Thursday 04 August 2022
10:00am to 12:30pm
Chalon Suite, Mercure Hotel, Linkway West,
St Helens, WA10 1NG

NHS
Cheshire and Merseyside

Meeting of the Integrated Care Board

Agenda

Chair: Raj Jain

10:00am Resident Story

10:20am Formal start of the meeting

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
10:20am	**Preliminary Business**			
ICB/8/22/01	Welcome, Introductions and Apologies	Chair	Verbal	-
ICB/8/22/02	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/8/22/03	Minutes of the previous meeting: • 1 July 2022.	Chair	Paper Approval	Page 3-16
ICB/8/22/04	Board Action and Decision Logs	Chair	Paper For noting	Page 17-18
10:30am	**Standing Items**			
ICB/8/22/05	Report of the Chair	Chair	Verbal For noting	-
ICB/8/22/06	Report of the Chief Executive	GU	Paper For noting	Page 19-44
ICB/8/22/07	Report of the Place Director – St Helens	MP	Paper & Presentation For noting	Page 45-77
10:55am	**Sub-Committee Reports**			
ICB/8/22/08	Report of the Chair of the Remunertion Committee	TF	Paper For noting	Page 78-86
11:00am	**ICB Key Update Reports**			
ICB/8/22/09	Cheshire & Merseyside ICB Financial Plan / Budget 2022/23	CWi	Paper For approval	Page 87-102
ICB/8/22/10	Cheshire & Merseyside System Month 3 (Quarter One) Finance Report	CWi	Paper For noting	Page 103-118
ICB/8/22/11	Cheshire & Merseyside Month 3 (Quarter One) Performance Report	AM	Paper For noting	Page 119-149
11:30am	**ICB Business Items**			
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.	FL	Paper For approval	Page 150-163

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
ICB/8/22/13	Virtual Wards – update on their expansion across Cheshire and Merseyside	AM	Paper For information	Page 164-171
12:15pm	**Other Formal Business**			
ICB/8/22/14	Responses to questions raised by Members of the Public in relation to items on the agenda	Chair	For noting	-
ICB/8/22/15	AOB	Chair	Verbal	-
ICB/8/22/16	Closing remarks and review of the meeting and communications from it	Chair	Verbal For Agreement	- -
12:30pm	**CLOSE OF MEETING**			

Date and time of next meeting:

29 September 2022 10:00-12:30 – Committee Room, Bootle Town Hall, Oriel Road, Bootle, L20 7AE

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

GU	Graham Urwin, Chief Executive
MP	Mark Palethopre, Place Director for St Helens
CWi	Claire Wilson, Executive Director of Finance
AH	Anthony Middleton, Director of Performance and Planning
TF	Tony Foy, Non-Executive Director, Chair of the Remuneration Committee
FL	Dr Fiona Lemmens, Deputy Medical Director

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 Lewis' Building, 2 Renshaw Street, Liverpool L1 2SA

Friday 1st July 2022 at 10.30 am

UNCONFIRMED Draft Minutes

ATTENDANCE		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB ***(voting member)***
Ian Ashworth	IAS	Regular Participant, Director of Public Health, Cheshire West and Chester
Louise Barry	LBA	Regular Participant, Chief Executive Officer, Healthwatch Cheshire East and Healthwatch Cheshire West
Marie Boles	MBO	Interim Director of Nursing and Care, Cheshire & Merseyside ICB ***(voting member)***
Steven Broomhead	SBR	Partner Member, Chief Executive, Warrington Borough Council ***(voting member)***
Councillor Paul Cummins	PCU	Partner Member, Cabinet Member for Adult Social Care, Sefton Council ***(voting member)***
Warren Escadale	WES	Regular Participant Chief Executive, Voluntary Sector North West (VSNW)
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB ***(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)***
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)***

Name	Initials	Role
In attendance		
Emma Lloyd	Clerk	Minute taker

Apologies		
Name	**Initials**	**Role**
Adam Irvine	AIR	Partner Member, Chief Executive Officer, Community Pharmacy Cheshire & Wirral (CPCW) ***(voting member)***
Ann Marr	AMA	Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust ***(voting member)***

Item	Discussion, Outcomes and Action Points	Action by
ICB/22/01	**Welcome, Introductions and Apologies:** Raj Jain (RJA), Chair, introduced himself and welcomed all present to the first meeting of the NHS Cheshire & Merseyside Integrated Care Board ('NHS Cheshire and Merseyside'). RJA expressed a special welcome to the members of the public present and shared that he was keen for the public to understand what this Board will do to support the many citizens of Cheshire and Merseyside. RJA shared that the agenda for this meeting was mainly procedural and will deal with some initial governance matters. Future meetings, including the next one scheduled for 4th August 2022, will be more meaningful and interesting to members of the public. All members of the Board introduced themselves and confirm their roles/organisation being represented. RJA highlighted that the details of today's meeting have been included on the legacy CCG websites and the Cheshire and Merseyside Healthcare Partnership website, and future meetings will be promoted via the NHS Cheshire & Merseyside website which is being launched today (1st July 2022) and through wider communication channels. RJA shared that future ICB meetings will be held in each borough across Cheshire and Merseyside, and the next meeting on 4th August will be held in St Helens. RJA reminded all present that this is a meeting held in public and is not a public meeting; therefore, only board members/participants are able to contribute.	

	RJA noted that there is no public speaking time on the agenda for this meeting today, but the Board will look at the best way of engaging with the public for future meetings. RJA informed the public present that they could pass any questions arising from today's meeting to Jonathan Taylor, Head of Communications and Empowerment who will coordinate responses as appropriate. RJA informed those present that this meeting is not being recorded but some photographs are being taken. RJA confirmed that future meetings will be recorded. Board members were reminded to put their hand up if they wish to speak and to use the microphones provided when speaking. RJA thanked the members of all nine Clinical Commissioning Groups (CCGs) in Cheshire and Merseyside who have worked tirelessly through many challenges and produced excellent results for people of Cheshire and Merseyside and shared that they will continue to make an excellent contribution for the population through the ICB. Apologies were received in advance from Adam Irvine and Ann Marr. The reason for apologies was provided and the Board accepted these apologies. RJA read out the quoracy requirements and confirmed that the meeting today was quorate. **Outcome:** Apologies were accepted from Adam Irvine and Ann Marr **Outcome:** The meeting was confirmed to be quorate.	
ICB/22/02	**Declarations of Interest:** Annual declarations have been completed by all Board members with the exception of Louise Barry and Steve Broomhead, both due to annual leave. These will both be added to the Register of Interests, and this will be available via the NHS Cheshire and Merseyside website after the meeting. 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/22/03	**ICB Appointments - Report of the Chair:** RJA informed the Board and those present that, as Chair, he has been required to call an extraordinary meeting between the Chair, the Chief Executive Officer (CEO) and the Chair of the Audit	

Committee, as per the ICB Constitution, to make the appointments to this Board. RJA shared that this is the only time there will be a meeting within a meeting but highlighted the importance of this.

RJA referred to pages 4 to 13 of the meeting papers, which outlines his recommendations with regards to named individuals for the following:-

- 3 x Executive Members (Medical Director, Director of Finance, Director of Nursing)
- 3 x Non-Executive Members
- 6 x Partner Members.

RJA highlighted that Dr Raj Kumar is now unable to take up his appointment as a Partner Member for Primary Care and confirmed that work in the Primary Care community will commence to ensure that this Partner Member vacancy is appointed to this Board.

No issues were raised and the Chair, the CEO and the Chair of the Audit Committee agreed the recommendations outlined.

Outcome: NHS Cheshire & Merseyside's Chair, CEO and Chair of the Audit Committee approved the appointment of Claire Wilson, Director of Finance, as an Executive Member of the Integrated Care Board.

Outcome: NHS Cheshire & Merseyside's Chair, CEO and Chair of the Audit Committee approved the appointment of Professor Rowan Pritchard Jones, Medical Director, as an Executive Member of the Integrated Care Board.

Outcome: NHS Cheshire & Merseyside's Chair, CEO and Chair of the Audit Committee approved the appointment of Christine Douglas MBE, Director of Nursing and Care, as an Executive Member of the Integrated Care Board. They also agreed that Marie Boles, Interim Director of Nursing and Care, will fulfil this position until the substantive postholder commences.

Outcome: NHS Cheshire & Merseyside's Chair, CEO and Chair of the Audit Committee approved the appointments of Neil Large MBE, Tony Foy and Erica Morriss as Non-Executive Members of the Integrated Care Board.

Outcome: NHS Cheshire & Merseyside's Chair, CEO and Chair of the Audit Committee approved the appointments of Ann Marr OBE and Dr Joe Rafferty CBE as Partner Members of the Integrated Care Board.

Outcome: The Cheshire & Merseyside ICB noted that there is one Partner Member position on the Board that is vacant.

ICB/22/04	**Minutes of the last meeting:** RJA shared that, although this is the first meeting of NHS Cheshire and Merseyside, there have been shadow meetings to ensure readiness for this this meeting, and the last set of minutes from this shadow board meeting are provided within the meeting papers. RJA drew attention to the section on ICB Readiness to Operate Statement (ROS) and confirmed that this was submitted on 9th June 2022. The ROS submitted included RAG rated items, and included 37 blue rated items (no further action needed); 2 green rated items (requiring a small amount of additional work) and 1 that was not applicable. RJA shared that the green items related to work in progress linked to governance documentation and Emergency Preparedness, Resilience and Response (EPRR) training. RJA shared that the Shadow Board has undertaken a significant amount of work, for which the ICB is grateful and can take assurance from. No comments were received in respect of the minutes from the Shadow ICB meeting held on 9th June and were therefore approved as an accurate record of the meeting. **Outcome:** The Board approved the minutes from the Cheshire and Merseyside Shadow ICB meeting held on 9th June 2022.	
ICB/22/05	**ICB Constitution:** A copy of the ICB Constitution, the Conflicts of Interest Policy, the Standards of Business Conduct and the draft Public Engagement/ Empowerment Framework were provided in advance of the meeting. Clare Watson (CWA) informed the Board that the Constitution has been developed from the NHS England (NHSE) model template which is quite prescriptive but invited any questions or comments. Questions/Comments:- • Steve Broomhead (SBR) thanked CWA for the work on the constitution document but raised a query around the wording of section 3.7.2. SBR noted that across the nine local authority areas there are approximately 650 elected members and asked what constitutes an 'Executive' and where would elected members sit within this. SBR shared that he would like this item re-worded to reference elected members.	

	o GUR thanked SBR for highlighting that the language used by the NHS and local authorities is not the same and agreed that it would be useful to add a note to explain what is meant by the term 'Executive.' ***Action: The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board.***	Clare Watson
	• SBR noted the procedures outlined for nominees within section 3.7.5 of the ICB constitution and shared his view that these were too prescriptive for local authority members given the democratic way in which they work. o CWA confirmed that the constitution follows the NHSE model which is restrictive.	
	• Cllr Paul Cummins (PCU) shared his understanding that he is not present to represent any specific area of Cheshire and Merseyside, but to share views from a local authority perspective.	
	• Neil Large (NLA) referenced section 7.3 of the ICB constitution which outlines that all board and committee meetings held in public. NLA asked whether this will apply to the remuneration committee or whether this will not be held in public and instead will be reported to the Board. o GUR confirmed that some committees will not be held in public and also confirmed that the committee terms of reference will need to be reviewed to ensure they align with the constitution. ***Action: The wording of section 7.3 will be reviewed to ensure completeness***.	Clare Watson
	• Louise Barry (LBA) noted the level of public engagement and commended the work involved in producing the draft Public Engagement / Empowerment Framework. LBA shared that she would welcome these being passed through Health and Wellbeing Boards and Trust Boards. LBA confirmed that Healthwatch would support this process. o CWA confirmed that the ICB is keen to engage with Healthwatch and the voluntary sector and confirmed that this is the start of an ongoing process. o CWA welcomed Healthwatch's support and confirmed that she will work to include the ICB constitution on the local authority and other relevant agendas in the coming months. o Warren Escadale also recommended that this should also go to partner collaboratives.	
	• Warren Escadale (WES) highlighted the ten principles outlined in section 9.1.3 of the ICB Constitution and shared his view that these are fundamental. WES noted that the membership of the Board has been agreed at this meeting, but asked that consideration is given to the voluntary sector being recognised as full voting members of the Board in line with these principles.	

	o It was agreed that the membership and voting rights could be developed over time. • Tony Foy (TFO) thanked everyone involved in producing these documents and noted the level of engagement shown within the document. TFO highlighted that an ongoing challenge will be around ensuring that these work at Place level and for all neighbourhoods within the Cheshire and Merseyside footprint. o CWA confirmed that she would like the ICB to challenge itself to get closer to the public; the CCGs have enjoyed collaborative working with partner organisations throughout Covid and have been successful in engaging 'hard to reach' communities. CWA would like the ICB to build on this and engage with all its neighbourhoods. • SBR shared disappointment that the role of the local authority is not captured within the Public Engagement Framework document and requested that, as they are at the forefront of population health, are listed in the list of collaboration and partnership working. SBR asked that this is updated before the document is published. ***Action: It was agreed that the role of the local authority will be strengthened and added to the final version document prior to publication.*** • Erica Morriss (EMO) shared her view that the ICB Constitution is a crucial document and noted the voice of the people and the voluntary sector has helped to develop this. EMO highlighted the need to capture the voice from a quality perspective as well. • RJA highlighted that NHS Cheshire & Merseyside is a new organisation and it is therefore important that these open dialogues take place to get important matters correct. RJA thanked everyone for their input and shared that this reflects the advantage gained by having people around the table with different perspectives and insights, both professionally and personally. RJA shared his view that the Board will never sign off a public engagement completely but will continue to work on improving it. • RJA noted the comments around the appointment processes but highlighted that the NHS establishment and legislation have determined processes that we have to navigate. RJA shared his view that this Board is made up of people with good values who work with openness, transparency and the will to do the right thing, however, sometimes they have to take a less than perfect process and do the best with it. RJA added that, over time, it is likely that the ICB will have some influence in these processes but in the meantime, we will work in an open and transparent way so that decisions can be explained to the public.	Clare Watson

	• Dr Joe Rafferty (JRA) highlighted the principles outlined within section 6.2 of the Constitution document and suggested that the 'Seven Principles of Public Life' should be a separate item as they apply to all Board members. The NHS codes applicable to NHS staff can then be listed separately. ***Action: The principles in section 6.2.1 will be reviewed, revised and update where applicable and subject to Board approval.*** RJA recommended that, subject to the caveats outlined above and subject to further engagement work, the Board approves the ICB constitution, the Conflicts of Interest policy, the Business Conduct Standards and the Policy for Public Involvement. All Board members agreed with this. **Outcome:** The Board approved the NHS Cheshire and Merseyside Constitution subject to the caveats outlined. **Outcome:** The Board approved the Conflicts of Interest Policy of NHS Cheshire and Merseyside **Outcome:** The Board approved the Standards of Business Conduct of NHS Cheshire and Merseyside **Outcome:** The Board approved the Draft Public Engagement/Empowerment Framework of NHS Cheshire and Merseyside **Outcome:** The Board approved the Draft Policy for Public Involvement of NHS Cheshire and Merseyside	Clare Watson
ICB/22/06	**Scheme of Reservation and Delegation:** A copy of the following documents were provided prior to the meeting: • ICB Scheme of Reservation and Delegation. • ICB Functions and Decisions Map. • ICB Standing Financial Instructions. • ICB Operational Limits. Claire Wilson (CWI) shared that these four policy documents set out how the Board will exercise its responsibilities through decision making structures and ensure strong financial stewardship of resources. CWI highlighted the following:- • The Scheme of Reservation and Delegation sets out how and where decisions will be made. • The Functions and Decision map, and Financial Instructions sets out the rules and responsibilities for the management and stewardship of public money and resource.	

	• The Operational Delegated Limits outlines a committee or person's individual limits. • Approval is being sought for all four documents. Questions/comments: • SBR noted the diagram on page 241 of the meeting papers and shared his view that this indicates the ICB will approve the Health and Wellbeing Board strategies. SBR noted that each nine Health and Wellbeing Boards will have their own strategies to address, and it is not possible for the ICB to approve these, as responsibility for this sits with the individual local authority. SBR noted that the Health and Wellbeing Strategies could be used by the ICB to establish the key areas for their five-year plan but felt that this is not clearly expressed within the paper. o PCU agreed with SBR's comments and also highlighted that Health and Wellbeing Boards cannot sign off each other's strategies. o CWA confirmed that the aim was to show that the ICB will use each of the nine approved Health and Wellbeing Board strategies as building blocks to form the five-year strategy. ***Action: The diagram/wording on page 241 will be reviewed to make the link between the ICB and the Health and Wellbeing Boards clearer.*** **Outcome:** The Board approved the Scheme of Reservation and Delegation of NHS Cheshire and Merseyside **Outcome:** The Board approved the Functions and Decisions Map of NHS Cheshire and Merseyside **Outcome:** The Board approved the Standing Financial Instructions of NHS Cheshire and Merseyside **Outcome:** The Board approved the Operational Limits of NHS Cheshire and Merseyside	Claire Wilson
ICB/22/07	**ICB Committees:** Detailed proposals for the ICB Committee establishment were provided prior to the meeting. Clare Watson (CWA) highlighted the following points:- • The language and numbering are prescriptive and the ICB has to abide by NHS guidelines. • The ICB will meet in public monthly and will start meetings in Place based locations from August.	

- The Integrated Care Partnership will be referred to locally as the 'Health and Care Partnership' (HCP). This demonstrates the close working with local authorities over the last few years. Their first formal meeting is intended to be in October.
- A number of committees are required in order for the ICB to function and a list of the proposed committees is outlined in section 2 of the paper. These are formal committees and date/times will be published. Each committee will need its own Terms of Reference (TOR).
- The proposed structure includes other committees and advisory groups that will support the work of the ICB.
- There will be additional committees beyond the Cheshire & Merseyside footprint, including regional (joint committees with other ICBs) and national meetings.

Questions/comments:-

- PCU asked whether there was a separate constitution for the Health and Care Partnership. PCU also felt that there would have been a meeting prior to October.
  - RJA confirmed that the HCP is an important board and is a 'sister board' to the ICB. RJA confirmed that there is a meeting on 12th July 2022 and at this meeting there will be a paper outlining the milestones that need to be debated in order to develop a well establish partnership board. RJA shared that this process will take a couple of months to complete and this is why the first formal meeting has been set for October. RJA outlined the importance of getting it right rather than rushing.
  - CWA confirmed that, as of today's date, the ten founding members are the nine local authorities and the ICB. A paper will be presented at the meeting in July and RJA will be contacting all nine local authorities to outline the process for establishing the partnership.
  - PCU confirmed that he was satisfied with the reason behind the October meeting date.

- PCU asked whether Board members will have a choice in which committees they sit on.
  - RJA confirmed that the aim is to approach the most appropriate people to join the committees along with volunteers to get the balance correct.

- NLA noted that the HCP is referred to as a statutory committee and asked what procedures the committee will be working under and who is it a statutory committee of.
  - RJA shared his view that this will be a statutory committee of the ICS. RJA shared that the ICB is the NHS body and the ICP is the health and care partnership of Cheshire & Merseyside. This group will look at the wider agenda items that will be part of the objectives

	o RJA shared that he will take advice to get absolute clarity around what governance procedures they will be working under and to clarify the relationship between the partnership and the ICB. • Ian Ashworth (IAS) thanked the Board for recognising the work of the Health and Population Board and felt that this was important to ensure that different agencies and Places are represented. The Board agreed that these committees and meetings are an important enabler and need to be utilised effectively to get the best out of them. **Outcome:** The Board approved the core governance structure for NHS Cheshire and Merseyside **Outcome:** The Board approved the terms of reference of the ICB's committees. **Outcome:** The Board noted the proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board. **Outcome:** The Board noted 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/22/08	**ICB Roles:** A report to outline the proposals for lead ICB roles and the portfolios for named individuals was provided prior to the meeting. CWA highlighted that section two of the paper associated with agenda item ICB/22/03 highlights and appointments and named individuals. Prof Rowan Pritchard Jones (RPJ) noted that there is a proposed swap from the information contained within the paper. It is proposed that he, as Medical Director, takes on the SIRO role, and that Christine Douglas will be the Caldicott Guardian. RPJ confirmed that he will still undertake the Caldicott training to ensure that these two roles can challenge each other. **Outcome:** The 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/22/09	**ICB Policies Approach and Governance:** A report on the proposed approach to ICB Policies was provided prior to the meeting. CWA highlighted the following:- • The ICB is now a statutory organisation, but this has been built on the success of nine CCGs and the Health and Care partnership. • The report sets out the different categories of policies that it has developed or must develop. • The core constitutional policies have been adopted already at this meeting and this is the first set of policies that sit with the ICB. • The ICB is receiving approximately 1200 staff from nine CCGs and other sender organisations which are listed, and the Board is asked to note that the contractual HR policies will be transferred to the ICB alongside the transferring employees. These policies are:- the Pay Protection Policy, Long Service Policy and Special Leave Policy. If the ICB wish to make changes in the future, then this will be done through consultation. All other policies are considered to be non-contractually tied. • The recommendation from the Transition Board, which has overseen the safe closedown of the CCGs, is that NHS Cheshire & Merseyside has a single approach and adopts the NHS Cheshire CCG policy framework as an interim measure. The reason behind this recommendation is that the Cheshire CCGs merged recently and a full review of policies was undertaken by the CSU at that time and is therefore the most recently reviewed suite of policies. The proposal also includes setting up a task and finish group to review all policies across NHS Cheshire & Merseyside to see if there any additional policies that it wishes to adopt and use the committee structure for the approval of any reviewed policies. • There are number of commissioning policies that will transfer to the ICB and there is a small degree of variation between them. The proposal is to harmonise these as soon as possible to promote fairness and equity across NHS Cheshire & Merseyside. If agreed, a position statement will be published after the meeting to outline that the ICB will adopt all nine commissioning policies and look to harmonise over the next few months. Question/comments:- • RJA shared that this feels like the biggest change seen in the NHS for a generation and it is important that the population and staff are on board with this change. RJA noted that policies can be sensitive and agreed that a pragmatic way forward is to adopt the NHS Cheshire CCG policies, establish a task and finish group to timetable when policies will be review, and use the committee structure to bring policies back for review and approval.	

	RJA felt that it was important in the interim to have a consistent set of policies that are fit for purpose across the ICB. • RJA noted that it could be interpreted from the paper that the only HR polices are the three outlined above and asked for confirmation that this is not the case. o Chris Samosa (CSA) confirmed that these are the only contractual policies and there are other non-contractual HR policies. o CSA confirmed the review process on HR policies has started and the ICB will review in partnership with staff and trade unions to bring a simplified suite of policies. • LBA asked whether there was a timescale for the review and harmonisation of commissioning policies and asked whether there will be strong engagement with the public in this process. o CWA confirmed that the aim is to have this work completed by the end of this financial year. o RJA agreed that it was important that we include public engagement in this process. **Outcome:** The Board noted the contractual HR policies that will transfer to the ICB alongside the transferring staff from former organisations. **Outcome:** The Board endorsed the decision to adopt NHS Cheshire CCG's suit of policies as the ICB policy suite from 1st July 2022. **Outcome:** The Board agreed to establish a task and finish group to set out a proposed policy review process, using the committee structure for policy approval. **Outcome:** The Board noted the intention to develop a single suite of commissioning policies to support an equitable and consistent approach across Cheshire and Merseyside.	
ICB/22/10	**Any Other Business:** RJA noted that one AOB item had been received in advance: - • The Board is asked to note that a meeting of the Shadow Cheshire and Merseyside ICB Finance Committee took Place on 30th June 2022, and it is proposed that the minutes of this meeting go to the first meeting of the ICB's established Finance, Investment and Our Resources Committee. All agreed with this recommendation.	

	Outcome: 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. There was no other business.	
ICB/22/11	**Review of the meeting and communications from it:** RJA noted that some important approvals have been made and confirmed that a synopsis will be drawn up from this meeting. RJA expressed thanks again to the members of the public in attendance.	

Date of Next Meeting: 4th August 2022, 10.00 am to 12.30 pm
Mercure Hotel, Linkway West, St Helens, Merseyside WA10 1NG

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2022-23

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*	NEW
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*	NEW

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

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Decision Log 2022 - 2023

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

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report

04 August 2022

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS Cheshire and Merseyside

Date of meeting:	04 August 2022
Agenda Item No:	ICB/8/22/06
Report title:	Chief Executive Report
Report Author & Contact Details:	Graham Urwin, Chief Executive
Report approved by:	-

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

n/a

Executive Summary and key points for discussion

This report provides a summary of issues not otherwise covered in detail on the Board meeting agenda. This includes updates on:

- Primary care delegation
- Specialised commissioning
- Changes in the role of NHS England
- GP Patient Survey 2022 results
- George Cross award to the NHS
- UK Covid-19 Public Inquiry
- Anchor Institute
- All Together Fairer
- Cancer services and care across Cheshire and Merseyside results
- Liverpool Independent Clinical Services review
- Royal Liverpool University Hospital
- Countess of Chester NHS Foundation Trust Hospital System Improvement Board establishment.

Recommendation/ Action needed:	**The Board is asked to:** • **note** the contents of the report.

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:

The item involves sensitive HR issues	n/a
The item contains commercially confidential issues	n/a
Some other criteria. Please outline below:	n/a

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS Cheshire and Merseyside

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 ICB Board Assurance Framework or any other corporate or Place risk? (*please list*) n/a					
What level of assurance does it provide? n/a					
Limited		**Reasonable**		**Significant**	
Any other risks? No If **YES** please identify within the main body of the report.					
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) No					
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. No					
Any current services or roles that may be affected by issues as outlined within this paper?					

Document Development	**Process Undertaken & Impact Considerations**	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?				
	Patient / Public Involvement / Engagement	X			Note the update in the report on LUFHT
	Clinical Involvement / Engagement				
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?				
	Regulatory or Legal - any impact assessed or advice needed?				
	Health Inequalities – any impact assessed?				
	Sustainable Development – any impact assessed?	X			Note update in report on Anchor Institutes

Appendices:	• Anchor Institute Charter • Marmot 22 Beacon Indicators • Liverpool Independent Clinical Services Review Terms of Reference

Chief Executive's Report

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. Primary Care Delegation

2.1 The NHS's ambition to delegate NHS England's direct commissioning functions to ICB NHS bodies was realised on 1 July 2022 when the new Health and Care Act 2022 came into force. This enabled those bodies to hold a broader range of responsibilities, empowering them to better join up health and care, improve population health and reduce health inequalities.

2.2 From 1 July 2022, NHS Cheshire and Merseyside:

- assumed delegated responsibility for Primary Medical Services (previously delegated to all CCGs)
- received approval from NHS England's Board to take on delegated responsibility for Primary Care Pharmaceutical Services following a comprehensive due diligence exercise and the successful completion of national assessment processes.

2.3 All ICB bodies are required to take on any remaining primary care services from April 2023, and NHS Cheshire and Merseyside is currently making the necessary arrangements with NHS England to assume delegated responsibility for primary care optometry services and dental services. A similar due diligence and approval processes will be undertaken to enable safe delegation of these remaining services to take place on 1 April 2023.

3. Specialised Commissioning

3.1 At its meeting in September the Board will receive a paper providing detail on the progress being made locally around developing the plans to integrate those specialised services that will be delegated to us by NHS England. The Health and Care (2022) Act creates provisions for NHS England to delegate functions relating to the planning / commissioning of 'Directly Commissioned' services to Integrated Care Boards.

3.2 Specialised services are defined in legislation as services that meet at least one of four criteria (rarity, scarcity, cost and insurance risk) and support people with a broad range of rare and complex conditions. The nature of the services means high cost, low volume services delivered in specialist centres of care where patient flows span ICS and multi ICS geographies. Services are nationally prescribed to ensure specialist thresholds are met.

3.3 For 2022/23, Specialised Commissioning spend (which is provider based) in the Cheshire and Mersey system is £957m for English residents, with the highest value contracts being Alder Hey, Clatterbridge and Liverpool University Hospitals Foundation Trust (LUFT). Future responsibilities will be based upon District of Residence spend, estimated at c£750m. A due diligence and approval processes will be undertaken on those services to be delegated.

4. Changes in the role of NHS England

4.1 NHS England, Health Education England and NHS Digital have announced the merger of the three arm's-length bodies into NHS England.

4.2 There will be a new operating model for NHS England following the establishment of Integrated Care Systems, creating space to lead locally, working alongside the NHS England seven regions.

4.3 This will mean a significant change for NHS England, with more functions being delegated to Integrated Care Systems, including further delegation of direct commissioning functions. I will keep the Board updated on these developments.

5. NHS GP Patient Survey 2022

5.1 England together with Ipsos, have published on the 14 July 2022 the latest Official Statistics from the GP Patient Survey. The survey provides information on patients' overall experience of primary care services and their overall experience of accessing these services.

5.2 In Cheshire and Merseyside Integrated, 134,514 questionnaires were sent out, and 38,417 were returned completed. This represents a response rate of 29%, in line with the national average. Overall, the results show that overall patient experience and satisfaction with our local GP practices are similar to or better than the national picture. There are four areas where we are performing below the national average. These are:

- ease of getting through on the phone
- experience of making an appointment
- support for Long Term Conditions
- time taken to receive care when the practice is closed (i.e. Out of Hours).

5.3 The results of the 2022 GP Patient Survey do however demonstrate an overall drop in satisfaction with General Practice at a national level that is reflected in Cheshire and Merseyside.

5.4 Each Practice and Primary Care Network receive their results and can plan to address the areas for improvement that this survey highlights. The ICBs Primary Care Team will formulate a plan for improvement with actions to be taken at Practice, PCN, Place and System level. A full discussion on this will be presented to a future Board.

5.5 Further detail about the GP Patient Survey Results 2022 for Cheshire and Merseyside can be found at: https://www.gp-patient.co.uk/icsslidepacks2022#region5

6. NHS Receives the George Cross

6.1 The NHS was presented with the George Cross at Windsor Castle on Tuesday 12 July by HM The Queen - accompanied by HRH The Prince of Wales. This honour came one week after the NHS's 74th birthday, with the George Cross recognising the "courage, compassion and dedication" of staff throughout the pandemic and their service to the public for the last 74 years. I would also like to extend my gratitude and admiration to the thousands of staff and volunteers who have made and continue to make the NHS and Care services across Cheshire and Merseyside continue to deliver the excellent care that is received and needed to meet needs of our population.

7. UK COVID-19 Public Inquiry

7.1 Baroness Heather Hallett, officially launched the UK Covid-19 Inquiry on 21 July 2022 and opened its first investigation into how well prepared the UK was for a pandemic. Baroness Hallett, the Chair of the Inquiry, also set out an ambitious timetable, with preliminary hearings starting this year, and the first witnesses to be called next spring

7.2 Further details about the enquiry, including its Terms of Reference can be found at: https://covid19.public-inquiry.uk/

8. ICB Sustainability Update

8.1 The ICS' Anchor Institute Charter (Appendix One) was launched by the Chairman and myself at an anchor webinar on Tuesday 12 July 2022.[1]

[1] https://www.cheshireandmerseyside.nhs.uk/posts/health-leaders-sign-landmark-pledge-to-improve-social-values-in-cheshire-and-merseyside/ (last accessed 18.07.22)

8.2 The Charter sets out an agreed set of principles, anchored in local communities, for as many organisations across the region as possible to adopt. Anchor institutions can improve health through their influence on local social and economic conditions by adapting the way they employ people, purchase goods and services, use buildings and spaces, reduce environmental impact, and work in partnership.

8.3 As a signatory to the Charter, I am also encouraging other NHS organisations, local authorities and non for-profit organisations within the Integrated Care System (ICS) to also sign the Cheshire and Merseyside pledge, making them an anchor institution, thus bringing a fairer, more equal platform for people to live and work in.

9. Marmot Community - All Together Fairer

9.1 All Together Fairer[2] is Cheshire and Merseyside's collaborative approach to reducing health inequalities, informed by the country's leading voice on health inequalities, Professor Sir Michael Marmot and his team at the Institute of Health Equity (IHE).

9.2 All Together Fairer brings together public, private and third sector organisations with one shared aim: build a fairer, healthier Cheshire and Merseyside. This work is being coordinated by the Cheshire and Merseyside Health and Care Partnership's Population Health Board, and progress against

9.3 The ground breaking report makes eight recommendations outlined below. These recommendations are:

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure a healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill health prevention
- tackle racism, discrimination and their outcomes
- pursue environmental sustainability and health equity together.

9.5 System progress will be measured and monitored annually by 22 Beacon indicators (Appendix Two).

10. Cancer services and care across Cheshire and Merseyside

10.1 I was delighted to see the Cheshire and Merseyside results of the latest National Cancer Patient Experience Survey, which is run each year by NHS England to find out more about people's experiences of cancer services.

[2] https://www.champspublichealth.com/all-together-fairer (last accessed 18.07.22)

10.2 The results of the national 2021 survey – which involved almost 60,000 responses – have been published and show that patients in Cheshire and Merseyside rate their care as 9.1 out of 10, above the England average of 8.9 out of 10. In fact there were no questions where Cheshire and Merseyside scored lower than the expected range and there were a number of areas that scored higher than the expected range, including:

- 83% of patients said their diagnostic tests results were explained in a way they could completely understand (England average: 79%).
- 79% of patients thought their diagnosis was explained in a way that they could completely understand (England average: 76%).
- 94% of patients had a main point of contact within the care team (England average: 92%).
- 76% of patients felt they were always involved in decisions about their care and treatment while in hospital (England average: 70%).
- 80% of patients were always able to get help from ward staff when needed (England average: 76%).
- 72% of patients were always able to discuss worries and fears with hospital staff (England average: 67%).
- 91% of patients said they had received enough understandable information about their surgery before the procedure (England average: 89%).
- 37% of patients could definitely get enough emotional support at home from community or voluntary services after treatment (England average: 32%).

