sefton
8. Sefton place delivery and governance

Recommendation/ Action needed:	**The Board is asked to:** Note the contents of the report and presentation

Consideration for publication
Meetings of the Integrated Care Board will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:

NHS
Cheshire and Merseyside

Cheshire and Merseyside
Integrated Care Board Meeting

Consideration for publication	
The item involves sensitive HR issues	
The item contains commercially confidential issues	
Some other criteria. Please outline below:	

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	X
2. Tackle health inequality, improving outcome and access to services	X
3. Enhancing quality, productivity and value for money	X
4. Helping the NHS to support broader social and economic development	X

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X
2. Recovery	X
3. Getting Upstream	X
4. Building systems for integration and collaboration	X

Governance and Risk					
Does this report provide assurance against any of the risks identified in the Board Assurance Framework or any other corporate risk? (*please list*)					
What level of assurance does it provide? This report gives assurance that Sefton place has a mature approach to integration, excellent relationships with Sefton Borough Council, providers, and wider partners. We have a focused plan and alignment with the ICB priorities.					
Limited		**Reasonable**		**Significant**	X
Any other risks? No If yes please identify within the body of the report.					
Is this report required under NHS guidance or for statutory purpose? (*please specify*) No					
Any Conflicts of Interest associated with this paper? If Yes please state what they are and any mitigations. No					
Any current services or roles that may be affected by issues within this paper? No					

Document Development	Process Undertaken	Yes	No	N/A	Comments (i.e. date, method, impact e.g. feedback used)
	Financial Assessment/ Evaluation			X	
	Patient / Public Engagement			X	
	Clinical Engagement			X	
	Equality Analysis (EA) - any adverse impacts identified?			X	

	Legal Advice needed?			X	
	Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External)			X	

Next Steps:	Members of the Board to comment and give feedback to the Place Director

Responsible Officer to take forward actions:	Deborah Butcher – Place Director - Sefton

Appendices:	See presentation

Sefton Partnership

Sefton Place Directors Report

Deborah Butcher
Deborah.Butcher@Sefton.gov.uk

1. Introduction and Context

Sefton Council is the governing body for the Metropolitan Borough of Sefton in the county of Merseyside, north-western England. It is a constituent council of Liverpool City Region Combined Authority. Sefton is a leading coastal tourist destination with a flourishing visitor economy. Spanning the busy Port of Liverpool, the famous Antony Gormley's 'Another Place' installation, attractive beaches, and dunes, to the resort town of Southport, the diversity of the Borough providing a unique mix of urban and natural setting.
Sefton has an approximate area of some 155km2

Sefton has a population of approximately 275,899, and nearly 8,000 businesses. 24% of Sefton's population being 65 years old or over

Sefton Partnership

46 GP Surgeries and 212 GPs in Sefton serving 283,645. patients residing in the Borough, and 2 Acute Hospitals

Council Budget 2022/23
£207,732,741 (Adult Social Care 50% of this)
In 2021/22 the former CCGs combined budget was £575,464

Average House Price £160,174 (Bootle - £122,55. Formby £376,402)

67% of adults in Sefton overweight or obese in 2019/20

Sefton has 25 conservation areas, approximately 560 listed buildings, five Registered Historic Parks and Gardens, and 13 Scheduled Monuments.

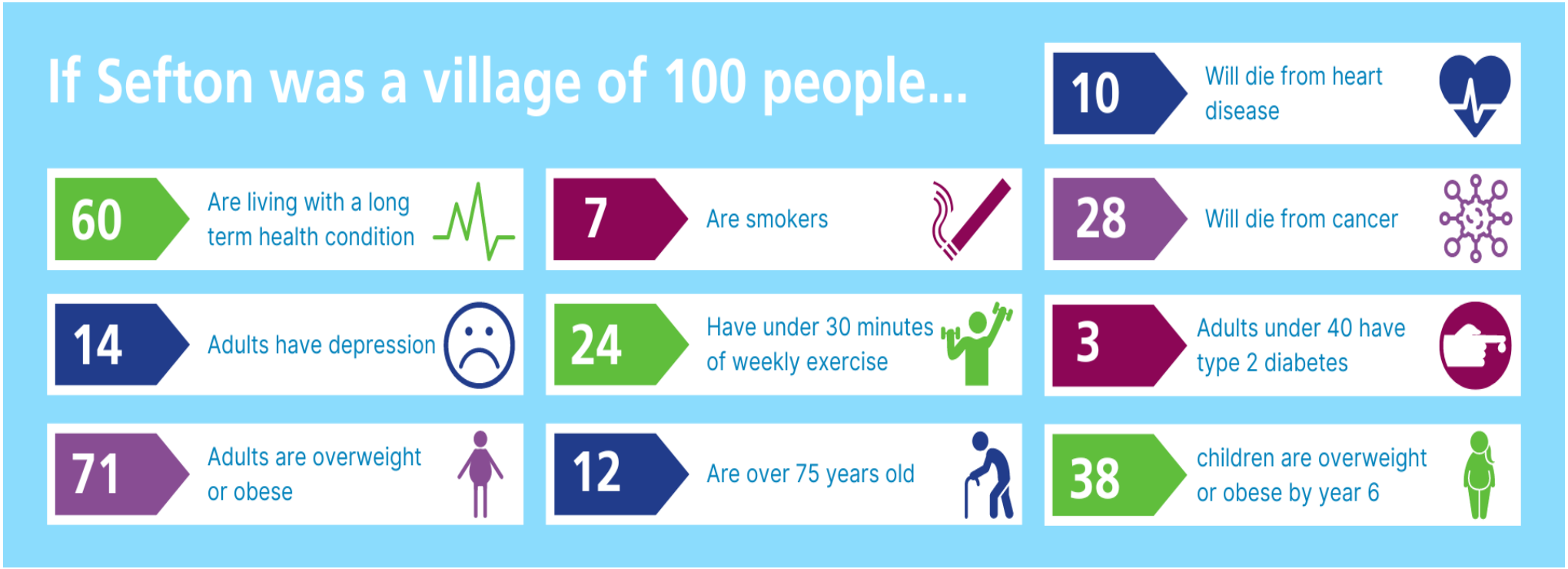
63% of pupils in Sefton achieved or exceeded the expected standard in reading, writing and maths. Higher than the LCR rate – 62%, yet lower than NW – 65%.

72% of Sefton residents aged between 16 and 64 were in employment between July 2020 and June 2021

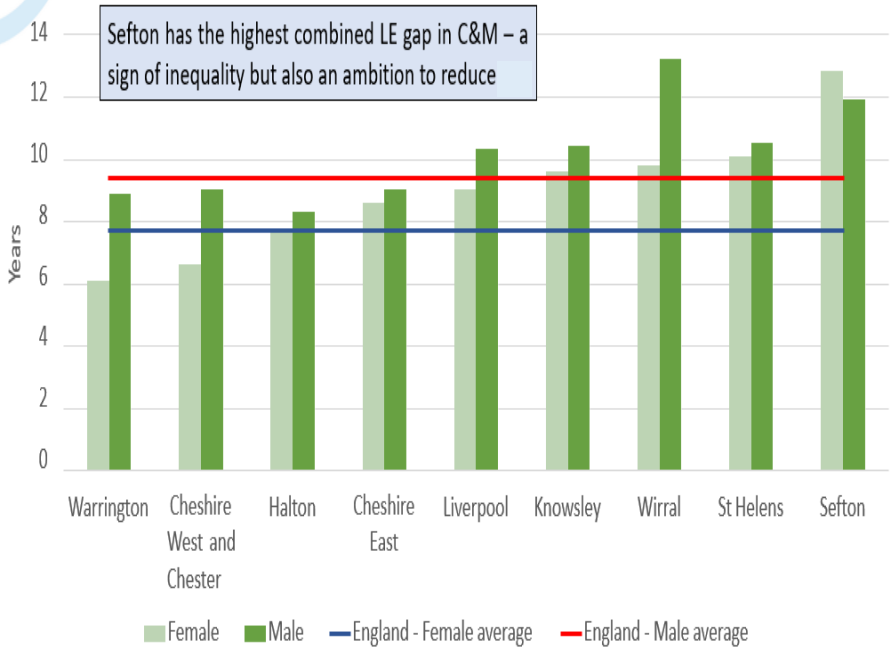
22-mile-long coastline, significant areas of docks, estuary, shore, dune, and woodland.

Sefton has 126,577 homes

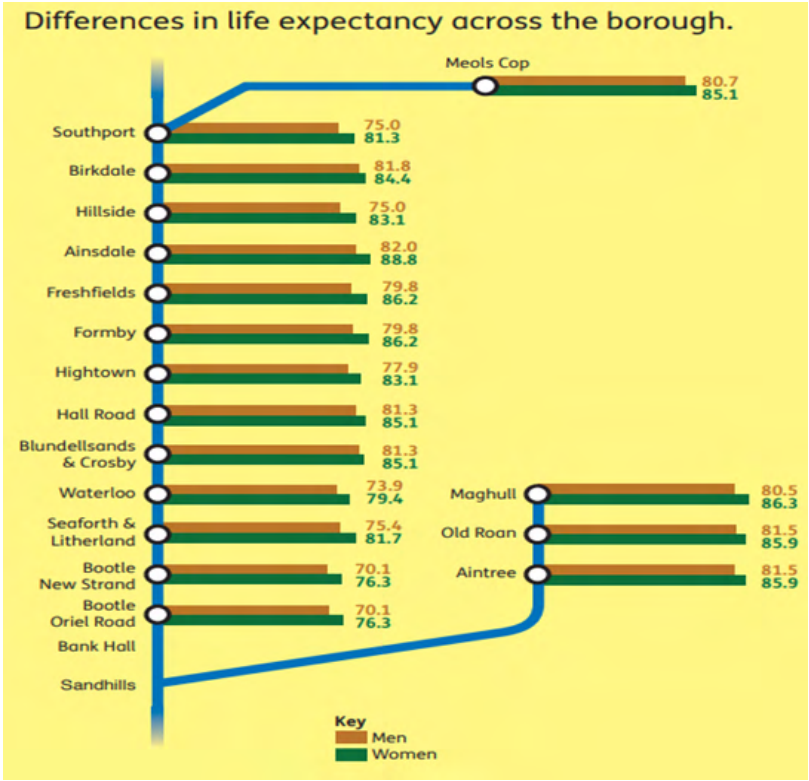
If Sefton was a village of 100 people



Gap in life expectancy – difference between most and least deprived decile in each LA in C&M 2017-2019



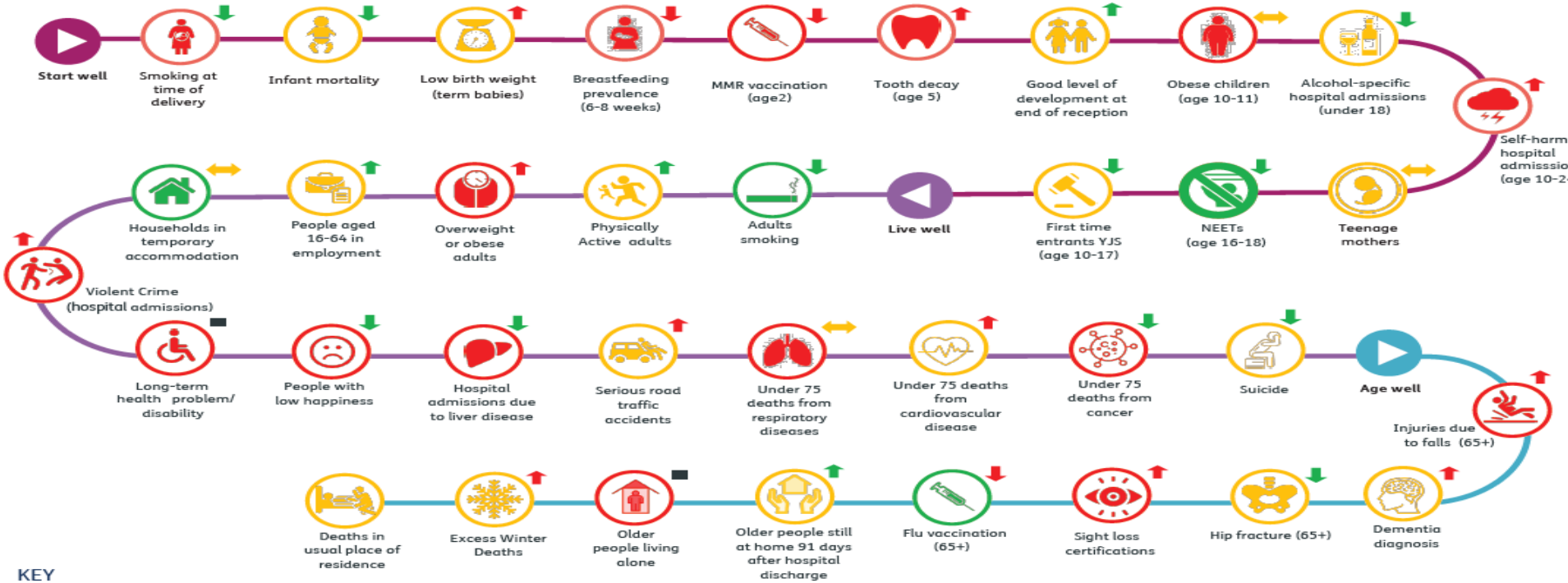
Source: Public Health England



Sefton's Health & Wellbeing Across the Lifecourse

Current Population 275,396

- 53,000 Under 18s
- 157.531 18 - 64
- 64,032 65+



KEY

Statistical significance to England:
- Better
- No different
- Worse

Direction of travel:
- Improved since last period
- Similar to last period
- Worse than last period

No comparator

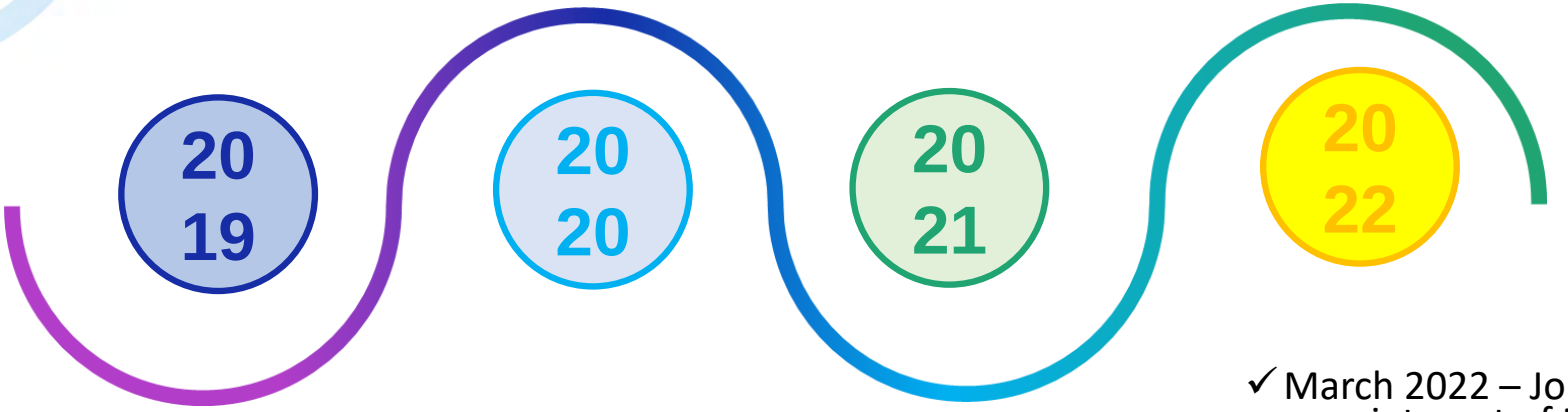
Based on a template from Halton Public Health Intelligence Team and work produced by Centre for Public Health, Liverpool John Moores University.
Icons made by Flaticon and available here: www.flaticon.com

PAGE 6

Sefton Council

Sefton 2030

2. Our Integration Journey



- ✓ Long held ambition
- ✓ Health and Wellbeing Board led Integrated Commissioning Group and Better Care Fund Working Group and 19-20 Sefton Transformation Programme

- ✓ Pandemic response saw a risk enabled approach across boundaries – made the case for what can be achieved
- ✓ CIPHA established
- ✓ Primary Care Networks fully embedded

- ✓ White Paper Feb 2021
- ✓ Political approval in April 2021 to start developing the place based infrastructure, recognition of joint single lead
- ✓ Development of Governance, Workforce and OD approach, Estates, Population Health, Communication and Engagement approach, Place priorities and delivery plan
- ✓ Maturity assessment in November 2021 as established - plans reset to take us to thriving

- ✓ March 2022 – Joint appointment of Place Director
- ✓ June 2022 – Cabinet approval to formally establish Sefton Partnership
- ✓ July 2022 – Sefton Partnership begins
- ✓ September 2022 - MoU signed by partners

3. Our Place Plan

One Vision

A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future.

Ten Ambitions

Start well

1. Every child will achieve the best start in their first 1001 days
2. Education and training will enable every young person to unlock the door to more choices and opportunities
3. Every child and young person will have a successful transition to adulthood

Live well

4. Health, care and wellbeing services across Sefton will work together
5. Everyone will have a fulfilling role which can support their needs
6. The wider system will have a strong role in prevention and early intervention

Age well

7. Older people will stay active, connected and involved
8. As people grow older they will be provided with support tailored to their needs
9. Our communities and the built environment will meet the needs of people as they get older

All age

10. The places where we live will make it easy to be healthy and happy, with opportunities for better health and wellbeing on our doorstep

Our first three priorities are based on what we knew were some of our biggest issues pre-COVID:

Mental health
Obesity
Community Resourcefulness and Prevention

Start Well → Live Well → Age Well → All Age

Protect the most vulnerable

Facilitate confident and resilient communities

Commission, broker and provide core services

Drivers of change and reform

Facilitate sustainable economic Prosperity (Cost of Living Crisis and Welfare reform)

Generate income for social reinvestment

Cleaner and Greener

Place-leadership and influencer

4.Place Director Objectives

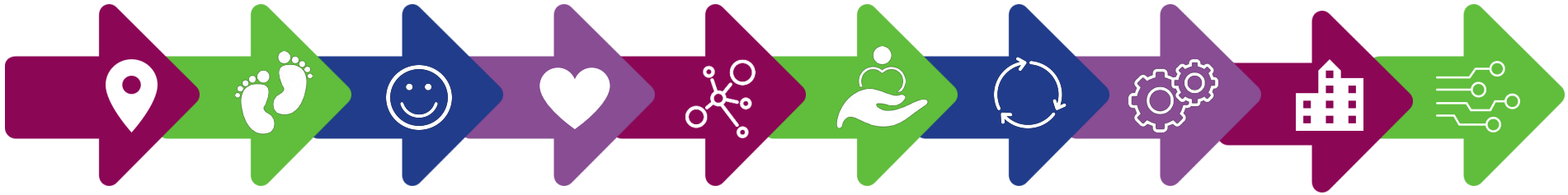
Place Development

Live Well

Primary Care Network Development

Wider Determinants

Integrated Estates



Start Well

Age Well

Adult Social Care

Workforce

Digital

Place Development

- Development monitoring framework and dashboard, including community insight

- Getting Sefton Place Partnership governance right
- Refresh of Sefton Place plan to include NHS operational planning priorities 22/23 and aligned to Health and Wellbeing Strategy

Start Well

Reduce waiting times - e.g. speech and language services

Improve CAMHs service in line with regional recommendations

Work to reduce childhood obesity

Live Well

Less use of secondary health services for those with complex lives

Improved access to early intervention and prevention for preventable diseases that have the greatest burden on Sefton residents

Improved community mental health model in line with national strategy

Reduction in adult obesity

Implementation of learning disabilities and neurodiversity strategies - in line with Transforming Care Agenda

Age Well

Implementation of Ageing Well Programme (Anticipatory Care, 2hr Urgent Response, Enhanced Care in Care Homes)

Integrated Community Team model across Sefton

Less need for secondary health services for those with frailty and dementia

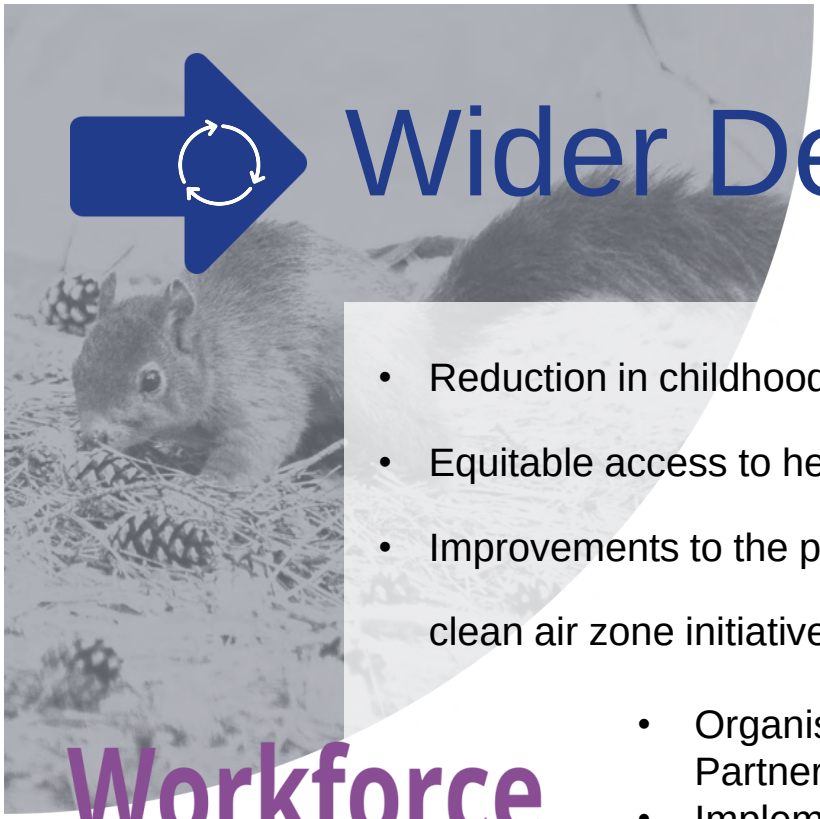
Primary Care Network Development

Develop plan to progress at least one step on the NHSE Primary Care Network framework

Development of a fully integrated estates strategy linked to One Public Estate (with improved access to Health and Diagnostics on the High as of deprivation)

Adult Social Care

Development of a fair cost of care and market sufficiency strategy to support our Care Homes and Domiciliary Care providers



Wider Determinants

- Reduction in childhood poverty
- Equitable access to healthcare
- Improvements to the physical environment across the borough (green spaces access, clean air zone initiatives)

Workforce

- Organisational development plan to support the work of the Sefton Partnership Board
- Implementation of the NHS System Leadership for Change programme across the partnership around identified key work streams
- Development of a place-based workforce plan to respond to local workforce risks and opportunities as part of wider ICB workforce planning approach, in conjunction with Health Education England

Digital

Development of a digital inclusion strategy across Health and Social Care to deliver the following vision;

"Through digital technologies we will transform the outcomes for our residents, empowering them to take control of their own health and wellbeing. We will transform the relationship between Health and Care Providers and its residents so there is improved access to online services. We will develop our workforces' digital skills and connect to the wider health and care environment to make intelligence-driven decisions".

Implement opportunities to utilise technology enabled care solutions (telehealth, telecare, remote monitoring solutions etc.) in line with strategy

Access to digital care records for adult social care providers

5. Big Ticket Items

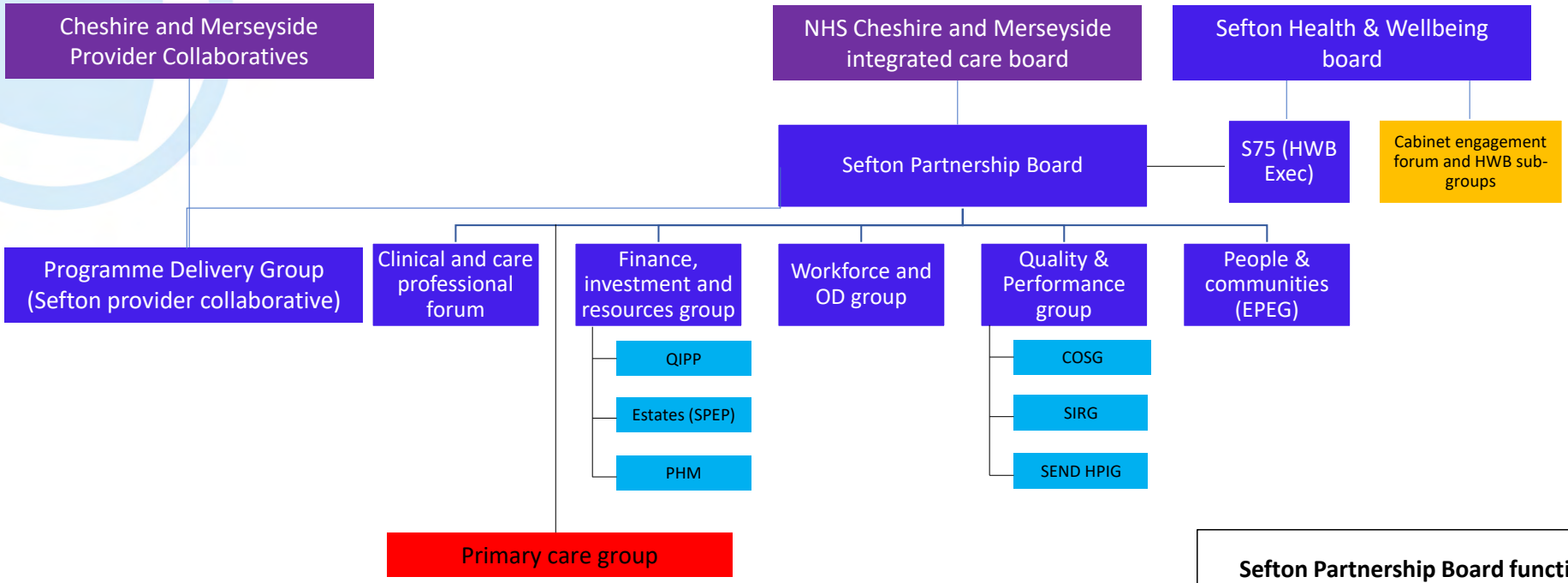
- Implementation of population health agenda to support reduction in unwarranted variation
- Elective & Cancer service recovery
- Planning for Winter/ how we meet demand for Urgent Care
- Primary Care Network progress and maturity and Sustainability of GP Practice
- Child and Adolescent Mental Health Services (CAHMS) and wider Special Educational Needs Disability (SEND) continual improvement

6. Patient story – Crisis Cafe

Thank you and Any Questions

Supplementary Information

1. Governance Chart
2. Engaging with Patients and Communities
3. Primary Care Estates further detail
4. Health Inequalities in Sefton.



Key:
QIPP: Quality Improvement, Prevention and Productivity
PHM: Population Health Management
CSOG: Complaints Oversight Group
SIRG: Serious Incident Review Group
SEND HPIG: SEND Health Performance Improvement Group

Sefton Partnership Board functions

Engaging with People and Communities

This diagram gives an overview of current communications and engagement (C&E) forums and structures that support the work of Sefton Partnership.

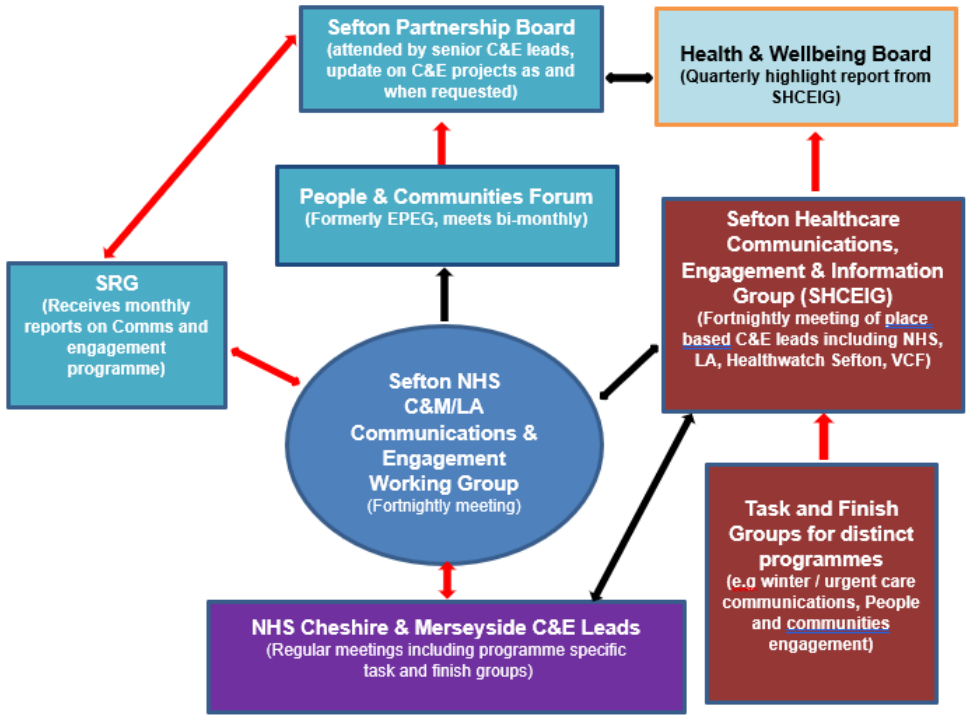
It shows formal reporting lines and highlights how C&E reports into the current Sefton Partnership programme structures.

It should be noted that there are a number of other existing groups that indirectly support the work of Sefton Partnership – such as the council led Sefton Public Engagement and Consultation Panel and Improving Information Group - which are not shown as part of this diagram but do link with this work programme.

KEY

Formal reporting line

Direct link



Engaging with People and Communities

"I don't feel there is a problem with the consultations as the majority of the Drs at my practice are excellent, the problem is managing to get an appointment in the first place. Impossible to get through on the phone between the 8.-8.30 timeline."

"There have been a couple of times myself or my children have needed to see the GP in person. The telephone consultation was straight forward and understandable and actually sometimes that was all I needed. When needed a face to face walk in appointment, it was easy, scheduled, small wait times and covid friendly"

"The receptionists have been friendly and empathetic, dealt with me very professionally"

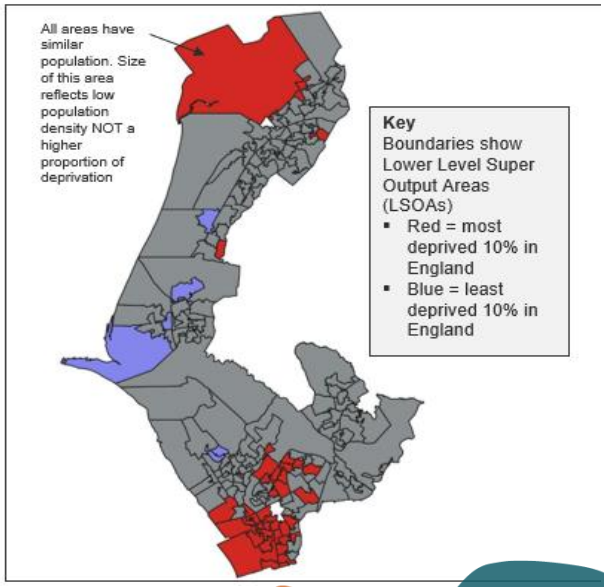
"Was referred by the doctor to [Southport] A&E very efficient and caring even though it was extremely busy. Was then sent to the day ward for bloods and an X-ray. The nurse was very thorough and left no stone unturned gave me a thorough examination. Thankyou to all the staff who work there."

"Long-winded recorded message before being connected, then very long waiting time in phone queue. Suggest more staff rather than cost-cutting measures that are detrimental to patients' health and well-being"

After my visit again with my son who is epileptic and had a seizure . All the staff made my son feel safe and relaxed and also made me calm . I cannot praise you all enough . The epilepsy team have made sure since the first day that my little boy had always known what to expect and done it in a caring way that he didn't get scared or nervous . Many thanks to each and everyone who works in Ormskirk hospital. From not just me but my son husband and family.

Child poverty, Covid-19 and cost of living

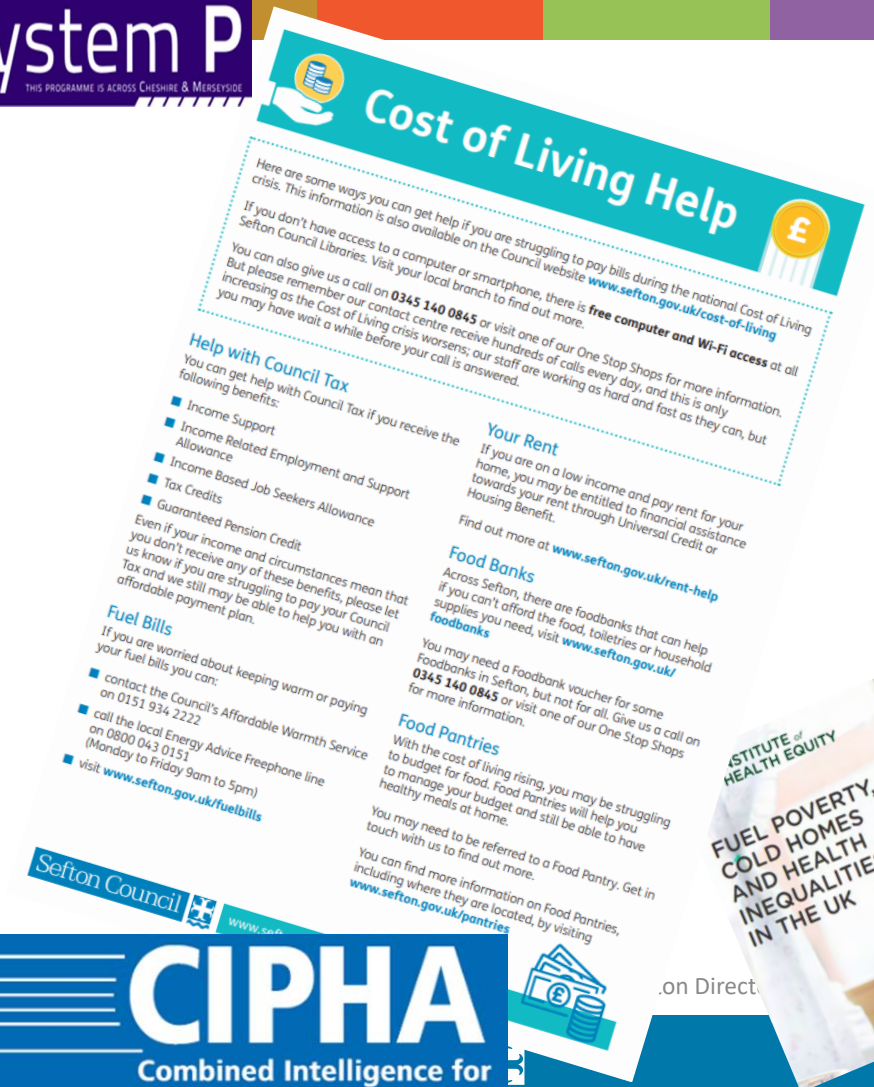
- Pre-pandemic Sefton had a higher than average rate of workless families. Child poverty related to in-work low income families grew significantly because of the pandemic. The number of individuals in employment and in receipt of Universal Credit was twice as high in January 2021 compared to March 2020.
- The expected impact of the pandemic on child poverty is an increase in health, social and income inequality – with a larger number of children at risk from poverty and a wider gap in those outcomes, which are most strongly associated with household income and community level deprivation.
- The impact of Coronavirus on need and inequality will require long-term action to mitigate impacts across the life-course. Equity-centred whole place approaches as set out in Health and Wellbeing Strategy and Children and Young People's Plan continue to provide the relevant framework to guide the response to changing patterns of need amongst children.

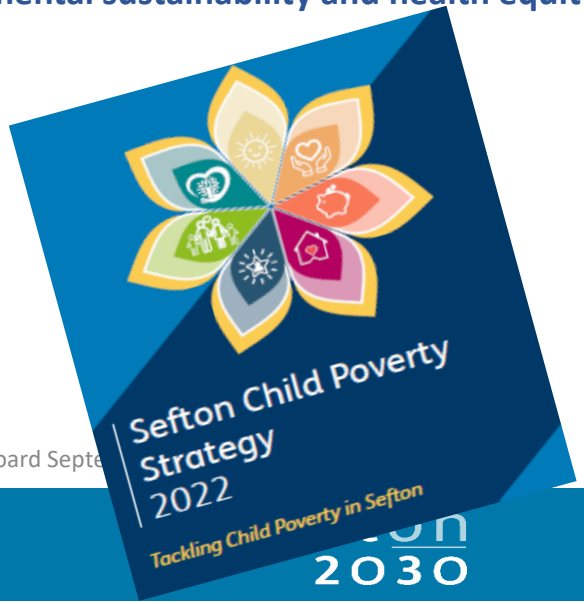


Focus on System P
THIS PROGRAMME IS ACROSS CHESHIRE & MERSEYSIDE

MARMOT

1. Give every child the best start in live.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill-health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together





CIPHA
Combined Intelligence for Population Health Action

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

29 September 2022

Liverpool University Hospitals Clinical Services Reconfiguration Proposals

Agenda Item No	ICB/9/22/**08**
Report author & contact details	Carole Hill, Associate Director for Strategy, Integration and Partnerships, NHS Cheshire and Merseyside, Liverpool Place
Report approved by (sponsoring Director)	Dr Fiona Lemmens, Deputy Medical Director, NHS Cheshire and Merseyside
Responsible Officer to take actions forward	Dr Fiona Lemmens

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB Board Meeting

Liverpool University Hospitals Clinical Services Reconfiguration Proposals

Executive Summary	Liverpool University Hospitals NHS Foundation Trust (LUHFT) has developed proposals to change the way five services are delivered. Since the merger of the Royal Liverpool and Broadgreen Hospitals NHS Trust and Aintree University Hospital NHS Foundation Trust in 2019, the new Trust (LUHFT) has undertaken a clinical integration programme, the rationale for which is to create single clinical teams for all trust specialties, to establish best-practice clinical models of care, and to locate services in the right place across the Trust's three sites. This model is intended to make the best use of specialist skills, resources and equipment, and to utilise its three sites in the most effective way, both for patients and staff. The services within the scope of this proposal are breast surgery, general surgery, nephrology, urology, and vascular care. The majority of these services are commissioned by NHS Cheshire and Merseyside Integrated Care Board (ICB) with some elements of four of the five services commissioned by NHS England (NHSE) Specialised Commissioning. Both NHS Cheshire and Merseyside ICB and NHSE Specialised Commissioning, are required to approve this proposal, in line with their statutory responsibilities. Mr Andrew Bibby, Director of Specialised Commissioning, will be in attendance at the NHS Cheshire and Merseyside ICB Board meeting on 29 September 2022 to allow for collective consideration and for a decision to be made jointly between the ICB Board and NHSE.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	x	x			
Recommendation	**The Board is asked to:** • **APPROVE** the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation. • **NOTE** the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.				
Key issues	This document summarises the proposal, how it has been developed and consulted on. The proposals are informed by the Trust's vision to provide the best healthcare, improve quality of care and health outcomes for patients.				
Key risks	These changes are necessary to support longer term clinical and financial sustainability for the Trust and the wider health and care system. Some of these proposals are interdependent with plans for the opening of the new Royal Liverpool Hospital.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	x		x	x	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	x	x	x	x	

Cheshire and Merseyside ICB Board Meeting

NHS Cheshire and Merseyside

Route to this meeting	The proposal was initially overseen by the North Mersey CCGs Committee in Common, with membership from Knowsley, South Sefton, Southport and Formby and Liverpool CCGs. Responsibility transferred to the Cheshire and Merseyside Joint Committee of CCGs when it was given delegated responsibility from the nine Cheshire and Merseyside CCGs during the transition to the Cheshire and Merseyside ICB. The Joint Committee approved the case for change and consultation plans.	
Management of Conflicts of Interest	N/A	
Patient and Public Engagement	These proposals have been subject to a formal public consultation, which is detailed in this document and the appended consultation report.	
Next Steps	Subject to approval of these proposals by NHS Cheshire and Merseyside ICB, and NHSE Specialised Commissioning, LUHFT will commence with mobilisation of these changes, some of which are incorporated into the plans for the opening of the new Royal Liverpool Hospital, which commences on 28 September through to 21 October 2022.	
Appendices	**CLICK HERE** to access all Appendices online (215 pages)	
	Appendix A	Public Consultation Report
	Appendix B	Equality Impact Assessment (x5)
	Appendix C	Business Case

Liverpool University Hospitals Clinical Services Reconfiguration Proposals

1. Executive Summary

1.1 Liverpool University Hospitals NHS Foundation Trust (LUHFT) has developed proposals to change the way five services are delivered.

1.2 Since the merger of the Royal Liverpool and Broadgreen University Hospitals NHS Trust and Aintree University Hospital NHS Foundation Trust in 2019, the new Trust (LUHFT) has undertaken a clinical integration programme, the rationale for which is to create single clinical teams for all trust specialties, to establish best-practice clinical models of care and to locate services in the right place across the trust's three sites. This model is intended to make the best use of specialist skills, resources and equipment, and to utilise its three sites in the most effective way, both for patients and staff.

1.3 The services within the scope of this proposal are breast surgery, general surgery, nephrology, urology, and vascular care. With the exception of breast surgery, these specialties all have elements of the service commissioned by NHSE Specialised Commissioning.

3.2 The Cheshire and Merseyside ICB, as commissioner of these services, is required to approve this proposal, in line with its statutory responsibilities. NHSE Specialised Commissioning is also required to approve the proposals related to general surgery, nephrology, urology, and vascular care.

2. Background

3.2 People in North Mersey, which encompasses the boroughs of Liverpool, Sefton and Knowsley, experience amongst the highest levels of poor health outcomes and health inequalities. The configuration of hospital services in North Mersey is fragmented, which constrains the ability to provide care in a multi-disciplinary joined up way, sometimes resulting in sub-optimal outcomes and inequalities. The legacy of a fragmented hospital landscape also increases costs, due to duplication and inefficiencies.

2.2 The merger of Aintree University Hospital NHS FT (AUHFT) and the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) to form Liverpool University Hospitals NHS Foundation Trust (LUHFT) took place in 2019. At the point of merger, the two trusts duplicated over 20 clinical services over three sites. The Trust predominantly serves the populations of Liverpool, Sefton, Knowsley and, for some specialist services, provides services to wider populations in Merseyside, Cheshire, and North Wales.

2.3 The merger business case set out a model for single service teams delivering twenty-four hour, seven-day services, intended to improve patient experience and outcomes, as well as facilitating greater opportunities for patients to participate in clinical trials, maximising research and development capability and helping attract and retain the best staff.

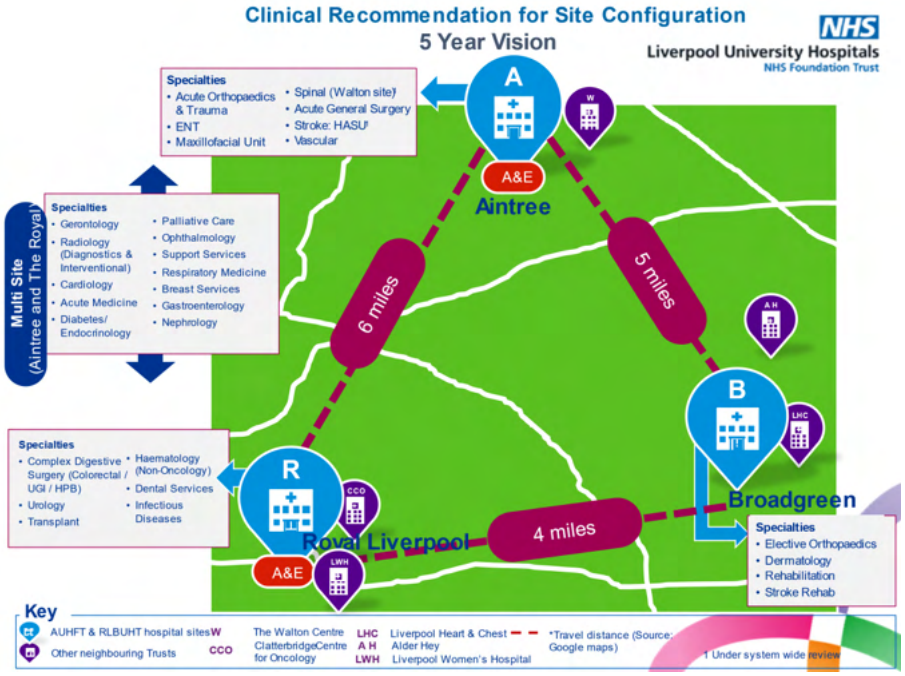
2.4 The consolidation of services within LUHFT is one component of a long-term vision for all acute and specialist services for the North Mersey population; incorporating the city's Knowledge Quarter, home to the largest cluster of science, health, education, digital and cultural expertise in the region.

3. Strategic Context

3.2 The One Liverpool strategy supported further integration of adult acute services to ensure clinical and financial sustainability and improved health outcomes. This approach was endorsed by the other North Mersey CCGs and the wider Liverpool system providers. The overarching rationale for the LUHFT clinical integration programme is to co-locate services by whether they largely deliver planned care or urgent care. Bringing together planned services can enable capacity to be protected and enables dependent specialties to work better together. Concentrating the majority of urgent care on another site enables acute services to provide improved trauma assessment and better access to specialist urgent care, so that patients have better access to the right expertise at the right time.

3.2 The Aintree Hospital site already brings together a critical mass of urgent and emergency care services, determined by being the Cheshire and Merseyside Major Trauma Centre and due to its co-location with the trauma-related neurology services delivered by The Walton Centre. The new Royal Liverpool Hospital, co-located with the new Clatterbridge Cancer Centre and the city's Knowledge Quarter, provides opportunities to focus predominantly on complex planned care, including cancer care. The Royal Liverpool site would however retain an A&E service as the city requires this service across both acute sites. Broadgreen Hospital is the location for rehabilitation, as well as an elective service for orthopaedics. Not all services will be located on just one site, although the principle of single clinical teams will be implemented across all services. The proposed configuration of services for LUHFT across specialties is illustrated in Diagram One.

Diagram One



4. Overview of Proposals

4.1 This current phase of clinical integration proposals is to establish single services and single teams within LUHFT for the following specialties:

- General surgery
- Vascular services
- Urology services
- Nephrology services
- Breast services.

4.2 The development of these proposals has been clinically led and they have emerged from option appraisal processes for each service. The proposed clinical model for each service is summarised below:

4.3 **General Surgery.** General surgery focuses on surgery of the abdominal area and intestines including the subspecialities of upper gastrointestinal tract, liver, colon, pancreas, and other major parts of the endocrine system. The original scope of this proposal was both planned general surgery for upper gastrointestinal, liver and colorectal surgery, which are currently delivered at Aintree University Hospital (AUH) and Royal Liverpool Hospital (RLH) sites, and Broadgreen Hospital, and Emergency General Surgery which is currently delivered at AUH and RLH sites. Each site provides different models of service and there are limitations in terms of service provision, with variation in clinical pathways and standards, patient experience and outcomes.

4.4 The proposal to establish all emergency general surgery on the Aintree site, which was incorporated into the initial service change proposals consulted on, has been paused and will not be part of the immediate phase of implementation. It has been agreed that further work will be undertaken with aligned services, including anaesthetics, A&E and radiology, to understand and develop interdependent workforce models and pathways for emergency general surgery. More work is also required to assess the potential impact of the proposal for emergency general surgery on the wider system, particularly the impact on NWAS resources, as well as the need to assess whether this proposal would lead to an increase in activity at neighbouring acute trusts, particularly St Helens and Knowsley's Whiston site.

4.5 The proposal that the ICB is now being asked to approve is to establish an elective service at the new RLH. This will be for the surgical specialties of upper gastrointestinal surgery, colorectal, and liver surgery. Pancreatic surgery services are already located at the RLH site.

4.6 **Vascular Services.** Liverpool Vascular and Endovascular Service (LiVES) has been an established single service for several years and serves the Merseyside region as well as a tertiary service for parts of the North of England, Isle of Man and North Wales. It is based on a hub and spoke model, with the main hub based at the RLH site, and 'spoke' sites based at AUH, Whiston and Liverpool Heart and Chest (LHCH) hospitals. The greatest challenge within this service is that of capacity, both in terms of theatres and beds, as well as challenges due to the need for inter-hospital transfers and access to Interventional Radiology services.

4.7 The proposed clinical model would see the relocation of LiVES services to the AUH site. The proposal will enable expansion of the service with additional theatre capacity and an optimum mix of intensive care and general acute beds, intermediate care beds, as well as access to a CT scanner, outpatient and vascular laboratory and research facilities.

4.8 **Urology.** Urology is a large surgical specialty which involves the treatment of conditions of the urinary tract and male genital tract. This includes some very common cancers including prostate cancer, bladder, kidney and testicular cancer and some common but debilitating conditions such as kidney stones. Urological services have been provided by two separate units across the Royal and Aintree sites. The units have largely functioned as separate, duplicated services, although a common leadership structure was established in 2020. The proposed clinical model is to establish a single site inpatient urology base for both elective and non-elective care at the new RLH, with outpatient services and day case procedures to be provides at RLH and the AUH site.

4.9 **Breast Services.** The breast service provides diagnosis and treatment of benign breast disorders and breast cancer, currently being provided by separate units across the Royal and Aintree sites. The current services have different clinical pathways, varying access to services and variation in patient experience. The proposed model for the breast service is for all surgery, both cancer and benign, to be consolidated at the new RLH site with dedicated breast inpatient and day-case beds. Outpatients and diagnostic services would remain at both sites. The breast screening service would remain at the Broadgreen site as part of the national NHS Breast Screening Programme.

4.10 **Nephrology.** The LUHFT renal team provide all aspects of kidney care - acute kidney injury (AKI); chronic kidney disease (CKD); renal replacement therapy (RRT); constructive management of patients who choose not to have dialysis/transplant; and a transplantation service for Merseyside, parts of Cheshire and North Wales. The service is currently provided at AUH.

4.11 The greatest challenge within the nephrology service is prompt and equitable access to kidney services for patients. There is an increasing prevalence of renal disease in the population and demands on current services – in particular dialysis services – which will increase in the next few years. The proposed clinical model is to establish a Mersey and Cheshire renal service, centralising nephrology services at the new RLH site while providing in-reach consultant cover at AUH to ensure appropriate care for patients with kidney disease as a co-morbidity. The proposed model will ensure that all complex renal patients in the region have equitable access to a bespoke specialist service.

5. Proposal Development Process

5.1 A pre-consultation business case (PCBC) set out the clinical options appraisal process, proposed clinical models, patient benefit case, workforce, finance, quality and equality impact, engagement and estate proposals. This document informed engagement and assurance processes.

5.2 **Local Authority Overview and Scrutiny.** NHS bodies have a legal duty to consult with local authority Health Overview and Scrutiny Committees (OSC) when considering any proposal for a substantial development or variation in the way services are delivered. The four North Mersey CCGs, which represented the majority of patients that use services provided by LUHFT, presented the case for change for these proposals to Knowsley, Liverpool and Sefton OSCs in January 2022. The OSCs considered all five service change proposals to be substantial variations and agreed to convene a joint OSC.

5.3 **NHS England Assurance.** The proposals were reviewed by NHS England (NHSE) through a two-stage process, to seek assurance that LUHFT and commissioners were complying with their statutory duties and other responsibilities under the CCG Assurance Framework.[1] NHS England confirmed support to progress the proposals through a formal public consultation. NHSE stated that actions from the LUHFT System Improvement Board should be cross referenced so that the impact of these proposals would be considered from a quality and performance perspective.

5.4 As part of the NHSE Assurance process, the North West Clinical Senate were asked to undertake an independent clinical review of the proposed models of care. The overall objective of the review was to determine whether there are any clinical reasons why the proposed models of care should not be implemented. The Clinical Senate review gave assurance for all five services and recognised that the proposed models of care create potential for excellent service delivery, as well as attractive employment and training opportunities for clinical staff.

5.5 **NHS Governance.** The four former North Mersey CCGs had a track record of working collaboratively on major service change proposals, as they shared patient flows into these acute services. Previously, such proposals would be progressed by a North Mersey CCG Committee in Common, with formal commissioning decisions taken by each CCG Board or through the North Mersey Joint Committee, which had delegated authority for specific North Mersey work programmes. Due to the timing of this proposal, with CCGs being dis-established at the end of June 2022 and transitional governance arrangements in place until this point, the programme was overseen by the Cheshire and Merseyside CCGs Joint Committee (JCC) until the end of June 2022, after which accountability for final approval of these proposals resides with the Cheshire and Merseyside Integrated Care Board (ICB).

5.6 While the majority of the care covered by the proposals is the commissioning responsibility of NHS Cheshire and Merseyside ICB, there is also an element of NHSE specialised commissioning within four of the five service areas (vascular, general surgery, nephrology and urology), and specialised commissioning colleagues have been engaged in development of the proposals. The specialised commissioning element to this programme means that the final business case will also require approval from the NHSE regional team. To facilitate this decision, Mr Andrew Bibby, Director of Specialised Commissioning, will be in attendance at the NHS Cheshire and Merseyside ICB Board meeting on 29 September 2022 to allow for collective consideration and for a decision to be made jointly between the C&M ICB Board and NHSE.

