NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside (held in public)

27 March 2025
09:00am – 12:20pm
The Events Hall,
The Heath Business and Technical Park,
Runcorn, WA7 4QX.
Sitemap details: https://theheath.com/sitemap-2/

Public Notice: Meetings of the Board of NHS Cheshire and Merseyside are business meetings which for transparency are held in public. They are not 'public meetings' for consulting with the public, which means that members of the public who attend the meeting cannot take part in the formal meetings proceedings. The Board meeting is live streamed and recorded.

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

Public Speaking Time: 09:00am
Further detail at: https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-march-2025/

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
09:30am	**Preliminary Business**				
ICB/03/25/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain *ICB Chair*	For information	-
ICB/03/25/02	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 on the **ICB website**)*	Verbal		For assurance	-
ICB/03/25/03	Chairs announcements	Paper		For information	Page 6
ICB/03/25/04	Experience and achievement story	Film	-	For Information	-
09:35am	**Leadership Reports**				
ICB/03/25/05	Report of the ICB Chief Executive	Paper	Graham Urwin *Chief Executive*	For approval	Page 9
ICB/03/25/06 **09:50am**	Report of the ICB Director of Nursing and Care	Paper	Chris Douglas *Director of Nursing & Care*	For assurance	Page 23
ICB/03/25/07 **10:00am**	NHS Cheshire and Merseyside Finance Report Month 10	Paper	Mark Bakewell *Director of Finance*	For assurance	Page 29
ICB/03/25/08 **10:10am**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	Page 70
ICB/03/25/09 **10:20am**	Consolidated report of the ICB Directors of Place	Paper	Carl Marsh *Place Director (Warrington)* Alison Lee *Place Director (Knowsley)*	For assurance	Page 112
10:35am	**ICB Business Items and Strategic Updates**				
ICB/03/25/10	Cheshire and Merseyside Cancer Alliance Update	Paper and Presentation	Jon Hayes *CMCA Managing Director* John McCabe *CMCA Medical Director*	For assurance	Page 150

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/03/25/11 **10:55am**	Liverpool Adult Acute and Specialist Providers Case for Change	Paper	James Sumner *Joint Chief Executive, LUFHT & LWH*	For approval	Page 172
ICB/03/25/12 **11:15am**	Report on the October/November 2024 public engagement on Improving Hospital Gynaecology and Maternity Services in Liverpool	Paper	Dr Fiona Lemmens *Deputy Medical Director*	For assurance	Page 215
ICB/03/25/13 **11:30am**	NHS Cheshire and Merseyside 2025-26 Joint Forward Plan (Annual Refresh)	Paper	Clare Watson *Assistant Chief Executive*	For approval	Page 319
ICB/03/25/14 **11:40am**	NHS Cheshire and Merseyside Financial Plan 2025-2026	Paper	Mark Bakewell Director of Finance	For approval	Page 333
ICB/03/25/15 **12:00pm**	Supporting Care Leavers Into Employment	Paper and Presentation	Mike Gibney Chief People Officer	For decision	Page 349
12:10pm	**Meeting Governance**				
ICB/03/25/16	Minutes of the previous meeting: • 30 January 2025.	Paper	Raj Jain *ICB Chair*	For approval	Page 359
ICB/03/25/17	Board Action Log	Paper	Raj Jain *ICB Chair*	To consider	Page 374
12:15pm	**Reflection and Review**				
ICB/03/25/18	Closing remarks and review of the meeting	Verbal	Raj Jain *ICB Chair*	For information	-
12:20pm	**CLOSE OF MEETING**				

Consent items

All these items have been read by Board members and the minutes of the March 2025 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/03/25/19	Board Decision Log **(CLICK HERE)**	For information	-
ICB/03/25/20	NHS Cheshire and Merseyside Green Plan 2025-28	For assurance and approval **Board decisions within:** • **ICB Green Plan** - *recommendation from the System Sustainability Board for the ICB Board to* ***approve the NHS Cheshire and Merseyside Green Plan 2025-28***	Page 377
ICB/03/25/21	Emergency Preparedness Resilience and Response Core Standards 2024-25 Assurance Report	For assurance • ***note*** *the contents of the report* • ***note*** *the significant improvement on the 2023/24 self-assessment compliance rating.*	Page 395
ICB/03/25/22	ICB Committee Chairs Highlight Reports: • Audit Committee (*ICB/03/25/22a)* • Children and Young Peoples Committee (*ICB/03/25/22b)* • Finance, Investment and Our Resources Committee (*ICB/03/25/22c)* • Quality and Performance Committee (*ICB/03/25/22d)* • Remuneration Committee (*ICB/03/25/22e)* • System Primary Care Committee (*ICB/03/25/22f*)	For assurance and approval **Board decisions within:** • **Audit Committee Chairs Highlight Report** – *recommendation from the Committee for the ICB Board* ***to approve the minor amendments to and the adoption of the updated ICB Scheme of Reservation and Delegation (SORD) and ICB Operational SORD***	Page 402
ICB/03/25/23	Confirmed Minutes of ICB Committees: • Audit Committee – December 2024 • Children and Young Peoples Committee – November 2024 • Finance, Investment and Our Resources Committee – January 2025 • Finance, Investment and Our Resources Committee – February 2025 • Quality and Performance Committee – January 2025 • Quality and Performance Committee – February 2025 • System Primary Care Committee – December 2024	For assurance	Page 376

Date and start time of future meetings

29 May 2025, 09:00am, venue tbc
19 June 2025, 09:00am – online meeting via MS Teams
31 July 2025, 09:00am, Venue tbc
25 September 2025, 09.00am, venue tbc
27 November 2025, 09:00am venue tbc

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

Following its meeting held in Public, the Board will hold a meeting in Private from 12:45pm

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Report of the Chair of NHS Cheshire and Merseyside

Agenda Item No: ICB/03/25/03

Responsible Director: Raj Jain, ICB Chair

Report of the Chair of NHS Cheshire and Merseyside (March 2025)

1. Introduction

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **note** the updates within the report.

3. Key updates of note

3.1 **NHS Chair and Chief Executives meeting.**

On Thursday 13 March 2025 all NHS Chairs and Chief Executives were required to attend a meeting in London led by the outgoing Chief Executive of the NHS (Amanda Pritchard) and the new Interim Chief Executive (Sir James Mackey). During this meeting we were informed of the current state of finances of the country and the impacts this has on NHS expenditure in 2025/26. Cheshire and Merseyside has the largest deficit of all systems, though as a percentage of its large budget it ranks in the middle of all ICBs. We must act to ensure we continue to improve our access and safety standards whilst delivering financial efficiency. Further comment on this will be made by the ICB Chief Executive at the March 2025 ICB Board meeting.

3.2 **Appointment of the ICB Chief Executive**

Since the last meeting of the Board in January 2025 the ICB has successfully undertaken the recruitment process for a new Chief Executive, following the decision of Graham Urwin to retire at the end of June this year. Following a robust national recruitment process, which included the involvement of a range of ICB staff and system stakeholders, I am pleased to announce the appointment of Cathy Elliot. Cathy, who joins us from the beginning of June, will bring a wealth of varied skills and experience to Cheshire and Merseyside which will be instrumental in helping the ICB to lead the system and work collaboratively with partners in delivering against the impending 10 Year Plan.

3.3 **Non-Executive Member Updates**

Neil Large has now left the ICB having taken on the appointment of Interim Chair of The Countess of Chester NHS Foundation Trust.[1] I would like to express my thanks to Neil for all of the support he has provided to the Board and colleagues since the establishment of the ICB in 2022 and wish him well in his new role.

[1] https://www.cheshireandmerseyside.nhs.uk/posts/the-countess-of-chester-hospital-nhs-foundation-trust-appoints-interim-chair/

3.4 With the departure of Neil, the ICB has progressed the appointment of an additional Non-Executive Member for an interim period of six months. I would like to welcome Mike Burrows who brings a wealth of experience to the ICB.

3.5 **Visit of NHS England Chair to Cheshire and Merseyside**
On the 27 February 2025 we welcomed the current NHS England Chair Richard Meddings to Cheshire and Merseyside for a roundtable discussion with the Board. The meeting with Richard was a fantastic opportunity to discuss both the achievements of and innovations being undertaken across the region as well as the challenges being faced.

3.6 Whilst he was in the region, Richard also visited the Living Well Service outreach bus that was operating that day out of the Chun Wah supermarket in Liverpool. Richard got to meet the staff running the services as well as many of the Chinese Community Champions and volunteers who are instrumental in promoting to and supporting the community to access such services. Richard also visited Paddington Community Diagnostics Centre to hear more about the role they are playing in transforming access to care and patient outcomes.

3.7 Following his visit Richard wrote back to the ICB expressing his gratitude for providing him with an invaluable opportunity to deepen his understanding of how the ICB's work is making a meaningful difference to patients and the wider community, and expressed his thanks to everyone for making his visit so informative and engaging. I would like to echo that gratitude to Board members and ICB staff who made this an excellent meeting.

3.8 **Freedom To Speak Up**
Following the Annual Freedom To Speak Up (FTSU) update to Board at its January 2025 Board meeting[2] the Board had a FTSU development session which outlined further the responsibility of the Board and the importance of this agenda. Board members have also been required to complete the FTSU Self-Assessment/Reflection tool to help the board reflect on its current position and the improvement needed to meet the expectations of the NHS England, National Guardian Offices and Care Quality Commission in relation to FTSU and its arrangements within our ICB. If not done so already, Board members are requested to complete the self-reflection tool before the end of March 2025.