10.3 More information about the survey and the full set of results can be found at: https://www.ncpes.co.uk/

11. Liverpool Independent Clinical Services review

11.1 The Cheshire and Merseyside ICS (acting as our shadow board) agreed to commission an independent review of acute and specialist services delivered in Liverpool. Although the quality of acute services in the city is good, the configuration of hospital services is fragmented, which constrains the ability to provide care in a multi-disciplinary joined up way, sometimes resulting in sub-optimal outcomes, inequalities and higher costs.

11.2 Some progress has already been made in integrating acute services, following the merger of the Royal Liverpool and Aintree University Hospitals. However, there is potential for effective integration of services across the city's seven acute, specialist and community NHS Trusts.

11.3 The objective of the review is to make recommendations to ensure acute hospital services in Liverpool are fit for purpose for the future; to improve health outcomes and patient experience; improve equity; reduce variation; improve productivity and make best use of the assets of this health and care system. The review will also seek to address the long-term clinical sustainability of Liverpool Women's Hospital NHS Trust.

11.4 The review will address care pathway improvement and propose an optimum model for acute care and will make recommendations about prioritising future service changes and innovation. Another output of the review will be a detailed implementation plan to be delivered collaboratively across the health and care system.

11.5 The review specification was developed with and was approved via the One Liverpool Partnership Board, which includes a cross section of representatives from across the Liverpool Health and Social Care System. A copy of the final specification is appended to this report (Appendix Three).

11.6 To undertake the technical procurement process, NHS Liverpool CCG secured the support of the NHS Shared Business Service (SBS) procurement team and on behalf of the ICB conducted a 'mini competition' from Lot 6 'Transformation and Change Support' of the national 'Health Systems Support Framework' (HSSF).

11.7 Following the completion of the procurement, the review will be conducted by the successful bidder - consultants, Carnall Farrar. The review commences in August and will report in approximately six months.

12. Royal Liverpool University Hospital

12.1 Liverpool University Hospitals NHS Foundation Trust (LUHFT) has confirmed that the move to the new Royal Liverpool University Hospital will begin on 28 September 2022.

12.2 The Trust took partial possession of the building from construction partners Laing O'Rourke on 11 July, which allows the Trust to start the final phase of work to prepare for moving patients and staff across to the new hospital. The Trust will begin its 24-day move plan that will see staff, patients and services move across to the new building in a phased approach, to be completed by 21 October 2022.

12.3 The new Royal Liverpool Hospital will play an important part in changing the way healthcare services are delivered across North Mersey and improving the quality and standards of care for patients.

12.4 To support the transition to the new hospital, significant investment is being made across all sites within the Trust, including a £52m investment package at Aintree University hospital, which includes a £16m investment to improve the Emergency Department as well as the development of hybrid operating theatres for specialist surgical services. The development of the new hospital is supported by the New Hospital Programme which is investing in infrastructure across the NHS.

12.5 In addition, there are proposals to move five services between the Royal and Aintree University Hospital, also run by LUHFT, which are subject to public consultation, which closes on 02 August 2022. The consultation which began in June 2022, is part of a wider plan to better organise where care happens across Aintree, the Royal Liverpool, and Broadgreen hospitals.

13. Countess of Chester NHS Foundation Trust Hospital System Improvement Board establishment

13.1 Over the last 12 months the Trust has been providing additional assurance to Regulators and Commissioners about a number of focussed aspects of service delivery; relating to maternity care, urgent and emergency care, elective waiting times, data timeliness, quality, and serious incident management.

13.2 Following a period of enhanced surveillance, in April 2022 NHS England formally established a System Improvement Board, which included the appointment of an improvement director to support the development and implementation of an improvement plan.

13.3 The Trust Executives, alongside key ICB senior staff, are a key part of the System Improvement Board which provides collective oversight of the delivery of actions to ensure the required pace of improvement. The System Improvement Board has shared responsibility for ensuing that the appropriate solutions and support to challenges are identified. The Trust improvement plan was presented and agreed subject to the development of milestones and timeline for delivery.

Cheshire and Merseyside
Health and Care Partnership

Cheshire and Merseyside

Anchor Institution Charter Principles

What is an anchor institution?

‘Anchor institutions’ are usually large public sector organisations rooted in and connected to their local communities. They can improve health through their influence on local social and economic conditions by adapting the way they employ people, purchase goods and services, use buildings and spaces, reduce environmental impact, and work in partnership.

An anchor institute is a place-based organisation invested in its local area. Examples include councils, universities, colleges, housing associations and emergency services.

By their very nature, these organisations also spend substantial amounts of money within the local area. While most of their employees are likely to live within the local area, and spend their wages there, they also have significant procurement and investment spend which can also be spent locally.

They have a collective interest in seeing their local area improve and are always looking for more opportunities to advance collaboration with them.

The place

Cheshire and Merseyside Health and Care Partnership: Local Authorities, NHS Providers, Clinical Commissioning Groups, Voluntary and Community Sector, Suppliers, Business and Industry.

The Five Anchor Institution Pillars

Purchasing locally and for social benefit

Using buildings and spaces to support communities

Widening access to quality work

Working more closely with local partners

Reducing environmental impact

Our journey so far

Since November 2021 two virtual events have taken place to begin shaping our charter and considering the benefits associated with becoming an anchor institute. This includes including purchasing more locally and for social benefit; using buildings and spaces to support communities; working more closely with local partners; reducing the environmental impact; and widening access to good jobs.

We were able to learn from the positive work of other organisations, both within and outside of Cheshire & Merseyside, that are on an anchor journey. C&M is already home to anchor institutions and we envisage that our work will build on and complement this but by no means replace.

The webinars brought together cross sector partners including voluntary, charity, faith, public and business sectors to work with Cheshire and Merseyside Health and Care Partnership and shape our region's development as a better place to live and work.

The feedback gathered from these events enabled the development of the initial principles which will be shared with members of the local communities to ensure ownership, before being implemented as the Cheshire and Merseyside framework, helping to reduce health inequalities.

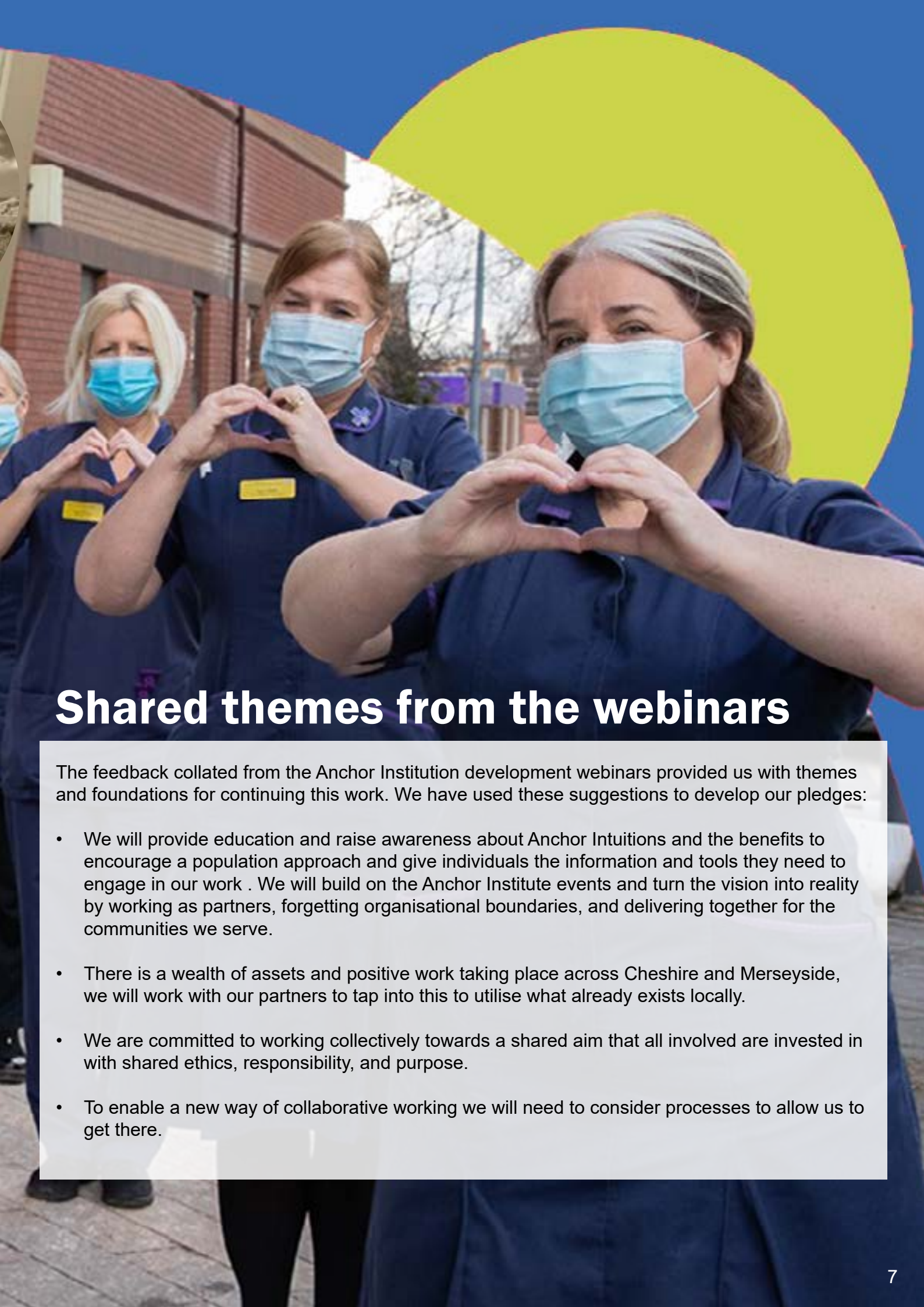
Principles and Priorities

Our Principles as an Anchor System:

- As an Anchor Institution we commit to the real living wage and creating equality within our local job sector.
- We pledge to employ and purchase, locally, in the first instance with an aim to support the wealth of local businesses within our geography.
- We pledge to work closely with partners and, where possible, ensure our buildings are viewed as local, community assets.
- We are committed to measuring and evidencing the progress made as a result of becoming an Anchor Institution.

Our Priorities as an Anchor System

- Develop and implement a Net Zero plan, setting out our journey towards zero carbon by 2040 or sooner.
- Our Anchor work is complemented by the Social Value Charter, to provide alignment organisations involved will have achieved, or be willing to achieve, the C&M Social Value Award within six months of signing.
- Anchor organisations will be involved in and sign up to the Cheshire and Merseyside Prevention pledge (currently applicable to Trusts only), driving a population approach to prevention and working alongside the national Core20PLUS5 supporting the efforts to reduce health inequalities.
- Develop an Anchor Network Progression Framework to help organisations self-assess progress/ ambitions as an anchor.



Shared themes from the webinars

The feedback collated from the Anchor Institution development webinars provided us with themes and foundations for continuing this work. We have used these suggestions to develop our pledges:

- We will provide education and raise awareness about Anchor Intuitions and the benefits to encourage a population approach and give individuals the information and tools they need to engage in our work . We will build on the Anchor Institute events and turn the vision into reality by working as partners, forgetting organisational boundaries, and delivering together for the communities we serve.

- There is a wealth of assets and positive work taking place across Cheshire and Merseyside, we will work with our partners to tap into this to utilise what already exists locally.

- We are committed to working collectively towards a shared aim that all involved are invested in with shared ethics, responsibility, and purpose.

- To enable a new way of collaborative working we will need to consider processes to allow us to get there.

Marmot Priorities
Best Start - Healthy Lifestyles - Employment - Healthy, Sustainable Places and Communities - Preventing Ill Health - People Maximising their Potential and Capabilities (strengths / assets) - Address racism - Pursue environmental sustainability

The Public Services (Social Value) Act 2012)
Social Value Themes
Social - Economic - Enviromental

Local Sustainable Community Strategy Outcomes	Local Social Value Charter, Framework, Tools and Templates	Local Industrial Strategy Priorities	Social Innovation Incubator	Local Enterprise Partnership Priorities

Local Suppliers, Business and Industry - Corporate Social Resposibility

Anchor Organisations: Local Authorities, NHS Providers, CCGs, Voluntary and Community Sector Organisations

Cheshire and Merseyside Health and Care Partnrship Sector Organisations

By signing this charter, we are committed to its principles, and will align our processes to encompass them, where possible, when we design, shape, buy and deliver services.

Signed

Designation

Organisation

TAKING ACTION IN CHESHIRE AND MERSEYSIDE

Local authorities and/or the NHS cannot take on the required actions to reduce health inequalities alone; many lie outside their direct remit and they do not have sufficient resources, capacity and levers to achieve that. It is important that the HCP and ICPs embed partnerships with the VCFSE sector, other public services, local authorities and businesses to influence these wider conditions which shape health.

IHE proposes recommendations covering each of the Marmot 8 themes and the following system-wide recommendations for action across the Cheshire and Merseyside system.

1. Increase and make equitable funding for social determinants of health and prevention.

2. Strengthen partnerships for health equity.

3. Create stronger leadership and workforce for health equity.

4. Co-create interventions and actions with communities.

5. Strengthen the role of business and the economic sector in reducing health inequalities.

6. Extend social value and anchor organisations across the NHS, public services and local authorities.

7. Develop social determinants of health in all policies and implement Marmot Beacon indicators.

A set of local Marmot Beacon indicators, developed in partnership with hundreds of local stakeholders, will monitor actions on the social determinants of health in Cheshire and Merseyside.

The report proposes the following 22 indicators, aligned with the 8 Marmot themes, covering areas which are considered critical in reducing health inequalities. This social determinants indicator set was co-created with Cheshire and Merseyside and will be monitored by the Combined Intelligence for Population Health Action (CIPHA) programme.

Life expectancy		Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
Give every child the best start in life					
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
Enable all children, young people and adults to maximise their capabilities and have control over their lives					
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
Create fair employment and good work for all					
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
Ensure a healthy standard of living for all					
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
Create and develop healthy and sustainable places and communities					
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
Strengthen the role and impact of ill health prevention					
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
Tackle racism, discrimination and their outcomes					
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
Pursue environmental sustainability and health equity together					
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)~	Yearly	LA	IMD	Active lives survey

** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.*

*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a negative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

**** These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

***** To be used to demonstrate annual changes, interpretation to factor in population changes.*

~ Active Lives Survey states the length of continuous activity is at least 10 minutes.

LIVERPOOL INDEPENDENT CLINICAL SERVICES REVIEW

BID / SERVICE SPECIFIATION

1 Introduction

This external review is being commissioned to ensure acute hospital services in Liverpool are fit for purpose for the future, to improve outcomes and patient experience, improve equity, reduce variation, improve productivity, efficiency and effectiveness making best use of the systems assets.

Cheshire and Merseyside Integrated Care System (C&M ICS) have been asked by NHSE/I to commissioning an independent review of the acute care model with a view to identifying opportunities that will improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness. The review needs to address the longstanding issue and position of Liverpool Women's Hospital NHS Trust, which has been subject to clinical review, however a solution is yet to be agreed. There are areas of outstanding practice and service which should be identified and built upon.

However, no service exists in isolation, the review must consider the opportunities to deliver care closer to home and principles, as set out in the "One Liverpool" strategy (https://www.liverpoolccg.nhs.uk/media/4145/000918_one_liverpool_strategy_v6.pdf) and the interdependencies with, and obligations to, the Cheshire and Merseyside System as a whole and beyond.

Our objectives are to:

1. Identify the optimum acute care model for Liverpool, and make recommendations about the priority of the service changes that need to be made (considering any consequences on out of hospital care including Mental Health)
2. Identify the risks and governance implications for any proposed model on the wider role played by all the Liverpool trusts in relation to services provided to populations outside of the city boundary, ensuring that the needs of these populations are appropriately met, and that due consultation is given to reducing existing inequalities of access.
3. Identify opportunities to move care closer to home/digitise the service model and consequences on Community and primary care (physical and mental health services, all age, all ethnicity), and consideration of the consequences for social care.
4. Improve equity and integration in terms of access and outcome (clinical and patient experience) in line with the aims and objectives of the ICS and One Liverpool Strategy.
5. Describe the outcomes and solution that will achieve financial and operational sustainability from a revenue and capital perspective giving recommendations on value for money.

2 Scale and scope of the review

The independent review will:

- Develop an acute care model for secondary and tertiary services across Liverpool and corresponding out of hospital model for primary and community services that must deliver
  - Best clinical/evidence-based practice and be patient focused
  - Reduce clinical risk
  - Improve equity and quality (clinical, patient experience and outcome)
  - Efficient and effective (value for money)
  - Safe and sustainable (workforce and financial)
- Ensure that the proposed model incorporates the opportunities to maximise education, research, and innovation opportunities, that enhances the reputation of the Liverpool system both nationally and internationally and improves workforce supply and retention
- Identifies opportunities to modernise service models, through better use of technology and telehealth and delivered as close to home as possible and delivers sustainable services out of hospital supported by a single longitudinal care record.
- Identify areas of good practice that could be rolled out/shared.
- Identify the estate and infrastructure (including Digital) requirements of any proposals and associated workforce, capital/revenue consequences
- Identify the risks to delivery and governing implications of any proposed models
- Consider the patient and public engagement and consultation requirements in any solution/options

This review should be conducted in full recognition of the NHS Long Term Plan and One Liverpool Strategy. The One Liverpool Strategy commits to being all age, all ethnicity, physical and mental health, aimed at empowering residents, improving equity and outcome focused.

3 Population included

It must be recognised that Liverpool Hospitals and community based providers offer services to a large population from across Merseyside, particularly across Liverpool, Sefton, and Knowsley. Tertiary providers also offer services to patients from Cheshire, Merseyside, Isle of Man, North Wales and nationally. Also supporting service provision at neighbouring District General Hospitals (DGH's), and train future staff for a significantly wider footprint.

The Cheshire & Merseyside Acute & Specialist Trusts provider collaborative (CMAST) will be included in the process as a major stakeholder.

4 Organisations to be included

1) To be included in the review, key organisations are as follows:

    a. NHS Trusts

        a. Alder Hey Children's NHS Foundation Trust (FT)
        b. Clatterbridge Cancer Centre NHS FT
        c. Liverpool Women's Hospital NHS FT
        d. Liverpool Heart and Chest Hospital NHS FT
        e. Liverpool University Hospitals FT
        f. Mersey Care NHS FT
        g. The Walton Centre NHS FT

    b. General Practice – 1 Local Medical Committee (LMC) 9 Primary Care Networks (PCNs)
    c. Liverpool City Council
    d. Cheshire & Merseyside Acute & Specialist Trusts Provider Collaborative and Cheshire and Merseyside out of hospital collaborative

5 Accountability for the review

The Review will be commissioned by Liverpool Clinical Commissioning Group (CCG) on behalf of the ICS (until the Integrated Care Board is established) with day-to-day oversight through the One Liverpool Partnership Board. Regular updates and reports will be provided to the C&M ICB. Engagement with other partners will be built into the communication plan

6 Conflicts of Interest

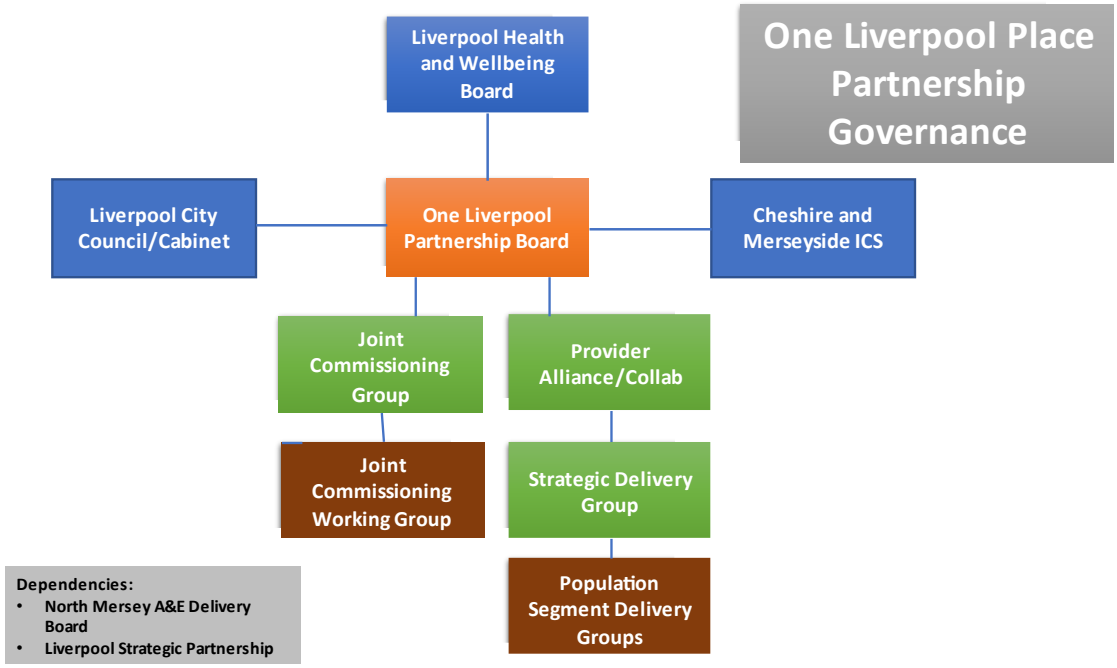
The Review will be independent, however arrangements to manage conflicts and potential conflicts of interest to ensure that recommendations made will be taken and seen to be taken, without any possibility of the influence of external or private interest.

7 Working Groups

To assist the review team deliver on its role and responsibility, the One Liverpool Partnership Board will provide guidance and support to the review process, support the establishment of working groups and agree the membership, role, and remit for each working group.

8 Monitoring Effectiveness

The One Liverpool Partnership Board will ensure delivery of the agreed work plan and deliverables in line with timescales. It will keep and provide regular updates on progress, issues, and risks to the C&M ICB. The local Liverpool governance diagram which describes the approach to local oversight is as follows:



9. Outcome and Timescales

Stage 1

Production of a detailed acute model of care and corresponding out of hospital model for primary and community services, together with an associated report considering the requirements outlined above, that describes any opportunity for wider reform and or consequences for other services across the system.

Our outcomes objectives for this review are:

- improved outcomes and equity for the population
- ensure patient/user/citizen centred services
- improved quality, safety, and patient experience
- improved efficiency and effectiveness
- increased ability to recruit and retain staff

The detailed acute model of care and associated report must set out the following:

- *An acute care model for secondary and tertiary services across Liverpool and a corresponding out of hospital model for primary and community services*

- *A description of the outcomes and solutions that will achieve financial and operational sustainability from a revenue and capital perspective giving recommendations on value for money*
- *Demonstrates how the proposed model incorporates opportunities to maximise education, research, and innovation opportunities, to enhance the reputation of the Liverpool system both nationally and internationally and improves workforce supply and retention*
- *Identifies opportunities to modernise service models, through better use of technology and telehealth, delivered as close to home as possible and delivers sustainable services out of hospital supported by a single longitudinal care record.*
- *Identify areas of good practice that could be rolled out/shared.*
- *Identify the estate and infrastructure (including Digital) requirements of any proposals and associated workforce, capital/revenue consequences*
- *Any identified risks, including but not limited to any consequences for :*
    - *Out of hospital care including Mental Health*
    - *Community and Primary Care (physical and mental health services, all age),*
    - *Social care*
- *Opportunities to improve equity and integration in terms of access and outcome (clinical and patient experience)*
- *Any identified governance implications,*
- *Any workforce risks/opportunities,*
- *A summary of sustainable capital and revenue requirements/consequences,*
- *High level actions which are clearly prioritised and based on clinical risk and patient outcome/benefit.*
- *A clear summary of the recommendations and decisions required.*

It is expected that this stage will take no more than 3 months from contract commencement and be complete by 30th September 2022.

PLEASE NOTE – A GATEWAY REVIEW WITH THE COMMISSIONER WILL BE REQUIRED BEFORE COMMENCEMENT OF STAGE 2.

Stage 2

Produce a detailed implementation plan that sets out the priorities for delivering the new model of care in a timely manner together with a corresponding report outlining the following aspects.

The plan and report must:

- *Clearly set out, in priority order, the actions required to implement the proposed changes with clear timescales for implementation and suggested action owners*

- *Consider the need for fulfilling statutory responsibilities to engage and consult on any new model, ensuring that the needs of the local population are appropriately met, and that due consultation is given to reducing existing inequalities of access.*
- *Set out clearly the clinical and workforce leadership requirements to deliver the plans.*
- *Consider and recommend the appropriate governance arrangement to support timely decision making and value for money.*

It is expected that Stage 2 will take no more than 3 months from the end of Stage 1 and be complete by 31st December 2022.

The proposed methodology, time scale and clinical leadership of this review needs to be set out in any proposal as part of the procurement process and be in place for the commencement of the contract noting the staged approach set out above.

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Place Director Report – St Helens

04 August 2022

Cheshire and Merseyside
Integrated Care Board Meeting

NHS
Cheshire and Merseyside

Date of meeting:	04 August 2022
Agenda Item No:	ICB/8/22/07
Report title:	Place Director Report - St Helens
Report Author & Contact Details:	Mark Palethorpe - markpalethorpe@sthelens.gov.uk
Report approved by:	Mark Palethorpe – NHS Place Director and Executive Director of Integrated Health and Social Care. St Helens

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 St Helens Place Director Report aim to provide an overview of our integration journey, our challenges and delivery ambitions at place. The report provides the Board with:

1. A brief history of St Helens and its proud heritage
2. An introduction to the borough and its assets, whilst recognising our post-industrial legacy and challenges that brings to the planning and delivery of services.
3. Our integration journey and the benefits that is having on meeting the challenges described above.
4. The St Helens People's Plan articulates our ambition for the next five years and our quest to reduce health inequalities.
5. The plan has three focused priorities, that is underpinned by reducing health inequalities:
   - Mental Wellbeing
   - Healthy Weight
   - Resilient Communities.
6. Our Inequalities Agenda is rooted in becoming a Marmot community, we have an Inequalities Commission which took the better start in life has its first priority but pivoted to look at immediate measures to help tackle the cost-of-living crisis. The roll out of an expansion of food pantries is now being operationalise in one of our workstreams.
7. We use several vehicles to engage with people and communities which includes face to face, surveys, forums and partner agencies to build a rich picture of what is needed as well as 'taking the temperature' of the experiences of residents in St Helens.
8. Our strategy and delivery is led by our 'St Helens Cares wider partnership team' and our strong governance arrangements has matured over the years whilst adjusting to system developments as required.
9. Finally, we have a long-term plan, but recognise the need for the rapid delivery of 'big ticket items' which will have significant and immediate positive impact for citizens.

Cheshire and Merseyside
Integrated Care Board Meeting

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:	
The item involves sensitive HR issues	n/a
The item contains commercially confidential issues	n/a
Some other criteria. Please outline below:	n/a

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 St Helens has a mature approach to integration, excellent relationships with the Local Authority, providers, and wider partners. We have a focused plan and good 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						

Cheshire and Merseyside
Integrated Care Board Meeting

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:	Mark Palethorpe – NHS Place Director and Executive Director of Integrated Health and Social Care.

Appendices:	Presentation

ST HELENS
CARES

St Helens NHS Place Director's Report

ICB Board

4th August 2022

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NHS Cheshire and Merseyside

ST HELENS CARES

ST HELENS
CARES

1. History of St Helens

1. History of St Helens

NHS Cheshire and Merseyside

ST HELENS CARES

The development of the town was spurred on by the rapid population growth in the region during the Industrial Revolution. Between 1629 and 1839 St Helens grew from a small collection of houses surrounding an old chapel, to a village before becoming the significant urban centre of the four primary manors and surrounding townships that make up the modern town.

Timeline

1552 - A chapel dedicated to St Helen is mentioned for the first time. The town takes its name from the chapel.

1746 - A turnpike road is built to Liverpool

1762 - A canal is cut. Coal mining in the St Helens area booms.

1773 - The British Cast Plate Glass Manufacturers opens. Glass making in St Helens booms.

1826 - William Pilkington founds a glassworks in St Helens

1828 - Josias Gamble sets up a chemical works in St Helens

1833 - The railway comes to St Helens

1839 - St Helens Town Hall is built

1868 - St Helens is given a corporation and mayor

1876 - A new Town Hall is built

Glass producer Pilkington is the town's only remaining large industrial employer; previously, it was home to Beechams the Gamble Alkali Works, Ravenhead United Glass Bottles, Triplex, Daglish Foundry and Greenall's brewery.

1881 - Horse drawn trams begin running in St Helens

1884 - The Providence Hospital opens

1885 - St Helens sends its first MP to parliament

1893 - Samuel Taylor gives Taylor Park to the town

1899 - The first electric trams run in St Helens

1911 - The first cinema in St Helens opens

1946 - The last trams run in St Helens

1974 - St Helens is made a metropolitan borough

1991 - Sutton Manor Colliery Closes

2009 - The Dream unveiled

2009 - St Helens becomes part of the Liverpool City Region

2021 - St Helens RFC won the Super League Championship for the 9th time

St Helens RFC 'Saints' is the most successful teams of the modern Super League era

ST HELENS
CARES

2. Introduction and Context

Key Statistics

OUR BOROUGH

Our borough is situated in Merseyside and is proud to be part of the Liverpool City Region. It covers an area of 136 square kilometres and is home to over 180,000 people with 4,800 businesses based in the borough. It is a place with a strong identity and cultural history, rooted in our world-famous rugby league team and our proud industrial heritage including England's first canal, a section of the world's first passenger railway, pharmaceutical, coal and glass industries.

£146m
Council Budget

92 public parks and green spaces (720 hectares)

St Helens Borough covers 136sqm, **65%** is green space. There is a good motorway, train and bus network

7m recycling and waste collections made per year

758 dwellings completed in 2019/20, **25%** were affordable housing

£141k
Average house price in St Helens (£262k - England)

Almost a quarter of St Helens residents live in the **10%** most deprived neighbourhoods in the country

74.8%
of people in St Helens are in work, higher than the NW (74.2%)

0.62
The number of jobs per 100 people. (0.87 - England)

26 Total enterprises per 1,000 population (42 - England)

Over **70%** of 5-year-olds achieved a good level of development in the early years learning goals, **better** than the North West average

Almost **33%** of adults have level 4 (degree level) qualification, a 30% increase in 10 years. The number of people without any qualifications has decreased over the same time period

Life expectancy at birth

77.8 years - Male
(79.6 years -England)

81.2 years - Female
(83.2 years - England)

69.2%
of adults are overweight or obese (62.3% - England)

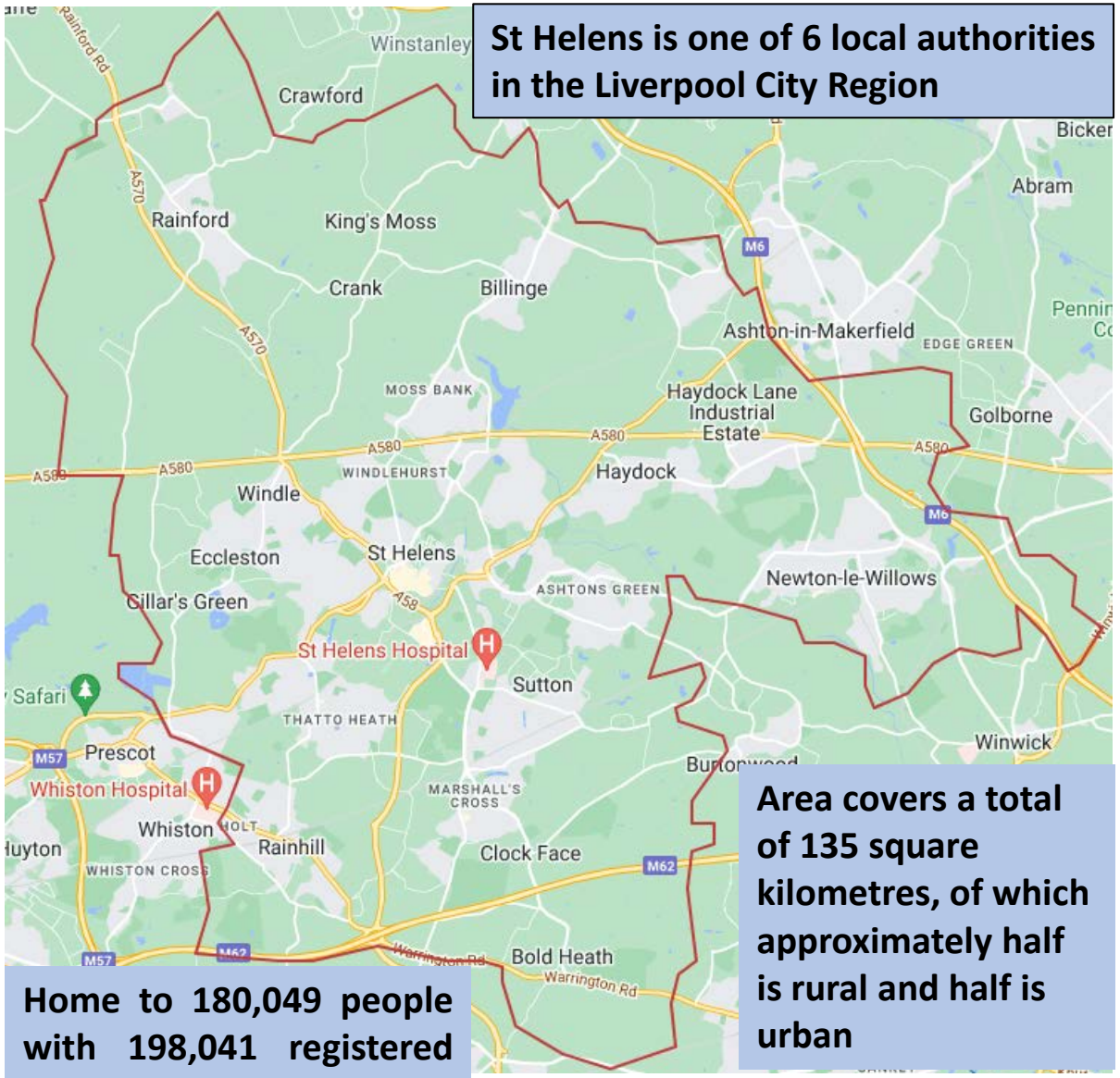
NHS
Cheshire and Merseyside

ST HELENS CARES

1. Introduction to St Helens

NHS Cheshire and Merseyside

ST HELENS CARES



St Helens is one of 6 local authorities in the Liverpool City Region

Area covers a total of 135 square kilometres, of which approximately half is rural and half is urban

Home to 180,049 people with 198,041 registered patients in 34 GP practice

Assets

- Amazing volunteers
- Green space
- St Helens heroes
- Tackling fuel poverty
- Suicide prevention
- Investment in the Town Centre and Earlestown
- Partnerships
- Heritage and culture

Challenges

- Too many children in the care system
- Loneliness
- Low pay
- Poor diet
- Low educational attainment
- Funding cuts
- Self-harm
- High rates of COVID-19

St.Helens local authority life course statistics 2021

A comparison to England

St.Helens FACTS

Population

About **180,585** people live In St.Helens.