5.7 **Public Consultation.** This is a complex proposal encompassing five distinct service changes, each of which needed to be clearly articulated. However, they are all informed by the same clinical objectives and an overarching vision and rationale for the delivery of services across one trust and its three hospital sites.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

5.8 The consultation was guided by legal principles for a legitimate consultation, known as the Gunning principles which require that:

- proposals are still at a formative stage.
- there is sufficient information to give 'intelligent consideration'.
- there is adequate time for consideration and response.
- 'Conscientious consideration' must be given to the consultation responses before a decision is made.

5.9 The public consultation took place over 8 weeks, from 7 June - 2 August 2022, with the consent of the Joint OSC. This length was due to the challenging timescales to complete this process prior to the planned opening of the new Royal Liverpool Hospital from September 2022.

5.10 The key engagement methods for this consultation are set out in the full consultation report which is at Appendix A. A total of 2,817 people provided feedback in the questionnaire. Approximately 75% were members of the public and 25% health care professionals. Across the sample, nearly half of respondents lived in Liverpool (48%), with smaller proportions living in Sefton (24%), Knowsley (12%) and other areas including Wirral (5%), St Helens (3%), Halton (2%), West Lancashire (2%) and Warrington (1%).

5.11 Respondents were asked to provide their feedback on the overarching clinical plan for the distribution of services across the three hospital sites. Most thought it was a good plan (43%), followed by those who thought it was a good plan in some respects but not all (29%). The remaining respondents (28%) did not think it is a good plan or were still unsure. Key generic issues and concerns expressed through the public consultation included:

- travel, transport, parking and accessibility.
- maintaining continuity of care and joined up care for patients accessing different services.
- ensuring adequate staffing provision and training opportunities.
- ability of single sites to cope with the increased demand.
- ability of North West Ambulance Services (NWAS) to cope with the increased demand, as well as the risk and delays involved with transferring patients between hospital sites.
- the impact on patient safety and outcomes given the risk involved with transferring patients between hospital sites and increasing the demand on single sites.

5.12 The consultation report sets out feedback on the proposals for each of the five services. A summary of responses is detailed in the table below:

Breast Services	2 in 3 respondents (65%) agreed that 'this is a good plan' and just over half (51%) reporting that they would be happy with the plan as proposed. A further 27% didn't believe it was a good plan
General Surgery	over half (59%) agreed that 'this is a good plan', most of which (45%) said they would be happy with the plan as proposed. Approximately 1 in 3 respondents (31%) did not think 'this is a good plan
Nephrology	3 in 4 respondents (76%) agreed that 'this is a good plan' and 2 in 3 respondents (63%) reported that they would be happy with the plan as proposed. A much smaller proportion (17%) didn't think it was a good plan.
Urology	over 2 in 3 respondents (69%) agreed that 'this is a good plan', and over half (56%) reported that they would be happy with the plan as proposed. Approximately 1 in 4 respondents (25%) did not think it was a good plan.
Vascular Services	2 in 3 respondents (66%) agreed that 'this is a good plan' and over half (55%) reported that they would be happy with the plan as proposed. Approximately 1 in 4 (24%) didn't think it was a good plan,

5.13 Where people had concerns and alternative suggestions, they were articulated and represented in the consultation report. These are summarised in the following paragraphs.

5.14 **Access and Travel Times.** Concerns were expressed about the potential impact of increased journey times for some patients and visitors. Respondents mainly living in Sefton and Liverpool (with postcodes predominantly near Aintree Hospital) raised concerns about the travel and transport to the Royal Liverpool and residents in South Liverpool raised the same concerns about travel and transport to Aintree. In response, LUHFT should measure outcome improvements for these services to evidence and communicate that better outcomes and patient experience from making these changes outweighs longer travel times for some patients.

5.15 LUHFT will conduct additional engagement with patients and families/friends about their experiences once the service changes are implemented, to understand the true impact of the change for visitors, and if any further mitigations can be identified. Patient information material will be produced containing information about local travel and transport options.

5.16 **Patient Safety and Transfers.** Another key theme which emerged was around the transfer of patients in an emergency from the Royal Liverpool to Aintree Hospital for some of these services. Respondents, including health care professionals, recognised that some patients would continue to present at the emergency department of the Royal Liverpool. They also commented that it may be difficult for ambulance staff to determine where a patient needs to be transferred to, and that they might take them to the wrong hospital, creating delays which can potentially impact the patient's safety. Some respondents were concerned whether the ambulance service would be able to respond with additional transfers.

5.17 The Trust and North West Ambulance Service have worked closely together in developing these plans and have undertaken modelling to assess the number of transfers between sites, providing assurance that these transfers would be managed and would not impact negatively on patient safety.

5.18 Some respondents were concerned that in locating a service on only one site, that a patient presenting at another site would not receive the best care. In mitigation, the Trust would communicate how they will ensure medical cover and manage this from a patient safety perspective.

5.19 **Staff Engagement.** There has been ongoing staff engagement regarding these proposals, however some staff used the consultation to highlight concerns. Opportunities for staff to raise issues and provide input should continue to be promoted prior to, during and after the new services are established.

5.20 Following the public consultation, equality impact assessments have been updated for each of the five services, which can be viewed in Appendix B.

6. Full Business Case

6.1 The Business Case should ensure that the final proposal is sustainable in service, economic and financial terms and includes any additional revenue and capital investment. It also incorporates how views captured by consultation have been taken into account. It is built from the earlier pre-consultation business case (PCBC). A final business case, at Appendix 3 was due to be approved by the LUHFT Trust Board on 22nd September 2022.

6.2 LUHFT has planned for the financial investment required to deliver the proposed clinical models. For the vascular service, an extension at Aintree will create two bespoke hybrid operating theatres and re-modelling of current theatres. The costs are part of the £14.8m capital plan budgeted for Aintree Hospital's development, which also includes Emergency Department extension and additional capacity for critical care.

6.3 Full year additional revenue costs for these services are £3.58M, predominantly representing workforce costs. There is no ask for additional revenue from commissioners.

6.4 The ICB recognise that the pre-consultation business case was developed before the Covid Pandemic and that the current financial climate in the NHS is significantly different. The ICB is therefore committed to working with LUHFT to ensure the findings of the ongoing Liverpool System Acute Services Review and the Independent LUHFT Financial Review are taken into consideration and that any future proposed increases in revenue or capital costs related to these service reconfigurations are considered within an agreed financial strategy for the Liverpool system that addresses the current financial pressures.

7. Next Steps

7.1 Subject to approval of these proposals by the Cheshire and Merseyside ICB, and NHS England Specialised Commissioning, LUHFT will commence with mobilisation of these changes, some of which are incorporated into the plans for the opening of the new Royal Liverpool Hospital, which commences on 28th September through to 21st October 2022.

8. Recommendations

8.1 This paper sets out proposals for the next phase of the clinical integration of services delivered by Liverpool University Hospitals for the populations of Knowsley, Liverpool and Sefton, and for some specialist services, across a bigger population. The proposals align with the system vision for single service teams delivering twenty four-hour, seven-day services, to improve patient experience and health outcomes by eliminating unwarranted variation and duplication and establishing excellent clinical standards. As LUHFT is the largest single trust in Cheshire and Merseyside, the proposal will also have a positive impact on outcomes and sustainability for the whole Integrated Care System.

8.2 **The Board is asked to:**

- **APPROVE** the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation.
- **NOTE** the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

29 September 2022

Assurance Process for Substantial Change

Agenda Item No	ICB/9/22/10
Report author & contact details	Neil Evans – Associate Director of Strategy and Collaboration neilevans@nhs.net
Report approved by (sponsoring Director)	This report has been approved by Clare Watson (Assistant Chief Executive)
Responsible Officer to take actions forward	Neil Evans – Associate Director of Strategy and Collaboration.

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB Board Meeting

Assurance Process for Substantial Change

Executive Summary	This paper outlines that Cheshire and Merseyside Integrated Care Board (ICB) is the organisation with statutory responsibility for ensuring that NHS substantial service change processes comply with legislative requirements, this duty had previously sat with Clinical Commissioning Groups. A number of substantial change initiatives are already underway, and a project and programme mapping exercise are taking place which will identify if there are any further initiatives which should be managed through this process. Those schemes already identified across Cheshire and Merseyside which are being managed through the substantial service change process are: • East Cheshire Trust and Stockport Joint Clinical Strategy • Maternity Intrapartum service repatriation following suspension during pandemic at East Cheshire Trust • Configuration of services across Liverpool University NHS Foundation Trust sites • Liverpool Women's Hospital future service development plans • Redesign of Stroke Services in North Mersey • Shaping Care Together Programme focused on Acute Sustainability at Southport and Ormskirk Trust • Eastern Sector Cancer Hub work which focuses on developing services for populations within the Mid Mersey population • Review of Cheshire and Merseyside Commissioning Policies to remove historical differences in access and service provision in predecessor CCGs. The creation of Cheshire and Merseyside ICB supports the development of a consistent best practice approach to developing and implementing any service changes and this will include the ICB developing a prioritisation model and financial framework to ensure schemes are targeted at delivery of our key strategic priorities.

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

Recommendation	**The Board is asked to note:** • the work undertaken with NHS England, and any programmes identified as meeting the threshold for substantial change, to ensure compliance with national policy and legislation. • that the Transformation Committee will offer an assurance mechanism for the Board. • the "project and programme mapping" exercise underway across the ICB, which will identify any further programmes of work to be managed through this process. • the plan to develop a prioritisation process, including financial framework, by which to ensure our resources are targeted most appropriately in order to deliver the ICP strategy and ICB Five Year Joint Forward Plan. • any relevant changes contained within the ICB Engagement and EDI Policies will be incorporated into the processes when these Policies are approved by the ICB Board during the Autumn

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB
Integrated Care Board Meeting

Key issues	Section 2 outlines the statutory duties which the ICB is accountable for in ensuring that NHS change undertaken in our area is compliant with legislation; this includes responsibilities in relation to engagement as well as equality, diversity and inclusion. The ICB has been working closely with identified programmes of work and NHS England to ensure these duties are met.			
Key risks	There are a significant number of legacy change programmes underway, some of which are long standing and have seen considerable engagement activity. The scale of change, and likely financial requirement to deliver, may prove challenging as the NHS enters a period of even greater financial challenge. If schemes can't be implemented as planned this could create both reputational risk and challenges around ongoing service delivery. Section 3.6 outlines the intention to develop a prioritisation process, including a financial framework to support mitigation of this risk.			
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**
	x	x	x	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
	x	x	x	x
Route to this meeting	This report was considered by the ICB Transformation Committee on 22 September who noted the content of the report and supported the recommended next steps.			
Management of Conflicts of Interest	No conflicts identified			
Patient and Public Engagement	Not applicable directly to the paper. Patient and Public Engagement is integral to all the major change programmes and is assured through both ICB and NHS England Assurance Processes.			
Next Steps	• the "project and programme mapping" exercise underway will identify any further programmes of work which should be managed through this process. • develop a prioritisation process, including financial framework, by which to ensure our resources are targeted most appropriately in order to deliver the ICP strategy and ICB Five Year Joint Forward Plan. • any relevant changes contained within the ICB Engagement and Equality Diversity and Inclusion (EDI) Policies will be incorporated into the processes when these Policies are approved by the ICB Board during the Autumn.			
Appendices	**Appendix A**	Process for managing substantial service change from the NHS England guidance (Planning, assuring and delivering service change for patients)		
	Appendix B	Current timeline for substantial change initiatives already identified in C&M ICB plans		

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB
Integrated Care Board Meeting

Assurance Process for Substantial Change

1. Executive Summary

1.1 Cheshire and Merseyside Integrated Care Board (ICB) is the organisation with statutory responsibility for ensuring that NHS substantial service change processes comply with legislative requirements, this duty had previously sat with Clinical Commissioning Groups.

1.2 The national guidance remains largely unchanged in terms of the role of NHS England in assuring that ICBs adopt the previous duties held by CCGs.

1.3 A number of substantial change initiatives are already underway across Cheshire and Merseyside, and a project and programme mapping exercise is taking place which will identify if there are any further initiatives which should be managed through this process.

1.4 Those schemes already identified across Cheshire and Merseyside which are being managed through the substantial service change process are:

- East Cheshire Trust and Stockport Sustainable Services Programme
- Maternity Intrapartum service repatriation following suspension during pandemic at East Cheshire Trust
- Liverpool University Hospitals Clinical Services Reconfiguration
- Liverpool Women's Hospital future service development plans
- Redesign of Stroke Services in North Mersey
- Shaping Care Together Programme focused on Acute Sustainability at Southport and Ormskirk Trust
- Eastern Sector Cancer Hub work which focuses on developing services for populations within the Mid Mersey population
- Review of Cheshire and Merseyside Commissioning Policies to remove historical differences in access and service provision in predecessor CCGs.

1.5 The creation of Cheshire and Merseyside ICB supports the development of a consistent best practice approach to developing and implementing any service changes and this will include the ICB developing a prioritisation model and financial framework to ensure schemes are targeted at delivery of our key strategic priorities.

2. Background

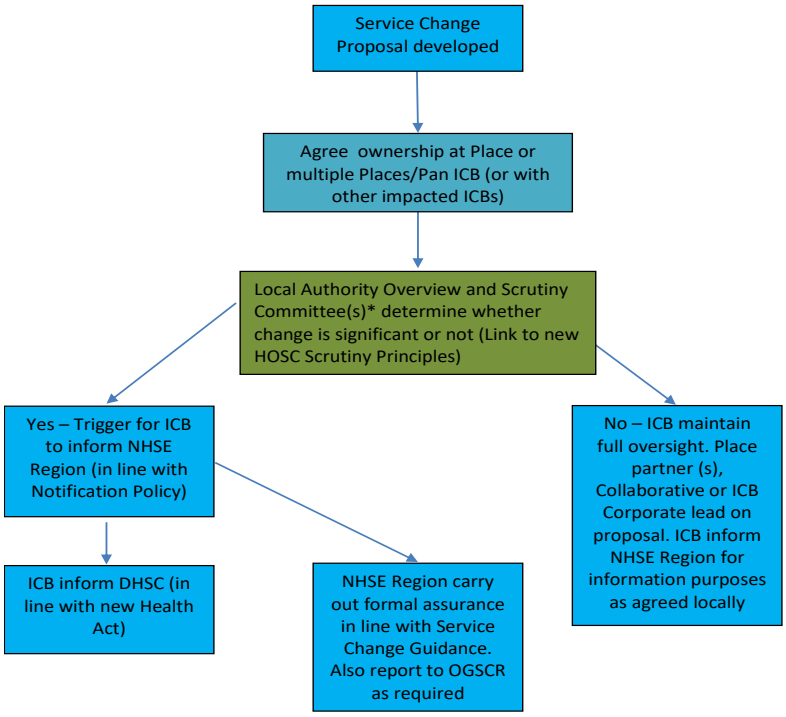
2.1 Cheshire and Merseyside Integrated Care Board is the organisation with statutory responsibility for ensuring that NHS substantial service change processes comply with legislative requirements, this duty had previously sat with Clinical Commissioning Groups. The process described in the document 'Planning, assuring and delivering service change for patients' provides guidance around the assurance processes associated with this process.

2.2 Where there is a change to the way NHS services are to be provided there is a requirement to ensure engagement, or consultation, takes place with our local stakeholders, and where the change is significant in nature to consult with local authority Overview and Scrutiny Committee to agree if the change is considered substantial and requires formal consultation with our public. This paper focuses on the process that assures changes of this nature rather than the entire service change cycle.

2.3 NHS England retains a responsibility for assuring that where a change has been determined, with the relevant Local Authority Overview and Scrutiny Committee, to be a substantial service change that the relevant processes have been followed. The ICB meets with NHS England each month to review those service change initiatives which are considered substantial. As part of the individual programme lifecycle a series of assurance checkpoint assessments take place.

2.4 As shown in Diagram One changes may impact on either single or multiple Places, or across the whole ICB. This may require joint arrangements between Places or other ICBs, where the change impacts residents outside of Cheshire and Merseyside; for example the programmes referenced within the appendices at East Cheshire and Southport and Ormskirk Trust services.

Diagram One



*Note provision for Cheshire and Mersey Joint OSC is being coordinated through Knowsley. Some changes may need Joint Committee and Joint OSC with Local Authorities in neighbouring ICB areas.

2.5 This paper focusses on summarising the approach, and the projects which have been assessed to meeting the trigger criteria to enter the NHS England assurance process, to assure substantial service change proposals referenced in the diagram above. Within Cheshire and Merseyside there are already a number of service change proposals underway, and being led out by Place or ICB Corporate teams:

Cheshire East

- East Cheshire Trust and Stockport Foundation Trust Sustainable Services Programme
- Maternity Intrapartum service repatriation following suspension during pandemic at East Cheshire Trust

Liverpool

- Liverpool University Hospitals Clinical Services Reconfiguration
- Liverpool Women's Hospital future service development plans
- Redesign of Stroke Services in North Mersey

Sefton

- Shaping Care Together Programme focused on Acute Sustainability at Southport and Ormskirk Hospital Trust

Eastern Sector Cancer Hub work (Halton, Knowsley, St Helens and Warrington Places)

- focuses on developing services for populations within the Mid Mersey population

Review of Cheshire and Merseyside Commissioning Policies to remove historical differences in access and service provision in predecessor CCGs. To include but not limited to sub-fertility, procedures of limited clinical value, gluten free prescribing

2.6 The programmes listed above are at various stages of maturity and the current milestones are summarised in Appendix B. In addition the cycle of local elections is included in this appendix and is mapped against plans to ensure compliance with national requirements in relation to purdah pre-election periods.

2.7 The creation of Cheshire and Merseyside ICS presents an opportunity to achieve consistency of approach, across our system, in developing and implementing service change proposals in order to maximise the outcomes delivered.

3. Key Considerations when undertaking substantial change

3.1 The national legislative processes, and supporting guidance, in relation to service change remain unchanged following the creation of Integrated Care systems, in July. The responsibility for ensuring the NHS processes are compliant moved from CCGs to the ICB as the successor organisation. NHS England continue to assure substantial change programmes; and the process can be seen in Appendix A and as can be seen includes a series of assurance checkpoints and regular reporting from the ICB (including with/for our Providers).

3.2 As described in Section 2 change can be initiated in any part of the ICS and this process relates to NHS change. The actual leadership and oversight of change will generally be within our Places but can be through Corporate Teams or Provider Collaboratives. The Assistant Chief Executive Directorate will provide a central point of contact to facilitate both local ICB assurance of change activity as well as with NHS England on significant changes.

3.3 There are a range of responsibilities set out for the NHS in the NHS Act of 2006 which the NHS is accountable for and include the need for either engagement, or consultation. Under the 2013 Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) regulations where a Local Authority Overview and Scrutiny Committee determines the proposed change is substantial this determines the need for consultation. If they believe appropriate processes have not been followed the Local Authority can make a referral to the Secretary of State.

3.4 The 2018 guidance referenced in Section 2 highlights four tests to consider when assuring service change:

- strong public and patient engagement
- consistency with current and prospective need for patient choice
- a clear clinical evidence base
- support for proposals from clinical commissioners
- there is an additional NHS England test where proposals intend to reduce hospital bed numbers to ensure robust alternatives or rationale exist.

3.5 Where there is a need for capital expenditure to support the substantial service change there is additional assurance from NHS England, beyond the local ICB assurance to assess affordability within the ICS capital envelope or wider availability. This is summarised in Appendix A as (unless <£15m and funded from local ICS capital) requiring:

- Strategic Outline Case
- Outline Business Case
- Full Business Case.

3.6 The programmes listed in 2.5 are at various stages of maturity but the creation of the ICS presents an opportunity to take a whole Cheshire and Merseyside approach to prioritising these schemes, against the strategic priorities and financial constraints we operate within; both in relation to capital and revenue implications of service changes. A process for undertaking this prioritisation of proposed change will be developed to include a financial framework and to ensure any revisions to approach contained within the revised policies referenced in section 3.8 below.

3.7 The development of the prioritisation process is planned to be addressed through a regional approach, as the constraints to implementing change are not unique to Cheshire and Merseyside. This needs to consider the constraints we work within; including not only the financial costs, but service quality, safety, access and sustainability, workforce, programme resource and wider social and political implications of the potential changes.

3.8 Engagement and Consultation is a key part of the service change process and work is taking place to finalise our updated ICB Engagement, and Equality Diversity and Inclusion (EDI) Policies which will support the process outlined in this paper. These policies are due to be presented to the ICB Board during the Autumn and will be reflected in the individual service change programme plans.

3.9 Whilst the ICB strategies are being finalised there are a number of statutory duties in relation to Equality Act Public Sector Equality Duty (PSED); that the strategy will contain, and in the context of this paper it is important to highlight. The ICB have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

3.10 These are sometimes referred to as the three aims or arms of the general equality duty. The Act explains that having ‘due regard’ for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics.
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

3.11 The duty is designed to shift the onus from individuals to organisations, placing an obligation on public authorities to positively promote equality, not merely to avoid discrimination. The general equality duty therefore requires the Integrated Care Board to consider how it will positively contribute to the advancement of equality and good relations. It requires equality considerations to be reflected into the design of policies, strategies, practices and the design and delivery of services.

3.12 **Due regard and making fair financial decisions**. Failure to make decisions without a clear line of sight Public Sector Equality Duty (PSED) is unlawful and case law has set out broad principles about what the ICB needs to do to demonstrate due regard to the aims of the PSED. These are sometimes referred to as the 'Brown principles' and set out how courts interpret the duties:

Decision-makers are aware of their duty to have "due regard" for the identified aims. Decision makers (usually a board or those legally responsible for the organisation) at the time of making a decision, on whether to accept or pass a policy/service change, must be cognisant of PSED and it be part of their deliberation. This means making sure that an Equality Assessment Report is part of the committee papers, that the committee refers to it at the time of decision making and this is documented in the minutes.

They consider the general equality duty before and during discussions of a particular policy as well as at the time a decision is taken. This means that it is important right at the start of the process – when developing policy/service change proposals, to start to consider the implications of the change on the protected characteristics covered by the Equality Act 2010. In practice a clear line of sight has to be established so that the Equality Assessment starts when the policy/service change proposal begins– any equality implications should be feeding into the design of the policy/service change as it is developed. Where a 'potential discrimination' is identified this needs to be addressed and mitigated.

The equality duty is exercised in substance, with rigour and with an open mind. The Equality Act 2010 is UK legislation that requires compliance – it requires 'proof' that the organisation has considered all the salient facts and evidence when it actions policy or service change linked to the removal of discrimination. As such it is not a 'tick box' exercise. The High Court has rigorous tests in Judicial Reviews to assess whether or not the Equality Act 2010 has been adhered to properly. The best way to show that the organisation is meeting requirements, is to develop a strong Equality Assessment system and governance process.

The equality duty is not delegated to a third party. Firstly, the commissioning body must ensure that if the Provider is a non-NHS body then it is clear that PSED is still active. Secondly, any Equality Analysis report is automatically the responsibility of the organisation regardless of who does it. The expectation is that they are done in house – with specialist help if needs be – and not commissioned off to a third-party organisation, who hands a completed document back.

The equality duty is constantly valid. Whilst there is an expectation to identify any potential equality consideration at the time of developing a policy / proposed service change, the duty does not stop once approved by the decision makers. The work of the new policy or strategy needs to be evaluated at specific times to test whether or not in practice the policy/service being delivered is meeting the demands of Equality Act 2010 and the final Equality Assessment that the board considered.

Good practice records are kept when it comes to regard for the aims in order to prove that the general equality duty was fulfilled. Minutes of meetings should evidence an 'equality trail', that PSED was considered, usually via an EIA.

3.13 **Health Inequalities Duty and other public law requirements**. ICBs have a statutory duty to "have regard to the need to reduce inequalities between patients" in terms of access to and outcomes from health services. ICBs also have a "duty to promote integration" in certain circumstances, including where doing so is expected to reduce inequalities in access and outcomes.

3.14 Failure to correctly manage the duties including PSED, the duty on Health Inequalities and the necessary consultation processes (Gunning Principles) during the decision-making process is unlawful and could lead to legal challenge. It is essential that robust processes and governance structures are developed to ensure Quality impacts (to ensure appropriate steps are in place to safeguard quality whilst delivering significant changes to service delivery), equality impacts and health inequalities impacts are considered to inform ICB decision making. When the legal duties are fully managed it brings insights, proofs and evidence that add to and demonstrate that safe, quality services are commissioned and clearly helps to develop better and stronger models of care that improve access and outcomes for the benefit of patients.

3.15 As outlined in the earlier paper considered by the committee on "project and programme mapping" the full range of activity taking place across the ICS. Any additional schemes which meet the criteria for substantial change will be identified and managed in line with the processes referenced in this paper.

4. Recommendations

4.1 The Board is asked to **note**:

- the work undertaken with NHS England, and any programmes identified as meeting the threshold for substantial change to ensure compliance with national policy.
- the "project and programme mapping" exercise underway across the ICB, which will identify any further programmes of work to be managed through this process.
- the plan to develop a prioritisation process, including financial framework, by which to ensure our resources are targeted most appropriately in order to deliver the ICP strategy and ICB Five Year Joint Forward Plan.
- any relevant changes contained within the ICB Engagement and EDI Policies will be incorporated into the processes when these Policies are approved by the ICB Board during the Autumn.

NHS Cheshire and Merseyside Integrated Care Board Meeting

29 September 2022

Assurance Process for Substantial Change

Appendices

NHS
Cheshire and Merseyside

Appendix B

Current timeline for substantial change initiatives already identified in plans

NHS Cheshire and Merseyside Major Change Programme 2022/2024

Programme	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Notes
Southport and Ormskirk Health System – Shaping Care Together			**Tranche 1:** PCBC development & Stage III Assurance (H2 22/23 - H1 April-Sep 24/25) developing FCBC and Stage 2 Assurance															Timeline developed through to March 2027
North Liverpool Stroke configuration	ICB Board - 4 August	Joint OSC (with West Lancs) Royal and S&O HyperAcute to Aintree 19 Sept																Phase 2 - Stroke HASU frontdoor to separate unit due 23-24
LUFT service reconfiguration (Aintree and Royal)	Liverpool University Hospitals – Consultation proposal for next phase of clinical integration closes 2 August	LUHFT Board 8th Sept ICB Board 29th Sept Joint OSC 30 Sept	Go live for some services															
Liverpool Womens (component of wider review of acute and specialist services in Liverpool)	Private paper to ICB Bard 4th August			Work completed on Acute and Specialist service review														Stage 1 Assurance completed May 22 and Liverpool Place preparing a response to feedback on areas highlighted
Liverpool UTC Plans (23/24)																		Timeline to be developed for 23-24 or later
Knowsley UTC Plans (23/24)																		Timeline to be developed for 23-24 or later
Cheshire West UTC (23/24)																		Timeline to be developed for 23-24 or later
Cheshire East UTC (23/24)																		Timeline to be developed for 23-24 or later
East Cheshire Maternity		Board Decision	**Implementation** – including estates work / training for staff / ensuring safe transition from interim arrangements. Sep 2022 – April 2023															
East Cheshire and Stockport shared clinical strategy	**Phase 2 :** Produce Pre Consultation Business Case (if required) Plan for and commence implementation of service changes where no formal further process is required									**Phase 3:** Undertake public consultation and production of decision-making business case (if required) On-going implementation of service changes where no formal further process is required							**Phase 4:** Nov 2023 – April 2025 Programme Implementation	
C&M standardised Commissioning Policies (PLCV, over the counter prescribing, gluten free etc)	Programme Plan in development								Go Live									Plan to be presented at October ICB Board
C&M standardised Sub Fertility Policy – to be live by 1/4/23.	Programme Plan in development								Go Live									Plan to be presented at October ICB Board
Eastern Cancer Hub (St Helens, Knowsley, Halton and Warrington)		Clinical Review of proposals to be completed to agree future timeline																Budget needed for consultation. Previously passed through stage 2 of assurance process but will need to be reviewed based on clinical review (Sept 22)

Local election calendar

Council	2023		2024		2025		2026		2027	
	Pre-election	Election	Pre-election	Election	Pre-election	Election	Pre-election	Election	Pre-election	Election
Liverpool City Region Mayor					20/03/2025	01/05/2025				
City of Liverpool Mayor	Position will be removed at the May 2023 elections and will be replaced with a council leader and cabinet model									
Cheshire East (whole council)	23/03/2023	04/05/2023							25/03/2027	06/05/2027
Cheshire West & Chester (whole council)	23/03/2023	04/05/2023							25/03/2027	06/05/2027
Halton (third of council)	23/03/2023	04/05/2023	21/03/2024	02/05/2024			26/03/2026	07/05/2026	25/03/2027	06/05/2027
Knowsley (third of council)	23/03/2023	04/05/2023	21/03/2024	02/05/2024			26/03/2026	07/05/2026	25/03/2027	06/05/2027
Liverpool (whole council)	23/03/2023	04/05/2023	21/03/2024	02/05/2024			26/03/2026	07/05/2026	25/03/2027	06/05/2027
Sefton (third of council)	23/03/2023	04/05/2023	21/03/2024	02/05/2024			26/03/2026	07/05/2026	25/03/2027	06/05/2027
St Helens (whole council)							26/03/2026	07/05/2026		
Warrington (whole council)			21/03/2024	02/05/2024						
Wirral (third of council)	23/03/2023	04/05/2023	21/03/2024	02/05/2024			26/03/2026	07/05/2026	25/03/2027	06/05/2027

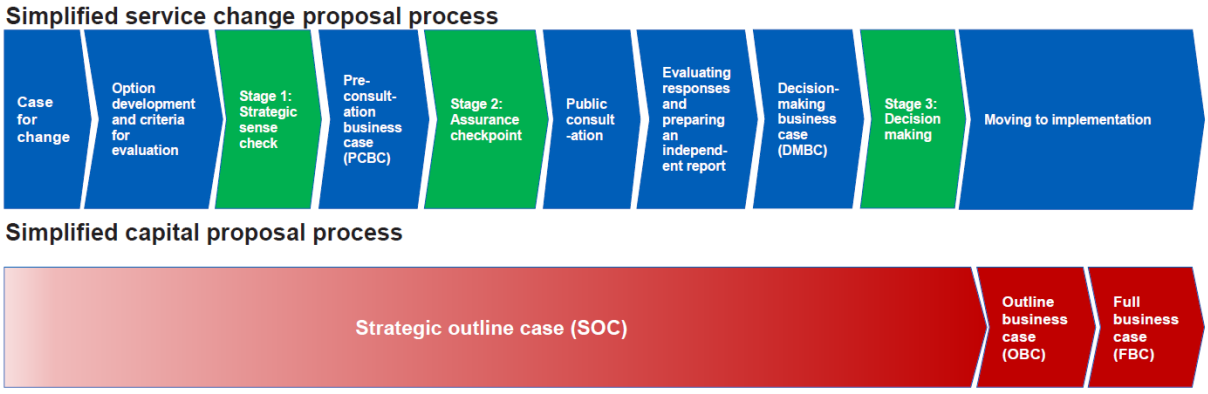
Pre-election period is six-weeks prior to the election date, NHS England and or Cabinet Office guidance should be followed.

NHS
Cheshire and Merseyside

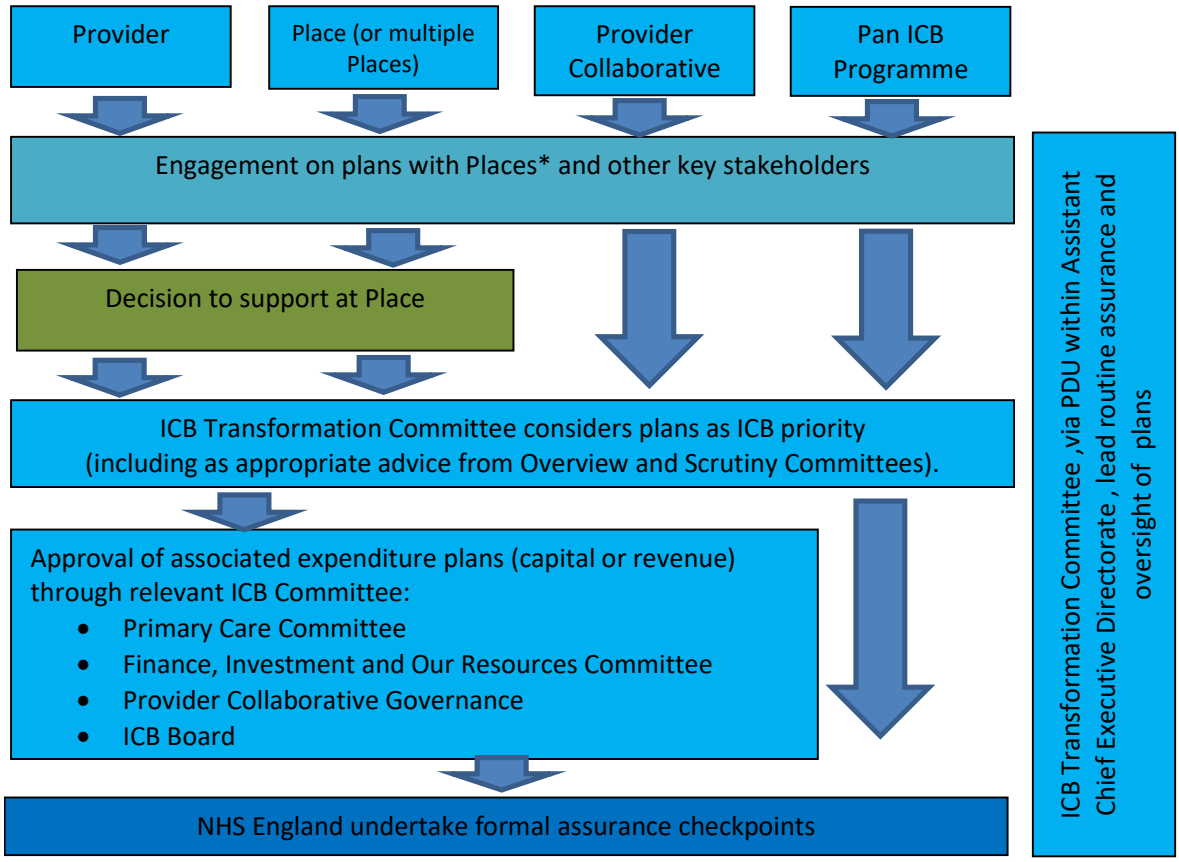
Appendix A

Process for managing substantial service change from the NHS England guidance

Figure 1: Alignment of service change proposal process and capital proposal process



Flow Chart for Substantial Change: developed with NHS England



*Place governance may vary but in this context describes the full cross section of partners at Place

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

29 September 2022

Developing the Cheshire and Merseyside Integrated Care Partnership

Agenda Item No	ICB/9/22/**12**
Report author & contact details	Clare Watson, Assistant Chief Executive Clare.watson@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Clare Watson

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB Board Meeting

Developing the Cheshire and Merseyside Integrated Care Partnership

Executive Summary	This paper briefly updates ICB board members on progress to date on formally establishing the Integrated Care Partnership (ICP) in Cheshire and Merseyside.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** Note the progress in developing the ICP (known locally as Cheshire and Merseyside Health Care Partnership (HCP)) and agree to receive a further update at the November ICB Board meeting following the first formal meeting of the HCP in early November.				
Key issues	Within each Integrated Care System there is a statutory requirement to establish an ICP. The ICP has the duty to develop an Integrated Care Strategy which the ICB has a duty to refer to when carrying out its functions and in developing its Five Year Forward Plan.				
Key risks	No key risks identified				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X	X	X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X	X	X	X	
Route to this meeting	This paper has been informed following engagement with the founding members of the Cheshire and Merseyside HCP.				
Management of Conflicts of Interest	No conflicts anticipated.				
Patient and Public Engagement	-				
Next Steps	Further work is required to determine the membership of the Cheshire and Merseyside ICP and the development of its Terms of Reference and formal establishment. In line with the principles and commitments of the ICBs Public and Patient Engagement Framework, engagement will be undertaken with our patients and public to help inform them of the role of the ICP and how they can influence the development of the Integrated Care Strategy for Cheshire and Merseyside.				
Appendices	**Appendix A**	Kings Fund Diagrammatic illustration of an Integrated Care System			

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB
Integrated Care Board Meeting

Developing the Cheshire and Merseyside Integrated Care Partnership

1. Executive Summary

1.1 The Health and Care Act (2022) established 42 Integrated Care Systems (ICS) across England on a statutory basis on 1 July 2022. ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

1.2 Within an ICS there is an Integrated Care Board (ICB) which is the statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area.

1.3 Within each ICS there is also a requirement to establish and Integrated Care Partnership (ICP). An ICP is a statutory committee that has to be jointly formed between the NHS ICB and all upper-tier local authorities that fall within the ICS area. The intent of the ICP is to bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

1.4 ICPs are a critical part of an ICS and the journey towards better health and care outcomes for the people they serve.

1.5 Appendix A provides a helpful illustration of what an ICS structure should be composed of.

1.6 Cheshire and Merseyside (C&M) has an established Health and Care Partnership (HCP), which has been in place since 2020 and is the committee from which the C&M ICS's ICP will develop. It has been proposed that the new ICP will be known as the HCP because this is a trusted and well-respected brand with partners and stakeholders.

1.7 It is important to state that the HCP does not stand alone in Cheshire and Merseyside – it is an **additional** and new statutory component of an existing Health and Care System comprising multiple agencies whose work and respective statutory duties impact significantly on people health and wellbeing.

1.8 This paper briefly updates ICB board members on progress to date on formally establishing the new HCP in Cheshire and Merseyside and what more needs to be done.

Cheshire and Merseyside ICB
Integrated Care Board Meeting

2. Background

2.1 To meet the requirements for the Health and Care Act 2022 work has been developed to establish an ICP in Cheshire and Merseyside. The proposals have been informed by the legislative requirement, policy, and discussion with partners. We have built on the foundations of the former Health Care Partnership.

2.2 The HCP will be the 'guiding mind' of the health and care system, providing a forum for Local Authority and NHS leaders to come together with important stakeholders from across the system and community. The HCP will lead on the creating an integrated care strategy and will be the lead system committee for driving forward the Marmot agenda and reducing inequalities and avoidable mortality.

2.3 The HCP's current 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"

2.4 The HCP's current 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"

2.5 The partners of the HCP will generate an integrated care strategy and oversee, from a system perspective, the 22 key Marmott indicators to improve health and care outcomes and experiences for the population of Cheshire and Merseyside, for which all partners will be accountable.

2.6 Nationally, the Care Act expects ICPs to provide opportunity to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for local populations. ICPs are meant to facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. Such joined up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.

2.7 Integrated care strategies must be developed for the whole population using best available evidence and data and should be built bottom up from local assessments of needs and assets identified at place level. The Act also places a duty for the ICB to have regard to the Joint Strategic Needs Assessments (JSNAs), Integrated Care Strategy and Joint Local Health and Wellbeing Strategies when exercising its functions.

2.8 In line with the expectations of the Act and building on existing local system priorities, it is suggested that the initial work programme of the Cheshire and Merseyside HCP includes:

- 5-year Integrated Care Strategy
- Marmot communities and Population Health
- Anchor Institutions

- Sustainability/green agenda
- Place development and maturity
- Cost of living crisis
- Winter.

3. Establishing our HCP – chronology and next steps

3.1 In November 2021, the then C&M HCP Board agreed that a task and finish group be established to explore the issues and requirements in establishing a new HCP/ICP and report back with recommendations on how to progress.

3.2 The task and finish group membership came from officers, lay and elected representatives from C&M HCP, NHS Trusts, CCGs, Local Authorities including Public Health, Voluntary Sector Northwest and Healthwatch.

3.3 Three meetings were held looking at: Principles, Scope, Membership AND Chairing. The existing membership were surveyed, and initial recommendations were developed in the absence of formal national guidance.

3.4 Outputs on the work of the task and finish group were reported to the March 2022 HCP Board meeting. Conscious that at the time of its work no designate ICB Chair had been identified as well as upcoming local elections for some of our local authorities and the ongoing pandemic, a pause was put on the work.

3.5 **Recent developments.** The Department of Health and Social Care released the next stage of its guidance[1] about ICPs, and therefore during July and early August system partners were briefed on the current situation in Cheshire and Merseyside, understanding of guidance and legislation and C&M HCP founding members nominations were sought from the ICB and nine local authorities in Cheshire and Merseyside.

3.6 At the same time founding members were asked to consider Chair and Vice Chair arrangements that would advance partnership working. The ICB Chair, as the ICB's founding member, recommended that nominations for Chair of the C&M HCP came from someone who held political office in one of our local authorities to ensure we reflect our local communities. There was also a recommendation that the ICB Chair be joint Vice Chair to ensure good connection with the sister statutory committee of Cheshire and Merseyside ICS, namely the ICB Board. It was recommended that the other Vice Chair come from the voluntary sector to signal the important of their work and cement influence.

3.7 A workshop of most founding members took place on 20 September 2022 where Louise Gittins, Leader of Cheshire West and Chester Local Authority was supported unanimously by those at the event as the designate Chair of the C&M HCP. This followed nominations and support from founding members who had responded by the 5 September 2022 deadline.

[1] https://www.england.nhs.uk/integratedcare/resources/key-documents/

3.8 It was suggested that an open process takes place for applicants from the voluntary and faith sectors to be selected as joint Vice Chair of the C&M HCP. We will aim to do this for the first formal meeting of the C&M HCP which will take place in early November.

3.9 The C&M HCP will be governed by a set of principles and ways of working which are based on a combination of what has been deemed important by local stakeholders together with national expectations.

3.10 Initial principles designed at the workshop include:

- primacy of Place for planning and delivery
- subsidiarity model with decision making at the closest feasible level to delivery
- each Place is accountable to work for the benefit of Cheshire and Merseyside as a whole, in addition to Place based interests
- act and behave as a learning system.

3.11 Membership and attendance at the C&M HCP are still to be recommended by the founding members, but key partners and stakeholders will be engaged over the next few weeks to confirm this.

3.12 There is significant flexibility for ICPs to determine their own arrangements, including their membership and ways of working. Membership however must include one member appointed by the ICB, one member appointed by each of the relevant local authorities, and others to be determined locally. This may include social care providers, public health, Healthwatch, VCSE organisations and others such as local housing or education providers

3.13 As well as formal meetings, to enable wider engagement in, and co-production of, the ICS's work, further mechanisms will be put in place to enable all stakeholders a point of influence:

- a wider assembly of partners, to be held at least annually. Broad participation will be sought to attend and contribute to the work of Cheshire and Merseyside ICS
- linkages will be made with existing networks, groups and governance structures, including staff fora and insights gained from place and neighbourhood engagement.

3.14 **Key next steps.** Follow up from the workshop that was held on 20 September 2022 including support and approval of Louise Gittins as designate Chair of the ICP and appointment of joint Vice Chair from the voluntary and faith sector.

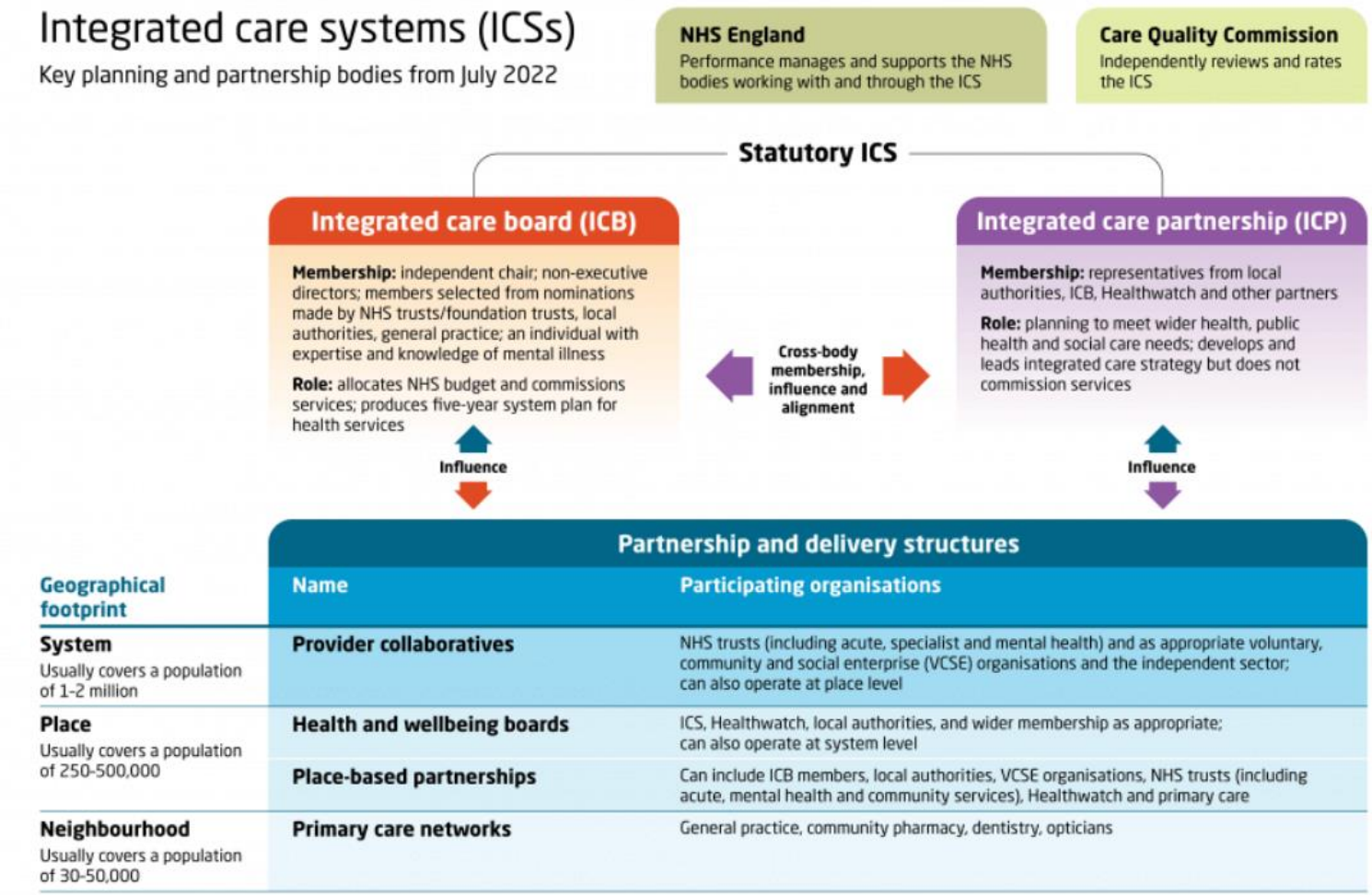
3.15 Work will also need to progress in:

- developing a formal Terms of Reference for the HCP
- engagement with the relevant legal/democratic services teams within each Local Authority to understand the process and timeline to formally enter into a joint committee arrangement between the C&M ICB and the nine C&M Local Authorities
- in line with the principles and commitments of the ICB's Public and Patient Engagement Framework, engagement will be undertaken with our patients and public to help inform them of the role of the HCP and how they can influence the development of the Integrated Care Strategy for Cheshire and Merseyside

4. Recommendations

4.1 It is recommended that the ICB note the progress in developing the C&M ICP (known locally as Cheshire and Merseyside Health Care Partnership (HCP)) and receives a further update at its November Board meeting following the first formal meeting of the C&M HCP in early November.

Appendix A



Source: Kings Fund. https://www.kingsfund.org.uk/audio-video/integrated-care-systems-health-and-care-act

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

29 September 2022

Cheshire & Merseyside System Month 5 Finance Report

Agenda Item No	ICB/9/22/**13**
Report author & contact details	Mark Bakewell – Deputy Director of Finance
Report approved by (sponsoring Director)	Claire Wilson – Executive Director of Finance
Responsible Officer to take actions forward	Claire Wilson – Executive Director of Finance

NHS Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Cheshire & Merseyside System Month 5 Finance Report

Executive Summary	This report updates the Board on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				
Recommendation	**The Board is asked to:** • Note the contents of this report in respect of the Month 5 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.				
Key issues					
Key risks	Financial risks associated with delivery of financial position set out in the paper				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X		X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
			X	X	
Next Steps	Continued monitoring of financial forecasts for revenue and capital allocations. Further development of cost improvement plans and system wide efficiency opportunities. Development of financial strategy to support future financial sustainability.				
Appendices	Appendices 1-6 gives details of the narrative in the main body of the report.				

System Finance Report to 31st August 2022 (Month 5)

Executive Summary

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

M5 Performance - Revenue

As at 31st August 2022 (Month 5), the ICS 'System' is reporting an aggregate deficit of £45.1m against a planned deficit of £32m resulting in an adverse year to date variance of £13.1m.

As set out in the table below, this is due to a lower than expected year-to-date surplus position of £5.8m for CCGs/ ICB (compared to a plan profile value of £8.2m) and a year-to-date deficit in the NHS providers of £50.9m (compared to plan profile of £40.2m).

Sector	2022/23 Annual Plan £m Surplus / (Deficit)	2022/23 YTD Plan £m Surplus / (Deficit)	2022/23 YTD Actual £m Surplus / (Deficit)	YTD Variance £m Surplus / (Deficit)	2022/23 Forecast £m Surplus / (Deficit)	Forecast Variance £m Surplus / (Deficit)
CCG/ICB	19.7	8.2	5.8	(2.4)	19.7	(0.0)
NHS Providers Trusts	(50.0)	(40.2)	(50.9)	(10.7)	(50.1)	(0.1)
Total System	**(30.3)**	**(32.0)**	**(45.1)**	**(13.1)**	**(30.4)**	**(0.1)**

The ICB and NHS providers continue to forecast achievement of the annual planned deficit of £30.3m. However, there are a number of risks that will require management as a system to ensure that the plan is delivered.

M5 Performance - Capital

As at 31st August 2022, progress of the system's local operational capital programme expenditure remains below year to date planned values by £30.4m as described in the main body of the report. However, with regards to the outturn position, current forecasts suggest an overspend position of £8.8m, largely associated with required Reinforced Autoclaved Aerated Concrete (RAAC) expenditure at Mid Cheshire Hospitals NHS Foundation Trust exceeding planned values which is subject to ongoing discussion with the Trust and national NHS England team.

Further enquires are being made with regards to funding streams for RAAC and other areas of forecast expenditure to ensure that values are as accurate as possible given any potential slippage relating to supply chain issues. The system will work collaboratively to ensure that any slippage is managed by bringing forward expenditure in other areas to ensure that all capital resources are utilised in year.

In respect of the national capital programme there is currently a £2.5m variance to plan year to date but minimal variance against the forecast outturn position.

System Finance Report to 31st August 2022 (Month 5)

Introduction

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

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

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

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

5) As a result, the additional surplus above plan of £6.7m originally reported by CCGs has been transferred to the ICB.

Month 5 (August) Performance

ICB/CCG performance

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

7) The ICB is currently reporting a year-to-date surplus of £5.8m compared to an original planned surplus of £8.2m (when adjusted for the original) resulting in an adverse variance to plan of £2.4m as per the below table.

	Net Expenditure	Net Expenditure	Net Expenditure	Net Expenditure
	Plan	Actual	Variance	Variance
	31/08/2022	31/08/2022	31/08/2022	31/08/2022
	YTD	YTD	YTD	YTD
	£'000	£'000	£'000	%
System Revenue Resource Limit	(979,145)			
ICB Net Expenditure				
Acute Services	516,729	516,845	(117)	(0.0%)
Mental Health Services	92,603	94,607	(2,004)	(2.2%)
Community Health Services	100,646	100,292	354	0.4%
Continuing Care Services	53,407	53,037	370	0.7%
Primary Care Services	101,168	98,486	2,682	2.7%
Other Programme Services	10,262	10,223	39	0.4%
Reserves / Contingencies	(9,628)	(662)	(8,966)	93.1%
Delegated Primary Care Commissioning including	88,631	90,305	(1,674)	(1.9%)
a) Primary Medical Services	77,215	77,960	(745)	(1.0%)
b) Pharmacy Services	11,416	12,344	(929)	(8.1%)
ICB Running Costs	7,873	7,882	(9)	(0.1%)
Total ICB Net Expenditure	964,234	973,389	(9,155)	(0.9%)
TOTAL ICB Surplus/(Deficit)	**14,912**	**5,756**	**(9,155)**	(0.9%)
**** NB - CCG Q1 Adjustment***	***(6,716)***		***6,716***	
Adjusted Surplus	***8,195***	***5,756***	***(2,439)***	

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

a. Mental Health - increased volume and value of Packages of Care, including Out of Area placements and Non-Contracted Activity.
b. Primary Care Services - current underspend on prescribing and GPIT but this is not expected to continue to the end of the year.
c. Reserves – due to accepted planning risks as outlined below
d. Primary Care Delegated budgets – overspend areas include enhanced services, estates and other local discretionary expenditure.
e. Delegated Pharmacy pressures (ICB responsibility from 1st July 2022)

f. Efficiency savings are built into the year-to-date position and reflects a favourable position of the £2.5m but a significant proportion of this is non-recurrently delivered. Further detail is provided in the sections below.

9) Further work is required to review transactions from predecessor organisations to ensure a consistency of approach to accounting policies e.g the basis for accruals in areas such as prescribing.

10) Running costs forecasts also require further validation to include assessment of new ICB structure and changes to hosted service arrangements.