4. Contact details for more information

Raj Jain
ICB Chair

Megan Underwood, Executive Assistant
megan.underwood@cheshireandmerseyside.nhs.uk

[2] https://www.cheshireandmerseyside.nhs.uk/media/tbbbigkh/cm-board-jan2025-full-packv3_compressed.pdf

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Report of the Chief Executive

Agenda Item No: ICB/03/25/05

Responsible Director: Graham Urwin, Chief Executive

Report of the Chief Executive (March 2025)

1. Introduction

1.1 This report covers some of the work which takes place by the Integrated Care Board which is not reported elsewhere in detail 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. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **consider** the updates to Board and seek any further clarification or details
- disseminate and cascade key messages and information as appropriate
- **approve** the variation to the Specialised Commissioning Joint Controller Agreement set out in Appendix One.

3. NHS England and ICB national announcements

3.1 Colleagues will have heard last week the announcement from the Prime Minister[1] regarding the intent to abolish NHS England within the next two years and bring its functions into the Department of Health and Social Care, and that the combined headcount of both organisations is expected to be cut by 50%. Additionally, we also received confirmation that all Integrated Care Boards will need to reduce their running (both management and programme) costs by 50% by Quarter 3 2025/26, and that NHS Trusts will need to cut their 'corporate services' budgets back to pre-pandemic levels. At the time of writing this report there has not been any further detail released however should there be before the Board meeting then I will look to provide an update to Board.

3.2 This is a truly challenging time for the NHS and our dedicated workforce, whose wellbeing we will continue to put great emphasis on and provide support to. We will continue to keep our staff engaged and involved as we consider the plans that will be required in order to meet the 50% running cost reduction whilst balancing the requirement to deliver on the financial, quality, safety and performance priorities of the ICB and the system.

4. Quarter 3 Assurance Meeting with NHS England

4.1 The ICB's Quarter 3 Assurance meeting with NHS England North West took place on 29 January 2025 and focused on a range of areas including the

[1] https://www.gov.uk/government/news/worlds-largest-quango-scrapped-under-reforms-to-put-patients-first

delivery of key performance targets, financial performance ahead of year end and the 2025/2026 Operational Planning round. Discussions highlighted:

- **Cancer**: The ICB is delivering above national average cancer survival for the first time, with diagnostic access and earlier detection key contributors to that achievement. NHS England acknowledged the significant achievement this represents and intends to highlight this work as a national exemplar.
- **Urgent & Emergency Care (U&EC)**: Continued focus is required to deliver further improvements in U&EC performance, including ambulance handover and 4 hour performance, which the system expects to achieve 76% delivery by year end.
- **Elective & Diagnostics:** Whilst the System continues to strive to achieve zero 65 week waits by year end it is likely there will be approximately 250 patients waiting at the end of March 2025. The system's strong diagnostic performance was commended, and a joint commitment was made to share lessons learnt in delivering and sustaining performance.
- **Finance:** The ICB's commitment to deliver an out-turn deficit of £200 million was noted, the Regional Team will work closely with ICB colleagues as year-end approaches to support the mitigation of any risks to delivery
- **2025/2026 Planning Approach:** The discussion took place prior to the publication of the planning guidance. The challenging context of this year's planning round was recognised and a commitment to close working throughout the process was re-stated.
- **EPRR Assurance:** The demonstrable improvement in EPRR assurance and strengthened governance arrangements since the last assurance submission were noted.

4.2 I am pleased that the progress made by the system across a range of areas including diagnostics and cancer care have been recognised by NHS England. We will continue to work with regional colleagues to deliver further improvement in performance in key areas such as U&EC, as well as financial recovery.

5. Requirement to extend the Joint Controller Agreement with NHS England in relation to delegation of specialised commissioning

5.1 In January the ICB Board approved the updated Delegation Agreement for specialised services. As part of this approval, it was noted that the transfer of NHS England staff supporting specialised services to the North West ICBs (NHS Lancashire and South Cumbria ICB will host these staff on our behalf) was now due to happen on 01 July 2025.

5.2 We have received the attached letter from NHS England (Appendix One) requiring us to extend the Joint Controller Agreement in relation to NHS England providing the administrative and management services for specialised services by the NHS England regional teams until 30 June 2025 pending these staff moving across to be employed by NHS Lancashire and South Cumbria ICB. A further update on the workforce arrangements beyond July 2025 will be shared with the Board during Quarter 1 of 2025-26.

5.4 **The Board is asked to:**

- **Approve** the Chief Executive confirming in writing to NHS England the approval of NHS Cheshire and Merseyside to extend the current Joint Controller agreement until the staff transfer from NHS England to the North West ICBs on 1st July 2025 (NHS Lancashire and South Cumbria ICB as host).

6. Engagement around future arrangements for supporting people with Long COVID

6.1 Further to the information included within my update to Board in January 2025 in relation to the cessation of the national ring fenced allocation used to fund local Long COVID services and the decision of the ICB Executive Committee, the ICB is currently undertaking the review of future options for ensuring appropriate support is available for patients with Long COVID. It is planned that an options appraisal and recommendation will be brought to the ICB Board in May 2025 to make this decision.

6.2 In order to inform these options, we have undertaken significant engagement including:

- an online survey which ran between 14 February and 16 March 2025. This has received 518 responses and 9 email responses, with responses from:
  - 210 current Long COVID service users
  - 83 previous Long COVID service users
  - 40 people who have had Long COVID but did not access Long COVID services
  - additionally, we had feedback from 22 carers, and 51 staff (27 from within and 24 outside of Long COVID services).

6.3 We have commissioned an external organisation to undertake an independent analysis of the survey results and prepare a report. This analysis will be completed by mid-April.

6.4 Additionally, we have also undertaken/undertaking the following:

- our ICB commissioning leads for the review have also been holding a range of sessions to directly gather to the views and experiences from providers, staff, patient groups, and charities with an interest in long COVID;
- we are liaising with a number of ICBs around England who are undertaking, or have undertaken similar reviews to understand their experiences of changing their support for people with Long COVID
- undertaking an evidence review of the latest research
- reviewing correspondence from both service users and staff outlining their experience of care for themselves/people with Long COVID.

6.5 In advance of finalising the options appraisal we will form an “expert panel” to assess the options using an agreed assessment criteria (comprising a representative group of service users, clinical professionals with direct expertise in Long COVID and GPs). The final options and updated Equality and Quality

Impact Assessments will then be considered through the ICB governance process, including our Clinical Effectiveness Group, in advance of the final options and recommendation being considered at a public ICB Board Meeting in May 2025.

6.6 Further public information is available on the ICB website. Further communications with our public and local stakeholders will be undertaken throughout the process to keep them informed of progress.

7. Update on the consultation on cessation of NHS funded Gluten Free Prescribing

7.1 Following Board approval at its meeting in November 2024 the ICB commenced the start of its 6-week public consultation on 28 January 2025 and which was completed on the 11 March 2025. The ICB received an excellent response to the consultation with over 1,000 responses received to the online questionnaire. All responses are being analysed by an independent organisation, who will provide an independent consultation report to the ICB and which will inform the final decision making report that will come back to the ICB Board at its May 2025 meeting.

7.2 This final decision report will also be informed by the feedback that has and will be received from Local Authority Health and Overview Scrutiny Committee (HOSC) meetings. Following agreement from the Board to proceed with the public consultation, the ICB met with eight of the nine Cheshire and Merseyside Local Authority HOSCs to inform them of the ICBs proposals and seek their determination as to whether they thought our proposals constituted a substantial development or variation (SDV) in services, which would result in the requirement for the ICB to formally consult with the HOSC(s).

7.3 Seven of the eight HOSCs agreed the proposals constituted as an SDV and as such Joint HOSC meetings (of the seven Local Authorities)[2] are in the process for the ICB to attend during April and early May to enable the ICB to formally consult and for the Local Authority HOSCs to scrutinise the ICBs proposals.

8. Update on Clinical Policy Harmonisation Phase Three Engagement

8.1 The six-week engagement for the third phase of the ICBs Clinical policy harmonisation closed on 19 February 2024 this was the final phase which allowed public, patients and stakeholder to feedback on the remaining 25 policies. 116 responses were received in total. The team are in the process of analysing the results and pulling together a report which will be presented back to the ICBs Clinical Effectiveness Group in May 2025. Once complete a total of 109 policies will have been harmonised across Cheshire and Merseyside since its establishment. More information can be found on our website at https://www.cheshireandmerseyside.nhs.uk/get-involved/previous-consultations-and-engagements/clinical-policies/.

[2] Joint HOSC on behalf of the following 7 Councils: Cheshire East, Halton, Knowsley, Liverpool, Sefton, Warrington and Wirral.

9. NHS Staff Survey 2024

9.1 The national NHS Staff Survey 2024 results were published on 18 March 2025.[3] A more detailed report on the results for the ICB and the Cheshire and Merseyside system will be presented to the Board at its meeting in May 2025, however in summary the latest staff survey results for the ICB indicate largely stable scores across key themes, with modest fluctuations (Table One).

Table One: Staff Survey Briefing: Key Highlights and Next Steps for 2025

People Promise Area		Score (out of 10)	
		2024	2023
1	We are compassionate and inclusive	7.47	7.48
2	We work flexibly	7.45	7.28
3	We are a team	7.25	7.19
4	We have a voice that counts	6.79	6.81
5	We are recognised and rewarded	6.65	6.67
6	We are safe and healthy	6.40	6.35
7	We are always learning	5.13	5.23

9.2 While no drastic changes were observed in the People Promise area scores from the 2023 results the overall findings highlight specific areas requiring attention to improve staff experience and engagement:

1. Staffing Levels and Work Pressures
Concerns around adequate staffing persist, impacting perceptions of workplace safety and morale. Sub-scores indicate increased work pressures, reinforcing the need for strategic workforce planning and resourcing solutions.

2. Career Development and Appraisals
Perceptions around career development opportunities have declined, and appraisal scores remain static. This suggests a need to strengthen pathways for growth and ensure appraisals are meaningful and developmental.

3. Engagement and Advocacy
Staff engagement scores have slightly declined, with advocacy remaining a key area for improvement. Investing time in this area and fostering a stronger sense of organisational belonging will be critical to driving engagement.