Deprivation

43.3% of the St.Helens population live in the top **20%** most deprived areas in England.

Child Poverty

31.6% of children aged 0-15 live in poverty in St.Helens.

KEY

Statistical significance to England

- Better
- No different
- Worse

Produced by St.Helens Integrated Intelligence & Improvement Service.

Icons available from: www.iconfinder.com & www.flaticon.com

ST HELENS CARES

Context – Borough

NHS
Cheshire and Merseyside

Aristotle

St Helens Health Inequalities Electoral Ward profiles

NHS Midlands and Lancashire Commissioning Support Unit

ST HELENS CARES

Quintile 1 – 5

Indicator	Billinge and Seneley Green	Blackbrook	Bold	Earlestown	Eccleston	Haydock	Moss Bank	Newton	Parr	Rainford	Rainhill	Sutton	Thatto Heath	Town Centre	West Park	Windle	St. Helens	England
Total population	10,535	10,173	9,868	11,926	11,812	11,423	11,033	12,573	13,370	7,720	10,968	11,792	13,243	11,745	11,424	10,980		
Population aged 65 years and over	3,114	2,387	1,790	1,792	3,039	2,510	2,519	1,934	1,829	2,447	3,166	2,511	2,272	1,824	2,005	2,064		
Black and Minority Ethnic Population	1.2	1.6	1.4	2.7	1.9	1.3	1.1	2.6	1.9	1.2	3.3	1.4	3.7	2.7	1.8	1.2		
Child Development at age 5	67.9	49.7	62.7	61.9	75.3	56.8	65.8	66.5	54.2	64.7	67.1	59.3	65.5	52.6	60.9	66.0	70.2	71.8
Child Poverty, English Indices of Deprivation, 2019	12.5	20.6	33.2	25.3	6.6	20.2	23.1	20.7	39.5	7.3	11.3	28.1	23.6	36.8	23.2	19.5	23.7	17.1
Deaths from all cancer, all ages	87.6	102.9	128.0	134.2	99.5	104.2	106.8	118.3	155.9	101.3	87.3	136.8	112.0	130.5	100.4	95.0	110.4	100.0
Deaths from all cancer, under 75 years	103.7	107.7	127.4	137.8	105.8	107.5	102.7	124.8	161.4	76.2	99.6	130.5	90.8	143.7	101.8	85.7	111.8	100.0
Deaths from all causes, all ages	88.6	107.1	124.4	132.5	98.6	119.3	99.1	121.1	186.1	97.9	99.3	145.9	129.8	177.2	114.2	109.3	119.4	100.0
Deaths from all causes, under 75 years	91.4	118.4	140.1	162.7	98.3	115.2	106.6	115.2	206.0	79.6	97.1	135.6	137.1	216.9	116.7	122.3	126.4	100.0
Deaths from causes considered preventable, under 75 years, SMR	99.0	131.7	147.1	183.2	86.5	109.4	112.4	109.4	244.5	76.4	90.7	125.5	141.9	253.7	129.3	121.1	132.2	100.0
Deaths from circulatory disease, all ages	86.0	98.1	131.7	126.3	90.9	118.7	95.8	118.2	173.6	82.8	92.8	127.4	112.6	151.5	107.2	112.0	111.4	100.0
Deaths from circulatory disease, under 75 years	85.7	105.9	178.2	184.4	76.9	146.8	93.9	152.9	215.5	81.7	84.7	130.2	145.8	215.0	98.0	113.3	127.7	100.0
Deaths from coronary heart disease, all ages	94.2	112.1	122.6	152.1	78.7	128.9	95.1	128.6	186.8	80.7	88.4	116.5	124.2	164.3	113.1	101.0	114.3	100.0
Deaths from respiratory diseases, all ages	115.9	143.4	149.0	177.4	101.8	142.4	106.0	161.8	222.7	104.2	113.2	177.5	150.4	224.8	169.7	119.5	144.0	100.0
Deaths from stroke, all ages	64.4	103.0	114.2	96.6	99.4	96.3	83.0	114.6	165.4	77.6	94.7	149.8	79.8	136.4	122.1	115.7	105.2	100.0
Emergency admissions for injuries in under 5s	19.4	14.5	13.2	16.8	11.4	15.8	14.5	12.0	17.2	17.5	14.5	19.2	15.4	14.9	14.3	10.1	15.1	12.3
Emergency admissions in under 5s	188.6	243.0	283.2	201.3	252.9	220.4	198.6	182.5	228.5	256.4	226.2	232.6	233.3	240.7	247.6	230.5	220.9	162.1
Emergency hospital admissions for all causes	99.3	125.2	140.1	146.2	101.9	135.0	127.1	122.5	156.2	103.2	119.2	140.4	154.5	184.0	144.6	118.1	133.0	100.0
Emergency hospital admissions for Chronic Obstructive Pulmonary Diseas..	91.8	103.4	138.0	153.6	54.9	116.6	106.2	115.2	213.8	55.8	86.9	132.9	153.2	207.6	136.5	96.6	119.2	100.0
Emergency hospital admissions for coronary heart disease	110.3	163.8	182.7	166.5	106.5	151.4	124.9	138.7	139.6	115.8	126.1	141.8	153.2	170.5	156.5	140.3	140.7	100.0
Emergency hospital admissions for hip fracture in 65+	79.2	121.6	98.5	129.5	80.3	116.7	90.7	92.4	138.8	116.0	100.6	160.3	123.9	148.5	106.1	81.7	109.5	100.0
Emergency hospital admissions for injuries in 15 to 24 years old	141.5	244.8	270.4	246.1	202.3	179.7	254.1	206.3	285.7	218.7	253.4	242.8	233.4	417.6	289.4	215.4	251.3	132.1
Emergency hospital admissions for injuries in under 15 years old	136.5	123.8	131.8	148.5	92.2	114.0	123.0	107.7	136.7	126.4	142.0	185.7	115.3	115.7	109.5	107.1	124.9	97.8
Emergency hospital admissions for Myocardial Infarction (heart attack)	109.5	160.9	161.7	150.0	100.6	138.0	117.6	141.1	143.9	114.2	124.8	130.4	125.0	149.0	127.9	127.8	130.7	100.0
Emergency hospital admissions for stroke	91.5	90.5	109.1	126.5	97.0	99.1	98.6	118.5	127.9	89.4	98.9	118.1	128.5	144.5	105.9	100.2	108.2	100.0
Fuel Poverty, 2018	10.6	11.7	11.7	10.8	9.1	10.7	11.8	10.9	14.1	9.7	9.6	11.4	11.9	12.2	12.8	11.3	11.3	10.3
GCSE Achievement	63.9	59.4	44.3	52.4	71.0	60.1	51.5	48.2	45.7	79.3	65.0	44.1	46.7	46.6	58.9	66.7	56.4	56.6
General fertility rate: live births per 1,000 women aged 15-44 years	52.0	53.4	62.3	66.6	50.9	58.6	60.8	69.6	72.1	43.6	57.1	60.5	65.7	64.5	61.9	65.1	61.4	60.6
Hospital stays for self harm	109.4	162.7	232.3	292.3	120.3	179.5	225.6	148.5	269.9	153.1	154.5	258.6	196.5	417.9	275.5	194.7	220.1	100.0
IMD Score, 2019	15.5	27.0	38.3	38.9	12.5	25.7	32.9	26.0	57.0	13.8	16.6	34.1	36.4	54.8	33.3	24.1	31.5	21.7
Incidence of all cancer	96.5	99.9	119.3	120.4	102.6	107.9	101.8	98.7	109.3	102.9	102.4	105.1	111.3	108.8	90.8	108.8	104.9	100.0
Incidence of breast cancer	90.1	88.4	123.4	81.0	92.4	87.1	81.7	100.0	71.3	101.1	102.7	96.1	98.3	69.8	99.2	102.1	92.8	100.0
Incidence of colorectal cancer	105.5	107.2	89.5	128.6	105.0	148.6	112.0	119.5	88.2	83.3	112.8	134.6	102.3	90.9	78.5	155.2	110.7	100.0
Incidence of lung cancer	87.4	122.6	137.8	165.9	72.8	123.9	96.7	117.6	228.9	110.8	103.8	130.2	129.9	163.7	107.5	91.3	120.4	100.0
Incidence of prostate cancer	88.4	85.5	119.4	86.3	111.6	86.9	87.0	76.8	50.6	112.9	89.9	62.0	82.8	50.4	75.1	69.6	84.5	100.0
Income deprivation, English Indices of Deprivation, 2019	9.4	15.5	23.0	23.3	7.0	15.3	18.6	15.6	33.0	7.3	9.4	18.7	21.1	31.6	17.8	13.8	18.2	12.9

Our Tartan Rug

Indicators at ward level

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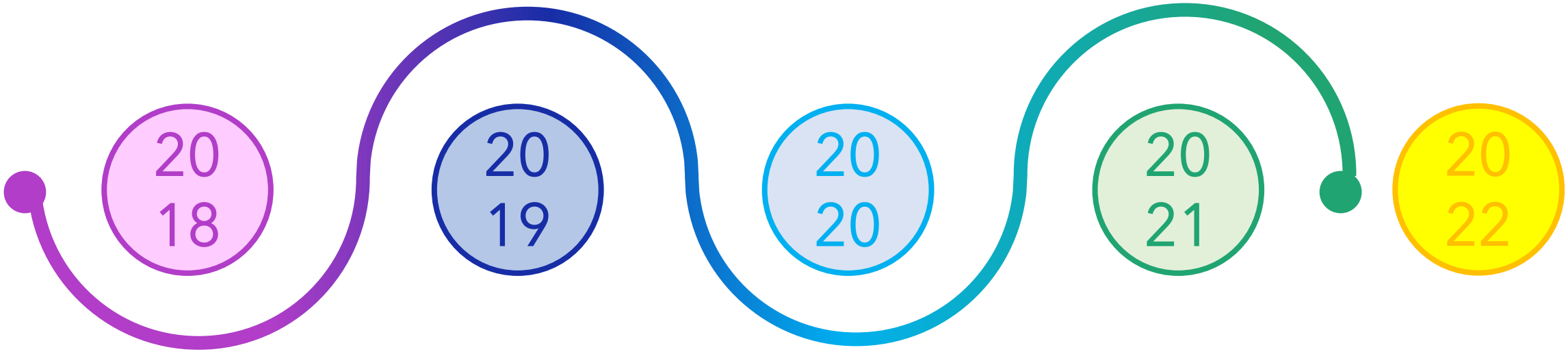
3. Our Integration Journey

2. St Helens Cares Integration Journey

NHS Cheshire and Merseyside

ST HELENS CARES



Initial Integration

- Joint AO and LA Exec Director Post
- Joint Exec Leadership Team
- Contact Cares Established
- Shared Care Records

Embedding Integration

- Integrated BI Team (LA/Trust/CCG)
- PCNs Established
- S.75, MOU & governance set up & Stakeholder forum
- Launch of Contact Cares with SPOC

Responding to the Pandemic

- Rapid response enabled by Integration & partnership
- CIPHA Pilot established at Place
- First MVC in C&M delivering more than 500,000 jabs
- Cancer line in place

Designing future Place Working

- New AO appointed
- New place plan launched with focused priorities
- Vax Bus roaming serving borough's underserved
- Children and Families Hub in place

Delivering at Place & System

- C&M ICB and Place Launch
- Deliverables this year:
  - Care Communities
  - Health Innovation Hub
  - Food Pantries Expansion
  - Hope Pathway
  - Life Rooms

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3. People's Plan 2022 – 2027 (St Helens Place)

3 St Helens Place Based Partnership Plan

NHS Cheshire and Merseyside

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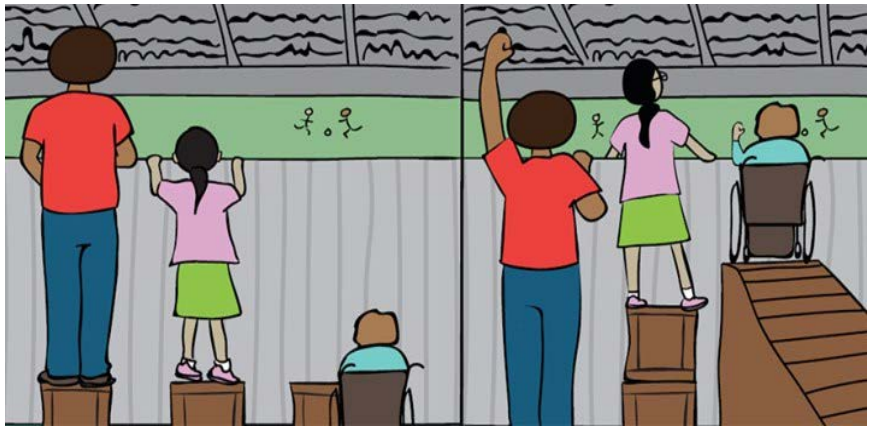
Our Vision

One Place, One System, One Ambition
Improving people's lives in St Helens together

Our Mission

Bringing people closer together, by tackling health inequalities in St Helens



Our Priorities

1. Mental Wellbeing

By 2027, we will
A. Prevention and reduction of self-harm and suicide

B. Expand VCS capacity to support mental health and wellbeing

C. Improve the wellbeing of children and young people

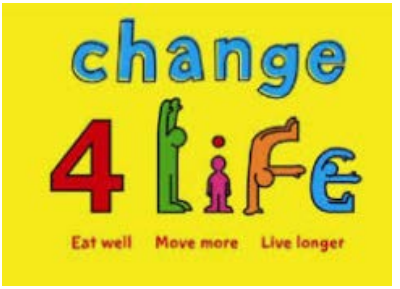
Five Ways to Wellbeing

2. Healthy Weight

By 2027, we will:
A. Support healthy eating choices in the Borough

B. Encourage residents to lead a more active lifestyle

C. Reduce diabetes



3. Resilient Communities

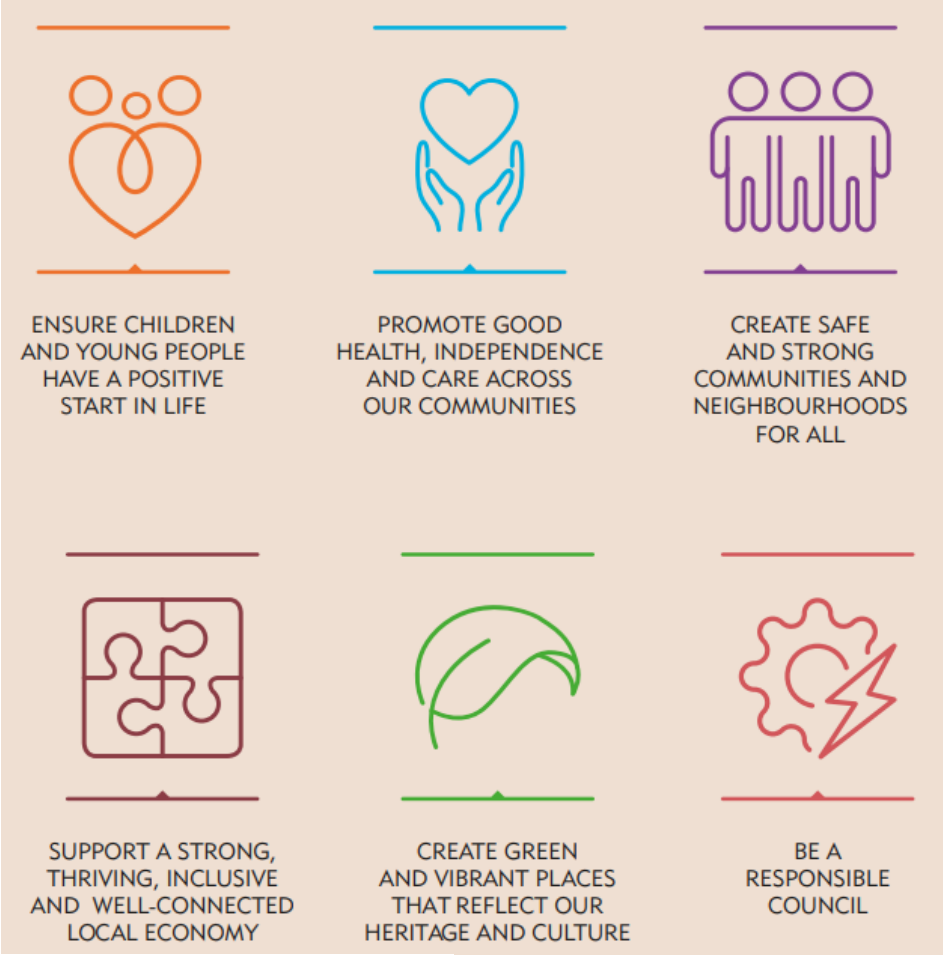
By 2027, we will:
A. Supporting people to live independently

B. Reduce social isolation and loneliness

C. Care Communities in our four localities/networks

D. Develop a Health & Care Skills Innovation Hub

St Helens Council Borough Strategy 2021 - 2030



- LOCALITY WORKING
- WORKPLACE WELLBEING
- TACKLING INEQUALITIES
- CLIMATE CHANGE
- STRATEGIC DEFICIT
- COMMISSIONING
- DIGITAL TRANSFORMATION
- PERFORMANCE MANAGEMENT

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5. Place Priorities

Improving Mental Wellbeing

- Prevention and reduction of self-harm and suicide
- Expand Voluntary Community Sector capacity to support mental health and wellbeing
- Improve the mental wellbeing of children, young people and families

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Zero Suicide

Training for all St Helens employers

PATHWAY TO HOPE
Because No One Should Face Mental Illness Alone

Rapid referrals for self-harm patients

Complex Lives

The Children's Society

St Helens Good Childhood Inquiry Report 2020

Improving the mental wellbeing of children and young people

- **Under 5s – Best Start in Life/ Family Hubs**
- **Whole School Approach- BMH 0-19, Link programme, Youth Engagement Workers (Youth Provision)**
- **Crisis Management**
- **VCS- Community Resilience**
- **Complex Families**

The LIFE ROOMS

THE LISTENING SERVICE
Providing mental health support to young people aged 12-18

Promoting Healthy Weight

- Encourage residents to lead a more active lifestyle
- Support healthy eating choices in the Borough
- Reduce diabetes

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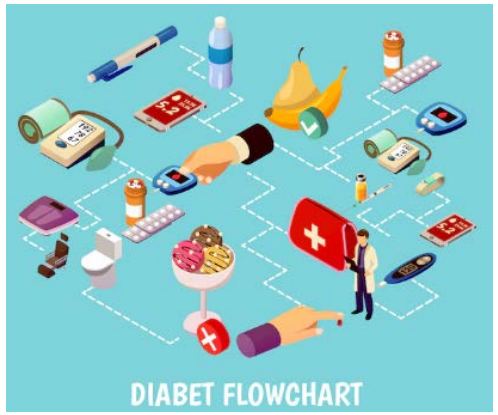
NHS Cheshire and Merseyside

Your Local PANTRY

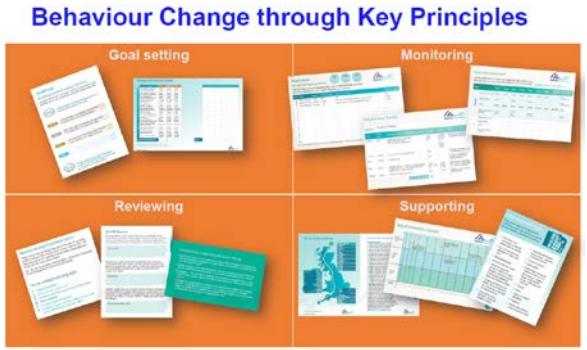


Food Pantries
Expanding our current provision of 3 Food Pantries to 10 + a mobile unit

Diabetes reduction
Stratifying and case finding citizens at risk from diabetes and putting in place preventative measures

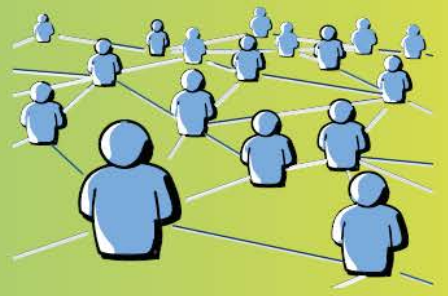
Active Lives strategy launch – August 2022
Getting St Helens moving more

Active Partnerships
Engaging Communities, Transforming Lives



Develop Resilient Communities

- Supporting people to live independently
- Reduce social isolation and loneliness
- Develop a Health and Care Innovation Hub
- Implement Care Communities in our four localities/networks



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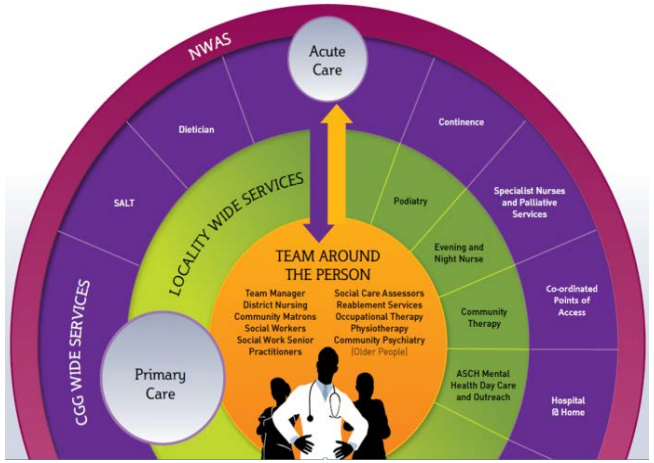
NHS Cheshire and Merseyside



Care Communities

- Care Communities pilot October 2022:
- Multi-disciplinary teams centred around the PCNs

TEC Technology Enabled Care

Health and Social Care Academy & Innovation Hub

- Business case – Nov 2022
- Pilot schemes from April 2023

Digital Developments

- LTC mgt (COPD, diabetes
- ED Streaming and redirection to PC & UTC
- Telehealth self mgt
- Falls prevention & alerts
- Social Care

Health Innovation Hub

Towns Fund

primary care: Fuller Stocktake report

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6. Inequalities Agenda

Priorities Underpinned by reducing Inequalities

- Give every child the **best start** in life
- Enable all to **maximise capabilities and have control** over their lives
- Create **fair employment and good work**
- Ensure a healthy s**tandard of living** for all
- Create healthy and sustainable **places and communities**
- Strengthen the role of ill-health **prevention**
- **Tackle discrimination, racism** and their outcomes
- Pursue **environmental sustainability** and health equity together

NHS Cheshire and Merseyside

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MARMOT

PHM Tools

Focus on System P

THIS PROGRAMME IS ACROSS CHESHIRE & MERSEYSIDE

CIPHA

Combined Intelligence for Population Health Action

Inequalities Commission Established 2021

Chair – CEO YMCA

Purpose:

- Identify areas for local action and interventions to increase equality and opportunity
- Becoming a 'Marmot Community'
- Link in with the localities approach, engage with local people and communities
- Listen to local people and hear local testimony, as well as use quantitative evidence…….

Immediate Priority

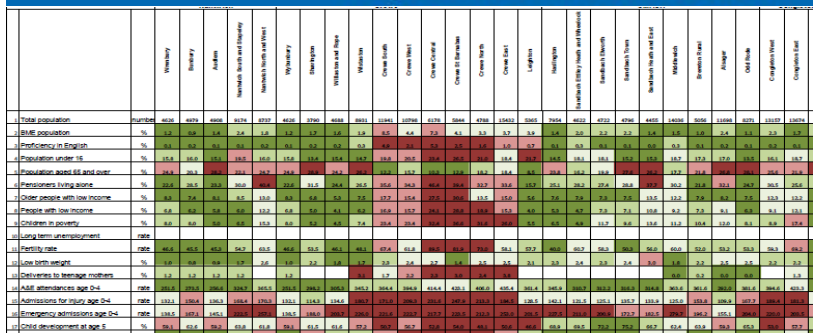
Fuel and Food Crisis:

- Rapid expansion of food pantry operationalised through Healthy Weight Group
- Cold Homes programme - Torus

First Priority

Healthy start in life:

- early years hubs
- Digital exclusion
- school readiness



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7. Engaging and Co-Producing with our Communities

6. Engaging with People &Communities

Living a good life in St Helens:

St Helens Cares Stakeholder Forum

Instrumental in providing a forum for debate on key pieces of work, for example, the St Helens People's Plan, and understanding health inequalities in St Helens.

Talkfest

Our Talkfest events will continue going forward and will be offered in a number of ways (face to face, Virtually and via a freephone number) to make sessions accessible to all. Talkfest is our way of engaging with as many different people, communities, partners and providers in St Helens as possible including schools, workplaces, community, partners and third sector and voluntary organisations.

St Helens Cares Festival

A week of sharing best practice and learning across the Place including an Awards Celebration

Learning Disabilities Mortality Review (LeDeR) Programme

The aim of the group is to engage and involve service users alongside parent and carers when developing material and engagement activities for our learning disabilities community.

The Children's Society – St Helens Good Childhood Inquiry

A bespoke online survey was designed in collaboration with St Helens council using questions on key aspects of well-being developed through the Good Childhood research programme. More than 3,200 children took part.

Children's and Young People's Engagement and Experience Group

Made up of organisations who work directly with children and young people. The aim is to bring together all relevant organisations to ensure the voice of the child is heard and with regard to health and social care services, it ensures children and young people have the opportunity to get involved and have their say.

Residents Survey

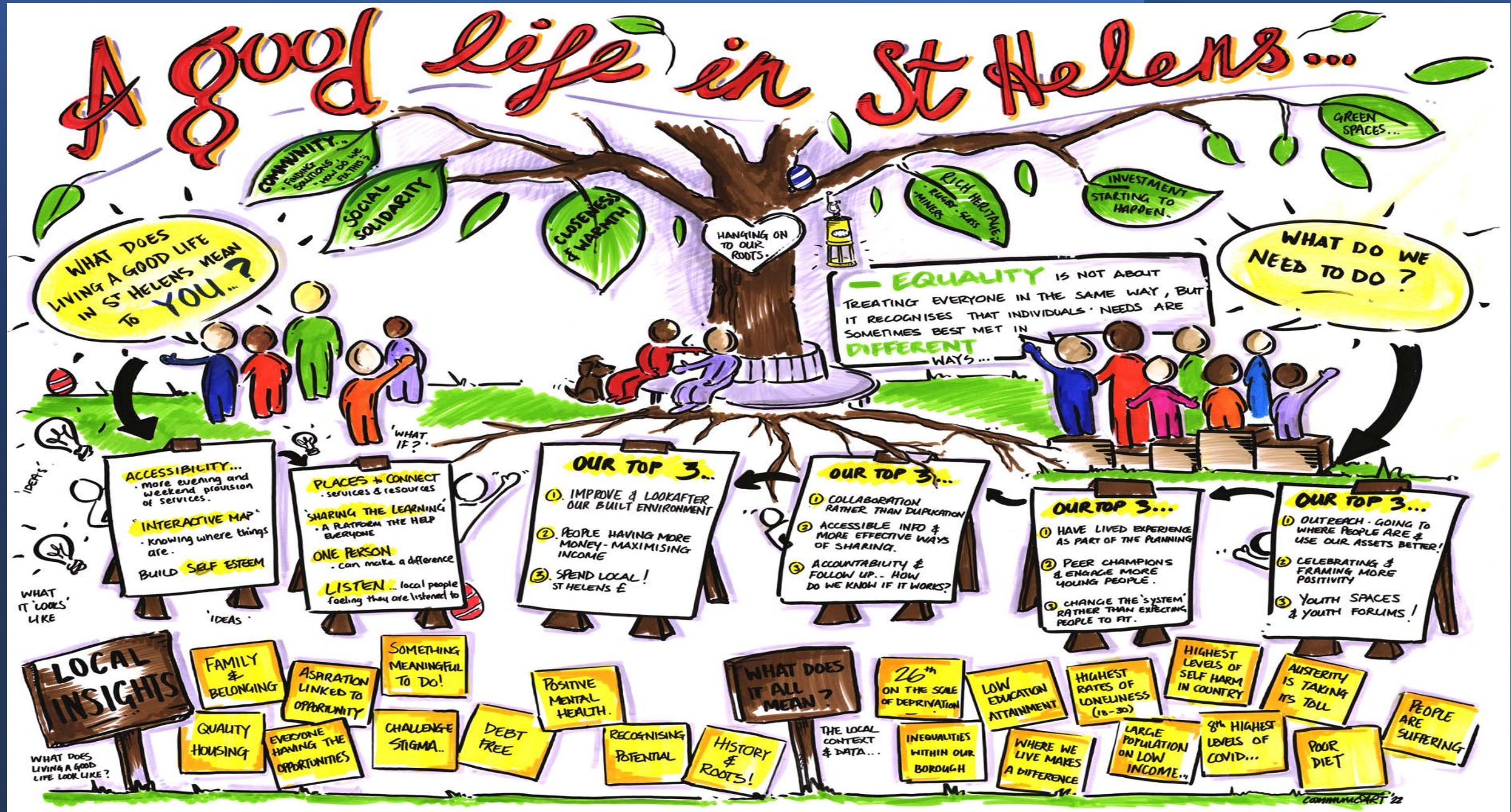
An online survey to gain insight regarding our Place Priorities

Healthwatch

We continued to hold listening events in partnership with Healthwatch St Helens to support the community in a number of different topics relating to health and social care. We also provide information on how to look after yourself and promote local community heath and care services and when to use them.