11) The ICB continues to forecast achievement of the annual planned surplus of £19.7m. However, there are several risks that are being actively managed to ensure the plan is delivered. This includes a step change in the focus on the development of recurrent efficiencies.

12) Analysis is also being undertaken at ex-ccg / place level to understand the drivers for the adverse variance and emerging risks. Cheshire East, Cheshire West and Wirral are showing adverse year to date positions compared to the planned values submitted in June 2022. Further work is being led by the Executive Director of Finance with Place Directors / and supporting Associate Directors of Finance to review expenditure drivers and identify potential mitigating actions to support recovery of the in-year position.

NHS Provider Performance

13) The table below summarises the combined NHS provider position to the end of August 2022 reflecting a year-to-date cumulative deficit position of £50.9m compared to a year-to-date profile plan figure of £40.2m. Further detail is provided in appendix 2.

	M5 YTD Plan £m	M5 YTD Actual £m	M5 YTD Variance £m	Annual Plan £m	M5 Forecast ACTUAL £m	M5 Forecast VARIANCE £m
Cheshire and Wirral Partnership NHS Foundation Trust	1.0	1.0	0.0	2.9	2.9	0.0
Countess of Chester Hospital NHS Foundation Trust	(4.4)	(9.9)	(5.5)	(3.1)	(3.1)	(0.0)
East Cheshire NHS Trust	(1.9)	(1.9)	0.0	(2.6)	(2.6)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.0	1.0	0.0	2.3	2.3	(0.0)
Liverpool University Hospitals NHS Foundation Trust	(15.5)	(17.7)	(2.2)	(30.0)	(30.1)	(0.1)
Liverpool Women's NHS Foundation Trust	0.6	0.8	0.1	0.6	0.6	0.0
Mersey Care NHS Foundation Trust	1.7	1.7	(0.0)	5.7	5.7	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(6.2)	(6.9)	(0.7)	(10.4)	(10.4)	0.0
Southport And Ormskirk Hospital NHS Trust	(8.0)	(8.0)	0.0	(14.2)	(14.2)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(3.1)	(3.1)	0.0	(4.9)	(4.9)	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.7	1.2	0.5	1.6	1.6	(0.0)
The Walton Centre NHS Foundation Trust	0.7	0.9	0.1	2.9	2.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(6.3)	(6.5)	(0.2)	(6.1)	(6.1)	0.0
Wirral Community Health and Care NHS Foundation Trust	0.3	0.3	0.0	0.7	0.7	0.0
Wirral University Teaching Hospital NHS Foundation Trust	0.7	(2.3)	(3.0)	0.0	0.0	0.0
Total Providers	**(40.2)**	**(50.9)**	**(10.7)**	**(50.0)**	**(50.1)**	**(0.1)**

14) Five provider Trusts have reported an adverse year to date deficit position for months 1-5, resulting in an adverse position compared to plan of £10.7m.

15) Although providers continue to forecast achievement of the annual planned £50m deficit several risks will require management as a system to ensure delivery of the plan. Key pressures relate to underachievement on delivery of planned cost improvement programmes, rising inflation with regard to energy and operational pressures associated with continued provision of escalation bed capacity.

16) Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£53.5m) offset set by favourable movements in Income (£33.2m) and non-pay items (£9.6m) as per the table below.

Surplus / (Deficit)	2022/23 Year-to-date				2022/23 Forecast			
	Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend	
	£m	£m	£m	%	£m	£m	£m	%
Income excluding COVID Reimbursements	2,327.3	2,359.3	32.0	1.4%	5,596.0	5,643.0	47.0	0.8%
COVID-19 Reimbursements	5.0	6.3	1.2	24.5%	10.7	12.5	1.9	17.5%
Total Income	2,332.3	2,365.5	33.2	1.4%	5,606.7	5,655.6	48.9	0.9%
Pay	(1,515.8)	(1,569.3)	(53.5)	3.5%	(3,632.8)	(3,703.7)	(70.9)	2.0%
Non Pay	(816.1)	(809.4)	6.7	(0.8%)	(1,926.7)	(1,908.3)	18.4	(1.0%)
Non Operating Items (exc gains on disposal)	(40.6)	(37.7)	2.9	(7.2%)	(97.2)	(93.7)	3.5	(3.6%)
Total Expenditure	(2,372.5)	(2,416.4)	(43.9)	1.9%	(5,656.7)	(5,705.7)	(49.0)	0.9%
C&M NHS Providers	**(40.2)**	**(50.9)**	**(10.7)**	**0.5%**	**(50.0)**	**(50.1)**	**(0.1)**	**0.0%**

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

- **Countess of Chester NHS Foundation Trust**
  Variance to plan driven by delays in progressing the agreed cost improvement target and further investment required to support quality improvement together with significant increases in agency staffing costs. Delivery of financial plan remains a key risk.
- **Liverpool University Hospitals NHS Foundation Trust (LUFT)**
  An external financial review has been undertaken to support the Trust in its wider improvement programme, identifying the drivers of the deficit and reviewing the underlying financial position. The Trust continues to forecast in line with plan for 2022/23 and is developing a financial strategy to address the longer-term drivers of the deficit with the support of system partners.
- **Mid Cheshire NHS Foundation Trust (MCHFT)**
  In year pressures associated with the impact of rising demand for urgent care and delays to delivery of recurrent cost improvement plans. Cost Improvement

development is a key area of focus for the Trust and work continues on mitigations to support delivery of the plan.

- **Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH)**
  Small adverse variance to plan as a result of continuation of escalation bed capacity originally planned to be closed. Work continues with system partners to manage out of hospital bed capacity to support timely discharges for patients.
- **Wirral University Teaching Hospitals NHS Foundation Trust**
  The Trust set an ambitious plan to deliver a breakeven position for the year. The adverse variance to plan is a result of continuation of escalation bed capacity and slower than planned CIP delivery. It is working with system partners where out of hospital capacity is needed to support patient discharges to the most appropriate setting for their needs.

Efficiencies

ICB Efficiencies

18) The ICB is currently reporting a £2.5m favourable variance to plan YTD as a result of non-recurrent benefits released by CCGs in Q1. The ICB is currently forecasting to achieve the planned efficiencies of £68.8m. However, there remains a level of unidentified efficiency as highlighted below that requires identification in order to deliver the plan.

19) The ICB has established a programme approach to identification, development and tracking of efficiencies and this is a key focus of the corporate executive team and Place Directors. Detailed reports will be developed for future reporting periods to allow the Board to seek further assurance on delivery of the recurrent target.

Provider Efficiencies

20) Provider efficiency schemes are £10m behind plan at month 5, efficiencies of £80m have been delivered to date compared to a plan of £90m. However, only £29.8m of this has been delivered recurrently (£50.1m non-recurrently) and this is a key risk to the underlying financial position of the system. (The detail by provider is included in Appendix 3)

Risks & Mitigations

ICB Risks & Mitigations

21) Following review of the month 5 financial position a number of risks are emerging that will require actions to mitigate during the year in order for the ICB to achieve the planned surplus of £19.7m.

22) A recent ICB financial planning risk review has identified a current potential of £67.3m of 22/23 financial year risks with a series of potential mitigations assessed at a value of £55.2m leaving a residual unmitigated risk of £12.1m. Key risks are included in the table below:

Risk	Gross Risk £m	Residual Risk after Mitigations £m
Drawdown funding not received	(7.7)	(7.7)
Delegated Pharmacy over performance	(3.4)	0.0
Additional System Efficiencies	(16.1)	(3.5)
ICB Additional Efficiencies/Operational Pressures	(40.1)	(0.9)
Total ICB	**(67.3)**	**(12.1)**

23) The ICB is working alongside system partners to ensure mitigation plans are in place to manage risks including the following:

- Follow up with NHSE national team regarding the recent withdrawal of previously approved drawdown funding (and previously agreed with CCGs as part of 2:1 agreements in 2019/20) and understanding of consequential impact.
- Further discussions with NHSE regional team regarding the over performance in Delegated Pharmacy transferred to the ICB on the 1st July 2022.
- Agreement of recovery plans for 'places' currently off track to plan (Wirral, East and West Cheshire).
- Review of ICB expenditure budgets including SDF, HCP programmes.

Provider Risks & Mitigations

NHS England collect gross risk data from each provider, together with the mitigations currently being managed. A net risk position is then calculated for each system.

For Cheshire and Merseyside, £203m of gross risk is being reported across providers, with mitigations being pursued for £130m of this, leaving a net risk position of £73m. Non delivery of CIP, energy inflation, ERF clawback and pay pressures are being flagged as the main risks at month 5, however, some energy risks will be further mitigated with the recent policy announcement on energy price caps. This net risk is not reflected in forecast positions, with all Trusts continuing to report in line with plan.

Further validation of risks and the associated mitigations are required as part of Month 5 review

Other Performance Indicators

Cash

ICB

24) The ICB is expected to manage its cash balances during the year so that the closing cash balance at bank should be no greater than either 1.25% of the monthly drawdown or £250k, whichever is greater.

25) The cash balance for the ICB at the end of August was £27.4m which equates to 5.3% of the cash drawdown for August. This was higher than planned, but partly reflects further requirements to understand the cash patterns of the new organisation, budget holder responsibilities and workflow arrangements to clear invoices that were unable to be paid during the cutover period in July in order to ensure the ICB remains within the recommended balances.

C&M NHS Providers

26) From a provider perspective total cash levels as detailed in Appendix 3 have reduced by 9% from the level at the end of the 2022/23 financial year. Aggregate provider balances as at month 5 were £829.8m, compared with £912.1m at the end of 2021/22.

Better Payment Practice Code

ICB

27) The ICB Better Payment Practice Code performance by value at the end of August was,
    a. 82% of invoices to Non NHS suppliers and 100% of invoices to NHS suppliers were paid on time.
    b. performance by volume was 86% for NHS suppliers and 91% for Non NHS suppliers.
28) The target for both measures is 95% and therefore unfortunately the Better Payments Practice Code (BPPC) target was not fully met but again reflects the challenges of emerging from cut-over period.

29) A number of factors have understandably affected the ICBs ability to meet the target to date August including the setting up of the new ICB financial system and linked transfer of all legacy invoices from CCG ledgers (during the first 3 weeks of July by SBS) with subsequent coding and approval of this significant volume of invoices causing delays to payments and therefore performance measures have not been met.

30) Meeting the target as an ICB will be challenging until such time as the backlog of invoices are cleared and will continue to keep suppliers appraised on progress, but

performance will continue to be tracked / monitored in order to deliver the required cumulative position by the end of the year.

C&M NHS Providers

31) For providers as set out in the table included in Appendix 4, only 3 providers are currently meeting the targets for invoice payment by both value and number measures within the 95% target.

32) Prompt settlements of invoices to small private and charitable sector suppliers is regarded as critical, particularly considering the current economic landscape.

Capital

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

34) As per the table below, at month 5, progress of the system's operational capital programme expenditure (excluding IFRS 16 impact) remains below year-to-date planned values by £30.4. However, given that local providers only recently received notification of the System's approved operational capital priorities for 2022/23, the current level of under spend is considered reasonable and is expected to recover over forthcoming months.

35) The position in relation to the national capital programme is a £2.5m year to date underspend.

	Month 5: YTD Charge against Capital Allocation (excluding IFRS 16 impact) £m	Month 5: Forecast Charge against Capital Allocation (excluding IFRS 16 impact) £m	Month 5: YTD National programmes and other items chargeable to CDEL £m	Month 5: Forecast National programmes and other items chargeable to CDEL £m
Plan Expenditure	75.2	224.8	43.3	190.9
Actual / Forecast Expenditure	44.8	233.5	45.8	191.0
Variance to Plan (under) / over	**-30.4**	**8.8**	**2.5**	**0.1**

36) The system plans to deliver breakeven against its total 2022/23 capital limit of £224.7m through targeted management of any slippage on the 2022/23 capital envelope over the remainder of the year.

37) However, the local operational capital programme is currently forecasting an over spend of £8.8m which is relation to Mid Cheshire Reinforced Autoclaved Aerated Concrete (RAAC) which required further investigation. Further detailed information is included in Appendix 6.

Primary Care Capital

38) C&M ICB has a capital allocation of £4.7m for Primary Care, but also benefits this year from a legal charge redemption of £1.235m.

39) NHSE Primary Care commissioners have engaged with GP practices and premises grant requests totaling £1.826m in 22/23 with a further 23/24 impact of £0.846m have been received and reviewed against the requirements of the Premises Directions. ICB approval for these schemes is in the process of being granted.

40) In addition, the C&M digital lead is developing proposals for GPIT.

Mental Health Capital

41) The ICS has secured £6.7m of MH PDC capital funds alongside £11.9m C&M CDEL Operational Capital over the next three years giving a total fund of £18.6m.

42) Mental Health Capital bids were submitted totaling £15m relating to a MH Urgent Response Centre, MH Urgent Care Crisis Line and MH Urgent Treatment Centre.

43) These schemes have now received national approval conditional upon:

- Project completion in line with the programme and cashflow included in the proposal documentation.
- Ongoing progress reporting to regional leads, for onward communication to national workstream leads for the programme.
- Capturing baseline benefits data prior to project commencement, to align with anticipated outcomes as highlighted in proposal documentation, and demonstrating improvement no later than 1 year after project completion.
- Total capital cost across all proposals (including those not yet submitted) will remain within the total ICB allocation on a year-on-year basis.

44) Work is ongoing to confirm schemes to utilise the remaining £3.6m.

Recommendations

The Board is asked to:

45) Note the contents of this report in respect of the month 5 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.

Appendix 1

2022/23 plan submissions by CCG / NHS provider

CCG / ICB	Full Year Plan (Deficit) / Surplus
	£ 000's
NHS HALTON CCG	(3,340)
NHS KNOWSLEY CCG	12,051
NHS SOUTH SEFTON CCG	(4,051)
NHS SOUTHPORT AND FORMBY CCG	(6,336)
NHS ST HELENS CCG	(1,905)
NHS WARRINGTON CCG	(2,302)
NHS WIRRAL CCG	7,499
NHS CHESHIRE CCG	(27,663)
NHS LIVERPOOL CCG	18,259
Total CCG Position	(7,788)
NHS LIVERPOOL CCG - as ICB Host	27,802
Total ICB Planned (Deficit/Surplus)	**20,014**

Cheshire & Merseyside Provider Organisation	Full Year Surplus / (Deficit) £'000s
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4,630
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	2,856
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	(3,066)
EAST CHESHIRE NHS TRUST	(2,554)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2,328
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	(30,010)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	563
MERSEY CARE NHS FOUNDATION TRUST	5,698
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	(10,415)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	(14,175)
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	(4,949)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1,621
THE WALTON CENTRE NHS FOUNDATION TRUST	2,868
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	(6,106)
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	684
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	19
TOTAL	**(50,008)**

Appendix 2

System Financial Position: Combined Year-to-date Financial Position by Organisation as at Month 5 (31st August 2022)

	M5 YTD Plan £m	M5 YTD Actual £m	M5 YTD Variance £m	Annual Plan £m	M5 Forecast ACTUAL £m	M5 Forecast VARIANCE £m
CCGs/ICB	8.2	5.8	(2.4)	19.7	19.7	(0.0)
	8.2	**5.8**	**(2.4)**	**19.7**	**19.7**	**(0.0)**
Providers:						
Alder Hey Children's NHS Foundation Trust	(1.2)	(1.2)	0.0	4.6	4.6	(0.0)
Bridgewater Community Healthcare NHS Foundation Trust	(0.2)	(0.2)	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.0	1.0	0.0	2.9	2.9	0.0
Countess of Chester Hospital NHS Foundation Trust	(4.4)	(9.9)	(5.5)	(3.1)	(3.1)	(0.0)
East Cheshire NHS Trust	(1.9)	(1.9)	0.0	(2.6)	(2.6)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.0	1.0	0.0	2.3	2.3	(0.0)
Liverpool University Hospitals NHS Foundation Trust	(15.5)	(17.7)	(2.2)	(30.0)	(30.1)	(0.1)
Liverpool Women's NHS Foundation Trust	0.6	0.8	0.1	0.6	0.6	0.0
Mersey Care NHS Foundation Trust	1.7	1.7	(0.0)	5.7	5.7	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(6.2)	(6.9)	(0.7)	(10.4)	(10.4)	0.0
Southport And Ormskirk Hospital NHS Trust	(8.0)	(8.0)	0.0	(14.2)	(14.2)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(3.1)	(3.1)	0.0	(4.9)	(4.9)	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.7	1.2	0.5	1.6	1.6	(0.0)
The Walton Centre NHS Foundation Trust	0.7	0.9	0.1	2.9	2.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(6.3)	(6.5)	(0.2)	(6.1)	(6.1)	0.0
Wirral Community Health and Care NHS Foundation Trust	0.3	0.3	0.0	0.7	0.7	0.0
Wirral University Teaching Hospital NHS Foundation Trust	0.7	(2.3)	(3.0)	0.0	0.0	0.0
Total Providers	**(40.2)**	**(50.9)**	**(10.7)**	**(50.0)**	**(50.1)**	**(0.1)**
Total System	**(32.0)**	**(45.1)**	**(13.1)**	**(30.3)**	**(30.4)**	**(0.1)**

Note: brackets denote deficit/overspend.

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS Cheshire and Merseyside

Appendix 3

System Efficiencies: Current Performance and Forecast Outturn as at Month 5 (31st August 2022)

	M5 YTD Plan £m	M5 YTD Actual £m	M5 YTD Variance £m	Annual Plan £m	M5 Forecast ACTUAL £m	M5 Forecast VARIANCE £m
CCGs/ICB	28.7	35.9	7.2	68.8	68.8	(0.0)
	28.7	**35.9**	**7.2**	**68.8**	**68.8**	**(0.0)**
Providers:						
Alder Hey Children's NHS Foundation Trust	5.0	4.4	(0.6)	14.5	14.5	(0.0)
Bridgewater Community Healthcare NHS Foundation Trust	1.4	1.4	0.0	4.2	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	3.3	3.0	(0.3)	8.3	2.9	0.0
Countess of Chester Hospital NHS Foundation Trust	3.0	3.0	0.0	13.4	(3.1)	0.0
East Cheshire NHS Trust	1.6	1.6	(0.0)	5.5	(2.6)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.0	1.0	(1.0)	4.9	2.3	0.0
Liverpool University Hospitals NHS Foundation Trust	24.3	21.8	(2.6)	75.0	(30.1)	0.5
Liverpool Women's NHS Foundation Trust	2.3	2.3	(0.0)	5.6	0.6	(0.0)
Mersey Care NHS Foundation Trust	9.5	9.5	0.0	22.8	5.7	0.0
Mid Cheshire Hospitals NHS Foundation Trust	7.0	6.8	(0.2)	16.8	(10.4)	0.0
Southport And Ormskirk Hospital NHS Trust	3.3	3.3	0.0	10.8	(14.2)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	8.5	8.5	0.0	28.1	(4.9)	(0.0)
The Clatterbridge Cancer Centre NHS Foundation Trust	2.8	2.0	(0.8)	6.8	1.6	0.0
The Walton Centre NHS Foundation Trust	1.7	1.7	0.1	4.9	2.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	4.1	4.1	0.0	15.7	(6.1)	0.0
Wirral Community Health and Care NHS Foundation Trust	1.7	1.4	(0.3)	4.1	0.7	0.0
Wirral University Teaching Hospital NHS Foundation Trust	8.7	4.1	(4.6)	20.8	0.0	(0.0)
Total Providers	**90.1**	**79.8**	**(10.2)**	**262.2**	**(40.2)**	**0.5**
Total System	**118.7**	**115.7**	**(3.0)**	**330.9**	**28.5**	**0.5**

Recurrent/Non-recurrent split of Provider CIP delivery

	Recurrent Efficiencies (£m)				Non recurrent Efficiencies (£m)				TOTAL Efficiencies (£m)				
Org Name	M5 YTD Actual	M5 YTD Variance	Forecast Outturn Forecast	Forecast Outturn Variance	M5 YTD Actual	M5 YTD Variance	Forecast Outturn Forecast	Forecast Outturn Variance	M5 YTD Actual	M5 YTD Variance	Full Year Forecast	Full Year Variance	YTD as % of FOT
Alder Hey Children's NHS Foundation Trust	0.6	(2.5)	9.7	0.0	3.9	1.9	4.8	0.0	4.4	(0.6)	14.5	0.0	31%
Bridgewater Community Healthcare NHS Foundation Trust	0.5	(0.1)	1.9	0.0	0.9	0.1	2.3	0.0	1.4	0.0	4.2	0.0	34%
Cheshire and Wirral Partnership NHS Foundation Trust	1.0	0.4	2.7	0.0	2.0	(0.7)	5.6	0.0	3.0	(0.3)	8.3	0.0	36%
Countess of Chester Hospital NHS Foundation Trust	1.7	0.4	5.5	0.0	1.3	(0.4)	7.9	0.0	3.0	0.0	13.4	0.0	22%
East Cheshire NHS Trust	0.0	(1.1)	1.6	(1.9)	1.5	1.1	3.9	1.9	1.6	(0.0)	5.5	0.0	29%
Liverpool Heart and Chest Hospital NHS Foundation Trust	0.6	(1.0)	3.7	(0.1)	0.4	0.0	1.2	0.1	1.0	(1.0)	4.9	0.0	20%
Liverpool University Hospitals NHS Foundation Trust	5.9	(6.3)	32.0	0.0	15.9	3.7	43.5	0.5	21.8	(2.6)	75.5	0.5	29%
Liverpool Women's NHS Foundation Trust	1.3	(0.1)	3.8	(0.4)	0.9	0.1	1.8	0.4	2.3	(0.0)	5.6	(0.0)	40%
Mersey Care NHS Foundation Trust	6.4	(0.1)	15.6	0.0	3.1	0.1	7.2	0.0	9.5	0.0	22.8	0.0	42%
Mid Cheshire Hospitals NHS Foundation Trust	0.8	(1.5)	6.2	(0.9)	5.9	1.3	10.6	0.9	6.8	(0.2)	16.8	0.0	40%
Southport And Ormskirk Hospital NHS Trust	3.3	0.0	10.8	0.0	0.0	0.0	0.0	0.0	3.3	0.0	10.8	0.0	30%
St Helens And Knowsley Teaching Hospitals NHS Trust	4.0	(4.5)	22.1	0.0	4.5	4.5	6.0	(0.0)	8.5	0.0	28.1	(0.0)	30%
The Clatterbridge Cancer Centre NHS Foundation Trust	0.6	(1.3)	2.4	(2.0)	1.4	0.5	4.3	2.0	2.0	(0.8)	6.8	0.0	30%
The Walton Centre NHS Foundation Trust	0.6	(0.6)	2.0	(2.1)	1.1	0.6	2.9	2.1	1.7	0.1	4.9	0.0	35%
Warrington and Halton Teaching Hospitals NHS Foundation	0.7	(0.8)	6.5	0.0	3.3	0.8	9.2	0.0	4.1	0.0	15.7	0.0	26%
Wirral Community Health and Care NHS Foundation Trust	0.6	(0.5)	2.7	(0.0)	0.8	0.2	1.4	0.0	1.4	(0.3)	4.1	0.0	33%
Wirral University Teaching Hospital NHS Foundation Trust	1.1	(4.6)	13.7	(0.2)	3.0	0.1	7.2	0.2	4.1	(4.6)	20.8	(0.0)	20%
C&M Provider TOTAL	**29.8**	**(24.1)**	**142.8**	**(7.7)**	**50.1**	**13.9**	**119.9**	**8.2**	**79.8**	**(10.2)**	**262.7**	**0.5**	**30%**

Appendix 4

Provider Cash: Cash balances as at Month 5 (31st August 2022)

PROVIDER:	MONTH 5 ACTUAL £m	31/03/2022 BALANCE £m	% INCREASE TO MONTH 12 £m
Alder Hey Children's NHS Foundation Trust	80.5	91.5	(12.0%)
Bridgewater Community Healthcare NHS Foundation Trust	25.1	26.2	(4.1%)
Cheshire and Wirral Partnership NHS Foundation Trust	36.1	41.1	(12.1%)
Countess of Chester Hospital NHS Foundation Trust	35.4	40.9	(13.4%)
East Cheshire NHS Trust	40.6	37.3	8.8%
Liverpool Heart and Chest Hospital NHS Foundation Trust	41.3	42.7	(3.3%)
Liverpool University Hospitals NHS Foundation Trust	162.3	211.4	(23.2%)
Liverpool Women's NHS Foundation Trust	6.6	11.2	(41.1%)
Mersey Care NHS Foundation Trust	98.1	84.2	16.5%
Mid Cheshire Hospitals NHS Foundation Trust	26.0	26.7	(2.7%)
Southport And Ormskirk Hospital NHS Trust	6.1	18.5	(66.9%)
St Helens And Knowsley Teaching Hospitals NHS Trust	62.2	54.2	14.9%
The Clatterbridge Cancer Centre NHS Foundation Trust	77.4	80.7	(4.1%)
The Walton Centre NHS Foundation Trust	39.4	40.7	(3.3%)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	40.7	44.7	(8.8%)
Wirral Community Health and Care NHS Foundation Trust	19.2	23.8	(19.3%)
Wirral University Teaching Hospital NHS Foundation Trust	32.6	36.4	(10.4%)
Total Providers	**829.8**	**912.1**	**-9%**

Appendix 5

Provider BPPC: Performance against BPPC targets as at Month 5 (31st August 2022)

Providers	Month 5 22/23			
	BPPC Non NHS - By Number	BPPC Non NHS - By Value	BPPC NHS - By Number	BPPC Non NHS - By Value
Alder Hey Children's NHS Foundation Trust	63.2%	68.0%	86.7%	81.5%
Bridgewater Community Healthcare NHS Foundation Trust	100.0%	99.6%	99.3%	99.5%
Cheshire and Wirral Partnership NHS Foundation Trust	86.3%	77.1%	89.9%	94.9%
Countess of Chester Hospital NHS Foundation Trust	93.9%	83.8%	90.5%	91.1%
East Cheshire NHS Trust	99.6%	94.4%	95.2%	96.6%
Liverpool Heart and Chest Hospital NHS Foundation Trust	99.6%	98.0%	98.5%	96.6%
Liverpool University Hospitals NHS Foundation Trust	97.0%	84.1%	93.2%	90.1%
Liverpool Women's NHS Foundation Trust	83.8%	44.1%	85.2%	80.2%
Mersey Care NHS Foundation Trust	92.3%	94.5%	94.0%	95.2%
Mid Cheshire Hospitals NHS Foundation Trust	95.0%	67.8%	91.2%	90.8%
Southport And Ormskirk Hospital NHS Trust	94.8%	80.2%	95.3%	90.8%
St Helens And Knowsley Teaching Hospitals NHS Trust	89.4%	97.1%	97.3%	96.8%
The Clatterbridge Cancer Centre NHS Foundation Trust	99.1%	98.7%	99.7%	98.3%
The Walton Centre NHS Foundation Trust	74.3%	57.3%	87.8%	88.2%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	85.4%	83.4%	92.5%	92.7%
Wirral Community Health and Care NHS Foundation Trust	83.3%	88.0%	91.9%	89.9%
Wirral University Teaching Hospital NHS Foundation Trust	95.5%	91.0%	95.3%	95.3%

Appendix 6

Provider Capital: Current Performance and Forecast Outturn as at Month 5 (31st August 2022)

(based on formal reporting to NHSEI)

PROVIDER:	M5 YTD PLAN £m	M5 YTD ACTUAL £m	M5 YTD VARIANCE £m	ANNUAL PLAN £m	M5 FORECAST ACTUAL £m	M5 FORECAST VARIANCE £m
Alder Hey Children's NHS Foundation Trust	1.8	1.6	0.2	8.9	8.9	0.0
Bridgewater Community Healthcare NHS Foundation Trust	1.3	0.1	1.2	2.1	2.1	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.4	0.8	0.7	2.6	2.6	0.0
Countess of Chester Hospital NHS Foundation Trust	4.6	4.7	(0.1)	19.9	19.9	0.0
East Cheshire NHS Trust	2.5	0.5	2.0	6.1	6.1	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	3.1	2.6	0.5	11.3	11.3	0.0
Liverpool University Hospitals NHS Foundation Trust	22.5	9.8	12.6	62.6	62.6	0.0
Liverpool Women's NHS Foundation Trust	5.5	2.9	2.5	8.8	8.8	0.0
Mersey Care NHS Foundation Trust	2.1	0.8	1.3	11.1	10.9	0.1
Mid Cheshire Hospitals NHS Foundation Trust	8.5	7.6	0.9	29.0	38.0	(8.9)
Southport And Ormskirk Hospital NHS Trust	2.8	1.7	1.1	11.3	11.3	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	2.4	1.0	1.4	4.5	4.5	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	2.9	0.1	2.8	7.0	7.0	(0.0)
The Walton Centre NHS Foundation Trust	2.3	0.6	1.7	5.7	5.7	0.0
Warrington and Halton Teaching Hospitals NHS Foundation	3.6	3.2	0.4	12.5	12.5	0.0
Wirral Community Health and Care NHS Foundation Trust	2.7	2.1	0.6	9.4	9.4	0.0
Wirral University Teaching Hospital NHS Foundation Trust	5.2	4.6	0.6	11.9	11.9	0.0
Total Charge against System Operational Capital	**75.2**	**44.8**	**30.4**	**224.8**	**233.5**	**(8.8)**

Note: brackets denote deficit/overspend

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Quality and Performance Report

29 September 2022

Agenda Item No	ICB/9/22/**14**
Report author & contact details	Anthony Middleton, Director of Planning and Performance Christine Douglas MBE, Director of Nursing and Care Rowan Pritchard – Jones, Medical Director
Report approved by (sponsoring Director/ Chair)	-
Responsible Officer(s) to take actions forward	Anthony Middleton, Director of Planning and Performance Christine Douglas MBE, Director of Nursing and Care Rowan Pritchard – Jones, Medical Director

NHS Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Quality and Performance Report (September 2022)

Executive Summary	The attached presentation provides on overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact and mitigations.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** • **note** the contents of the report and take assurance on the actions contained.				

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

Appendices	**Appendix A**	Quality and Performance Report September 2022

NHS
Cheshire and Merseyside

Cheshire & Merseyside ICB
Quality and Performance Report

Agenda Item No	**ICB/9/22/14**
Report author & contact details	Anthony Middleton, Director of Planning and Performance Christine Douglas MBE, Director of Nursing and Care Rowan Pritchard – Jones, Medical Director
Report approved by (sponsoring Director)	-
Responsible Officer(s) to take actions forward	Anthony Middleton Christine Douglas MBE Rowan Pritchard Jones

Sentinel Indicators – 22/23

NHS
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National Performance Ambitions	Risk at 1st Draft Stage	Expected Risk (final)
Eliminate 104 week waiters by the end of June 2022		
Eliminate 78 week waiters by the end of March 2023		
25% reduction in outpatient follow up attendances		
5% of outpatient attendances to convert to PIFU pathways		
10% more patients to complete treatment through a combination of completed pathways (4% via clock stops and 6% via Advice & Guidance deflections)		
Increase day cases, ordinary admissions, OPFA and OP with procedures (excluding OPFU) by 10% on 2019/20 levels **(to attract ERF)**		
Increase diagnostic activity to 120% pre-pandemic levels **(issues with specific modalities)**		
Improvements to cancer treatments against cancer standards (62 days urgent ref to 1st treatment, 28 faster diagnosis & 31 day decision to treat to 1st treatment)		

Ref RB HH 2022-08-23

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Graham Urwin
Chief Executive
Cheshire and Mersey ICB

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23 August 2022

By email

Dear Graham

I am writing to acknowledge receipt of the Cheshire and Merseyside Health and Care Partnership Integrated Care Systems (ICS) final operating plan for 2022/23 and set out next steps.

The objectives set out in 2022/23 priorities and operational planning guidance were based on COVID-19 returning to a low level. Your plan has been developed in the context of a changing external environment as a result of new COVID-19 variants and the impact of wider economic factors on the costs of delivery. Although it is inevitable that the ongoing level of healthcare demand from COVID-19 will impact on systems' ability to fully deliver on some of these objectives, we must continue to build on the progress made to date and target recovery of activity as COVID-19 infection rates fall.

As set out in the recent letter to Chief Executives and Finance Directors, systems and providers will be funded for the pay award. However, as the pay award is above the level the Government funded in the NHS settlement last year, it means that we must now re-prioritise resources nationally. We will do this alongside providing investment to maintain safe services, including the creation of additional bed capacity.

NHS England has reviewed your submission in this context, and we have set out below some key elements of your plan that require further review and follow up action. Please could you share this letter with your full Board for consideration. In addition to the elements of your plan described below there are some technical issues that require follow up action, these items will be picked up in detailed feedback from the appropriate NHS England lead.

Elective and cancer care

Systems should continue to focus on meeting the ambitions to reduce long waits for elective care and the cancer backlog over the rest of this year.

The plans submitted by your system included ambitious trajectories for the recovery of elective care and diagnostic activity from quarter one onwards when compared to recent activity levels and the focus by the system now needs to be on the implementation of actions to deliver the trajectories and maintain this over the coming winter period to ensure the delivery of the trajectories for 78 week waits, 52 week waits and the reduction of the cancer.

It is acknowledged that the system is planning to achieve the 78 week target, but this will require focused attention during the remainder of the year to ensure delivery.

Although the 62 cancer backlog target is planned to be achieved in plans, Tier 1 and Tier 2 meetings are now being established to monitor this process with particular providers of concern for both 78ww and 62 day cancer backlog patients. A continued focus with these providers is needed to support, momentum, and delivery.

There needs to be further work undertaken by the system to reduce the number of follow up Outpatient appointments and Patient Initiated Follow Up appointments to achieve the national ambition.

In relation to diagnostic recovery the system needs to do further work to achieve the national target

Emergency care and system resilience

Systems should continue to focus on meeting the ambitions to reduce long waits for elective care and the cancer backlog over the rest of this year.

At the same time, it is acknowledged that unrelenting non-elective pressures persist, and this is having an impact not just on patient flow but also delivery of services in the round.

Throughout July, most acute trusts across Cheshire & Merseyside were operating at 92%+ G&A bed occupancy. And as of 24 July, there were just over 1,000 patients in hospital beds across C&M with no criteria to reside but who had not yet been discharged. This figure equates to just under 23% of C&M's acute hospital bed base.

All of which is contributing to increased patient safety risks within emergency departments that are routinely being forced to accommodate more patients than normal capacity would allow. Over the course of the end of June/beginning of July, 13.7% of all patients who presented to an emergency department across C&M spent longer than 12 hours from time of arrival in ED. Similarly 5.2% of all ambulances arriving at a hospital across C&M were delayed for over 60 waiting to hand over their patient to the ED team.

Recognising the current set of demands on systems, it is critical that we continue to increase capacity in and out of hospitals to support performance and patient flow, particularly in emergency services. NHS England will continue to work with you on plans to increase capacity to reduce ambulance delays and long waits in Emergency Departments as part of the current operational response and ahead of winter. We will confirm funding and plans to support these goals including the funding for virtual wards over the coming weeks.

Mental health and Learning Disability and Autism

- Mental health
    - MHIS achievement – The MHIS is the minimum investment expected within the Mental Health Operational Plan. Cheshire and Merseyside reported a planned over-delivery of £3.1m which was identified as an error due to incorrect inflation assumptions in Warrington and Halton Place. The revised and expected forecast outturn the ICS will report in-year will be £0.95m over-delivery due inflationary

increase assumptions in Prescribing and Continuing Health Care. Further to discussion in the regional July 22 Triangulation meetings, the ICS is requested to consider the reported higher than average planned spend on Prescribing and complex placements.

- Cumulative growth against Long Term Plan (LTP) trajectories, highlighting areas where systems are investing below 85% of LTP analytical tool expected growth (investment in ambulance response and perinatal investment is particularly low across a large number of systems) – Cheshire and Merseyside report investment below 85% of the LTP analytical tool expected growth in three categories: Ambulance Response, IAPT and CYP Eating Disorders. It is noted that a significant increase in investment levels in Ambulance Response is anticipated in 2023/24, following the announcement of the Capital Funding for additional Mental Health Response Vehicles and current indication reflect that a total of three vehicles are to be requested for Cheshire and Merseyside. Feedback from the system regarding challenges in separating out levels of investment across the CYP and CYP Eating Disorder categories is also noted, including that the CYP category reflects an investment level of 144% of LTP analytical tool expected growth. It is also noted that investment in IAPT is subject to confirmation of trainee numbers and that this will be reviewed and updated by the system. ICB's wishing to request rebasing to correct any material MHIS errors will have an opportunity in September 22 (5-16) with regional review/assurance 19-23rd. Further details on this will be provided by the Regional Finance team.
- Activity Metric Performance – In particular highlighting the importance of (1) CYP access if plan is below trajectory as we have seen an increase demand for services across the country and (2) SMI physical health checks which were heavily affected by the pandemic. Cheshire and Merseyside plans to achieve 9 out of 13 of the MH LTP activity targets in 2022/23. Recovery action plans have been developed for those LTP activity targets unlikely to be met which include Perinatal Mental Health Access, Access to Psychological Therapies, Zero Inappropriate Out of Area Placements and Individual Placement and Support access. Recovery plans will be assured through the Regional Triangulation meetings and quarterly "Deep Dive" meetings with the National Team.
- Overall Workforce growth and take up of new roles for example Psychological Wellbeing Practitioner as there are more new roles being trained than take up in system plans – The National team have recognised that systems will configure their workforce models in line with local need, and the analysis provided for systems to compare their workforce growth to the LTP analytical tool's workforce growth is intended to be highly indicative for this reason. Cheshire and Merseyside are reporting lower than expected levels of workforce growth in Perinatal, IAPT, Community Mental Health, Adult Community Crisis and a reduction in Acute Inpatient all of which require review to ensure the planned workforce growth will enable the achievement of the MH LTP Activity set out in the operational plan. Workforce growth in Children and Young People is reported to be 271% of indicative growth in the LTP Analytical Tool, it is recommended that this is reviewed in terms of achievability.

- Learning disability and autism
  - Adult inpatient trajectories

Finance

Delivering system-level financial balance remains a key requirement for all ICBs. We are pleased to see that you have submitted a balanced plan, noting the £30m deficit related to LUHFT's hospital move in September 2022.

The additional funding provided to systems during the planning round was provided on the basis that the following ongoing conditions are adhered to:

- Commit to recurrent delivery of efficiency schemes from quarter 3 to achieve a full year effect in 2023/24 to compensate for any non-recurrent measures required to achieve 22/23 plans.
- Fully engage in national pay and non-pay savings initiatives which we plan to launch in the coming months, in particular around national agreements for medicines and other non-pay purchasing.
- Monitoring of agency usage by providers, and compliance with usage and rate limits.
- Compliance with a similar set of conditions in relation to bank staff
- Any consultancy spend above £50,000 and any non-clinical agency usage require prior approval from the NHS England regional team.
- Internal audit to be commissioned to produce a report covering the Healthcare Financial Management Association (HFMA) publication - Improving NHS financial sustainability: are you getting the basics right?
- Systematically review excess inflation figures in plans. Further details of this process will be issued in due course.
- and
- Ongoing review of additional costs associated with LUHFT's hospital move.

Workforce

- Planning a total Acute, Ambulance, Community, Mental and Specialist health workforce increase of +2% (+1,477 WTE). Within this, substantive staff are planned to increase by +3.2% (+2,195 WTE), and bank and agency use are planned to decrease by -11.4% and -10.2% respectively (-551 WTE and -167 WTE).
- Within the substantive plans, registered nursing, midwifery, and health visiting staff are showing a planned increase of +5.1% (+1,035 WTE), which would result in a vacancy rate of 4.9% at end March 2023. Allied health professionals are planned to increase by +4.7% (+225 WTE), support to clinical staff by +3.5% (+618 WTE) and medical and dental staff by +3.1% (+193 WTE).
- In Primary Care, the total workforce is planned to increase by +4.5% (+305 WTE). There is growth in all staff groups, but Direct Patient Care roles (Additional Roles Reimbursement Scheme funded) have been particularly prioritised with an increase of +8.9% (+57 WTE).
- Nursing and midwifery – Adult, Mental Health and Learning Disability will prove challenging in 22/23, with higher growth forecasts than we are likely to see based on current projections for net supply (using observed behaviour, supplemented with latest intel including retention, changes in training numbers etc). Midwives and child expansions may be possible. It is difficult to comment on the remaining Nursing & Midwifery staff groups, but they are likely to be challenging, as they will inevitably

recruit from the rest of the Nursing & Midwifery workforce, plus will require appropriate training to develop the workforce (especially for the Intensive Care Unit expansions and in community nursing).
    - Therapeutic radiography is likely to prove challenging.
    - For medical and dental - acute internal medicine and medical oncology will prove most challenging for the expansion identified.
    - For healthcare science \ technical staff there is a planned increase of +5% (250) across the North West, this would appear consistent with additional activity, but there is no detail on which staff groups that would include. As such it is difficult to provide assessment of the supply \ demand equation.
- For other staff groups, it is more difficult to provide comment as they either haven't been 'split out' at appropriate staff group level (i.e., Health Care Science staff groupings) and from which to be able to do a supply \ demand assessment, or the workforce is dependent on factors which are not influenced by education and training, i.e., Administrative & Clerical or managerial roles.
- 2-hour urgent community response for Cheshire & Merseyside +82%.
- Workforce Supply remains the most significant risk. Workforce gaps are being driven by national and international shortages of some roles. Competition from local employers for talent in non- clinical roles is growing, particularly in the retail and hospitality sector where pay is often above NHS rates of pay (specifically at B2/3).

ICBs should monitor delivery against their workforce plans and work with colleagues at all levels to consider whether actions to improve substantive recruitment, retention and staff health and wellbeing are sufficient to meet workforce demand.

Triangulation

Delivery of plans should continue to be monitored and reviewed regularly with regards to the triangulation of Finance, Workforce, and Productivity.

Next Steps

We will continue to work with you to address the issues highlighted above and ensure you are able to access the necessary development support to strengthen the system' capability and capacity for delivery.

We will review progress in context of the changing external environment through our regular monitoring meetings.

If you wish to discuss the above or any related issues further, please let me know.

Yours sincerely

Richard Barker

Regional Director (North West)

Performance Report : Sections

NHS
Cheshire and Merseyside

Performance Report : Board Summary

NHS Cheshire and Merseyside

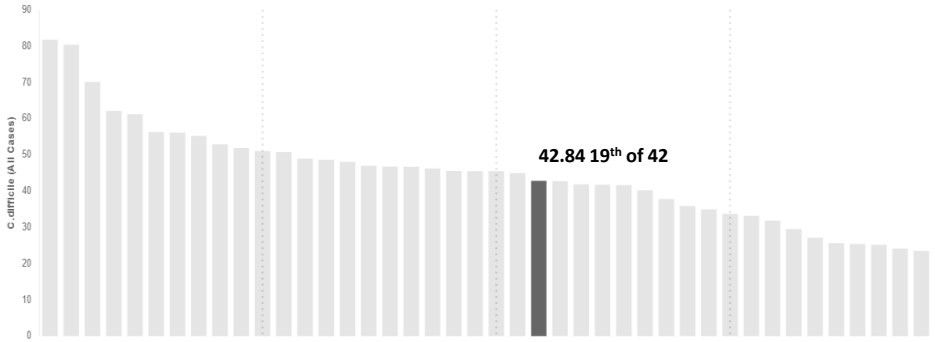
Sentinel Metrics	Issue explanation/cause	Mitigating Actions and impact	Date
Urgent Care	• Demand across all access points exceeding pre-covid levels, with high occupancy levels in Acute sectors. • Workforce challenges affecting all sectors including social care with patients no longer requiring acute care at very high levels. • Ability to maintain ambulance response times across all categories challenging.	• 22/23 Winter planning – ICB led • Place "best practice checklist" for discharge and admission avoidance developed. • Non recurrent bed capacity schemes mobilised using national funding. • Virtual Ward Roll expansion. • NWAS single triage development. • C&M integral to NWAS hospital turnaround improvement programme	• August • End of Sept • From Sept • March '23 • Aug/Sept • October
Planned Care	• Comparatively strong recovery of activity levels with reducing long waits. • 2 providers holding greatest risk around 78 week waits.	• Risk assessed against winter plan • Independent sector now integral to elective programme • Mutual aid between providers across C&M and NW • Outpatient transformation schemes	• Ongoing
Cancer Care	• Activity surpassing pre-covid levels • Backlog reducing although remains comparatively high. • Capacity challenges in small number of diagnostic modalities.	• Expansion of community diagnostic hubs • Mutual aid / Combined waiting lists • Expansion of community diagnostic hubs	• 2023/24 • Ongoing
Primary Care	• Primary care demands high • Total primary care activity above pre-covid baseline	• Service model delivery – face to face, telephone, virtual • Variation at place being managed via PCN's	• Ongoing

Section I: Quality, Access, Outcomes and People

Section I: Quality, Access, Outcomes and People: Clostridium difficile infections

NHS Cheshire and Merseyside

C.Difficile infection counts and 12-month rolling rates of all cases



C.Difficile infection counts and 12-month rolling rates of all cases **ICS/NW/England**

Summary

Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	**41.62**	**42.08**	**42.84**
North West	**53.39**	**53.39**	**51.87**
England	**44.26**	**44.52**	**45.48**

C.Difficile infection counts and 12-month rolling rates of all cases

Provider Trend

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Alder Hey	7.56	7.38	7.21	7.04	6.79	6.58	7.95	7.95	6.36	6.36	-	-
Countess of Chester Hospital	51.79	53.19	57.34	62.32	60.62	60.26	61.34	64.87	64.16	66.28	-	-
East Cheshire	18.55	13.18	12.98	11.79	12.51	12.28	10.19	10.19	11.11	12.04	-	-
Liverpool Heart and Chest	24.66	23.79	22.99	19.76	18.91	15.93	13.11	10.93	8.74	6.56	-	-
Liverpool University Hospitals	42.34	43.79	46.00	45.86	45.76	45.50	45.03	45.22	47.86	48.81	-	-
Liverpool Women's	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-
Mid Cheshire Hospitals	19.12	17.20	17.99	17.18	19.13	17.98	19.90	21.43	22.45	22.45	-	-
Southport and Ormskirk Hospital	60.80	64.55	59.61	55.60	51.50	52.58	54.38	54.38	51.91	54.38	-	-
St Helens and Knowsley	50.43	48.70	47.43	45.76	45.81	44.33	42.83	40.49	40.49	41.66	-	-
The Clatterbridge Cancer Centre	90.69	101.94	107.83	104.15	100.62	101.88	110.97	115.08	110.97	115.08	-	-
The Walton Centre	21.11	18.18	20.47	22.68	22.34	19.59	19.30	21.72	16.89	14.48	-	-
Warrington and Halton Hospitals	40.95	37.09	37.28	37.45	38.41	40.48	39.76	40.31	39.21	35.89	-	-
Wirral University Teaching Hospital	56.23	56.08	54.17	49.65	55.19	56.81	59.61	62.17	63.45	66.43	-	-

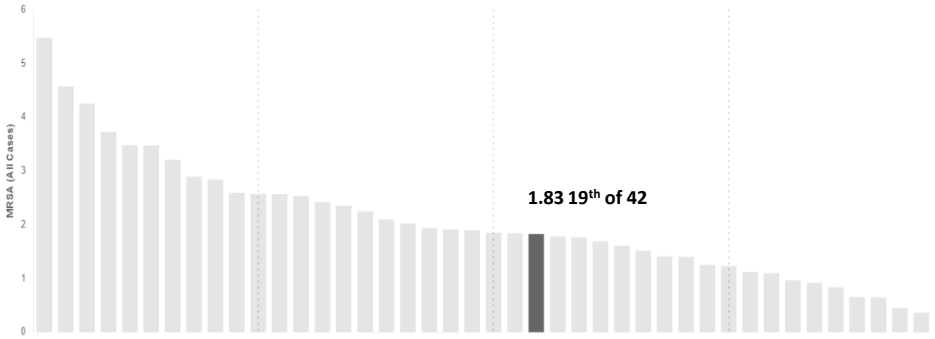
The number of C.Difficile infections (all cases) for the last 12 months/ The rolling 12 Month average occupied bed days per 100,000 beds

Section I: Quality, Access, Outcomes and People

Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia infections

NHS Cheshire and Merseyside

MRSA bacteraemia all cases counts and 12-month rolling rates



MRSA bacteraemia all cases counts and 12-month rolling rates **ICS/NW/England**

Summary

Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	**1.83**	**1.73**	**1.83**
North West			
England	**2.03**	**2.05**	**1.87**

MRSA bacteraemia all cases counts and 12-month rolling rates

Provider Trend

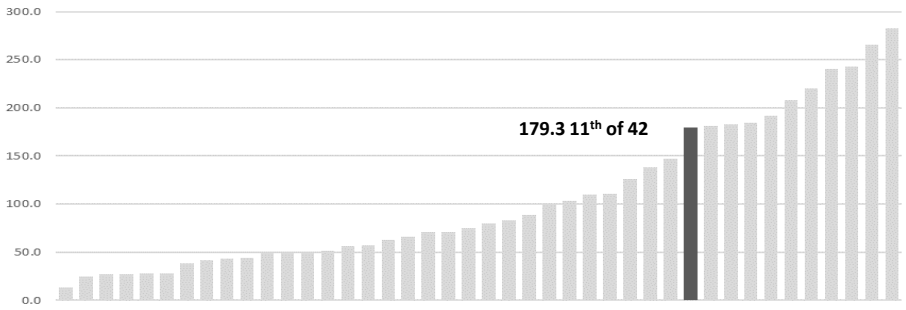
Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Alder Hey	0.00	0.00	1.80	1.76	1.70	1.65	1.59	1.59	1.59	1.59	-	-
Countess of Chester Hospital	0.66	1.35	1.37	1.38	1.39	1.40	1.41	1.41	1.41	1.41	-	-
East Cheshire	2.06	2.03	2.00	1.97	1.93	1.89	2.78	3.70	3.70	3.70	-	-
Liverpool Heart and Chest	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-
Liverpool University Hospitals	1.58	1.37	1.55	1.35	1.34	1.71	1.51	1.89	1.51	1.70	-	-
Liverpool Women's	3.86	3.80	3.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-
Mid Cheshire Hospitals	1.09	1.07	1.06	1.56	1.55	1.54	1.53	1.53	1.53	2.55	-	-
Southport and Ormskirk Hospital	2.64	3.49	3.46	3.42	3.38	3.34	3.30	3.30	3.30	3.30	-	-
St Helens and Knowsley	2.05	2.03	1.61	1.59	1.58	1.57	1.56	1.56	1.56	1.17	-	-
The Clatterbridge Cancer Centre	0.00	0.00	0.00	4.53	4.37	4.25	4.11	4.11	4.11	4.11	-	-
The Walton Centre	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-
Warrington and Halton Hospitals	0.00	0.00	0.56	0.56	0.56	1.11	1.10	1.10	1.10	1.66	-	-
Wirral University Teaching Hospital	0.45	0.45	0.44	1.32	1.30	1.72	2.13	2.13	2.13	1.70	-	-

The number of MRSA infections (all cases) for the last 12 months / The rolling 12 Month average occupied bed days per 100,000 beds

Section I: Quality, Access, Outcomes and People: Digital Weight Management Services

Cheshire and Merseyside

Number of referrals to NHS digital weight management services - crude rate per 100,000 population



Number of referrals to NHS digital weight management services - crude rate per 100,000 population

ICS/NW/England Summary

Organisation	Q2 21/22	Q3 21/22	Q4 21/22
Cheshire and Merseyside	**31.3**	**83.5**	**179.3**
North West	**28.1**	**76.1**	**137.7**
England			**111.6**

Number of referrals to NHS digital weight management services - crude rate per 100,000 population

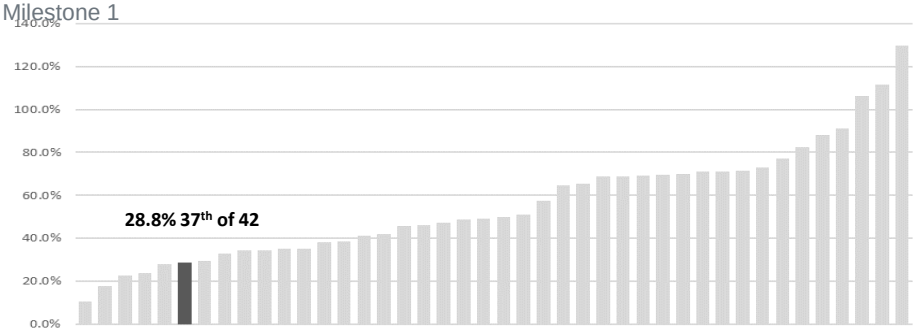
Provider Trend

Organisation	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Cheshire	1.2	24.3	73.0	139.9
Halton	0.0	0.0	6.9	294.3
Knowsley	0.0	58.5	106.8	117.8
Liverpool	0.3	66.9	156.3	408.4
South sefton	0.0	10.2	4.7	40.1
Southport & Formby	0.0	11.6	194.2	283.9
St Helens	0.0	32.6	64.5	154.6
Warrington	0.6	23.0	25.4	13.3
Wirral	0.0	13.6	58.4	54.1

Section I: Quality, Access, Outcomes and People: Diabetes Prevention programme

NHS
Cheshire and Merseyside

The number of people who have achieved Milestone 1 of the NHS Diabetes Prevention Programme, as a proportion of the number of people profiled to achieve Milestone 1