4. Strengths in Flexibility and Teamwork
While not statistically significant, improvements were seen in flexible working and team cohesion—both traditionally strong areas based on previous results. Sustaining and building on these positive aspects can help reinforce a supportive work culture.

9.3 Over the next few weeks, the 2024 results will be presented at Executive meetings and key forums, including 'We Are One', the Staff Engagement Forum, and staff networks. In addition, staff will be invited to participate in focus

[3] https://www.nhsstaffsurveys.com/

group sessions aimed at gathering their feedback to inform improvement plans going forward.

10. Changes to the GP's national contract for 2025-2026

10.1 At the end of February 2024, NHS England announced the changes to the GP Contract for 2025-26.[4] A summary of some of the key areas are given below noting we are awaiting final specifications/details for some of these;

- overall increase in investment of £889m in the core practice contract and the Network Contract Directed Enhanced Service (DES) - which provides 7.2% cash growth on the contract funding envelope
- streamlining and reducing OOF indicators (Quality and Outcomes Framework) with an emphasis on secondary prevention/CVD
- adjustments to some vaccination and immunisation payments/asks
- the publishing of a patient charter which will set out the standards a patient can expect from their practice
- a new national enhanced service for Advice and Guidance to support even closer working between general practice and secondary care and to further support the government's commitment to move more care from secondary care into community settings
- changes to the Network Contract Directed Enhanced Service (DES) Additional Roles (ARRS) to aide more flexible PCN (Primary Care Network) recruitment - with no restrictions on numbers or type of ARRS staff who are covered – including GPs and practice nurses – and an increase in the maximum reimbursement element for the GPs.

10.2 These changes were preceded by a set of asks for ICBs in relation to Primary Medical, under the Operational Planning Guidance.[5] This asks ICBs to put in place plans to improve general practice contract oversight, commissioning, and transformation and to address unwarranted variation in 25/26 – to support improved access – finalised plans are expected from ICBs by June 2025.

10.3 The implications for our operating model are that there will need to be a more consistent single metric set of approaches for access improvement – including onward reporting - to meet the Planning Guidance asks. Within the Planning Guidance, Patient Experience measurements are highlighted and this will dovetail into our local Healthwatch survey report due in May 2025, to support a revised overall approach. The ICBs System Primary Care Committee will oversee the implementation of the above noting that much of the contract changes will be subsumed into business as usual across the ICB and managed/reported at Place level.

10.4 We are also currently waiting for further Guidance on '**the red tape challenge'** recommendations and focus on further improvement to the Primary/Secondary Care interface ensuring Trust contract levers are maximised. This is being managed at Place level with local trusts.

[4] https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2025-26/#annex-c-cvd-prevention-indicators-2025-26-qof-points-and-thresholds
[5] https://www.england.nhs.uk/operational-planning-and-contracting/

11. Neighbourhood Health

11.1 The Neighbourhood Health Guidelines 2025/26 were published by NHS England on 30 January 2025[6] to help ICBs, local authorities and health and care providers continue to progress neighbourhood health in 2025/26 in advance of the publication of the 10 Year Health Plan. The guidance outlined the six components of neighbouhood health to create a common understanding of what lies at its core and setting out a framework for action that can be tailored to our local needs. The six components are:

- Population Health Management
- Modern General Practice
- Standardising Community Health Services
- Neighbourhood multi-disciplinary team
- Integrated intermediate care with a 'Home First' approach
- Urgent neighbourhood services.

11.2 Figure one below shows the aims for all neighbourhoods over the next 5-10 years, however for the 2025/26 period systems are being asked to focus on the innermost circle to prevent people from spending unnecessary time in hospital and care homes. Focus should also be on supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs, according to NHS England analysis.

Figure One

11.3 Work is ongoing with our teams and partners in designing the neighbourhood health model across our places, as well as work to address the 2025/26 priorities. A more detailed paper will come to a future Board meeting outlining progress and plans for implementation.

[6] https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/

12. Sexual Safety Charter

12.1 To mark Sexual Abuse & Sexual Violence Awareness Week (03-09 February 2025) NHS England launched nationally the sexual safety in healthcare charter[7] and asked all NHS organisations to sign up to pledge their firm position of banishing any form of workplace harassment. I can confirm that the ICB has signed up to this Charter (Appendix Two), and by signing up to the Charter we are confirming that we are actively working to eradicate the incidence of sexual harassment and abuse in the workplace, and to have a culture of respect and commitment to safeguarding the wellbeing of every staff member. As a compassionate organisation, we are clear that any form of workplace harassment or behaviour is not acceptable.

12.2 The new Worker Protection (Amendment of Equality Act 2010) Act 2023, creates a duty on employers to take reasonable steps to prevent sexual harassment of their employees in the workplace. We need to ensure staff who experience sexual misconduct feel confident to ask for support and appropriate action will be taken if the individual chooses to report an incident.

12.3 The ICB is in the process of creating a new policy, new supportive reporting routes as well as training Domestic Abuse and Sexual safety workplace allies who will become a safe point of contact for colleagues to access support or advice.

13. NHS Cheshire and Merseyside publishes Air Quality Framework

13.1 Poor air quality significantly impacts our health, affecting everyone from policymakers to patients. That's why NHS Cheshire and Merseyside has developed a comprehensive Air Quality Framework [8] to address the root causes of air pollution, make clear the links between poor air quality and poor physical and mental health, and empower individuals to take proactive measures to improve air quality in their homes and communities.

13.2 The framework is not an isolated effort – it is part of a broader mission to enhance air quality. That's why NHS Cheshire and Merseyside is partnering with local authorities and environmental organisations to craft strategies, share resources, and actively combat air pollution. Good air quality is essential for our health and wellbeing and healthcare institutions play a vital role in promoting clean air. Breathing polluted air poses serious health risks, leading to respiratory issues, allergies, and even more severe conditions.

13.3 To launch this initiative, NHS Cheshire and Merseyside will implement a series of targeted actions, including promoting active travel, sustainable transport, reducing emissions, and collaborating with healthcare professionals and community members. Healthcare experts will contribute their knowledge, while community voices will help shape a cleaner, healthier future for everyone.

[7] https://www.england.nhs.uk/long-read/sexual-safety-in-healthcare-organisational-charter/
[8] https://www.cheshireandmerseyside.nhs.uk/media/1tgjjcu4/cheshire-and-merseyside-integrated-care-board-air-quality-framework-jan25.pdf

13.4 Progress will be monitored via ongoing air quality monitoring and in the analysis of health outcomes to ensure the initiatives are making a meaningful difference.

13.5 Every individual in Cheshire and Merseyside deserves to breathe clean air – it is a fundamental right that should be protected and upheld for the wellbeing of present and future generations.

14. Smoking Ends Here

14.1 Directors of Public and Population Health in Cheshire and Merseyside came together on No Smoking Day 2025 (12 March 2025) to launch 'Smoking Ends Here' - a bold new initiative to create a smoke-free future for the sub-region. The campaign, part of a commitment to reduce smoking rates, shone a spotlight on the benefits of quitting smoking while supporting residents to take the first step towards a healthier life. To officially launch the campaign, Liverpool's iconic St John's Beacon was transformed into a striking 480ft cigarette, serving as a powerful visual symbol of the harmful effects of smoking across the city. Messages highlighting the benefits of stopping smoking are displayed on the structure.

14.2 As part of the campaign a brand-new website, smokingendshere.com has now officially launched offering expert advice, access to free support, and practical tools to help people quit smoking for good.

15. Vaccination Updates

15.1 The government has accepted the Joint Committee on Vaccination and Immunisation (JCVI) advice that the NHS should plan for a seasonal COVID-19 vaccination programme in spring 2025.[9] The announced and authorised cohorts for the spring 2025 programme will cover:

- adults aged 75 years and over
- residents in a care home for older adults
- individuals aged 6 months and over who are immunosuppressed, as defined in COVID-19: the green book, chapter 14a

15.2 Vaccination for all eligible cohorts will commence on the 01 April 2025, the campaign will end on the 17 June 2025. There will be 330 vaccination sites across Cheshire and Merseyside. Vaccine for the Spring / Summer campaign will be Spikevax with Comirnaty available for those who are under 18 years old. As in previous years, the Living well service has been contracted as the outreach service for Covid vaccinations in Cheshire and Merseyside to cover the Spring/Summer Campaign. This service will help us to extend our reach into communities to help support the uptake of the covid vaccination. The National team have predicated an uptake of 49% nationally for the Spring/Summer campaign.

[9] plan for a seasonal COVID-19 vaccination programme in spring 2025

16. Decisions taken at the Executive Committee

16.1 Since the last Chief Executive report to the Board in January 2025, the following items have been considered by the Executive Team for decision:

- **Cheshire East Musculo-Skeletal (MSK) Business Case.** Committee members received a report that outlined a proposal to implement a MSK interface single point of Access Service for the east of Cheshire East Place. The Committee considered the options within and agreed the option around partial implementation of the proposal, limiting the scope to hips and knees, and agreed that the ICBs Financial Control and Oversight Group would oversee it progress
- **Annual Report and Accounts.** Committee members received an update report on the timeline and plans to develop the ICBs 2024-25 Annual Report and Accounts. Members considered and supported the proposal within regarding streamlining the Performance Report section of the Annual Report.

16.2 At its meetings throughout February and March 2025, the Executive Committee has also considered papers on or discussed the following areas:

- All Age Continuing Care Programme Update
- Recovery Committee report
- NHS Staff Survey 2024 ICB results
- Financial Planning
- Planning Guidance
- Vacancy Control Updates
- Healthy Neighbourhoods
- ICB HR Roadmap
- Operating Model.

16.3 At each meeting of the Executive Team, there are standing items on quality, finance, urgent emergency care, non-criteria to reside performance, industrial action, primary care access recovery, and Place development where members are briefed on any current issues and actions to undertake. At each meeting of the Executive Team any conflicts of interest stated are noted and recorded within the minutes.