Working with our deaf community

During 2021/22 we worked closely with the Deafness Resource Centre to ensure our deaf community had the same access to information as the general population. Two face to face engagement sessions took place with support from BSL interpreters. The information leaflet developed was shared at the sessions and translated into a BSL video


A good life in St Helens...
COMMUNITY
SOCIAL SOLIDARITY
CLOSENESS & WARMTH
HANGING ON TO OUR ROOTS.
RICH HERITAGE
INVESTMENT STARTING TO HAPPEN!
GREEN SPACES...
WHAT DOES LIVING A GOOD LIFE IN ST HELENS MEAN TO YOU...?
EQUALITY IS NOT ABOUT TREATING EVERYONE IN THE SAME WAY, BUT IT RECOGNISES THAT INDIVIDUALS' NEEDS ARE SOMETIMES BEST MET IN DIFFERENT WAYS...
WHAT DO WE NEED TO DO?
'WHAT IF?'
'IDEAS'
WHAT IT 'LOOKS' LIKE
'IDEAS'
ACCESSIBILITY... more evening and weekend provision of services.
'INTERACTIVE MAP' knowing where things are.
BUILD SELF ESTEEM
PLACES to CONNECT services & resources
'SHARING THE LEARNING' A PLATFORM THE HELP EVERYONE
ONE PERSON can make a difference
LISTEN... local people feeling they are listened to
OUR TOP 3..
1. IMPROVE & LOOKAFTER OUR BUILT ENVIRONMENT
2. PEOPLE HAVING MORE MONEY - MAXIMISING INCOME
3. SPEND LOCAL! ST HELENS £
OUR TOP 3...
1. COLLABORATION RATHER THAN DUPLICATION
2. ACCESSIBLE INFO & MORE EFFECTIVE WAYS OF SHARING.
3. ACCOUNTABILITY & FOLLOW UP.. HOW DO WE KNOW IF IT WORKS?
OUR TOP 3...
1. HAVE LIVED EXPERIENCE AS PART OF THE PLANNING
2. PEER CHAMPIONS & ENGAGE MORE YOUNG PEOPLE.
3. CHANGE THE 'SYSTEM' RATHER THAN EXPECTING PEOPLE TO FIT.
OUR TOP 3...
1. OUTREACH - GOING TO WHERE PEOPLE ARE & USE OUR ASSETS BETTER!
2. CELEBRATING & FRAMING MORE POSITIVITY
3. YOUTH SPACES & YOUTH FORUMS!
LOCAL INSIGHTS
WHAT DOES LIVING A GOOD LIFE LOOK LIKE?
FAMILY & BELONGING
QUALITY HOUSING
ASPIRATION LINKED TO OPPORTUNITY
EVERYONE HAVING THE OPPORTUNITIES
SOMETHING MEANINGFUL TO DO!
CHALLENGE STIGMA..
DEBT FREE
POSITIVE MENTAL HEALTH.
RECOGNISING POTENTIAL
HISTORY & ROOTS!
WHAT DOES IT ALL MEAN?
THE LOCAL CONTEXT & DATA...
26th ON THE SCALE OF DEPRIVATION
INEQUALITIES WITHIN OUR BOROUGH
LOW EDUCATION ATTAINMENT
WHERE WE LIVE MAKES A DIFFERENCE
HIGHEST RATES OF LONELINESS (18-30)
LARGE POPULATION ON LOW INCOME..
HIGHEST LEVELS OF SELF HARM IN COUNTRY
8th HIGHEST LEVELS OF COVID...
AUSTERITY IS TAKING ITS TOLL
POOR DIET
PEOPLE ARE SUFFERING
CommuniCART '22

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8. Place Delivery and Governance

Fully Integrated Place Senior Leadership Structure across NHS and Council

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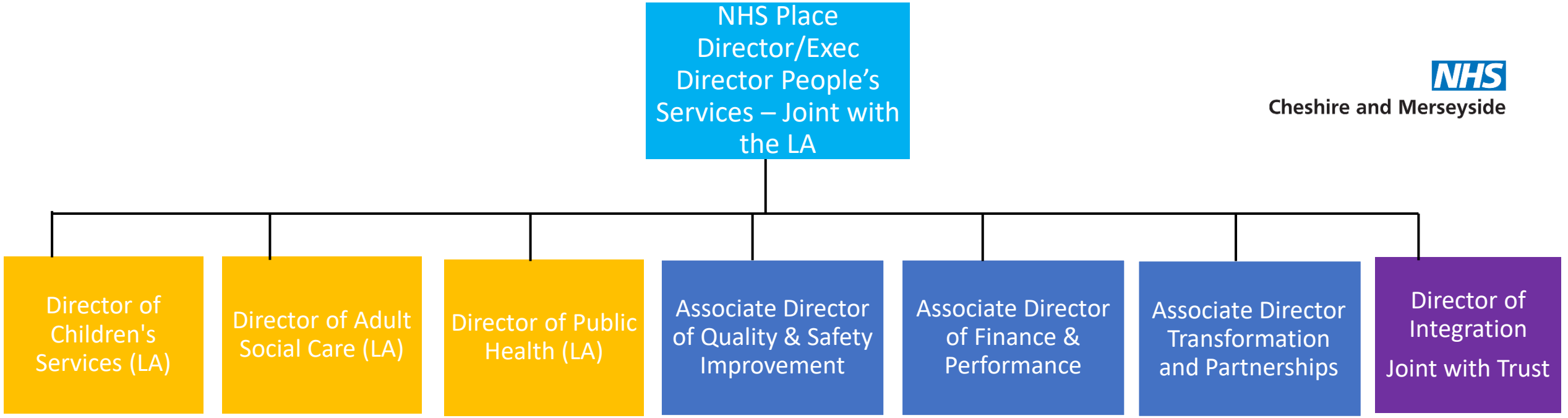
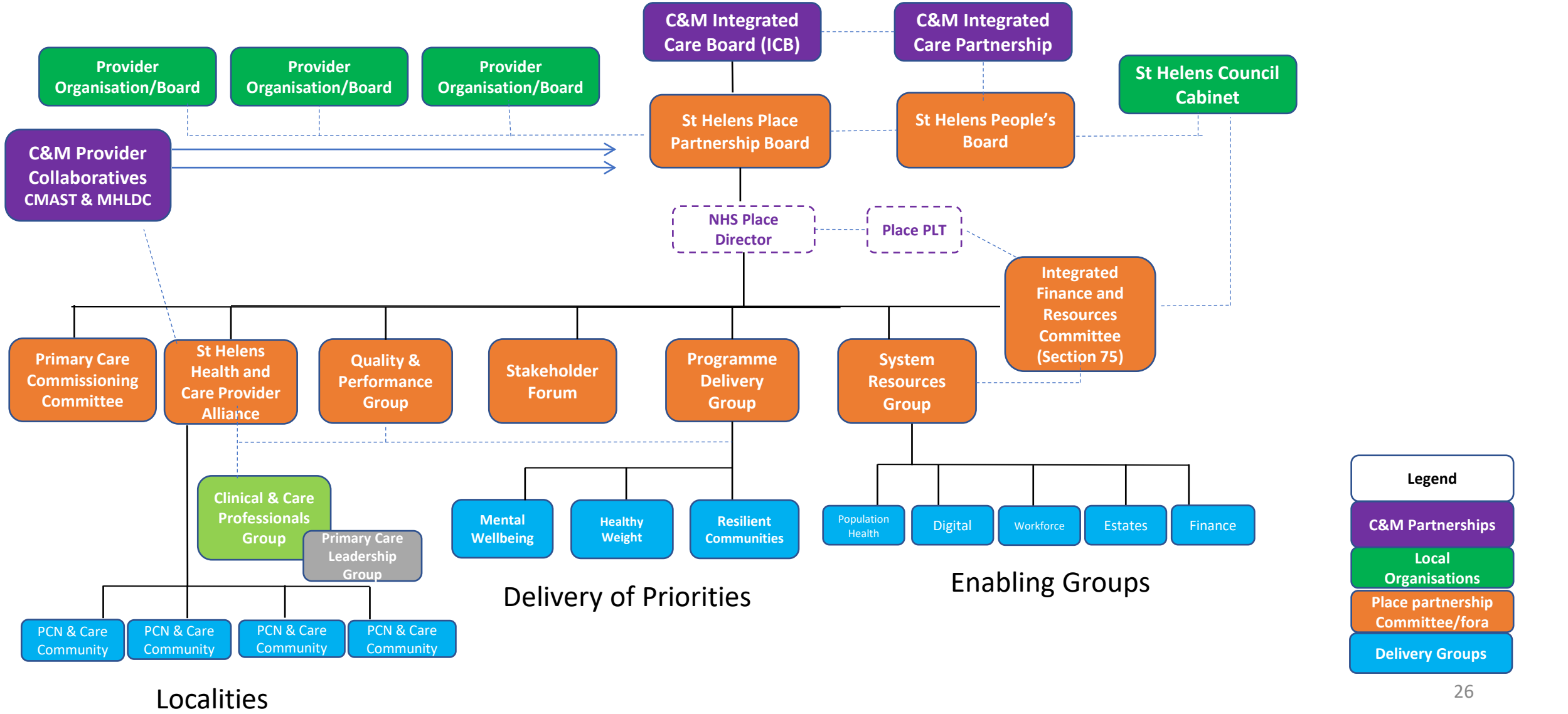
NHS Cheshire and Merseyside



St Helens Cares Place Governance



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9. Big Ticket Items for 2022/23

9. Our Big Ticket Items for St Helens

NHS Cheshire and Merseyside

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Achieve the agreed shared outcomes

Significant Improvement in our Children Services

Implementation of a 'Care Communities' approach in our localities

Support providers to reduce system pressures in U&EC

Tackle the root causes of inequalities and promote inclusive growth

Effectively implement the significant Adult Social Care funding changes and be Inspection ready

Further integration of workforce, systems, processes and intelligence

Support the Cheshire and Merseyside ICB and the other 8 Places to improve the life chances and health and wellbeing of the population.

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Thank you
Any Questions

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Remuneration Committee Chair

4 August 2022

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS Cheshire and Merseyside

Date of meeting:	04 August 2022
Agenda Item No:	ICB/8/22/08
Report title:	Report of the Remuneration Committee Chair
Report Author & Contact Details:	Matthew Cunningham, Associate Director of Corporate Affairs and Governance, matthew.cunningham@nhs.net
Report approved by:	Tony Foy, ICB Non-Executive Member, Remuneration Committee Chair

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
n/a

Executive Summary and key points for discussion

The Remuneration Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 01 July 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
- ICB Very Senior Manager Pay Framework
- ICB Partner Member Remuneration Principles.

The next meeting of the Committee is scheduled to be held on 20 September 2022.

Recommendation/ Action needed:	**The Board is asked to:** • **note** the contents of the report.

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:

The item involves sensitive HR issues	n/a
The item contains commercially confidential issues	n/a
Some other criteria. Please outline below:	n/a

NHS Cheshire and Merseyside Integrated Care Board Meeting

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

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	x
2. Recovery	
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 ICB Board Assurance Framework or any other corporate or Place risk? (*please list*) n/a					
	What level of assurance does it provide? n/a					
	Limited		**Reasonable**		**Significant**	
	Any other risks? No If **YES** please identify within the main body of the report.					
	Is this report required under NHS guidance or for a statutory purpose? (*please specify*) No					
	Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. No					
	Any current services or roles that may be affected by issues as outlined within this paper? n/a					

	Process Undertaken & Impact Considerations	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
Document Development	Financial – any resource impact?	X			Pay framework has been considered and informed by finance input and implications considered with respect to ICB running costs
	Patient / Public Involvement / Engagement			X	
	Clinical Involvement / Engagement			X	
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?	X			Salary proposals have been scrutinised to ensure that they are justifiable and there is no bias on grounds of race, sex, or other protected characteristics.
	Regulatory or Legal - any impact assessed or advice needed?		X		
	Health Inequalities – any impact assessed?				
	Sustainable Development – any impact assessed?			X	

Next Steps:	The ICB Chief People Officer will progress confirmation to individuals concerned regarding the outcome of the approval of the recommendations within the ICB Very Senior Manager Pay Framework The ICB Chief People Officer will progress development of a draft model of principals for partner member remuneration to be circulated for consideration by the Remuneration Committee.

Responsible Officer to take forward actions:	TOR - Matthew Cunningham, Associate Director of Corporate Affairs and Governance Very Senior Manager Pay Framework & Partner Member Remuneration Principles– Christine Samosa, Chief People Officer

Appendices:	C&M ICB Remuneration Committee Terms of Reference v1:1

Glossary of Terms	Explanation or clarification of abbreviations used in this paper
C&M	Cheshire and Merseyside
ICB	Integrated Care Board
VSM	Very Senior Manager

Report of the Remuneration Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Remuneration Committee (Statutory Committee)	The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary the committee is required to : • confirm the ICB pay policy including adoption of any national or local pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors. The Committee will: • adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective • advise upon and oversee contractual arrangements Directors, including but not limited to termination payments. The Committee's duties are as follows: For the Chief Executive, Directors and other Very Senior Managers: • determine all aspects of remuneration including but not limited to salary, • determine arrangements for termination of employment and other contractual terms and non-contractual terms. For all staff: • determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change). • oversee contractual arrangements • determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate. For Non-Executive Directors (NEDs): • determine the ICB remuneration policy (including the adoption of pay frameworks) • oversee contractual arrangements.	Tony Foy, ICB Non-Executive Member

Committee	Principal role of the committee	Chair
	Additional functions that the ICB has chosen to include in the scope of the committee include: • functions in relation to nomination and appointment of (some or all) Board members through convening an ICB Appointments Panel • functions in relation to performance review/ oversight for directors/senior managers • succession planning for the Board • assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR) • board development which maybe progressed through a discreet working group.	

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

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

Decision /Action Log Ref No.	Meeting Date	Issues considered
REM-AC-22-03	01.07.22	**Partner Member Remuneration Principles.** The Committee considered a verbal update on the intent to develop a set of principles for Partner Member remuneration. The Committee agreed for the ICBs Chief People Officer to progress their development and these would be considered by the Committee at a future meeting.

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

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

Decision /Action Log Ref No.	Meeting Date	Issues considered
	01.07.22	**C&M ICB VSM Pay Framework** The Committee considered a report outlining the work undertaken to determine the recommendations on C&M ICB VSM remuneration and which had been informed by national guidance.

<table>
<tr><th>Decision /Action Log Ref No.</th><th>Meeting Date</th><th>Issues considered</th></tr>
<tr><td></td><td></td><td>
The committee considered the criteria that had been applied to determine the appropriate remuneration which included the following:

1. All remuneration should be within the nationally determined pay ranges for that post.
2. Only in exceptional circumstances should a director be placed at the top of the pay range.
3. In line with the national guidance there is no provision for any additional allowances.
4. The ICB must be able to explain the rationale for salary decisions to members of the public.
5. The total remuneration package for directors must be affordable and should cost no more than the combined costs of the predecessor CCGs management costs.
6. All Directors must make appropriate declarations of any conflict of interests.
7. All Directors must fulfil the requirements of the Fit and Proper Persons Test.

The national pay framework for ICB’s is as follows

<table>
<tr><td>Role</td><td>Minimum</td><td>Maximum</td></tr>
<tr><td>Executive Director of Finance</td><td>£154,000</td><td>£182,000</td></tr>
<tr><td>Executive Director of Nursing</td><td>£143,000</td><td>£170,000</td></tr>
<tr><td>Medical Director</td><td>£143,000</td><td>£170,000</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Other Director level posts</td><td>£121,000</td><td>£158,000</td></tr>
</table>

REM-DEC-22-03 The committee agreed the salaries of all directors within the above ranges and confirmed that they would not consider any salary in excess of the nationally recommended pay ranges.

REM-DEC-22-04 The committee also considered the salaries for those place directors that are joint appointments with the Local Authorities and who will remain employee of the local authority - the same criteria was applied and again no salary will exceed the pay ranges above.
</td></tr>
</table>

Decision /Action Log Ref No.	Meeting Date	Issues considered
REM-AC-22-02		The Committee agreed to the recommendations on VSM pay for all individuals in scope. Discussion took place on the need to develop a performance management framework for director level posts and a proposal will be considered at a future committee meeting. **Retention of talent** The committee discussed a paper on how the talent that exists in the ICB can be retained and the commitment that the organisation wishes to give to staff that we will endeavor to secure for all and seek to avoid compulsory redundancy during any change process. Further work will be undertaken on the development of a staff charter to incorporate this approach.

4. Issues for escalation to the ICB Board

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

Decision /Action Log Ref No.	Meeting Date	Issue for escalation
-	01.07.22	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 / Action Log Ref No.	Meeting Date	Recommendation from the Committee
REM-AC-22-01	01.07 22	**Terms of Reference** The Committee considered its Terms of Reference and made a number of minor proposed amendments for consideration. The changes were to be collated and circulated to Committee members ahead of further consideration at the September meeting of the Committee.

6. Recommendations

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

- **note** the contents of the report

7. Next Steps

7.1 **The following will happen:**

- the ICB Chief People Officer will confirm to individuals concerned the outcome of the approval of the recommendations within the ICB Very Senior Manager Pay Framework
- the ICB Chief People Officer will progress development of a draft model of principals for partner member remuneration to be circulated for consideration by the Remuneration Committee.

NHS
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NHS Cheshire and Merseyside Integrated Care Board Meeting

ICB Financial Plan / Budget 2022/23

04 August 2022

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS Cheshire and Merseyside

Date of meeting:	04 August 2022
Agenda Item No:	ICB/8/22/09
Report title:	ICB Financial Plan / Budget 2022/23
Report Author & Contact Details:	Mark Bakewell (Deputy Director of Finance)
Report approved by:	Claire Wilson (Executive Director of Finance)

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

Plan updates have previously been presented to the Cheshire and Merseyside System Oversight Board and Finance Committee.

Executive Summary and key points for discussion

This paper presents the final financial plan for Cheshire and Merseyside Integrated Care System (C&M ICS) for 2022/23 and sets out proposed budgets for the Integrated Care Board (ICB) for the same period.

Development of the operational plan for the year has been subject to engagement and collaboration across all NHS organisations in the system over recent months and has been developed in line with the national NHS planning guidance requirements. Oversight and assurance to has been provided via the System Oversight Board and Finance Committee and a final plan submission was made on 20th June 2022.

The Board is asked to note the £30.3m deficit position for C&M ICS which consists of a £19.7m forecast surplus within the Integrated Care Board (ICB) and a £50.0m deficit within NHS providers. Both positions are detailed within this paper including the level of savings required in order to achieve this planned deficit position.

It should be noted the 2022/23 financial year period, covers 3 months of CCG existence (between April – June 2022) and 9 months of the ICB from 1st July 2022, but the system has been working collectively during this period to form a single planning process.

Each Integrated Care System was required to submit a revised version of its financial plans on the 20th of June 2022. This resubmission was based on requirements for financial position improvement from a previous deficit position and to reflect the additional funding announcement in respect of inflationary pressures.

The paper also describes the intended approach towards an initial programme expenditure split for budgetary control purposes between 'Central ICB' and 'Place' budgets for the 2022/23 financial year.

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Recommendation/ Action needed:	**The Board is asked to:** • **support** the financial plan submission made on the 20 June 2022 by the ICB / ICS in relation to the 2022/23 financial year including resource and expenditure assumptions, particularly noting the level of efficiencies required to achieve the planned deficit position. • **approve** the proposed initial split for budgetary control purposes between 'Central ICB' and 'Place' budgets for the 2022/23 financial year resulting in a headline 20% / 80% split respectively.

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:	
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	
4. Building systems for integration and collaboration	X

Governance and Risk						
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*) Financial Planning requirements						
What level of assurance does it provide?						
Limited		**Reasonable**	X	**Significant**		
Any other risks? Yes / No. If **YES** please identify within the main body of the report.						
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) Yes – Approval of Financial Plan						
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. No						
Any current services or roles that may be affected by issues as outlined within this paper? No						

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	Process Undertaken & Impact Considerations	Yes	No	N/A	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
Document Development	Financial – any resource impact?			X	
	Patient / Public Involvement / Engagement			X	
	Clinical Involvement / Engagement			X	
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?			X	
	Regulatory or Legal - any impact assessed or advice needed?			X	
	Health Inequalities – any impact assessed?			X	
	Sustainable Development – any impact assessed?			X	

Next Steps:	

Responsible Officer to take forward actions:	Claire Wilson, Executive Director of Finance

Appendices:	None

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ICB Financial Plan / Budget 2022/23

1. Executive Summary

1.1 This paper presents the final financial plan for Cheshire and Merseyside Integrated Care System (C&M ICS) for 2022/23. Plan development and assurance has been undertaken prior to submission on 20 June 2022 by the ICB predecessor forum – the Cheshire and Merseyside System Oversight Board.

1.2 The Board is asked to note the £30.3m deficit position for C&M ICS which consists of a £19.7m forecast surplus within the Integrated Care Board (ICB) and a £50.0m deficit within NHS providers. Both positions are detailed within this paper including the level of savings required in order to achieve this planned deficit position.

1.3 It should be noted the 2022/23 financial year period, covers 3 months of CCG existence (between April – June 2022) and 9 months of the ICB from 1st July 2022, but the system has been working collectively during this period to form a single planning process.

1.4 The paper also describes the intended approach towards an initial programme expenditure split for budgetary control purposes between 'Central ICB' and 'Place' budgets for the 2022/23 financial year.

2. Introduction / Background

2.1 The Cheshire and Merseyside operational planning process has been in development since February 2022 and has been subject to engagement and collaboration across all NHS organisations in the system. Oversight and assurance to has been provided via the System Oversight Board and Finance Committee and a final plan submission was made on 20 June 2022.

2.2 Each Integrated Care System was required to submit a revised version of its financial plans on the 20 June 2022. This resubmission was based on requirements for financial position improvement from a previous deficit position and to reflect the additional funding announcement in respect of inflationary pressures.

3. ICB Financial Plan

3.1 **Integrated Care Board Financial Plan.** The net financial position of the ICB statutory body for the 2022/23 financial year is shown in the below table, reflecting a £19.7m surplus plan.

	£'000s
Total ICB Allocation (confirmed and non-confirmed)	5,696,711
Total ICB Forecast Expenditure (total intra and inter system)	(5,677,042)*
Surplus/(deficit) for the period/year	**19,669**

(* Negative indicates expenditure)

3.2 **Revenue Resource Allocations.** The below table summarises the resource allocations available to Cheshire and Merseyside ICB for the 2022/23 financial year totaling £5.697bn

ICB Recurrent Allocations	£'000
ICB Programme Allocation	4,795,169
Ockenden Funding	3,731
Primary Medical Care Services	450,704
Running costs	48,138
ICB Programme Allocation – Additional Funding	52,901
Total ICB recurrent Allocation	**5,350,643**
ICB Non-Recurrent Allocation	
Health Inequalities Funding	11,537
Elective Services Recovery Funding	91,510
COVID Funding	108,915
Service Development Fund (SDF)	114,348*
ICB Programme Allocation – Additional Funding	19,758
Total ICB Non-Recurrent Allocation (confirmed)	**346,068**
Total ICB Allocation	**5,696,711***

* SDF – Of which £32.6m is indicative

3.3 Allocations for the 2022/23 financial year, include the 3 month period of CCG life span (up to June 2022) and then the ICB for 9 month period from 1st July 2022– March 2023. CCG expenditure during the first 3-month period will be matched by resource allocations to result in an overall break-even period as a central adjustment and will be from within the overall annual resource allocation for the full financial year. Values are presented on a full year basis

3.4 As per table above, it should be noted that of the £5.7bn resource for the 2022/23 financial year around £346m is non-recurrent in nature and specifically includes allocations for Elective Recovery and COVID-19, which are not currently expected in 2023/24 and will have a further impact on the underlying position of the ICB unless expenditure is also managed non-recurrently.

3.5 The ICB has also been subject to a reduction to its resource allocation relating to 'convergence' of £52m which reflects its distance from target allocation for the 2022/23 year (currently estimated at £350m). Further movement towards target allocation are expected in future years which would result in further efficiency requirements.

3.6 **Revenue Expenditure Summary.** The below table provides further information on planned ICB expenditure for the 2022/23 financial year across both programme and running costs resulting in an overall spend of £5.677m, however it should be noted that this includes a number of planning assumptions that are set out later in this paper which will need to be carefully monitored and risks appropriately managed.

ICB Total Expenditure	**£'000**
Acute Service Expenditure	(2,932,923)
Mental Health Service Expenditure	(549,593)
Community Health Service Expenditure	(482,965)
Continuing Care Service Expenditure	(316,353)
Primary Care Medical Service Expenditure	(486,206)
Primary Care Services Expenditure	(570,143)
Other Programme Expenditure	(289,051)
Total ICB Commissioning (Programme) Expenditure	**(5,627,234)**
Total ICB Running Costs	(49,808)
Total ICB Expenditure	**(5,677,042)**

3.7 Due to the current deficit position, the ICB does not include any 'contingency' or 'un-allocated' reserves within its 2022/23 plan assumptions.

3.8 **Planning Assumptions.** The above expenditure values include a number of assumptions that have been used to forecast annual expenditure levels.

- inclusion of prior system commitments set out in the table below.
- there have been several other system assumptions made for 2022/23 financial year based on previous commitments and efficiency requirements.

3.9 These key assumptions are included within the below tables.

Pre-commitment Expenditure Assumptions	**22/23 Budgets £m**
Prior Commitments • HSLI - £4.0M • Longmoor House - £1.95m • Stroke (North Mersey) - £2.0m (Based on PCBC) • FIT Testing - £0.5m	£8.45m
Total	**£8.45m**

Other System Assumptions	**22/23 Budgets £m**
Assumed SDF Contribution (non-C&M)	(£9.6m)
Brokerage Agreements (ICB – Drawdown Slippage)	(£3.0m)
Other System Efficiency Assumptions	(£14.2m)
Total	**(£26.8m)**

3.10 A general ICB efficiency requirement of £68.8m against forecast expenditure is also required within the plan (further detail included in CCG level information section below)

3.11 **CCG Level Information.** The full year financial plan is a combination of 3 months of CCG allocation / expenditure assumptions and 9 months of likely ICB spend levels. Further information is included in the below table regarding respective CCG level position (and is linked with later section regarding place level delegation and reporting arrangements from 1 July 2022).

3.12 Of the £5.697bn allocation, £32.56m remains indicative in relation to SDF funding. It is not anticipated that the indicative allocations result in any additional risk to the system but will only be transacted by NHS England later in the financial year and are not reflected fully in plan submissions in line with guidance.

3.13 Savings requirement at CCG/Place level are as per below table, with planned efficiency savings being required to be generated from non-NHS provider budget expenditure categories as a result of the agreed 22/23 financial approach for the ICB (fixed contracts values for NHS providers which account for around £3.4bn or 60% of annual expenditure).

3.14 The below table shows savings requirements at historic CCG level and equate to savings in the region of 4%- 4.5% of influenceable spend given the above approach in the 2022/23 financial year.

CCG / ICB	Plan (Deficit) / Surplus	Efficiencies £
	£ 000's	£ 000's
NHS HALTON CCG	(3,340)	(3,570)
NHS KNOWSLEY CCG	12,051	(5,412)
NHS SOUTH SEFTON CCG	(4,051)	(3,300)
NHS SOUTHPORT AND FORMBY CCG	(6,336)	(2,788)
NHS ST HELENS CCG	(1,905)	(6,266)
NHS WARRINGTON CCG	(2,302)	(5,043)
NHS WIRRAL CCG	7,499	(9,058)
NHS CHESHIRE CCG	(27,663)	(18,908)
NHS LIVERPOOL CCG	18,259	(14,415)
Total CCG Position	(7,788)	(68,760)
NHS LIVERPOOL CCG - as ICB Host	27,457	(23,825)
Total ICB Planned (Deficit) / Surplus	19,669	**(92,585)**

3.15 The ICB efficiency plans will need to be closely monitored and progress will be reported to the Board each month. There will be an assessment undertaken following the Q1 period and review of CCG delivery for the 1st quarter and residual requirements for the ICB / place for Q2-4.

3.16 **System (ICS) Position.** The submissions made by NHS providers in relation to Cheshire & Merseyside providers as part of the overall ICS plan are as per the below table, this includes values associated with the level of cost improvement savings required within the 2022/23 financial year.

Cheshire & Merseyside Provider Organisation	Surplus / (Deficit) £'000s	Level of Saving Requirements £ '000s	Savings as % of total forecast expenditure
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4,630	14,496	4.10%
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	0	4,197	4.67%
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	2,856	8,274	3.73%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	(3,066)	13,396	4.25%
EAST CHESHIRE NHS TRUST	(2,554)	5,498	2.88%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2,328	4,890	2.33%
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	(30,010)	75,000	6.80%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	563	5,603	3.92%
MERSEY CARE NHS FOUNDATION TRUST	5,698	22,784	3.52%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	(10,415)	16,772	4.81%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	(14,175)	10,800	4.36%
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	(4,949)	28,100	5.42%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1,621	6,765	2.72%
THE WALTON CENTRE NHS FOUNDATION TRUST	2,868	4,947	3.02%
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	(6,106)	15,730	4.87%
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	684	4,100	4.21%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	19	20,837	4.74%
TOTAL	**(50,008)**	**262,189**	**4.63%**

3.17 **Financial planning risks and assumptions**

- ambitious and challenging efficiency plans in both ICB and provider plans which equate to approx. 4.4%. Successful delivery of these plans will be critical in supporting not only the in year delivery of the plan but also need to be delivered recurrently in order to support future financial sustainability of the system.
- assumes full delivery of activity plans and receipt of 100% of available system Elective Recovery Fund income (approximately £115m).
- assumes COVID-19 activity is stable through the year at levels estimated in national panning guidance assumptions (at approx. 2% bed occupancy) which will present a particular risk over the winter months.
- challenges continue to be faced significant levels patients in acute beds who no longer meet criteria to reside, this continues to be a key area of focus for local system partners in each place.

3.18 **ICB / Place Level Reporting.** ICB Budgets are proposed to be split into three categories

- Budgets to be held and managed at ICB Level
- Budgets to be held at Place Level
- Running Costs (to be held at ICB Level but with an agreed place-based structure that will be monitored appropriately at local level once agreed).

3.19 Appendix 1 provides an overarching summary of the intended approach to delegation of budget, either to be centrally at ICB level or held at place and managed in accordance with the ICB scheme of delegation.

3.20 This results in the following apportionment of 2022/23 budgets as per the below table and results in a 80% / 20% indicative split of budgets between place / ICB. This will be reviewed for 2023/24 as the wider system operating model is developed.

	ICB £ 000's	Place £ 000's	Total **£ 000's**
Acute Services	422,063*	**2,510,860**	**2,932,923**
Total ICB Acute Service Expenditure	**422,063**	**2,510,860**	**2,932,923**
Mental Health Services	47 *	549,546	**549,593**
Total ICB Mental Health Service Expenditure	**47**	**549,546**	549,593
Community Services	39,224*	443,741	**482,965**
Total ICB Community Health Service Expenditure	**39,224**	**443,741**	**482,965**
Continuing Care Services	0	**316,353**	**316,353**
Total ICB Continuing Care Service Expenditure	**0**	**316,353**	**316,353**
Primary Medical Services - General Practice Core Contracts / National Requirements	448,094		**448,094**
'Local' Enhanced services		38,111	**38,111**
Pharmacy Services *			***0***
Total ICB Primary Medical Services Expenditure	**448,094**	**38,111**	**486,206**
Prescribing / Oxygen		485,349	**485,349**
Out of Hours	26,668		**26,668**
PC – Other	41,026	563	**41,589**
GP IT Costs	16,537		**16,537**
Total ICB Primary Care Service Expenditure	**84,231**	**485,912**	**570,143**
Total ICB Other Programme Service Expenditure	**95,374**	**193,678**	**289,052**
Total ICB Commissioning Service Expenditure	**1,089,033**	**4,538,201**	**5,627,234**
Total ICB Running Costs	**49,808**	**0**	**49,808**
Total ICB Expenditure	**1,138,841**	**4,538,201**	**5,677,042**
	20%	80%	

3.21 ICB held budgets within Acute / Mental Health / Community Categories relate to 'Top-Up' / COVID / ERF' and 'Inter' / 'LVA' adjustments.

3.22 **CCG / Place.** With regards to budget allocations at place level, further work is required ahead of the 2023/ 24 financial year to review allocation formula and implications at a local level and also to align to national workstreams in this area are updated. It should be noted that the change in 'footprints' between CCG and 'Place' will need to be reflected within the new reporting arrangements to include

- the merging of 2 Sefton CCG's into 1 'Sefton' place and
- the split of NHS Cheshire CCG into 2 'Places' in the form of Cheshire East and Cheshire West.

3.23 **NHS Cheshire CCG.** Further analysis has been undertaken with regards to the requirements of splitting of Cheshire CCG into East & West Cheshire place budgets, with a proposal initially discussed by the CCG Finance & Resource Sub Committee in June 2022.

A number of options have been considered:

- **Option 1:** Based on use of legacy CCG resource allocations (back to 2019/20 financial year)
- **Option 2:** based on use of derived expenditure values from the 2021/22 financial year to reflect contractual commitments relating to each 'place'.
- **Option 3:** 'hybrid' option, building upon option 1 but to reflect allocation growth /changes over the period.

3.24 Following discussion at CCG Finance and Resource Committee in June 2022, option 2 is recommended as the basis for the 2022/23 financial year with no material difference identified between option 2 and 3. A wider piece of work will be undertaken ahead of 2023/24 financial year in respect of place level allocations.

3.25 **Indicative Place Budgets.** Therefore, with regards to the apportionment of place level budgets between the 9 places the proposed values can be seen in the below table.

	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral	**Grand Total**
Acute Service Expenditure	323,470	337,915	136,722	171,836	527,707	278,568	195,725	195,218	343,699	**2,510,860**
Mental Health Service Expenditure	66,940	65,398	30,488	37,151	121,519	60,855	47,231	45,887	74,078	**549,546**
Community Health Service Expenditure	60,104	44,169	22,917	34,040	104,320	61,851	29,360	29,965	57,016	**443,741**
Continuing Care Services	54,312	45,081	14,341	15,245	59,751	33,161	22,111	24,044	48,309	**316,353**
Local Primary Care & Prescribing Expenditure	73,322	70,518	24,920	34,722	106,813	65,193	40,753	35,694	72,087	**524,023**
Other Programme	19,187	21,170	17,831	19,797	32,564	28,196	25,743	10,678	18,512	**193,678**
Grand Total	**597,335**	**584,251**	**247,219**	**312,791**	**952,673**	**527,824**	**360,923**	**341,486**	**613,700**	**4,538,201**

3.26 Contract Information continues to be developed at place level reflecting submitted plan values at the time of submission, but will iterate during the course of the financial year due to below:

- Confirmation / Distribution of 'anticipated' SDF funding
- Confirmation of Mental Health Investment Funding
- Confirmation of other resource allocation adjustments.

3.27 With regards to the key aspects of 'place' budgets in 2022/23 and responsibilities at place level the following should be noted.

3.28 Given the continuation of 'fixed contract values' with NHS providers for the financial year and alignment with plan submission, there should be no variance from planned values in these areas of programme expenditure, with any additional investments needing to be considered in line with ICB governance and scheme of delegation.

3.29 Any areas of 'contract overperformance' will need to monitoring by respective ICB / Place leads and associated budget managers as per normal financial management arrangements with the requirement for the ICB to understand the drivers and available mitigations as appropriate.

3.30 Given the above, place leadership team will be required to consider to management of 'influenceable' spend at place level (in areas such as prescribing, continuing / packages of care, local pooled budgets) alongside the delivery of relative share of required savings 'inherited' from predecessor CCG plans. Place leadership teams will need to consider the relative balance between recurrent and non-recurrent savings opportunities and consider the underlying financial position of the ICB in all local decision-making process regarding financial investment / savings decisions.

3.31 Regular reviews will be undertaken of the governance architecture (including Standing Financial Instructions, Scheme of Reservation and Delegation, Authorised Signatory List) during 22/23 financial year to ensure that there is an effective system in place, particularly as the ICB works through the implications of the operating model between central and place-based approaches.

4. Recommendations

4.1 The board are asked to:

- **support** the financial plan submission made on the 20th June 2022 by the ICB / ICS in relation to the 2022/23 financial year including resource and expenditure assumptions, particularly noting the level of efficiencies required to achieve the planned deficit position.
- **approve** the proposed initial split for budgetary control purposes between 'Central ICB' and 'Place' budgets for the 2022/23 financial year resulting in a headline 20% / 80% split respectively.