The number of people who have achieved Milestone 1 of the NHS Diabetes Prevention Programme, as a proportion of the number of people profiled to achieve Milestone 1

ICS/NW/England Summary

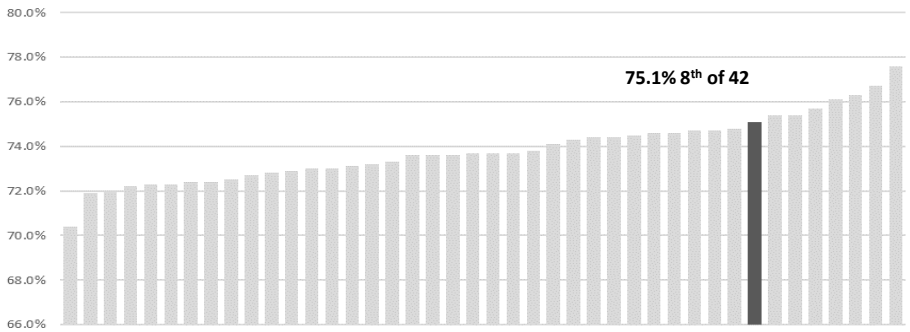
Organisation	Q2 21/22	Q3 21/22	Q4 21/22
Cheshire and Merseyside	27.5%	25.3%	28.8%
North West	32.1%	31.1%	35.0%
England			55.6%

The number of people who have achieved Milestone 1 of the NHS Diabetes Prevention Programme, as a proportion of the number of people profiled to achieve Milestone 1

Section I: Quality, Access, Outcomes and People: Cancer – proportion of people that survive at lest 1 year after diagnosis

NHS
Cheshire and Merseyside

Cancer – proportion of people that survive at lest 1 year after diagnosis



Cancer – proportion of people that survive at lest 1 year after diagnosis
ICS/NW/England Summary

Organisation	2018
Cheshire and Merseyside	**75.1%**
North West	**74.2%**
England	**73.8%**

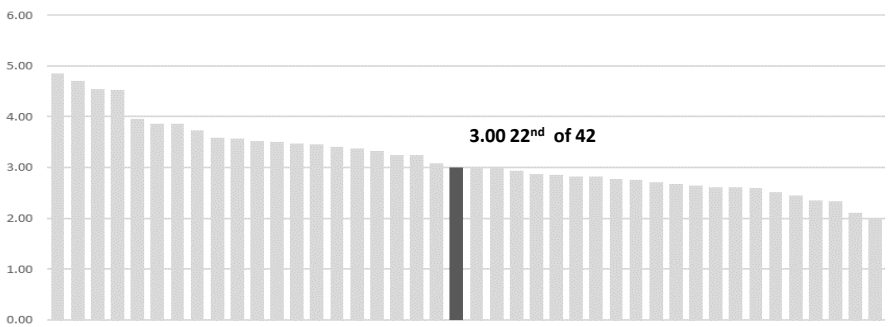
Cancer – proportion of people that survive at lest 1 year after diagnosis

Place	2018
Cheshire	76.1%
Halton	73.4%
Knowsley	73.5%
Liverpool	73.7%
South Sefton	74.8%
Southport & Formby	76.8%
St Helens	74.8%
Warrington	74.7%
Wirral	76.0%

Section I: Quality, Access, Outcomes and People: Maternity – number of still births per 1,000 total births

NHS Cheshire and Merseyside

Maternity – number of still births per 1,000 total births



Maternity – number of still births per 1,000 total births

ICS/NW/England Summary

Organisation	2018	2019
Cheshire and Merseyside	**3.27**	**3.00**
North West	**3.67**	**3.51**
England		**3.20**

Maternity – number of still births per 1,000 total births

Organisation	2018	2019
Countess of Chester		1.63
East Cheshire		2.01
Liverpool Women's	3.90	3.70
Mid Cheshire Hospitals	3.11	2.74
Southport & Ormskirk Hospitals		0.00
St Helens & Knowsley		3.04
Warrington & Halton Hosptials		1.90
Wirral Community	3.14	5.01

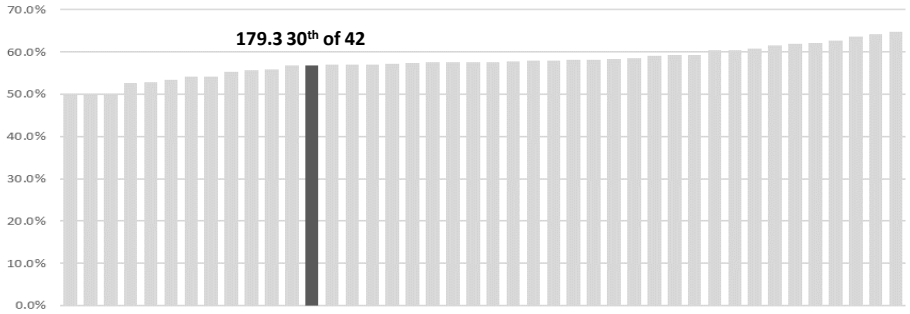
Place	2018	2019
Cheshire		
Halton		2.87
Knowsley	3.48	2.07
Liverpool	3.72	3.55
South Sefton	2.95	4.00
Southport & Formby		
St Helens	4.12	5.58
Warrington		
Wirral	2.77	4.73

* Small number suppression in effect

Section I: Quality, Access, Outcomes and People: % Of staff selecting Agree or Strongly Agree - My organisation takes positive action on health and well-being (2021)

NHS
Cheshire and Merseyside

% of staff selecting Agree or Strongly Agree - My organisation takes positive action on health and well-being (2021)



% of staff selecting Agree or Strongly Agree - My organisation takes positive action on health and well-being (2021) **ICS/NW/England Summary**

Organisation	2021
Cheshire and Merseyside	**56.9%**
North West	**55.8%**
England	**57.0%**

% of staff selecting Agree or Strongly Agree - My organisation takes positive action on health and well-being (2021)

Provider

Organisation	2021
Alder Hey	66.1%
Countess of Chester	42.5%
East Cheshire	58.8%
Liverpool heart & Chest	68.5%
Liverpool University Hospitals	47.6%
Liverpool Women's	55.0%
Mid Cheshire Hospitals	60.6%
Southport & Ormskirk Hospitals	56.3%
St Helens & Knowsley	60.0%
The Clatterbridge Cancer Centre	55.4%
The Walton Centre	65.5%
Warrington & Halton Hosptials	63.8%
Wirral University teaching Hospital	50.0%
Cheshire & Wirral Partnership	63.0%
Mersey Care	60.6%
Bridgewater Community Healthcare	63.3%
Wirral Community	54.3%

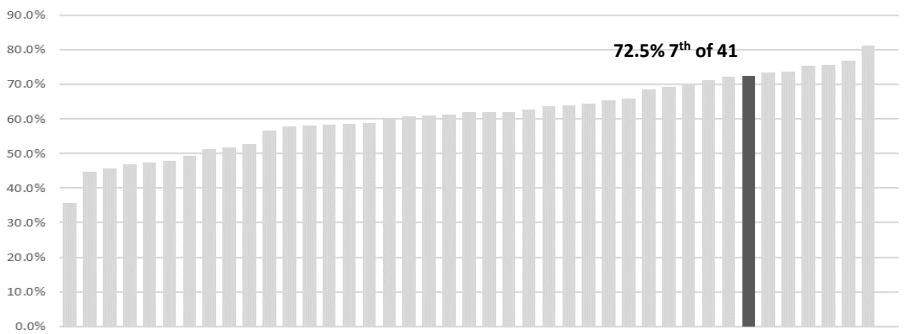
CCG

Organisation	2021
Cheshire	60.3%
Halton	-
Knowsley	-
Liverpool	-
South Sefton	75.9%
Southport & Formby	75.9%
St Helens	-
Warrington	-
Wirral	-

Section I: Quality, Access, Outcomes and People:
Staff flu vaccination rates - Providers

NHS
Cheshire and Merseyside

Staff flu vaccination rates - Providers



Staff flu vaccination rates – Providers

ICS/NW/England Summary

Organisation	Dec 21	Jan 22	Feb 22
Cheshire and Merseyside	**70.7%**	**71%**	**72.5%**
North West			
England	**59.5%**	**60.4%**	**61.1%**

Staff flu vaccination rates - Providers

Provider

Organisation	Nov-21	Dec-21	Jan-22	Feb-22
Alder Hey	53.7%		53.7%	53.7%
Countess of Chester	80.7%	84.3%	85.3%	85.3%
East Cheshire	56.4%	56.4%	59.2%	54.8%
Liverpool Heart & Chest	63.7%	66.3%	65.9%	67.3%
Liverpool University Hospitals	72.3%	86.2%	86.7%	86.7%
Liverpool Women's	54.3%	56.1%	57.0%	57.0%
Mid Cheshire Hospitals	68.7%	78.0%	76.7%	79.0%
Southport & Ormskirk Hospitals	53.0%	62.6%		
St Helens & Knowsley	59.1%	66.5%	70.1%	72.1%
The Clatterbridge Cancer Centre	58.1%	63.7%		
The Walton Centre	52.7%	56.9%	57.3%	57.3%
Warrington & Halton Hosptials	53.9%	56.5%	57.0%	
Wirral University teaching Hospital	56.3%	64.3%	66.9%	65.2%
Cheshire & Wirral Partnership	46.1%	56.1%	59.4%	58.6%
Mersey Care	40.1%	58.6%	61.5%	61.6%
Bridgewater Community Healthcare	55.2%	62.4%	68.8%	68.1%
Wirral Community	51.9%	67.6%	72.3%	71.6%

Section II: Urgent Care

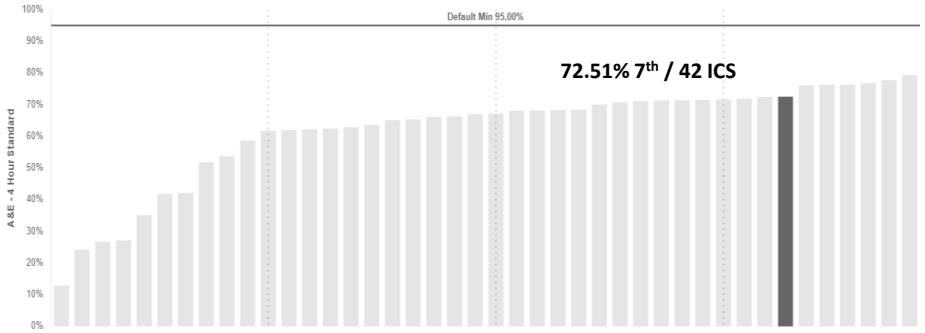
Sentinel Metrics:-

- The % of people seen within 4 hours of arrival at AED (all attendance types)
- The % of people seen within 4 hours of arrival at AED (all attendance types) AED attendances (Type 1)
- % of pre-COVID activity (Mar 19-Feb 20)
- Ambulance Response Times (Average Minutes)
- Ambulance Handover Times (Average Minutes)
- Beds Occupied by people who do not meet the criteria to reside (%)

Section II: Urgent Care Performance: The % of people seen within 4 hours of arrival at AED (all attendance types)

NHS Cheshire and Merseyside

AED 4 Hr Performance ICS National Benchmark:



AED 4 Hr Performance ICS Benchmark

Organisation	May-22	Jun-22	Jul-22	Aug-22 *
Cheshire and Merseyside	71.85%	72.09%	71.07%	72.51%
North West	71.18%	69.81%	69.21%	N/A
England	65.07%	64.31%	71.00%	N/A

** August Position is latest unpublished data*

AED 4 Hr Performance ICS Provider Trend

ICS Providers

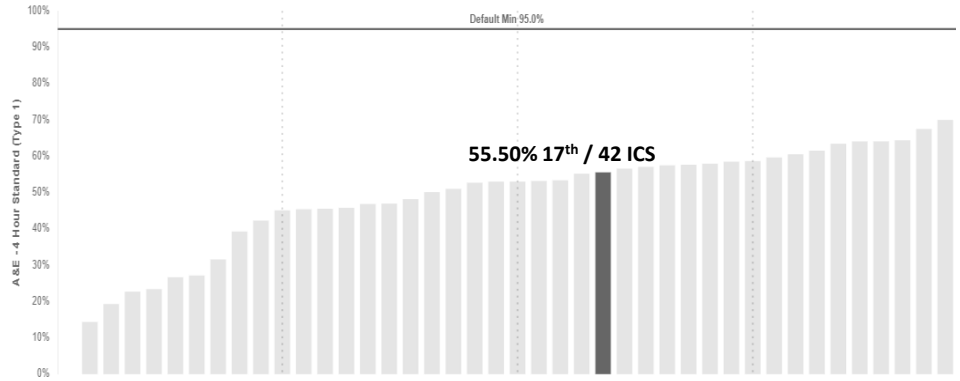
CCG Provider

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Alder Hey	73.42%	72.46%	66.17%	74.59%	80.26%	77.06%	64.16%	72.62%	73.71%	77.73%	76.02%	90.17%
Bridgewater Community Healthcare	99.30%	97.83%	98.85%	98.99%	99.34%	95.92%	94.11%	93.73%	95.04%	96.60%	96.12%	98.61%
Countess of Chester Hospital	60.17%	58.75%	61.26%	60.73%	65.14%	65.03%	62.31%	57.37%	59.07%	59.59%	55.15%	57.40%
East Cheshire	56.66%	62.84%	61.77%	61.38%	64.03%	57.94%	55.22%	55.84%	54.83%	57.07%	54.25%	56.36%
Liverpool University Hospitals	64.59%	64.07%	63.98%	66.22%	68.66%	67.81%	66.94%	66.77%	65.98%	66.95%	66.65%	67.23%
Liverpool Women's	97.53%	96.72%	98.75%	95.77%	97.18%	94.38%	90.39%	90.97%	92.89%	92.17%	89.56%	90.52%
Mersey Care	99.66%	98.55%	98.81%	99.84%	99.39%	99.30%	99.72%	98.70%	95.44%	92.59%	95.18%	96.42%
Mid Cheshire Hospitals	62.43%	63.92%	67.41%	60.22%	60.87%	58.36%	56.18%	55.79%	59.86%	59.97%	58.00%	62.31%
Southport and Ormskirk Hospital	78.08%	77.42%	79.03%	78.27%	76.03%	75.33%	74.89%	80.55%	77.04%	77.70%	73.80%	73.69%
St Helens and Knowsley	70.31%	67.25%	70.00%	70.00%	69.33%	65.75%	64.45%	66.59%	65.78%	65.06%	64.12%	62.36%
Warrington and Halton Hospitals	73.42%	70.59%	70.38%	68.78%	69.72%	67.61%	68.72%	69.73%	70.50%	69.53%	70.11%	72.10%
Wirral Community	99.31%	98.70%	99.25%	99.70%	99.35%	99.28%	97.98%	99.14%	98.30%	97.35%	98.19%	99.18%
Wirral University Teaching Hospital	63.44%	62.61%	59.49%	60.57%	59.11%	63.05%	61.45%	63.13%	63.36%	64.52%	62.25%	63.58%

Section II: Urgent Care Performance: The % of people seen within 4 hours of arrival at AED (Type 1)

NHS Cheshire and Merseyside

AED 4 Hr Performance (Type 1) ICS National Benchmark:



AED 4 Hr Performance (Type 1) ICS Benchmark

Organisation	May-22	Jun-22	Jul-22	Aug-22 *
Cheshire and Merseyside	55.80%	56.30%	53.80%	55.50%
North West	56.19%	55.42%	53.97%	N/A
England	52.48%	51.40%	57.00%	N/A

** August Position is latest unpublished data*

AED 4 Hr Performance (Type 1) ICS Provider Trend

ICS Providers

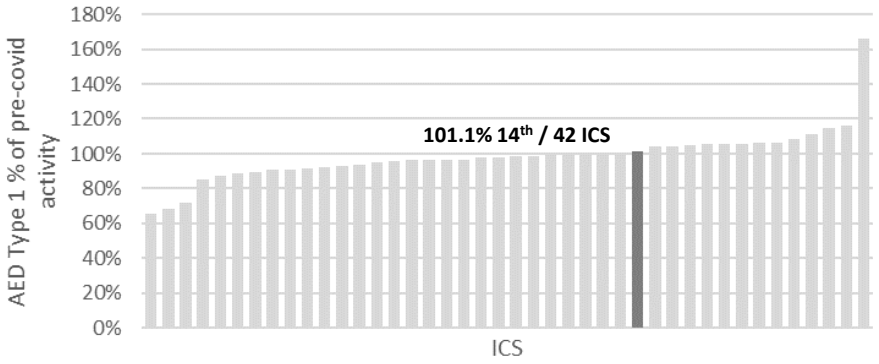
CCG Provider

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Alder Hey	73.4%	72.5%	66.2%	74.6%	80.3%	77.1%	64.2%	72.6%	73.7%	77.7%	76.0%	90.2%
Countess of Chester Hospital	56.8%	55.7%	57.8%	58.0%	61.9%	62.0%	58.5%	54.5%	56.8%	57.5%	51.8%	54.9%
East Cheshire	56.5%	62.6%	61.6%	61.2%	63.8%	57.7%	54.9%	55.5%	54.5%	56.8%	54.0%	56.1%
Liverpool University Hospitals	52.1%	51.7%	51.7%	52.1%	54.5%	53.0%	51.6%	51.8%	51.7%	52.9%	51.6%	52.7%
Mid Cheshire Hospitals	51.4%	53.1%	57.2%	49.2%	49.4%	46.2%	41.9%	41.3%	45.8%	45.4%	42.4%	47.9%
Southport and Ormskirk Hospital	71.7%	70.6%	72.9%	71.7%	69.6%	68.1%	68.0%	76.1%	69.6%	70.3%	64.4%	63.3%
St Helens and Knowsley	54.5%	51.0%	55.4%	55.3%	55.7%	49.7%	48.0%	50.7%	48.7%	47.3%	45.8%	43.8%
Warrington and Halton Hospitals	64.7%	61.2%	60.9%	59.3%	59.6%	57.1%	59.0%	58.5%	60.5%	58.4%	60.2%	62.3%
Wirral University Teaching Hospital	51.4%	49.9%	46.6%	48.6%	46.9%	52.3%	49.6%	50.4%	51.1%	51.7%	48.6%	50.6%

Section II: Urgent Care Performance: AED attendances (Type 1) % of pre-COVID activity (Mar 19-Feb 20)

NHS Cheshire and Merseyside

AED attendances (Type 1) % of Pre-COVID Activity



AED Attendances (Type 1) % of Pre-covid Activity Benchmark

Organisation	May-22	Jun-22	Jul-22	Aug-22 *
Cheshire and Merseyside	107.82%	106.94%	101.10%	N/A
North West	93.05%	108.27%	101.81%	N/A
England	102.39%	104.58%	91.82%	N/A

** Aug Position is latest unpublished data*

AED Attendances (type 1): Provider Trend

ICS Providers

Organisation	Jul-22	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Alder Hey	117.13%	108.85%	112.72%	116.48%	99.18%	91.45%	105.20%	109.63%	111.27%	109.73%	114.72%	111.16%	106.75%
Countess of Chester Hospital	116.94%	110.53%	113.61%	108.95%	104.71%	106.74%	106.48%	35.84%	110.98%	109.73%	121.21%	112.98%	110.19%
East Cheshire	107.55%	100.52%	104.67%	103.99%	99.58%	90.41%	92.19%	101.92%	114.15%	99.76%	103.97%	106.52%	102.59%
Liverpool University Hospitals	102.64%	101.20%	101.42%	103.23%	99.49%	95.70%	94.25%	99.76%	103.77%	98.88%	100.14%	100.48%	95.07%
Mid Cheshire Hospitals	112.76%	111.50%	111.77%	113.54%	110.79%	105.60%	105.00%	108.85%	121.54%	112.05%	113.46%	118.35%	109.35%
SouthPort and Ormskirk Hospital	107.09%	100.52%	106.85%	107.86%	98.68%	89.03%	95.99%	100.27%	112.84%	138.63%	114.79%	114.71%	104.48%
St Helens and Knowsley	103.69%	100.13%	98.99%	95.85%	93.00%	91.49%	91.77%	97.17%	104.16%	97.13%	102.08%	100.91%	93.31%
Warrington and Halton Hospitals	111.18%	106.34%	109.56%	110.44%	105.39%	99.77%	98.80%	102.67%	120.40%	106.71%	107.81%	107.01%	100.11%
Wirral University Teaching Hospita	112.94%	110.79%	107.50%	104.10%	102.70%	96.28%	103.85%	106.81%	111.00%	101.61%	109.24%	105.85%	104.76%
Cheshire and Merseyside	108.59%	104.65%	105.99%	105.82%	100.73%	95.96%	98.08%	96.52%	110.44%	106.62%	107.82%	106.94%	101.10%

Section II: Urgent Care Performance: Ambulance Response Times (Average Minutes)

NHS Cheshire and Merseyside

Ambulance Response Times Standard (average)

Call category	
Ambulance Response Cat 1 Mean	7 minutes
Ambulance Response Cat 2 Mean	18 minutes
Ambulance Response Cat 3 90th percentile	2 Hours
Ambulance Response Cat 4 90th percentile	3 Hours

Ambulance Response Times (Average Minutes) C1 benchmark

Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	00:09:37	00:08:50	00:09:04
North West	00:08:31	00:08:00	00:08:12
England	00:09:02	00:08:36	00:09:06

Ambulance Response Times: Category Trend, Cheshire & Merseyside

Call Category	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Ambulance Response Cat 1 Mean	00:07:21	00:07:50	00:07:42	00:08:29	00:07:55	00:08:07	00:09:02	00:07:32	00:07:26	00:09:37	00:08:50	00:09:04
Ambulance Response Cat 2 Mean	00:19:50	00:28:13	00:31:51	00:42:35	00:23:48	00:26:45	00:46:07	00:24:25	00:21:15	01:01:27	00:41:05	00:48:47
Ambulance Response Cat 3 90th Percentile	01:59:14	03:19:40	03:41:19	04:42:49	02:14:55	02:43:38	04:53:56	01:52:04	02:05:29	10:23:44	06:52:02	08:06:26
Ambulance Response Cat 4 90th Percentile	03:00:25	04:12:02	04:36:17	06:23:45	04:33:58	05:45:05	08:47:37	03:38:00	03:51:23	15:58:13	11:27:13	17:32:52

Section II: Urgent Care Performance: Ambulance Arrival to Clear Times (Average Minutes) and Ambulance Handover times % over 60 minutes

NHS
Cheshire and Merseyside

Ambulance Handover (arrival to clear) time (average minutes) – Standard is 30 minutes

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Aintree University	00:40:36	00:41:00	00:37:46	00:38:27	00:39:30	00:39:47	00:41:53	00:45:43	00:39:54	00:38:43	00:37:57	00:38:51
Alder Hey	00:30:11	00:29:58	00:29:02	00:30:40	00:28:36	00:29:47	00:31:34	00:29:33	00:31:31	00:31:08	00:31:54	00:33:25
Arrowe Park	00:50:34	00:44:54	00:44:18	00:40:40	00:44:08	00:36:34	00:50:35	00:50:08	00:45:53	00:43:26	00:48:53	00:53:09
Countess of Chester	00:32:35	00:35:08	00:33:11	00:37:15	00:36:58	00:35:29	00:40:41	00:45:59	00:36:44	00:31:52	00:40:12	00:42:26
Leighton	00:33:00	00:33:26	00:33:22	00:32:53	00:32:21	00:35:17	00:36:24	00:36:18	00:36:40	00:36:52	00:36:51	00:36:11
Macclesfield General	00:39:53	00:42:04	00:42:25	00:37:35	00:40:24	00:44:07	00:46:20	00:47:39	00:42:43	00:38:17	00:42:45	00:40:06
Royal Liverpool University	00:32:50	00:32:21	00:33:02	00:40:25	00:31:38	00:32:50	00:41:48	00:39:55	00:36:47	00:38:42	00:42:58	00:40:32
Southport District General	00:35:42	00:36:38	00:43:09	00:37:57	00:39:43	00:46:50	00:46:51	00:44:41	00:35:36	00:37:41	00:48:10	00:43:51
Warrington	00:29:38	00:34:27	00:30:13	00:29:13	00:29:04	00:30:24	00:42:59	00:39:26	00:32:17	00:37:02	00:41:43	00:43:35
Whiston	00:39:16	01:02:40	00:54:43	00:49:14	00:53:56	00:57:18	01:10:16	00:55:27	00:36:27	00:47:08	00:48:46	00:57:50
Cheshire and Merseyside (average)	00:36:26	00:39:16	00:38:07	00:37:26	00:37:38	00:38:50	00:44:56	00:43:29	00:37:27	00:38:05	00:42:01	00:43:00
NorthWest (NWAS)	00:36:48	00:40:21	00:38:29	00:39:23	00:39:09	00:37:13	00:42:06	00:42:27	00:37:56	00:39:45	00:42:53	00:43:18

Ambulance Handover (arrival to handover) Times (% over 60 Minutes) – Standard is zero

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Aintree University	5.5%	7.0%	4.2%	5.2%	5.2%	5.8%	6.4%	8.5%	5.3%	3.8%	4.2%	4.0%
Alder Hey	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Arrowe Park	13.6%	13.3%	11.5%	8.7%	7.6%	5.0%	14.9%	12.8%	11.3%	9.2%	8.4%	5.0%
Countess of Chester	1.2%	5.3%	2.1%	4.4%	3.4%	2.9%	5.9%	9.8%	3.1%	0.5%	5.8%	5.7%
Leighton	0.8%	2.1%	0.4%	0.4%	0.2%	1.0%	1.0%	0.7%	0.9%	0.8%	1.2%	0.8%
Macclesfield General	5.0%	6.5%	6.1%	2.0%	3.5%	6.9%	7.9%	6.6%	4.1%	2.0%	2.8%	3.3%
Royal Liverpool University	2.8%	3.4%	3.4%	6.8%	1.2%	2.9%	7.4%	3.8%	3.7%	3.8%	4.2%	3.1%
Southport District General	3.2%	6.0%	9.9%	4.8%	5.5%	10.6%	11.5%	10.4%	3.2%	4.2%	12.1%	9.0%
Warrington	2.4%	7.4%	2.7%	1.9%	1.7%	3.3%	10.8%	8.9%	3.5%	6.2%	10.0%	10.5%
Whiston	6.4%	20.9%	15.8%	11.1%	12.1%	16.0%	18.9%	12.1%	1.9%	5.9%	6.4%	8.3%

Section II: Urgent Care Performance: Beds Occupied by people who do not meet the criteria to reside (%)

NHS Cheshire and Merseyside

Beds Occupied by people who do not meet the criteria to reside and are not discharged ICS Benchmark

Organisation	May-22	Jun-22	Jul-22	Aug-22 *
Cheshire and Merseyside	18.15%	20.82%	22.80%	22.30%
North West	16.77%	17.30%	17.5%	19.5%
England	-	-	-	-

** August Position is latest unpublished data*

Beds Occupied by people who do not meet the criteria to reside and are not discharged (%) Provider Trend

ICS Providers

Organisation	Dec-21*	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22*
Countess of Chester Hospital	4.8%	10.8%	11.8%	14.1%	22.0%	18.7%	12.8%	15.7%	12.3%
East Cheshire	21.4%	25.2%	26.8%	24.0%	25.3%	23.4%	20.3%	22.8%	22.6%
Liverpool University Hospitals	5.1%	9.7%	9.3%	9.1%	10.8%	12.7%	17.2%	21.4%	22.0%
Mid Cheshire Hospitals	17.4%	25.7%	22.7%	20.3%	21.2%	23.1%	20.9%	22.7%	22.1%
Southport and Ormskirk Hospital	6.2%	15.0%	13.6%	11.5%	7.1%	5.4%	2.7%	5.8%	8.2%
St Helens and Knowsley	16.6%	18.2%	19.3%	16.7%	18.6%	15.7%	18.4%	20.4%	21.7%
Warrington and Halton Hospitals	16.1%	24.4%	25.0%	25.7%	25.3%	22.6%	21.9%	23.1%	14.6%
Wirral University Teaching Hospita	9.4%	15.0%	25.6%	23.9%	23.2%	22.6%	26.2%	28.0%	29.3%
Cheshire and Merseyside	10.1%	16.2%	17.5%	16.5%	17.6%	17.2%	18.4%	21.0%	20.6%

Section III: Planned Care

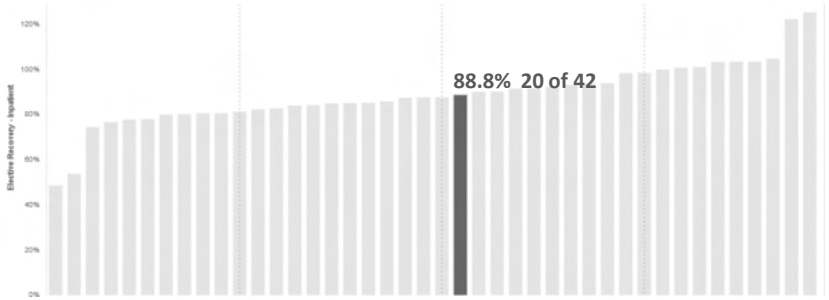
Sentinel Metrics:-

- Elective Inpatient Admissions % of pre-COVID activity (Mar 19-Feb 20)
- Day cases % of pre-COVID activity (Mar 19-Feb 20)
- Outpatient Follow ups % of pre-COVID activity (Mar 19-Feb 20)
- Outpatient (First) % of pre-COVID activity (Mar 19-Feb 20)
- The number of people waiting 78 Weeks or more
- Patient Initiated Follow-ups (PIFU)
- Advice and Guidance

Section III: Planned Care Performance: Elective Inpatient Admissions. % of pre-COVID activity (Mar 19-Feb 20)

NHS Cheshire and Merseyside

Elective inpatient admissions % of pre-COVID activity (Mar 19-Feb 20). ICS National Benchmark



Elective inpatient admissions % of pre-COVID activity (Mar 19-Feb 20). ICS/North West/National Benchmark

Organisation	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	84.28%	83.25%	80.91%	88.80%
North West	80.96%	83.55%	84.54%	92.02%
England	77.28%	79.02%	81.02%	85.35%

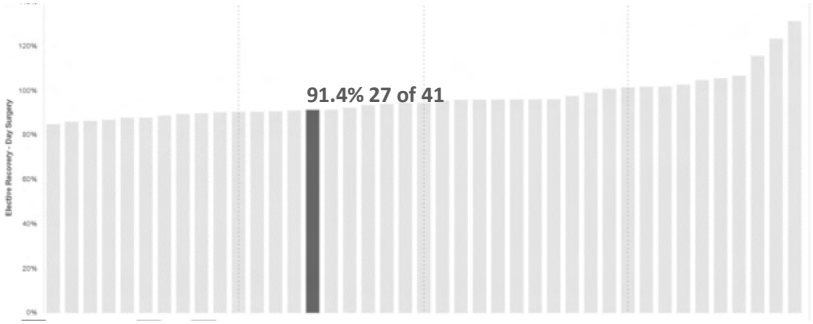
Elective Inpatient admissions % of pre-COVID activity (Mar-19-Feb20). ICS Provider Trend

Organisation	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Alder Hey	58.2%	60.1%	66.6%	-	55.8%	56.4%	58.4%	-	69.1%	67.0%	70.7%	67.9%
Cheshire and Wirral Partnership	100.0%	59.7%	73.0%	-	-	-	-	-	-	-	-	-
Countess of Chester Hospital	30.2%	62.1%	67.9%	59.0%	44.4%	41.5%	64.4%	87.5%	84.9%	69.8%	62.5%	75.8%
East Cheshire	66.7%	62.3%	45.3%	36.7%	52.4%	38.3%	81.3%	75.6%	57.4%	60.0%	69.0%	58.2%
Liverpool Heart and Chest	104.4%	82.6%	93.1%	73.8%	79.7%	84.9%	88.3%	73.4%	109.5%	105.6%	107.0%	121.3%
Liverpool University Hospitals	79.6%	78.3%	97.1%	114.1%	115.6%	113.6%	119.0%	127.2%	104.2%	98.3%	98.2%	105.9%
Liverpool Women's	113.6%	88.1%	125.7%	102.3%	80.6%	130.0%	96.4%	109.2%	119.6%	100.0%	85.7%	138.1%
Mersey Care	78.6%	47.7%	78.2%	59.7%	57.1%	78.6%	53.3%	61.4%	-	-	-	-
Mid Cheshire Hospitals	69.0%	84.4%	99.6%	84.8%	159.5%	117.2%	85.5%	130.1%	86.5%	139.1%	75.9%	99.2%
Southport and Ormskirk Hospital	70.3%	128.3%	104.4%	85.7%	107.1%	90.9%	74.4%	101.2%	129.0%	80.5%	80.0%	93.1%
St Helens and Knowsley	90.5%	88.7%	100.6%	77.9%	79.5%	84.9%	87.1%	92.1%	90.4%	84.5%	99.0%	87.2%
The Clatterbridge Cancer Centre	57.1%	84.4%	87.6%	83.9%	92.1%	73.3%	104.0%	62.1%	47.1%	70.8%	53.3%	73.0%
The Walton Centre	68.9%	80.3%	100.0%	87.0%	100.7%	87.4%	92.3%	96.8%	64.0%	85.7%	90.2%	81.5%
Warrington and Halton Hospitals	83.1%	96.9%	132.7%	128.2%	176.7%	147.3%	143.1%	198.3%	79.4%	63.2%	57.4%	82.5%
Wirral University Teaching Hospital	82.1%	78.1%	83.4%	90.9%	87.8%	81.5%	64.7%	95.4%	74.8%	80.5%	84.3%	97.4%

Section III: Planned Care Performance: Day cases % of pre-COVID activity (Mar 19-Feb 20)

NHS Cheshire and Merseyside

Day cases % of pre-COVID activity (Mar 19-Feb 20).
ICS National Benchmark



Day cases % of pre-COVID activity (Mar 19-Feb 20).
ICS/NW/National

Organisation	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	85.80%	93.99%	97.42%	91.40%
North West	86.02%	91.69%	89.27%	92.99%
England	89.48%	95.69%	94.22%	96.33%

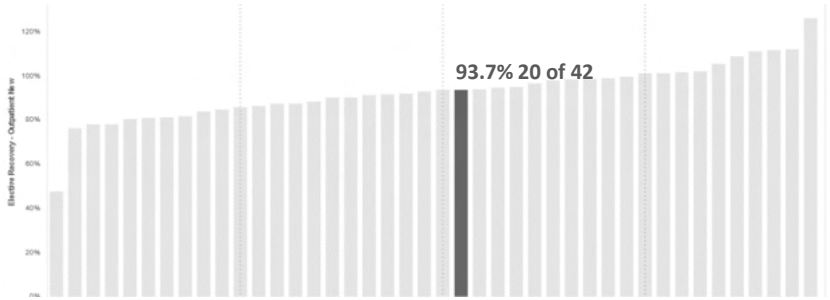
Day cases % of pre-COVID activity (Mar 19-Feb 20). Provider Trend

Organisation	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Alder Hey	99.7%	101.6%	117.8%	-	114.9%	110.7%	102.7%	-	118.9%	119.3%	124.0%	107.2%
Countess of Chester Hospital	31.5%	54.4%	61.7%	70.8%	67.8%	63.8%	65.0%	71.7%	71.7%	81.0%	76.3%	74.8%
East Cheshire	69.9%	62.5%	66.7%	64.6%	61.6%	67.2%	69.4%	75.0%	59.7%	66.8%	68.0%	67.8%
Liverpool Heart and Chest	89.4%	88.7%	94.7%	95.5%	90.6%	88.9%	91.4%	88.6%	91.3%	102.9%	100.0%	103.8%
Liverpool University Hospitals	69.5%	79.2%	78.4%	84.7%	84.0%	80.0%	82.5%	89.7%	83.2%	84.5%	82.8%	80.9%
Liverpool Women's	52.0%	58.3%	60.3%	58.5%	54.5%	63.4%	80.6%	77.2%	56.4%	66.2%	57.5%	58.8%
Mid Cheshire Hospitals	62.9%	68.0%	71.8%	74.8%	65.9%	68.0%	69.4%	81.9%	72.4%	76.5%	57.3%	63.7%
Southport and Ormskirk Hospital	62.1%	66.8%	72.7%	80.9%	67.8%	73.6%	76.1%	80.0%	90.3%	95.4%	85.4%	85.7%
St Helens and Knowsley	86.0%	90.5%	92.8%	88.1%	89.7%	84.1%	81.6%	89.4%	96.4%	99.5%	93.3%	99.9%
The Clatterbridge Cancer Centre	52.3%	63.0%	50.8%	54.5%	45.1%	68.0%	67.5%	75.1%	80.3%	75.9%	73.2%	84.2%
The Walton Centre	166.3%	136.2%	140.7%	150.9%	-	169.4%	173.9%	190.4%	176.9%	-	183.5%	141.8%
Warrington and Halton Hospitals	88.5%	83.8%	77.7%	74.9%	70.4%	70.8%	84.9%	78.7%	94.8%	103.3%	105.6%	95.9%
Wirral University Teaching Hospital	80.7%	89.2%	93.2%	97.6%	85.5%	86.9%	96.8%	95.1%	95.4%	103.2%	96.6%	95.5%

Section III: Planned Care Performance: Outpatient (First) % of pre-COVID activity (Mar 19-Feb 20)

NHS
Cheshire and Merseyside

Outpatient First % of pre-COVID activity (Mar 19-Feb 20). ICS National Benchmark



Outpatient First % of pre-COVID activity (Mar 19-Feb 20). ICS/NW/National Benchmark

Organisation	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	101.85%	94.76%	103.48%	93.70%
North West	87.83%	95.72%	95.53%	92.39%
England	90.37%	97.04%	95.12%	86.46%

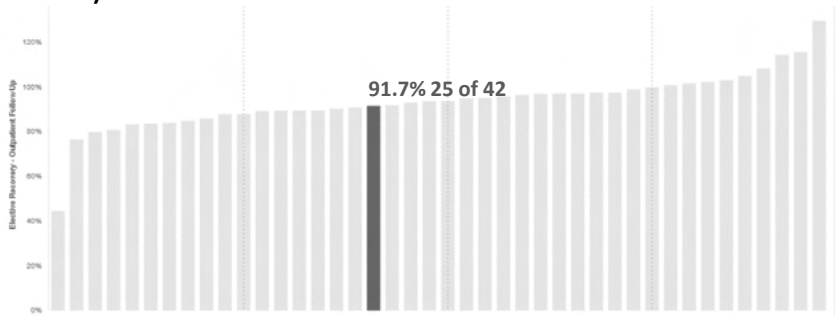
Outpatient (First) % of pre-COVID activity (Mar 19-Feb 20) Provider Trend

Organisation	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Alder Hey	107.4%	111.8%	110.4%	112.1%	105.9%	103.8%	108.9%	124.7%	94.0%	108.5%	109.6%	107.8%
Bridgewater Community Healthcare	78.4%	77.6%	82.7%	96.4%	81.2%	64.9%	81.3%	93.9%	81.1%	83.5%	86.6%	73.9%
Cheshire and Wirral Partnership	114.9%	120.6%	97.4%	-	-	-	-	-	-	-	-	-
Countess of Chester Hospital	55.7%	51.8%	51.9%	51.5%	52.4%	57.4%	57.3%	61.8%	58.3%	67.3%	66.1%	62.0%
East Cheshire	78.8%	78.5%	82.5%	79.1%	73.3%	75.8%	72.3%	78.2%	74.6%	81.8%	86.3%	73.2%
Liverpool Heart and Chest	140.3%	125.8%	139.2%	143.8%	153.5%	144.8%	141.0%	118.2%	145.9%	153.8%	126.5%	141.9%
Liverpool University Hospitals	101.0%	96.5%	94.5%	100.7%	95.0%	97.2%	101.4%	112.4%	97.4%	109.7%	110.5%	101.5%
Liverpool Women's	82.5%	88.2%	94.8%	87.5%	80.8%	82.9%	86.8%	74.8%	79.5%	86.0%	84.3%	78.3%
Mersey Care	-	-	-	-	-	-	166.3%	113.4%	-	-	-	-
Mid Cheshire Hospitals	88.7%	95.6%	92.4%	98.2%	95.4%	95.0%	96.3%	96.9%	96.5%	101.4%	92.9%	93.4%
Southport and Ormskirk Hospital	95.3%	97.1%	103.3%	101.8%	101.1%	105.8%	94.4%	109.1%	89.8%	93.3%	99.4%	88.0%
St Helens and Knowsley	98.9%	96.3%	90.1%	94.4%	96.0%	99.5%	100.5%	102.3%	103.8%	111.5%	110.8%	103.4%
The Clatterbridge Cancer Centre	112.3%	118.8%	123.4%	112.4%	120.5%	114.1%	116.6%	96.7%	132.3%	133.9%	134.4%	107.8%
The Walton Centre	92.2%	93.6%	97.6%	96.5%	80.4%	85.9%	95.1%	108.9%	87.6%	94.4%	95.4%	93.2%
Warrington and Halton Hospitals	93.4%	89.6%	88.0%	95.4%	86.6%	89.0%	95.5%	92.9%	84.7%	93.5%	92.1%	81.8%
Wirral University Teaching Hospital	100.0%	94.8%	93.7%	98.7%	97.3%	86.0%	106.4%	99.5%	101.7%	115.8%	106.5%	96.8%

Section III: Planned Care Performance: Outpatient Follow ups % of pre-COVID activity (Mar 19-Feb 20)

NHS
Cheshire and Merseyside

Outpatient Follow-up % of pre-COVID activity (Mar 19-Feb 20). ICS National Benchmark



Outpatient Follow-up % of pre-COVID activity (Mar 19-Feb 20). ICS/NW/National Benchmark

Organisation	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	96.95%	96.25%	98.09%	91.70%
North West	90.77%	98.17%	93.89%	88.23%
England	92.10%	98.42%	97.21%	94.48%

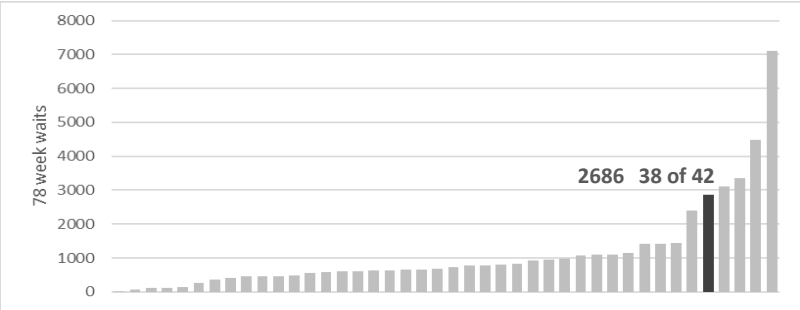
Outpatient Follow ups % of pre-COVID activity (Mar 19-Feb 20)

Organisation	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Alder Hey	114.2%	111.7%	114.1%	129.1%	131.6%	121.4%	117.5%	122.5%	117.9%	120.4%	111.4%	102.9%
Bridgewater Community Healthcare	82.5%	74.9%	83.4%	68.5%	73.0%	79.5%	81.6%	83.9%	63.6%	60.8%	62.9%	60.7%
Cheshire and Wirral Partnership	116.0%	132.3%	86.1%	-	-	-	-	-	-	-	-	-
Countess of Chester Hospital	58.5%	70.7%	69.9%	71.6%	71.0%	73.0%	73.9%	75.0%	74.8%	77.6%	80.0%	77.6%
East Cheshire	66.5%	68.6%	64.2%	72.4%	65.8%	60.0%	69.0%	65.6%	57.1%	63.9%	66.6%	56.7%
Liverpool Heart and Chest	107.3%	107.1%	99.2%	102.0%	104.0%	96.1%	98.2%	95.8%	101.8%	111.0%	110.1%	102.6%
Liverpool University Hospitals	86.7%	83.2%	80.1%	85.0%	86.1%	86.4%	86.0%	90.3%	80.6%	84.4%	83.0%	78.5%
Liverpool Women's	90.7%	88.7%	93.7%	94.7%	89.7%	92.7%	93.5%	91.4%	97.8%	98.4%	99.5%	82.0%
Mersey Care	119.7%	133.8%	128.3%	142.0%	135.6%	156.2%	152.4%	131.8%	-	-	-	-
Mid Cheshire Hospitals	92.1%	90.1%	88.1%	94.4%	88.3%	93.4%	91.1%	90.8%	102.5%	109.8%	94.0%	96.1%
Southport and Ormskirk Hospital	87.4%	85.0%	92.9%	94.6%	93.9%	96.3%	94.7%	91.6%	90.1%	95.3%	94.4%	88.5%
St Helens and Knowsley	104.3%	103.9%	100.4%	103.3%	104.8%	102.3%	106.5%	100.3%	99.0%	103.9%	104.1%	98.8%
The Clatterbridge Cancer Centre	138.7%	131.7%	129.2%	129.2%	129.5%	134.4%	128.0%	106.8%	149.4%	145.6%	157.5%	149.4%
The Walton Centre	104.8%	106.7%	109.8%	115.9%	110.5%	109.8%	112.0%	124.4%	108.7%	115.5%	107.2%	102.1%
Warrington and Halton Hospitals	98.2%	94.2%	92.8%	94.5%	91.3%	90.0%	95.8%	92.9%	93.8%	94.1%	94.3%	89.2%
Wirral University Teaching Hospital	110.8%	111.2%	113.2%	116.0%	110.7%	118.0%	118.3%	115.4%	115.0%	127.5%	118.7%	108.5%

Section III: Planned Care Performance: Waiting list. The number of people waiting 78 Weeks or more

NHS Cheshire and Merseyside

The number of people waiting 78 Weeks or more.
ICS Benchmark



The number of people waiting 78 Weeks or more. Benchmark

Organisation	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	3200	2962	2831	2686
North West	10161	9281	8416	8793
England	63639	59762	53911	51838

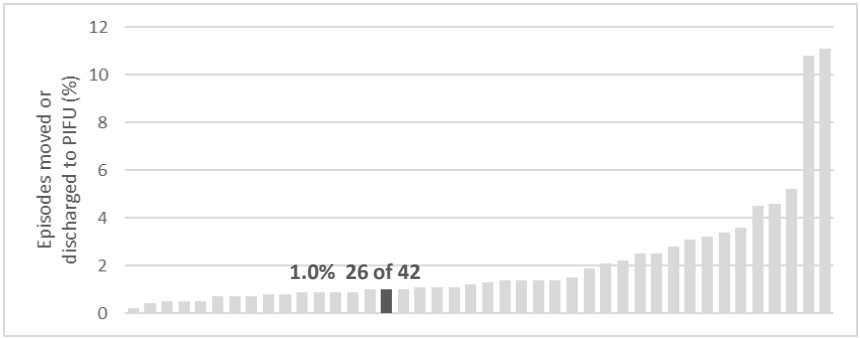
The number of people waiting 78 Weeks or more. Provider Trend

Organisation	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Alder Hey	76	97	114	61	40	34	22	16	16	17	12	5
Bridgewater Community Healthcare	0	0	0	0	0	0	0	0	0	0	0	0
Countess of Chester Hospital	-	-	1,705	1,750	1,701	1,821	1,567	1,433	1,034	859	697	411
East Cheshire	145	149	138	137	145	156	123	106	82	84	81	71
Liverpool Heart and Chest	25	23	19	12	13	11	10	9	6	9	14	11
Liverpool University Hospitals	1,876	2,242	2,146	1,810	1,546	1,581	1,303	1,198	1,308	1,215	1,257	1,364
Liverpool Women's	12	39	21	3	3	10	12	12	26	27	33	35
Mersey Care	-	-	8	6	6	6	6	6	4	2	0	0
Mid Cheshire Hospitals	140	123	89	65	62	62	56	60	61	73	83	98
Southport and Ormskirk Hospital	28	25	16	10	9	8	12	17	22	46	34	23
St Helens and Knowsley	390	462	414	368	360	315	291	259	328	288	286	325
The Clatterbridge Cancer Centre	0	0	0	0	0	0	0	0	0	0	0	0
The Walton Centre	22	20	12	10	36	38	27	22	20	30	11	16
Warrington and Halton Hospitals	399	439	384	327	309	315	251	193	221	239	238	234
Wirral Community	0	0	0	0	0	0	0	14	2	2	3	2
Wirral University Teaching Hospital	176	163	116	70	72	59	65	60	70	71	82	91

Section III: Planned Care Performance: Patient Initiated Follow-up (PIFU) – 5% Objective

NHS Cheshire and Merseyside

Patient Initiated Follow-up (PIFU) ICS Benchmark



Patient Initiated Follow-up (PIFU) Benchmark

Organisation	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	1.3%	1.8%	2.2%	1.0%
North West	1.1%	1.2%	1.4%	1.0%
England	1.3%	1.5%	1.6%	1.6%

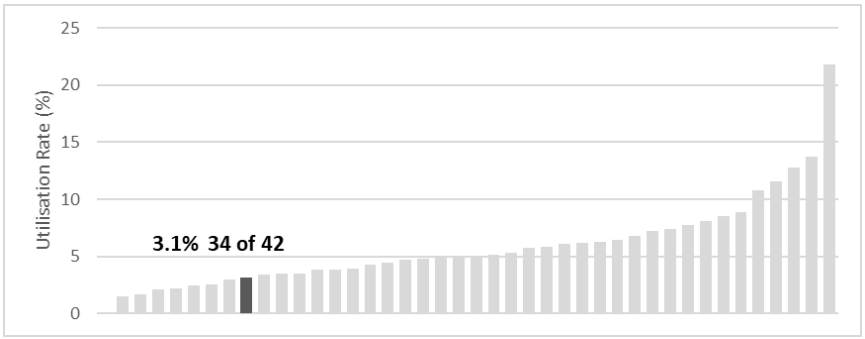
Patient Initiated Follow-up (PIFU) Provider Trend

Organisation	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Alder Hey	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.2%	0.5%	0.5%	0.1%	0.7%
Bridgewater Community Health Care												
Countess of Chester Hospital											0.8%	0.5%
East Cheshire	0.0%	0.0%	0.0%	1.1%	1.9%	2.2%	2.9%	2.8%	1.6%	1.6%	1.4%	1.5%
Liverpool Heart & Chest	0.3%	0.3%	0.0%	0.1%	0.1%	0.1%	0.3%	0.7%	0.3%	0.3%	0.7%	0.5%
Liverpool University Hospitals	0.1%	0.1%	0.2%	0.1%	2.5%	0.0%	1.6%	0.3%	1.0%	1.0%	1.7%	
Liverpool Women's	0.0%	0.0%	0.5%	0.6%	1.6%	0.0%	2.2%	0.8%	0.9%	0.9%	0.9%	1.0%
Mid Cheshire Hospitals	0.5%	0.5%	0.6%	0.7%	0.6%	0.7%	0.6%	0.4%	0.3%	0.3%	1.5%	1.2%
SouthPort and Ormskirk Hospital	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	2.7%	3.8%	3.8%	3.9%	4.1%
St Helens and Knowsley	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.7%	0.7%	0.8%
The Walton Centre	0.9%	0.9%	0.8%	0.9%	0.9%	1.4%	1.5%	2.1%	2.7%	2.7%	2.5%	2.5%
Warrington and Halton Hospitals	0.7%	0.7%	0.7%	0.8%	0.7%	0.9%	0.9%	2.4%	2.2%	2.2%	2.1%	2.1%
Wirral University Teaching Hospital	0.1%	0.1%	0.5%	0.5%	0.5%	0.6%	0.4%	0.5%	0.7%	0.7%	3.6%	1.5%

Section III: Planned Care Performance: Advice and Guidance – 6% Objective

NHS
Cheshire and Merseyside

Advice & Guidance ICS National Benchmark



Advice and Guidance ICS/North West/National

Organisation	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	4.1%	3.8%	3.1%	3.1%
North West	3.5%	3.3%	3.0%	2.0%
England	5.6%	4.5%	5.4%	5.5%

Advice and Guidance: Provider Trend

Organisation	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Alder Hey	1.8%	1.9%	1.9%	1.7%	2.8%	1.9%	3.1%	2.4%	2.0%	2.3%	2.0%	1.6%
Bridgewater Community Health Care	2.7%	2.5%	2.4%	2.2%	1.4%	2.1%	2.0%	2.1%	2.6%	2.0%	3.0%	1.7%
Countess of Chester Hospital	6.5%	7.2%	7.2%	8.7%	9.2%	6.0%	6.4%	6.4%	6.4%	6.3%	6.7%	5.3%
East Cheshire	0.4%	0.4%	0.5%	1.0%	0.6%	0.2%	0.3%	0.4%	0.3%	0.3%	0.3%	0.3%
Liverpool Heart & Chest	1.9%	2.1%	2.9%	1.9%	2.3%	2.0%	2.3%	2.3%	2.5%	3.0%	2.9%	2.2%
Liverpool University Hospitals	3.0%	2.9%	3.1%	2.8%	3.5%	3.0%	3.0%	3.3%	3.6%	3.5%	3.1%	2.8%
Liverpool Women's	2.1%	1.7%	1.5%	1.7%	1.9%	1.8%	2.1%	2.2%	2.1%	2.4%	1.9%	1.7%
Mid Cheshire Hospitals	1.0%	1.0%	1.0%	1.1%	1.1%	1.3%	0.9%	1.0%	1.2%	0.9%	1.2%	0.8%
SouthPort and Ormskirk Hospital	3.3%	2.7%	3.4%	3.7%	4.7%	4.4%	5.9%	4.8%	6.3%	7.2%	5.9%	6.2%
St Helens and Knowsley	0.5%	0.4%	0.7%	0.5%	0.6%	0.5%	0.6%	0.8%	0.8%	0.8%	0.9%	1.0%
The Walton Centre	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	5.8%	0.0%	17.0%	12.2%	11.8%	11.8%
Warrington and Halton Hospitals	3.5%	3.7%	4.0%	4.1%	4.7%	4.2%	4.6%	5.2%	4.4%	5.1%	5.7%	4.5%
Wirral University Teaching Hospital	0.0%	7.5%	8.6%	7.4%	8.7%	6.0%	9.5%	7.8%	8.0%	8.6%	7.8%	5.0%

Section IV: Cancer Care

Sentinel Metrics:-

- The number of people receiving first cancer treatment, % of pre-COVID
- The number of people waiting 62 days or more for first cancer treatment
- The number of people waiting 62 days or more for first cancer treatment, % of pre-COVID waiting list
- The percentage of patients referred for cancer treatment by their GP who waited for less than 14 days for treatment to start
- The percentage of patients diagnosed with cancer receiving treatment within 31 days of diagnosis
- Patients referred for cancer treatment by their GP waiting less than 62 days for treatment to start

Section IV: Cancer Care Performance: The number of patients receiving first cancer treatment, as a % of pre-COVID Activity (Mar 19-Feb20)

NHS Cheshire and Merseyside

The number of people receiving first cancer treatment

Organisation	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	1240	1510	1332	1485	1407	1355
North West	3262	3639	2916	3548	3441	3468
England	24960	28378	23523	28040	25091	26263

The number of people receiving first cancer treatment, % of pre-COVID Activity (Mar 19-Feb20) ICS/NW/National

Organisation	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseyside	91%	111%	97%	109%	104%	100%
North West	100%	112%	89%	109%	106%	106%
England	95%	108%	89%	106%	95%	100%

The number of people receiving first cancer treatment, % of pre-COVID Activity (Mar 19-Feb20). Provider Trend

ICS Providers	% of pre-pandemic baseline											
Organisation	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Alder Hey Children's Hospital	63%	126%	111%	111%	237%	95%	174%	95%	142%	79%	95%	79%
Bridgewater Community Healthcare	110%	55%	128%	119%	137%	156%	82%	110%	165%	137%	37%	128%
Countess of Chester Hospital	77%	124%	108%	92%	103%	81%	100%	103%	116%	98%	106%	99%
East Cheshire	71%	104%	94%	71%	83%	116%	75%	112%	89%	112%	110%	96%
Liverpool Heart and Chest Hospital	82%	97%	86%	120%	84%	93%	75%	135%	111%	151%	139%	89%
Liverpool University Hospitals	98%	96%	87%	99%	92%	86%	79%	93%	80%	78%	80%	81%
Liverpool Women's	109%	136%	140%	113%	113%	98%	121%	87%	79%	91%	98%	102%
Mid Cheshire Hospitals	106%	92%	97%	120%	79%	87%	88%	124%	102%	130%	132%	95%
Southport and Ormskirk Hospital	78%	95%	109%	121%	98%	121%	107%	124%	78%	137%	98%	114%
St Helens and Knowsley	105%	102%	107%	98%	106%	95%	96%	116%	115%	124%	106%	124%
The Clatterbridge Cancer Centre	113%	114%	113%	114%	102%	93%	84%	136%	110%	112%	124%	108%
The Walton Centre	95%	79%	87%	79%	87%	95%	127%	87%	87%	0%	72%	64%
Warrington and Halton Hospitals	91%	100%	66%	86%	86%	74%	98%	95%	73%	111%	113%	91%
Wirral University Teaching Hospital	107%	109%	112%	112%	111%	107%	103%	103%	87%	126%	89%	98%

Section IV: Cancer Care Performance: Waiting list. The number of people waiting 62 days or more as % of pre-COVID waiting list (Mar 19-Feb 20)

NHS Cheshire and Merseyside

The number of people waiting 62 days or more for first cancer treatment

Organisation	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Cheshire and Merseyside	1599	1586	1574	1805	1741	1919
North West	3890	3741	4152	4675	4489	5006
England	25808	27091	27865	30414	31036	33814

Sep 22 data is position as at 4th September 22

The number of people waiting 62 days or more for first cancer treatment. % of pre-covid waiting list (Mar 19-Feb 20) Benchmark

Organisation	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Cheshire and Merseyside	224%	222%	221%	253%	244%	269%
North West	207%	199%	221%	249%	239%	266%
England	181%	190%	195%	213%	218%	237%

Sep 22 data is position as at 4th September 22

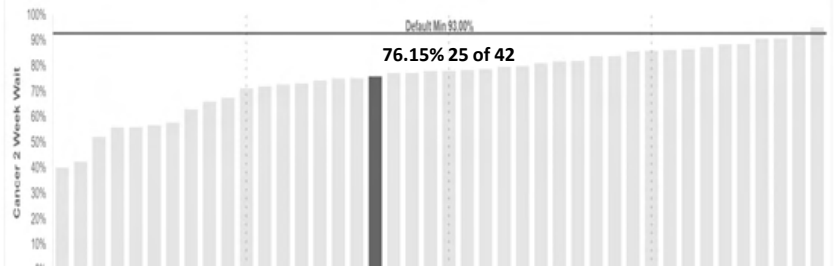
The number of people waiting 62 days or more for first cancer treatment. % of pre-covid waiting list (Mar 19-Feb 20) Provider Trend

Organisation	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Alder Hey Children's Hospital														
Bridgewater Community Healthcare														
Countess of Chester Hospital	200%	260%	254%	196%	387%	256%	202%	148%	159%	117%	97%	95%	111%	96%
East Cheshire	150%	115%	160%	200%	280%	380%	340%	295%	400%	270%	205%	320%	330%	380%
Liverpool Heart and Chest Hospital	100%	100%	133%	33%	233%	33%	100%	267%	233%	200%	133%	367%	233%	267%
Liverpool University Hospitals	206%	221%	168%	191%	207%	230%	189%	157%	233%	247%	263%	298%	281%	308%
Liverpool Women's	179%	190%	117%	86%	97%	138%	100%	93%	117%	179%	231%	369%	338%	352%
Mid Cheshire Hospitals	104%	196%	135%	167%	173%	198%	200%	165%	222%	222%	167%	218%	245%	353%
Southport and Ormskirk Hospital	143%	193%	200%	300%	319%	391%	478%	474%	500%	400%	391%	410%	367%	374%
St Helens and Knowsley	126%	182%	158%	151%	140%	157%	117%	140%	157%	196%	176%	196%	190%	236%
The Clatterbridge Cancer Centre	230%	239%	239%	239%	135%	222%	309%	283%	204%	343%	248%	291%	339%	343%
The Walton Centre														
Warrington and Halton Hospitals	367%	273%	233%	220%	233%	167%	147%	133%	193%	107%	180%	153%	120%	153%
Wirral University Teaching Hospital	75%	81%	79%	78%	87%	104%	113%	121%	145%	184%	227%	252%	225%	249%

Section IV: Cancer Care Performance: The percentage of patients referred for cancer treatment by their GP who waited for less than 14 days for treatment to start (Target 93%)

NHS Cheshire and Merseyside

The percentage of patients referred for cancer treatment by their GP who waited for less than 14 days for treatment to start: ICS National Benchmark.