17. Officer contact details for more information

Graham Urwin
Chief Executive

Megan Underwood, Executive Assistant,
megan.underwood@cheshireandmerseyside.nhs.uk

Appendices

Appendix One: Joint Controller Agreement Update – date extension letter from NHSE
Appendix Two: Sexual Safety Charter Principles

Our Ref: AB C&M ICB JCA Update 2025 03 04

North West England Specialised Commissioning Team

Regatta Place
Summers Road
Brunswick Business Park
Liverpool
L3 4BL

Email address: andrewbibby@nhs.net

Clare Watson
Assistant Chief Executive
Cheshire & Merseyside Integrated Care Board

BY EMAIL

4th March 2025

Dear Clare

Joint Controller Agreement Update: date extension to 30 June 2025

National timelines for Specialised Commissioning delegation, from NHS England to Integrated Care Boards (ICBs), changed in Q3 2024/25. This resulted in the need to extend the date of the Joint Controller Agreement from 31 March 2025 to **30 June 2025**. Additional services suitable for delegation in 2024/25 are unchanged (Annex 1) and will be delegated as planned from 1 April 2025. A Delegation Agreement Variation has been signed by each ICB and NHS England.

The fully executed original Delegation Agreement includes the Joint Controller Agreement (Schedule 6: Part 2). Pursuant to clause 1.1 NHS England North West are requesting written agreement from Cheshire & Merseyside (C&M), Greater Manchester (GM) and Lancashire and South Cumbria (LSC) Integrated Care Boards to extend the date of the JCA from 31 March 2025 to 30 June 2025 and reference the additional services to cover the period between delegation (from 1 April 2025) and staff transfer (1 July 2025).

NHS England IG Lead Rebecca Bray confirmed that the Joint Controller Agreement can be updated in writing between NHS England North West Region and ICBs. This is the approach being taken in other regions.

Please can you confirm your agreement by **31 March 2025.**

Yours sincerely

ANDREW BIBBY
Regional Director of Health & Justice and Specialised Commissioning (North West)

CC.
Neil Evans, C&M ICB
Matthew Cunningham, C&M ICB

Appendix Two – Sexual Safety in Healthcare Charter

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

NHS
Cheshire and Merseyside

As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviour
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Director of Nursing Report (March 2025)

Agenda Item No: ICB/03/25/05

Responsible Director: Chris Douglas, Executive Director of Nursing and Care

Director of Nursing Report (March 2025)

1. Purpose of the Report

1.1 The report provides an update on matters pertinent to the portfolio of the Executive Director of Nursing and Care regarding the quality, safety and patient experience of services commissioned by NHS Cheshire & Merseyside.

2. Executive Summary

2.1 An update is provided in relation to:

- Paediatric Audiology Services
- Partnership for Inclusion of Neurodiversity in Schools (PINS)
- Quality Impact Assessment
- Patient Safety – System Priorities Development.

3. Ask of the Integrated Care Board & Recommendations

3.1 The Integrated Care Board is asked to note the contents of the report for information purposes.

4. Reasons for Recommendations

4.1 This paper relates to current work that is taking place within the C&M ICS related to the Executive Director of Nursing & Care portfolio and is for information purposes.

5. Focus Areas

5.1 **Paediatric Audiology Services.** NHS England's Newborn Hearing Screening Programme (NHSP) completed an analysis of data for every baby born in England from 2018-2023. This identified 4 trusts, covering 5 services, that reported significantly fewer cases of permanent childhood hearing impairment than expected.

5.2 A thorough investigation of these services identified systemic issues, including poor-quality practices, inadequate staff training, substandard data and report management, inconsistencies in care, ineffective peer review processes, and a lack of UK Accreditation Service (UKAS) Improving Quality in Physiological Services (IQIPS) accreditation.

5.3 In response to these findings, national recommendations were issued to integrated care boards (ICBs) to assess compliance with established standards

and best practices. Widespread non-compliance confirmed these issues were systemic rather than isolated. This led to the development of the Paediatric Hearing Services Improvement Programme, created in collaboration with service providers, ICBs, NHS England regions, the Care Quality Commission, multidisciplinary experts, professional bodies, and patient groups.

5.4 The Programme's primary focus is to conduct a nationally coordinated review of all paediatric audiology services within the NHS in England and aims to identify and recall babies and children at risk, mitigate harm caused by misdiagnosis or delayed diagnosis, and support services in delivering quality improvement interventions.

5.5 Following a stage 1 desktop review of service data by NHSE each service was provided with an assurance level. The ICB has seven site visits that will be completed by end of Q1 2025/26, these visits will include ICB Quality Leads, local Commissioning Leads and Subject Matter Experts (SMEs) identified via NHSE. The site visits are prioritised based on assurance levels following the stage 1 desktop review. The first visit was completed for the service at Wirral University Teaching Hospital on 14th March 2025. This visit allowed assurance that no immediate safety concerns were present, and SMEs confirmed good standards of clinical care, however also identified areas for improvement around operational efficiency and governance and oversight.

5.6 Areas for improvement will be monitored through an improvement plan presented at local quality contract meetings. Subsequent visits are proposed through April and May 2025 and will report full details via Quality and Performance Committee.

5.7 **Partnerships for Inclusion of Neurodiversity in Schools (PINS).** The national PINS project is funded by the Department for Education and managed by NHS England. Within Cheshire and Merseyside, we have 37 primary schools across 7 local authority areas involved in the project. The aim of the project is to support schools to develop their capacity to meet neurodiverse needs within mainstream primary schools, improving attendance, reducing exclusions and strengthening pupil wellbeing. This work aligns with the graduated approach to meeting special educational needs and the early identification, intervention and ongoing support element of the C&M NDP redesign.

5.8 Support for PINS schools was identified through schools completing a self-assessment questionnaire which was based on six domains:

- Leadership, Culture and Values
- Mental Health
- Readiness to Learn (behaviour)
- Teaching and Learning
- The environment (sensory)
- Communication.

5.9 All schools identified the first four of these as a priority, with only four identifying the last two as a priority. Training and on-site visits for 'auditing', coaching,

advising and school specific training covered all these areas. Schools within the project have received the equivalent of 37.5 hrs of support, comprising both training and on-site specialist support for implementation of different ways of working.

5.10 We started with the premise that C&M has all the services needed to cover these areas with a high level of expertise and experience. Our aim was to build on collaborative working with local services and partners wherever possible to embed and secure sustainability of support and working relationships. Where there were capacity issues (sensory and communication) we used our commissioned third sector, and where there was a gap in services, (ND related behaviour) we also used our third sector providers. This involved cross boundary collaboration and is seen as a positive added value result of PINS in C&M.

5.11 Seventeen hours of training provided to every school via Microsoft Teams. The sessions were run by local authorities, NHS and third sector providers representing the whole of C&M. Training was recorded so that schools can cascade it to a range of staff at times that are suitable for them. They report that it was helpful for senior leaders to 'trial' it first so that they could decide what was the best use of training in their context.

5.12 The local Parent Carer Forum has been a key partner within each of these schools, working to ensure approaches to supporting pupils with neurodiverse needs are co-produced and developing partnership between school and parents. This has been a particularly demanding project for PCFs who met with parents and schools in each of 4 to 6 schools. The capacity demand of this work has been challenging for most of them.

5.13 The early indications are that the work has been well received and schools report a positive difference which will be monitored to evaluate impact and effectiveness over the next twelve months. The project will continue next year with existing schools (to support embedding and sustainability) and thirty new schools. The project is being evaluated at a national level by Exeter University, Cordis Bright and CFE through, forums, interviews and surveys. It should be noted that impact reviewed after twelve months will be more useful than current evaluation – early signs.

5.14 The DFE is sufficiently assured of the effectiveness of the work, that the project will continue next year 2025-2026. This phase will continue with our existing schools to support embedding and include thirty new primary schools. As neurodiversity is challenging and high profile nationally and particularly in the findings of Area SEND Inspections, it is important that all local authority areas have engaged in PINS. We therefore want to see schools from Halton and Wirral included in this coming year.

5.15 **Quality Impact Assessment (QIA).** A QIA is a continuous process to ensure that commissioning decisions, business cases, projects and other business plans are assessed for the potential consequences on quality with any

necessary mitigating actions outlined in a uniform way. It ensures a consistent approach to assessing the impact of change.

5.16 Given the new planning round underway, and the significant financially challenging context for NHS service delivery, the ICB felt it prudent to review and refresh its QIA policy and process to ensure it remains fit for purpose.

5.17 This review coincided with a similar review of the ICB approach to Equality Analysis, to ensure that the impact of any changes to service delivery or design considered the potential differential effects upon those with protected characteristics.

5.18 The revised policy will be presented to the April 2025 Quality & Performance Committee for assurance and subsequent approval, which will allow for any improvements to take effect within the new financial year of 2-25/2026, further details will be provided through the ICBs May 2025 Chair's report.

5.19 **Patient Safety – System Priorities Development.** In line with the patient safety strategic developments discussed through the previous Director of Nursing and Care report, the role of the ICB as system convenor allows for collective focus on priority areas for safety, both investigation and improvement.

5.20 Individual providers will have considered and defined their individual priorities for safety investigation and safety improvement within their Patient Safety Incident Response Framework Plans. The development of system wide safety priorities offers a perspective wider than individual organisations and to consider the overall population within Cheshire and Merseyside.

5.21 This work will provide a key direction of focus for system safety and support individual partners to align in investigation and improvement where appropriate. The process for defining system safety priorities has sought wide engagement from partners about their intelligence around the greatest safety risks. In addition to local intelligence gathering, a range of data sources have been used to consider local health outcome challenges, inequalities and service usage to ensure priorities chosen provided the greatest benefit for our population.

5.22 As the safety priorities are defined, consideration of system stakeholder input into improvement is key with workshops planned to explore the role that all parties can have with regards to enhancing safety. Finally proposed Safety Priorities will be brought for approval at the May 2025 Board meeting.