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Appendix One

ICB Expenditure Category	Cheshire & Merseyside ICB Level	Place	Rationale / Supporting Notes
Programme			
Acute			
Acute Services – NHS Providers	x*	x	Contracts Held by ICB Level but managed by lead 'place' Contract Expenditure budgets split at place level (with budgets held by each place) includes Ambulance contracts * ICB to manage 'Inter' contracts (e.g Non C&M Providers) at system level * ICB hold system resources for Top-Up / COVID / ERF
Acute Services - Independent / Commercial Sector		x	Contracts Managed at Place Level, Reporting at Place Level when / where available
Acute Services - Other Non - NHS		x	Contracts Managed at Place Level, Reporting at Place Level when / where available
Acute Services - Other Net Expenditure		x	Contracts Managed at Place Level, Reporting at Place Level when / where available
Community			
Community Services – NHS Providers	x*	x	Contracts Held by ICB Level but managed by lead 'place' Contract Expenditure budgets split at place level (with budgets held by each place) * ICB to manage 'Inter' contracts (e.g Non C&M Providers) at system level
Community Services - Independent / Commercial Sector		x	Locally Commissioned Community Contracts Managed at 'Place Level' e.g Care Home, AQP Contracts
Community Services - Other Non - NHS (Voluntary, Hospice)		x	Locally Commissioned Community Contracts held at 'Place Level'
Mental Health			
Mental Health Services - NHS	x*	x	Contracts Held by ICB Level but managed by lead 'place' Contract Expenditure budgets split at place level (with budgets held by each place) * ICB to manage 'Inter' contracts (e.g Non C&M Providers) at system level

ICB Expenditure Category	Cheshire & Merseyside ICB Level	Place	Rationale / Supporting Notes
Mental Health Services - Independent / Commercial Sector		x	Contracts Managed at Place Level, Reporting at Place Level when / where available
Mental Health Services - Other Non – NHS / Other Net		x	Locally Commissioned Community Contracts held at 'Place Level'
Continuing Health / Packages of Care			
Continuing Health / Packages of Care (Adults & Childrens)		x	Consistent Model across C&M, local implementation
Learning Disability and Autism Placement Costs		x	
Funded Nursing Care		x	
Personal Health Budgets		x	
Primary Care			
i) General Practice Core & Nationally Determined Contract Payments including			
GMS / PMS / APMS	x		Based on National Contracts / Guidance
National Enhanced Services	x		Based on National Contracts / Guidance
Premises	x		Based on National Contracts / Guidance
QOF	x		Based on National Contracts / Guidance
Investment and Impact Fund (IIF)	x		Based on National Contracts / Guidance
Additional Roles Reimbursement Scheme	x		Based on National Contracts / Guidance
GP Out Of Hours Contracts	x		
Other Primary Care Costs (Locum / Workforce Development)	x		
Local Enhanced Services		x	
Local Investment (Quality Improvement etc)		x	
ii) Primary Care Dental Contracts			
Core Contract	*x*		*Not Applicable until 23/24*
Local Enhanced Services		*x*	*Not Applicable until 23/24*
iii) Primary Care Optometry Contracts			*Not Applicable until 23/24*
Core Contract	*x*		*Not Applicable until 23/24*
Local Enhanced Services		*x*	*Not Applicable until 23/24*
iv) Community Pharmacy Contracts			
Core Contract	x		From Q1 22/23

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ICB Expenditure Category	Cheshire & Merseyside ICB Level	Place	Rationale / Supporting Notes
Local Enhanced Services		x	From Q1 22/23
GPIT	x		
Prescribing			
Primary Care Prescribing (Inc Oxygen)		x	
Other Programme examples			
Better Care Fund		x	
Estates (Subsidies / Voids / Other Costs)		x	
NHS 111		x	
Patient Transport		x	

Noting further work required during 22/23 to ensure consistency of reporting approach in relation to previous CCG approaches

NHS
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NHS Cheshire and Merseyside Integrated Care Board Meeting

Cheshire and Merseyside System Finance Report – Month 3 (June 2022)

04 August 2022

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS Cheshire and Merseyside

Date of meeting:	04 August 2022
Agenda Item No:	ICB/8/22/10
Report title:	Cheshire and Merseyside System Finance Report – Month 3 (June 2022)
Report Author & Contact Details:	Mark Bakewell – Deputy Director of Finance
Report approved by:	Claire Wilson – Executive Director of Finance

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
n/a

Executive Summary and key points for discussion

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.

Recommendation/ Action needed:	**The Board is asked to:** • **Note** the contents of this report in respect of the Month 3 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.

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:

The item involves sensitive HR issues	n/a
The item contains commercially confidential issues	n/a
Some other criteria. Please outline below:	n/a

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	
4. Building systems for integration and collaboration	

Governance and Risk					
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*) **Yes, delivery of required position / financial performance**					
What level of assurance does it provide?					
Limited		**Reasonable**	x	**Significant**	
Any other risks? **Financial risks associated with delivery of financial position set out in the paper**					
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) **Yes, delivery of required position / financial performance**					
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken.					
Any current services or roles that may be affected by issues as outlined within this paper? **No**					

Document Development	**Process Undertaken & Impact Considerations**	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?			X	
	Patient / Public Involvement / Engagement			X	
	Clinical Involvement / Engagement			X	
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?			X	
	Regulatory or Legal - any impact assessed or advice needed?			X	
	Health Inequalities – any impact assessed?			X	
	Sustainable Development – any impact assessed?			X	

Next Steps:	Continued monitoring of Financial Forecasts for revenue and capital allocations

Responsible Officer to take forward actions:	Mark Bakewell – Deputy Director of Finance

Appendices:	Appendices 1-3 gives details of the narrative in the main body of the report.

System Finance Report to 30th June 2022 (Month 3)

1. Executive Summary

1.1 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, 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.

1.2 **M3 Year to Date performance – Revenue.** As at 30th June 2022 (Month 3), the ICS 'System' is reporting an aggregate deficit of £25.4m against a planned deficit of £27.0m resulting in a favourable year to date variance of £1.6m mainly as a result of better than expected performance on the CCG / ICB during quarter 1. As set out in the table below, this is due to a year-to-date surplus position of £11.9m in the CCG / ICB (compared to a plan profile value of £5.0m) offset by year-to-date deficit in the NHS providers of £37.3m (compared to plan profile of £32.0m).

Sector	2022/23 Annual Plan *(20th June submission)* £m Surplus / (Deficit	2022/23 YTD Plan *(20th June submission)* £m Surplus / (Deficit)	2022/23 Performance to 30th June 2022 £m	Variance £m Surplus / (Deficit)
CCG / ICB	20.0	5.0	11.9	6.9
NHS Providers Trusts	(50.0)	(32.0)	(37.3)	(5.3)
Total	**(30.0)**	**(27.0)**	**(25.4)**	**(1.6)**

1.3 **Year to Date performance – Capital.** As at 30th June, progress of the system's local operational capital programme expenditure remains below year to date planned values by £5m and £12.6m respectively, as described in the below table. There is a similar position in respect of the national capital programme with a £6.6m variance to plan but it should be recognised that the reporting period is still based on information as at May 2022 (Month 2).

	22/23 Annual Plan values £m (exc IFRS 16)	Month 3: Charge against Capital Allocation (excluding IFRS 16 impact) £m	22/23 Annual Plan values £m (inc IFRS 16)	Month 3: Charge against Capital Allocation (including IFRS 16 impact) £m	Month 2: National programmes and other items chargeable to CDEL £m
Plan Expenditure	224.7	18.8	250.1	37.8	26.5
Actual / Forecast Expenditure	224.7	13.8	250.1	25.2	19.9
Variance to Plan (under) / over	**0**	**(5.0)**	**0**	**(12.6)**	**(6.6)**

2. Introduction

2.1 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.

2.1 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 One.

2.2 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.

2.3 At the end of quarter one and in all financial performance circumstances, CCGs will 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.

3. Month 3 (June) Performance

3.1 **CCG/ICB performance.** The table below summarises the combined CCG position for quarter 1 of the 2022/23 financial year resulting in a year-to-date cumulative surplus position of £11.9m compared to a year to date plan figure of £5.0m.

	2022/23 M3 YTD PLAN Surplus / (Deficit) £m	2022/23 M3 YTD ACTUAL Surplus / (Deficit) £m	2022/23 M3 YTD VARIANCE Surplus / (Deficit) £m
CCGs:			
NHS Cheshire CCG	(6.9)	(7.1)	(0.2)
NHS Halton CCG	(0.8)	0.4	1.2
NHS Knowsley CCG	3.0	3.8	0.8
NHS Liverpool CCG	11.5	5.7	(5.9)
NHS South Sefton CCG	(1.0)	2.2	3.2
NHS Southport and Formby CCG	(1.6)	(0.2)	1.4
NHS St Helens CCG	(0.5)	0.6	1.0
NHS Warrington CCG	(0.6)	0.0	0.6
NHS Wirral CCG	1.9	6.7	4.8
	5.0	**11.9**	**6.9**

3.2 As per the above table (also Appendix One), 7 out of the 9 CCG's have achieved a year-to-date surplus position for months 1-3, with a favourable position compared to profiled plan for the quarter one period. This has largely been achieved due to favourable movements compared to 2021/22 year end assumptions across the majority of CCG's, but as there is a time lag of up to date information in a number of programme expenditure areas (e.g 6 week time lag in prescribing information) it is difficult to confirm in-year run rates compared to plan values and therefore forecast outturn assumptions in the context of the below.

3.3 These movements are therefore fortuitous in relation to the 2022/23 financial year and are in the majority of cases non-recurrent benefit. These favourable variances and also need to consider against the relatively high level of 'QIPP' savings that are built into CCG / ICB planning assumptions (in the region of 4%-4.5% of influenceable spend), with an element still high risk and requiring further assurance to be provided during the remainder of the financial year by relevant ICB / Place leads.

3.4 It should be noted that the Liverpool CCG 'surplus' position includes these C&M system 'host' assumptions during the q1 period (as per the agreement for the last 2 financial year) with the adverse year to date performance (compared to plan values) largely due to unmitigated system risk issues as set out in the financial plan and offset similar favourable movements in the direct CCG position.

3.5 However, in line with the above, as C&M CCGs have collectively underspent compared to plan at Q1 by £6.9m, this will be adjusted through a resource allocation adjustment process to result in the CCGs achieving a break-even to plan at Q1 close and will result in an equivalent transfer of resource to the ICB in M4-12.

3.6 CCG's have submitted Quarter 1 accounts during July'22 and will be audited during the latter part of the financial year as per national guidance received on approach to CCG / ICB audit arrangements.

3.7 **NHS Provider Performance.** The table below summarises the combined NHS provider position for Quarter One of the 2022/23 financial year resulting in a year-to-date cumulative surplus position of £37.3m compared to a year-to-date profile plan figure of £32.0m.

	2022/23 M3 YTD PLAN Surplus/ (Deficit) £m	2022/23 M3 YTD ACTUAL Surplus/ (Deficit) £m	2022/23 M3 YTD VARIANCE Surplus (Deficit) £m
Providers:			
Alder Hey Children's NHS Foundation Trust	(0.7)	(0.7)	0.0
Bridgewater Community Healthcare NHS Foundation Trust	(0.3)	(0.3)	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	0.4	0.4	(0.0)
Countess of Chester Hospital NHS Foundation Trust	(4.8)	(6.6)	(1.7)
East Cheshire NHS Trust	(1.5)	(1.5)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	0.6	0.6	0.0
Liverpool University Hospitals NHS Foundation Trust	(10.3)	(11.8)	(1.5)
Liverpool Women's NHS Foundation Trust	0.3	0.3	0.0
Mersey Care NHS Foundation Trust	0.6	0.6	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(4.9)	(5.3)	(0.4)
Southport And Ormskirk Hospital NHS Trust	(5.1)	(5.1)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(3.3)	(3.3)	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.4	0.6	0.2
The Walton Centre NHS Foundation Trust	0.5	0.6	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(4.3)	(4.6)	(0.2)
Wirral Community Health and Care NHS Foundation Trust	0.2	0.2	(0.0)
Wirral University Teaching Hospital NHS Foundation Trust	0.3	(1.5)	(1.7)
	(32.0)	**(37.3)**	**(5.3)**

3.8 As per the above table (also Appendix 1), 5 NHS provider Trusts have reported an adverse year to date deficit position for months 1-3, resulting in an adverse position compared to plan for the quarter one period of £5.3m.

3.9 Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£33.7m) offset set by favourable movements in Income (£13.4m) and non-pay items (£14.9m) as per the below table.

Surplus / (Deficit)	Year-to-date			
	Plan	Actual	Under/(over) spend	
	£m	£m	£m	%
Income excluding COVID Reimbursements	1,394.4	1,406.4	12.0	0.9%
COVID-19 Reimbursements	3.0	4.5	1.4	47.6%
Total Income	1,397.4	1,410.8	13.4	1.0%
Pay	(911.5)	(945.2)	(33.7)	(3.7%)
Non Pay	(493.6)	(480.1)	13.5	2.7%
Non Operating Items (exc gains on disposal)	(24.3)	(22.9)	1.4	5.9%
Total Expenditure	(1,429.5)	(1,448.2)	(18.7)	(1.3%)
C&M NHS Providers	**(32.0)**	**(37.3)**	**(5.3)**	**(0.4%)**

3.10 In respect of the individual trust positions, the following commentary has been provided by the organisations currently reporting an adverse performance against plan:

Countess of Chester NHS Foundation Trust

- The Trust is reporting an adverse variance of £1.7m against the M3 deficit position of £4.8m, overspending areas include: Nursing Pay £2.2m, Medical Pay £1.5m, Outsourcing Costs £0.9m, Drugs £0.3m and under-recovery of Car Parking Income £0.2m.
- The Trust currently has circa 50 Covid patients requiring cohorting, an increased number of non-elective patients and a high number of delayed transfers of care which has meant that the Trust has implemented its internal Serious Escalation Policy. Pressures relating to Cerner implementation and data validation are also contributing to this position.
- The Trust has weekly executive oversight meetings focussing on the financial position, and regular Trust Board challenge, linked to delivery of the Trust 's Improvement Plan (supported by NHS E/I, and following the recent adverse Care Quality Commission Report).
- The Emergency Care Intensive Support Team (ECIST) have also been working with the Trust to ensure that patient demand and capacity are better matched.
- Cost Improvement Programme delivery remains a challenge for the Trust, although work remains focused on reviewing all areas of potential and working with operational managers to build credible plans.

Liverpool University Hospitals NHS Foundation Trust (LUFT)

- LUHFT continues to operate in an extremely challenged environment with demand for services growing alongside an increase in COVID-19 cases. As a consequence, capacity opened on both the AUH and RUH sites as part of winter escalation remain open (4 wards). The higher incidence of COVID-19 has had an impact on staff attendance, resulting in the continued use of premium agency to cover gaps and maintain patient safety.
- The Trust is currently working with PWC and the ICB on an in-depth review of its financial plan for 2022/23, with a report expected towards the end of August. The Trust will use the outputs of this report, in conjunction with the ICB and relevant system partners to support the deliverability of a more sustainable financial position moving forward and achievement of its plan for the year.
- CIP delivery for Q1 is ahead of plan, with £15.6m delivered against a plan of £13.7m. The full year value of schemes currently sits at £51m and work continues within the organisation to identify further programmes of work, using relevant benchmarking such as model hospital and other tools, to build the remainder of the programme up to deliver the £75.0m efficiency target for the year.

Mid Cheshire NHS Foundation Trust (MCHFT)

- At month 3 MCHFT is reporting a variance £0.4m off plan with a deficit of £5.4m compared to a planned £5m deficit. In month, the pay costs remain high reflecting the continuation of unplanned care pressures which has resulted in an extended bed base above planned levels, the introduction of corridor care to support patients waiting in ED and high levels of premium pay costs associated with additional nursing, HCA and Medical workforce in order to staff the respective units safely. In addition, there has been an under recovery of visitor car parking income, relating to footfall at the Trust.
- The Trusts' efficiencies plan is phased for the latter months of the financial year, and currently of the £16.8m target, £9m has been identified in the full year forecast, presenting a risk for the latter months of the financial year. This challenge to the efficiency plan, along with the current levels of expenditure, are under constant review by the executive team, by the performance and finance committee and at the Trust Board. The balance of demand driven financial pressure and delivering efficiencies is in part hindered by the need to keep patients safe, particularly within the Trusts' Urgent Care department e.g. corridor care and unfunded bedded escalation areas, all of which are currently the highest risks on the Trust Boards' risk register.

Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH)

- WHH has a small variance from plan of £200k at the end of Q1. Drugs overspend continues to be an issue along with clinical supplies. The plan assumes costs relating to additional bed capacity and ED/flow pressures will be mitigated from quarter 2 and this remains a risk. The Trust is working to reduce the pressure of additional wards by permanently recruiting staffing for an unfunded ward to reducing premium staff costs. The Trust has now opened a Same Day Emergency Care unit to support pressures in ED.
- The Trust has worked with Warrington Place to access an Adaptive fund to support discharge, these posts will be recruited to over the summer and will improve flow, no criteria to reside patients (NCR) and reduce bed pressures.
- The Trust has achieved its CIP plan up to month 3, however, the profile is more challenging as the year progresses. To support this challenge the Trust has appointed a clinical GIRFT lead and is looking at adding further support to the GIRFT / CIP programme from the finance team. There is a weekly Finance meeting, led by the CEO, with Executives and Care groups to review CIP progress, highlighting blockers to progress and understand where activity targets are not being met and what action is needed.
- The Trusts forecast of £6.1m deficit is extremely challenging but it is a challenge that the Trust Board is signed up to. The Trust recognises the opportunities within GIRFT and Model hospital and is using this data as a focus to drive efficiency without impacting negatively on patient care.

The challenge has been made more difficult with the ongoing COVID-19 patients and staff sickness, the significant number of no criteria to reside (NCR) patients and the higher levels of ED attendance. The Trust has reviewed the support in place to get staff back to work from sickness and training is being rolled out to all managers.

Wirral University Teaching Hospitals NHS Foundation Trust

- The Trust currently has 40 beds in escalation, down from 55 in month 1, but is also staffing 4 corridors due to pressure on beds caused primarily by the high number of patients that do not meet the criteria to reside in hospital (over 200 patients). This has caused a £1.7m pressure at month 3.
- The Trust currently has a £8.3m shortfall in respect of recurrent CIP identified, a £4.4m net pressure in respect of escalation and corridor care and £2.8m adverse variance in respect of premium staffing (bank and agency staff).
- The Trust continues to forecast a break-even position for the year but given the pressures set out above, this is now a significant risk which is receiving the highest level of focus in the Trust.

3.11 **Other Performance Indicators - Cash & Better Payment Practice Code.** Total Provider cash levels have reduced by 12% from the level at the end of the 2022/23 financial year with aggregate provider balances at month 3 being £804m, compared with £912m at the end of 2021/22.

PROVIDER:	22/23 MONTH 3 ACTUAL £m	31/03/2022 BALANCE £m	% Change From MONTH 12 £m
Alder Hey Children's NHS Foundation Trust	81.1	91.5	(11.4%)
Bridgewater Community Healthcare NHS Foundation Trust	25.9	26.2	(1.1%)
Cheshire and Wirral Partnership NHS Foundation Trust	35.8	41.1	(12.8%)
Countess of Chester Hospital NHS Foundation Trust	38.0	40.9	(7.1%)
East Cheshire NHS Trust	38.9	37.3	4.3%
Liverpool Heart and Chest Hospital NHS Foundation Trust	40.6	42.7	(5.0%)
Liverpool University Hospitals NHS Foundation Trust	155.6	211.4	(26.4%)
Liverpool Women's NHS Foundation Trust	6.4	11.2	(42.8%)
Mersey Care NHS Foundation Trust	95.3	84.2	13.2%
Mid Cheshire Hospitals NHS Foundation Trust	17.7	26.7	(33.7%)
Southport And Ormskirk Hospital NHS Trust	7.7	18.5	(58.1%)
St Helens And Knowsley Teaching Hospitals NHS Trust	69.8	54.2	28.8%
The Clatterbridge Cancer Centre NHS Foundation Trust	69.5	80.7	(13.9%)
The Walton Centre NHS Foundation Trust	36.6	40.7	(10.1%)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	38.0	44.7	(14.9%)
Wirral Community Health and Care NHS Foundation Trust	18.2	23.8	(23.6%)
Wirral University Teaching Hospital NHS Foundation Trust	29.3	36.4	(19.5%)
Total System	**804.4**	**912.1**	**(12%)**

3.12 The Better Payment Practice Code remains an area of close system monitoring, as set out in the table below, only 3 providers are currently settling invoices by both value and number within the target.

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

	Month 3 22/23	
	BPPC Non NHS - By Value	BPPC Non NHS - By Number
Alder Hey Children's NHS Foundation Trust	57%	65%
Bridgewater Community Healthcare NHS Foundation Trust	100%	99%
Cheshire and Wirral Partnership NHS Foundation Trust	87%	78%
Countess of Chester Hospital NHS Foundation Trust	93%	83%
East Cheshire NHS Trust	100%	93%
Liverpool Heart and Chest Hospital NHS Foundation Trust	100%	98%
Liverpool University Hospitals NHS Foundation Trust	98%	86%
Liverpool Women's NHS Foundation Trust	82%	41%
Mersey Care NHS Foundation Trust	93%	94%
Mid Cheshire Hospitals NHS Foundation Trust	97%	66%
Southport And Ormskirk Hospital NHS Trust	93%	79%
St Helens And Knowsley Teaching Hospitals NHS Trust	86%	97%
The Clatterbridge Cancer Centre NHS Foundation Trust	99%	98%
The Walton Centre NHS Foundation Trust	73%	54%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	84%	84%
Wirral Community Health and Care NHS Foundation Trust	81%	79%
Wirral University Teaching Hospital NHS Foundation Trust	97%	92%

3.14 **Capital.** 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.

3.15 As per the table below, at month 3, progress of the system's operational capital programme expenditure remains below year-to-date planned values by £5m and £12.6m respectively. 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.

3.16 The position in relation to the national capital programme remains in a similar position with a £6.6m year to date underspend.

	22/23 Annual Plan values £m (exc IFRS 16)	Month 3: Charge against Capital Allocation (excluding IFRS 16 impact) £m	22/23 Annual Plan values £m (inc IFRS 16)	Month 3: Charge against Capital Allocation (including IFRS 16 impact) £m	Month 2: National programmes and other items chargeable to CDEL £m
Plan Expenditure	224.7	18.8	250.1	37.8	26.5
Actual / Forecast Expenditure	224.7	13.8	250.1	25.2	19.9
Variance to Plan (under) / over	**0**	**(5.0)**	**0**	**(12.6)**	**(6.6)**

3.17 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. Further detailed information is included in Appendix 3.

3.18 **Primary Care Capital.** Work on identifying the Primary Care Capital priorities for 2022/23, against the notified capital allocation of £4.7m is due to commence shortly through the North West Primary Care Capital Steering Group. This outcome, as well as year-to-date progress, and will be formally reported in due course.

4. Recommendations

4.1 **The Board is asked to:**

- **note** the contents of this report in respect of the month 3 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.

5. Officer contact details for more information

Claire Wilson
Executive Director of Finance
Cheshire and Merseyside ICB

Mark Bakewell
Deputy Director of Finance
Cheshire and Merseyside ICB

Appendix One – 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 Two

Combined Year-to-date Financial Position by Organisation: Month 3

	2022/23 PLAN £m	Month 3 ACT £m	Month 3 VAR £m
CCGs:			
NHS Cheshire CCG	(6.9)	(7.1)	(0.2)
NHS Halton CCG	(0.8)	0.4	1.2
NHS Knowsley CCG	3.0	3.8	0.8
NHS Liverpool CCG	11.5	5.7	(5.9)
NHS South Sefton CCG	(1.0)	2.2	3.2
NHS Southport and Formby CCG	(1.6)	(0.2)	1.4
NHS St Helens CCG	(0.5)	0.6	1.0
NHS Warrington CCG	(0.6)	0.0	0.6
NHS Wirral CCG	1.9	6.7	4.8
	5.0	**11.9**	**6.9**
Providers:			
Alder Hey Children's NHS Foundation Trust	(0.7)	(0.7)	0.0
Bridgewater Community Healthcare NHS Foundation Trust	(0.3)	(0.3)	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	0.4	0.4	(0.0)
Countess of Chester Hospital NHS Foundation Trust	(4.8)	(6.6)	(1.7)
East Cheshire NHS Trust	(1.5)	(1.5)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	0.6	0.6	0.0
Liverpool University Hospitals NHS Foundation Trust	(10.3)	(11.8)	(1.5)
Liverpool Women's NHS Foundation Trust	0.3	0.3	0.0
Mersey Care NHS Foundation Trust	0.6	0.6	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(4.9)	(5.3)	(0.4)
Southport And Ormskirk Hospital NHS Trust	(5.1)	(5.1)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(3.3)	(3.3)	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.4	0.6	0.2
The Walton Centre NHS Foundation Trust	0.5	0.6	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Tı	(4.3)	(4.6)	(0.2)
Wirral Community Health and Care NHS Foundation Trust	0.2	0.2	(0.0)
Wirral University Teaching Hospital NHS Foundation Trust	0.3	(1.5)	(1.7)
	(32.0)	**(37.3)**	**(5.3)**
Total System	**(27.0)**	**(25.4)**	**1.6**

Note: brackets denote deficit/overspend.

Appendix Three

Provider Capital: Current Performance and Forecast Outturn as at Month 3 (30th June 2022)

(based on formal reporting to NHSEI)

PROVIDER:	ORIGINAL 2022/23 PLAN £m	REVISED 2022/23 PLAN £m	M3 YTD ORIGINAL PLAN £m	M3 YTD ACTUAL £m	M3 YTD VARIANCE £m
Alder Hey Children's NHS Foundation Trust	8.9	8.9	1.2	0.6	0.6
Bridgewater Community Healthcare NHS Foundation Trust	2.1	2.1	0.7	0.1	0.7
Cheshire and Wirral Partnership NHS Foundation Trust	2.6	2.6	1.0	0.4	0.6
Countess of Chester Hospital NHS Foundation Trust	19.9	19.9	3.8	3.8	(0.1)
East Cheshire NHS Trust	6.1	6.1	0.2	0.2	(0.0)
Liverpool Heart and Chest Hospital NHS Foundation Trust	11.3	11.3	1.4	1.6	(0.1)
Liverpool University Hospitals NHS Foundation Trust	62.6	62.6	8.2	1.5	6.7
Liverpool Women's NHS Foundation Trust	8.8	8.8	3.6	2.4	1.2
Mersey Care NHS Foundation Trust	11.1	11.0	(0.3)	(2.3)	1.9
Mid Cheshire Hospitals NHS Foundation Trust	29.0	29.0	3.0	4.8	(1.8)
Southport And Ormskirk Hospital NHS Trust	11.3	11.3	1.8	0.4	1.4
St Helens And Knowsley Teaching Hospitals NHS Trust	4.5	4.5	0.6	0.5	0.1
The Clatterbridge Cancer Centre NHS Foundation Trust	7.0	7.0	0.1	0.1	(0.1)
The Walton Centre NHS Foundation Trust	5.7	5.7	0.5	0.0	0.5
Warrington and Halton Teaching Hospitals NHS Foundation	12.5	12.5	1.9	3.1	(1.2)
Wirral Community Health and Care NHS Foundation Trust	9.4	9.4	1.2	1.0	0.3
Wirral University Teaching Hospital NHS Foundation Trust	11.9	11.9	3.7	0.5	3.2
Total Charge against System Operational Capital	**224.8**	**224.7**	**32.6**	**18.8**	**13.8**

Note: brackets denote deficit/overspend

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Month Three (Quarter One) Performance Report

04 August 2022

NHS Cheshire and Merseyside Integrated Care Board Meeting

Date of meeting:	04 August 2022
Agenda Item No:	ICB/8/22/11
Report title:	Month Three (Quarter One) Performance Report
Report Author & Contact Details:	Anthony Middleton, Director of Performance and Planning, Anthony.middleton@cheshire&merseyside.nhs.uk
Report approved by:	Anthony Middleton

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
Formal route is via the Cheshire and Merseyside Integrated Care Boards Quality and Performance Sub-Committee. Due to timing of the establishment of the committee, this report is direct to board by exception.

Executive Summary and key points for discussion
The attached presentation provides on overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care and Primary Care, as well as a summary of key issues, impact and mitigations.

Recommendation/ Action needed:	The Board is asked to note the contents of this inaugural report and take assurance on the actions contained. The Board is also asked to note the that the format of this report will develop over future months and the feedback from the Board will be incorporated.

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:	
The item involves sensitive HR issues	n/a
The item contains commercially confidential issues	n/a
Some other criteria. Please outline below:	n/a

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

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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 ICB Board Assurance Framework or any other corporate or Place risk? (*please list*)						
What level of assurance does it provide?						
Limited		**Reasonable**		**Significant**		
Any other risks? No. If **YES** please identify within the main body of the report.						
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) n/a						
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. n/a						
Any current services or roles that may be affected by issues as outlined within this paper?						

Document Development	**Process Undertaken & Impact Considerations**	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?	X			Outlined in report
	Patient / Public Involvement / Engagement				
	Clinical Involvement / Engagement	X			Outlined in report
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?				
	Regulatory or Legal - any impact assessed or advice needed?				
	Health Inequalities – any impact assessed?				
	Sustainable Development – any impact assessed?				

Next Steps:	Any feedback received from Board members on the Performance Report will be incorporated into the future report format.