The percentage of patients referred for cancer treatment by their GP who waited for less than 14 days for treatment to start ICS/NW/England Summary

Organisation	May-22	Jun-22	Jul-22
Cheshire and Merseyside	82.95%	77.16%	76.15%
North West	83.30%	74.06%	76.15%
England	83.22%	77.71%	77.82%

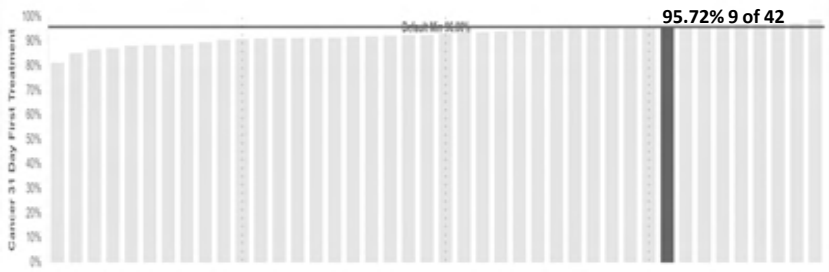
The percentage of patients referred for cancer treatment by their GP who waited for less than 14 days for treatment to start: ICS Provider Trend

Organisation	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Alder Hey	100.00%	100.00%	100.00%	96.30%	93.75%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Bridgewater Community Healthcare	95.22%	98.08%	94.01%	96.58%	97.97%	95.98%	93.97%	93.94%	94.03%	95.76%	93.19%	91.34%
Countess of Chester Hospital	69.65%	52.37%	52.73%	56.98%	60.41%	63.29%	81.89%	70.06%	65.75%	75.97%	70.70%	75.12%
East Cheshire	94.67%	92.66%	67.05%	58.92%	67.26%	80.50%	90.23%	90.53%	88.87%	89.36%	87.59%	89.70%
Liverpool Heart and Chest	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.31%	100.00%	100.00%
Liverpool University Hospitals	93.19%	92.84%	73.90%	68.19%	64.10%	65.47%	71.55%	71.98%	64.78%	69.64%	53.53%	52.05%
Liverpool Women's	96.42%	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.90%	52.71%	88.47%	93.29%
Mid Cheshire Hospitals	94.65%	94.04%	94.13%	81.50%	92.33%	80.88%	85.39%	93.24%	89.54%	93.80%	90.93%	88.35%
Southport and Ormskirk Hospital	76.47%	78.53%	78.54%	78.46%	77.18%	82.40%	77.13%	77.39%	86.10%	84.20%	74.55%	71.23%
St Helens and Knowsley	92.26%	89.00%	88.87%	75.35%	78.47%	73.49%	79.13%	84.34%	82.51%	88.29%	80.22%	75.74%
The Clatterbridge Cancer Centre	100.00%	100.00%	88.89%	100.00%	92.86%	90.00%	100.00%	93.75%	85.71%	100.00%	89.47%	100.00%
The Walton Centre	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	100.00%	96.30%
Warrington and Halton Hospitals	90.23%	95.86%	92.54%	78.29%	67.61%	68.57%	84.69%	90.60%	82.92%	88.04%	90.63%	86.54%
Wirral University Teaching Hospital	93.72%	95.74%	96.13%	87.85%	91.39%	76.16%	77.99%	76.16%	85.76%	96.60%	94.65%	94.40%

Section IV: Cancer Care Performance: The percentage of patients diagnosed with cancer receiving treatment within 31 days of diagnosis (Target 96%)

NHS Cheshire and Merseyside

The percentage of patients diagnosed with cancer receiving treatment within 31 days of diagnosis ICS National Benchmark



The percentage of patients diagnosed with cancer receiving treatment within 31 days of diagnosis NW/National Summary

Organisation	May-22	Jun-22	Jul-22
Cheshire and Merseyside	96.30%	96.45%	95.72%
North West	92.80%	93.53%	94.75%
England	91.60%	91.83%	92.88%

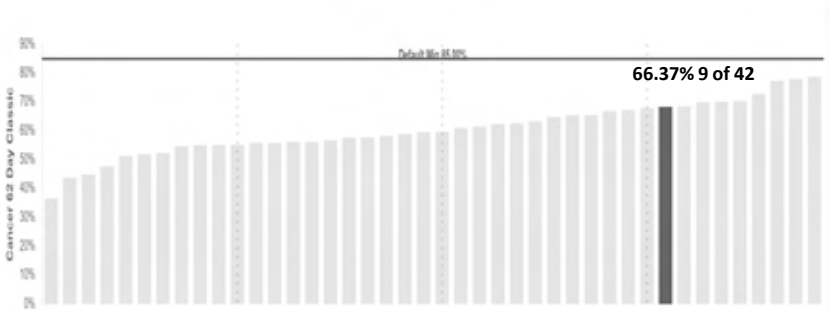
The percentage of patients diagnosed with cancer receiving treatment within 31 days of diagnosis. Provider Trend

Organisation	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Alder Hey	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Bridgewater Community Healthcare	83.33%	100.00%	92.86%	76.92%	93.33%	52.94%	100.00%	83.33%	100.00%	80.00%	100.00%	92.86%
Countess of Chester Hospital	91.36%	86.92%	86.73%	90.72%	87.96%	88.24%	92.38%	90.74%	93.44%	94.17%	94.59%	96.15%
East Cheshire	94.44%	98.11%	97.92%	94.44%	92.86%	66.10%	52.63%	77.19%	75.56%	84.21%	94.64%	83.67%
Liverpool Heart and Chest	100.00%	100.00%	100.00%	100.00%	100.00%	97.62%	100.00%	100.00%	98.00%	100.00%	98.41%	97.50%
Liverpool University Hospitals	92.39%	92.54%	92.59%	93.14%	94.59%	91.32%	88.74%	90.77%	93.30%	91.28%	92.89%	92.04%
Liverpool Women's	68.97%	52.78%	56.76%	86.67%	93.33%	84.62%	84.38%	95.65%	85.71%	83.33%	88.46%	96.30%
Mid Cheshire Hospitals	99.00%	94.25%	100.00%	98.25%	98.67%	97.56%	90.36%	98.29%	96.91%	96.75%	95.20%	97.78%
Southport and Ormskirk Hospital	95.65%	98.21%	96.88%	97.18%	93.10%	100.00%	96.83%	95.89%	91.30%	100.00%	93.10%	92.54%
St Helens and Knowsley	98.20%	96.77%	98.68%	99.04%	98.21%	98.02%	98.53%	98.37%	97.95%	98.85%	99.11%	96.20%
The Clatterbridge Cancer Centre	100.00%	98.81%	100.00%	99.60%	98.67%	97.09%	98.92%	100.00%	99.59%	100.00%	98.91%	99.58%
The Walton Centre	100.00%	100.00%	100.00%	100.00%	100.00%	91.67%	100.00%	100.00%	100.00%	-	100.00%	100.00%
Warrington and Halton Hospitals	98.57%	96.10%	98.04%	98.48%	96.97%	98.25%	100.00%	98.63%	100.00%	100.00%	98.85%	98.57%
Wirral University Teaching Hospital	96.43%	96.49%	95.43%	94.29%	94.83%	94.64%	95.06%	92.59%	91.18%	96.45%	96.40%	96.10%

Section IV: Cancer Care Performance: Patients referred for cancer treatment by their GP waiting less than 62 days for treatment to start (Target 85%)

NHS Cheshire and Merseyside

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



Patients referred for cancer treatment by their GP waiting less than 62 days for treatment to start ICS/NW/England Summary

Organisation	May-22	Jun-22	Jul-22
Cheshire and Merseyside	69.70%	65.92%	68.37%
North West	61.50%	56.07%	58.34%
England	61.50%	59.87%	61.60%

Patients referred for cancer treatment by their GP, screening or consultant upgrade waiting less than 62 days for treatment to start. Provider Trend

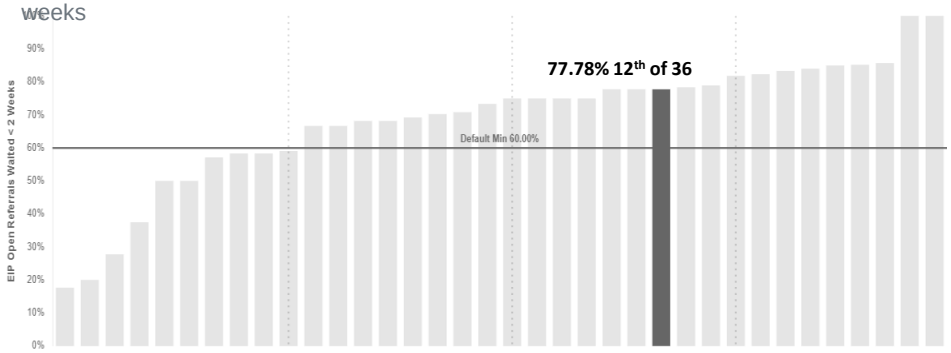
Organisation	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Alder Hey	-	-	-	-	100.00%	100.00%	-	-	100.00%	-	100.00%	100.00%
Bridgewater Community Healthcare	91.30%	72.73%	91.30%	83.33%	100.00%	84.62%	77.78%	90.91%	93.75%	100.00%	71.43%	80.00%
Countess of Chester Hospital	68.63%	71.59%	71.78%	70.34%	73.53%	60.91%	62.00%	63.19%	72.19%	67.90%	70.69%	76.35%
East Cheshire	74.00%	68.18%	75.36%	61.11%	48.15%	31.03%	42.00%	53.85%	49.18%	50.77%	47.30%	47.37%
Liverpool Heart and Chest	100.00%	93.75%	100.00%	96.88%	86.21%	85.29%	84.62%	100.00%	87.50%	76.47%	73.68%	55.00%
Liverpool University Hospitals	54.74%	67.09%	56.20%	62.55%	55.51%	56.36%	55.91%	52.47%	53.69%	45.35%	48.68%	49.17%
Liverpool Women's	16.22%	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%	22.73%	12.50%	10.00%
Mid Cheshire Hospitals	88.67%	84.35%	81.62%	81.93%	81.20%	67.74%	70.49%	71.52%	69.63%	76.79%	71.50%	78.72%
Southport and Ormskirk Hospital	57.89%	54.21%	66.33%	66.95%	62.18%	67.68%	58.95%	70.49%	48.28%	67.48%	62.11%	64.86%
St Helens and Knowsley	85.57%	85.47%	84.41%	82.87%	85.02%	83.41%	85.37%	86.26%	90.29%	83.17%	85.42%	77.58%
The Clatterbridge Cancer Centre	83.53%	87.32%	86.67%	88.64%	92.42%	78.21%	75.86%	69.44%	79.52%	80.00%	59.38%	75.34%
The Walton Centre	-	-	100.00%	100.00%	-	-	-	-	-	-	-	-
Warrington and Halton Hospitals	71.62%	64.17%	51.25%	73.47%	72.34%	74.07%	70.65%	77.14%	76.74%	83.33%	62.28%	70.75%
Wirral University Teaching Hospital	85.94%	84.43%	79.21%	79.66%	79.29%	79.62%	79.33%	75.88%	79.17%	79.57%	75.66%	79.89%

Section V: Mental Health & Learning Disabilities

Section V: Mental Health Performance: Early Intervention in Psychosis, percentage seen within 2 weeks

NHS Cheshire and Merseyside

Proportion of open referrals on EIP pathway that waited for treatment within two weeks



Proportion of open referrals on EIP pathway that waited for treatment within two weeks

ICS/NW/England Summary

Organisation	May-22	Jun-22	Jul-22
Cheshire and Merseyside	76%	68.18%	77.78%
North West			
England	68.80%	67.78%	68.68%

Proportion of open referrals on EIP pathway that waited for treatment within two weeks
Provider Trend

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Cheshire and Wirral Partnership	80.00%	-	-	-	-	-	-	-	-	-	-	-
Mersey Care	68.97%	79.17%	76.00%	72.41%	66.67%	69.23%	70.83%	72.73%	80.00%	73.91%	77.78%	-

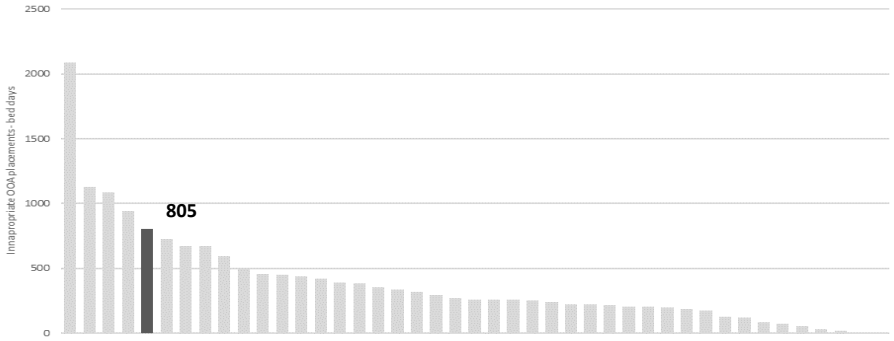
Place Trend

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
NHS Cheshire CCG	83.33%	-	-	-	-	-	-	-	-	-	-	-
NHS Halton CCG	-	50.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-
NHS Knowsley CCG	66.67%	50.00%	100.00%	66.67%	66.67%	100.00%	100.00%	50.00%	66.67%	50.00%	-	-
NHS Liverpool CCG	90.91%	80.00%	66.67%	61.54%	54.55%	63.64%	66.67%	70.00%	81.82%	72.73%	-	-
NHS South Sefton CCG	100.00%	100.00%	100.00%	100.00%	66.67%	66.67%	100.00%	100.00%	-	-	-	-
NHS Southport and Formby CCG	100.00%	100.00%	100.00%	100.00%	-	-	-	100.00%	100.00%	-	-	-
NHS St Helens CCG	50.00%	66.67%	66.67%	100.00%	50.00%	50.00%	50.00%	66.67%	75.00%	66.67%	-	-
NHS Warrington CCG	40.00%	100.00%	75.00%	100.00%	100.00%	50.00%	66.67%	66.67%	100.00%	100.00%	-	-
NHS Wirral CCG	75.00%	-	-	-	-	-	-	-	-	-	-	-

Section V: Mental Health Performance: Out of area placements

NHS
Cheshire and Merseyside

Total number of out of area placements days over the period



Total number of out of area placements days over the period

ICS/NW/England Summary

Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	1795	2015	805
North West	3450	3085	1835
England	18920	17655	17175

Total number of out of area placements days over the period

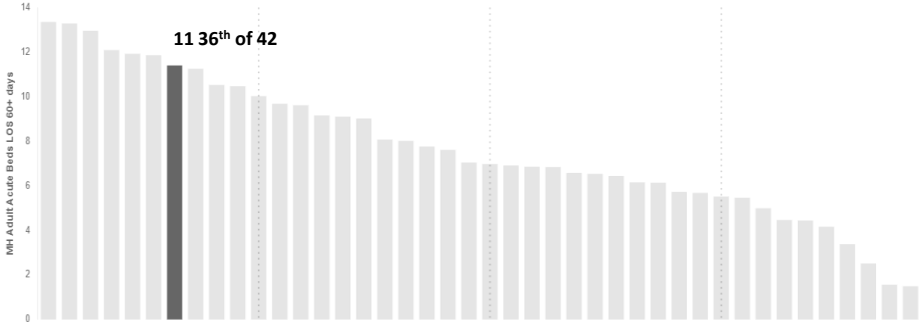
Place Trend

Organisation	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Cheshire	180	300	400	495	510	585	735	765	890	1045	1150	510
Halton	5	15	10	0	0	0	10	30	10	0	10	30
Knowsley	30	10	0	10	5	0	0	10	25	0	0	0
Liverpool	0	0	0	0	5	30	25	0	0	20	40	0
South sefton	0	0	0	0	0	0	0	0	0	0	0	0
Southport & Formby	0	0	0	0	0	0	0	0	0	0	0	0
St Helens	10	25	5	5	0	0	0	0	0	0	0	0
Warrington	110	20	0	0	10	30	30	10	0	0	0	0
Wirral	10	200	330	460	510	560	645	590	645	730	815	265

Section V: Mental Health Performance: MH Adult Acute Beds LOS 60+ days

NHS Cheshire and Merseyside

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



Rate of people discharged per 100,000 from adult acute beds aged 18 to 64 with a length of stay of 60+ days **ICS/NW/England Summary**

Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	**9**	**10**	**11**
North West			
England	**8**	**9**	**9**

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

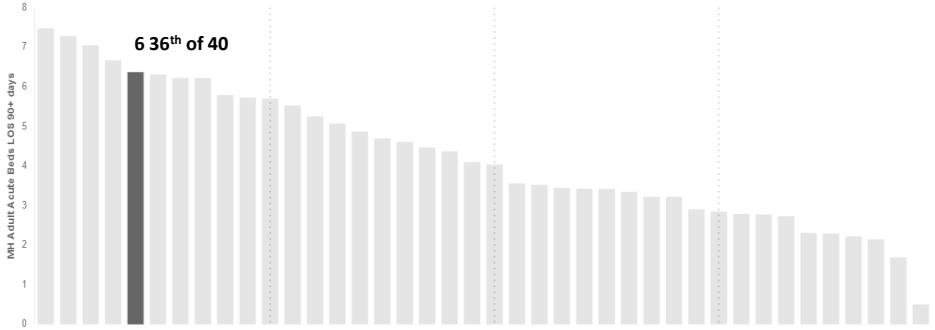
Place Trend

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
NHS Cheshire CCG	3	4	5	5	6	5	7	6	7	8	-	-
NHS Halton CCG	8	13	14	18	14	13	9	13	13	10	-	-
NHS Knowsley CCG	15	11	14	15	16	10	10	13	15	15	-	-
NHS Liverpool CCG	16	12	14	10	12	13	14	12	13	14	-	-
NHS South Sefton CCG	12	13	14	12	13	10	11	11	18	20	-	-
NHS Southport and Formby CCG	8	8	8	11	11	11	-	10	8	14	-	-
NHS St Helens CCG	13	9	7	8	8	5	5	12	17	18	-	-
NHS Warrington CCG	11	10	7	9	10	11	9	6	6	5	-	-
NHS Wirral CCG	6	5	4	7	7	9	6	6	6	6	-	-

Section V: Mental Health Performance: MH Adult Acute Beds LOS 90+ days

Cheshire and Merseyside

Rate of people discharged per 100,000 from adult acute beds aged 18 to 64 with a length of stay of 90+ days



Rate of people discharged per 100,000 from adult acute beds aged 18 to 64 with a length of stay of 90+ days **ICS/NW/England Summary**

Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	**5**	**6**	**6**
North West			
England	**5**	**5**	**5**

Rate of people discharged per 100,000 from adult acute beds aged 18 to 64 with a length of stay of 90+ days

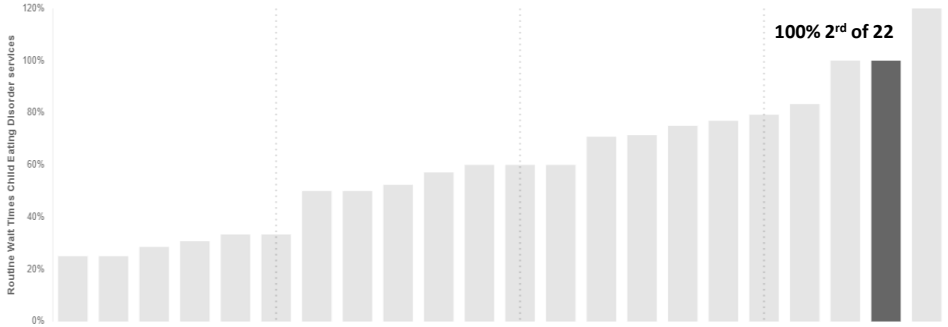
Place Trend

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
NHS Cheshire CCG	2	2	3	4	4	4	4	3	4	4	-	-
NHS Halton CCG	-	8	8	9	7	9	7	9	9	8	-	-
NHS Knowsley CCG	12	9	8	8	9	7	8	10	11	9	-	-
NHS Liverpool CCG	8	7	7	5	6	8	9	8	9	9	-	-
NHS South Sefton CCG	-	7	8	8	6	5	-	6	10	10	-	-
NHS St Helens CCG	8	8	5	6	5	-	-	10	14	15	-	-
NHS Warrington CCG	7	7	6	7	9	9	6	-	5	-	-	-
NHS Wirral CCG	-	-	-	4	4	5	3	3	4	3	-	-

Section V: Mental Health Performance: Children & young people with eating disorders seen in four weeks

NHS Cheshire and Merseyside

Proportion of referrals with eating disorders categorized as routine cases entering treatment within four weeks, aged 0-18



Proportion of referrals with eating disorders categorized as routine cases entering treatment within four weeks, aged 0-18

ICS/NW/England Summary

Organisation	May-22	Jun-22	Jul-22
Cheshire and Merseyside	83.0%	87.0%	100.0%
North West			
England	50.15%	54.90%	57.12%

Proportion of referrals with eating disorders categorized as routine cases entering treatment within four weeks, aged 0-18

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Cheshire and Wirral Partnership	-	10.0%	12.0%	-	-	-	-	-	-	-	-	-
Mersey Care	-	78.0%	87.0%	90.0%	94.0%	96.0%	97.0%	96.0%	95.0%	94.0%	96.0%	-

Place Trend

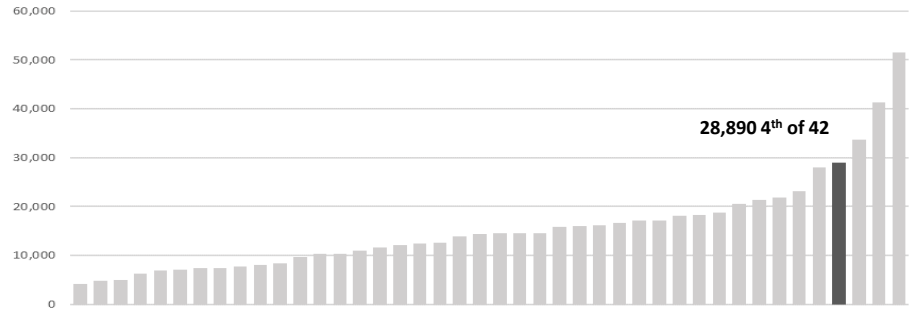
Organisation	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Cheshire	10.0%	12.0%	*	*	*	*	*	*	*
Halton	80.0%	88.0%	88.0%	85.0%	91.0%	100.0%	100.0%	100.0%	100.0%
Knowsley	83.0%	85.0%	100.0%	100.0%	100.0%	100.0%	95.0%	95.0%	94.0%
Liverpool	*	*	*	*	*	*	*	*	*
South sefton	*	*	*	*	*	*	*	*	*
Southport & Formby	*	*	*	*	*	*	*	*	*
St Helens	83.0%	89.0%	87.0%	96.0%	100.0%	100.0%	95.0%	80.0%	78.0%
Warrington	67.0%	84.0%	90.0%	94.0%	93.0%	91.0%	95.0%	100.0%	100.0%
Wirral	*	*	*	*	*	*	*	*	*

*Data Supressed

Section V: Mental Health Performance: Children and young people (ages 0-17) mental health services access (number with 1+ contact)

Cheshire and Merseyside

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



Children and young people (ages 0-17) mental health services access (number with 1+ contact) **ICS/NW/England Summary**

Organisation	Jan-22	Feb-22	Mar-22
Cheshire and Merseyside	27,985	27,530	28,890
North West	88,635	89,925	93,215
England	635,900	647,555	659,195

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

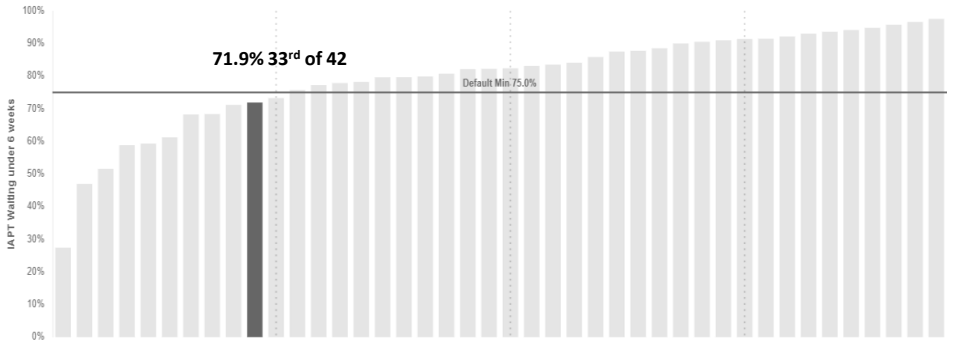
Place Trend

Organisation	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cheshire	6069	6180	6345	6495	6510	6495	6195	5820	5580	5400	5140	5270
Halton	1081	1092	1115	1110	1115	1150	1100	1055	1050	1095	1130	1230
Knowsley	1598	1681	1745	1725	1725	1745	1730	1760	1710	1740	1765	2020
Liverpool	7570	7755	8115	8160	7835	8015	7950	7915	8020	8025	7985	8495
South sefton	1563	1631	1665	1695	1690	1700	1735	1715	1740	1745	1765	1810
Southport & Formby	787	825	835	835	825	850	870	880	890	945	955	1010
St Helens	2955	2964	3015	2955	2925	2895	2805	2675	2560	2545	2460	2565
Warrington	2480	2586	2625	2650	2650	2715	2690	2650	2695	2755	2780	2830
Wirral	5074	5052	5225	5275	4585	4605	4375	4180	4055	3930	3740	3860

Section V: Mental Health Performance: IAPT waiting times within 6 weeks

NHS Cheshire and Merseyside

The percentage of IAPT Waiting under 6 weeks



The percentage of IAPT Waiting under 6 weeks

ICS/NW/England Summary

Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	71.1%	75.6%	71.9%
North West			
England	74.20%	76.12%	72.70%

The percentage of IAPT Waiting under 6 weeks

Provider Trend

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
Cheshire and Wirral Partnership	86.0%	87.1%	98.3%	53.4%	57.1%	66.3%	70.3%	61.7%	63.0%	61.1%	-	-
Mersey Care	53.0%	64.1%	75.6%	85.3%	92.8%	95.5%	95.0%	90.5%	94.3%	96.8%	-	-

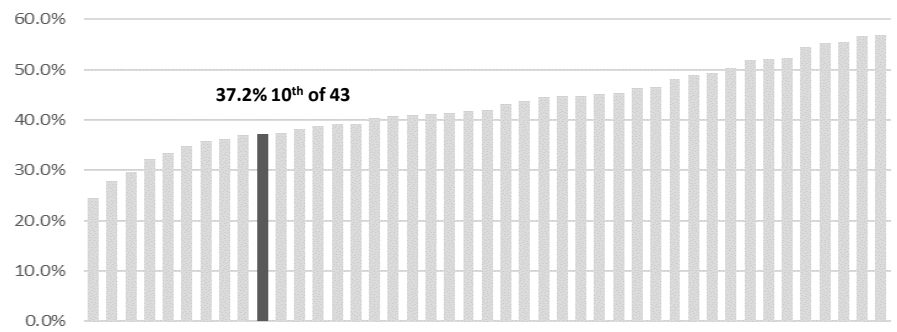
Place Trend

Organisation	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
NHS Cheshire CCG	84.3%	86.9%	93.1%	63.3%	67.4%	69.0%	70.4%	62.7%	63.7%	62.0%	-	-
NHS Halton CCG	97.3%	100.0%	95.7%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	96.4%	-	-
NHS Knowsley CCG	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	95.5%	93.8%	94.1%	100.0%	-	-
NHS Liverpool CCG	41.1%	52.7%	68.3%	80.8%	88.8%	94.1%	93.8%	86.1%	91.6%	95.8%	-	-
NHS South Sefton CCG	51.8%	64.8%	71.5%	61.3%	70.7%	79.6%	74.2%	69.7%	84.6%	80.0%	-	-
NHS Southport and Formby CCG	47.4%	54.5%	61.1%	61.0%	64.1%	73.8%	73.0%	71.0%	81.4%	76.8%	-	-
NHS St Helens CCG	94.7%	93.8%	100.0%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%	-	-
NHS Warrington CCG	93.4%	94.7%	86.2%	61.4%	62.8%	67.1%	61.4%	50.8%	60.7%	51.3%	-	-
NHS Wirral CCG	91.3%	87.6%	85.7%	80.1%	87.7%	89.6%	89.1%	83.5%	83.0%	86.0%	-	-

Section V: Mental Health Performance: Physical health checks for people with severe mental illness

NHS Cheshire and Merseyside

Physical health checks for people with severe mental illness



Physical health checks for people with severe mental illness

ICS/NW/England Summary

Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire and Merseyside	29.5%	36.2%	37.2%
North West	32.1%	41.7%	42.0%
England	34.9%	42.8%	43.5%

Physical health checks for people with severe mental illness

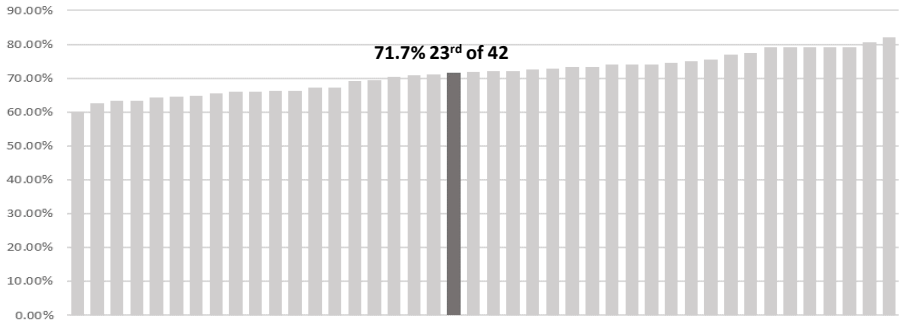
Place Trend

Organisation	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire	17.7%	14.2%	2.2%	18.1%	27.0%	27.7%	31.1%	36.0%	40.9%
Halton	31.1%	28.8%	28.7%	26.1%	31.1%	27.5%	31.1%	36.4%	37.7%
Knowsley	29.3%	22.2%	19.8%	17.3%	20.5%	20.4%	20.7%	27.0%	26.0%
Liverpool	28.6%	23.7%	20.5%	19.2%	24.6%	26.6%	31.0%	35.5%	36.5%
South sefton	19.0%	16.1%	12.3%	16.2%	20.8%	21.1%	23.9%	27.9%	30.0%
Southport & Formby	32.1%	28.0%	25.4%	22.4%	26.5%	27.3%	33.1%	47.4%	47.4%
St Helens	22.2%	18.2%	15.4%	11.5%	15.5%	16.6%	24.7%	31.5%	31.0%
Warrington	32.1%	27.2%	21.1%	20.3%	27.6%	31.4%	44.3%	60.5%	48.9%
Wirral	20.8%	15.5%	13.7%	12.0%	15.3%	17.8%	25.2%	35.9%	36.1%

Section V: Learning Disability Performance: Number of people aged 14+with a learning disability on the GP register receiving an annual health check

NHS Cheshire and Merseyside

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



Number of people aged 14+with a learning disability on the GP register receiving an annual health check **ICS/NW/England Summary**

Organisation	Q2 21/22	Q3 21/22	Q4 21/22
Cheshire and Merseyside	**24.5%**	**41.0%**	**71.7%**
North West	**22.3%**	**38.3%**	**68.0%**
England	**22.4%**	**40.5%**	**71.3%**

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

Place Trend

Organisation	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Cheshire	5.7%	20.0%	46.3%	77.8%	26.1%	47.5%	79.5%
Halton	1.3%	15.5%	41.7%	73.4%	26.3%	42.6%	78.6%
Knowsley	0.0%	0.0%	0.0%	70.9%	19.4%	34.3%	77.1%
Liverpool	7.7%	18.1%	41.5%	76.1%	25.9%	37.8%	67.6%
South sefton	8.9%	13.9%	23.8%	67.8%	19.3%	25.1%	65.0%
Southport & Formby	0.6%	8.4%	29.2%	72.7%	2.9%	38.9%	57.6%
St Helens	3.5%	12.5%	31.9%	67.8%	19.1%	40.5%	69.9%
Warrington	0.7%	22.0%	45.5%	72.2%	29.5%	48.4%	67.0%
Wirral	8.9%	17.7%	43.4%	75.0%	25.3%	40.0%	70.3%

Section VI: Primary Care

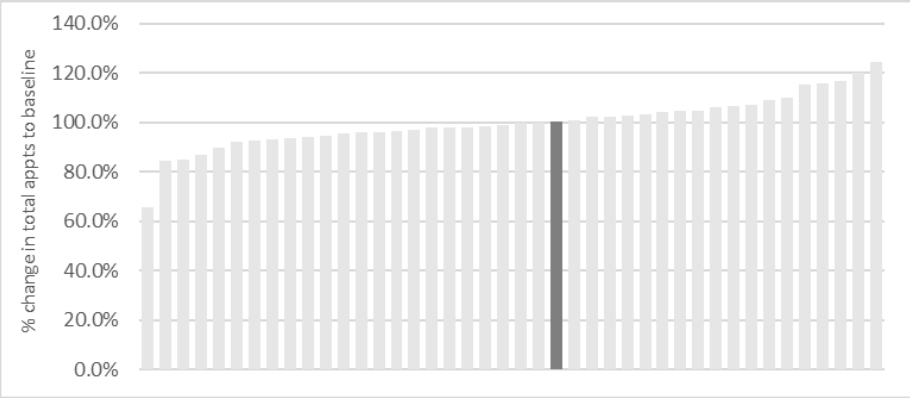
Sentinel Metrics:-

- Total appointments against pre-covid levels (Mar 19-Feb 20)
- Face to face appointments against pre-covid levels (Mar 19-Feb 20)
- Telephone appointments against pre covid levels (Mar 19-Feb 20)

Section VI: Primary Care Performance:
Total appointments delivered against pre-covid levels

NHS
Cheshire and Merseyside

Total appts ICS National benchmark: 0.1% to baseline, 24th of 42



Total appointments Benchmark

Organisation	May-22	Jun-22	Jul-22
Cheshire and Merseyside	15.2%	13.8%	0.1%
North West	13.6%	13.3%	-0.3%
England	11.4%	11.3%	-1.5%

Total appointments ICS Place Trend

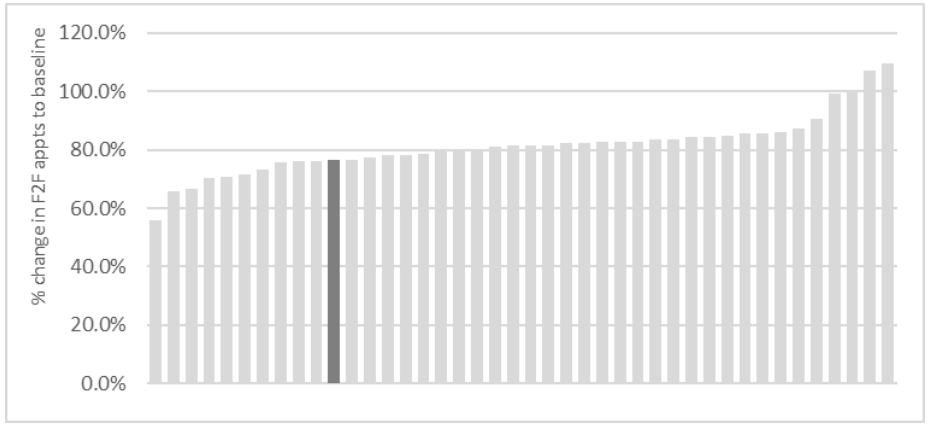
ICS Places

Organisation	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Cheshire	1.6%	2.8%	14.0%	3.0%	14.3%	7.5%	-7.3%	5.1%	16.5%	1.4%	15.7%	14.6%	2.5%
Halton	-3.5%	2.7%	18.4%	3.8%	10.0%	-1.7%	-16.8%	0.2%	8.9%	-6.4%	1.6%	2.6%	-9.1%
Knowsley	-7.3%	1.5%	5.5%	-0.5%	14.9%	2.3%	-8.9%	-1.8%	9.6%	-2.5%	9.7%	1.1%	-10.0%
Liverpool	1.9%	13.2%	16.8%	2.0%	19.6%	11.7%	3.3%	12.4%	26.2%	7.1%	16.1%	15.7%	-0.6%
South Sefton	-1.9%	1.2%	3.6%	-3.6%	10.2%	4.3%	-8.7%	-0.8%	11.9%	-4.9%	-0.2%	0.1%	-6.7%
Southport & Formby	3.5%	8.1%	22.2%	9.6%	19.9%	15.0%	2.4%	11.3%	20.6%	6.3%	13.6%	11.4%	-3.2%
St. Helens	-5.5%	3.8%	15.7%	3.5%	9.6%	4.4%	-4.8%	1.3%	15.0%	-2.8%	7.8%	3.3%	-6.0%
Warrington	8.9%	17.8%	18.2%	4.9%	18.3%	5.3%	-0.4%	13.6%	28.4%	10.4%	21.0%	20.6%	4.5%
Wirral	5.9%	17.0%	29.7%	9.6%	26.7%	20.8%	10.0%	21.6%	37.3%	16.4%	27.5%	27.8%	8.2%

Section VI: Primary Care Performance:
Face to Face appointments delivered against pre covid baseline

NHS
Cheshire and Merseyside

F2F appts ICS National benchmark: -23.5 % to baseline, 32nd of 42



Face to Face appointments Benchmark

Organisation	May-22	Jun-22	Jul-22
Cheshire and Merseyside	-12.5%	-12.8%	-23.5%
North West	-8.9%	-8.6%	-18.8%
England	-10.0%	-9.2%	-19.0%

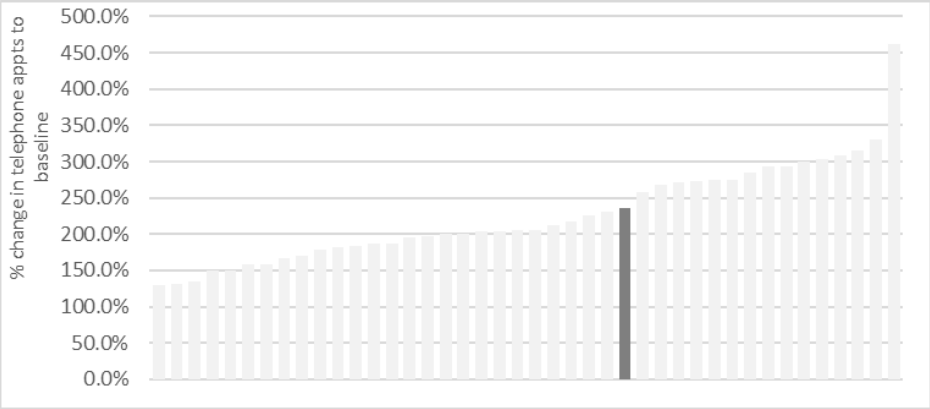
Face to face appointments ICS Place Trend

Organisation	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Cheshire	-40.0%	-35.4%	-21.0%	-24.6%	-21.2%	-28.3%	-38.8%	-28.5%	-20.1%	-27.6%	-14.3%	-13.9%	-25.3%
Halton	-30.2%	-25.5%	-6.3%	-14.4%	-11.4%	-22.5%	-34.3%	-18.5%	-8.8%	-20.5%	-13.4%	-11.7%	-20.6%
Knowsley	-34.8%	-28.6%	-26.0%	-24.3%	-16.3%	-30.9%	-35.6%	-27.6%	-19.2%	-29.3%	-20.3%	-26.0%	-31.6%
Liverpool	-36.7%	-28.0%	-23.3%	-25.5%	-13.4%	-22.9%	-31.3%	-22.7%	-12.1%	-25.1%	-17.5%	-16.9%	-27.4%
South Sefton	-48.7%	-39.7%	-33.9%	-30.6%	-23.1%	-28.9%	-40.1%	-31.5%	-20.7%	-32.2%	-23.0%	-26.4%	-33.3%
Southport & Formby	-43.4%	-39.5%	-20.6%	-24.0%	-20.8%	-23.8%	-33.8%	-27.3%	-20.8%	-25.2%	-18.5%	-19.6%	-30.5%
St. Helens	-36.9%	-29.6%	-14.4%	-20.9%	-20.3%	-27.6%	-34.5%	-29.1%	-18.1%	-28.6%	-17.3%	-17.1%	-24.0%
Warrington	-13.1%	-4.3%	-3.6%	-10.7%	-1.1%	-12.3%	-16.8%	-2.3%	8.2%	-4.9%	3.8%	3.4%	-10.4%
Wirral	-25.4%	-16.9%	0.7%	-13.1%	-2.2%	-9.3%	-19.0%	-9.3%	3.9%	-10.6%	0.2%	1.2%	-13.9%

Section VI: Primary Care Performance:
Telephone appointments delivered against pre-covid Baseline

NHS
Cheshire and Merseyside

Total appts ICS National benchmark: 236.2 % to baseline, 16th of 42



Telephone appointments benchmark

Organisation	May-22	Jun-22	Jul-22
Cheshire and Merseyside	282.6%	275.2%	236.2%
North West	329.9%	323.9%	278.8%
England	264.2%	260.1%	225.1%

Telephone appointments ICS Place Trend

Organisation	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Cheshire	301.1%	307.8%	326.9%	296.3%	337.6%	305.7%	253.9%	278.1%	302.8%	248.7%	268.5%	263.7%	231.4%
Halton	215.5%	224.3%	235.0%	199.9%	210.4%	188.8%	157.3%	179.1%	185.3%	151.1%	167.9%	163.5%	142.0%
Knowsley	309.7%	340.4%	385.9%	393.4%	516.4%	489.9%	316.1%	288.7%	316.4%	299.6%	325.3%	301.8%	262.4%
Liverpool	253.6%	271.8%	281.3%	223.9%	258.0%	239.9%	256.3%	265.3%	297.1%	248.1%	261.7%	250.2%	206.6%
South Sefton	359.5%	386.0%	372.2%	298.7%	335.2%	307.0%	316.9%	328.9%	346.9%	286.4%	301.3%	272.5%	226.2%
Southport & Formby	600.8%	553.5%	560.0%	470.0%	515.9%	439.6%	493.0%	539.6%	579.6%	440.9%	455.6%	444.7%	393.5%
St. Helens	336.7%	352.2%	379.6%	332.1%	370.2%	351.5%	313.7%	344.9%	371.1%	309.9%	340.6%	357.6%	304.1%
Warrington	330.4%	341.8%	355.4%	298.1%	343.0%	286.7%	277.7%	298.5%	343.5%	262.8%	295.7%	282.5%	245.6%
Wirral	368.6%	388.0%	393.3%	332.5%	385.6%	364.1%	341.2%	364.0%	394.9%	325.0%	335.9%	341.5%	295.2%

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Executive Director of Nursing& Care Report

29 September 2022

Agenda Item No	ICB/9/22/**15**
Report author & contact details	Michelle Creed, Interim Associate director of Nursing & Care
Report approved by (sponsoring Director)	Report approved by Chris Douglas Executive Director of Nursing & Care
Responsible Officer to take actions forward	Chris Douglas, Executive Director of Nursing & Care

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB
Integrated Care Board Meeting

Executive Director of Nursing & Care Report (September 2022)

Executive Summary	The Purpose of this report is to provide assurance from the Executive Director of Nursing & Care to the C&M ICB Board regarding the quality, safety and patient experience of services commissioned and provided across the geographical area of Cheshire & Merseyside. The report outlines the progress that the ICB has made regarding quality, safety and patient experience of services commissioned and provided across the geographical area of C&M. It demonstrates the progress made of the arrangements in place for ensuring the fundamental standards of quality are adopted and delivered.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		X
Recommendation	**The Board is asked to:** • To note the content of the report				
Key issues	Patient Safety Incident Response Framework (PSIRF) development to maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Headline findings of the One-to-One Midwifery Provider NHS England commissioned review by Niche Health and Social Care Consulting.				
Key risks	The forthcoming published findings and recommendations following the Joint Targeted Area Inspection of Cheshire East children's safeguarding partnership.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
			X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		X	X	X	
Route to this meeting	The quality, surveillance, oversight and assurance has been discussed and approved by the Quality & Performance Committee August 2022, September 2022.				
Management of Conflicts of Interest	N/A				
Patient and Public Engagement	N/A				
Next Steps	N/A				
Appendices	N/A				

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB
Integrated Care Board Meeting

Executive Director of Nursing & Care Report (September 2022)

1. Summary

1.1 The Purpose of this report is to provide assurance from the Executive Director of Nursing & Care to the C&M ICB Board regarding the quality, safety and patient experience of services commissioned and provided across the geographical area of Cheshire & Merseyside.

2. NHS and Independent Provider Trusts

2.1 **One to One Midwifery.** One to One Midwives was an independent sector provider established in 2010 to provide maternity services to NHS-funded clients through a midwifery-led, community-based, 'case loading' model, this aimed to provide a named midwife to care for a woman throughout all stages of her pregnancy. Despite attempts by stakeholders at a local, regional and national level to find solutions, these challenges proved insurmountable. The company went into voluntary administration on 1 August 2019 with estimated debt due to NHS Trusts of £2.4m for provider-to-provider charges.

2.2 NHS incident management plans were implemented for the safe transfer of more than 1,800 women to the care of local NHS Trusts. The plan was promptly and successfully implemented by mid-August 2019. An estimated additional cost of £1m was incurred by the NHS to manage the impact of the business cessation.

2.3 Niche Health and Social Care Consulting were asked by NHS England to review the circumstances which led to the cessation of community maternity services provided by One-to-One Midwives. The work included consideration of the commissioning and contracting processes, governance and oversight, and financial viability as well as the chronology of events which led to the cessation of the service. The report was embargoed at the time of writing this briefing, however, there are recommendations for:

- National and System learning
- Commissioners
- NHS Providers
- Independent Sector Providers.

2.4 The published report will be reviewed, and a briefing paper taken to the October 2022 ICB Quality & Performance Committee with recommendations for implementation of the findings.

2.5 **Joint Targeted Area Inspection.** The Joint Targeted Area Inspection was an intensive inspection of Cheshire East's children's safeguarding partnership, involving inspectors from Ofsted, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services and the Care Quality Commission.