6. Link to achieving the objectives of the Annual Delivery Plan

6.1 The current work plan and programmes complements the CQC/ ICS Quality Statements and in particular:

- How we work as partners for the benefit of our population
- Population Health
- Learning Culture.

7. Link to meeting CQC ICS Themes and Quality Statements

Theme One (T1) - Quality and Safety	
QS1	Supporting to People to live healthier lives. We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support
QS2	Learning culture. We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
QS3	Safe and effective staffing. We make sure there are enough qualified, skilled, and experienced people, who receive effective support, supervision, and development. They work together effectively to provide safe care that meets people's individual needs
Theme Two (T2) - Integration	
QS7	Safe systems, pathways and transitions. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services
QS8	Care provision, integration and continuity. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity
QS9	How staff, teams and services work together. We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services

8. Risks

8.1 Risks to delivery are outlined within programme risk registers and escalated to the appropriate ICB committee aligned to agreed governance routes.

9. Next Steps and Responsible Person to take forward.

9.1 The next steps are to continue with the agreed strategy and priorities for the outlined programmes.

10. Officer contact details for more information

Kerry Lloyd – Deputy Director of Nursing and Care
Kerry.lloyd@cheshireandmersesyide.nhs.uk

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Cheshire and Merseyside Integrated Care System Finance Report Month 10 (2024/25)

Agenda Item No: ICB/03/25/07

Responsible Director: Mark Bakewell, Executive Director of Finance

NHS
Cheshire and Merseyside

Cheshire and Merseyside System Finance Report Month 10

1. Purpose of the Report

1.1 This report provides an update to the Board of NHS Cheshire and Merseyside on the financial performance of the Cheshire and Merseyside ICS ("the ICS") at Month 10 2024/25, in terms of relative position against its financial plan, and alongside other measures of financial and operational performance (e.g., efficiency, productivity and workforce).

1.2 The Board is asked to note the contents of this report in respect of the Month 10 ICS financial position for both revenue and capital allocations within the 2024/25 financial year. There has been considerable risk in the delivery of both Provider and ICB financial positions.

1.3 At month 10 systems are required to formally continue forecasting achievement of the plan, however there will be an opportunity to amend the forecast at month 11 following discussion and agreement with NHSE.

2. Executive Summary

2.1 Regular financial performance reports are provided to the Finance, Investment and Resources Committee of the ICB who undertake detailed review and challenge on behalf of the Board.

2.2 On 2nd May 2024 the System 'ICS' plan submitted was a combined £215.8m deficit, consisting of £40.9m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £256.7m. This plan was not approved by NHSE, and subsequently a revised plan of £150m deficit (£62.3m surplus for the ICB and £212.3m for providers) was agreed and submitted on 12th June 2024.

2.3 NHS England issued an allocation of £150m 'revenue deficit support' to the ICB in month 6 to cover the deficit to allow the financial system plan to be modified to a balanced breakeven position. The funding was distributed to providers and in turn collective provider plans have improved. The revenue deficit support is deemed repayable to NHSE, phased from 2026/27.

2.4 As of 31st January 2025 (Month 10), the ICS system is reporting a YTD deficit of **£109.7m** against a planned YTD deficit of **£62.4m** resulting in an adverse YTD variance of **£47.3m** (0.7% of allocation). The adverse variance from plan has improved by £13.8m during month 10. The current in-year deficit of £109.7m would need to be recovered in the final two months of the year in order for the system to achieve the overall planned breakeven position.

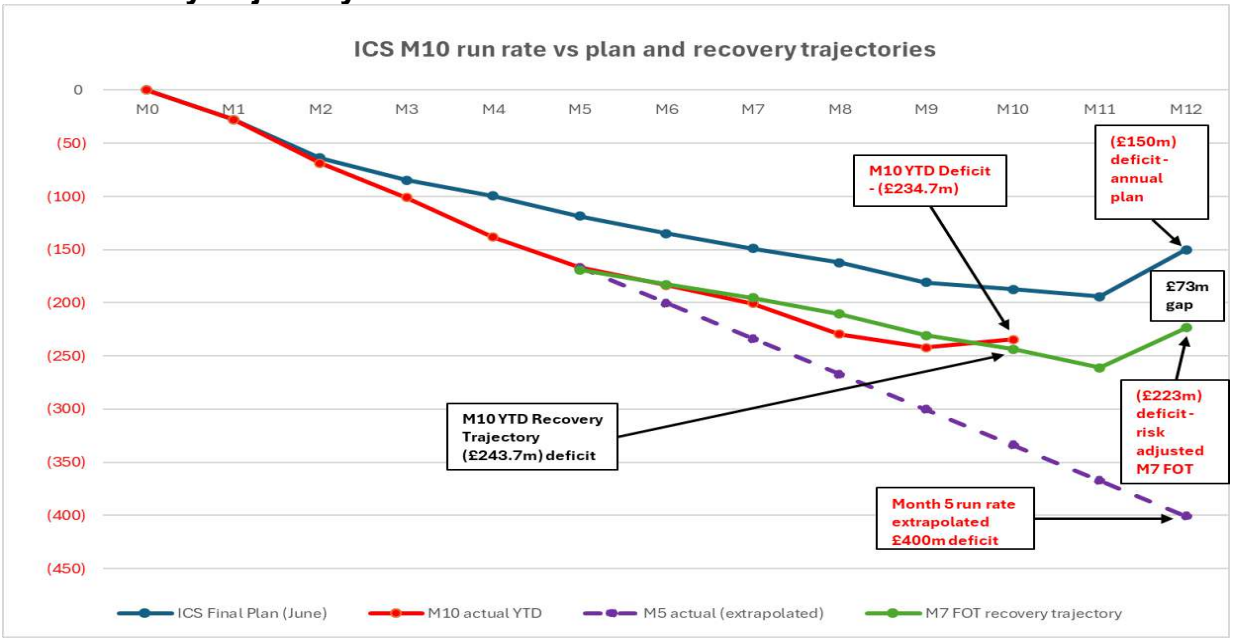
2.5 The ICS financial position as reported to NHS England at Month 10 is set out in **Table 1** below. NB: NHSE require the forecast to remain on plan at Month 10, this forecast carries a significant amount of risk with risk adjusted forecast value of **£77m** representing a level of unidentified migrations as at Month 10. This value has remained unchanged during the month. Systems will be given the opportunity to amend their forecast at month 11 following discussion and agreement with NHSE and sign off at board level. NHSE will then not expect any changes to the forecast between month 11 and month 12.

2.6 **Table 1 – Financial Performance Month 10 YTD and FOT**

	M10 YTD				24/25 FY Plan				24/25 Risk Adjusted FOT (FY)		
	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	FOT £m	Variance £m	Variance %	FOT £m	Variance to plan £m	Variance to plan %
ICB	51.9	22.5	(29.4)	-0.4%	62.3	62.3	0.0	0.0%	30.4	(32.0)	-0.4%
Total Providers	(114.3)	(132.1)	(17.9)	0.3%	(62.3)	(62.2)	0.0	0.0%	(73.4)	(40.6)	-0.6%
Total System	**(62.4)**	**(109.7)**	**(47.3)**	**-0.7%**	**0.0**	**0.0**	**0.0**	**0.0%**	**(43.1)**	**(72.6)**	**-1.0%**
Total Providers (exc. £150m rev support)	(239.3)	(257.1)	(17.9)	0.3%	(212.3)	(212.2)	0.0	0.0%	(253.8)	(40.6)	-0.6%
Total System (exc. £150m rev support)	**(187.4)**	**(234.7)**	**(47.3)**	**-0.7%**	**(150.0)**	**(150.0)**	**0.0**	**0.0%**	**(223.4)**	**(72.6)**	**-1.0%**

2.7 **Chart 1** below shows the profile of the ICS I&E plan and recent revised recovery trajectories against the actual M10 YTD run rate. It excludes the £150m revenue deficit support to evidence the comparable run rate position month to month (actual and forecast).

Chart 1 – ICS Financial Performance – YTD Run Rate vs Plan Profile and recovery trajectory



2.8 The Month 10 the risk adjusted forecast value of £72.6m unchanged during the month compared to Month 9. A summary of those organisations currently reporting a risk adjusted FOT adverse to plan is set out in **Table 2**, and how this compares to the previous risk adjustment position at Month 6 and Month 7.