Responsible Officer to take forward actions:	Anthony Middleton

Appendices:	Presentation

NHS
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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 • 100 day discharge programme adopted across all 'Place' • Non recurrent bed capacity schemes mobilised using national funding. • Virtual Ward Roll expansion. • NWAS single triage development.	• August • End of Sept • From Sept • March '23 • Aug/Sept
Planned Care	• Comparatively strong recovery of activity levels with reducing long waits. • 2 providers holding greatest risk around 104 week waits. • Increasing outpatient initiated follow up rates.	• Use of independent sector • Mutual aid between providers • 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

NHS
Cheshire and Merseyside

Section I: Urgent Care

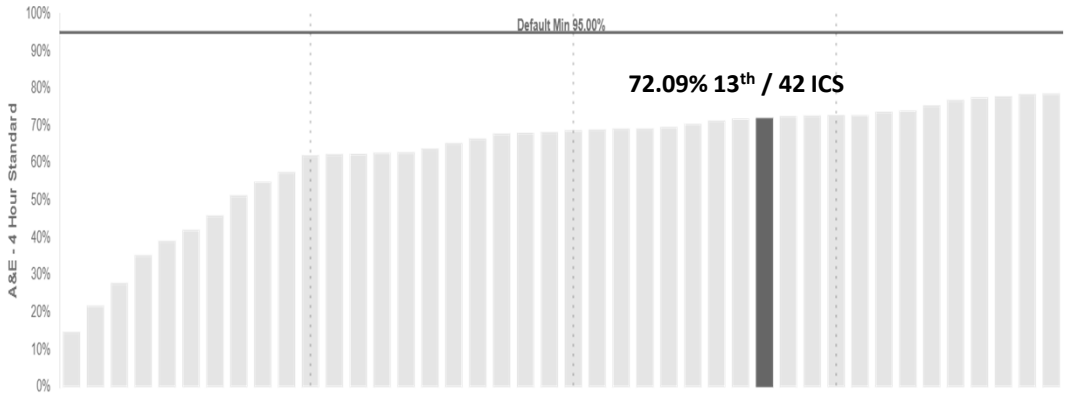
Sentinel Metrics:-

- 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 I: 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	Apr-22	May-22	Jun-22	July-22 *
Cheshire and Merseyside	72.51%	71.85%	72.09%	69.06%
North West	69.73%	71.18%	69.81%	N/A
England	64.65%	65.07%	64.31%	N/A

** July Position is latest unpublished data*

AED 4 Hr Performance ICS Provider Trend

ICS Providers

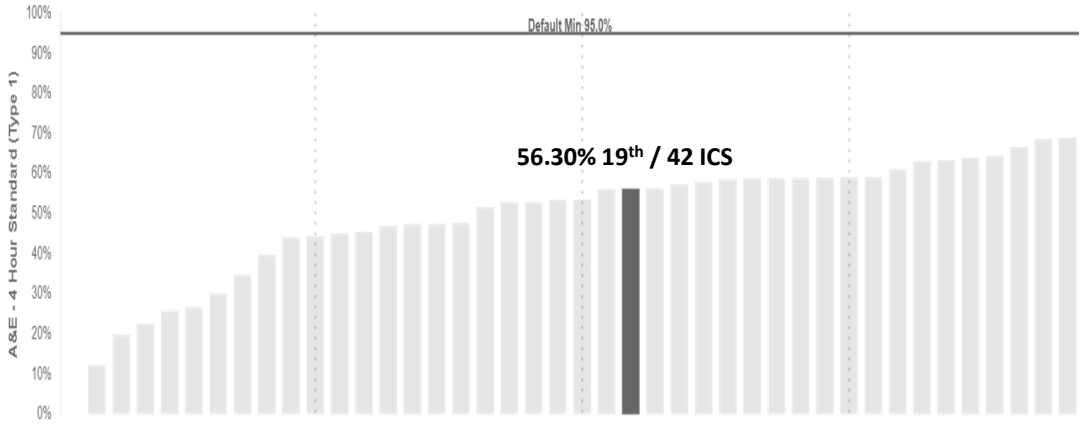
CCG Provider

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
Alder Hey	68.08%	88.11%	73.42%	72.46%	66.17%	74.59%	80.26%	77.06%	64.16%	72.62%	73.71%	77.73%
Bridgewater Community Healthcare	99.96%	99.96%	99.30%	97.83%	98.85%	98.99%	99.34%	95.92%	94.11%	93.73%	95.04%	96.60%
Countess of Chester Hospital	66.03%	63.24%	60.17%	58.75%	61.26%	60.73%	65.14%	65.03%	62.31%	57.37%	59.07%	59.59%
East Cheshire	60.30%	59.27%	56.66%	62.84%	61.77%	61.38%	64.03%	57.94%	55.22%	55.84%	54.83%	57.07%
Liverpool University Hospitals	65.90%	66.03%	64.59%	64.07%	63.98%	66.22%	68.66%	67.81%	66.94%	66.77%	65.98%	66.95%
Liverpool Women's	96.21%	96.31%	97.53%	96.72%	98.75%	95.77%	97.18%	94.38%	90.39%	90.97%	92.89%	92.17%
Mersey Care	99.68%	99.92%	99.66%	98.55%	98.81%	99.84%	99.39%	99.30%	99.72%	98.70%	95.44%	92.59%
Mid Cheshire Hospitals	66.20%	63.86%	62.43%	63.92%	67.41%	60.22%	60.87%	58.36%	56.18%	55.79%	59.86%	59.97%
Southport and Ormskirk Hospital	77.16%	77.19%	78.08%	77.42%	79.03%	78.27%	76.03%	75.33%	74.89%	80.55%	77.04%	77.70%
St Helens and Knowsley	67.95%	70.20%	70.31%	67.25%	70.00%	70.00%	69.33%	65.75%	64.45%	66.59%	65.78%	65.06%
Warrington and Halton Hospitals	72.64%	72.84%	73.42%	70.59%	70.38%	68.78%	69.72%	67.61%	68.72%	69.73%	70.50%	69.53%
Wirral Community	99.73%	99.48%	99.31%	98.70%	99.25%	99.70%	99.35%	99.28%	97.98%	99.14%	98.30%	97.35%
Wirral University Teaching Hospital	67.84%	66.28%	63.44%	62.61%	59.49%	60.57%	59.11%	63.05%	61.45%	63.13%	63.36%	64.52%

Section I: 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	Apr-22	May-22	Jun-22	July-22 *
Cheshire and Merseyside	54.30%	55.80%	56.30%	53.12%
North West	55.23%	56.19%	55.42%	N/A
England	51.76%	52.48%	51.40%	N/A

** July Position is latest unpublished data*

AED 4 Hr Performance (Type 1) ICS Provider Trend

ICS Providers

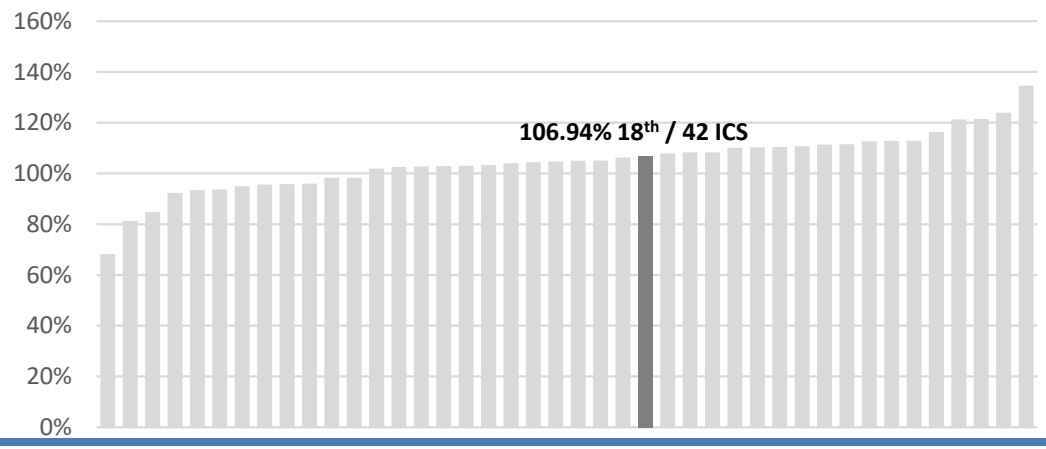
CCG Provider

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
Alder Hey	68.1%	88.1%	73.4%	72.5%	66.2%	74.6%	80.3%	77.1%	64.2%	72.6%	73.7%	77.7%
Countess of Chester Hospital	63.6%	60.6%	56.8%	55.7%	57.8%	58.0%	61.9%	62.0%	58.5%	54.5%	56.8%	57.5%
East Cheshire	60.0%	59.0%	56.5%	62.6%	61.6%	61.2%	63.8%	57.7%	54.9%	55.5%	54.5%	56.8%
Liverpool University Hospitals	54.1%	53.5%	52.1%	51.7%	51.7%	52.1%	54.5%	53.0%	51.6%	51.8%	51.7%	52.9%
Mid Cheshire Hospitals	55.5%	53.2%	51.4%	53.1%	57.2%	49.2%	49.4%	46.2%	41.9%	41.3%	45.8%	45.4%
Southport and Ormskirk Hospital	71.6%	70.9%	71.7%	70.6%	72.9%	71.7%	69.6%	68.1%	68.0%	76.1%	69.6%	70.3%
St Helens and Knowsley	50.9%	54.3%	54.5%	51.0%	55.4%	55.3%	55.7%	49.7%	48.0%	50.7%	48.7%	47.3%
Warrington and Halton Hospitals	64.5%	64.4%	64.7%	61.2%	60.9%	59.3%	59.6%	57.1%	59.0%	58.5%	60.5%	58.4%
Wirral University Teaching Hospital	58.5%	55.9%	51.4%	49.9%	46.6%	48.6%	46.9%	52.3%	49.6%	50.4%	51.1%	51.7%

Section I: 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	Apr-22	May-22	Jun-22	July-22 *
Cheshire and Merseyside	106.62%	107.82%	106.94%	100.46%
North West	104.45%	93.05%	108.27%	N/A
England	98.69%	102.39%	104.58%	N/A

** July Position is latest unpublished data*

AED Attendances (type 1): Provider Trend

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
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%
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%
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%
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%
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%
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%
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%
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%
Wirral University Teaching Hospital	112.94%	110.79%	107.50%	104.10%	102.70%	96.28%	103.85%	106.81%	111.00%	101.61%	109.24%	105.85%

Section I: 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	Mar-22	Apr-22	May-22
Cheshire and Merseyside	00:07:26	00:09:37	00:08:50
North West	00:09:04	00:08:31	00:08:00
England	00:09:35	00:09:02	00:08:36

Ambulance Response Times: Category Trend, Cheshire & Merseyside

Call category	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Ambulance Response Cat 1 Mean	00:07:11	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
Ambulance Response Cat 2 Mean	00:18:57	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
Ambulance Response Cat 3 90th Percentile	01:49:57	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
Ambulance Response Cat 4 90th Percentile	02:29:16	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

Section I: Urgent Care Performance: Ambulance Handover Times (Average Minutes) and Ambulance Handover times % over 60 minutes

NHS Cheshire and Merseyside

Ambulance Handover time (average minutes) – Standard is 30 minutes

Site	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Aintree University	00:23:23	00:26:16	00:27:05	00:28:51	00:24:21	00:25:27	00:26:48	00:27:07	00:28:13	00:31:50	00:26:20	00:25:21
Alder Hey	00:23:39	00:13:59	00:12:27	00:17:59	00:22:52	00:24:00	00:12:42	00:17:46	00:16:10	00:10:36	00:14:40	00:26:57
Arrowe Park	00:28:29	00:24:18	00:37:56	00:34:42	00:33:30	00:30:07	00:32:29	00:25:05	00:39:51	00:39:33	00:36:22	00:32:49
Countess of Chester	00:20:14	00:22:27	00:22:55	00:27:45	00:23:58	00:28:10	00:27:30	00:26:13	00:31:15	00:36:52	00:26:42	00:21:14
Leighton	00:20:32	00:20:08	00:21:18	00:22:49	00:20:51	00:20:25	00:19:38	00:22:08	00:24:13	00:24:02	00:24:12	00:23:23
Macclesfield General	00:24:14	00:23:36	00:28:13	00:32:07	00:30:52	00:24:15	00:28:48	00:32:28	00:35:30	00:34:30	00:29:37	00:25:10
Royal Liverpool University	00:18:10	00:23:31	00:19:21	00:19:48	00:20:20	00:27:36	00:18:26	00:19:57	00:30:44	00:27:16	00:24:43	00:24:32
Southport District General	00:20:42	00:19:40	00:23:20	00:26:26	00:31:28	00:25:22	00:27:12	00:35:04	00:34:39	00:32:32	00:23:48	00:25:39
Warrington	00:19:10	00:17:18	00:15:46	00:23:29	00:17:10	00:16:03	00:15:26	00:17:23	00:30:10	00:26:33	00:18:36	00:23:39
Whiston	00:25:59	00:35:08	00:25:39	00:50:50	00:41:44	00:35:00	00:40:58	00:45:10	00:56:45	00:41:55	00:21:17	00:31:08
Cheshire and Merseyside	00:22:35	00:24:22	00:24:38	00:30:31	00:27:23	00:26:25	00:26:49	00:27:37	00:35:18	00:33:10	00:25:26	00:26:19
NWAS	00:23:13	00:23:47	00:25:27	00:30:34	00:27:29	00:27:59	00:27:48	00:25:57	00:30:57	00:30:52	00:26:23	00:27:57

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

Site	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Aintree University	4.14%	4.81%	5.52%	6.97%	4.16%	5.21%	5.20%	5.77%	6.41%	8.51%	4.46%	3.84%
Alder Hey	0.20%	0.00%	0.00%	0.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.25%	0.00%
Arrowe Park	7.14%	5.65%	13.57%	13.35%	11.50%	8.74%	7.58%	4.96%	14.86%	12.80%	7.86%	9.19%
Countess of Chester	0.32%	1.01%	1.23%	5.31%	2.14%	4.42%	3.42%	2.93%	5.94%	9.81%	0.32%	0.52%
Leighton	0.21%	0.05%	0.81%	2.14%	0.43%	0.39%	0.17%	1.03%	0.99%	0.74%	0.22%	0.81%
Macclesfield General	2.51%	2.37%	4.95%	6.47%	6.10%	1.98%	3.51%	6.85%	7.89%	6.64%	2.53%	2.05%
Royal Liverpool University	2.27%	5.15%	2.77%	3.37%	3.35%	6.76%	1.18%	2.90%	7.44%	3.84%	2.35%	3.84%
Southport District General	2.12%	0.67%	3.15%	5.99%	9.87%	4.82%	5.45%	10.61%	11.52%	10.41%	2.16%	4.23%
Warrington	3.83%	2.85%	2.35%	7.39%	2.72%	1.86%	1.67%	3.34%	10.82%	8.88%	4.19%	6.21%
Whiston	7.52%	10.57%	6.41%	20.94%	15.79%	11.06%	12.14%	15.99%	18.85%	12.14%	8.32%	5.89%
Cheshire and Merseyside	3.64%	4.23%	4.62%	8.33%	6.27%	5.38%	4.63%	5.99%	9.42%	7.96%	3.88%	4.26%
NWAS	3.40%	3.60%	4.83%	8.28%	6.22%	6.21%	5.49%	5.36%	7.82%	7.60%	5.02%	5.59%

Section I: 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	Apr-22	May-22	Jun-22	July-22 *
Cheshire and Merseyside	17.24%	18.15%	20.82%	22.80%
North West	16.12%	16.77%	17.3%	17.5%
England	-	-	-	-

** July 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*
Countess of Chester Hospital	5.0%	10.8%	11.6%	14.1%	22.0%	18.7%	12.8%	15.5%
East Cheshire	19.9%	25.2%	26.8%	24.0%	25.3%	23.4%	20.3%	24.0%
Liverpool University Hospitals	5.2%	9.7%	9.3%	9.1%	10.8%	12.7%	16.5%	21.1%
Mid Cheshire Hospitals	18.0%	25.7%	22.7%	20.3%	21.2%	23.1%	20.9%	21.4%
Southport and Ormskirk Hospital	6.3%	15.0%	13.6%	11.5%	7.1%	5.4%	2.7%	5.3%
St Helens and Knowsley	16.9%	17.6%	19.3%	16.7%	18.6%	15.7%	18.4%	20.8%
Warrington and Halton Hospitals	16.4%	24.4%	25.0%	26.5%	25.3%	22.6%	21.9%	22.9%
Wirral University Teaching Hospita	9.6%	15.0%	25.6%	23.9%	23.2%	22.6%	26.2%	27.3%

NHS
Cheshire and Merseyside

Section II: Planned Care

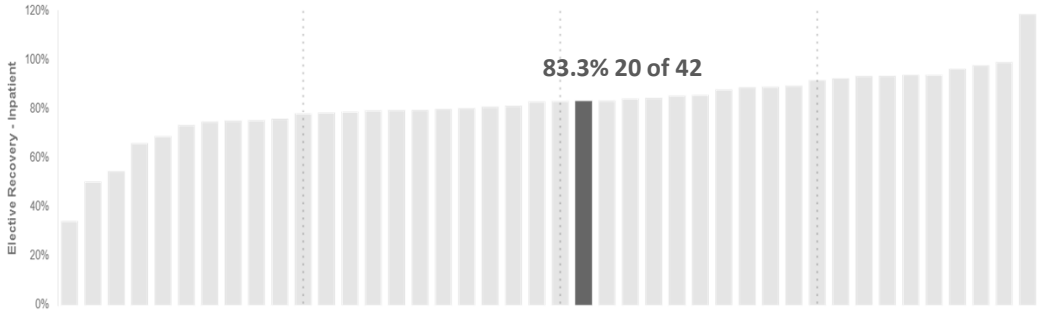
Sentinel Metrics:-

- 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 104 Weeks or more
- The number of people waiting 78 Weeks or more
- Patient Initiated Follow-ups (PIFU)
- Advice and Guidance

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

Cheshire and Merseyside Health and Care Partnership

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	Feb-22	Mar-22	Apr-22	May-22	Jun-22 *	Jul-22 *
Cheshire and Merseyside	89.49%	138.23%	84.28%	83.25%	86.81%	83.11%
North West	85.99%	98.94%	80.96%	83.55%		
England	79.80%	83.36%	77.28%	79.02%		

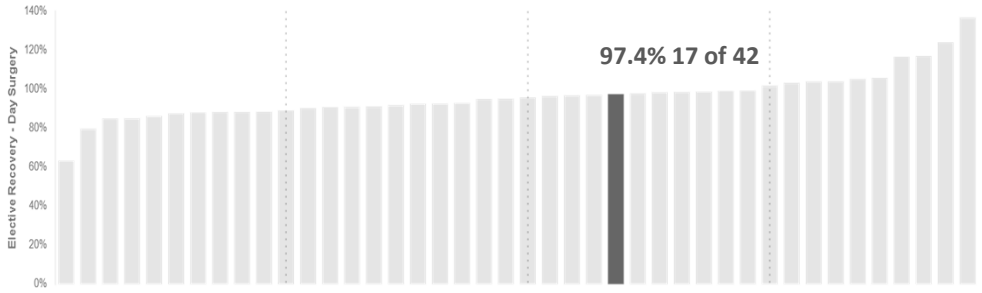
** June and July Position is latest unpublished data*

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

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Alder Hey	80.0%	73.6%	58.2%	60.1%	66.6%	-	55.8%	56.4%	58.4%	-	69.1%	67.0%
Cheshire and Wirral Partnership	90.9%	69.7%	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%	71.4%
East Cheshire	65.8%	68.6%	66.7%	62.3%	45.3%	36.7%	52.4%	38.3%	81.3%	75.6%	57.4%	60.0%
Liverpool Heart and Chest	75.0%	97.1%	104.4%	82.6%	93.1%	73.8%	79.7%	84.9%	88.3%	73.4%	109.5%	105.6%
Liverpool University Hospitals	89.7%	81.6%	79.6%	78.3%	97.1%	114.1%	115.6%	113.6%	119.0%	127.2%	104.2%	100.0%
Liverpool Women's	84.4%	122.7%	113.6%	88.1%	125.7%	102.3%	80.6%	130.0%	96.4%	109.2%	119.6%	100.0%
Mersey Care	34.1%	60.5%	78.6%	47.7%	78.2%	59.7%	57.1%	78.6%	53.3%	61.4%	-	-
Mid Cheshire Hospitals	79.1%	104.5%	69.0%	84.4%	99.6%	84.8%	159.5%	117.2%	85.5%	130.1%	84.2%	137.0%
Southport and Ormskirk Hospital	81.8%	109.8%	70.3%	128.3%	104.4%	85.7%	107.1%	90.9%	74.4%	101.2%	129.0%	80.5%
St Helens and Knowsley	93.7%	97.8%	90.5%	88.7%	100.6%	77.9%	79.5%	84.9%	87.1%	92.1%	90.4%	85.5%
The Clatterbridge Cancer Centre	39.4%	62.0%	57.1%	84.4%	87.6%	83.9%	92.1%	73.3%	104.0%	62.1%	47.1%	70.8%
The Walton Centre	82.0%	87.5%	68.9%	80.3%	100.0%	87.0%	100.7%	87.4%	92.3%	96.8%	64.0%	85.7%
Warrington and Halton Hospitals	76.2%	98.8%	83.1%	96.9%	132.7%	128.2%	176.7%	147.3%	143.1%	198.3%	79.4%	64.5%
Wirral University Teaching Hospital	78.1%	83.8%	82.1%	78.1%	83.4%	90.9%	87.8%	81.5%	64.7%	95.4%	74.8%	80.5%

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

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



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

Organisation	Feb-22	Mar-22	Apr-22	May-22	Jun-22 *	Jul-22 *
Cheshire and Merseyside	87.33%	85.80%	93.99%	97.42%	83.36%	75.67%
North West	90.13%	93.19%	86.02%	91.69%		
England	93.04%	98.47%	89.48%	95.69%		

** June and July Position is latest unpublished data*

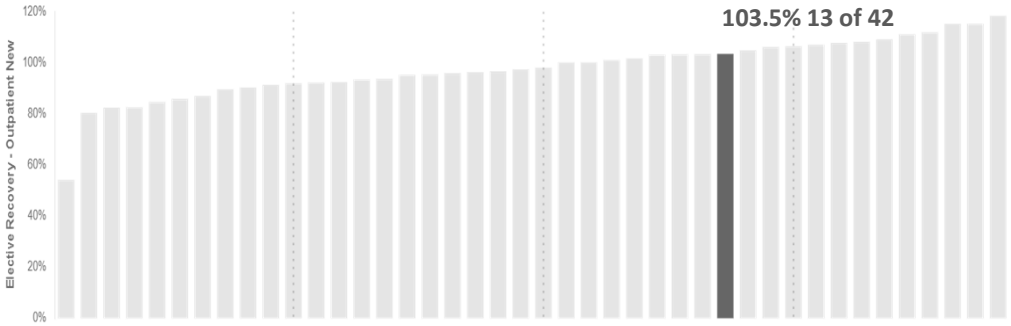
Daycases % of pre-COVID activity (Mar 19-Feb 20). Provider Trend

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Alder Hey	119.8%	101.1%	99.7%	101.6%	117.8%	-	114.9%	110.7%	102.7%	-	118.9%	119.3%
Countess of Chester Hospital	88.3%	61.3%	31.5%	54.4%	61.7%	70.8%	67.8%	63.8%	65.0%	71.7%	71.7%	80.8%
East Cheshire	71.6%	70.2%	69.9%	62.5%	66.7%	64.6%	61.6%	67.2%	69.4%	75.0%	59.7%	66.8%
Liverpool Heart and Chest	96.4%	88.3%	89.4%	88.7%	94.7%	95.5%	90.6%	88.9%	91.4%	88.6%	91.3%	102.9%
Liverpool University Hospitals	82.5%	75.6%	69.5%	79.2%	78.4%	84.7%	84.0%	80.0%	82.5%	89.7%	85.6%	86.9%
Liverpool Women's	62.3%	61.6%	52.0%	58.3%	60.3%	58.5%	54.5%	63.4%	80.6%	77.2%	56.4%	66.2%
Mid Cheshire Hospitals	70.9%	61.6%	62.9%	68.0%	71.8%	74.8%	65.9%	68.0%	69.4%	81.9%	71.8%	75.6%
Southport and Ormskirk Hospital	74.7%	81.3%	62.1%	66.8%	72.7%	80.9%	67.8%	73.6%	76.1%	80.0%	90.3%	95.4%
St Helens and Knowsley	90.8%	90.1%	86.0%	90.5%	92.8%	88.1%	89.7%	84.1%	81.6%	89.4%	96.4%	99.6%
The Clatterbridge Cancer Centre	62.1%	77.0%	52.3%	63.0%	50.8%	54.5%	45.1%	68.0%	67.5%	75.1%	80.3%	75.9%
The Walton Centre	138.0%	148.6%	166.3%	136.2%	140.7%	150.9%	-	169.4%	173.9%	190.4%	176.9%	-
Warrington and Halton Hospitals	94.8%	89.7%	88.5%	83.8%	77.7%	74.9%	70.4%	70.8%	84.9%	78.7%	94.8%	103.1%
Wirral University Teaching Hospital	81.8%	76.0%	80.7%	89.2%	93.2%	97.6%	85.5%	86.9%	96.8%	95.1%	94.6%	101.9%

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

Cheshire and Merseyside
Health and Care Partnership

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	Feb-22	Mar-22	Apr-22	May-22	Jun-22 *	Jul-22 *
Cheshire and Merseyside	97.66%	101.85%	94.76%	103.48%	103.04%	100.20%
North West	96.34%	102.27%	87.83%	95.72%		
England	108.19%	105.90%	90.37%	97.04%		

** June and July Position is latest unpublished data*

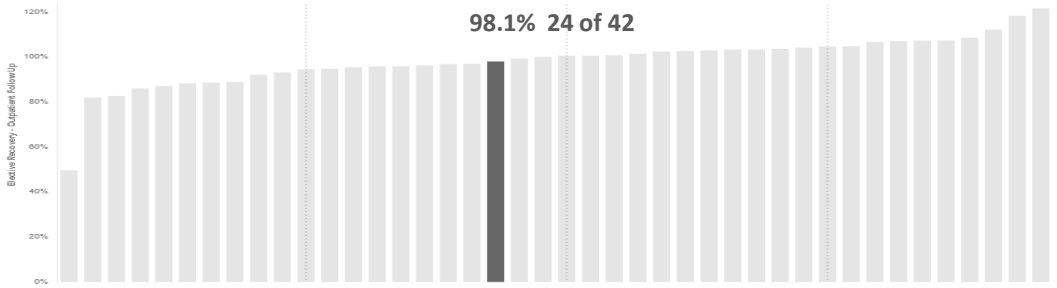
Outpatient (First) % of pre-COVID activity (Mar 19-Feb 20) Provider Trend

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Alder Hey	108.7%	103.5%	107.4%	111.8%	110.4%	112.1%	105.9%	103.8%	108.9%	124.7%	94.0%	107.8%
Bridgewater Community Healthcare	90.0%	77.6%	78.4%	77.6%	82.7%	96.4%	81.2%	64.9%	81.3%	93.9%	81.1%	83.5%
Cheshire and Wirral Partnership	155.8%	148.5%	114.9%	120.6%	97.4%	-	-	-	-	-	-	-
Countess of Chester Hospital	99.5%	92.4%	55.7%	51.8%	51.9%	51.5%	52.4%	57.4%	57.3%	61.8%	58.3%	64.8%
East Cheshire	82.9%	75.7%	78.8%	78.5%	82.5%	79.1%	73.3%	75.8%	72.3%	78.2%	74.6%	79.2%
Liverpool Heart and Chest	138.6%	149.6%	140.3%	125.8%	139.2%	143.8%	153.5%	144.8%	141.0%	118.2%	145.4%	153.0%
Liverpool University Hospitals	100.2%	96.3%	101.0%	96.5%	94.5%	100.7%	95.0%	97.2%	101.4%	112.4%	97.4%	107.5%
Liverpool Women's	84.3%	80.9%	82.5%	88.2%	94.8%	87.5%	80.8%	82.9%	86.8%	74.8%	79.3%	83.8%
Mersey Care	154.2%	-	-	-	-	-	-	-	166.3%	113.4%	-	-
Mid Cheshire Hospitals	87.1%	83.0%	88.7%	95.6%	92.4%	98.2%	95.4%	95.0%	96.3%	96.9%	96.2%	101.1%
Southport and Ormskirk Hospital	95.7%	92.3%	95.3%	97.1%	103.3%	101.8%	101.1%	105.8%	94.4%	109.1%	89.7%	92.2%
St Helens and Knowsley	101.1%	94.8%	98.9%	96.3%	90.1%	94.4%	96.0%	99.5%	100.5%	102.3%	103.8%	111.4%
The Clatterbridge Cancer Centre	118.3%	107.3%	112.3%	118.8%	123.4%	112.4%	120.5%	114.1%	116.6%	96.7%	132.3%	133.5%
The Walton Centre	90.1%	95.6%	92.2%	93.6%	97.6%	96.5%	80.4%	85.9%	95.1%	108.9%	87.4%	92.1%
Warrington and Halton Hospitals	91.3%	84.8%	93.4%	89.6%	88.0%	95.4%	86.6%	89.0%	95.5%	92.9%	84.7%	93.2%
Wirral University Teaching Hospital	102.2%	95.0%	100.0%	94.8%	93.7%	98.7%	97.3%	86.0%	106.4%	99.5%	101.7%	115.2%

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

Cheshire and Merseyside Health and Care Partnership

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	Feb-22	Mar-22	Apr-22	May-22	Jun-22 *	Jul-22 *
Cheshire and Merseyside	98.80%	96.95%	96.25%	98.09%	100.20%	93.85%
North West	100.46%	106.82%	90.77%	98.17%		
England	99.67%	107.47%	92.10%	98.42%		

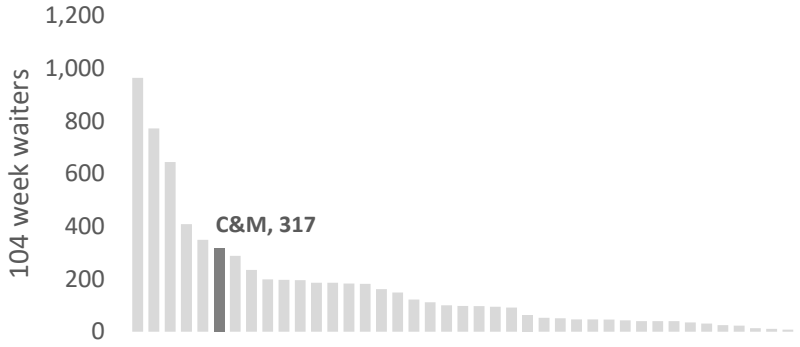
** June and July Position is latest unpublished data*

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

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Alder Hey	122.4%	115.0%	114.2%	111.7%	114.1%	129.1%	131.6%	121.4%	117.5%	122.5%	117.9%	119.2%
Bridgewater Community Healthcare	79.2%	79.5%	82.5%	74.9%	83.4%	68.5%	73.0%	79.5%	81.6%	83.9%	63.6%	60.8%
Cheshire and Wirral Partnership	110.8%	113.5%	116.0%	132.3%	86.1%	-	-	-	-	-	-	-
Countess of Chester Hospital	89.5%	75.1%	58.5%	70.7%	69.9%	71.6%	71.0%	73.0%	73.9%	75.0%	74.8%	74.5%
East Cheshire	72.7%	65.2%	66.5%	68.6%	64.2%	72.4%	65.8%	60.0%	69.0%	65.6%	57.1%	62.8%
Liverpool Heart and Chest	107.7%	105.8%	107.3%	107.1%	99.2%	102.0%	104.0%	96.1%	98.2%	95.8%	101.6%	110.6%
Liverpool University Hospitals	85.1%	81.3%	86.7%	83.2%	80.1%	85.0%	86.1%	86.4%	86.0%	90.3%	80.6%	83.8%
Liverpool Women's	97.4%	89.0%	90.7%	88.7%	93.7%	94.7%	89.7%	92.7%	93.5%	91.4%	97.5%	96.0%
Mersey Care	119.3%	115.0%	119.7%	133.8%	128.3%	142.0%	135.6%	156.2%	152.4%	131.8%	-	-
Mid Cheshire Hospitals	92.8%	88.8%	92.1%	90.1%	88.1%	94.4%	88.3%	93.4%	91.1%	90.8%	102.4%	109.4%
Southport and Ormskirk Hospital	96.3%	94.2%	87.4%	85.0%	92.9%	94.6%	93.9%	96.3%	94.7%	91.6%	90.0%	94.7%
St Helens and Knowsley	105.8%	100.2%	104.3%	103.9%	100.4%	103.3%	104.8%	102.3%	106.5%	100.3%	99.0%	103.6%
The Clatterbridge Cancer Centre	138.4%	141.4%	138.7%	131.7%	129.2%	129.2%	129.5%	134.4%	128.0%	106.8%	149.4%	144.8%
The Walton Centre	103.8%	110.7%	104.8%	106.7%	109.8%	115.9%	110.5%	109.8%	112.0%	124.4%	108.5%	111.8%
Warrington and Halton Hospitals	94.1%	88.3%	98.2%	94.2%	92.8%	94.5%	91.3%	90.0%	95.8%	92.9%	93.7%	93.9%
Wirral University Teaching Hospital	120.7%	110.1%	110.8%	111.2%	113.2%	116.0%	110.7%	118.0%	118.3%	115.4%	115.0%	122.4%

Section II: Planned Care Performance: Waiting list. The number of people waiting 104 Weeks or more

The number of people waiting 104 weeks or more.
ICS Benchmark



The number of people waiting 104 weeks or more.