2.6 The inspection took place from 27 June to 15 July 2022 and focused on the multi-agency identification of risk and need in response to child criminal exploitation, including sexual exploitation. The final findings will be published in the form of a letter. Inspectors identified several areas for development across the partnership and as partners we are working at pace to address these through a multiagency improvement plan. The published findings and recommendations will be presented to the Quality & Performance Committee.

3. Patient Safety

3.1 **Patient Safety Incident Response Framework (PSIRF).** The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

3.2 The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

3.3 The PSIRF is not a different way of describing what came before, it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead, it advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

3.4 Organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes. To do so, information is collected and synthesised from a wide variety of sources, including wide stakeholder engagement.

3.5 The principles and practices within the PSIRF embody all aspects of the NHS Patient Safety Strategy and wider initiatives under the strategy, including the introduction of patient safety specialists, development of a national patient safety syllabus, development of the involving patients in patient safety framework and introduction of the Learn from Patient Safety Events service. The NHS Patient Safety Strategy sits alongside and supports the NHS Long Term Plan.

3.6 The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

3.7 Organisations that provide NHS-funded secondary care under the NHS Standard Contract but are not NHS trusts or foundation trusts (e.g., independent provider organisations) are required to adopt this framework for all aspects of NHS-funded care

3.8 Primary care providers may wish to adopt this framework, but it is not a requirement. Primary care providers that wish to adopt this version of the framework should work with their Integrated Care Board (ICB) to do so. Further exploration of roll out to Primary Care is required.

3.9 The implementation and impact of PSIRF is being evaluated via a National Institute for Health Research (NIHR)-funded study that started in May 2022. The National Patient Safety Team will use the evaluation findings together with national indicators of effectiveness to inform future iterations of PSIRF in formative and summative manner, to enable the NHS to continue to improve its approach to patient safety management. The national team will continue to build on the foundations set by PSIRF in developing a safety management system that ensures a methodical and systematic approach to risk management as used in other high-risk industries.

3.10 Seventeen early adopter provider organisations tested the introductory version of the PSIRF alongside their commissioners (now ICBs) and NHS England regional leads. An independent evaluation of the early adopter programme found widespread support for the PSIRF; all recommendations from this were carefully considered by the National Patient Safety Team when revising PSIRF documents. The experience of early adopters and insights gained from the early adopter programme have also informed this revision.

3.11 In Cheshire & Merseyside we are beginning the process of implementation of PSIRF and this will be developed and presented through the Quality & Performance Committee as to progress along with the completion of current incidents utilising the existing response model. A date for full implementation of PSIRF will be confirmed at a later date.

4. Quality Surveillance, Oversight and Assurance

4.1 The landscape of health and care has changed following the passage of the Health and Social Care Act 2022. There has been a requirement to review the quality surveillance, oversight, and assurance governance mechanisms in place across Cheshire & Merseyside (C&M). As Integrated Care Boards (ICBs) develop and we recover from the pandemic, it is crucial that ICBs recognise their Triple Aim duty to deliver high quality care and put quality, including safety, at the forefront of planning and decision-making.

Cheshire and Merseyside ICB
Integrated Care Board Meeting

4.2 **How will we achieve this in Cheshire & Merseyside?** Quality is at the heart of all that we do. Each NHS organisation has individual responsibilities to ensure the delivery of high-quality care. ICB NHS bodies also have statutory duties to act with a view to securing continuous improvement in quality. We have arrangements in place for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them. ICBs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care. ICB NHS bodies will need to resource quality governance arrangements, including leading System Quality Groups (previously Quality Surveillance Groups) and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement.

4.3 **C&M ICB Quality & Performance Committee.** The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Q&P Committee provides the ICB assurance that it is delivering on its statutory and regulatory functions in respect of quality which is set out in Shared Commitment to Quality and enshrined in H&SC Act 2022. Membership and Terms of Reference agreed, with the inaugural meeting held in August 2022. A workplan is in place. Reporting to: C&M Integrated Care Board (ICB)

4.4 **Place Quality & Performance Groups.** Will be responsible for local system quality, safety and experience of services delivered across health and care, reducing inequalities, improve outcomes, support local provider collaboratives in each Place. Place Partnerships will collectively plan, deliver, and monitor services within a locally defined 'place.' This bottom-up approach will be an important enabler to meaningful collaboration, improvement of service planning and delivery, and a forum to allow partners to collectively address wider determinants of health.

4.5 **Standardised Terms of Reference**: agreed at C&M Quality & Performance Committee in August 2022. All Places across C&M (Cheshire East, Cheshire West, Wirral, Liverpool, Sefton, Knowsley, St Helens, Halton, Warrington) consulted locally on membership and have scheduled dates in the diary for the calendar year. Monthly Key Issues reports are provided to C&M ICB Quality & Performance Committee. Reporting to:

- Place Based Partnership Board
- C&M ICB Quality & Performance Committee
- Working in partnership with:
- C&M System Quality Group
- Provider Collaboratives.

4.6 **C&M System Quality Groups (SQG).** A strategic forum were partners from across health, social care, public health, regulators, and wider partners within the C&M ICB can join up around common priorities. Routinely and systematically share insight and intelligence, identify opportunities for improvement and concerns/risks to quality, and develop system responses to enable ongoing improvement in the quality of care and services across the C&M ICB. Membership and Terms of Reference agreed at C&M Quality & Performance Committee in August 2022, with the inaugural meeting held in July 2022. Reporting to:

- C&M ICB Quality & Performance Committee
- Regional Northwest System Quality Group.

4.7 **Provider Collaboratives.** Accountable for delivery, efficient use of resource and decision-making, streamline ways of working, shared vision, and commitment to collaborate at scale. C&M have 3 Provider Collaboratives:

- C&M Acute, Specialist Trusts (CMAST),
- C&M Community, Mental Health & Learning Disability Trust (CMCMHLD),
- C&M Primary Care Networks (CMPCNs).

4.8 Reporting to:

- Provider Trust Boards
- C&M ICB.

4.9 Working in partnership with:

- CMAST, CMCMHLD, PCN Boards
- C&M Integrated Care Partnership (ICP)
- Place Quality & Performance Groups
- C&M System Quality Group.

4.10 **Clinical and Professional Leadership**. All ICSs must develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. We have developed a C&M Clinical and Care Professional Framework. We will ensure professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decisionmakers, with a central role in setting and implementing ICB strategy. These arrangements support and enhance those of the organisations within the ICB footprint, which are responsible for the professional and clinical leadership of their people and services.

5. Conclusion

5.1 The content of the report outlines the progress that the ICB has made regarding quality, safety and patient experience of services commissioned and provided across the geographical area of C&M. It demonstrates the progress made of the arrangements in place for ensuring the fundamental standards of quality are adopted and delivered.

6. Recommendations

6.1 The Board is asked to note the report.

NHS
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NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Audit Committee Chair

29 September 2022

Agenda Item No	ICB/9/22/**16**
Report author & contact details	Matthew Cunningham, matthew.cunningham@nhs.net
Report approved by (sponsoring Director/ Chair)	Neil Large, Chair of the Audit Committee
Responsible Officer(s) to take actions forward	Claire Wilson, Executive Director of Finance Mark Bakewell, Deputy Director of Finance Matthew Cunningham, Associate Director of Corporate Affairs and Governance

NHS
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Cheshire and Merseyside ICB Board Meeting

Report of the Audit Committee Chair

Executive Summary	The Audit Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 06 September 2022. This was the first formal meeting of the Committee. The meeting was quorate and was able to undertake its business. Main items considered at the meeting included: • Committee Terms of Reference • update on the ICB approach to Conflicts of Interest management • update on the approach to develop a risk framework for the ICB • an update on the process for the production of the Annual Report and Accounts 2022-2023 • Internal Audit recommendation against CCG Legacy Issues • 2022/23 Internal Audit Plan for the ICB • ICB Anti-Bribery and Counter Fraud Policy • 2022/23 ICB Anti-Fraud Plan • ICB Counter Fraud Champion appointment • information governance policies and Privacy Statements • internal and external audit arrangements for the ICB going forward. The next meeting of the Committee is scheduled to be held on 06 December 2022.

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

Recommendation	**The Board is asked to:** • **note** the items covered by the Audit Committee at its first meeting • **approve** the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee (Appendix A) • **note** the approval of the Internal Audit Plan for the ICB • **approve** the Committee recommendation to approve the ICB Anti-Bribery and Counter Fraud Policy (Appendix B) and its subsequent publication • **note** the approval of the ICB Anti-Fraud Plan • **approve** the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role • **approve** the Committee recommendation to approve the ICB Information Governance Policies and statements / Privacy notices (Appendix C - H) and their subsequent publication • **note** the future plans regarding Internal and External Audit arrangements for the ICB.

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

Management of Conflicts of Interest	None	
Next Steps	Following consideration of this paper and if approvals against the recommendations are provided by the Board then: • an updated Terms of Reference will be published on the ICB website • the ICB Anti-Bribery and Counter Fraud Policy will be published on the ICB website and details provided to ICB staff • details of the ICB Counter-fraud champion will be published on the ICB website and details provided to ICB staff • ICB Information Governance Policies and Privacy Notices will be published on the ICB website and details provided to ICB staff.	
Appendices	**CLICK HERE** to access all Appendices online (143 pages)	
	Appendix A	Committee Terms of Reference v1:1
	Appendix B	ICB Anti-Bribery and Counter Fraud Policy
	Appendix C	Information Governance Breach Reporting Policy
	Appendix D	Information Governance Code of Conduct
	Appendix E	Employee Privacy Notice
	Appendix F	Public Privacy Notice
	Appendix G	Data Protection and Security Policy
	Appendix H	Information Governance Handbook

Report of the Audit Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Audit Committee (Statutory Committee)	The main purpose of the Committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	Neil Large, Non-Executive Director

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
-	06.09.22	**ICB Conflicts of Interest Update**. Committee members received an update on the ICBs work around implementing the ICBs Conflicts of Interest (COI) Framework, and the population of and management of its COI registers. Members also received an update with regards development of COI training for ICB and the scoping of a single management system for the ICB. Internal Audit confirmed that part of the Internal Audit Plan and Counter Fraud plan is to review Conflicts of Interest framework of the ICB. Actions were taken away to strengthen further the policy and also for the Associate Director of Corporate Affairs and Governance to work with the Chief People Officer around COI training for staff and Board members. The Committee: • noted the progress made so far in the establishing the NHS C&M processes around the management of Conflicts of Interest including the establishment of a published Declaration of Interest Register. • took assurance that the processes established are robust and in line with national guidance. • noted intended next steps, including the issues presented regarding consistency and interdependencies.
-	06.09.22	**ICB Risk Framework Development.** Committee members received an update on the development of the ICB Risk Framework and the steps that are being taken

Decision Log Ref No.	Meeting Date	Issues considered
		prior to the Framework coming to the ICB Board for approval, scheduled for October 2022. Committee members received updates on progress regarding developing a Board Assurance Framework approach for the ICB, training that will need to be developed to support standard approach to risk (rationalization and management), development of risk registers, handling of legacy risks and key next steps and timelines for an implementation plan. The development of a workshop on risk for the ICB Board was seen as a priority to progress. The Committee endorsed the risk management strategy and noted the implementation plan and expectation to bring further detail to the Board at a future meeting of the Board.
	-	**Annual Report and Accounts 2022-23.** Committee members received a briefing note in respect of the Annual Report and Accounts requirements in relation to both the Q1 (CCG) and Q2-Q4 (ICB) periods within the 22/23 financial year. Annual Report guidance states that a first draft Annual Report should be produced for early October 2022, however, will exclude the annual accounts and staff costs. ICB Annual Report and Accounts guidance for Q2-Q4 is yet to be received although is expected in November / December. The ICB will be expected to publish on their public website Q1 CCG accounts and Q2-Q4 ICB Annual Report and Accounts by 11 July 2023 and hold a public Annual General Meeting to present the Annual Report and Accounts by 30 September 2023. The Chief Executive will be expected to sign off both Q1 and Q2-4 Annual Report and Accounts. Committee members noted the expected arrangements for the 2022/23 Annual Report and Accounts.
-	06.09.22	**C&M CCGs Legacy Issues – Internal Audit Recommendations.** The Committee received an pdate from MIAA on the Internal Audit Recommendations report on CCG legacy issues. There were no recommendations to highlight to the Committee at this stage. MIAA will be providing a further update to the Committee at its meeting in December 2022.
-	06.09.22	**Internal and External Audit and Counter Fraud Contracts**. Committee members received a report from the Deputy Director of Finance regarding contract arrangements for both internal and external audit. No representatives from Internal or External Audit organisations were present for this item of the meeting.

Decision Log Ref No.	Meeting Date	Issues considered
		Committee members: • noted that the 9 predecessor CCG Governing Bodies supported the continuation of the current internal and audit providers to ensure consistency of approach for Q1 CCG reporting and Q2-Q4 ICB reporting. Members noted that the ICB has honoured the five year MOU for internal audit and counter-fraud services with MIAA, with a further market review to be undertaken for after March 2024 • noted that a one-year extension to contract had also been approved for External Audit provision for Grant Thornton for the 2022/23 period • noted that a procurement exercise will be required for the 2023/24 period and beyond for the External Audit provision, and the requirement to have undertaken this exercise by the end of December 2022 • an Audit Panel will be arranged to take forward the arrangements.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
-	06.09.22	**Committee Terms of Reference.** At its meeting Committee members considered and agreed proposed revisions to the Committees Terms of Reference. It was agreed by the Committee that the Vice Chair of the Audit Committee would be Erica Morriss, Non-Executive Director on the ICB Board.
-	06.0.22	**Draft Internal Audit Plan 2022/23.** The Committee received an update from MIAA on the Draft Internal Audit Plan 2022/23 which is based on national guidance and local and national risks. The plan includes audit reviews at Place level in terms of Conflicts of Interests and Place level assurance framework. Committee members were informed that NHSE recently mandated a Key Financial Controls Audit review and this will be undertaken in two phases to provide assurance that the most significant key controls are appropriately designed and operating effectively at the ICB. Additionally, the Data Security Protection Toolkit (DSPT

Decision Log Ref No.	Meeting Date	Issues considered
		review will be undertaken. The Committee approved the draft ICB Internal Audit Plan for 2022/23.

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
-	-	-

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
-	06.09.22	**Committee Terms of Reference.** At its meeting Committee members considered and agreed proposed revisions to the Committees Terms of Reference. Additions are highlighted in **blue** and revisions in ~~**red**~~. **The main change is in relation to enabling the Committee to have the authority to:** *"Commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board."* Amendments have also been made to the quoracy arrangements for the Committee, as well as strengthening within the TOR the reporting requirements and expectations to the ICB Board. **The Board is asked to approve the recommendation of the Audit Committee to approve its revised Terms of Reference.**
-	06.09.22	**ICB Anti-Bribery and Counter Fraud Policy.** At its meeting Committee members considered and approved the ICBs Anti-Bribery and Counter Fraud Policy which has been developed by ICBs Anti-Fraud Specialist. ICBs Anti-Bribery and Counter Fraud Policy intended to provide a guide for all ICB employees [regardless of

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
		position or employment status], contractors, consultants, vendors and other internal and external stakeholders who have a professional or business relationship with the ICB, on what fraud and corruption are in the NHS; what everyone's responsibility are to prevent fraud, bribery and corruption; and also how to report concerns and/or suspicions with the intention of reducing fraud to a minimum within the ICB. This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud, corruption or bribery. The Policy provides a framework for responding to suspicions of fraud, bribery and corruption, advice and information on various aspects of fraud, bribery and corruption and implications of an investigation. It is not intended to provide a comprehensive. **The Board is asked to approve the ICB Anti-Bribery and Counter Fraud Policy and its subsequent publication.**
-	06.09.22	**ICB Counter Fraud Champion appointment.** Committee members heard about the requirement for the ICB to have a Counter Fraud Champion and that they have to be employed by the ICB, have a senior role and have an element of strategic oversight and influence in the ICB. The remit of the Counter Fraud Champion is to support the anti-fraud specialist but the accountability line is with the Executive Director of Finance. The remit includes championing and promoting counter fraud and reporting key messages across the organisation, identifying opportunities, facilitating access to information and progressing and implementing recommendations, along with facilitation and liaison. The establishment of a network of Counter Fraud Champion is being developed and is a work in progress. It was proposed that ICB Deputy Director of Finance would act as the interim Counter Fraud Champion until further guidance is available. The introduction of Counter Fraud Ambassadors will be discussed at the 9 Places. The Committee supported this proposal. **The Board is asked to approve the Committee recommendation that the Deputy Director of Finance is appointed as the interim ICB Counter Fraud Champion.**

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
-	06.09.22	**Information Governance Policies.** Committee members were presented with a number of Information Governance Policies for review. A number of minor amends were requested for the policies prior to them being submitted to the Board for approval, however the Committee endorsed the following policies to be approved by the Board: • Information Governance Breach Reporting Policy • Information Governance Code of Conduct • Employee Privacy Notice • Public Privacy Notice • Data Security and Protection Policy • Information Governance Handbook. **The Board is asked to approve the Committee recommendation that the named IG Policies are approved by the Board.**

6. Recommendations

6.1 **The ICB Board is asked to:**

- **note** the items covered by the Audit Committee at its first meeting
- **approve** the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee (Appendix A)
- **note** the approval of the Internal Audit Plan for the ICB
- **approve** the Committee recommendation to approve the ICB Anti-Bribery and Counter Fraud Policy (Appendix B) and its subsequent publication
- **note** the approval of the ICB Anti-Fraud Plan
- **approve** the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role
- **approve** the Committee recommendation to approve the ICB Information Governance Policies and statements / Privacy notices (Appendix C - H) and their subsequent publication
- **note** the future plans regarding Internal and External Audit arrangements for the ICB.

7. Next Steps

7.1 Following consideration of this paper and if approvals against the recommendations are provided by the Board then:

- an updated Terms of Reference will be published on the ICB website
- the ICB Anti-Bribery and Counter Fraud Policy will be published on the ICB website and details provided to ICB staff
- details of the ICB Counter-fraud champion will be published on the ICB website and details provided to ICB staff
- ICB Information Governance Policies and Privacy Notices will be published on the ICB website and details provided to ICB staff.

NHS
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NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Quality & Performance Committee Chair

29 September 2022

Agenda Item No	ICB/9/22/**17**
Report author & contact details	Michelle Creed, Interim Associate Director of Nursing & Care Michelle.Creed@nhs.net
Report approved by (sponsoring Director/ Chair)	Tony Foy, Chair
Responsible Officer to take actions forward	Kerrie Lloyd, Deputy Director of Nursing & Care

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB Board Meeting

Report of the Quality & Performance Committee Chair

Executive Summary	The purpose of this report is to provide assurance to the C&M Integrated Care Board in regard to key issues, considerations, approvals and matters of escalation considered by the C&M ICB Quality & Performance Committee in securing continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centered, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X	X		
Recommendation	**The Board is asked to:** 1. Section 2 - note the content 2. Section 3 - note the content and the issues considered by the Committee and actions taken. 3. Section 4 - Consider the matters escalated to the ICB Board regarding: ▪ No One is Listening Enquiry ▪ Annual Health Checks for People with Learning Disabilities 4. Section 5 - Approve the amendments to the revised Terms of Reference for the ICB Quality & Performance Committee.				
Key issues	▪ No One is Listening Enquiry ▪ Health Checks for People with Learning Disabilities				
Key risks					
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X	X	X	X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X	X	X	X	
Management of Conflicts of Interest	No conflicts of interest declared at the Committee.				
Next Steps	Noted in the body of report.				
Appendices	**Appendix A**	No One is Listening Report			
	Appendix B	Quality & Performance Committee Terms of Reference			

Report of the Quality & Performance Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Quality & Performance Committee	The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues. In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties: • Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); and • Adult safeguarding and carers (the Care Act 2014).	Tony Foy

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
QPC/9/22/04	08/09/2022	**ICB Quality & Performance Committee Workplan** 2022/2023 has been developed to include statutory duties, roles and responsibilities and key quality and safety transformation programme reporting.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Decision Log Ref No.	Meeting Date	Issues considered
		Leads are identified for each area and reporting timescales identified.
QPC/9/22/07	08/09/2022	**Quality & Performance Dashboard** The work to date was noted in regard to the development of Patient View and the team congratulated on the extensive work completed. Further work required to ensure the focus of performance data is triangulated across Nursing, Medical and Performance directorates and there is a clear narrative submitted. Executive Leads meeting to discuss.

QPC/9/22/08	08/09/2022	**Place Quality & Performance Groups Aggregated Report.**
		The Committee received a paper providing assurance regarding the quality, safety and experience of services commissioned across the C&M geographical area from each of the 9 Places, being Cheshire East, Cheshire West, Wirral, Liverpool, Sefton, Knowsley, St Helens, Halton and Warrington.
		
		Key discussion points:
		• ICB Service Improvement Boards progress, action plans, areas of concern and next steps for
		  ○ Countess of Chester Hospitals NHS FT,
		  ○ Liverpool University Hospitals NHSFT
		• Enhanced surveillance
		  ○ Cheshire & Wirral Partnership Trust
		• Place Risk Registers
		• Sefton Place, Domestic Homicide Review threshold met.
		• Wirral Place, rising C.Difficile infection rates a system priority.

QPC/9/22/09	08/09/2022	**GP survey Results** The results of the 2022 GP Patient Survey demonstrate an overall drop in satisfaction with General Practice at a national level that is reflected in Cheshire and Merseyside. The committee discussed whilst important not to ignore this fact it is good to note that practices in Cheshire and Merseyside have performed better than the national average for most indicators. Clearly, covid was a factor in some practices returning to normal and both the LMC and practices have stressed this. Committee agreed that In Cheshire and Merseyside we aspire to having outstanding, high quality General Practice for the people we serve. We can use these results to help inform and improve. The committee discussed the importance of each Place to continue to work with challenged PCN's and individual practices to improve patient experience. The Chair suggested that we may choose at a future meeting to hear from Place Q&P Groups about continuing challenges and progress.

Decision Log Ref No.	Meeting Date	Issues considered
		Medical Directorate have a focused initiative underway with clear actions.
QPC/9/22/13	08/09/2022	**Cheshire & Merseyside Antimicrobial Prescribing Board** This report provided the Quality and Performance Committee members with assurance on the work led by the Cheshire and Merseyside Antimicrobial Resistance (AMR) Joint Oversight Board. The AMR Joint Oversight Board role is to co-ordinate a shared strategic direction for the management and improvement of health care associated infections (HCAI's) and anti-microbial prescribing and create a network of senior professionals to lead delivery of the strategic objectives for Antimicrobial Resistance (AMR) / Antimicrobial Stewardship (AMS), Gram negative Blood stream infection (GNBSI), Infection Prevention and Control (IPC) and sepsis across the Cheshire and Mersey footprint, supported by 9 Place system plans. Quarterly reporting will be to Committee. Key success to date: ▪ The catheter passport has been successfully rolled out in September 2021 across Cheshire and Merseyside to raise awareness through standardizing information for staff and patients in receipt of catheter care. ▪ Board members are committed and have attended two all day NHSE regional workshops in February and July 2021. ▪ Hydration pilot – Cheshire and Merseyside are one of seven areas nationally to successfully bid for funding on behalf of the northwest region to pilot assistive technology to improve hydration in the elderly population. A total of 300K has been awarded to the Northwest region, led by Cheshire and Merseyside ICS.
QPC/9/22/17	08/09/2022	**Medicines Optimization and Safety** Paper received for assurance. To enable Cheshire and Merseyside ICB to meet all statutory requirements and provide future quality and performance assurance in relation to community pharmacy commissioning, medicines and prescribing the ICB is currently out to recruitment for an ICS Chief Pharmacist. The Chief Pharmacist role will provide strategic leadership for: • the pharmacy profession and workforce within the ICS • medicines commissioning and supply • emergency planning, preparedness and resilience

Decision Log Ref No.	Meeting Date	Issues considered
		• medicines and prescribing initiatives with a focus on reducing unwarranted variation, promoting equity of access and supporting transformational change and, • supporting COVID-19 recovery and the restoration of sustainable services.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
QPC/9/22/05	08/09/2022	Minutes of the previous minutes were approved as a true and accurate record of the meeting
QPC/9/22/06	08/09/2022	Action Log reviewed and Actions Closed or Updated.
QPC/9/22/08	08/09/2022	Committee considered and Approved the Terms of Reference for all 9 Place Quality and Performance Groups.
QPC/9/22/11	08/09/2022	**C&M Quality Impact Assessment Policy** This item was considered. Approval was deferred as additional work is required to finalise the Policy. Scheduled for future meeting.
QPC/9/22/14	08/09/2022	**North Mersey Urgent and Emergency Care CQC System Inspection findings** Report received for assurance which gave an overview of the new CQC inspection methodology used to undertake a review of urgent and emergency care services across Liverpool, Knowsley, South Sefton and St. Helens as a system. The findings of the review were outlined and the work to date undertaken across the North Mersey system to collate the recommendations into one action plan, align with other related work, and the governance and oversight to ensure effective implementation, and assessment of the impact of the improvement work. A system Executive Safety Huddle is in place with focus on: ▪ System workforce ▪ Telehealth growth ▪ Urgent Treatment Centre (UTC) development ▪ Care Homes & provision of packages of care ▪ Specialist Trust escalation increase ▪ Data quality ▪ Modelling and forecasting ▪ Discharge structure & infrastructure ▪ Avoiding attendances and admissions

Decision Log Ref No.	Meeting Date	Issues considered

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
QPC/9/22/15	08/09/2022	**C&M Transforming Care Programme** The Transforming Care Programme is a national programme led by NHS England which is all about improving health and care services so that more people with learning disabilities and/or autism can live in the community, with the right support, close to home and have the same opportunities as anyone else. A comprehensive paper was received. Key discussion points: • CYP Inpatient admissions have reduced significantly to currently 6 • For Adults, our admission rates have increased to 101 (23 above target) • 14 Delayed Discharges been identified. A recovery plan is in place • 38 Care and Treatment Reviews (CTR's) are out of date within NHSE. A task and finish group has been set up to address this issue • Safe and Well Being Reviews completed, and report being prepared on the findings and will come back to future meeting. Key issue for escalation in regard to **Annual Health Checks** (AHC) for people with Learning Disabilities (LD). • Annual Health Check (AHC) is a GP enhanced service. • From 1st April 2022 reporting returned to the LD Annual Health Check dataset as the published data source. • The delivery of LD Annual Health Checks is treated as a priority and work is undertaken to monitor and encourage uptake, as well as quality assure and implement improvements, where identified. • During Q1 and Q2 there has been a focus to reach and make appointments for those who have not

Decision Log Ref No.	Meeting Date	Issue for escalation
		received an LD AHC in the past 12 months+ in addition to those that are due their checks. Reporting on 'outstanding AHCs' from 2021/22 has proven challenging. Standardised reporting is being developed across Cheshire and Merseyside BI to enable consistent reporting. • **Current performance at Q2. ranges between 2 -10% across all Places against a target of 70%**
QPC/9/22/19	08/09/2022	**No One is Listening Enquiry** All Party Parliamentary Group (APPG) on Sickle Cell and Thalassaemia have published a report on 15th November 2022 entitled, No One's Listening' in respect to 'serious failing' into the care of patients with sickle cell. The ground-breaking inquiry, led by Rt Hon Pat McFadden MP, found "serious care failings" in acute hospital services, including A&E and evidence of attitudes underpinned by racism. The report was triggered by the Coroner's report into the death of Evan Nathan Smith in North Middlesex hospital. Following the publication of the Coroner's report, the APPG facilitated three evidence sessions, hearing from patients, clinicians, and politicians. They took evidence from a wide range of witnesses and received over a hundred written submissions. The report is a result of that evidence (**Appendix A**). The focus of the report has clearly highlighted the experience of patients with sickle cell and their lived experience of treatment received, including their fears and avoidance of accessing secondary care services. The feeling that many sickle cell patients have been left with is that that they are not a priority, that their suffering is not considered important and that treatment that would not be accepted for other patient groups is ignored when it relates to sickle cell. The tragic and avoidable death of Evan Nathan Smith has highlighted the report suggests, the need to take action to prevent future avoidable deaths and near misses among sickle cell patients. The report has called for the Secretary of State for Health and Social Care, the Chief Executive of NHS England, and • **leaders of the new Integrated Care Systems to adopt improving sickle cell care as a key priority** o Question to the Board is this a priority currently? Who will take a leadership role in oversight?

Decision Log Ref No.	Meeting Date	Issue for escalation
		• **Furthermore, NHSE have requested an ICS System Action Plan to set out steps to achieve the recommendations set out in the report.** ○ Request the Cheshire & Merseyside Acute & Specialist Trust (CMAST) Provider Collaborative and the Mental Health & Community Provider Collaboratives should develop a cohesive action plan to address the recommendations in the report and agree the timescale for progress reporting.

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
QPC/9/22/03	08/09/2022	**Committee Terms of Reference.** At its meeting Committee members considered and agreed proposed revisions to the Committees Terms of Reference. Additions are highlighted in **blue** and revisions in ~~**red**~~. **The main change is in relation to enabling the Committee to have the authority to:** *"Commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board."* Amendments have also been made to the membership and quoracy arrangements for the Committee. **The Board is asked to approve the recommendation of the Quality and Performance Committee to approve its revised Terms of Reference (Appendix B).**

6. Recommendations

6.1 **The ICB Board is asked to:**

- **Note** the content of Section 2.
- **Note** the content of Section 3 and the issues considered by the Committee and actions taken.
- **Note** the content of Section 4: Consider the matters escalated to the ICB Board regarding:
  - No One is Listening Enquiry
    - Is Sickle Cell and Thalassaemia an ICS Priority?

- Request the Cheshire & Merseyside Acute & Specialist Trust (CMAST) Provider Collaborative and the Mental Health & Community Provider Collaboratives should develop a cohesive action plan to address the recommendations in the report and agree the timescale for progress reporting.
  - Annual Health Checks for People with Learning Disabilities
- Note the content of Section 5:
  - **Approve** the revised Terms of Reference for the ICB Quality & Performance Committee (Appendix B).

November 2021

All-Party Parliamentary Group
appg Sickle Cell and Thalassaemia

SICKLE CELL SOCIETY

NO ONE'S LISTENING:

AN INQUIRY INTO THE AVOIDABLE DEATHS AND FAILURES OF CARE FOR SICKLE CELL PATIENTS IN SECONDARY CARE

CONTENTS

ABOUT THE SCTAPPG

The All-Party Parliamentary Group on Sickle Cell and Thalassaemia (SCTAPPG) was formed in December 2008 with the aim of keeping sickle cell and thalassaemia on the political agenda and facilitating a two-way dialogue between policymakers and those affected by sickle cell and thalassaemia.

The SCTAPPG holds regular meetings and has published a number of policy reports on issues such as the institutional failures of Personal Independence Payment for those living with sickle cell and thalassaemia, the lack of representation of sickle cell and thalassaemia in the education of pre-registration nurses and midwives, the impact of prescription charges for those living with sickle cell and thalassaemia and the effect of the Covid-19 pandemic on the sickle cell community.

FOREWORD

The All-Party Parliamentary Group on Sickle Cell and Thalassaemia (SCTAPPG) exists to argue the case for more understanding of sickle cell and better treatment for those who live with the condition.

In the past we have produced reports on the treatment of people living with sickle cell in the fields of employment, NHS care and the benefits system.

This report was triggered by the Coroner's report into the death of Evan Nathan Smith in North Middlesex hospital. Evan was a young man with his whole life in front of him. The mistakes made in his treatment leading to his early and avoidable death brought into sharp focus the lack of understanding of sickle cell, the battles patients have to go through to get proper treatment and the terrible consequences which can come about as a result.

Following the publication of the Coroner's report earlier this year, the APPG held three evidence sessions, hearing from patients, clinicians and politicians. We took evidence from a wide range of witnesses and received over a hundred written submissions. We are profoundly grateful to all who contributed. This report is a result of that evidence.

The findings in this report reveal a pattern of many years of sub-standard care, stigmatisation and lack of prioritisation which have resulted in sickle cell patients losing trust in the healthcare system that is there to help them, feeling scared to access hospitals, expecting poor treatment from some of those who are supposed to care for them and fearing that it is only a matter of time until they encounter serious care failings.

Underneath the individual recommendations in the report are two more fundamental points. The first is a deep sense of anger and frustration that many of these failings have been pointed out in different ways before but have not been properly acted upon, leaving people with sickle cell to go through the same enormously distressing experiences over and over again.

The second is the question of race. Sickle cell is a condition that predominantly affects black people. People of every race have a right to equality in health treatment. Yet the experience of people living with sickle cell is that the failings in treatment and the lack of understanding outlined in this report show deep inequality in the healthcare system. This is a serious and longstanding issue which must be addressed.

The publication of this report must lead to major change in the care sickle cell patients receive. We have made a number of recommendations based on the evidence we received and call on the Secretary of State for Health and Social Care, NHS England & NHS Improvement and the numerous other stakeholders we have directed recommendations at to prioritise taking action.

In the APPG we hope that the greater awareness of health inequalities following the pandemic results in urgent action to ensure sickle cell patients finally receive care at a standard to which they are entitled, and for which they have waited far too long.

Rt Hon Pat McFadden MP
Chair, All-Party Parliamentary Group on Sickle Cell and Thalassaemia

EXECUTIVE SUMMARY

Our inquiry sought to examine the level of care sickle cell patients receive when accessing secondary care and to determine the action that is required to improve care for sickle cell patients.

While many patients we heard from were keen to highlight their gratitude to those healthcare professionals who go above and beyond in the care they provide, we heard that this level of care is sadly not the norm.

Sickle cell patients too often receive sub-standard care, with significant variations in care depending on which staff happen to be on duty or which area of the country a patient is in. While care in specialist haemoglobinopathy services is generally felt to be of a good standard, this is far from the case on general wards or when accessing Accident & Emergency (A&E) departments. Care failings have led to patient deaths over decades and 'near misses' are not uncommon. There is routine failure to comply with national care standards or NICE standards around pain relief when patients attend A&E. Shockingly, this sub-standard care has led many patients to fear accessing secondary care, or even outright avoid attending hospitals.

A significant factor in the sub-standard care sickle cell patients often receive is a lack of effective joined-up care. The evidence we received highlighted that communication failings between different departments within the same hospital often impact sickle cell care. Patient care plans that have been specifically developed to ensure routine care are often ignored.

Community care for sickle cell patients is generally inadequate or non-existent which leads to unnecessary admissions to hospitals.

We were told that awareness of sickle cell among healthcare professionals is low, with sickle cell patients regularly having to educate healthcare professionals about the basics of their condition at times of significant pain and distress. We heard from patients and clinicians alike that this low awareness arises from inadequate training in the condition for trainee nurses and medics.

Partially as a result of the low levels of awareness and insufficient training in sickle cell, patients are regularly treated with disrespect, not believed or listened to, and not treated as a priority by healthcare professionals. Many of those we received evidence from highlighted the role of racism in the negative attitudes towards sickle cell patients, which overwhelmingly affects people with African or Caribbean heritage.

We also heard that there is inadequate investment in sickle cell care. Services are under-resourced and under-staffed and there has been a distinct lack of investment in sickle cell research and treatments over decades, right up to the present day.

Based on the evidence we received, the SCTAPPG makes the following recommendations, separated below by the section of our report in which they appear:

Sub-standard care on general wards and in A&E

- The North London Integrated Care System to develop a plan for improving sickle cell services, in partnership with relevant stakeholders, and share learnings with other ICSs across the country.
- Department of Health and Social Care to commission an evidence review by the Getting It Right First Time programme examining the case for and against implementing dedicated sickle cell wards at all specialist centres.
- North Middlesex University Hospital NHS Trust to engage with Betty & Charles Smith regarding an appropriate memorial tribute to their son Evan, such as the naming of a ward after Evan, in line with their wishes.
- NHS Trusts to share findings of all internal reviews into incidents involving serious sickle cell care failings with the National Haemoglobinopathy Panel so that learnings can be communicated to haemoglobinopathy teams across the country.
- Health Education England to develop an e-learning module based on the national standards of care developed by the Sickle Cell Society in partnership with clinical experts and the UK Forum on Haemoglobin Disorders, which should be mandatory for all healthcare professionals providing sickle cell care in high-prevalence areas.
- All NHS Trusts to develop an action plan setting out how they will ensure compliance with the NICE clinical guideline around the delivery of pain relief within 30 minutes for sickle cell patients, with appropriate advice from the NHS England Clinical Reference Group for Haemoglobinopathies pain sub-group.
- Care Quality Commission to adopt compliance with the NICE clinical guideline for delivery of pain relief within 30 minutes for sickle cell patients as essential criteria when assessing NHS Trusts.
- NICE to revise clinical guideline around pain relief for sickle cell patients to set out standards relating to pain management in the entirety of a sickle cell crisis, not just delivery of the first dose.
- Royal College of Emergency Medicine and Royal College of Physicians to develop guidance for staff working in A&E and on general wards making clear that sickle cell patients should be prioritised for treatment as a medical emergency due to the high risk of fast medical deterioration, to be distributed by NHS Trusts.
- Care Quality Commission to undertake a thematic review of sickle cell care in secondary care, involving direct input from patients and the Haemoglobin Disorders Peer Review Programme Clinical Leads, providing guidance around what good care should look like.
- National Haemoglobinopathy Panel to work with Haemoglobinopathy Coordinating Centres to plan equitable access to psychological support services for sickle cell patients who require such support.

Failings in providing joined-up sickle cell care

- All NHS Trusts to require that haematology teams are informed whenever a sickle cell patient accesses or is admitted to the hospital to ensure the patient's clinical history is known and advice can be passed on regarding their care, with compliance reported via the NHS England and NHS Improvement Specialised Services Quality Dashboards.
- NHS Trusts to develop individualised care plans for, and in partnership with, each sickle cell patient, with the patient and any relevant carers provided with a copy of the plan.
- National Haemoglobinopathy Register to develop capability to host sickle cell patient care plans that are accessible across the NHS.
- The Secretary of State for Health and Social Care to instruct all Integrated Care Systems to develop plans to provide community care for sickle cell patients in their area, including integration with third sector providers and community care organisations.

Low awareness of sickle cell among healthcare professionals and inadequate training

- All universities to include comprehensive training in sickle cell as part of curriculums for trainee healthcare professionals, covering diagnosis, presentations, management, acute complications (such as pain, acute chest syndrome, stroke) and ongoing care and featuring direct contributions from sickle cell patients.
- The Nursing and Midwifery Council and the General Medical Council to urgently commission a review of their approach to sickle cell training, in collaboration with the sickle cell community.
- The NMC and GMC to strengthen requirements around the level of sickle cell training required for university curriculums to be approved.
- Royal College of Pathologists to include as part of haematology speciality training a compulsory rotation to a large regional haemoglobinopathy centre for trainees in low incidence regions who would not otherwise have as much opportunity to gain direct experience of managing sickle cell patients.
- Health Education England to provide additional funding for sickle cell training programmes for healthcare professionals, including for training in the delivery of blood transfusions for non-specialist doctors.

Negative attitudes towards sickle cell patients

- Secretary of State for Health and Social Care to implement charge-free prescriptions for sickle cell patients.
- Health Education England, the Nursing and Midwifery Council, the General Medical Council, universities and other medical training providers to ensure training programmes address diversity and racial bias awareness.
- NHS Race and Health Observatory, working closely with Haemoglobinopathy Coordinating Centres, specialist haemoglobinopathy teams, community sickle cell teams, other professionals involved in care provision and the sickle cell community, to undertake a study into sickle cell care in relation to race and ethnicity, examining the impact of racist attitudes and the extent of inequalities in funding and prioritisation for sickle cell compared with other conditions.
- NHS England & NHS Improvement to require NHS Trusts to conduct and report regular audits of patient involvement in decisions about their care, utilising patient feedback, in line with NICE clinical guideline stating that sickle cell patients (and their carers) should be regarded as experts in their condition.
- NHS England & NHS Improvement to establish formal sickle cell patient advisory groups, based on consultation with the Patient and Public Voice Assurance Group, to work in partnership with and conduct oversight of NHS sickle cell services.

Inadequate investment in sickle cell care

- NHS England & NHS Improvement to provide increased funding for sickle cell services in recognition of the consistent underfunding of sickle cell services when compared with services for other conditions. This should include dedicated funding for NHS Trusts to improve apheresis capacity across the country.
- Clinical Commissioning Groups and local authorities to provide additional funding for third sector providers and community care organisations for social prescription in relation to sickle cell to reduce pressure on NHS services.
- Department of Health and Social Care to convene organisations including Health Education England, the General Medical Council, the Nursing and Midwifery Council, the medical royal colleges and medical and nursing schools to come together with senior sickle cell service representatives to engage in effective workforce planning for sickle cell services, including the allocation of specialist training opportunities.
- All NHS Trusts to ensure that specialised service funding is invested in meeting recommended sickle cell service staffing numbers.
- UK Research and Innovation and the National Institute for Health Research to launch dedicated sickle cell research opportunities, including supporting and funding research into genetic therapies to cure sickle cell disorder.
- NHS England & NHS Improvement to report results of Managed Access Programme for Crizanlizumab to support roll-out following the drug's approval.

SICKLE CELL IN SECONDARY CARE: NOT A PRIORITY?

In May 2021, the SCTAPPG launched an inquiry into the care sickle cell patients receive when accessing secondary care services in the UK. The inquiry followed a number of high-profile examples of failings in care for people with sickle cell disorder which contributed to growing awareness of the challenges sickle cell patients still often face in receiving appropriate care.

Among the most notable of these was the tragic death of sickle cell patient Evan Nathan Smith in North Middlesex University Hospital in April 2019, which received renewed focus following the publication of the coroner's inquest into Evan's death in April 2021. The inquest found that Evan's death would not have happened were it not for failures in the care he received. With healthcare professionals, sickle cell patients and their families having repeatedly highlighted similar incidents, including avoidable deaths and 'near misses', over many years, the SCTAPPG was determined to highlight the issues sickle cell patients face when accessing secondary care.

The inquiry, chaired by SCTAPPG Chair Rt Hon Pat McFadden MP, featured three oral evidence sessions held in June 2021, with SCTAPPG members receiving testimony from expert witnesses including sickle cell patients, patients' carers and family members, clinicians and representatives from relevant healthcare bodies. In addition, the SCTAPPG issued a call for written evidence which resulted in the receipt of over 100 submissions from key stakeholders.

Below, we explore the main themes that emerged from the evidence we received.

SUB-STANDARD CARE ON GENERAL WARDS AND IN A&E

One of the most consistent themes of the evidence we received was related to sickle cell patients receiving sub-standard care when admitted to general wards or attending Accident & Emergency (A&E) departments.

Variations in care: "It really is like a lottery"

Many patients felt that the quality of care they received was dependent upon factors such as which staff happened to be on duty. One told us that "if it is the staff who are familiar with me then the care is great, if the staff do not know me then it can be problematic".[1] Another stated that some staff "are exceptional – dedicated, committed and loved by patients", but that "unfortunately, this is the exception rather than the norm."[2]

The latter also noted that care varies "from hospital to hospital" and the geographical differences in sickle cell care was another strong theme of the evidence we received. Liz Blankson-Hemans, a sickle cell patient, told us: "The standard of care for sickle cell disease in the UK ranges from very good to extremely patchy depending on where you live in the UK."[3]

Often, this was thought to be attributable to some areas having less ethnically diverse populations, and thus fewer sickle cell patients. One patient told us that: "Hospitals in areas without a significant ethnic minority population tend to know very little about [sickle cell] and treat you like some alien life form".[4]

A haematologist based in an area with few sickle cell patients said that "in consequence staff do not build up an experience base in management of sickle cell disease, in particular with acute complications requiring urgent review or admission."[5]

However, others felt that geographical differences in care standards were apparent regardless of the patient population in the area. Liz Blankson-Hemans wrote that "even in 'good' areas... it can vary depending on which pockets you live in, such as for example, London compared to Hertfordshire, although they share boundaries and populations of African, Caribbean or South Asian and Mediterranean people".[6]

Another patient told us: "I live just outside of the M25 and considering the prevalence of the disease in London ... I would have expected the care to be equally as good in my area both in primary and secondary care and it never fails to surprise me the lack of knowledge and help that the local healthcare staff have."

1 Anonymous, written evidence
2 Anonymous, written evidence
3 Liz Blankson-Hemans, written evidence
4 Anonymous, written evidence
5 Anonymous, written evidence
6 Liz Blankson-Hemans, written evidence

The patient went on to state that he will soon be going to university and worries about the standard of care he will receive if he attends a university in an area where sickle cell is less prevalent, noting that it should be his right to receive "high quality care regardless of where I am and where I access the care".[7]

Reflecting on his experience of living in many different areas of the country as a sickle cell patient, Shubby Osoba concluded: "It really is like a lottery with regards to the kind of care that you receive. Sometimes the care can be really good, and that normally is if you're being seen by a team who knows you, who have an understanding of what sickle cell is, and in particular an understanding of you. I think one of the issues is that whilst you can get lucky and find someone that does know what sickle cell is, if you're in the right part of the country, if you go into hospital at the right time of day, on a weekday, all of that can help, but if not, then the chances of meeting someone who even knows what sickle cell is can be slim."[8]

Global Blood Therapeutics' submission noted that geographical variation in care "is particularly important as the geography of [sickle cell] is starting to change with patients increasingly moving out of London – home to 25 out of 53 of the listed Sickle Cell Centres in the UK – to the wider South East and other urban areas ... All patients, regardless of where they live, must have equal access to the most effective care and support available."[9]

Cedi Frederick, Chair of North Middlesex University Hospital NHS Trust, told us that the development of Integrated Care Systems present an opportunity for hospitals and other providers to work together to improve services for sickle cell patients and ensure a more consistent standard of service. While we welcome Mr Frederick's assurance that sickle cell will be a focus of the North London Integrated Care System, it was disappointing that our invitation for a representative from the North London ICS to provide evidence to our inquiry was turned down and that there has been no subsequent contact from ICS representatives with the SCTAPPG or the Sickle Cell Society. Such lack of engagement does little to dispel the perception that sickle cell is not a priority for healthcare leaders.

The recent commissioning of Haemoglobinopathy Coordinating Centres and designation of specialist haemoglobinopathy services by NHS England & NHS Improvement are welcome steps towards addressing the levels of variation in sickle cell care but there remains much work to be done to achieve uniformly high-standard services. With all 42 Integrated Care Systems expected to be fully operational in England by April 2022, ICS leaders must ensure that progress continues to be made in the effective commissioning of sickle cell services.

Recommendation: The North London Integrated Care System to develop a plan for improving sickle cell services, in partnership with relevant stakeholders, and share learnings with other ICSs across the country.

7 Anonymous, written evidence
8 Shubby Osoba, oral evidence session, 9 June 2021
9 Global Blood Therapeutics, written evidence

Specialist v non-specialist variation: "Clinicians had not got a clue or the care was so poor it was negligent"

Patients and their relatives often emphasised the contrast between their positive experiences of care in haematology departments with the care received on general wards or in A&E. One relative of a sickle cell patient, for example, told us that the care provided to her husband on the haematology ward is "consistently of a high standard", with staff who are "caring and are experts in their field. They understand the physical and emotional strains of the illness and are highly skilled, knowledgeable, and compassionate." By contrast, the submission described repeated issues in A&E, including delays in receiving treatment, lack of awareness of sickle cell among staff and, "almost every time my husband presents at A&E", having to "battle" for effective pain relief.[10]

Richard Patching described the care his wife Carol receives at her regular outpatient appointments at the haematology unit as "very good" but noted that the "problems arise" when she attends A&E or is admitted to a general ward.[11]

June Okochi told us her experience of specialist services is "really positive", noting that she has had "great relationships" with the haematology teams at every hospital she has been admitted to. However, June added: "Where I have found the quality of care to be very poor is Accident & Emergency. In those specific situations, there's been a couple of near misses where my outcomes could have been more dire than they were. I would say the general care on the wards as well can be quite poor, depending on what time of the day, what time of the week, your relationship with the nurses, etc."[12]

Similarly, Zainab Garba-Sani said that her care on haematology wards tends to be "much better" than on a general ward "because at least the nurses know what they're doing … so you're not having to educate people whilst you're already in quite a vulnerable position".13 Kye Gbangbola told us: "Some of my haematologists have said, 'call me if you need me to speak to the hospital doctors'; those calls, I have no doubt, have saved my life several times over, both when clinicians had not got a clue or the care was so poor it was negligent."[14]

The general consensus among patients and their carers that care is of a lower quality outside of haematology departments was supported by healthcare providers. One haematologist told us that "many hospitals have insufficient beds for patients with sickle disorders and as such they may be placed in non-haematology wards where, at best, their care needs are not fully met and, at worst, their condition may deteriorate."[15] Another healthcare professional noted that "patients have described difficult experiences of care when they present at hospital outside of the working hours of the [sickle cell] specialist care team."[16] Whittington Health NHS Trust acknowledged inpatient care as an area in need of improvement, following "significant feedback from patients that care has deteriorated since being transferred to a different ward".[17]

10 Anonymous, written evidence
11 Richard Patching, written evidence
12 June Okochi, oral evidence session, 9 June 2021
13 Zainab Garba-Sani, oral evidence session, 30 June 2021
14 Kye Gbangbola, written evidence
15 Anonymous, written evidence
16 Anonymous, written evidence
17 Whittington Health NHS Trust, written evidence

Some felt the solution to the often-sub-standard care on general wards is to ensure sickle cell patients are always placed on haematology wards. A haematologist told us she felt she was "lucky to work in an environment where my colleagues understand and support the need for appropriate sickle cell inpatient management.

This is especially in the case of inpatient care where sickle cell patients are seen as haematology patients and prioritised for care on the haematology wards. I know that this does not always occur in other centres but I feel this helps to maintain good knowledge of the staff caring for patients when they are admitted."[18]

Others argued that there should be dedicated wards for sickle cell patients. The UK Forum on Haemoglobin Disorders wrote: "Similar to other specialist conditions e.g. cardiac, renal etc., care of sickle patients in a dedicated ward where nursing staff are specially trained and acquire the knowledge, skills and competence to care for this patient group is essential. Specialist teams can provide good effective pain relief in a holistic, supportive setting allowing for the rapid reduction of stress and pain … Conversely, being nursed on a general ward, without specialist knowledge, with a low patient to nurse ratio, often results in delayed pain relief, more pressure on the nursing teams and a more antagonistic environment."[19]

Betty Smith, Evan Nathan Smith's mother, told us that "sickle cell patients, particularly those with underlying conditions should not be moved around the hospital or placed in unsuitable wards with no access to oxygen or a nurse call bell. It would be ideal to have a dedicated sickle cell ward in hospitals".[20]

Specialist wards were also advocated on the basis that it would help to mitigate the risk of immunocompromised sickle cell patients picking up infections on general wards.[21]

Clinicians giving evidence to the inquiry also felt that dedicated sickle cell wards could be useful, albeit caveated with reservations about the potential implications of their introduction. Dr Arne de Kreuk, Consultant Haematologist at North Middlesex Hospital, told us that "a dedicated ward is something that all healthcare professionals have on their wish list, where you have your own team of nurses and doctors surrounding you. I think a dedicated ward would make a difference. However, it could also backfire, because sickle cell patients can have other problems, for example post-surgical problems".[22]

Similarly, Dr Emma Drasar, Consultant Haematologist at The Whittington Hospital and University College London Hospital, said: "We'd like to have, potentially, our own unit staffed by haematology specialists. The problem is that can lead to the level of knowledge within the rest of the Trust falling even further down and potentially prejudicial attitudes becoming more entrenched. So it's very difficult. I think it's a balance. I think having our own unit where we can give significant high-quality care, that's the aim of all haematologists and nursing staff, people involved in looking after these people."[23]

The general consensus of the evidence we received is that sickle cell patients should either be treated on dedicated sickle cell wards or on specialist haematology wards. We believe it would be beneficial for the Department of Health and Social Care to commission an evidence review looking further into the case for and against implementing dedicated sickle cell wards.

18 Anonymous, written evidence
19 UK Forum on Haemoglobin Disorders, written evidence
20 Betty Smith, oral evidence session, 30 June 2021
21 Anonymous, written evidence; Anonymous, written evidence
22 Dr Arne de Kreuk, oral evidence session, 16 June 2021
23 Dr Emma Drasar, oral evidence session, 16 June 2021

Recommendation: Department of Health and Social Care to commission an evidence review by the Getting It Right First Time programme examining the case for and against implementing dedicated sickle cell wards at all specialist centres.

Deaths and 'near misses': "How many other people have ended up dying in the way that she did?"

We were told of a number of incidents in which failures in care resulted in patient deaths. Bell Ribeiro-Addy MP, a member of the SCTAPPG, told the inquiry of the death of her close friend Adjuah Annan, who died after being given an overdose of a morphine-based painkiller during a sickle cell crisis. Compounding the tragedy, this followed the deaths of "a few of her cousins [with] sickle cell [who] had all died before the age of 25". There was no inquest into Adjuah's death, leading Bell to ask: "how many other people have been through what [she] went through and ended up dying in the way that she did and were not... investigated?" [24]

Betty and Charles Smith outlined a catalogue of failures that led to the avoidable death of their son Evan. These failings began with Evan's treatment for gallstones, a condition more common among sickle cell patients, which involved Evan having a stent placed in his biliary duct and his gall bladder removed. Evan faced repeated delays in receiving appropriate treatment and there were numerous errors by medical staff, including failing to develop and share care plans and missing crucial medical developments that should have been identified.