Table 2 – Risk Adjusted FOT vs Plan as at Month 10

Org	FY Plan 24/25	Month 6		Month 7		Month 9 and Month 10		M6 to M10	M6 to M10 movement explained by:			TOTAL
		M6 Risk Adjusted FOT Position	M6 Risk Adjusted Variance vs Plan	M7 Risk Adjusted FOT Position	M7 Risk Adjusted Variance vs Plan	M10 Risk Adjusted FOT Position	M10 Risk Adjusted Variance vs Plan	Movement on Risk Adjusted FOT Position	*Adverse movement linked to PAY AWARD*	*PAY AWARD impact absorbed in position*	*Other changes*	
	£m	£m	£m	£m	£m	£m	£m	£m	*£m*	*£m*	*£m*	£m
Alder Hey Children's	3.4	4.4	1.0	3.4	0.0	3.4	0.0	(1.0)	*(1.0)*	*0.0*	*0.0*	(1.0)
Bridgewater Community	2.1	0.2	(2.0)	0.1	(2.1)	0.1	(2.1)	(0.1)	*0.0*	*0.0*	*(0.1)*	(0.1)
Cheshire & Wirral Partnership	1.5	1.5	0.0	1.5	0.0	1.5	0.0	0.0	*0.0*	*0.0*	*0.0*	0.0
Countess of Chester Hospitals	(23.6)	(23.5)	0.0	(25.8)	(2.2)	(25.4)	(1.8)	(1.8)	*(1.8)*	*0.0*	*0.0*	(1.8)
East Cheshire Trust	(14.4)	(14.3)	0.1	(14.3)	0.1	(14.3)	0.1	0.0	*0.0*	*(0.8)*	*0.8*	0.0
Liverpool Heart & Chest	14.1	14.1	0.0	14.1	0.0	14.1	0.0	0.0	*0.0*	*0.0*	*0.0*	0.0
Liverpool University Hospitals	(80.5)	(95.3)	(14.8)	(98.8)	(18.3)	(98.8)	(18.3)	(3.5)	*(3.5)*	*0.0*	*0.0*	(3.5)
Liverpool Women's	(28.5)	(28.5)	0.0	(28.5)	(0.0)	(28.5)	(0.0)	0.0	*0.0*	*(0.8)*	*0.8*	0.0
Mersey Care	7.1	7.1	0.0	7.1	(0.0)	7.1	(0.0)	0.0	*0.0*	*(1.0)*	*1.0*	0.0
Mid Cheshire Hospitals	(35.6)	(38.8)	(3.2)	(39.1)	(3.5)	(38.6)	(3.0)	0.2	*(0.3)*	*(0.5)*	*1.0*	0.2
Mersey & West Lancs	(26.7)	(26.6)	0.0	(26.6)	0.0	(26.6)	0.0	0.0	*0.0*	*(0.7)*	*0.7*	0.0
The Clatterbridge Centre	0.9	0.9	0.0	0.9	0.0	0.9	0.0	0.0	*0.0*	*0.0*	*0.0*	0.0
The Walton Centre	5.3	5.3	0.0	5.3	0.0	5.3	0.0	0.0	*0.0*	*0.0*	*0.0*	0.0
Warrington & Halton Hospitals	(27.8)	(34.8)	(7.0)	(36.4)	(8.6)	(36.4)	(8.6)	(1.6)	*(1.6)*	*0.0*	*0.0*	(1.6)
Wirral Community	6.5	6.5	0.0	6.5	0.0	6.5	0.0	0.0	*0.0*	*(0.2)*	*0.2*	0.0
Wirral University Hospitals	(16.3)	(22.9)	(6.6)	(23.3)	(7.0)	(23.3)	(7.0)	(0.4)	*(0.4)*	*0.0*	*0.0*	(0.4)
TOTAL (C&M Providers)	(212.3)	(244.8)	(32.4)	(253.8)	(41.5)	(252.9)	(40.6)	(8.2)	*(8.6)*	*(4.0)*	*4.4*	(8.2)
C&M ICB	62.4	37.5	(24.9)	30.4	(32.0)	30.4	(32.0)	(7.1)	*0.0*	*0.0*	*(7.1)*	(7.1)
TOTAL ICS	(150.0)	(207.3)	(57.3)	(223.4)	(73.5)	(222.6)	(72.6)	(15.3)	*(8.6)*	*(4.0)*	*(2.8)*	(15.3)

2.9 It should be noted that a £234.7m Month 10 YTD deficit (excluding deficit support) exceeds the full year £150m deficit plan. This reflects the challenging profile of the plan where CIPs have been assumed to deliver towards the end of the year as well as a number of planned transactions in Month 12. The in month surplus achieved was due to receipt of non-recurrent income offsetting M1-9 costs that was originally planned in M12 e.g. enquiry funding. The current run rate will need to continue to improve significantly in order for the system plan to be achieved and so focus of CIP plans and expenditure run rate reductions will be critical over the remaining months to support the recovery trajectories and mitigate the £72.6m gap.

2.10 This risk value has been reported to NHS England and discussed via the regular assurance and intervention meetings. All organisations are expected to reflect the formal board approved changes to FOT at Month 11 and discussions remain ongoing with NHS England with regard all available mitigations to deliver the best possible position against the plan. This is set out in more detail in section 3.38

3. Financial Performance Month 10

ICS financial performance – M10

3.1 As of 31st January 2025 (Month 10), the ICS is reporting a YTD deficit of £109.7m against a planned YTD deficit of £62.4m resulting in an adverse YTD variance of £47.3m. The forecast reported to NHSE remains in line with the achievement of the balanced system plan, however a net risk of £77m is reported. Although the YTD position has improved in-month, the system would need to fully recover the remaining £109.7m deficit in the final two months of the year.

3.2 The system YTD deficit has reduced by £20m during the month which represents an improvement in the variance from plan of £13.8m (provider positions improving by £5.4m and the ICB position improving by £8.5m). Whilst this is a positive movement in the trajectory of spending for the second consecutive month, the system must make a judgement over the most favourable position it can realistically deliver and potentially look to revise the forecast at month 11.

3.3 ICB overspending areas continue to be in relation to the cost of Continuing Health Care (CHC) and Mental Health packages although the trajectory of overspend has significantly improved following a review of the balance sheet and commitments. The pressure on prescribing budgets has remained largely unchanged this month based on the latest prescribing data available and factoring in anticipated savings linked to the medicines waste campaign. Commitments against reserves have been reviewed, and any surplus balances and slippage have been factored into both the YTD and FOT positions. NHS Provider trust pressures relate primarily to the impact of industrial action in June and July, under-delivery of efficiency savings, underperformance on ERF targets at Wirral Teaching Surgical Centre, the cost of the review at Countess of Chester and the impact of the cyber-attack at Wirral Teaching in November

3.4 **Table 3** sets out the financial performance surplus/(deficit) at Month 10 at organisation level.

Table 3 – ICS Financial Performance M10 YTD by organisation

Financial performance surplus/(deficit) for the purposes of system achievement (excluding £150m deficit support)	M10 YTD Plan	M10 YTD Actual	M10 YTD Variance	M10 YTD Variance	M10 YTD Actual (excluding 10/12ths of £150m deficit support)	Full Year Annual Plan (exc £150m deficit support)	Month 10 YTD as a % of FY plan
	£m	£m	£m	%	£m	£m	%
C&M ICB	51.9	22.5	(29.4)	-0.4%	22.5	62.3	36%
Alder Hey Children's	1.5	0.6	(0.9)	-0.2%	0.6	3.4	19%
Bridgewater Community	1.4	(2.4)	(3.8)	-4.6%	(2.4)	2.1	-111%
Cheshire & Wirral Partnership	1.0	1.2	0.2	0.1%	1.2	1.5	81%
Countess of Chester Hospitals	(8.9)	(11.5)	(2.6)	-0.9%	(23.2)	(23.6)	98%
East Cheshire Trust	(6.2)	(6.5)	(0.3)	-0.2%	(13.6)	(14.4)	95%
Liverpool Heart & Chest	11.5	11.4	(0.1)	-0.0%	11.4	14.1	81%
Liverpool University Hospitals	(67.3)	(69.6)	(2.3)	-0.2%	(109.4)	(80.5)	136%
Liverpool Women's	(10.0)	(10.0)	0.0	0.0%	(24.1)	(28.5)	84%
Mersey Care	5.2	5.2	0.0	0.0%	5.2	7.1	73%
Mid Cheshire Hospitals	(11.6)	(12.0)	(0.4)	-0.1%	(29.5)	(35.6)	83%
Mersey & West Lancs	(18.5)	(13.1)	5.3	0.7%	(26.3)	(26.7)	99%
The Clatterbridge Centre	0.6	0.7	0.0	0.0%	0.7	0.9	74%
The Walton Centre	4.4	4.7	0.3	0.2%	4.7	5.3	89%
Warrington & Halton Hospitals	(13.2)	(17.1)	(3.9)	-1.3%	(30.8)	(27.8)	111%
Wirral Community	2.2	2.2	0.0	0.0%	2.2	6.5	33%
Wirral University Hospitals	(6.4)	(15.8)	(9.4)	-2.2%	(23.9)	(16.3)	146%
Total C&M ICS	**(62.4)**	**(109.7)**	**(47.3)**	**-0.7%**	**(234.7)**	**(150.0)**	**156%**

ICB Financial Performance – M10

3.5 The ICB has reported a YTD surplus of £22.5m compared to a planned surplus of £51.9m, resulting in an adverse variance to plan of £29.4m as per **Table 4** below.

Table 4 – ICB Financial Performance M10 YTD

	M10 YTD Plan £m	Actual £m	Variance £m	Variance %
ICB Net Expenditure:				
Acute Services	3,118.1	3,106.3	11.8	0.4%
Mental Health Services	595.2	617.0	(21.8)	-3.7%
Community Health Services	587.9	583.6	4.3	0.7%
Continuing Care Services	336.6	360.0	(23.4)	-6.9%
Primary Care Services	536.6	547.1	(10.5)	-2.0%
Other Commissioned Services	12.9	11.9	1.0	7.8%
Other Programme Services	53.9	51.7	2.3	0.0%
Reserves / Contingencies	0.7	0.0	0.7	100.0%
Delegated Specialised Commissioning	513.9	507.5	6.4	1.3%
Delegated Primary Care Commissioning	716.1	716.4	(0.3)	0.0%
Primary Medical Services	471.4	470.8	0.6	0.1%
Dental Services	159.3	159.1	0.2	0.1%
Ophthalmic Services	22.3	22.4	(0.0)	-0.2%
Pharmacy Services	63.1	64.1	(1.0)	-1.6%
ICB Running Costs	41.4	41.4	0.0	0.0%
Total ICB Net Expenditure	**6,513.3**	**6,542.8**	**(29.4)**	**-0.5%**
Allocation adjustment for reimbursable items	0.0	0.0	0.0	0.0%
TOTAL ICB Surplus/(Deficit)	**51.9**	**22.5**	**(29.4)**	**-0.5%**

3.6 The year-to-date pressure is driven by the following issues:

a) Continuing Healthcare – continued pressures linked to cost and volume of eligible CHC clients exceeding planning assumptions. An adverse variance

of £23.4m is reported at Month 10 however this is an improvement of £5.4m compared to month 9. This is largely due to a review of the balance sheet including a review of packages open but not billed.

b) Mental Health Services – overspend of £21.8m reported at Month 10 of which £20m relates to packages of care. The variance from plan has remained worsened by £1m this month, however this is a significant reduction in the trajectory of overspending observed in earlier months.