Organisation	Feb-22	Mar-22	Apr-22	May-22	Jun-22 *
Cheshire and Merseyside	1,127	963	515	317	42
North West	4,915	3,572	2,437	1,480	
England	23,281	16,796	12,735	8,028	

** June position is latest unpublished data*

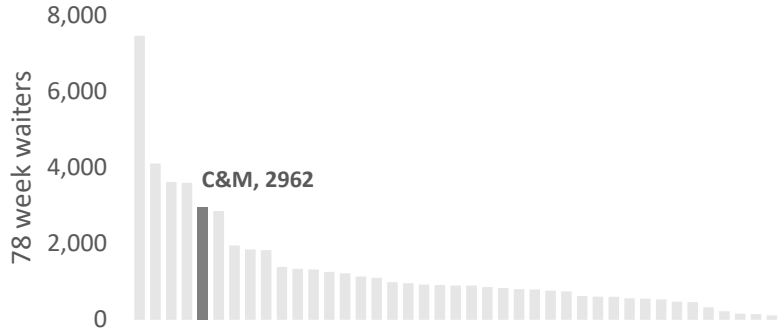
The number of people waiting 104 weeks or more. Provider Trend

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Alder Hey	17	22	23	27	57	19	14	7	4	2	2	0
Bridgewater Community Healthcare	0	0	0	0	0	0	0	0	0	0	0	0
Countess of Chester Hospital	31	49	-	-	347	413	420	565	596	652	310	186
East Cheshire	6	12	15	23	23	42	54	56	48	37	29	23
Liverpool Heart and Chest	0	0	0	1	0	1	3	4	5	5	5	2
Liverpool University Hospitals	17	43	85	187	295	340	345	384	325	183	116	62
Liverpool Women's	0	1	1	3	1	0	0	1	1	0	0	0
Mersey Care	-	-	-	-	0	0	0	1	1	1	0	0
Mid Cheshire Hospitals	0	1	1	1	0	1	3	5	9	8	7	1
Southport and Ormskirk Hospital	0	0	0	1	0	0	0	1	1	1	0	0
St Helens and Knowsley	1	5	6	13	16	26	38	49	47	30	20	6
The Clatterbridge Cancer Centre	0	0	0	0	0	0	0	0	0	0	0	0
The Walton Centre	0	0	0	0	0	0	10	10	9	3	3	13
Warrington and Halton Hospitals	1	5	13	21	37	43	45	73	70	28	22	22
Wirral Community	0	0	0	0	0	0	0	0	0	12	1	2
Wirral University Teaching Hospital	1	3	3	7	10	5	5	4	11	1	0	0

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

Cheshire and Merseyside Health and Care Partnership

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



The number of people waiting 78 Weeks or more. Benchmark

Organisation	Feb-22	Mar-22	Apr-22	May-22	Jun-22 *	Jul-22 *
Cheshire and Merseyside	3,745	3,405	3,200	2,962	3,203	3,138
North West	12,588	10,619	10,161	9,281	10,713	10,866
England	68,493	62,754	63,639	59,762		

** June and July Position is latest unpublished data*

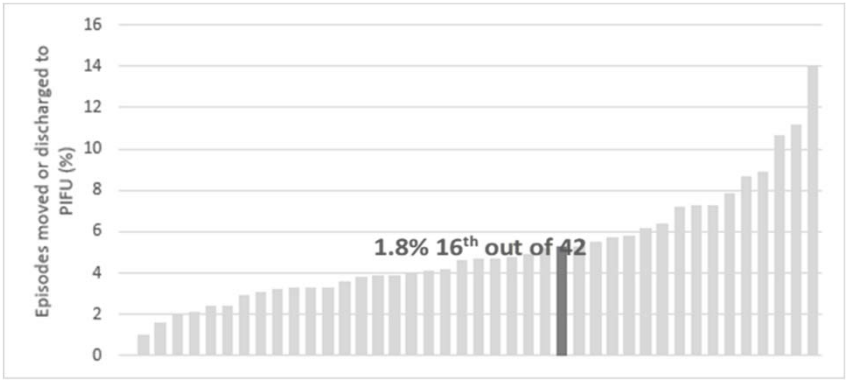
The number of people waiting 78 Weeks or more. Provider Trend

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Alder Hey	75	80	76	97	114	61	40	34	22	16	16	17
Bridgewater Community Healthcare	0	0	0	0	0	0	0	0	0	0	0	0
Countess of Chester Hospital	813	942	-	-	1,705	1,750	1,701	1,821	1,567	1,433	1,034	859
East Cheshire	110	112	145	149	138	137	145	156	123	106	82	84
Liverpool Heart and Chest	13	17	25	23	19	12	13	11	10	9	6	9
Liverpool University Hospitals	1,131	1,484	1,876	2,242	2,146	1,810	1,546	1,581	1,303	1,198	1,308	1,215
Liverpool Women's	4	4	12	39	21	3	3	10	12	12	26	27
Mersey Care	-	-	-	-	8	6	6	6	6	6	4	2
Mid Cheshire Hospitals	83	113	140	123	89	65	62	62	56	60	61	73
Southport and Ormskirk Hospital	6	11	28	25	16	10	9	8	12	17	22	46
St Helens and Knowsley	193	274	390	462	414	368	360	315	291	259	328	288
The Clatterbridge Cancer Centre	0	0	0	0	0	0	0	0	0	0	0	0
The Walton Centre	22	18	22	20	12	10	36	38	27	22	20	30
Warrington and Halton Hospitals	254	337	399	439	384	327	309	315	251	193	221	239
Wirral Community	0	0	0	0	0	0	0	0	0	14	2	2
Wirral University Teaching Hospital	89	117	176	163	116	70	72	59	65	60	70	71

Section II: 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	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Cheshire and Merseyside	0.3%	0.7%	0.7%	1.3%	1.8%
North West	0.6%	0.8%	0.9%	1.1%	1.2%
England	1.1%	1.2%	1.3%	1.3%	1.5%

Patient Initiated Follow-up (PIFU) Provider Trend

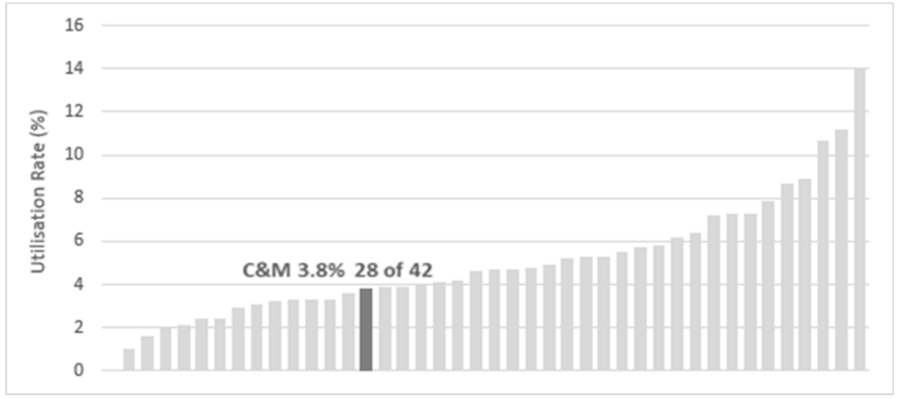
ICS Providers

Organisation	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Alder Hey	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.2%	0.4%	0.5%
Bridgewater Community Health Care										
Countess of Chester Hospital										
East Cheshire	0.0%	0.0%	0.0%	1.1%	1.9%	2.2%	2.9%	2.8%	1.9%	1.6%
Liverpool Heart & Chest	0.0%	0.3%	0.0%	0.1%	0.1%	0.1%	0.3%	0.7%	0.4%	0.2%
Liverpool University Hospitals	0.1%	0.1%	0.2%	0.1%	2.5%	0.0%	1.6%	0.3%	2.1%	1.0%
Liverpool Women's	0.0%	0.0%	0.5%	0.6%	1.6%	0.0%	2.2%	0.8%	0.8%	1.0%
Mid Cheshire Hospitals	0.4%	0.5%	0.6%	0.7%	0.6%	0.7%	0.6%	0.4%	0.3%	0.3%
SouthPort and Ormskirk Hospital	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	2.6%	7.2%	19.2%
St Helens and Knowsley	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.7%
Warrington and Halton Hospitals	0.8%	0.7%	0.7%	0.8%	0.7%	0.9%	0.9%	2.4%	1.8%	2.2%
Wirral University Teaching Hospital	0.0%	0.1%	0.5%	0.5%	0.5%	0.6%	0.4%	0.5%	0.6%	0.8%

Section II: 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	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Cheshire and Merseyside	2.8%	3.6%	3.2%	4.1%	3.8%
North West	3.1%	3.7%	3.4%	3.5%	3.3%
England	5.5%	6.0%	5.9%	5.6%	4.5%

Advice and Guidance: Provider Trend

ICS Providers

Organisation	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Alder Hey	1.8%	1.9%	1.9%	1.7%	2.8%	1.8%	3.1%	2.3%	2.0%	1.8%
Bridgewater Community Health Care	2.7%	2.5%	2.4%	2.2%	1.4%	2.1%	2.0%	2.1%	2.6%	1.3%
Countess of Chester Hospital	6.5%	7.2%	7.2%	8.7%	9.2%	6.0%	6.3%	6.4%	6.3%	5.4%
East Cheshire	0.4%	0.4%	0.5%	1.0%	0.6%	0.2%	0.3%	0.4%	0.3%	0.2%
Liverpool Heart & Chest	1.9%	2.1%	2.9%	1.9%	2.3%	1.8%	2.3%	2.2%	2.3%	2.4%
Liverpool University Hospitals	2.9%	2.8%	3.0%	2.7%	3.4%	2.9%	2.9%	3.1%	3.4%	2.5%
Liverpool Women's	2.1%	1.7%	1.5%	1.7%	1.8%	1.7%	2.1%	2.1%	1.9%	2.0%
Mid Cheshire Hospitals	1.0%	1.0%	1.0%	1.1%	1.1%	1.3%	0.8%	0.9%	1.0%	0.6%
SouthPort and Ormskirk Hospital	3.2%	2.7%	3.4%	3.6%	4.7%	5.3%	5.6%	4.6%	9.4%	7.7%
St Helens and Knowsley	0.5%	0.4%	0.7%	0.5%	0.6%	0.5%	0.6%	0.8%	0.8%	0.6%
The Walton Centre	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	5.8%	0.0%	17.1%	25.1%
Warrington and Halton Hospitals	3.5%	3.7%	4.0%	4.1%	4.7%	4.1%	4.5%	5.1%	4.2%	3.8%
Wirral University Teaching Hospital	0.0%	7.5%	8.6%	7.5%	8.8%	6.7%	9.5%	7.8%	8.1%	7.7%

NHS
Cheshire and Merseyside

Section III: 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 III: 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	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Cheshire and Merseyside	1275	1240	1510	1322	1485
North West	3309	3262	3639	2916	3548
England	25524	24960	28378	23523	28040

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

Organisation	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Cheshire and Merseyside	94%	91%	111%	97%	109%
North West	101%	100%	112%	89%	109%
England	97%	95%	108%	89%	106%

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

Organisation	Baseline*	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Alder Hey Children's Hospital	6	63%	126%	111%	111%	237%	95%	174%	95%	142%	79%
Bridgewater Community Healthcare	11	110%	55%	128%	119%	137%	156%	82%	110%	165%	137%
Countess of Chester Hospital	105	77%	124%	108%	92%	103%	81%	100%	103%	116%	98%
East Cheshire	51	71%	104%	94%	71%	83%	116%	75%	112%	89%	112%
Liverpool Heart and Chest Hospital	45	82%	97%	86%	120%	84%	93%	75%	135%	111%	151%
Liverpool University Hospitals	280	98%	96%	87%	99%	92%	86%	79%	93%	80%	78%
Liverpool Women's	27	109%	136%	140%	113%	113%	98%	121%	87%	79%	91%
Mid Cheshire Hospitals	95	106%	92%	97%	120%	79%	87%	88%	124%	102%	130%
Southport and Ormskirk Hospital	59	78%	95%	109%	121%	98%	121%	107%	124%	78%	137%
St Helens and Knowsley	212	105%	102%	107%	98%	106%	95%	96%	116%	115%	124%
The Clatterbridge Cancer Centre	221	113%	114%	113%	114%	102%	93%	84%	136%	110%	112%
The Walton Centre	13	95%	79%	87%	79%	87%	95%	127%	87%	87%	0%
Warrington and Halton Hospitals	77	91%	100%	66%	86%	86%	74%	98%	95%	73%	111%
Wirral University Teaching Hospita	157	107%	109%	112%	112%	111%	107%	103%	103%	87%	126%

Section III: 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	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Cheshire and Merseysi	1298	1599	1586	1574	1522
North West	3042	3890	3741	4152	4156
England	21376	25808	27091	27865	28386

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

Organisation	Mar-22	Apr-22	May-22	Jun-22	Jul-22 *
Cheshire and Merseyside	182%	224%	222%	221%	213%
North West	162%	207%	199%	221%	221%
England	150%	181%	190%	195%	199%

** July position is latest unpublished data*

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

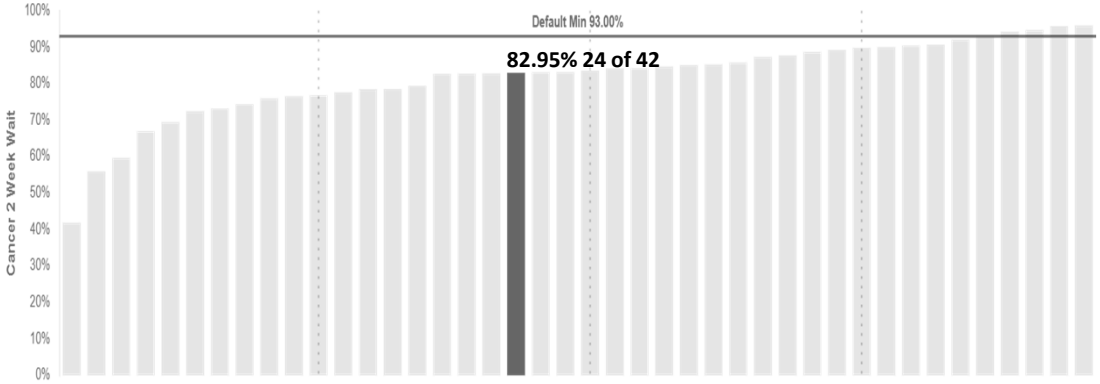
ICS Providers

Organisation	Baseline	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Countess of Chester Hospital	121	200%	260%	254%	196%	387%	256%	202%	148%	159%	117%	97%	82%
East Cheshire	20	150%	115%	160%	200%	280%	380%	340%	295%	400%	270%	205%	210%
Liverpool Heart and Chest Hospital	3	100%	100%	133%	33%	233%	33%	100%	267%	233%	200%	133%	267%
Liverpool University Hospitals	256	206%	221%	168%	191%	207%	230%	189%	157%	233%	247%	263%	253%
Liverpool Women's	29	179%	190%	117%	86%	97%	138%	100%	93%	117%	179%	231%	290%
Mid Cheshire Hospitals	49	104%	196%	135%	167%	173%	198%	200%	165%	222%	222%	167%	180%
Southport and Ormskirk Hospital	58	143%	193%	200%	300%	319%	391%	478%	474%	500%	400%	391%	381%
St Helens and Knowsley	72	126%	182%	158%	151%	140%	157%	117%	140%	157%	196%	176%	125%
The Clatterbridge Cancer Centre	23	230%	239%	239%	239%	135%	222%	309%	283%	204%	343%	248%	270%
Warrington and Halton Hospitals	15	367%	273%	233%	220%	233%	167%	147%	133%	193%	107%	180%	207%
Wirral University Teaching Hospital	67	75%	81%	79%	78%	87%	104%	113%	121%	145%	184%	227%	222%

Section III: 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	Mar-22	Apr-22	May-22
Cheshire and Merseyside	79.92%	77.10%	82.95%
North West	79.40%	79.80%	83.30%
England	80.56%	79.05%	83.22%

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

ICS Providers

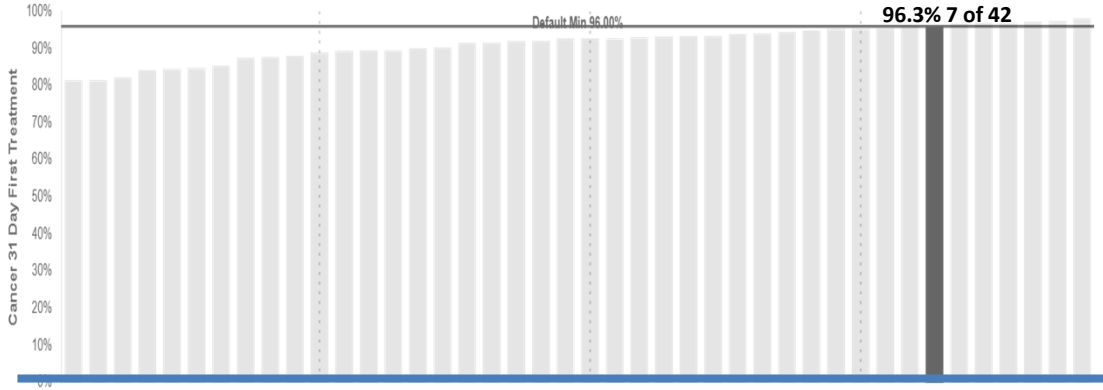
CCG Provider

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Alder Hey	100.00%	100.00%	100.00%	100.00%	100.00%	96.30%	93.75%	100.00%	100.00%	100.00%	100.00%	100.00%
Bridgewater Community Healthcare	-	97.07%	95.22%	98.08%	94.01%	96.58%	97.97%	95.98%	93.97%	93.94%	94.03%	95.76%
Countess of Chester Hospital	78.17%	83.97%	69.65%	52.37%	52.73%	56.98%	60.41%	63.29%	81.89%	70.06%	65.75%	75.97%
East Cheshire	62.43%	74.46%	94.67%	92.66%	67.05%	58.92%	67.26%	80.50%	90.23%	90.53%	88.87%	89.36%
Liverpool Heart and Chest	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.31%
Liverpool University Hospitals	94.34%	93.63%	93.19%	92.84%	73.90%	68.19%	64.10%	65.47%	71.55%	71.98%	64.78%	69.64%
Liverpool Women's	96.20%	95.32%	96.42%	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.90%	52.71%
Mid Cheshire Hospitals	96.95%	95.24%	94.65%	94.04%	94.13%	81.50%	92.33%	80.88%	85.39%	93.24%	89.54%	93.80%
Southport and Ormskirk Hospital	87.51%	82.52%	76.47%	78.53%	78.54%	78.46%	77.18%	82.40%	77.13%	77.39%	86.10%	84.20%
St Helens and Knowsley	85.97%	91.13%	92.26%	89.00%	88.87%	75.35%	78.47%	73.49%	79.13%	84.34%	82.51%	88.29%
The Clatterbridge Cancer Centre	100.00%	100.00%	100.00%	100.00%	88.89%	100.00%	92.86%	90.00%	100.00%	93.75%	85.71%	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%	100.00%	-
Warrington and Halton Hospitals	91.19%	90.98%	90.23%	95.86%	92.54%	78.29%	67.61%	68.57%	84.69%	90.60%	82.92%	88.04%
Wirral University Teaching Hospital	97.20%	95.36%	93.72%	95.74%	96.13%	87.85%	91.39%	76.16%	77.99%	76.16%	85.76%	96.60%

Section III: 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	Mar-22	Apr-22	May-22
Cheshire and Merseyside	95.23%	95.23%	96.30%
North West	94.80%	93.70%	92.80%
England	93.40%	92.80%	91.60%

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

ICS Providers

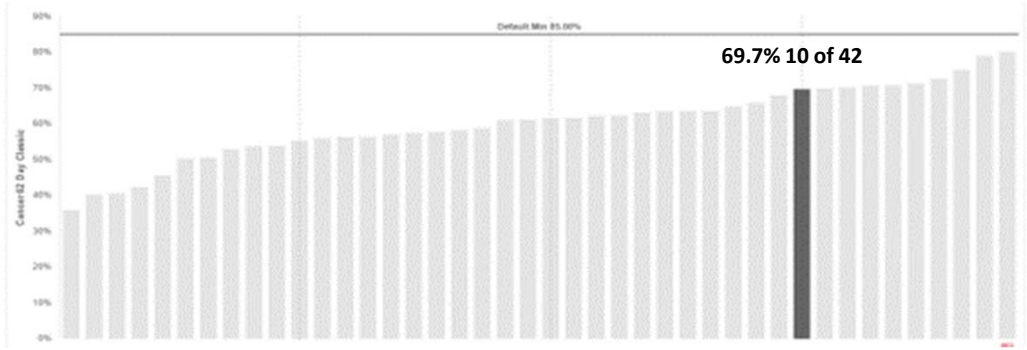
CCG Provider

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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	-	100.00%	83.33%	100.00%	92.86%	76.92%	93.33%	52.94%	100.00%	83.33%	100.00%	80.00%
Countess of Chester Hospital	94.34%	96.04%	91.36%	86.92%	86.73%	90.72%	87.96%	88.24%	92.38%	90.74%	93.44%	94.17%
East Cheshire	84.21%	95.00%	94.44%	98.11%	97.92%	94.44%	92.86%	66.10%	52.63%	77.19%	75.56%	84.21%
Liverpool Heart and Chest	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	97.62%	100.00%	100.00%	98.00%	100.00%
Liverpool University Hospitals	93.75%	93.88%	92.39%	92.54%	92.59%	93.14%	94.59%	91.32%	88.74%	90.77%	93.30%	91.28%
Liverpool Women's	68.00%	64.52%	68.97%	52.78%	56.76%	86.67%	93.33%	84.62%	84.38%	95.65%	85.71%	83.33%
Mid Cheshire Hospitals	95.83%	94.51%	99.00%	94.25%	100.00%	98.25%	98.67%	97.56%	90.36%	98.29%	96.91%	96.75%
Southport and Ormskirk Hospital	100.00%	100.00%	95.65%	98.21%	96.88%	97.18%	93.10%	100.00%	96.83%	95.89%	91.30%	100.00%
St Helens and Knowsley	98.43%	96.86%	98.20%	96.77%	98.68%	99.04%	98.21%	98.02%	98.53%	98.37%	97.95%	98.85%
The Clatterbridge Cancer Centre	99.20%	99.18%	100.00%	98.81%	100.00%	99.60%	98.67%	97.09%	98.92%	100.00%	99.59%	100.00%
The Walton Centre	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	91.67%	100.00%	100.00%	100.00%	-
Warrington and Halton Hospitals	96.88%	98.84%	98.57%	96.10%	98.04%	98.48%	96.97%	98.25%	100.00%	98.63%	100.00%	100.00%
Wirral University Teaching Hospital	99.24%	96.32%	96.43%	96.49%	95.43%	94.29%	94.83%	94.64%	95.06%	92.59%	91.18%	96.45%

Section III: 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	Mar-22	Apr-22	May-22
Cheshire and Merseyside	67.95%	70.29%	69.70%
North West	67.00%	65.50%	61.50%
England	67.40%	65.20%	61.50%

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

Organisation	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Alder Hey	-	-	-	-	-	-	100.00%	100.00%	-	-	100.00%	-
Bridgewater Community Healthcare	100.00%	100.00%	91.30%	72.73%	91.30%	83.33%	100.00%	84.62%	77.78%	90.91%	93.75%	100.00%
Countess of Chester Hospital	77.21%	70.40%	68.63%	71.59%	71.78%	70.34%	73.53%	60.91%	62.00%	63.19%	72.19%	67.90%
East Cheshire	59.46%	70.89%	74.00%	68.18%	75.36%	61.11%	48.15%	31.03%	42.00%	53.85%	49.18%	50.77%
Liverpool Heart and Chest	100.00%	100.00%	100.00%	93.75%	100.00%	96.88%	86.21%	85.29%	84.62%	100.00%	87.50%	76.47%
Liverpool University Hospitals	68.54%	64.41%	54.74%	67.09%	56.20%	62.55%	55.51%	56.36%	55.91%	52.47%	53.69%	45.35%
Liverpool Women's	20.00%	16.13%	16.22%	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%	22.73%
Mid Cheshire Hospitals	84.56%	76.67%	88.67%	84.35%	81.62%	81.93%	81.20%	67.74%	70.49%	71.52%	69.63%	76.79%
Southport and Ormskirk Hospital	70.65%	77.14%	57.89%	54.21%	66.33%	66.95%	62.18%	67.68%	58.95%	70.49%	48.28%	67.48%
St Helens and Knowsley	85.71%	86.15%	85.57%	85.47%	84.41%	82.87%	85.02%	83.41%	85.37%	86.26%	90.29%	83.17%
The Clatterbridge Cancer Centre	91.57%	97.26%	83.53%	87.32%	86.67%	88.64%	92.42%	78.21%	75.86%	69.44%	79.52%	80.00%
The Walton Centre	-	-	-	-	100.00%	100.00%	-	-	-	-	-	-
Warrington and Halton Hospitals	63.77%	74.29%	71.62%	64.17%	51.25%	73.47%	72.34%	74.07%	70.65%	77.14%	76.74%	83.33%
Wirral University Teaching Hospital	85.25%	84.66%	85.94%	84.43%	79.21%	79.66%	79.29%	79.62%	79.33%	75.88%	79.17%	79.57%

NHS
Cheshire and Merseyside

Section V: Primary Care

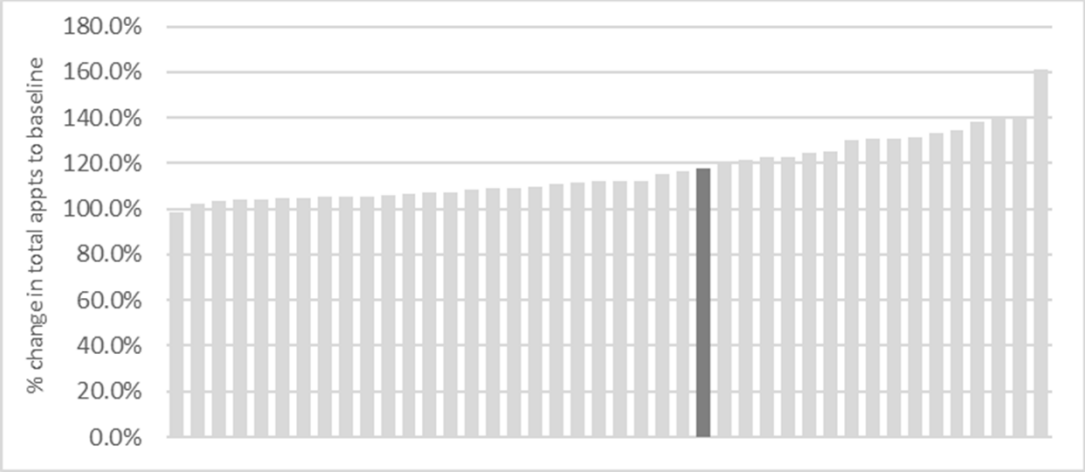
Sentinel Metrics:-

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

NHS Cheshire and Merseyside

Total appts ICS National benchmark: 15.2 % to baseline, 17 of 42



Total appointments Benchmark

Organisation	Mar-22	Apr-22	May-22
Cheshire and Merseyside	121.2%	104.3%	115.2%
North West	129.1%	110.8%	123.1%
England	122.0%	104.7%	116.3%

Total appointments ICS Place Trend

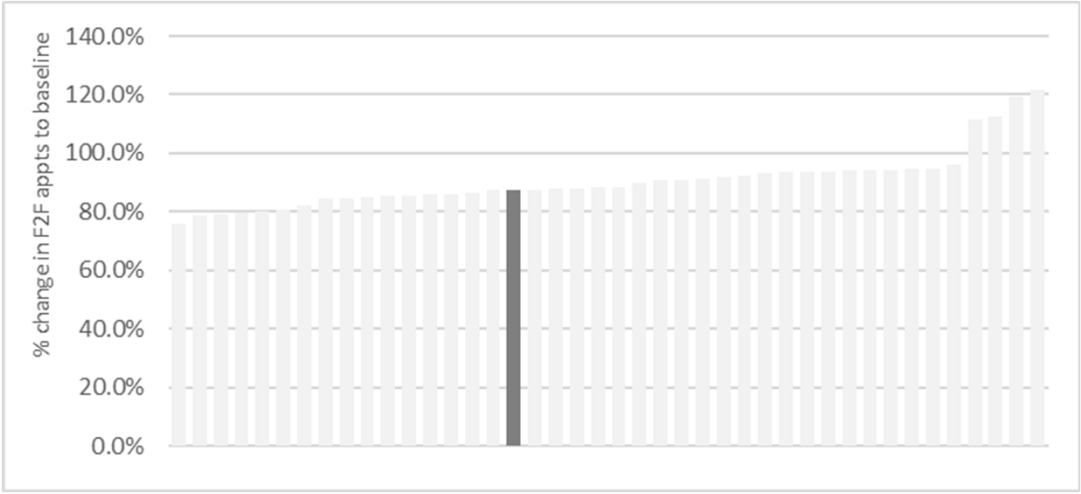
ICS Places

Organisation	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Cheshire	99.6%	118.9%	97.7%	102.8%	114.0%	103.0%	114.3%	107.5%	92.7%	105.1%	116.5%	101.4%	115.7%
Halton	90.1%	112.4%	96.5%	102.7%	118.4%	103.8%	110.0%	98.3%	83.2%	100.2%	108.9%	93.6%	101.6%
Knowsley	91.9%	108.4%	92.7%	101.5%	105.5%	99.5%	114.9%	102.3%	91.1%	98.2%	109.6%	97.5%	109.7%
Liverpool	101.8%	122.3%	101.9%	113.2%	116.8%	102.0%	119.6%	111.7%	103.3%	112.4%	126.2%	107.1%	116.1%
South Sefton	92.4%	107.6%	92.3%	101.2%	103.6%	96.4%	110.2%	104.3%	91.3%	99.2%	111.9%	95.1%	99.8%
Southport & Formby	96.2%	117.4%	103.5%	108.1%	122.2%	109.6%	119.9%	115.0%	102.4%	111.3%	120.6%	106.3%	113.6%
St. Helens	92.2%	112.5%	94.5%	103.8%	115.7%	103.5%	109.6%	104.4%	95.2%	101.3%	115.0%	97.2%	107.8%
Warrington	110.5%	132.2%	108.9%	117.8%	118.2%	104.9%	118.3%	105.3%	99.6%	113.6%	128.4%	110.4%	121.0%
Wirral	108.3%	128.4%	105.9%	117.0%	129.7%	109.6%	126.7%	120.8%	110.0%	121.6%	137.3%	116.4%	127.5%

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

NHS Cheshire and Merseyside

F2F appts ICS National benchmark: -12.5 % to baseline, 26 of 42



Face to Face appointments Benchmark

Organisation	Mar-22	Apr-22	May-22
Cheshire and Merseyside	88.0%	77.3%	87.5%
North West	90.8%	79.8%	91.1%
England	91.3%	79.8%	90.2%

Face to face appointments ICS Place Trend

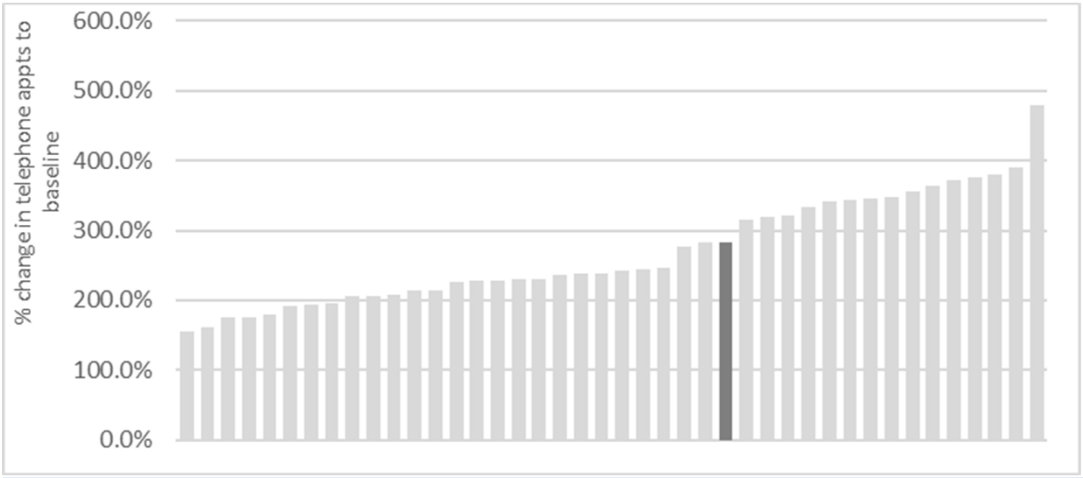
ICS Places

Organisation	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Cheshire	59.8%	72.0%	60.0%	64.6%	79.0%	75.4%	78.8%	71.7%	61.2%	71.5%	79.9%	72.4%	85.7%
Halton	66.1%	80.7%	69.8%	74.5%	93.7%	85.6%	88.6%	77.5%	65.7%	81.5%	91.2%	79.5%	86.6%
Knowsley	65.2%	77.0%	65.2%	71.4%	74.0%	75.7%	83.7%	69.1%	64.4%	72.4%	80.8%	70.7%	79.7%
Liverpool	62.0%	76.2%	63.3%	72.0%	76.7%	74.5%	86.6%	77.1%	68.7%	77.3%	87.9%	74.9%	82.5%
South Sefton	51.2%	59.7%	51.3%	60.3%	66.1%	69.4%	76.9%	71.1%	59.9%	68.5%	79.3%	67.8%	77.0%
Southport & Formby	56.3%	66.0%	56.6%	60.5%	79.4%	76.0%	79.2%	76.2%	66.2%	72.7%	79.2%	74.8%	81.5%
St. Helens	60.8%	76.3%	63.1%	70.4%	85.6%	79.1%	79.7%	72.4%	65.5%	70.9%	81.9%	71.4%	82.7%
Warrington	85.6%	105.0%	86.9%	95.7%	96.4%	89.3%	98.9%	87.7%	83.2%	97.7%	108.2%	95.1%	103.8%
Wirral	75.4%	90.3%	74.6%	83.1%	100.7%	86.9%	97.8%	90.7%	81.0%	90.7%	103.9%	89.4%	100.2%

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

NHS Cheshire and Merseyside

Total appts ICS National benchmark: 282.6 % to baseline, 16 of 42



Telephone appointments benchmark

Organisation	Mar-22	Apr-22	May-22
Cheshire and Merseyside	319.2%	264.0%	282.6%
North West	376.8%	308.9%	330.8%
England	297.0%	243.2%	264.8%

Telephone appointments ICS Place Trend

ICS Places

Organisation	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Cheshire	298.2%	359.2%	301.1%	307.8%	326.9%	296.3%	337.6%	305.7%	253.9%	278.1%	302.8%	248.7%	268.5%
Halton	196.8%	252.1%	215.5%	224.3%	235.0%	199.9%	210.4%	188.8%	157.3%	179.1%	185.3%	151.1%	167.9%
Knowsley	281.8%	339.6%	309.7%	340.4%	385.9%	393.4%	516.4%	489.9%	316.1%	288.7%	316.4%	299.6%	325.3%
Liverpool	270.9%	311.6%	253.6%	271.8%	281.3%	223.9%	258.0%	239.9%	256.3%	265.3%	297.1%	248.1%	261.7%
South Sefton	391.4%	427.2%	359.5%	386.0%	372.2%	298.7%	335.2%	307.0%	316.9%	328.9%	346.9%	286.4%	301.3%
Southport & Formby	514.8%	660.3%	600.8%	553.5%	560.0%	470.0%	515.9%	439.6%	493.0%	539.6%	579.6%	440.9%	455.6%
St. Helens	336.8%	406.4%	336.7%	352.2%	379.6%	332.1%	370.2%	351.5%	313.7%	344.9%	371.1%	309.9%	340.6%
Warrington	367.1%	401.0%	330.4%	341.8%	355.4%	298.1%	343.0%	286.7%	277.7%	298.5%	343.5%	262.8%	295.7%
Wirral	360.2%	432.9%	368.6%	388.0%	393.3%	332.5%	385.6%	364.1%	341.2%	364.0%	394.9%	325.0%	335.9%

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire.

4 August 2022

NHS Cheshire and Merseyside Integrated Care Board Meeting

Date of meeting:	04 August 2022
Agenda Item No:	ICB/8/22/12
Report title:	Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire.
Report Author & Contact Details:	Carole Hill, Associate Director of Strategy, Integration & Partnerships, Liverpool Place
Report approved by:	Dr Fiona Lemmens, Deputy Medical Director

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
Previously overseen by the Cheshire & Merseyside Joint Committee of CCGs.

Executive Summary and key points for discussion
The purpose of this paper is to present the proposal for a Comprehensive Stroke Centre to be established to serve the populations of Knowsley, Liverpool, Sefton and West Lancashire. Responsibility for commissioner decision-making will be with the Cheshire and Merseyside Integrated Care Board (ICB) and with the Lancashire and South Cumbria ICB due to the proposal impacting on hyper acute stroke services for the population of West Lancashire.

Recommendation/ Action needed:	**The Board is asked to:** • **approve** the proposal for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire.

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:	
The item involves sensitive HR issues	n/a
The item contains commercially confidential issues	n/a
Some other criteria. Please outline below:	n/a

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS Cheshire and Merseyside

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	

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 ICB Board Assurance Framework or any other corporate or Place risk? (*please list*) n/a					
	What level of assurance does it provide? n/a					
	Limited		**Reasonable**		**Significant**	
	Any other risks? Yes / No If **YES** please identify within the main body of the report.					
	Is this report required under NHS guidance or for a statutory purpose? (*please specify*) n/a					
	Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken.					
	Any current services or roles that may be affected by issues as outlined within this paper? Yes – outlined within the paper.					

	Process Undertaken & Impact Considerations	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
Document Development	Financial – any resource impact?	x			Outlined within the report
	Patient / Public Involvement / Engagement	x			Outlined within the report
	Clinical Involvement / Engagement	x			Outlined within the report
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?	x			Outlined within the report
	Regulatory or Legal - any impact assessed or advice needed?	X			Outlined within the report
	Health Inequalities – any impact assessed?	x			Outlined within the report
	Sustainable Development – any impact assessed?				