Evan contracted sepsis and klebsiella during the procedure to have his stent removed and was admitted to North Middlesex University Hospital the following day. Here, there were again repeated failings, with the haematology team initially not being informed of Evan's admission, despite the A&E medical staff having been informed that he had an underlying sickle cell condition.

Once informed of his admission, the haematology team declined to take lead responsibility for Evan, meaning his care was led by the gastroenterology team, who were not specialists in his haematology condition. There were further treatment delays and oversights, which included the nurse responsible for Evan's care failing to recognise that he was experiencing a sickle cell crisis, which "resulted in Evan having to call the ambulance from his bed to plead for oxygen, but it was refused because he was already in a hospital bed". Doctors failed to escalate findings that confirmed low oxygen saturation levels and possible onset of a crisis and opportunities were missed to provide Evan with a blood transfusion that the coroner's inquest found would have saved his life.[25]

> "Sometimes it feels like you're living on borrowed time because you've been in those situations and you're just lucky that you're still alive to be able to tell the story"
>
> – Zainab Garba-Sani, sickle cell patient

It is clear that what happened to Evan was an example of experiences that are far too common for sickle cell patients. In a stark illustration of the scale of the problem, results of a Coroner's inquest into yet another avoidable death of a sickle cell patient arrived shortly before publication of this report. The inquest found that Tyrone Airey's death from a morphine overdose during a sickle cell crisis in Northwick Park Hospital in March 2021

24 Bell Ribeiro-Addy MP, oral evidence session, 30 June 2021
25 Charles Smith, oral evidence session, 30 June 2021

was avoidable, with nursing staff having insufficient training to provide the care that would have prevented Tyrone's death.[26]

Rather than the failings in Evan and Tyrone's care being isolated incidents, we were told of numerous 'near misses' experienced by sickle cell patients in which they could have had a worse outcome. Sadeh Graham told us that delayed treatment on a general ward and the absence of a haematologist led to her admission to an intensive care unit, remarking: "That admission, and others have been similar in terms of the neglect and inadequate care Evan Nathan Smith received ... [the] difference is that I escaped with my life."[27]

As in Evan's case, Alex Luke described an incident in which the care he received on a general ward was so poor that he felt compelled to call an ambulance from his ward bed "because the doctors were very delayed to come to my rescue – for a few days, actually – and the pain was intensifying, and my mental health was going down the hill at that point. I was asking myself, what's the whole point of staying here, really?"[28]

Most of the clinicians we heard from had experienced 'near misses' involving sickle cell patients, often involving failures during blood transfusions. These often arise due to poor communication or low awareness of sickle cell, we were told. A Paediatric Clinical Lead based in a haemoglobinopathy team said she had encountered "several" near misses, "usually relating to failure to identify potential seriousness of the situation or propensity to deteriorate rapidly".[29] Dr Emma Drasar told us she had seen "a significant number of near misses with my sickle cell patients during my career, the majority of which have been caused by single point of failure systems [where one failing part of a system causes the entire system to collapse, such as having an overreliance on one consultant with a specialist interest in red cell conditions, whose absence causes problems] and poor education and understanding of sickle cell disorders in combination with a lack of resource".[30]

Professor Jo Howard, Consultant Haematologist at Guy's and St Thomas' Hospital and Chair of the NHS England Haemoglobinopathies Clinical Reference Group, said that she has encountered "three or four" such incidents and that they "have always been used as a learning experience and led to review of services and service improvements". However, she added: "It is important that the same happens with the tragic case of Evan Nathan Smith. Unfortunately, the case and the lessons learnt have not yet been shared with the national haemoglobinopathy community and it is vital this is done with some speed."[31]

While findings from North Middlesex University Hospital NHS Trust's review have since been shared with the haemoglobinopathy community, it is concerning that it took so long for this to occur. The very least that should happen after serious incidents of the type outlined above is that lessons are learned and shared to avoid repetition.

Recommendation: North Middlesex University Hospital NHS Trust to engage with Betty & Charles Smith regarding an appropriate memorial tribute to their son Evan, such as the naming of a ward after Evan, in line with their wishes.

Recommendation: NHS Trusts to share findings of all internal reviews into incidents involving serious sickle cell care failings with the National Haemoglobinopathy Panel so that learnings can be communicated to haemoglobinopathy teams across the country.

26 MyLondon, Sickle cell sufferer, 46, left screaming in agony died after hospital neglect, https://www.mylondon.news/news/sickle-cell-sufferer-singer-songwriter-21730986. Accessed 8 October 2021.
27 Sadeh Graham, written evidence
28 Alex Luke, oral evidence session, 9 June 2021
29 Anonymous, written evidence
30 Dr Emma Drasar, written evidence
31 Professor Jo Howard, written evidence

Lack of compliance with national care standards: "It is life threatening!"

A significant factor in the sub-standard care sickle cell patients often receive in secondary care is the lack of adherence to national care standards, a source of frustration to patients and clinicians alike.

Sickle cell patient Liz Blankson-Heman asked: "Why is the standard of care so abysmal in some pockets despite [there being] a fully authoritative document written by experts in the field and applicable to the whole of the UK?" She added that, from her experience, it seemed that national care standards "may not be routinely used".[32]

Professor Jo Howard appeared at the same oral evidence session as Betty and Charles Smith and noted that a number of the failings in the care their son Evan received would not have occurred had national care standards been adhered to. For example, she said: "One of the national standards of care that we've produced in the document with the Sickle Cell Society a few years ago was that each specialist unit should have specialist guidance on looking after patients with sickle cell disease and having preoperative guidance is one of those things, so either there was guidance in place at the hospital and it wasn't followed, or it wasn't there."[33]

Likewise, Professor Howard added, "the national standards for sickle cell say that [for] any patient with sickle cell admitted to hospital, the haematology team should be informed, so the 48-hour delay initially in them even being informed [in Evan's case] is pretty shocking and that's something that would be outside standards of care. [Informing the haematology team] should have happened."[34]

> "There are many examples of excellent guidelines about how to look after people with sickle cell disorders around the country. However, these are of no use if no one looks at them."
>
> Dr Emma Drasar, Consultant Haematologist, The Whittington Hospital and University College London Hospital and Chair, Haemoglobinopathy Coordinating Centres

Written evidence from NICE referred to its clinical guidelines which state that "an acute painful sickle cell episode should be treated as an acute medical emergency … and that analgesia should be offered within 30 minutes of presentation at hospital".[35] In practice, standards around delivering pain relief are regularly not met.

Jaspreet Kaur told us that "overdue pain relief was the norm" during her friend's admissions as an inpatient[36] and Stephanie George wrote that "90% of the time, I will receive pain relief between 45 minutes to over 60 minutes [after] attending A&E".[37] Angela Thomas described waiting "in A&E for two to three hours while my pain got steadily worse until I was screaming out in pain"[38], while another patient referred to an incident in which they were left in "paralysing pain" for almost 24 hours, only to discover

32 Liz Blankson-Hemans, written evidence
33 Professor Jo Howard, oral evidence session, 30 June 2021
34 Ibid.
35 NICE, written evidence
36 Jaspreet Kaur, written evidence
37 Stephanie George, written evidence
38 Angela Thomas, written evidence

when a new doctor came on shift that the medication which was part of their care plan, and which they had been informed was not available, had been available all along.[39]

Another patient wrote: "I have also seen some sickle cell patients wait so long for nurses to come with their pain relief, to the point where the patient was crying so much they could not breath properly because of the pain."[40] Kye Gbangbola told us: "Every time I have been in hospital, I have constantly suffered more pain than necessary due to ward staff not responding to my medical needs", including pain relief.[41]

Evidence from patients highlighted that lack of compliance with pain relief standards has been a persistent issue for years, rather than being a development related to recent pressures on the health service. The consensus of the evidence we received was that the failure to deliver pain relief within the time limits set out by NICE is often a result of low awareness of sickle cell among healthcare professionals and stigmatising attitudes that mean patients are not listened to or taken seriously. Both of these issues are explored further later in this report.

Clinicians also highlighted the lack of compliance with standards around delivering pain relief. University College London Hospital's written evidence referred to an audit conducted in 2021 of compliance with NICE sickle cell pain management recommendations in A&E, which showed "very suboptimal adherence (30%)".[42] Dr Shivan Pancham, a Consultant Haematologist in the West Midlands area, told us that compliance with the NICE clinical guideline on pain relief in A&E in her NHS Trust is around 20%, compared with over 90% in the haemoglobinopathy unit.[43] We were referred to a 2016 survey looking at experiences of pain relief among sickle cell patients, which found that only 30% of adults, 48% of children and 42% of parents felt that pain relief was provided to them in a timely manner in their most recent emergency healthcare episode".[44]

Dr Emma Drasar noted the frequent failure to deliver pain relief within 30 minutes and added that there are also "often delays with subsequent doses which again leads to poorly managed pain". Dr Drasar suggested that this might require a change to the NICE clinical guidelines to focus not just on the timing of the first dose but on "overall pain control within the episode and requisite observations being performed".[45]

Patients and clinicians told us that sickle cell patients must be prioritised for treatment, in line with national care standards. One patient said that "once it is identified that the patient has sickle cell it should be escalated as their medical condition can deteriorate quickly into a life-threatening situation".[46] Similarly, Betty Smith told us: "Patients with sickle cell condition should be prioritised as a matter of urgency particularly where deadlines and timescales for procedures are specified in patients' records."[47] Dr Shivan Pancham also noted that sickle cell patients in A&E "should automatically move into our priority line. The guidelines are there."[48]

Whittington Health NHS Trust told us that they will be developing and implementing a plan to increase compliance with the NICE guideline for patients to receive pain relief within 30 minutes[49]

39 Anonymous, written evidence
40 Anonymous, written evidence
41 Kye Ggbangbola, written evidence
42 University College London Hospital, written evidence
43 Dr Shivan Pancham, oral evidence session, 9 June 2021
44 Dr Subarna Chakravorty, written evidence
45 Dr Emma Drasar, written evidence
46 Elizabeth Aiyedofe, written evidence
47 Betty Smith, oral evidence session, 30 June 2021
48 Dr Shivan Pancham, oral evidence session, 9 June 2021
49 Whittington Health NHS Trust, written evidence

and NHS England & NHS Improvement's submission stated: "Further work is underway to improve the management of acute pain (percentage of patients being given pain relief within half an hour of presentation, usually in A&E settings). In February the [NHS England Clinical Reference Group for Haemoglobinopathies] formed a multi-stakeholder pain subgroup to look at new ways of treating acute and chronic pain in [sickle cell disorder] and to improve education and research in this area."[50]

It is evident that such work needs to be an absolute priority for the NHS, given the current widespread failures to comply with NICE guidelines or to meet the national standards of care developed by the Sickle Cell Society, in partnership with clinical experts and the UK Forum on Haemoglobin Disorders. As one patient put it to us: "It is life threatening! Delays to managing the pains leads to ... organ damage and death ... We are presenting at a hospital because we need help to make us better."[51] Sickle cell patients are currently being failed by the system that should be providing them with this help and the consequences of these failings can be extremely serious.

Recommendation: Health Education England to develop an e-learning module based on the national standards of care developed by the Sickle Cell Society in partnership with clinical experts and the UK Forum on Haemoglobin Disorders, which should be mandatory for all healthcare professionals providing sickle cell care in high-prevalence areas.

Recommendation: All NHS Trusts to develop an action plan setting out how they will ensure compliance with the NICE clinical guideline around the delivery of pain relief within 30 minutes for sickle cell patients, with appropriate advice from the NHS England Clinical Reference Group for Haemoglobinopathies pain sub-group.

Recommendation: Care Quality Commission to adopt compliance with the NICE clinical guideline for delivery of pain relief within 30 minutes for sickle cell patients as essential criteria when assessing NHS Trusts.

Recommendation: NICE to revise clinical guideline around pain relief for sickle cell patients to set out standards relating to pain management in the entirety of a sickle cell crisis, not just delivery of the first dose.

Recommendation: Royal College of Emergency Medicine and Royal College of Physicians to develop guidance for staff working in A&E and on general wards making clear that sickle cell patients should be prioritised for treatment as a medical emergency due to the high risk of fast medical deterioration, to be distributed by NHS Trusts.

Fear and avoidance of hospitals: 'I do not trust the people who have sworn to protect us, because many times they have failed'

A large number of patients told us that their experiences of sub-standard care meant that they feared accessing secondary care, while others told us that they feel compelled to avoid attending hospital altogether.

50 NHS England & NHS Improvement, written evidence
51 Anonymous, written evidence

Patients described a "real reluctance" to attend hospital[52], "apprehension and avoidance of hospital"[53] and feeling "traumatised and afraid to go into hospital"[54].

> "Why should any one of us have to prepare ourselves mentally before we go into hospital?"
>
> – Ifunanya Obi, sickle cell patient

Kye Gbangbola said that his experiences have left him with a sense that "it's better to suffer at home, at least I will have some level of pain relief".[55] Stephanie George wrote: "I have anxiety when I have to attend the hospital because I'm scared of the care I am about to receive. I do not trust the people who have sworn to protect us, because many times they have failed."[56]

Jaspreet Kaur told us her friend who has sickle cell "does everything she can to avoid a hospital admission, to avoid the mental strain of another battle with the doctors and nurses when she does not have the energy to advocate for herself" and that "delaying admission to hospital sometimes means that her clinical condition deteriorates rapidly as a consequence."[57]

Shubby Osoba said that his experiences of secondary care have been so poor that he saved up £3,000 for an oxygen machine and "would much rather try and care for myself … as opposed to taking the gamble of going into hospital, potentially being sat in A&E for hours whilst someone tells you, 'Have some paracetamol, have some ibuprofen.'"[58]

Dr Emma Drasar noted that the difference between sickle cell and many other conditions is that sickle cell patients will continually have to access healthcare throughout their lives. Therefore, when patients have poor experiences: "They're going to be afraid of going into a healthcare environment then, and they might stay at home longer when, perhaps, from a health perspective, that's not what they should do, and not what I'd advise them to do as their consultant."[59]

The fact that so many sickle cell patients have had such poor experiences of secondary care that they avoid hospital altogether is an outrage. Such evidence demonstrates a deep failing in the care sickle cell patients receive.

Recommendation: Care Quality Commission to undertake a thematic review of sickle cell care in secondary care, involving direct input from patients and the Haemoglobin Disorders Peer Review Programme Clinical Leads, providing guidance around what good care should look like.

Recommendation: National Haemoglobinopathy Panel to work with Haemoglobinopathy Coordinating Centres to plan equitable access to psychological support services for sickle cell patients who require such support.

52 Claire T, written evidence
53 Anonymous, written evidence
54 Anonymous, written evidence
55 Kye Gbangbola, written evidence
56 Stephanie George, written evidence
57 Jaspreet Kaur, written evidence
58 Shubby Osoba, oral evidence session, 9 June 2021
59 Dr Emma Drasar, oral evidence session, 16 June 2021

FAILINGS IN PROVIDING JOINED-UP SICKLE CELL CARE

A significant factor in the sub-standard care sickle cell patients often receive is a lack of effective joined-up care. Such failings include poor communication between healthcare professionals within the same hospital, non-adherence to patient care plans and the lack of an appropriate level of community care for sickle cell patients.

Poor coordination within hospitals: "They blamed each other for what had happened to me when it was an obvious lack of communication"

The coordination of sickle cell care within hospitals was highlighted as a particular issue, with a consistent theme being the failure to alert haematology teams to the arrival of a sickle cell patient to another part of the hospital.

Araba Mensah noted that there is often no coordination with the haematology team when her daughter accesses other departments such as orthopaedics.[60] Others highlighted failures to alert the haematology team when accessing A&E, with a patient referring to "a lack of willingness to make contact with the relevant specialists to seek advice which resulted in severe prolonged pain and trauma".[61]

Sickle Cell Suffolk wrote: "Once we are admitted to a ward we have to ask the ward [whether they] have advised the haematology department we have been admitted. The response is always 'not yet'. It is our experience that the haematologist visits the patient on day three. This is not adequate [and] is purely because they have not been made aware."[62]

> "Our haematologist should be informed immediately of our admissions. Not hours or days after but immediately!"
>
> – Sickle cell patient

As referred to above, failures to coordinate care had a particularly tragic outcome for Evan Nathan Smith. Betty Smith told us there was no evidence from Evan's records that advice was sought from the sickle cell team prior to his stent removal procedure, despite the procedure placing Evan at an increased risk of sepsis.[63]

Furthermore, Evan's father Charles set out the failure of A&E medical staff to alert the haematology team to Evan's presentation the following day,

60 Araba Mensah, written evidence
61 Claire T, written evidence
62 Sickle Cell Suffolk, written evidence
63 Betty Smith, oral evidence session, 30 June 2021

despite Evan having informed them that he had an underlying sickle cell condition: "It was later revealed that the haematology team were not informed until two days later of Evan's admission and a series of missed opportunities and delays transpired over the following five days before his rapid deterioration and death". Even once the haematology team had been made aware of Evan's presence in the hospital, a failure to coordinate resulted in there being a lack of clarity as to which department had overall responsibility for Evan's care, leading, Charles told us, to "substandard care" that led to Evan's death.[64]

As Betty Smith told us, Evan's death was the result of "a lack of integrated and joined-up working within the medical teams caring for Evan. Medical teams should not work in silos when caring for sickle cell patients, rather in collaboration … to optimise outcomes for patients."[65]

Another patient described experiencing severe pain while under the care of the rheumatology department and being refused a request to be seen by a haematologist "because I was under the rheumatologist's care". A CT scan revealed that the patient had had a stroke, at which point the haematologist took responsibility for their care. The patient concluded: "In my opinion this could have been prevented if they had just communicated with the rheumatologists about my sickle cell. By this time, it was far too late for the haematologists to act … When both consultants came to talk to me, they blamed each other for what had happened to me when it was an obvious lack of communication."[66]

The transition from paediatric care to care as an adult for sickle cell was also highlighted repeatedly as an area of concern. One patient carer told us that the transition for her niece took place "without adequate preparation of what to expect or how different adult care is. One minute the family is involved and can talk to doctors and the next minute [it's], 'Sorry, we can only talk to your niece and, whatever your concerns, we are sorry, but she is now an adult', which is very unhelpful in an already complex situation."[67]

Araba Mensah described her and her daughter's carers being halfway through singing happy birthday on her daughter's 17th birthday when a porter arrived to take her to the adult ward: "We were not given any warning that she was going to be transferred to the adult ward and there was no preparation whatsoever. It was so abrupt and totally brutal." Once on the adult ward, her daughter was regularly moved around and received very little interaction other than to be given her medicine: "To go directly, without any preparation, from the children's ward where there are teachers, play specialists and one's parent, to complete isolation on the adult ward was devastating. The situation was so horrendous that she felt abandoned, unwanted and uncared for to such an extent that she became severely depressed."[68]

> "Better communication is needed between staff. You communicate with one staff member and they do not tell others or write it down, therefore we are always explaining things to different staff"
>
> – Sickle Cell Suffolk patient group

64 Charles Smith, oral evidence session, 30 June 2021
65 Betty Smith, oral evidence session, 30 June 2021
66 Anonymous, written evidence
67 Anonymous, written evidence
68 Araba Mensah, written evidence

The transition from paediatric to adult care is a known problem. University College London Hospital noted that progress has been made in recent years but that a 2020 peer review of sickle cell services found that "many services still lack the robust processes needed to ensure a safe transfer of care to adult services".[69] Dr Fatima Kagalwala, a Paediatric Haematology Lead, called for better national guidance on making the transition from paediatric to adult care, which suggests those working on the ground feel that they lack appropriate support to improve the situation.[70]

Professor Jo Howard told us of concerted efforts within her Trust to improve the coordination of care, including providing joint clinics with renal physicians, orthopaedic doctors, neurologists, respiratory physicians, urologists, the pain-management team, obstetricians and cardiologists. A policy for peri-operative management was developed with the anaesthetic team and the haematology team is informed of every patient with sickle disease who is having surgery, which results in a daily visit by the haematology team.[71] The development of such multidisciplinary teams and procedures should be adopted by all NHS Trusts, with guidance from NHS England & NHS Improvement

Recommendation: All NHS Trusts to require that haematology teams are informed whenever a sickle cell patient accesses or is admitted to the hospital to ensure the patient's clinical history is known and advice can be passed on regarding their care, with compliance reported via the NHS England and NHS Improvement Specialised Services Quality Dashboards.

69 University College London Hospital, written evidence
70 Dr Fatima Kagalwala, written evidence
71 Professor Jo Howard, written evidence

Failure to comply with patient care plans: "They said, 'That care plan is not for this hospital.' I was very shocked"

In theory, patient care plans exist to prevent the type of failings in joined-up care outlined above. However, we were told that sickle cell patients often have their care plans ignored or disregarded when accessing secondary care.

One patient told us that they had worked with consultants to agree a care plan but that other healthcare professionals, such as junior doctors, "decide to do something else".[72] Another wrote: "I have seen far too many human errors and mistakes that could have been well avoided if the nurses or doctors just took the time to read their patient's notes or even talk to the patient and listen to them in order to get an understanding of the patient's care plan."[73]

Following repeated incidents of poor care in A&E, one woman told us, she and her husband made a complaint to the hospital which led to the agreement of a protocol between the Consultant Haematologist and A&E Consultant. However, she told us, "it is rarely followed correctly and consistently … One of the medical staff actually told my husband if he wouldn't accept the alternative pain relief offered … then he could not have anything – all in spite of his having an agreed protocol written by Consultants at the very same hospital."[74]

Richard Patching wrote of his wife Carol's experiences: "From A&E, Carol is always transferred to the acute medical unit (AMU). Pre-Covid times, I would be with her for this transfer and I would have to tell the staff on AMU all about Carol's care requirements. The hope then is that the staff will consult Carol's care plan and that they will in any case have the basic knowledge of how to care for a sickle cell patient. In practice, Carol is always moved onto another general medical ward and always in the middle of the night. Her care plan and all the advice I gave never go with her."[75]

Similar experiences of care plans being ignored were recounted in the oral evidence we heard. Alex Luke told us about being refused the pain relief medication he requested and asking the doctors to look at his care plan which outlined that he should be given it if in severe pain: "They said, 'That care plan is not for this hospital.' I was very shocked."[76]

Kye Gbangbola referred to having been given a letter by a doctor, "very much like [a] care plan", to give to healthcare professionals if refused appropriate care. Nevertheless, "I've had healthcare workers ignore that letter. When they do this, the reason for it is, 'You have to wait your turn.'"[77]

It seems perverse that patient care plans specifically designed to ensure patients receive appropriate and consistent care are then ignored by healthcare professionals, often working in the same NHS Trust that developed the care plan. It is clear that a crucial part of improving care for sickle cell patients is greater adherence to patient care plans.

Recommendation: NHS Trusts to develop individualised care plans for, and in partnership with, each sickle cell patient, with the patient and any relevant carers provided with a copy of the plan.

Recommendation: National Haemoglobinopathy Register to develop capability to host sickle cell patient care plans that are accessible across the NHS.

72 Anonymous, written evidence
73 Anonymous, written evidence
74 Anonymous, written evidence
75 Richard Patching, written evidence
76 Alex Luke, oral evidence session, 9 June 2021
77 Kye Gbangbola, oral evidence session, 9 June 2021

Lack of community care: "Community care is deficient"

The lack of an appropriate level of community care for sickle cell patients is another example of failing to provide joined-up care, which adds to pressure on hospitals and fails sickle cell patients.

One haematologist told us that "community care is deficient", with the lack of integration across health and social care systems contributing to the sub-standard care sickle cell patients receive. Where there are successful projects, they struggle to secure funding, they added, citing as an example "an excellent Sickle Cell Society pilot scheme providing practical domestic support to patients suffering pain and wishing to remain at home … despite demonstrating the clear benefits of such an approach, no further funding was made available, with the project falling somewhere between health and social care."[78]

Professor Jo Howard described community nursing support for sickle cell as "very patchy", with some areas having "excellent" support and others having none available.[79] Liz Blankson-Hemans wrote that community care for sickle cell is "completely randomised and not comprehensive", even in areas of high-prevalence.[80]

As noted by the Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee, by assisting with social needs, community services can "keep patients well and out of hospital".[81] Whittington Health NHS Trust told us it has been "very successful at reducing hospital admissions through our community offering" and plans to look into how this can be expanded "to help patients better manage their condition at home and therefore reduce A&E attendances and hospital admissions".[82]

This clearly also benefits patients, as noted by Dr Rachel Kesse-Adu: "Sickle patients do not want to have their lives interrupted by hospital admission so bolstering our community services and listening to patient and clinician groups to focus on what keeps our patients well at school, home and work, and what supports in the community will allow this, is fundamental."[83]

NHS Blood and Transplant suggested that the development of Integrated Care Systems "should help NHS providers and other key stakeholders to work across organisational boundaries and deliver improved access to treatment. The ICSs should focus on reducing the existing bureaucracy around contracting and funding between organisations that currently acts as a major barrier to access for patients across the NHS."[84]

Given ICSs have been explicitly designed to bring services together and ensure better joined-up care, we agree that the development of ICSs offers an excellent opportunity for a renewed approach to the delivery of community care for sickle cell patients which will ensure joined-up care, reduce pressure on hospitals and improve patient experience.

Recommendation: The Secretary of State for Health and Social Care to instruct all Integrated Care Systems to develop plans to provide community care for sickle cell patients in their area.

78 Anonymous, written evidence
79 Professor Jo Howard, written evidence
80 Liz Blankson-Hemans, written evidence
81 Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee, written evidence
82 Whittington Health NHS Trust, written evidence
83 Dr Rachel Kesse-Adu, written evidence
84 NHS Blood and Transplant, written evidence

LOW AWARENESS OF SICKLE CELL AMONG HEALTHCARE PROFESSIONALS AND INADEQUATE TRAINING

Low levels of awareness of sickle cell among healthcare professionals is another significant factor in the sub-standard care sickle cell patients receive in secondary care. These low levels of awareness are a result of inadequate training around sickle cell for healthcare professionals and trainee nurses and medics.

Lack of awareness of sickle cell: "I am teaching them more than they are doing the job at hand"

Almost all of the evidence we received during the inquiry referred to low levels of awareness of sickle cell among healthcare workers on general wards and in A&E.

A representative assessment of the situation came from Denise Owusu-Ansah, who wrote: "In my experience, the poorer quality care I have received has primarily been due to a lack of knowledge and/or experience of my condition on the part of the healthcare professional. There appears to be a very superficial level of knowledge of the condition and little if any understanding of the degree of pain that can be caused by a sickle cell crisis, the range of symptoms a sickle cell patient can experience and the very basic first steps that should be taken in the event of a sickle cell crisis."[85] Patients contrasted the low awareness of sickle cell among healthcare professionals with other similar conditions such as cystic fibrosis.[86]

One patient told us: "I have been hospitalised in wards where the doctors have asked me, "what do we do for you, I have no idea at all?".[87] Another referred to experiences of presenting to A&E and lack of awareness of sickle cell among the healthcare workers leading to "a lot of delay and Googling/discussing with [a] colleague"[88], an understandable cause for alarm.

We heard from a patient who referred to seeing approximately five different members of staff in A&E and "it became obvious none of them knew what I was talking about and didn't know what to do, which they admitted"[89]. A number of different patients testified to having been asked how long they had

85 Denise Owusu-Ansah, written evidence
86 Carol Burt, written evidence; Anonymous, written evidence; Kye Gbangbola, written evidence
87 Anonymous, written evidence
88 Anonymous, written evidence
89 Anonymous, written evidence

had sickle cell or when they 'caught it' by healthcare professionals who evidently did not understand that the condition is present from birth.[90]

Araba Mensah highlighted the consequences for her daughter's care of the low levels of awareness of sickle cell among healthcare professionals, which included not being administered oxygen or blood transfusions at the correct time, failure to deliver pain relief and missing associated conditions because of a lack of understanding that they could be linked to her sickle cell disorder.[91]

> "It should be as shocking for a senior trained medical staff [member] to say they have never heard of sickle cell disorder as it would be for them to say they had never heard of cystic fibrosis or diabetes."
>
> – Liz Bankson-Hemans, sickle cell patient

Patients reported that, due to the low levels of awareness among the healthcare workers they encounter, they feel that they have to educate staff themselves. The mother of a sickle cell patient told us that "sickle cell patients and relatives are forced to be their health advocates as knowledge of the condition is sparse"[92], while one patient wrote that due to the lack of specialist nurses on the ward he accesses, "I find that I am teaching them more than they are doing the job at hand"[93]. While many patients value being able to advocate on their own behalf and rightly consider themselves to be the expert on their own condition, there is a world of difference between a patient having the opportunity to contribute to decisions around their care with an informed expert and feeling forced to explain basic information about their condition during a time of significant pain and distress.

Again, some felt that geographical differences were apparent in the levels of awareness of sickle cell. One patient told us that "... outside of London, in my experience medical staff do not have an understanding of what sickle cell is or how to manage it". Their submission went on to explain that they had been admitted to hospital while away at university but the seriousness of their condition was only understood when they switched their care to a hospital in London, where they were admitted to intensive care and informed by their doctor that if they had stayed at the original hospital, "I would have died, as my crisis was very life threatening and was not being taken seriously".[94] NHS Blood and Transplant's submission noted that, among those providing care, there is "less expertise where hospitals see fewer patients".[95]

Another patient told us that staff turnover was a factor: "We are only seen by our main consultants occasionally and treated by junior doctors with minimal knowledge about sickle cell. The high turnover rate of these junior doctors has an impact on our care."[96]

Evidence from the Haemoglobin Disorders Peer Review Programme Clinical Leads also highlighted their findings around low levels of awareness of sickle cell, leading to poor care: "Urgent care of patients in non-specialised settings were fraught with poor experience of care. Most patients pointed to the knowledge deficit among emergency department

90 Sadeh Graham, written evidence; Vanessa Williams, written evidence
91 Araba Mensah, written evidence
92 Anonymous, written evidence
93 Anonymous, written evidence
94 Amanda, written evidence
95 NHS Blood and Transplant, written evidence
96 Anonymous, written evidence

(ED) and general practice staff in management of [sickle cell] and frequently expressed stigmatisation and allegations of drug-seeking behaviour."[97]

Referring to the same peer review, University College London Hospital's submission noted: "There was suboptimal awareness and expertise amongst nursing staff in relation to this disease especially in the non-specialist centres ... This was indeed reflected in the feedback from some patients during the recent peer review, emphasising the lack of knowledge of some ward staff about sickle cell disease when they were admitted in an emergency to the ED and to general wards."[98]

The Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee cited low staff awareness as a factor behind adverse events related to inappropriate transfusion: "Due to lack of staff awareness, patients with sickle cell may be transfused inappropriately or with blood not meeting specific requirements." Their submission referred us to data reported to the Serious Hazards of Transfusion (SHOT) UK haemovigilance scheme between 2010 and 2019, which showed that 2.8% of all Specific Requirement Not Met errors occurred in patients with sickle cell disorder.[99]

Generally, in contrast to on general wards and in A&E, patients felt satisfied that sickle cell is well understood by haematology teams. However, this was not uniform. Sickle Cell Suffolk told us that in their experience of a local hospital, "the haematology staff do not have enough knowledge on sickle cell and are not able to advise the medical staff adequately", citing an incident where one of their members was on a general ward and "the haematologist asked the nursing staff why she was on a fluid drip ... Given this is a basic need for a sickle cell patient, it did not fill the patient with confidence about her care."[100]

Inadequate training: "The negative impact of this on patients' care cannot be overstated"

The clear consensus from those who provided evidence to our inquiry was that the low levels of awareness of sickle cell among healthcare professionals is a result of inadequate training in the condition.

Carol Burt told us that during her training as a nurse in the 1980s, she recalled receiving training material with "less than six lines" on sickle cell "compared with pages and reams of literature for cystic fibrosis. In reality, I have nursed three people with cystic fibrosis in the whole of my career and can't mention how many individuals with sickle cell disease".[101] Similarly, Stephanie George said that she had a single one-hour session on sickle cell during her midwifery training, and concluded: "how are staff going to know about [sickle cell] when the teaching itself is substandard?"[102]

97 Haemoglobin Disorders Peer Review Programme Clinical Leads, written evidence
98 University College London Hospital, written evidence
99 Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee, written evidence
100 Sickle Cell Suffolk, written evidence
101 Carol Burt, written evidence
102 Stephanie George, written evidence

> "We are concerned why patients with sickle cell conditions should be nursed on wards where nurses are not fully trained to understand the complexities of this condition and respond appropriately. This, to us, is evidence of substandard care."
>
> – Betty Smith, mother of Evan Nathan Smith

One Consultant Haematologist felt that medical undergraduate and postgraduate training does a good job of including training around sickle cell alongside other aspects of haematology but that "[t]his is not the case across all areas of the medical profession … there is a lack of training within nursing studies, especially [on] recognising the long-term health implications of the condition".103

However, other haematologists felt even this was too positive an assessment of the level of sickle cell training. One told us that most A&E departments "are staffed by clinicians (doctors and nurses) who have little training or awareness of [sickle cell]".104 Dr Emma Drasar wrote: "… education about sickle cell disorders is extremely patchy … Even when it is included it is given comparatively little time on the curriculum … Outside of haematology e.g. in general or speciality medicine the situation is significantly worse and people can become consultants having never been taught about sickle cell disorder or having had very limited education and clinical experience. Similar issues occur in other allied healthcare professional groups including nursing."105

Professor Jo Howard told us: "In the nursing training, there is no set educational information about sickle cell disease so you can complete your nursing training with very little information about sickle cell disease, and every nurse should have that. Likewise, the training for medics on sickle cell disease is very, very poor so both those things should be improved. Anyone who's likely to look after patients with sickle cell disease, so any general medical staff, should all have additional education. My personal thought is that should be mandatory and it's not … It wouldn't be that difficult, it would need some money and some time to develop some national training that everyone had to undergo so at least they had some kind of basic understanding of sickle cell and when it was important."[106]

University College London Hospital said that the "welcome" recent restructuring of haemoglobinopathy provision needs to be accompanied by "major investment in staff and training … healthcare providers in other interconnecting specialties such as A&E and intensive care need targeted and funded retraining, so that prejudicial assumptions that often exist about the genuine needs of patients and therapeutic options available to sickle patients do not harm patients either physically or psychologically."[107]

Responding to the widespread concern around the level of training around sickle cell for nurses, Dr Geraldine Walters from the Nursing and Midwifery Council (NMC) explained to us that the NMC assesses nurses against "high-level, outcome-focused standards" rather than listing specific conditions in the regulatory standards. The NMC is responsible for assessing and approving university curriculums, however, and Dr Walters told us that "the

103 Anonymous, written evidence
104 Dr Subarna Chakravorty, written evidence
105 Dr Emma Drasar, written evidence
106 Professor Jo Howard, oral evidence session, 30 June 2021
107 University College London Hospital, written evidence

curriculum-level can focus on specific diseases within [those high-level standards]", with NMC's "visitors check[ing] with the university whether the right components have been included.[108]

It is clear to us from the evidence we received, including from the NMC, that change is needed in the way nurses are trained to ensure sickle cell patients receive the care they deserve. While we understand that the NMC's approach to regulatory standards is based on high-level standards, rather than requirements around specific conditions, it is apparent from the evidence that too often these high-level standards are not being met.

Dr Walters told us the high-level standards include "things like patient assessment, cultural competence, understanding of tests and investigations, person-centred care, diversity", as well as pain management and that "you need to listen to the patient. You need to have respect for them. You need to be aware of any issues which might impact the way you treat them, and you need to know the boundaries of your own competence.".[109] However, as will be outlined further in the next section of the report, sickle cell patients often do not feel they receive care in a "person-centred" manner, nor with respect to diversity or appreciation of cultural differences. Sickle cell patients often do not receive assessments in an appropriate manner when, for example, attending A&E and, as explored above, far too frequently do not receive appropriate pain management.

> "Every single person in healthcare knows that if your face droops, you have to call an ambulance because of a stroke. Everyone knows that if you've got pain on your chest that radiates into the left arm, every second matters. I think we need to get out there that sickle cell presents with X, Y and Z; it's a similar medical emergency."
>
> – Dr Arne de Kreuk – Consultant Haematologist, North Middlesex Hospital and Deputy Lead, North London Haemoglobinopathy Centre

Furthermore, even if accepting that the appropriate level for ensuring nurse training focuses on specific conditions is at university curriculum-level, it seems apparent that the current curriculums are not sufficient to ensure nurses have an appropriate level of knowledge of sickle cell, given the overwhelming consensus of the evidence we received was that nurses still too often have low awareness of sickle cell. It was welcome that Dr Walters acknowledged that "there might be other ways that we can strengthen our quality assurance around what goes into the curriculum"[110], and we recommend that the NMC prioritises reassessing its requirements around the level of training in sickle cell required to ensure university curriculums are passed as meeting the NMC's standards.

108 Dr Geraldine Walters, oral evidence, 16 June 2021
109 Ibid.
110 Ibid.

This is particularly important given the concerns we heard about the regional variations in 'on the job' training nurses and other healthcare professionals are exposed to around sickle cell. Dr Walters told us that: "Half of the hours of training are spent in clinical practice; half are in the university. So we know that there are some people who qualify who might have had quite a lot of exposure to sickle cell and thalassaemia. Others will have had relatively little."[111]

Haematologists also expressed concern at the regional variations in gaining experience around sickle cell during training. Professor Jo Howard told us: "It is very easy for nurses and doctors (particularly in low prevalence areas) to complete their training without learning about [sickle cell] and without ever seeing a patient with [sickle cell disorder]". Noting that haematology trainees outside London "may not receive adequate hands-on training", Professor Howard advocated "a short period in a sickle centre" as part of training activity.[112]

A second haematologist agreed, writing: "I trained in Haematology in the East of England, which has historically always had only a small number of patients with sickle cell disease. No formal training opportunity existed to go on secondment to a larger city centre (e.g. in London) to gain experience in management in a regional centre. Most of the training offered is via courses … rather than with actual patient care. Training is not adequate in the low frequency regions, and specialist training for haematology speciality training should include a compulsory rotation to a large regional haemoglobinopathy centre for trainees in low incidence regions who would not otherwise gain much experience."[113]

Another haematologist felt that there is good training in haemoglobinopathy in London and the south-east but that "for trainees outside large urban centres with smaller population this can be a bit patchy", adding: "For nursing and medical student training, very little time is spent in haematology as a whole, and even less so in haemoglobinopathy, and hence sickle patient management … The negative impact of this on patients' care cannot be overstated".[114]

A number of healthcare professionals and providers referred us to existing or planned training around sickle cell. Dr Arne de Kreuk told us that he would like to see more use of "drills and simulations of what can happen", which he uses in his own teaching, telling us: "I always start with two or three cases that start similarly and end very differently. I challenge the students and doctors and nurses, 'Okay, what would you do? What would your management plan be here?' I think a very practical, hands-on, maybe with modern technology, simulation module where you can actually see what happens, would be very vital."[115] University Hospitals of Leicester NHS Trust also highlighted the use of simulation training for junior doctors in its hospitals.[116]

The National Haemoglobinopathy Panel (NHP)'s submission referred to its monthly multidisciplinary team (MDT) meeting for clinical specialists as a key educational opportunity for those involved in patient care, including non-members such as senior consultants, nurses, psychologists and trainee doctors attending as observers. In addition to holding webinars and seminars on specific areas of sickle cell care, the NHP's future plans include establishing a repository of complex cases that could be accessed by clinicians for learning, as well as analysing and sharing lessons from the first twelve months of NHP MDTs.[117]

We also received examples of good practice in the delivery of training around sickle cell from individual hospitals. This included regular training in sickle cell for non-specialist staff at Evelina London Children's Hospital and Guy's and St. Thomas' NHS Foundation

111 Ibid.
112 Professor Jo Howard, written evidence
113 Anonymous, written evidence
114 Dr Rachel Kesse-Adu, written evidence
115 Dr Arne de Kreuk, oral evidence session, 16 June 2021
116 University Hospitals of Leicester NHS Trust, written evidence
117 National Haemoglobinopathy Panel, written evidence; Professor Baba Inusa, oral evidence session, 16 June 2021

Trust.[118] The West London Haemoglobinopathy Coordinating Centre noted that a pilot initiative embedding appropriate learning on sickle cell in the nursing and medical curriculum at Imperial College London "has received positive feedback from students".[119]

The UK Forum on Haemoglobin Disorders and the Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee referred us to educational opportunities they provide and efforts they have made to expand such training to non-specialist healthcare professionals.[120] However, the latter told us "we could do more with more targeted training days for specific groups of healthcare professionals."[121]

Similarly, NHS Blood and Transplant informed us that it could, "if so commissioned and funded appropriately, provide nationwide teaching on transfusion in haemoglobin disorders to all staff groups ... We want to increase the audience of our courses to healthcare professionals in training, not just haematology trainees to transfusion requirements and haemoglobinopathies, as it is usually not specialist doctors that initially see haemoglobinopathy patients when they are acutely unwell, and they may have little awareness of appropriate management."[122]

We welcome the examples cited to us of existing training around sickle cell and planned or potential future training. We hope to see continued development and sharing of best practice in training provision around sickle cell from individual hospitals and healthcare bodies. Nevertheless, despite these specific examples of good practice, it is clear from our inquiry that nothing less than a fundamental step change is needed in relation to training for healthcare professionals around sickle cell. Much existing training, while certainly useful and welcome, does not reach those who are most in need of it because it relies on healthcare professionals choosing to undertake it or having the time in which to do so. Comprehensive pre-qualification training in sickle cell for all healthcare professionals, alongside retraining for existing healthcare professionals is, therefore, essential.

Recommendation: All universities to include comprehensive training in sickle cell as part of curriculums for trainee healthcare professionals, covering diagnosis, presentations, management, acute complications (such as pain, acute chest syndrome, stroke) and ongoing care and featuring direct contributions from sickle cell patients.

Recommendation: The Nursing and Midwifery Council and the General Medical Council to urgently commission a review of their approach to sickle cell training, in collaboration with the sickle cell community.

Recommendation: The NMC and GMC to strengthen requirements around the level of sickle cell training required for university curriculums to be approved.

Recommendation: Royal College of Pathologists to include as part of haematology speciality training a compulsory rotation to a large regional haemoglobinopathy centre for trainees in low incidence regions who would not otherwise have as much opportunity to gain direct experience of managing sickle cell patients.

Recommendation: Health Education England to provide additional funding for sickle cell training programmes for healthcare professionals, including for training in the delivery of blood transfusions for non-specialist doctors.

118 Evelina London Children's Hospital, written evidence and Guy's and St. Thomas' NHS Foundation Trust adult haematology service, written evidence
119 West London Haemoglobinopathy Coordinating Centre
120 UK Forum on Haemoglobin Disorders, written evidence and Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee, written evidence
121 Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee, written evidence
122 NHS Blood and Transplant, written evidence

NEGATIVE ATTITUDES TOWARDS SICKLE CELL PATIENTS

Partially as a result of the low levels of awareness and insufficient training in sickle cell, patients are frequently subject to prejudicial attitudes, treated with a lack of respect or prioritisation and undermined or disbelieved when accessing secondary care. The weight of the evidence suggests that such negative attitudes towards sickle cell patients are also often underpinned by racism.

Racial inequality as a factor in sickle cell care: "Care is clouded by stereotypical perceptions of black people"

With sickle cell disorder primarily affecting people with African or Caribbean heritage, racism was regarded by many to be a key factor in the sub-standard care sickle cell patients often receive.

Some patients shared with us examples of particularly overt racism. Calvin Campbell told us he has "had to deal with doctors and nurses openly being racist towards me and others ... I've been called the 'n' word to my face and much worse".[123]

Another patient told us she had experienced "nurses who would witness you being racially abused and still treat you as the instigator or just assume before even getting the facts. I have witnessed patients being racially harassed by other patients and then the nurses would be rushing to placate the instigator rather than the victim".[124]

We were told of an occasion when a consultant told a patient that "the care I was receiving was much better than the care I would have received if it was in my parents' country (in West Africa). She cannot compare the UK to Africa. I was born here so I should surely get the right treatment."[125]

> "Don't look at the colour of our skin first, look in our face and see the pain and help us."
>
> – Diane Crawford, sickle cell patient

Alex Luke described an incident in which he experienced a sickle cell crisis on the motorway and had to call an ambulance. When the ambulance arrived, he was asked to provide identification, an experience he ascribed to racist prejudice.[126]

Patients told us that racist attitudes often affect healthcare professionals' perceptions of sickle cell patients, for example in the frequent assumption that they are 'drug-seekers'. Diane Crawford said that: "As sickle is mainly a black illness, they jump to the conclusion that we're all 'junkies' and not in pain at all ... If we were cancer patients it would be totally different, they have high doses of morphine, no questions asked and extra if they need it because they are mainly white people."[127]

Similarly, June Okochi told us: "I definitely feel that race does play a significant role in how patients are treated, especially in A&E. I think there is the misconception that the drug-seeking patients are back here again".[128] Dr Arne de Kreuk echoed this, telling us: "I do strongly feel that [racism] is a problem on the wards, in A&E and even among doctors. There are publications about this, that illustrate that the perception is that sickle cell patients are difficult, are after painkillers. That perception is still out there and is, I think, deeply rooted, possibly even in training programmes. That perception is something we come across a lot."[129]

Bell Ribeiro-Addy was among many to point to research "that [shows] people believed that black people experience less pain, and because they

123 Calvin Campbell, written evidence
124 Anonymous, written evidence
125 Anonymous, written evidence
126 Alex Luke, oral evidence session, 9 June 2021
127 Diane Crawford, written evidence
128 June Okochi, oral evidence session, 9 June 2021
129 Dr Arne de Kreuk, oral evidence session, 16 June 2021

believe they experience less pain, a lot of the time they're having to beg for pain killers and that creates a massive issue."[130]

Kye Gbangbola referred to evidence from a study in the USA showing that doctors denied pain relief to black sickle cell patients based on their belief that black people have higher pain thresholds or are opioid addicts, yet research in the same journal showed people with sickle cell disorder display lower levels of addiction than the general population.[131]

Many cited the lack of prioritisation of sickle cell compared to other conditions, as outlined above, as being the result of racial inequalities. Stephanie George stated: "I do believe that if sickle cell predominately affected people who are not from African or Caribbean origins, then the care would be completely different ... If you compare [sickle cell] to cystic fibrosis, the difference of care and awareness is staggering. Cystic fibrosis affects fewer people in the UK than [sickle cell] but research has shown the level of awareness and funding for [cystic fibrosis] is much higher."[132]

Araba Mensah told us that "care is clouded by stereotypical perceptions of black people", noting that, while it is sometimes said that sickle cell is not prioritised because it is an 'invisible condition', "there are other "non-visible" conditions that are treated positively. For example, there is a huge disparity between care for patients with sickle cell and care for other blood disorders like leukaemia. Unlike sickle cell, leukaemia patients are treated with dignity, empathy, compassion and sympathy."[133]

Zainab Garba-Sani referred to the fact that hydroxyurea, until recently the only licensed treatment for sickle cell in the UK, is "free for cancer patients and it's not free for sickle cell patients", which is "probably a chief indication of institutional racism".[134]

A number of submissions argued that the very fact that there are few treatments and low levels of research into sickle cell is an example of racism. Araba Mensah wrote: "The illness has been marginalised and kept out of the mainstream and not seen as deserving or warranting research into treatments because it affects blacks and there is no money to be made in it."[135]

Clinicians contrasted the level of funding and resourcing for sickle cell services with that available to conditions that primarily affect those of a Caucasian background. A haemoglobinopathy clinician wrote: "Compared to other inherited conditions, many of which tend to affect Caucasian populations e.g. cystic fibrosis and haemophilia, [sickle cell] is woefully under resourced in the UK."[136] Dr Emma Drasar made the same point: "... despite the recent changes by NHS England there is massive and chronic funding disparity and under-resourcing compared to similar genetic disorders e.g. cystic fibrosis and haemophilia which predominately impact Caucasians."[137]

Professor Jo Howard told us that the UK Forum on Haemoglobin Disorders has run "very effective" anti-racism teaching.[138] We agree with the suggestion that this type of training needs to be expanded and incorporated as an essential element of training for all healthcare professionals.

Recommendation: Secretary of State for Health and Social Care to implement charge-free prescriptions for sickle cell patients.

130 Bell Ribeiro-Addy MP, oral evidence session, 30 June 2021
131 Kye Gbangbola, oral evidence session, 9 June 2021
132 Stephanie George, written evidence
133 Araba Mensah, written evidence
134 Zainab Garba-Sani, oral evidence, 30 June 2021
135 Araba Mensah, written evidence
136 Anonymous, written evidence
137 Dr Emma Drasar, written evidence
138 Professor Jo Howard, written evidence

Recommendation: Health Education England, the Nursing and Midwifery Council, the General Medical Council, universities and other medical training providers to ensure training programmes address diversity and racial bias awareness.

Recommendation: NHS Race and Health Observatory, working closely with Haemoglobinopathy Coordinating Centres, specialist haemoglobinopathy teams, community sickle cell teams, other professionals involved in care provision and the sickle cell community, to undertake a study into sickle cell care in relation to race and ethnicity, examining the impact of racist attitudes and the extent of inequalities in funding and prioritisation for sickle cell compared with other conditions.

Disrespectful treatment: "No sympathy, no compassion, no empathy"

Patients and carers reported frequent disrespectful treatment from healthcare professionals. Araba Mensah, whose daughter has sickle cell disorder, provided a stark summary of her experience of the local hospital: "Staff are unfriendly, judgemental, prejudiced and have preconceived ideas about the patients. There is a definite air of hostility, suspicion and a "them and us" culture between the staff and patients which is really, really sad and distressing to see. Staff do not respect the patients. There is no sympathy, no compassion, no empathy and no appreciation of what the patients are going through."[139]

> "Being ill with sickle cell vaso-occlusive crisis can feel tantamount to being invisible for the amount you feel heard or respected."
>
> – Kye Gbangbola, Chair of Trustees, Sickle Cell Society and patient representative

We were provided with countless examples of this disrespectful treatment. One patient told us: "I have experienced sneers and laughter with comments like 'this is a movie in here', commenting on my sickle cell pain crisis."[140]

A patient outlined an incident in which they were administered the wrong blood, resulting in severe side-effects. However, they told us: "The consultants blamed me and made me feel like I had done something wrong."[141]

Another patient described being admitted to a general ward, and "upon arrival, staff felt it was appropriate to say 'oh no, this one is going to be hard work'. When I questioned why this was said about me as they did not know me, the response was 'well, sickle patients require a lot of work and can be difficult'."[142] This was echoed by a patient carer, who told us that healthcare professionals "label the patients as 'demanding' [or] 'difficult' just because the patients have to press and literally beg for pain medication or help".[143]

Patients reported feeling they had to consciously be aware of their tone during agonising pain to avoid being seen as too aggressive or demanding. One

139 Araba Mensah, written evidence
140 Anonymous, written evidence
141 Anonymous, written evidence
142 Claire T, written evidence
143 Anonymous, written evidence

wrote: "I am a patient and understanding person, so most healthcare professionals, do not view me as 'demanding'; silence leads to better treatment."[144] Another said: "I have had to take on certain roles so that the healthcare professional in charge will treat me well when I am brought into the A&E. For example, I will compliment them, be overly nice to them and explain I am a good person. I will explain the scenario that led to my crisis and beg them to help me."[145]

Angela Thomas told us: "... having a crisis is a scary thing when it happens, not just what physical pain your body goes through, but what treatment are you going to have ... although I am the one in excruciating pain, I still have to be aware of my tone speaking to staff as they have in the past ignored me or taken my pain for aggressive behaviour."[146] Shubby Osoba said that he feels he has to adopt his "professional voice" and even go to the lengths of changing into smarter clothes while experiencing a pain crisis before going to hospital so that he will be taken seriously.[147]

It is unacceptable that sickle cell patients going through a highly distressing experience feel that they have to be act in a certain manner out of fear of receiving disrespectful treatment from healthcare professionals due to prejudicial attitudes.

144 Anonymous, written evidence
145 Anonymous, written evidence
146 Angela Thomas, written evidence
147 Shubby Osoba, oral evidence session, 9 June 2021

Failure to believe or listen to patients: "The first response is always one of disbelief"

As NICE highlighted in their written evidence submission, their clinical guideline around managing acute painful episodes in hospital for sickle cell disease states that "patients (and their carers) should be regarded as experts in their condition".[148]

This is evidently far too often not the case. While patients noted that there are many diligent, dedicated, kind healthcare professionals, sickle cell patients frequently encounter secondary care staff who do not believe them or fail to have regard for their expertise in their condition.