The current forecast adverse variance to plan for Continuing Healthcare is £27.5m and £24.3m for complex packages of care. **Appendix 1** contains details of the forecast variance by place and shows the key drivers for the pressure.

c) A pressure of £16m is reported on the prescribing budget at Month 10 based on November-24 prescribing data. The forecast overspend on prescribing budgets is reported to be £19.7m which has remained unchanged since month 9. The forecast anticipates savings will be made in the final two months of the year through the full delivery of remaining medicines efficiency plans and £5m savings generated through the medicines waste campaign.

Further analysis on the cost per prescribing day is included in chart 2 within paragraph 3.7.

d) Reserves – The month 10 position includes a £0.7m favourable variance on reserves. Reserves have been reviewed and where possible, uncommitted reserves and slippage on investments has been released into both the year to date and forecast position.

e) Running costs - Costs remain within the running cost allowance following the reduction in allocation this year. A further 10% reduction will be made to the running cost allowance in 2025/26.

f) Efficiency – The ICB reports a £4.6m shortfall against the planned efficiency savings plans for month 10. Key areas of slippage are within pathway transformation (£1.2m) and prescribing efficiencies (£1.1m) and CHC (£1.4). The ICB forecasts that it will fully achieve the £72.2m efficiency plan by the end of the year and further savings will be secured to offset slippage where it has occurred. All efficiency savings reported are recurrent as the ICB ceased reporting non-recurrent efficiency this year to focus on the delivery of recurrent long-term savings.

3.7 For prescribing **Chart 2** shows that the cost per prescribing day were marginally lower in the first quarter than the previous year, however during the following 5 months, costs have been consistently higher, showing an average increase of 3.7% compared to the same period in 2023/24. Despite the increase in cost compared to the previous year, the average cost per prescribing day did reduce in October (£62.1k per day compared to an average of £67.2k). This remained reasonably stable at £63.7k per day within the November data.

Chart 2 – Cost per Prescribing Day

3.8 Details of ICB performance split by place is shown below, and more detail is provided in **Appendix 2. Table 5** sets out in summary the Month 10 Place performance:

Table 5 – Place M10 – Financial Performance

	M10 YTD Plan £000's	M10 YTD Actual £000's	M10 YTD Variance £000's
Cheshire - East	(43,361)	(51,771)	(8,410)
Cheshire - West	(35,535)	(38,867)	(3,332)
Halton	(7,816)	(9,640)	(1,824)
Knowsley	9,886	9,161	(725)
Liverpool	8,842	(222)	(9,064)
Sefton	(8,762)	(18,661)	(9,899)
St Helens	(9,283)	(11,943)	(2,660)
Warrington	(3,843)	(3,432)	410
Wirral	(17,268)	(26,779)	(9,512)
ICB	159,047	174,623	15,576
Total ICB	**51,908**	**22,468**	(29,440)

Provider Financial Performance – M10

3.9 **Table 6** below sets out the ICS Month 10 YTD financial position, split by individual provider alongside ICB position.

Table 6 – ICS M10 Financial Performance

Financial performance surplus/(deficit) for the purposes of system achievement (excluding £150m deficit support)	M10 YTD Plan	M10 YTD Actual	M10 YTD Variance	M10 YTD Variance	M10 YTD Actual (excluding 10/12ths of £150m deficit support)	Full Year Annual Plan (exc £150m deficit support)	Month 10 YTD as a % of FY plan
	£m	£m	£m	%	£m	£m	%
C&M ICB	51.9	22.5	(29.4)	-0.4%	22.5	62.3	36%
Alder Hey Children's	1.5	0.6	(0.9)	-0.2%	0.6	3.4	19%
Bridgewater Community	1.4	(2.4)	(3.8)	-4.6%	(2.4)	2.1	-111%
Cheshire & Wirral Partnership	1.0	1.2	0.2	0.1%	1.2	1.5	81%
Countess of Chester Hospitals	(8.9)	(11.5)	(2.6)	-0.9%	(23.2)	(23.6)	98%
East Cheshire Trust	(6.2)	(6.5)	(0.3)	-0.2%	(13.6)	(14.4)	95%
Liverpool Heart & Chest	11.5	11.4	(0.1)	-0.0%	11.4	14.1	81%
Liverpool University Hospitals	(67.3)	(69.6)	(2.3)	-0.2%	(109.4)	(80.5)	136%
Liverpool Women's	(10.0)	(10.0)	0.0	0.0%	(24.1)	(28.5)	84%
Mersey Care	5.2	5.2	0.0	0.0%	5.2	7.1	73%
Mid Cheshire Hospitals	(11.6)	(12.0)	(0.4)	-0.1%	(29.5)	(35.6)	83%
Mersey & West Lancs	(18.5)	(13.1)	5.3	0.7%	(26.3)	(26.7)	99%
The Clatterbridge Centre	0.6	0.7	0.0	0.0%	0.7	0.9	74%
The Walton Centre	4.4	4.7	0.3	0.2%	4.7	5.3	89%
Warrington & Halton Hospitals	(13.2)	(17.1)	(3.9)	-1.3%	(30.8)	(27.8)	111%
Wirral Community	2.2	2.2	0.0	0.0%	2.2	6.5	33%
Wirral University Hospitals	(6.4)	(15.8)	(9.4)	-2.2%	(23.9)	(16.3)	146%
Total C&M ICS	(62.4)	(109.7)	(47.3)	-0.7%	(234.7)	(150.0)	156%

3.10 There are 7 Trusts reporting a material year-to-date adverse variance to plan. An explanation of the key drivers of the YTD variances are set out below:

- **Alder Hey Children's NHS Foundation Trust**
  £0.9m adverse variance YTD, forecast to plan.
  The key driver of the £0.9m YTD variance is linked to the unfunded element of the pay award driven by differential skill mix than national assumptions. The trust is continuing to review its run rate and outturn forecast in order to mitigate this position

- **Bridgewater Community NHS Foundation Trust**
  £3.8m adverse variance YTD, risk adjusted FOT £2m adverse to plan.
  Key drivers of the £3.3m YTD variance are operational issues linked with premium paediatric locum spend and other demand led pay pressures £2.0m; £2.50m adverse YTD CIP variance; which is partially offset by £0.7m non recurrent items relating to prior year.

  Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £2.0m adverse to plan due to under-achievement of integration savings with Warrington, with a likely further deterioration give the YTD run rate against plan. This is being escalated at CEO/DOF level and also seeking to be addressed through the phase 2 intervention process supported by PWC.

- **Countess of Chester NHS Foundation Trust**
  £2.6m adverse variance YTD, risk adjusted FOT £1.8m adverse to plan
  In the previous months, a key driver of the YTD variance was costs associated with the public enquiry. This has now been resolved through additional funding received from NHS England.
  The £2.6m YTD adverse variance is attributable to; £0.7m industrial action net of funding received to date; an adverse CIP YTD variance from £6.5m against the plan, and c£1m pay award pressure; These three items have been offset by non-recurrent budgetary underspends elsewhere.

  Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £1.8m adverse to plan, directly linked to the impact of the pay award.

- **Liverpool University Hospitals NHS Foundation Trust**
  £2.3m adverse variance YTD, £18.3m risk adjusted FOT adverse to plan
  £1m of the YTD variance is attributable to industrial action net of funding received. Key drivers of the remaining £1.3m YTD variance are: £7.7m undelivered CIP and £2.7m pay award impact and £2m other operational pressures on non-pay; offset by c£10.1m expected ERF overperformance, non-recurrent technical items and balance sheet release.

  Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £18.3m adverse to plan. This is attributable to trust assessed impact of the pay award £3.5m and £14.8m non-delivery of CIP associated the no criteria to reside patients. This is being escalated and addressed through the phase 2 intervention process.

  The settlement of a legal claim is a key component of the trust's delivery of the FOT, and this has been assumed in the current risk adjusted FOT. The trust is liaising with the ICB and the national NHSE on this specific issue.

- **Mid Cheshire Hospitals NHS Foundation Trust**
  £0.4m adverse variance YTD, £3.3m risk adjusted FOT adverse to plan
  £0.2m of the YTD variance is attributable to industrial action. Key drivers of the remaining £1.9m YTD variance are: £3.3m under delivery on CIP plan YTD, £3.0m operational pressures linked to continuation of escalation capacity, offset by £4.4m of additional income associated with ERF and commercial activities and other non-recurrent benefits, and a £1.5m benefit of planned EPR implementation being delayed until later in the financial year.

  Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £3.3m adverse to plan. This is being escalated and addressed through the phase 2 intervention process.

- **Warrington and Halton Teaching Hospitals NHS Foundation Trust**
  £3.9m adverse variance YTD, £8.6m risk adjusted FOT adverse to plan
  The £3.9m adverse variance to date relates to; £0.7m impact of industrial action over June and July, £0.2m adverse impact from the pay award, £1m shortfall on YTD CIP; and other £2.0m operational pressures linked to

escalation and specialling. This is a net adverse variance after the distribution of funding via NHSE for industrial action and pay award uplifts.

Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £8.6m adverse to plan. The £8.6m risk adjusted forecasts is driven by £7.0m delay on CIP and local integration plans, and £1.6m pay award impact. This is being escalated and addressed through the phase 2 intervention process.

- **Wirral University Teaching Hospitals NHS Foundation Trust**
  £9.4m adverse variance YTD, £7.0m risk adjusted FOT adverse to plan
  £0.5m of the YTD variance is attributable to industrial action. Key drivers of the remaining £8.1m YTD variance are; £10.7m elective underperformance across surgical specialties T&O and Urology driven by under-utilisation of C&M Surgical Centre by system partners, consultant vacancies and CSSD downtime; £2.9m acute pay overspend within ED medical and ED nursing driven primarily by corridor care, with work on-going to review rotas and how to reduce shifts subject to escalated rates of pay; £3m impact and loss of income resulting from cyber-attack; and The above has been mitigated to an extent by c.£3.5m of underspends and vacancies elsewhere across the Trust, and c.£5m balance sheet release.