Next Steps:	Subject to receiving approval from the Cheshire and Merseyside ICB and the Lancashire and South Cumbria ICB, the first phase of implementation, bringing together a single hyper-acute stroke service for the first 72 hours of care, will be established from 19th September 2022.

Responsible Officer to take forward actions:	Dr Fiona Lemmens

Appendices:	• APPENDIX ONE Final Business Case • APPENDIX TWO Supporting appendices, including the Formal Public Consultation Report

Glossary of Terms	**Explanation or clarification of abbreviations used in this paper**
C&M	Cheshire and Merseyside
ICB	Integrated Care Board

Hyper-acute stroke services in North Mersey and West Lancashire – Business Case for approval

1. Summary

1.1 The purpose of this paper is to present the proposal for a Comprehensive Stroke Centre to be established to serve the populations of Knowsley, Liverpool, Sefton and West Lancashire.

1.2 Responsibility for commissioner decision-making will be with the Cheshire and Merseyside Integrated Care Board (ICB) and with the Lancashire and South Cumbria ICB due to the proposal impacting on hyper acute stroke services for the population of West Lancashire.

2. Introduction

2.1 Currently, hyper-acute stroke services in North Mersey are delivered at the Royal Liverpool University Hospital, Aintree University Hospital and Southport Hospital. The Walton Centre, on the Aintree site, provides a thrombectomy service, a specialist clot-removing procedure which delivers improved outcomes for eligible patients. Broadgreen Hospital provides stroke rehabilitation care. North Mersey hyper-acute stroke services are mostly used by people living in Knowsley, Liverpool, Sefton and West Lancashire.

2.2 These stroke services do not currently meet best practice guidelines for providing the very highest quality care or make the most of the specialist stroke workforce. There is a shortage of stroke nurses, therapists and doctors, and expertise is currently spread across three different sites. This makes it very difficult to ensure that patients have access to the care that they need all of the time, especially during the critical period immediately after a stroke has taken place.

2.3 Local clinicians developed a case for change setting out the vision for a Comprehensive Stroke Centre, bringing together teams providing hyper-acute services alongside those able to offer thrombectomy. Both thrombectomy and thrombolysis can significantly reduce the severity of disability caused by a stroke; bringing stroke services into a specialist centre would increase the use of these two treatments. This approach has already delivered benefits for patients in other parts of the country and is supported by the Stroke Association.[1]

[1] https://www.stroke.org.uk/sites/default/files/new_pdfs_2019/our_policy_position/psp_-_reorganising_acute_stroke_services.pdf

2.4 In 2019, a series of workshops were held with people working in stroke services and other key stakeholders (including stroke survivors), to help work through and refine potential solutions. Also in 2019, targeted engagement was undertaken with stroke survivors and their families, to inform a pre-consultation business case (PCBC). However, due to the Covid-19 pandemic the programme was paused. Work restarted to progress this proposal in 2020/21.

3. Strategic Context

3.1 A stroke is a serious life-threatening medical condition that occurs when the blood supply to part of the brain is cut off by a blood clot or bleeding from a blood vessel. Strokes are a medical emergency and urgent treatment is essential. The sooner a person receives treatment for a stroke, the better the chance of recovery. Stroke strikes suddenly and can result in a devastating range of disabilities or death. It is one of the most significant public health issues of our time, with a profound and growing impact on society, our economy, individuals and families:

- stroke is the leading cause of disability and the fourth largest cause of death in the UK;
- stroke costs the UK economy £26 billion per year, including £3.2bn cost to NHS, £5.2bn to social care and £15.8bn in informal care. This is forecast to rise to between £61bn and £91bn by 2035.
- there are 80,000 stroke admissions in England each year and over 1 million stroke survivors, half of whom have a disability resulting from their stroke;
- by 2035, the number of strokes will increase by almost half and the number of stroke survivors by a third;
- half of stroke survivors are living with four or more other health conditions.

3.2 Transforming stroke care is a priority within the NHS Long Term Plan, which points to strong evidence that hyper acute interventions such as brain scanning and treatments such as thrombolysis are best delivered as a centralised hyper-acute stroke service delivered by a smaller number of well-equipped and staffed hospitals. This would see an increase in the number of patients receiving high-quality specialist care, meeting seven-day standards for stroke care which comply with national clinical guidelines. In addition, mechanical thrombectomy[2] and thrombolysis[3] can significantly reduce the severity of disability caused by a stroke.

[2] **Thrombectomy**, also known as mechanical clot retrieval, is the surgical removal of a blood clot in an artery. It is used to treat some strokes caused by a blood clot (ischaemic stroke) and it aims to restore blood flow to the brain.

[3] **Thrombolysis** is the breakdown of blood clots formed in blood vessels, using medication.

4. Current Services

4.1 The current providers of inpatient stroke services are Liverpool University Hospitals (at both the Royal Liverpool and Aintree sites) and Southport & Ormskirk Hospitals NHS Trust. Tertiary neuroscience services are provided by The Walton Centre NHS Foundation Trust, which delivers regional thrombectomy services across most of the Cheshire & Merseyside footprint. The most recent data on the number of confirmed strokes for each of the Hospital trusts providing hyper acute stroke services is as follows:

Strokes admitted - 19/20				
	Aintree	Royal	Southport	Total
2019/20 reported stroke numbers	524	556	397	1477

5. Clinical Model of Care

5.1 The proposal for a Comprehensive Stroke Service should meet the following clinical standards:

- 90% of patients should be directly admitted to a specialist stroke unit;
- patients should have access to specialist stroke care 24 hours a day, 7 days a week. This standard is not met in all sites;
- people with stroke should be treated on a specialist stroke unit for at least 90% of their hospital stay. For North Mersey this is only 62%;
- a specialist stroke unit should have at least 500-600 confirmed stroke admissions per year to provide the scale required to deliver effective and efficient 7-day services. Not all sites currently achieve the minimum recommended number of strokes per annum;
- none of the 3 current North Mersey Hyper Acute Stroke Units (HASUs) at the Royal, Aintree and Southport hospital sites admit patients to the clinical standard of 90% of patients treated within 4 hours;
- patients should be assessed by a specialist stroke consultant, stroke trained nurse and therapist within 24 hours. Currently there are insufficient numbers of stroke consultants and other specialist staff to meet this standard on all sites;
- following a brain scan, suitable patients should have thrombolysis within 1 hour of arriving at hospital. In North Mersey thrombolysis was provided to 7.2% of patients in 2018/19, the target in the NHS Long Term Plan is 20% by 2025;
- patients requiring medical thrombectomy should receive it as soon as possible and within 5 hours of arriving at hospital. In North Mersey 1.4% of patients received this in 2019/20, the NHS Long Term Plan target is 10% by 2022;
- after the first 72 hours, or once they are stable, patients should continue to be cared for on a stroke unit until they can be discharged with a comprehensive plan for ongoing rehabilitation, either to home or inpatient rehabilitation. In North Mersey, there is variation between CCG populations in the scope of the early supported discharge pathway.

5.2 The proposed new model of care would mean that suspected acute stroke patients would be taken by ambulance or referred by GP directly to a new single comprehensive stroke centre, which would be co-located with acute neurosurgical and stroke thrombectomy services. Patients self-presenting at other local A&E sites would be reviewed, with an on-site stroke specialist nurse, before being transferred to the stroke centre.

5.3 The model of care would require the establishment of an Acute Stroke Admission Unit, co-located with A&E which would receive patients directly at the front door. Patients assessed not to have had a stroke but in need of other care would be referred to A&E.

5.4 The service would have direct access to specialist scanners in order to maximise the number of patients who are able to receive thrombectomy and thrombolysis. Co-location with the Walton Centre thrombectomy service would significantly increase the number of patients that are able to access thrombectomy within the appropriate time window.

5.5 After the initial 72 hours of stroke care, patients would continue to be managed at an acute stroke unit for further care at a hospital closest to home, if not suitable for discharge. It is expected that up to 50% of patients would be discharged from hospital with support from the ESD (Early Supported Discharge) team, supporting patients to recover in their own homes.

5.6 The proposal that has emerged has been co-designed by clinical staff from the three trusts that currently provide stroke care locally - Liverpool University Hospitals NHS Foundation Trust (LUHFT), Southport and Ormskirk Hospital NHS Trust and The Walton Centre NHS Foundation Trust. Commissioners, patients who have experienced hyper acute stroke services and the Stroke Association have also been closely involved.

5.7 The preferred clinical model that emerged from an options appraisal process was for a centralised Comprehensive Stroke Centre on the Aintree Hospital site, co-located with specialist services provided by the Walton Centre and with post 72 hours care provided closer to home at either Aintree, Broadgreen or Southport hospitals. This model would bring together stroke clinicians into one networked team, providing a single comprehensive stroke service for the populations of Liverpool, Sefton, Knowsley and West Lancashire.

5.8 The first phase of the move of hyper acute stroke services from Southport and Ormskirk Trust and from the Royal Liverpool hospital is planned to take place on 19 September 2022, subject to support for the proposal from the Cheshire and Merseyside and Lancashire and South Cumbria ICBs. This timescale has been agreed by providers in response to the fragility of the current Southport and Ormskirk service which only has one specialist stroke consultant. This phase involves use of the current front door Emergency Department to receive patients and an expanded HASU area in the Stroke Department of the main hospital.

5.9 The second phase of implementation involves the capital works to establish a dedicated front door for stroke patients with a stroke assessment unit to be co-located with the Emergency Department on the Aintree site. This phase of the proposal would commence from 2023/24.

5.10 A final business case has been approved by the Trust Boards within scope of this proposal (Appendix One).

6. Finances

6.1 The Final Business Case (FBC) detailed the revenue costs for the hyper acute stroke service, at £7.05M per year, summarised below:

	FBC WTE	FBC £000
Direct staffing	97.87	4,594
Pharmacy	3.24	201
Radiology	14.05	857
NWAS		763
Estates & Other		638
Total		**7,053**

6.2 This cost is higher than the costs in the pre-consultation business case, which were assessed at circa £2.8m per year.

6.3 A notional budget of £2m has been incorporated into the Cheshire and Merseyside ICS financial plans for 2022/23 reflecting a part year effect assumption of phased implementation during the year and also that Lancashire and South Cumbria ICS has included £250k revenue costs in its plans, which represents the services to be provided to the population of West Lancashire.

6.4 Senior clinicians and Directors of Finance, within Trusts and ICBs, have done further work to review revenue costs within the revised full year expenditure figure of £7.05m, and to understand further the financial drivers for the proposed delivery model.

6.5 Increases in revenue costs are largely associated with the establishment of a separate hyper-acute assessment centre at the Aintree site, which are predominantly workforce costs to resource the ‘front door’ assessment service as an additional area of service provision, but these costs will not be incurred until at least April 2023.

6.6 Other increases between the PCBC and FBC version have been considered and would appear to be consistent with validation of the operating model but will require ongoing review.

6.7 It is expected that the part-year revenue costs for 2022/23 will be £2.55M and £285k capital (NWAS), as detailed in the table below, mainly as a result of phasing of the service changes but particularly due to the timing of establishing the 'front door' assessment service. On this basis, the anticipated costs in 2022/23 year are as follows:

	2022/23 costs				
	Revenue				Capital
	Full Year Impact £000	Phasing (Mid September-22) £000	22/23 Impact £000		£000
Clinical cost	4,594				
Less Assessment centre (not likely until April '23)	(1,938)				
	2,656	50%	1,328		
NWAS	822	50%	411		
- non-recurrent			91		285
Radiology	937	50%	469		
Pharmacy	201	50%	101		
Estates	600	25%	150		
- non-recurrent					4,000
Total costs			**2,549**		**4,285**

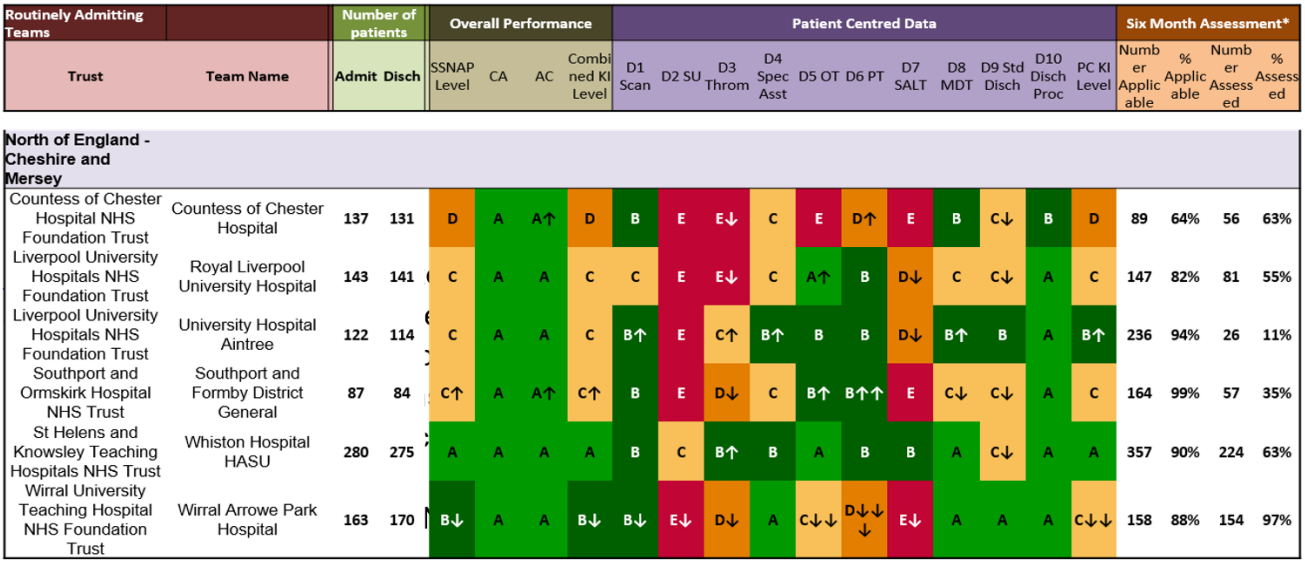
6.8 System Partners will work together to close the resulting 22/23 gap of £0.3m (difference between £2.25m and £2.55m) but it is considered to be an acceptable level of risk given the commitment to resolving the issue in the longer term. It is also necessary to confirm the capital resource position in relation to the 22/23 financial year within the ICB.

6.9 It is recognised that solutions for the funding of recurrent costs from 2023/24 are still to be agreed. It has been agreed that work will be undertaken immediately to:

- benchmark revenue costs with other hyper acute stroke services already established, including those in mid-Mersey, Salford and Wirral. This will provide further assurance that revenue costs are reasonable and represent value for money.
- adopt an open book principle to reviewing costs across all partners.
- propose a future funding solution, within a defined timescale, to enable this to be incorporated into financial plans for Trusts and the ICB from 2023/24.
- Undertake a lessons-learned review to support improved planning, including financial planning, for future ICS service change programmes.

7. Outcomes

7.1 The primary source for measuring outcomes and performance for stroke services is the Sentinel Stroke National Audit Programme (SSNAP), which measures the quality and organisation of stroke care in the NHS. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards. There are 10 Domains covering 44 Key Indicators of stroke care. A high level SSNAP dashboard is below. (Key to indicators [4]).



Routinely Admitting Teams		Number of patients		Overall Performance				Patient Centred Data										Six Month Assessment*			
Trust	Team Name	Admit	Disch	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	PC KI Level	Number Applicable	% Applicable	Number Assessed	% Assessed
North of England - Cheshire and Mersey																						
Countess of Chester Hospital NHS Foundation Trust	Countess of Chester Hospital	137	131	D	A	A↑	D	B	E	E↓	C	E	D↑	E	B	C↓	B	D	89	64%	56	63%
Liverpool University Hospitals NHS Foundation Trust	Royal Liverpool University Hospital	143	141	C	A	A	C	C	E	E↓	C	A↑	B	D↓	C	C↓	A	C	147	82%	81	55%
Liverpool University Hospitals NHS Foundation Trust	University Hospital Aintree	122	114	C	A	A	C	B↑	E	C↑	B↑	B	B	D↓	B↑	B	A	B↑	236	94%	26	11%
Southport and Ormskirk Hospital NHS Trust	Southport and Formby District General	87	84	C↑	A	A↑	C↑	B	E	D↓	C	B↑	B↑↑	E	C↓	C↓	A	C	164	99%	57	35%
St Helens and Knowsley Teaching Hospitals NHS Trust	Whiston Hospital HASU	280	275	A	A	A	A	B	C	B↑	B	A	B	B	A	C↓	A	A	357	90%	224	63%
Wirral University Teaching Hospital NHS Foundation Trust	Wirral Arrowe Park Hospital	163	170	B↓	A	A	B↓	B↓	E↓	D↓	A	C↓↓	D↓↓↓	E↓	A	A	A	C↓↓	158	88%	154	97%

7.2 In order to monitor the anticipated improvement in patient outcomes, a North Mersey stroke dashboard is in development that incorporates SSNAP indicators, in addition to outcome indicators for stroke mortality. It will also enable benchmarking. The draft dashboard will be developed further with performance targets for phases one and two of implementation.

LUHFT will also consider the most effective way to undertake local evaluation of patient experience and feedback, which could be incorporated into the dashboard.

The draft dashboard is overleaf:

[4] https://www.strokeaudit.org/SupportFiles/Documents/Clinical-Audit-Resources/Simplified-Technical-Info-version-3-(September-201.aspx

Overarching Outcomes/Process Measures of North Mersey HASU

Measure	Metric	Direction	Target	Baseline	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24
1. Number of stroke patients (72 hour cohort)	Number	Increase	> Baseline	1415				
2. % all stroke patients given thrombolysis	Percentage	Increase	20	9				
3. % of patients receiving thrombectomy	Percentage	Increase	10	1.4				
4. % of patients directly admitted to a stroke unit within 4 hours of clock start	Percentage	Increase	75-90	12.3				
5. % of patients who spent at least 90% of their stay on stroke unit	Percentage	Increase	85-90	54.5				
6. Reduce average length of stay for stroke patients	Days	Reduce	18.0 - 17.0	18				
7. Stroke in hospital deaths	Number	Reduce	TBC	TBC				
8. Stroke mortality rates, under 75 (age standardised)	Rate per 100,000	Reduce	<16.0	16				
9. Stroke mortality rates, over 75 (age standardised)	Rate per 100,000	Reduce	<456.5	456.5				
Patients who would recommend stroke services in North Mersey	Percentage	Increase	TBC	TBC				
Staff who would recommend stroke services in North Mersey	Percentage	Increase	TBC	TBC				

SSNAP Performance - North Mersey HASU

Trust/Site	NW HASU Site					
Measure	2021/22 Baseline	2022/23 Target	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24
1. Overall SSNAP Level	D	B				
Domain 1. Scanning	C	A				
Domain 10. Discharge processes	A	B				
Domain 2. Stroke Unit	E	B				
Domain 3. Thrombolysis	D	B				
Domain 4. Specialist Assessments	D	B				
Domain 5. Occupational Therapy	C	B				
Domain 6. Physiotherapy	C	B				
Domain 7. Speech and Language Therapy	D	C				
Domain 8. Multidisciplinary Team Working	D	B				
Domain 9. Discharge	B	A				

SSNAP Performance - Cheshire and Merseyside Benchmark

Measure	Aintree Hospital	Countess of Chester	St Helens Trust	Wirral Hospital
1. Overall domain score	D	D	B	B
Domain 1	C	B	B	B
Domain 10	A	A	A	A
Domain 2	E	E	C	E
Domain 3	D	E	C	D
Domain 4	D	B	B	B
Domain 5	C	E	B	B
Domain 6	C	E	C	B
Domain 7	D	E	B	D
Domain 8	D	C	A	A
Domain 9	B	B	C	A

8. Governance, Scrutiny and Assurance

8.1 The proposal has been reviewed by an independent NHS Clinical Senate, at the request of NHS England, to ensure there is a sound clinical evidence base and compliance with clinical best practice and standards. The Clinical Senate review endorsed the new clinical model of care and the proposal for the reconfiguration of local hyper acute stroke services.

8.2 The proposal has been reviewed by NHS England through a two-stage process, to seek assurance that commissioning bodies are complying with their statutory duties and other responsibilities under the NHSE/I Assurance Framework.[5]

8.3 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, including in the context of access or location. The five CCGs which represented the majority of patients that use services provided by LUHFT, presented the case for change for these proposals to Knowsley, Liverpool, Sefton and West Lancashire OSCs in January 2022. All the OSCs considered this proposal to be a substantial variation in the way services are currently delivered and agreed to convene a joint OSC. The joint OSC scrutinised the Pre-Consultation Business Case and the engagement / consultation plans prior to the launch of the formal public consultation and have received the findings from the consultation. The Joint OSC will undertake a final review of the process on 07 September 2022 after a decision is made by commissioners.

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

8.4 Responsibility for final commissioner approval of the proposal now resides with the Cheshire and Merseyside Integrated Care Board (ICB). It is intended that the proposal will be considered by the ICB at its meeting on 04 August 2022. As this proposal also impacts on the population of West Lancashire, the proposal was also presented to the Lancashire and South Cumbria ICB for consideration at its meeting on 27 July 2022.

9. Engagement and Public Consultation

9.1 Patients, public and key stakeholders have been involved throughout every stage of this process. Effective involvement requires an open and transparent approach to explaining the proposal to change the delivery of hyper acute stroke services; providing opportunities to provide views and influence this change.

9.2 Pre-consultation engagement was also undertaken to obtain valuable insights from people who have experience of hospital stroke services, also involving the Stroke Association which gave access to their network of support groups in every part of the catchment area.

9.3 Commissioners launched a formal public consultation, from 22 November 2021 to 14 February 2022. The consultation provided opportunities for people to give their views on the proposal. The consultation presented a preferred option for the creation of a single Comprehensive Stroke Centre on the Aintree University Hospital site, which would receive all patients with a suspected stroke for the first 72-hours of care. The consultation provided a range of opportunities for people to give their feedback on the proposal, to suggest other options and additional improvements.

9.4 580 people completed the questionnaire and 55 people participated in online or phone qualitative engagement sessions. Therefore, in total, more than 630 people, participated in the consultation.

9.5 44% of respondents agreed that bringing staff from different hospitals together to create a Comprehensive Stroke Centre at Aintree University Hospital was the best plan for improving the care people receive in the first 72 hours after having a stroke.

9.6 52% of people said they would be happy to be treated at a hospital that was further away from the one they might be treated at now if it meant they would be getting the best care.

9.7 Of those disagreeing with the proposal, or who were unsure, approximately half felt there was a better potential solution which hadn’t been considered. Two main concerns were expressed by these respondents. The first was that such a specialist centre should be located as close as possible to where patients live to ease access for family members.

The second was concern about ambulance journey times and potential traffic congestion in receiving timely treatment from a single centre.

9.8 The above results are broadly in line with the findings from the 2019 pre-consultation engagement with stroke survivors and their families conducted in partnership with the Stroke Association. Most stroke patients and their carers were in favour of bringing stroke services together in one single location. They could see the benefit of developing a 'centre of excellence' staffed by specialists and providing a comprehensive range of support services at one centralised location.

9.9 In summary, there was support for a single hyper-acute stroke service. However, this was conditional on a range of factors, including an efficient ambulance service that could respond quickly to patient need, better access for friends and family and better post-stroke support services. The findings from the consultation have informed the final business case, including a mitigation plan to address issues and concerns.

10. Conclusion

10.1 This paper sets out the proposal for a Comprehensive Stroke Centre to deliver a new model of care for hyper acute stroke services for the people of Knowsley, Liverpool, Sefton and West Lancashire. This proposal is designed to improve outcomes for people who experience stroke and to eliminate unwarranted variation in care and outcomes by bringing together stroke services with access to the best treatments, delivered by a networked team of specialist clinicians, providing consistently high-quality stroke care 24/7, regardless of where people live across this catchment area.

11. Recommendations

11.1 **The Board is asked to:**

- **Approve** the proposal for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire.

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board Meeting

Virtual ward expansion across Cheshire and Merseyside

04 August 2022

NHS Cheshire and Merseyside Integrated Care Board Meeting

NHS Cheshire and Merseyside

Date of meeting:	04 August 2022
Agenda Item No:	ICB/8/22/13
Report title:	Virtual ward expansion across Cheshire and Merseyside
Report Author & Contact Details:	Geraldine Murphy-Walkden, Programme Director geraldine.murphywalkden@knowsleyccg.nhs.uk
Report approved by:	Anthony Middleton, Director of Performance and Planning

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

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

The Cheshire and Merseyside plan to expand virtual wards across Cheshire and Merseyside was agreed by the Cheshire and Merseyside Health and Care Partnership Executive team at its meeting on 14 June 2022.

A paper outlining the expansion of virtual wards across Cheshire and Merseyside was also considered in November 2021 by the Joint Committee of the nine former Cheshire and Merseyside CCGs.

Executive Summary and key points for discussion

The 2022/23 Priorities and Operational Planning requirements ask all ICSs to deliver 40-50 virtual ward 'bed' capacity per 100k over 18 years population by December 2023. At 40 per 100,000 Cheshire and Merseyside (C&M) threshold is 877 virtual beds available at any one time. C&M plans to deliver 900 'beds' by December 2023 with option for additional 15% surge to support winter flow and system pressure. National funding is available:

- in 2022/23 £200m via system development funding - fair share is £9.865M (subject to national assurance of plans: narrative, workforce, finance).
- in 2023/24 £250m is available nationally with the expectation Integrated Care Board (ICB) match funds C&M allocation of £12.3M (national award subject to delivery of plan) 'Budget' in 23/24 circa £24.6M.
- from 2024/25 no further national funding is available, expectation ICB will cover all costs, with potential realisation of benefits offsetting expenditure. E.g., reduced Length of stays, avoided admission and other benefits.

Recommendation/ Action needed:	**The Committee is asked to:** • **note** the planned extension of virtual wards across Cheshire and Merseyside and future funding requirements.

NHS Cheshire and Merseyside
Integrated Care Board Meeting

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:	
The item involves sensitive HR issues	n/a
The item contains commercially confidential issues	n/a
Some other criteria. Please outline below:	n/a

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	

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 ICB Board Assurance Framework or any other corporate or Place risk? (*Please list*) n/a						
What level of assurance does it provide?						
Limited		**Reasonable**		**Significant**		
Any other risks? **Yes** / No. If **YES,** please identify within the main body of the report.						
Is this report required under NHS guidance or for a statutory purpose? (*Please specify*) n/a						
Any **Conflicts of Interest** associated with this paper? If **YES,** please state what they are, and any mitigations undertaken. n/a						
Any current services or roles that may be affected by issues as outlined within this paper? The telehealth hub services operating in Merseycare, Wirral and Cheshire require expansion to support the increasing number of Virtual Ward beds. An options appraisal of the optimum configuration for resilience, efficiency, value, and effectiveness is currently being undertaken.						

	Process Undertaken & Impact Considerations	Yes	No	N/A	**Comments** (i.e., date, method, impact e.g., feedback used). ***Greater detail to be covered in main body of report***
Document Development	Financial – any resource impact?	x			Financial template completed as part of virtual ward plan developed to support expansion – agreed by ICB Director of Finance prior to national submission 20/06/2022. Full allocation pending national plan approval.
	Patient / Public Involvement / Engagement	x			Patient and user feedback gathered as part of operating service delivery- regularly used to inform local and national evaluation, changes required and service expansion
	Clinical Involvement / Engagement	x			Narrative template completed describing clinical model required for the plan developed to support expansion – agreed by Clinical leads prior to national submission 20/06/2022
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?	x			EIA completed by Merseycare
	Regulatory or Legal - any impact assessed, or advice needed?	x			DPIA, QIA. DSA completed by Merseycare/ IMersey
	Health Inequalities – any impact assessed?	x			Community Services vary across C&M. The additional investment is being used to level up to a consistent model reducing inequalities and unwarranted variation.
	Sustainable Development – any impact assessed?	x			Impact of the service metrics are being captured as part of the evaluation measures

Next Steps:	Mobilise early phased services – Quarter 1 funding released to C&M – executive approval to proceed in line with planned approach 14/06/2022.

Responsible Officer to take forward actions:	Anthony Middleton, Director of Performance and Planning, Cheshire and Merseyside ICB

Appendices:	n/a

NHS Cheshire and Merseyside Integrated Care Board Meeting

Glossary of Terms	Explanation or clarification of abbreviations used in this paper
ARI	Acute respiratory infections
C&M	Cheshire and Merseyside
DPIA	Data Protection Impact Assessment
DSA	Data Sharing Agreement
EIA	Equality Impact Assessment
ICB	Integrated Care Board
QIA	Quality Impact Assessment
SDF	System Development Funding

Virtual ward expansion across Cheshire and Merseyside

1. Executive Summary

1.1 Virtual wards support people, who would otherwise be in hospital, to receive the care and treatment they need in their own home or usual place of residence. Support delivered through VWs is clinically supervised and can include remote monitoring using apps, technology platforms, wearables, and medical devices such as pulse oximeters. Care may also involve face-to-face visits from multi-disciplinary teams based in the community, sometimes called Hospital at home.

1.2 2022/23 Priorities and Operational Planning require all Integrated Care Systems (ICS) to deliver 40-50 virtual ward 'bed' capacity per 100k of over 18 years population by December 2023. At 40 per 100,000 Cheshire and Merseyside (C&M) threshold is 877 virtual beds available at any one time. Currently C&M have a virtual ward capacity of 180 beds. The expansion will look to increase this volume to 587 by the end of 22/23 increasing to 900 'beds' by December 2023 with option for additional 15% surge to support winter flow and system pressure once at full capacity.

1.3 National funding is available via £200m in the system development funding in 2022/23. C&M's fair share is £9.865M (subject to national assurance of plans: narrative, workforce, finance). In 2023/24 £250m is available with the expectation the Integrated Care Board (ICB) match funds C&M allocation of £12.3M (national award subject to delivery of plan) providing a 'Budget' in 23/24 circa £24.6M. From 2024/25 there is no further national funding with the expectation ICBs will cover all costs, with realisation of benefits offsetting expenditure. To support system evaluation the programme has commissioned the Innovation Agency to evaluate impact of virtual wards. This work will describe impact on a range of metrics using qualitative and quantitative data from impact on length of stay, hospital, and other care attendances through to patient, carer, and staff confidence to use the service.

2. Introduction / Background

2.1 C&M are leaders in virtual ward development using remote monitoring with experience of delivering at scale. C&M system is 1 of 10 sites selected and funded to support the national team in rapid evaluation of impact. COVID-19 virtual wards were mobilised during the pandemic following the national operating procedure which has been expanded by C&M clinical leaders to support other conditions and acute respiratory infections (ARI), i.e., COPD, Bronchiectasis and Community acquired pneumonia. A Heart failure VW pilot is operating in Liverpool Universities NHS Foundation Trust (LUHT). Frailty virtual ward experience is being leveraged from Wirral University Teaching Hospital NHS Foundation Trust (WUTH) as part of the expansion plan and Cancer virtual ward pathways are in development working with Clatterbridge Centre for Oncology. C&M are well placed to use local and national experience to agree a consistent approach to services. Working with clinical leaders at a system level, with hospital teams and place-based mobilisation C&M will respond to the national requirement to deliver virtual ward capacity to increase care options.

3. Main Body

3.1 C&Ms vision for virtual wards, aligned to the national definition, is to: -

- deliver safe, quality care for appropriate patient cohort(s) offering a variety of referrers clear pathways into virtual wards with appropriate hand-offs between services
- ensure digital literacy is not a barrier for patients with care personalised to needs
- ensure patients not eligible for virtual wards receive the correct services appropriate to conditions, a no wrong front door approach
- allow system visibility of capacity, occupancy and key metrics informing ICS, regional, and national teams monitoring and evaluation.

3.2 C&M will look to achieve: -

- well utilised virtual wards
- avoidable admissions for patients suitable to be cared for in a virtual wards
- reduced length of stay for patients able to 'step down' to a virtual wards
- acute bed capacity liberated to mitigate winter pressures/ support elective recovery
- workforce used more efficiently, in hospital and in the community
- improved Patient & Staff experience
- reduction in nosocomial infection for virtual wards patients and a reduction in deconditioning
- escalation of deteriorating patients to acute care ensuring continued patient safety.

3.3 Virtual ward beds will be linked to hospital flows with the following distribution: -

Speciality	No of VW beds per acute site
Frailty	30
Acute Respiratory Infections (COPD, CAP, Bronchiectasis, COVID)	30
Heart Failure	15
Cancer & Palliative care	25
	* LUHT = 2 sites

3.4 Planned mobilisation: -

- ARI - Early adopters St Helens and Knowsley Teaching Hospital NHS Foundation Trust (STHK), Warrington and Halton Hospitals NHS Foundation Trust (WUHT) followed by all sites by end of 2022/23
- Frailty- Early adopter WUHT followed by all sites by end of 2022/23
- Heart Failure - Early adopter LUHT during 2022/23 followed by all sites during 2023/24
- Cancer & Palliative Care - Early adopter WUHT, STHK followed by all sites during 2023/24.

3.5 Virtual wards will provide an alternative to admission and early supported discharge reporting to the system transformation board. Investment will be used to level up services offering a consistent model of care, closing relevant gaps in community services inherited by the ICB

3.6 The C&M virtual ward model will embed: -

- consensus Clinical pathways and escalations common across the system
- pathway's technology enabled using the same technology/platform, easy to use devices and wearables, with patient and carer support commissioned on use
- scale elements & 'once for many' providing efficiencies/minimising staffing challenges
- 24/7 365 cover
- personalised care /shared decision for all those using virtual ward services flexible resources / mutual aid agreements across services / innovative staffing solutions e.g. rotation/training/joint appointments
- provider collaborative delivery models with clear accountable & clinical governance
- aligned communication - system and public.

4. Recommendations

4.1 **The Board is asked to:**

- to **note** the planned extension of virtual wards across Cheshire and Merseyside and future funding requirement.

5. Officer contact details for more information

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