Patients often face scepticism that they are in as much pain as they say they are. Charlotte Mensah wrote: "Our pain is often downplayed, overlooked or straight up ignored. The doctors and nurses sometimes imply that we're exaggerating, faking, or lying about our symptoms ... the NHS Constitution makes a point about how every patient should be treated with compassion and empathy, but in my experience, only 15-20% of doctors and nurses do this."[149] Angela Thomas told us that "hospital staff can be unsympathetic and believe it is a cry for attention".[150]

Zainab Garba-Sani described being "not believed and undermined as a patient with sickle cell", such as being told, "You could at least look a little bit more unwell, you look absolutely fine, what's wrong with you, should you be here?".[151] Araba Mensah told us: "... each time [my daughter] presents at the hospital with a crisis as well as any of these complications, the first response is always one of disbelief at the extent of her pain and suffering".[152] Likewise, another patient felt that sickle cell patients often develop a high threshold for pain and so when they attend hospital in pain "we are looked upon as if we are lying about our pain, as most health professionals except us to be rolling and crying out loud before they believe we are actually in pain".[153]

> "Going into hospital as a sickle cell patient requires you to put on an armour because from the moment you reach A&E it becomes your job to convince everyone you are really in that much pain and are not simply there for medication"
>
> – Sickle cell patient

This failure to believe how much pain patients are experiencing often leads to accusations of illicit drug-seeking behaviour by healthcare professionals who do not believe that they actually require the pain relief to which they are entitled. Among the many examples we heard of such incidents, Angela Thomas wrote that "because morphine is the medication that eases my pain", she faces questioning while trying to deal with the pain "to fathom whether I am in pain or just want the pain medication because I am an addict".[154]

148 NICE, written evidence
149 Charlotte Mensah, written evidence
150 Angela Thomas, written evidence
151 Zainab Garba-Sani, oral evidence session, 30 June 2021
152 Araba Mensah, written evidence
153 Anonymous, written evidence
154 Angela Thomas, written evidence

Another patient recounted an occasion in which a doctor reduced the level of pain relief medication they had been administered by another doctor: "When I corrected them, they called me a liar and made comments with the nurse about me lying to get more pain medication. Later that night, when they checked my record, they realised they were wrong and mis-practised."[155]

Mikell Allison provided us with another example of such stigmatising attitudes leading to a serious outcome, after encountering nurses who have "preconceived ideas (prejudice) that sickle cell patients are 'drug addicts' only there for the morphine. On one such occasion [when] I was admitted in 2009 with a particularly bad crisis, a nurse refused to administer pain relief. Being at the peak of crisis I could only say, 'You can't do that. I have been prescribed the pain medicine'. He then gave me the medication but I ended up in intensive care as my condition worsened."[156]

Sadeh Graham, a sickle cell patient who works in the healthcare system, told us that she only received appropriate treatment when her professional status was known: "The handful of admissions that have been okay or the times I received the appropriate dose of opioids was only due to [healthcare professionals] knowing I was a clinical pharmacist. This is something I used to find heartbreaking because as a sickle cell patient alone I will never be believed".[157]

A number of patients felt that making formal complaints about poor care did not lead to improvements because they were not believed or ignored. One patient outlined a time in which a nurse, while trying to cannulate her vein "repeatedly hit my hand hard because the line didn't go in, blaming me. I tried to make a formal complaint but wasn't taken seriously, and I had no witness, so I had to concede."[158]

Others reported making complaints that did not even receive a response or, worse, resulted in them receiving worse treatment. Charlotte Mensah said that, at her local hospital, "patients are often scared to stand up for themselves, call doctors out on their behaviour, or make a complaint, because it's common knowledge amongst sickle patients … that if you offend, upset or anger the doctors, the quality of your care (and by extension your health) will worsen."[159] Likewise, another patient told us: "Patients feel afraid at times to make complaints … or escalate a problem because of fear of being bullied or having their treatment impeded. I have personally experienced this myself in the past".[160]

Dr Emma Drasar told us there needed to be a change in behaviour among some healthcare professionals based on her experience of supporting sickle cell patients: "Patients often report that they feel stigmatised against, that people don't listen to what they say. I've had patients contact me and other haematology colleagues directly to try and advocate on their behalf … We're all doing a lot of teaching, but if people don't internalise that knowledge and change their behaviour based on it, then however good your teaching is, however good your guidelines are, people have to act on what they're being taught."[161]

A repeated theme of patients' evidence was the importance of healthcare professionals understanding that patients are experts in their own condition and should be listened to and respected. One patient told us that too often "doctors and nurses

155 Anonymous, written evidence
156 Mikell Allison, written evidence
157 Sadeh Graham, written evidence
158 Anonymous, written evidence
159 Charlotte Mensah, written evidence
160 Anonymous, written evidence
161 Dr Emma Drasar, oral evidence session, 16 June 2021

have their 'plan for me' but fail to listen to what I'm saying about my history or what I've already used/ tried at home before presenting to hospital."[162]

> "The lack of collaborative work between health professionals/healthcare workers and patient leads to poor and sometimes tragic outcomes"
>
> – Daniel Gunn, sickle cell patient

Ifunanya Obi wrote: "I've heard too many times while being in hospital, 'I didn't know that, are you sure?' Like they are implying I don't know anything because I'm a patient ... I feel a lot of people giving care to us think they know it all and can't learn anymore which is really bad because it puts a bad name on those that really want to learn and help".[163]

Failing to listen to patients can have serious implications for the care they receive. A patient told us of an experience they had had where they requested the insertion of a femoral line into their groin to provide a blood transfusion, knowing that their veins were too damaged to be used: "I could see that he did not like being told and felt he knew better, I could feel his body language saying 'I know what I am doing, I don't need to be told, it will be fine.' The pain that I felt from that needle trying to penetrate through hard scar tissue became evident by those screams echoing throughout the hospital theatre and corridors. I was quickly sedated before receiving an apology and a look of regret from a flustered anesthetist. He should have listened, I wasn't telling him how to do his job I was just letting him know what my body needed because of my knowledge through my past experiences."[164]

162 Anonymous, written evidence
163 Ifunanya Obi, written evidence
164 Anonymous, written evidence

Such experiences highlight the importance of treating patients as experts in their condition, in line with NICE guidelines. As Bell Ribeiro-Addy put it: "Who is going to know better about their care and what needs to be done than the individual and their family members and the people that care for them?"[165]

Recommendation: NHS England & NHS Improvement to require NHS Trusts to conduct and report regular audits of patient involvement in decisions about their care, utilising patient feedback, in line with NICE clinical guideline stating that sickle cell patients (and their carers) should be regarded as experts in their condition.

Recommendation: NHS England & NHS Improvement to establish formal sickle cell patient advisory groups, based on consultation with the Patient and Public Voice Assurance Group, to work in partnership with and conduct oversight of NHS sickle cell services.

Lack of prioritisation: "People are treated as an added-on"

Sickle cell patients told us that they are often made to feel like they are not a priority for healthcare professionals. One patient told us that "we feel that the hospital here and nationwide actually puts sickle cell patients' needs at the very bottom of healthcare. We feel and see we're being undermined, undervalued, and not being listened to when we are trying to gain some semblance of peace and dignity while in hospital at our worst and weakest time in our already tumultuous lives."[166]

Calvin Campbell referred to experiences of having to wait too long for pain relief and then being told "'you're not the only sick person on the ward' or 'there are sick people I have to deal with', as if someone with sickle cell in the middle of a crisis and in excruciating pain is not considered sick".[167]

Kye Gbangbola told us: "I have been taken to A&E and sat for many hours, waiting for doctors to attend and see me. I would repeatedly ask for pain relief, I'd repeatedly ask for doctors, including their resident sickle cell specialist, only to be told, 'You have to wait.' So you wait, and there is no one to tell that things are not going well … Annoyed and angry healthcare workers, they make patients feel like a pest just for asking for pain relief."[168]

> "Generally, it has been a constant battle to get adequate care for my child. I have to push for further investigation in all elements of my child's healthcare and, speaking to other parents, they are experiencing the same."
>
> – Sickle cell patient carer

Another patient described being in hospital with an extremely high temperature and asking a nurse for some ice cubes and assistance with tepid sponging as "from personal experience I was concerned in case I started fitting". After being refused the ice, "he continued to inform me that he has more important things to do than to stand beside me sponging me down".[169]

A member of the parent and child support group for Darent Valley Hospital, Kent highlighted a lack of prioritisation when taking her daughter for blood

165 Bell Ribeiro-Addy, oral evidence session, 30 June 2021
166 Anonymous, written evidence
167 Calvin Campbell, written evidence
168 Kye Gbangbola, oral evidence, 9 June 2021
169 Anonymous, written evidence

transfusions: “We are asked to come over by 10am and we will be sitting and waiting up till 1pm before the blood comes. We often leave around 6pm or 7pm and, at times, after the night staff have started their shift.”[170]

Professor Jo Howard referred to similar findings of a national peer review, where “there was a lot of repeated examples about where people felt like second-class citizens, where they’re treated as an ‘added-on’, where they’re treated in cancer centres, because a lot of haematology is cancer so the sickle patients can just go along to the same centre.”[171]

There was a disturbing theme in the evidence we received of patients having their ability to call for aid while in hospital taken away or ignored. A friend of a patient recounted visiting her friend on a number of occasions and finding that the sound from her friend’s buzzer had been turned off, which she felt made it “easier for the staff to ignore the patients”. On another occasion, she witnessed a healthcare professional throw her friend’s buzzer out of reach.[172] Another patient told us: “Some nurses will deliberately come and silence the call bell and walk off without notifying the appropriate staff members of the requests being made by the patient.”[173]

Zainab Garba-Sani described being admitted onto a hospital ward “in quite a lot of pain and my pain medication was wearing off … I buzzed the buzzer literally about every 30 minutes for about four hours, before then getting up myself and trying to find someone. I then found a nurse and the nurse said, ‘can you go and sit back down, we'll come to you, just press the buzzer’. I was like, ‘well, that's what I’ve been doing for the last how many hours’ … It’s that feeling of being completely ignored, not given the pain medications that you needed and that you’re requesting.”[174]

Similarly, another patient told us: “I have met nurses who, in order nullify my cries of agony, pulled the bed curtains around me and ignored my cries for help … At times I was in fear for my life. No one was listening to me but actively ignoring my cries for help, while attending other patients as they tiptoed around my bed.”[175]

Patients and clinicians told us that sickle cell is often treated as less of a priority than other health conditions. According to Dr Arne de Kreuk: “If an A&E member of staff has to prioritise between a sickle cell patient in pain and someone who’s broken a leg, unfortunately, they’re not treated equally.

Often, sickle cell is regarded as something that can wait, despite the fact that the first line of the NICE guidance very clearly says, ‘Treat a sickle cell crisis as a medical emergency.’”[176]

Madeleine Glover, a haematology nurse, told us that, in her experience, sickle cell patients often have their appointments for apheresis (automated exchange blood transfusion) procedures moved at short notice “to accommodate other patient groups”. She further outlined a number of ways in which access to specialist haematology services for sickle cell patients “is secondary to access allowed to other patients, principally those with cancer”, including capping the number of sickle cell patients who may attend day unit services, failing to consider current or likely demand for haemoglobinopathy patients when planning space in day care settings that also host cancer patients and giving priority for the use of side rooms and bed spaces to cancer patients.[177]

170 Parent and child support group, Darent Valley Hospital, Kent, written evidence
171 Professor Jo Howard, oral evidence session, 30 June 2021
172 Anonymous, written evidence
173 Anonymous, written evidence
174 Zainab Garba-Sani, oral evidence session, 30 June 2021
175 Anonymous, written evidence
176 Dr Arne de Kreuk, oral evidence session, 16 June 2021
177 Madeleine Glover, written evidence

Patients also highlighted feeling that other conditions are prioritised more in secondary care. One said that, as their care was often provided alongside cancer patients, "we unconsciously are pitted against each other and cancer will almost always win...

For example, if a [sickle cell] patient requests pain relief before a cancer patient, though the medication is due to be given, the cancer patient will receive their medications before a sickle patient. We frequently hear the words, 'I will be with you soon; I have other patients who need me'. In that moment, you are not one of their patients".[178]

Another felt that "there also seems to be some strange sort of competition or bias towards preferential treatment to those with white cell conditions. This is unspoken, yet whenever [there are] any changes to ward structure or patient treatment, it is the sickle patients who always have to give ground."[179]

These examples all demonstrate the shocking extent to which sickle cell patients are treated as though they are not a priority when accessing secondary care and the frequency with which they are made to feel their condition is not as serious as others.

178 Anonymous, written evidence
179 Anonymous, written evidence

INADEQUATE INVESTMENT IN SICKLE CELL CARE

Sickle cell patients, carers and clinicians all noted the low levels of investment in sickle cell services and research into the condition, particularly when compared with other similar medical conditions. The recent move by NHS England & NHS Improvement to commission sickle cell as a specialised service, including the formation of Haemoglobinopathy Coordinating Centres, is welcome but was felt by many to have still not adequately addressed the problem of inadequate funding for sickle cell services.

Under-resourcing of sickle cell services: "It has the feeling of an underfunded and underinvested 'Cinderella' area of medicine"

We were told that under-resourcing of sickle cell services is a significant contributor to sub-standard care. One patient who attends a London hospital told us that there are only between four and eight beds allocated to sickle cell patients on the haematology ward they access and asked "how sickle cell patients are meant to feel safe when we can't even get a bed on our own specialist ward".[180]

Sadeh Graham said that the haematology ward at the hospital in the West Midlands she attends has no access for sickle cell patients, with only nine beds in the haematology ward, which are reserved for patients with other conditions. The lack of available beds for sickle cell patients requiring pain management means patients are often "turned away to go home or sit in A&E for hours and be subject to poor care", Sadeh told us.[181]

The under-resourcing of sickle cell services was also raised by many of the clinicians we received evidence from. Professor Jo Howard noted that "the majority of hospitals" are unable to provide apheresis out of hours, which results in "patients travelling halfway across the country". Professor Howard described this as a "funding issue … there hasn't been enough investment in that".[182]

Evidence from the Haemoglobin Disorders Peer Review Programme Clinical Leads highlighted the lack of support sickle cell services receive from NHS Trust leaders to address areas of clinical care considered to be of 'immediate risk' or 'concern' during reviews. Whereas in a national renal care review in 2016, 63% of services stated that their Trusts had supported them to address such concerns in a post-hoc survey, "this was the case in a fraction of services in the [sickle cell] reviews. Specifically, 25% (in 2010-2011); 35% (in 2012-2013); 39% (in 2014-2016)

180 Anonymous, written evidence
181 Sadeh Graham, written evidence
182 Professor Jo Howard, oral evidence session, 30 June 2021

and 54% (in 2018-2020) of haemoglobinopathy services received Trust support to address areas considered 'immediate risk' or 'concern' to patient care." The Clinical Leads of the Haemoglobin Disorders Peer Review Programme concluded that "this reflects the lack of Trust executive-level interest in providing material and human resources required to improve care of people with haemoglobin disorders". [183]

Many clinicians contrasted the level of resource provided to sickle cell services with that provided to other similar conditions. One haematologist said that, in their opinion, sickle cell patients do not receive "anything like the level of care that other patient groups with chronic disease do, and it has the feeling of an underfunded and underinvested 'Cinderella' area of medicine".[184]

> "While the recent restructuring of haemoglobinopathy provision is a welcome recognition of the existence of a problem, structural reorganisation without major investment in staff and training (especially of staff in other specialties) will not be enough."
>
> – National Haemoglobinopathy Panel

Dr Rachel Kesse-Adu told us that, despite feeling her NHS Trust has one of the best-resourced sickle cell services in the country, "we do not even marginally compare when you hold us up to the resource and support both in the hospital and community that exists for other chronic conditions (such as cystic fibrosis) or other ailments such as cancer".[185]

Another haematologist told us that services for haemophilia and cystic fibrosis "provide a benchmark for holistic comprehensive care and sickle services generally fall below this standard" and that sickle cell is often the "poor relation" compared to cancer care in haematology departments. While this clinician welcomed the recent additional funding from NHS England, they told us that "the monies available did not match the requirements of the Specialised Haemoglobinopathy [Coordinating] Centre service specification, such that my employing Trust has accepted that it has to overspend on this budget".[186] Similarly, Professor Jo Howard told us the funding of red cell exchange transfusion "is not adequate and the tariff received by centres is less than it costs".[187]

We also heard that the level of resource varies hugely across the country. Dr Thomas Lofaro, a Consultant Haematologist who previously trained and worked in London and is now based in Hertfordshire, told us that "it is very difficult to provide the same level of service because of the great difficulties in accessing funding and support for this condition outside of major centres … patients may be fewer, but their needs are the same (or even more for lack of support) and the care we can provide is not the same".[188]

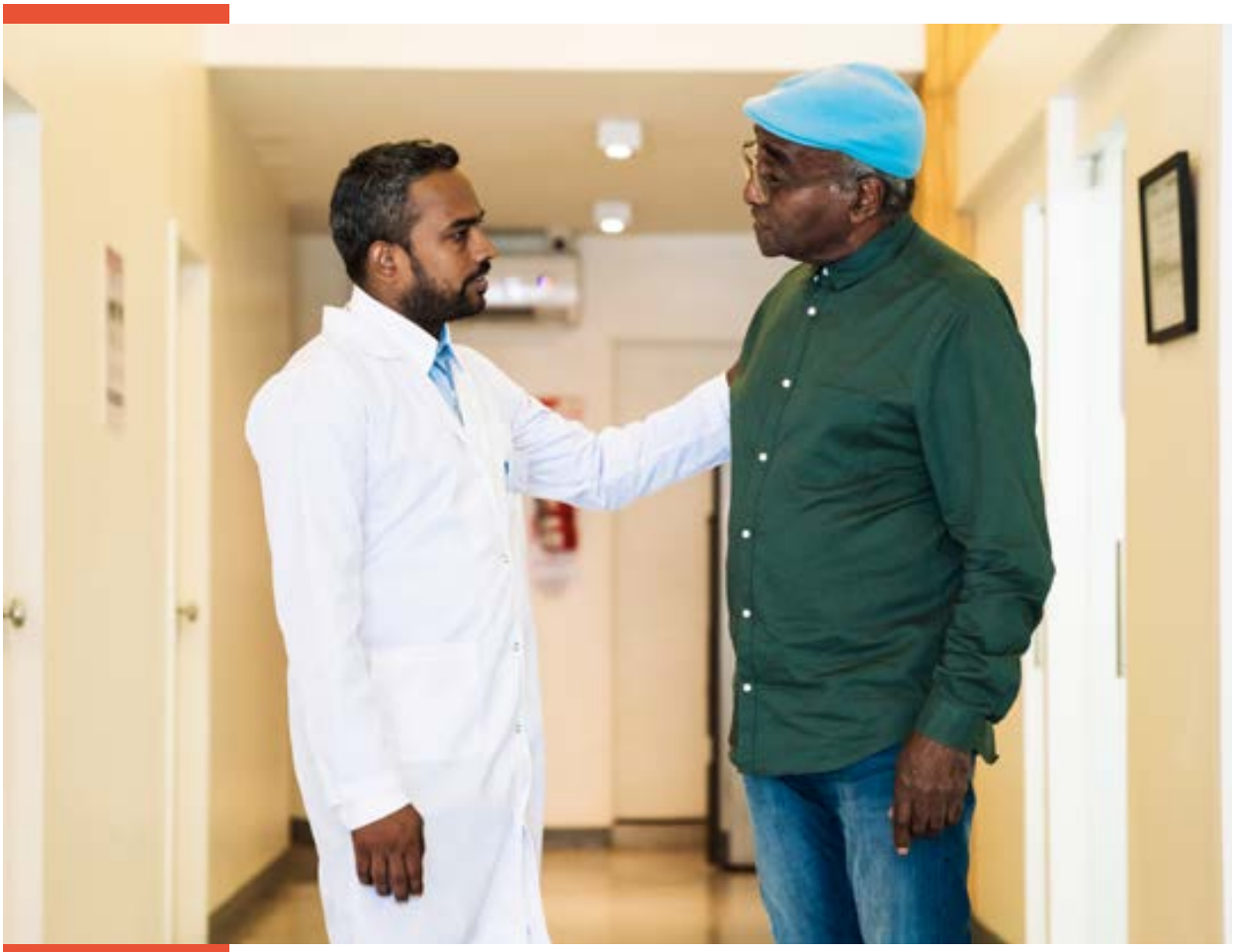
The under-resourcing of sickle cell services can have serious outcomes. For example, one patient told us that, aged seven, they required an exchange blood transfusion which could not be offered at their local hospital and were instead referred to a specialist paediatric intensive care unit in central London after ten days. This delay led to the patient being hospitalised for almost two months and in a

183 Haemoglobin Disorders Peer Review Programme Clinical Leads, written evidence
184 Anonymous, written evidence
185 Dr Rachel Kesse-Adu, written evidence
186 Anonymous, written evidence
187 Professor Jo Howard, written evidence
188 Dr Thomas Lofaro, written evidence

wheelchair for at least six months after that, followed by intensive physiotherapy, all of which impacted their education.[189]

Recommendation: NHS England & NHS Improvement to provide increased funding for sickle cell services in recognition of the consistent underfunding of sickle cell services when compared with services for other conditions. This should include dedicated funding for NHS Trusts to improve apheresis capacity across the country.

Recommendation: Clinical Commissioning Groups and local authorities to provide additional funding for third sector providers and community care organisations for social prescription in relation to sickle cell to reduce pressure on NHS services.



189 Anonymous, written evidence

Under-staffing of sickle cell services: "We are constantly facing a staffing crisis"

The lack of investment in sickle cell services is also apparent in the significant shortfall in appropriate numbers of healthcare professionals working in sickle cell care.

The British Society for Haematology told us that haemoglobinopathy "has a longstanding recruitment problem and an ageing staff demographic suggesting that shortages are likely to continue to be an issue". They referred us to three recent workforce surveys, run by the Royal College of Physicians, the Royal College of Pathologists and the British Society for Haematology, which they said "demonstrate a marked shortfall in consultant numbers over the next few years across all areas of haematology". In line with the evidence set out in the section above, the British Society for Haematology welcomed the recent changes to sickle cell service provision by NHS England but added, "the funding allocated to this service redesign was minimal, and for many centres did not cover the costs of establishing appropriately staffed core services".[190]

Haematologists we heard from echoed this concern around levels of staffing. Dr Emma Drasar told us that it is a struggle to attract enough staff to red cell haematology "which means we are constantly facing a staffing crisis … I exist in a state of anxiety around sustaining my service, worried that my patients will not receive good care unless I am there and in fear that I am not doing the best for my patients due to external forces".[191] Professor Jo Howard noted that national recommendations for staffing levels per patient numbers "are universally not met" for sickle cell services, adding: "The workload of [haemoglobinopathy] clinicians is huge and consistently exceeds contracted hours and 'burnout' is a major concern".[192]

> "Chronic under-staffing, under-training and under-funding of clinical positions (doctors, nurses and psychologists) is likely to have contributed to the lack of appropriate standard of care for patients"
>
> – Consultant Haematologist

Even more concerningly, the situation is getting worse, according to the Haemoglobin Disorders Peer Review Programme. In the 2016 review, 35% of sickle cell services stated that they had problems with time available for senior clinicians to provide leadership of the service or availability of consultant medical staff. By the 2020 review, this had risen to an astonishing 84% of services.[193]

The under-funding of services and inadequate levels of staffing can be a mutually reinforcing problem. The Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee told us that, as a result of the significant underfunding of sickle cell services, "there are significantly fewer numbers of specialised nurses, doctors, psychologists and support staff that

190 British Society for Haematology, written evidence
191 Dr Emma Drasar, written evidence
192 Professor Jo Howard, written evidence
193 Haemoglobin Disorders Peer Review Programme Clinical Leads, written evidence

have chosen to work within this service. They mainly move into oncology (white cells) and clotting with research and opportunities."[194]

Similarly, the UK Forum on Haemoglobin Disorders noted that "this under-resourced area has become increasingly challenging to recruit to ... Junior doctors struggle to find academic or research opportunities in haemoglobinopathies and will often take up research programmes in malignant or coagulation and hence will fall into that career path as Consultants".[195] Professor Jo Howard said that "even when posts are funded it is difficult to fill specialist posts and many are vacant".[196]

In addition to concerns around the number of haematology doctors and nurses, many submissions also mentioned shortfalls in specialist psychologist staff and community nurses to support sickle cell patients. Professor Jo Howard cited the difficulties many services have faced in obtaining funding for psychologists and other specialist staff as evidence that "the funding of [sickle cell] care does not seem to be a priority".[197]

Under-staffing is a significant problem in sickle cell care and, with the consensus being that the problem is currently on course to get worse, it is imperative that NHS England & NHS Improvement take action to address the issue to improve the care sickle cell patients receive.

Recommendation: Department of Health and Social Care to convene organisations including Health Education England, the General Medical Council, the Nursing and Midwifery Council, the medical royal colleges and medical and nursing schools to come together with senior sickle cell service representatives to engage in effective workforce planning for sickle cell services, including the allocation of specialist training opportunities.

Recommendation: All NHS Trusts to ensure that specialised service funding is invested in meeting recommended sickle cell service staffing numbers.

Underinvestment in sickle cell research and treatment: "Research has been woefully inadequate"

The long-standing lack of investment in sickle cell research and new treatments was repeatedly highlighted in the evidence we received. There are currently a very limited range of treatments available for sickle cell patients in the UK, with the two most significant being the use of blood transfusions and the medicine hydroxyurea, which can reduce the frequency of sickle cell crises.

Shortly before publication of this report, NHS England & NHS Improvement approved Crizanlizumab, the first new treatment for sickle cell in over 20 years, a welcome development but one that is well overdue. The evidence we received suggested the lack of new treatments for over two decades is a reflection of the health inequalities associated with sickle cell disorder.

194 Royal College of Pathologists' Transfusion Medicine Specialty Advisory Committee, written evidence
195 UK Forum on Haemoglobin Disorders, written evidence
196 Professor Jo Howard, written evidence
197 Ibid.

This lack of treatment availability is a result of low levels of research, we were told. Professor Jo Howard noted that there are very small numbers of sickle cell research-active clinicians in the UK and that it has been historically difficult to obtain funding, adding: "A lack of research into health outcomes hampers the introduction of new therapies as there is little data about the economic impact of sickle cell disorder."[198]

Araba Mensah was among those who highlighted the lack of research into sickle cell. She told us: "Considering the magnitude of the effect it has on sufferers' lives, research has been woefully inadequate over the decades ... The majority of patients are left with no option but to take painkillers for their condition while they live in hope that one day a medical breakthrough will provide them some much-needed relief."[199]

Again, many noted the contrast between levels of research and treatment-availability for sickle cell with those for other, similar conditions. A Consultant Haematologist told us that, unlike for cystic fibrosis, no specific funding streams are available for sickle cell research, meaning sickle cell researchers have to apply to generic funding calls.[200] Another said: "The lack of access to research is especially apparent when you compare the opportunities to patients with a cancer diagnosis to those in the sickle cell community, which is evident every day to those of us who work in environments where colleagues are involved in treating patients with cancer."[201]

While this lack of investment in research means that there are limited treatments available, frustration was also expressed that treatments available in other countries have not been approved in the UK. Professor Jo Howard told us there are "several new drugs and therapies" available in other countries which have not been approved in the UK "and are unlikely to be available for many years".[202]

University College London Hospital noted that NHS England has published clinical commissioning guidance for sibling Allogeneic Haematopoietic Stem Cell Transplantation for adults with sickle cell disease, which is potentially curative for those people with severe disease in whom other treatments have failed or have not been tolerated. Their submission called for additional funding from NHS England to ensure adequate investment in new clinical pathways to treat this cohort of patients.[203]

It is clear that decades of underinvestment in sickle cell research has led to a dearth of treatment options for sickle cell patients. Increasing the level of research and the availability of treatment options is key to improving sickle cell care outcomes.

Recommendation: UK Research and Innovation and the National Institute for Health Research to launch dedicated sickle cell research opportunities, including supporting and funding research into genetic therapies to cure sickle cell disorder.

Recommendation: NHS England & NHS Improvement to report results of Managed Access Programme for Crizanlizumab to support roll-out following the drug's approval.

198 Ibid.
199 Araba Mensah, written evidence
200 Dr Subarna Chakravorty, written evidence
201 Anonymous, written evidence
202 Professor Jo Howard, written evidence
203 University College London Hospital, written evidence

CONCLUSION

In addition to the issues explored over the course of this report, a further common theme of the evidence we received from patients and specialist sickle cell clinicians was anger and frustration that the same issues have been highlighted time and again over many years without any action.

It is a damning indictment of the way sickle cell patients have been treated that so many told us they fear, or actively avoid, accessing secondary care services. The feeling that many sickle cell patients have been left with is that that they are not a priority, that their suffering is not considered important and that treatment that would not be accepted for other patient groups is ignored when it relates to sickle cell. The only way this can be changed is by taking urgent steps to address the factors behind sub-standard care for sickle cell patients.

The shocking, tragic and avoidable death of Evan Nathan Smith was just the latest in a long line of deaths and near misses among sickle cell patients. Further avoidable deaths among sickle cell patients will be inevitable unless action is taken.

We urge all of those we have addressed recommendations to in this report to set out the steps they will be taking in response. More generally, we are calling for healthcare leaders, including the Secretary of State for Health and Social Care, the Chief Executive of NHS England & NHS Improvement and leaders of the new Integrated Care Systems to adopt improving sickle cell care as a key priority.

It is long past time that action is taken to improve sickle cell patients' experience of secondary care. The SCTAPPG looks forward to working with all relevant stakeholders to deliver the changes that are required.

ANNEX

EVIDENCE

The SCTAPPG would like to thank all those who provided evidence to the inquiry.

Oral evidence

The SCTAPPG conducted three oral evidence sessions with the following witnesses:

Wednesday 9th June 2021

- June Okochi (patient representative)
- Alex Luke (patient representative)
- Kye Gbangbola (Chair of Trustees, Sickle Cell Society and patient representative)
- Shubby Osoba (patient representative)
- Dr Shivan Pancham (Consultant Haematologist, Sandwell and West Birmingham NHS Trust)

Wednesday 16th June 2021

- Cedi Frederick (Chair, North Middlesex University Hospital NHS Trust)
- Dr Geraldine Walters CBE (Executive Director for Professional Practice, Nursing and Midwifery Council)
- Professor Baba Inusa (Consultant Paediatric Haematologist, Guy's and St Thomas' NHS Foundation Trust and Chair, National Haemoglobinopathy Panel)
- Dr Arne de Kreuk (Consultant Haematologist, North Middlesex Hospital and Deputy Lead, North London Haemoglobinopathy Centre)
- Dr Emma Drasar (Consultant Haematologist, The Whittington Hospital and University College London Hospital and Chair, Haemoglobinopathy Coordinating Centres)

Wednesday 30th June 2021

- Betty & Charles Smith (parents of Evan Nathan Smith)
- Professor Jo Howard (Consultant Haematologist, Guy's and St Thomas' NHS Foundation Trust and Chair, NHS England Haemoglobinopathies Clinical Reference Group)
- Bell Ribeiro-Addy MP (member, APPG on Sickle Cell and Thalassaemia and former care provider to sickle cell patient)
- Zainab Garba-Sani (patient representative)

Written evidence

The following individuals provided written evidence to the inquiry:

- Joana AllisonMikell Allison
- Liz Blankson-Hemans
- Carol Burt
- Calvin Campbell
- Dr Subarna Chakravorty
- Diane Crawford
- Dr Emma Drasar
- Kye Gbangbola
- Stephanie George
- Madeleine Glover
- Sadeh Graham
- Daniel Gunn
- Professor Jo Howard
- Dr Fatima Kagalwala
- Jaspreet Kaur
- Dr Rachel Kesse-Adu
- Dr Thomas Lofaro
- Araba Mensah
- Charlotte Mensah
- Ifunanya Obi
- Denise Owusu-Ansah
- Richard Patching
- Charles Phillip
- Mamme Prempeh
- Angela Thomas
- Dammy Shittu
- Dr Tullie Yeghen
- Amanda [surname withheld by request]
- Claire T [full surname withheld by request]
- We received a further 54 anonymous submissions.
- The following organisations provided written evidence to the inquiry:
- British Society for Haematology
- Crescent Kids
- Darent Valley Hospital Paediatric Centre
- Evelina London Children's Hospital
- Global Blood Therapeutics
- Guy's and St Thomas' NHS Foundation Trust adult haematology service

- Haemoglobin Disorders Peer Review Programme Clinical Leads
- National Haemoglobinopathy Panel
- National Institute for Health and Care Excellence
- NHS Blood and Transplant
- NHS England & NHS Improvement
- Royal College of Pathologists Transfusion Medicine Specialty Advisory Committee
- Serious Hazards of Transfusion
- Sickle Cell Suffolk
- Sickle Plus
- Sickle Cell Winning Ways
- South East Haemoglobinopathy Co-ordinating Centre
- UK Forum on Haemoglobin Disorders
- University College London Hospital
- West London Haemoglobinopathy Coordinating Centre
- Whittington Health NHS Trust

Parliamentarians who participated in the inquiry

Rt Hon Pat McFadden MP (Chair)

Janet Daby MP

Bell Ribeiro-Addy MP

Stella Creasy MP

Baroness Benjamin

Acknowledgement

This report was produced by Aidan Rylatt of Principle Consulting, working with the Sickle Cell Society as the SCTAPPG's secretariat.

Cheshire and Merseyside
Health and Care Partnership

Quality & Performance Committee

Terms of Reference

September 2022

Document revision history

Date	Version	Revision	Comment	Author / Editor
13.04.22	0.1	ICB Quality Committee	Initial Draft	Michelle Creed
11.05.22	0.2	ICB Quality Committee	Revision consultation comments	Michelle Creed
18.05.22	0.3	ICB Quality Committee	Revision consultation comments	Ben Vinter
07.06.22	0.4	ICB Quality & Performance Committee	Revision to include Quality & Performance	Ben Vinter
09.06.22	0.5	ICB Quality & Performance Committee	Revision consultation comments	Michelle Creed
24.08.22	0.6	ICB Quality & Performance Committee	Revision consultation comments	Michelle Creed

Review due

31 March 2023

1. Introduction

The Quality & Performance Committee (the "Committee") has been established in accordance with the Integrated Care Board's (ICBs) constitution.

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

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

2. Role and Purpose

The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care, coupled with a focus on performance.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit

<u>Quality</u>

- Ensure that there are robust processes in place for the effective management of quality, safety and patient experience.
- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern
- Oversee development of the ICB's key quality priorities, including priorities to address variation/ inequalities in care, and recommend these priorities to the ICB for inclusion in the ICB Strategy / Annual Plan
- Oversee and monitor delivery of the ICB key statutory requirements
- Review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care.
- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites

- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programs
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place
- Ensure processes are in place to enable the ICB to identify lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded
- Ensure that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report)
- Ensure that mechanisms are in place to systematically and effectively involve people that use services as equal partners in quality activities
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety

<u>Performance</u>

- Receive, review and scrutinise the integrated performance reports for the ICB with a focus on quality, safety and patient experience and outcomes.
- Ensure that contract quality performance is monitored on a monthly basis (or other periods as agreed for certain contract types as appropriate)
- Identify and scrutinise significant variations from plan of all Key Performance Indicators (KPIs)
- Scrutinise the appropriateness and robustness of any management actions to address identified performance issues in relation to the quality of services.
- Ensure actual and forecast contract over-performance or under-performance is quantified in financial terms and activity terms
- Benchmark recovery plans against trajectories
- Agree which of the underperforming contracts need to be brought to the attention of the ICB
- Ensure the implementation of the priorities set out in the Operational Planning Guidance
- Oversee the ongoing delivery of procurements and any major service change, with a focus on quality, safety and patient experience in line with statutory requirements
- In relation to quality of services, seek assurance that the procurement of services is consistent with relevant laws and that conflicts of interest have been declared, managed and published as required

In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties:

- Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); and
- Adult safeguarding and carers (the Care Act 2014).

In order to deliver this, the responsibilities of the Committee will include:

- Ensuring the ICB is informed in a timely manner of significant risks, issues and mitigation plans relating to quality and performance (in line with the remit of the Committee).

3. Authority

The Committee is authorised by the Board to:

- Request further investigation or assurance on any area within its remit
- Obtain such internal information as is necessary and expedient to the fulfil its functions
- Undertake, where necessary, 'deep dives' into specific issues that will enable it to gain a greater level of understanding and assurance into specific issues that fall within its remit
- Bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- Make recommendations to the ICB
- Escalate issues to the ICB
- Produce an annual work plan to discharge its responsibilities
- Approve the terms of reference of any sub-groups to the committee (e.g. System Quality Groups, Infection Prevention and Control, Local Maternity and Neonatal System, SEND Partnership Board)
- Delegate responsibility for specific aspects of its duties to sub-groups. The terms of reference of any sub-groups shall be approved by the Committee.
- Commission, review and authorise policies where they are explicitly related to areas within the remit of the committee as outlined within the terms of reference, or where specifically delegated to the Committee by the ICB Board.

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

4. Membership and Attendance

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

Membership of the Committee may be drawn from the ICB Board membership; the ICB' executive leadership team; officers of the ICB; members or officers of other bodies in the wider health and social care system; other individuals/representatives as deemed appropriate.

The Committee members shall be:

- Non-Executive Member of the ICB (Chair)
- Non-Executive Member of the ICB (Deputy Chair)
- ICB Director of Nursing & Care
- ICB Medical Director
- ICB Director of Performance and Planning
- Up to two lay members with lived experience ~~(e.g. Healthwatch, patient safety partners)~~

Up to two ICB Partner Members ~~(or their representatives)~~

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Committee Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

Attendees

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

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

5. Chair and Deputy-Chair

The Committee shall be chaired by a Non-Executive Member of the ICB. The Deputy Chair shall be a Member of the ICB.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB member to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.

6. Meetings

The Committee will meet in private.

The Committee will generally meet monthly and arrangements and notice for calling meetings are set out in the Standing Orders.

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

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

7. Quorum

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

- ~~At least one Non Executive Members of the ICB*;~~
- ~~At least one ICB Partner Member of the ICB*;~~
- ~~The Director of Nursing & Care or Medical Director*;~~
- ~~At least one lay member with lived experience *~~

- 1 x Non-Executive Director (to chair the meeting)
- 1 x other Non-Executive or Partner Members of the ICB
- The Director of Nursing & Care or Medical Director.

8. Decision-making and voting

Decisions should be taken in accordance with the Standing Orders.

The Committee will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote.

A person attending a meeting as a representative of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with paragraph 6, no member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

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

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

9. Administrative Support

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

10. Accountability and Reporting Arrangements

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

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will submit copies of its minutes and a report to the Board following each of its meetings. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

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

11. Behaviours and Conduct

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

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

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICBs' policy on managing conflicts of interest, Committee members should:

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

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

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

Equality diversity and inclusion

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

12. Monitoring Effectiveness and Compliance with Terms of Reference

The Committee will review its effectiveness at least annually

13. Review of Terms of Reference

These terms of reference will be reviewed at 6 months in 2022/23 and thereafter at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

29 September 2022

Report of the Chair of the C&M ICB System Primary Care Committee

Agenda Item No:	ICB/9/22/**18**
Report author & contact details	Christopher Leese, Associate Director of Primary Care c.leese@nhs.net
Report approved by (sponsoring Director/ Chair)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Christopher Leese

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICB Board Meeting

Report of the Chair of the C&M ICB System Primary Care Committee

Executive Summary	The C&M ICB System Primary Care Committee met on 28 August 2022. This was the first formal meeting of the Committee. The meeting was quorate and was able to undertake its business. Main items considered at the meeting included: • Terms Of Reference of the Committee • update on the Primary Care Operating Model for the Primary Care function ICB and Place ICB • update on national and local Primary Care Contracting • update on actions in relation to the General Practice Survey 2022 • update on the position relating to Primary Care finance • a policy was presented on the Dispute Resolution Process for Primary Care Contracts • endorsement of the minutes and decisions of the Pharmaceutical Services Regulations Committee which is the committee that has oversight of the Community Pharmacy Contract within the ICB (aligned from NHS England). • a Contracts update from Knowsley Place containing key assurances regarding PMS (Personal Medical Services) and related contracts. • West Cheshire Place list closure request submitted for decision. • West Cheshire Place Blacon estates funding submitted for decision • West Cheshire Place weekend working in relation to Willaston Practice submitted for decision • an update from Warrington Place in relation to their Enhanced Access Consultation submitted for Assurance • an update on the process for the ICB's transfer from NHS England of Dental and General • Ophthalmic Services (GOS), for information and assurance.

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

Recommendation	**The Board is asked to:** • **note** the contents of the report • **approve** the recommendation of the Committee to approve amendments to the Committees Terms Of Reference.
Key risks	Key risks were noted and mitigating actions confirmed for the transfer of Dental services, particularly in relation to due diligence in respect of the overall budget.

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

Management of Conflicts of Interest	None were identified at the meeting that caused any issues for continuation of the business

NHS Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Next Steps	Following consideration of this paper and if approvals against the recommendations are provided by the Board then: • an updated Terms of Reference will be published on the ICB website.	
Appendices	**Appendix A**	Committee Terms of Reference v1:1

Report of the C&M ICB System Primary Care Committee Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
System Primary Care Committee	The role of the System Primary Care Committee shall be to oversee, coordinate and promote alignment of the functions amongst Places relating to the commissioning of primary medical services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy.	Erica Morriss

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
	25.8.2022	• The Committee received an update on the Primary Care Operating Model • The Committee received an update on national and local Primary Care Contracting which defines much of the work undertaken in the primary care function. • The Committee received an update on actions in relation to the General Practice Survey 2022 which collates patient feedback on general practice services nationally. • The Committee received an update on the position relating to Primary Care finance • The Committee received the minutes and decisions of the Pharmaceutical Services Regulations Committee which were endorsed. This Committee regulates the Community Pharmacy Contract within the ICB, aligned currently from NHS England. • The Committee received an update from Knowsley Place for assurance in relation to their PMS (Primary Medical Services) Contracts and primary care financial position/actions • The Committee received an update from Warrington Place in relation to their Enhanced Access Consultation, noting the sign off from the

Decision Log Ref No.	Meeting Date	Issues considered
		Place Patient Engagement and Consultation Team of its adherence to the relevant principles and statutory duties. • The Committee received an update on the process for the ICB's transfer from NHS England of Dental and General Ophthalmic Services (GOS) for assurance and information.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
	25.8.2022	• The Committee supported a recommendation from West Cheshire Place to remove weekend working from the contract of Willaston Practice • The Committee supported the recommendation from West Cheshire Place to agree a list closure for Hope Farm Practice for four months • The Committee did not support a recommendation to agree funding and actions in relation to Blacon Practice, from West Cheshire Place. • The Committee agreed a Dispute Resolution Process for Primary Care Contracts (General Medical/Primary Medical and Alternative Provider of Primary Medical Services contracts)

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
		None

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendations
	25.8.2022	**Committee Terms of Reference.** At its meeting Committee members considered and agreed proposed revisions to the Committees Terms of Reference. Additions are highlighted in **blue** and revisions in ~~**red**~~. To support the following amends to the Terms of Reference which are also detailed in Appendix A That the SPCC could take place in public or private depending on the agenda item 4.2 of the ToR; This will need amending to be essential, advanced, national enhanced and local enhanced rather than core and enhanced. That further amends be expected once the scheme delegation is clear and the SFI's agreed within the next few months. This should be noted in the TOR. That the membership in 5.1 of the ToR covers the representation from each of the recognised primary care professional groups. LDC LOC LPC and LMC (LDC and LOC once Dental transfers to the ICB from 1.4.2023). That these groups are attendees rather than members. That the membership of other professional groups has yet to be agreed. The Committee supported the changes and agreed to recommend the changes for approval to the ICB Board at its next meeting.

6. Recommendations

6.1 **The ICB Board is asked to:**

- **note** the contents of the report
- **approve** the recommendation of the Committee to approve amendments to the Committees Terms of Reference.

7. Next Steps

7.1 Following consideration of this paper and if approvals against the recommendations are provided by the Board then:

- an updated Terms of Reference will be published on the ICB website.

NHS
Cheshire and Merseyside

C&M ICB

System Primary Care Committee

Terms of Reference v1.1

Document revision history

Date	Version	Revision	Comment	Author / Editor
January 2022	1.0	Initial ToRs		Ben Vinter
25.8.2022	21.1		Revisions following first meeting of System Primary Care Committee	Christopher Leese

Review due

- **Noting further amends be expected once the overall scheme delegation is clear and the SFI's agreed within the next few months.**

1. Introduction

NHS C&M has been established to

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

The System Primary Care Committee has been established to oversee the ICB's exercise of its statutory powers relating to the provision of primary medical services under the NHS Act 2006, as amended by the Health and Care Act 2022. The Committee is also established in line with the ICB Constitution and the Delegation Agreement.

2. Purpose

NHS C&M has established a series of Primary Care Committees (nine of which sit within place-based arrangements, the tenth being a System-wide Primary Care Committee with oversight of the full Cheshire & Merseyside area) to function as the corporate decision-making forum for the management of the delegated functions and the exercise of the delegated powers.

These Terms of Reference relate to the NHS C&M System-wide Primary Care Committee. Please see separate Place-Based Primary Care Committee ToR for the role of those committees within each place.

3. Statutory Framework

The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:

13YB Directions in respect of functions relating to provision of services

(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.

(2) In this section "relevant function" means—

(a) any function of NHS England under section 3B(1) (commissioning functions);

(b) any function of NHS England, not within paragraph (a), that relates to the provision of—

(i) primary medical services,

(ii) primary dental services,

(iii) primary ophthalmic services, or

(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;

(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);

(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).

82B Duty of integrated care boards to arrange primary medical services

(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.

(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).

In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) section 14Z34 (improvement in quality of services),
d) section 14Z35 (reducing inequalities),
e) section 14Z38 (obtaining appropriate advice),
f) section 14Z40 (duty in respect of research),
g) section 14Z43 (duty to have regard to effect of decisions)
h) section 14Z44 (public involvement and consultation),
i) sections 223GB to 223N (financial duties), and
j) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.

4. Delegated Powers and Authority – Role of the Committee

The Committee is established as a Committee of NHS C&M Integrated Care Board (ICB) in accordance with the NHS Act, as amended by the Health and Care Act 2022, and is subject to any directions made by NHS England or by the Secretary of State. The Committee is also established in line with the ICB Constitution and the Delegation Agreement.

The Committee has been established in accordance with the above statutory provisions to enable collective decision-making on the review, planning and procurement of primary care services in relation to GP primary medical services and community pharmacy as part of the NHS C&M's statutory commissioning responsibilities across Cheshire & Merseyside under delegated authority from NHS England.

In performing its role, the Committee will exercise its ~~management of the~~ functions in accordance with the agreement entered into between NHS C&M and NHS England. The agreement will sit alongside the delegation and terms of reference in accordance with the NHS C&M constitution.

The Committee will have the authority to commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

In carrying out its role, the Committee will work alongside the nine place-based Primary Care Committees, providing oversight and assurance of effective primary care services across Cheshire

& Merseyside. The Committee will also work closely with the Pharmaceutical Services Regulations Committee (PSRC).

The functions of the Committee are undertaken in line with NHS C&M's desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

4.1 Commissioning of Primary Medical Services

The role of the System Primary Care Committee shall be to oversee, coordinate and promote alignment of the functions amongst Places relating to the commissioning of primary medical services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy. This includes the following:

- Develop a system-wide Primary Care Strategy including implementing the GP Forward View, or successor, through robust contractual arrangements with general practices and appropriate developmental support.
- To review and consider the aggregate position of agreed service specifications and contractual proposals for all NHS C&M commissioned services from primary care providers
- Develop outline framework/ expectations in regard to GMS, PMS and APMS contracts (including the oversight and monitoring of contracts, approving material contractual action such as removing a contract)
- Newly designed enhanced services
- Performance monitoring, oversight and assurance, on agreed schemes and services, and compliance to NHSE/I; escalating issues on to NHSE/I in line with first level Delegation
- Making recommendations related to alignment of decisions on 'discretionary' payment in Place (e.g., returner/retainer schemes).
- To co-ordinate a common approach to the commissioning and delivery of primary care services
- To manage the budget for commissioning of primary care services, including delegated rents and rates in line with Premises Directions.

4.2 Commissioning of Community Pharmacy

- Develop outline framework/ expectations in regard to Community Pharmacy essential, advanced and national enhanced services–. Including associated budgets, quality assurance and all existing NHSEI functions.
- Local discretionary/ non-core schemes.

4.3 Additional responsibilities

- The NHS C&M Primary Care Committee will also carry out the following activities:
- Support Primary Care development across Cheshire & Merseyside including oversight of:
  - primary care networks (PCNs) ongoing development as the foundations of out-of-hospital care and building blocks of place-based partnerships
  - Workforce, resilience and sustainability

- Maximisation of GP Contract opportunities such as ARRS (Additional roles) and QOF outcomes
- To plan, including needs assessment, for primary care services across Cheshire & Merseyside and to support planning at scale for primary care
- Oversight of the development of an integrated Estates programme across Cheshire & Merseyside and at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies
- To consolidate risk reviews of primary care services, aggregating findings and supporting solutions/ mitigations at places
- To ensure contract proposals achieve health improvement and value for money
- To oversee quality and safety of services delivered in primary care – receiving regular reports from the ICB Quality and Performance Committee and Finance, Investment and Our Resources Committee providing updates and assurance on primary care related quality, finance and performance issues
- Ensure that conflicts of interest have been mitigated in line with the NHS C&M Conflicts of Interest Policy, and all actions/ decisions involving consultation with Committee members or GPs will record any declarations of interest.
- ~~Development of an integrated Estates programme at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies~~
- Ratifying time limited Place based recommendations related to this committee's remit or determining to 'call-in' such a recommendation and provide an alternative course of action

4.4 Risk Management

The Committee will ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) – these will include reference to relevant Place Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.

5. Membership & Attendance

5.1 Members

The membership shall consist of the following voting members:

- at least 1 ICB NED (Chair)
- at least 1 ICB Partner Member (1 to be the Deputy Chair)
- ICB Assistant Chief Executive (or Deputy)
- Associate Director of Primary Care
- ~~Representative from each of the recognised primary care professional groups in accordance with the remit of the Committee (i.e. general practice and community pharmacy)~~
- ICB Director of Nursing & Care
- ICB Director of Finance
- ICB Medical Director (or Associate Medical Director for Primary Care)
- Independent GP
- at least 2 Place Directors or designated individual from Place.

In attendance by invitation:

- Healthwatch nominated representative
- Public Health representative
- Local Medical Committee (LMC) representative
- Pharmaceutical Services Regulations Committee (PSRC) representative
- LOC (Local Optical Committee) representative (from 1.4.2023)
- LDC (Local Dental Committee) representation from 1.4.2023)
- Membership of other Professional Groups to be agreed/discussed further dependant on agenda item

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

5.2 Attendees

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

Meetings of the Committee may also be attended by ~~the following~~ other individuals, by the agreement of the Chair, who are not members of the Committee for all or part of a meeting as and when appropriate. ~~Such attendees will not be eligible to vote.~~

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

6. Meetings

6.1 Leadership

The Committee is Chaired by an ICB NED.

6.2 Quorum

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

- At least five Committee members in total, including;
  - At least one NED or system Partner*
  - At least one Clinically qualified Member*
  - At least two ICB Directors (or their nominated deputies).

**If regular members are not able to attend they should make arrangements for a ~~representative~~ deputy to attend and act on their behalf.*

6.3 Decision-making and voting

Decisions should be taken in accordance with the financial delegation of the Executive Directors and directors present and/or any authority delegated to the committee by the ICB and as outlined within the ICB~~. These terms of reference will be reviewed against the ICB~~ Scheme of Reservation and Delegation. ~~once that document is formally approved by the ICB.~~

The Committee will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote.

A person attending a meeting as a ~~representative~~ *deputy* of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with ICB policy, no member (or ~~representative~~ *deputy*) with a conflict of interest in an item of business will be allowed to vote on that item.

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

6.4 Frequency

The Committee will normally meet in private. However on occasions due to some agenda items the meeting may be held in public for all or part, to be agreed by the Chair depending on advice received and agenda item to be discussed. Due process in relation to Patient Consultation requirements should be considered when making this decision.

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

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

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

6.5 Administrative Support

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates are retained and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board

- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

6.6 Accountability and Reporting Arrangements

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

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will submit copies of its approved minutes and a key issues report to the ICB following each of its meetings. The Committee will also provide a key issues report to each of the place-based primary care committees and will receive an equivalent report from each of the place-based primary care committees.

The Committee will receive regular key-issues reports from the Pharmaceutical Services Regulations Committee (PSRC).

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

The outputs of the group may be reported to NHSE/I supporting assurance, awareness and interaction.

7. Behaviours & Conduct

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

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

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICB's policy on managing conflicts of interest, Committee members should:

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

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

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

Equality diversity and inclusion

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

8. Review

The Committee will review its effectiveness at least annually

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

SCHEDULE 1 – DELEGATED FUNCTIONS

A. Decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

   i. decisions in relation to Enhanced Services
   ii. decisions in relation to Local Incentive Schemes (including the design of such schemes)
   iii. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices
   iv. decisions about 'discretionary' payments
   v. decisions about commissioning urgent care (including home visits as required) for out of area registered patients

B. The approval of practice mergers
C. Planning primary medical care services in the Area, including carrying out needs assessments
D. Undertaking reviews of primary medical care services in the Area
E. Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list)
F. Management of the Delegated Funds in the Area
G. Premises Costs Directions functions
H. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
I. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

SCHEDULE 2 – RESERVED FUNCTIONS OF NHSE

A. Management of the national performers list
B. Management of the revalidation and appraisal process
C. Administration of payments in circumstances where a performer is suspended and related performers list management activities
D. Capital Expenditure functions
E. Public Health Section 7A functions under the NHS Act
F. Functions in relation to complaints management
G. Decisions in relation to the Prime Minister's Challenge Fund; and
H. Such other ancillary activities that are necessary in order to exercise the Reserved Functions