  Whilst the trust has not yet formally changed its FOT to NHSE it has reported a risk adjusted forecast of £7.0m adverse to plan. This is being escalated and addressed through the phase 2 intervention process.

3.11 **Table 7** sets out the provider year-to-date position compared to the Month 10 YTD plans by income, pay, non-pay and non-operating items. This shows that the aggregate YTD pay position is £87.3m (2.3%) adverse to plan, which is explained by; the net cost of medical cover during the industrial action in June and July of c£5.5m (0.2%); undelivered pay efficiencies YTD of £43.2m (1.1%); YTD pay award pressure £9m (0.2%); and selected operational pay pressures and underspends across several providers as set out in section 3.11 above (0.8%). NHS Providers are also reporting additional non pay inflation across drugs and consumables above those assumed in the plan and is a key contributor to the 6.9% YTD adverse variance on non-pay expenditure. A full breakdown of the expenditure variance by provider can be found in **Appendix 3.**

Table 7 – Provider Income and Expenditure vs YTD Plan

	M10 YTD			
	Plan	Actual	Variance	
	£m	£m	£m	%
Total Income	5,481.0	5,661.1	180.1	3.3%
Pay	(3,729.6)	(3,816.9)	(87.3)	-2.3%
Non Pay	(1,785.7)	(1,909.0)	(123.3)	-6.9%
Non Operating Items (excl gains on disposal)	(80.0)	(67.3)	12.7	15.9%
Total Provider Surplus/(Deficit)	(114.3)	(132.1)	(17.9)	-0.3%

NHS Provider Agency Expenditure

3.12 ICS NHS Providers set a plan for agency spend of £91.8m, compared to actual spend in 2023/24 of £128.5m. The System is required to manage agency costs within a ceiling and to demonstrate reduced reliance on agency staffing year on year. The ICS agency ceiling for 2024/25 is £120.6m.

3.13 Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency.

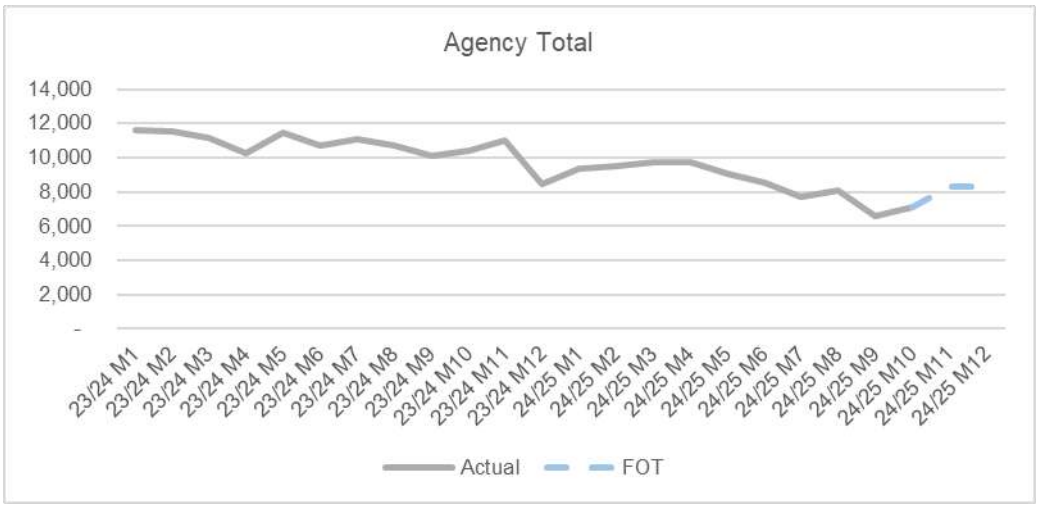
3.14 At Month 10, year to date agency spend is £85.4m (£7.6m above plan), equating to 2.2% of total pay. Nine Trusts are reporting a year-to-date adverse variance to plan. Trust level information on agency spend can be found in **Appendix 4**.

3.15 **Table 8** below sets out the aggregate agency performance as a system. This indicates providers are forecasting a £9.9m adverse variance to plan however remain within the national agency cap by £18.7m. **Chart 3** below sets out the agency expenditure monthly run rate from 23/24 to YTD Month 9 indicating a downward trajectory on track to deliver the forecast. Further work is ongoing in this area with providers and forms a key part of provider CIP plans and reductions in variable pay.

Table 8 – Provider Agency Expenditure

Agency Position against ICS ceiling	Plan YTD £m	Actual YTD £m	Variance YTD £m	Plan FY £m	FOT FY £m	Variance FY £m
All Providers Agency spend	(77.8)	(85.4)	(7.6)	(92.0)	(101.9)	(9.9)
ICS Agency Ceiling				(120.6)	(120.6)	
Variance to Ceiling				**28.6**	**18.7**	
Agency as a % of pay		**2.2%**			**2.3%**	

Chart 3 – Agency Expenditure Run Rate



Workforce

3.16 Workforce and its triangulation with finance, performance and productivity will continue to be key focus across the system. **Chart 4** sets out the provider WTEs run rate across 23/24 to Month 10 YTD 24/25 and the planned aggregate planned reductions forecast to the end of the year. **Appendix 5** sets out in more detail the movements at provider level.

Chart 4 – Workforce (WTE) Run Rate 23/24 and 24/25

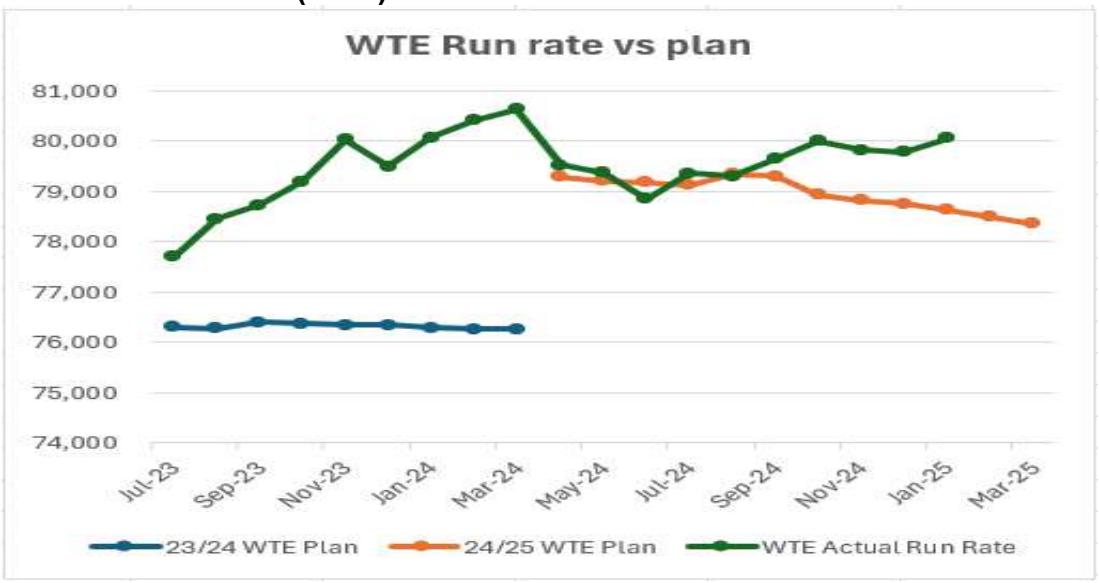


Table 9 – M10 Workforce movements vs M12 23/24 and M10 24/25 Plan

	2023/24	2024/25									M10 Variance		2024/25	
Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M3 Actual	M4 Actual	M5 Actual	M6 Actual	M7 Actual	M8 Actual	M9 Actual	M10 Actual	M1 to M10 Trend	M10 Variance from plan trajectory favourable / (adverse)		M12 Plan (March 25)	M10 Actual vs M12 Plan
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%	WTE	WTE
C&M Providers Total	**80,465**	**78,849**	**79,352**	**79,303**	**79,645**	**80,002**	**79,822**	**79,773**	**80,046**		**(1,420)**	**-1.8%**	**78,354**	**(1,692)**
by Sector														
Acute	50,353	49,296	49,704	49,604	49,616	49,868	49,637	49,668	49,731		(804)	-1.6%	48,688	(1,043)
Specialist	11,423	11,431	11,382	11,436	11,495	11,628	11,645	11,559	11,645		(234)	-2.1%	11,384	(262)
Community / MH	18,689	18,123	18,265	18,263	18,534	18,506	18,539	18,546	18,669		(382)	-2.1%	18,282	(387)
TOTAL Providers	**80,465**	**78,849**	**79,352**	**79,303**	**79,645**	**80,002**	**79,822**	**79,773**	**80,046**		**(1,420)**	**-1.8%**	**78,354**	**(1,692)**

3.17 The Month 10 provider workforce data indicate there is a 1,420 WTE adverse position against the YTD plan. Based on revised workforce trajectories submitted in July providers are 1,692 WTEs away from delivering expected workforce reduction forecast by March 2025. As part of the investigation and intervention Phase 2 work the workforce trajectories and pay controls have been reported and reviewed on a weekly basis for all providers up to December and also covered in the Balance Scorecard CEO meetings in January. Triangulation of the workforce plans with finance and performance will be a critical key component of the 2025/26 planning process.

System Efficiencies

3.18 For 2024/25 providers and ICB are planning delivery of £368m and £72m efficiencies respectively. The aggregate system efficiency plan of £440m represents 6.1% of ICB Allocations / Provider Expenditure.

3.19 **Table 10** shows at Month 10 there is currently a shortfall on planned CIP delivery of £23.3m against the ICS YTD plan, with £18.7m attributable against providers and £4.6m against the ICB. The £321.4m efficiencies delivered YTD represent 4.9% of ICS YTD expenditure/allocation against the annual plan of 6.1%, indicating a larger proportion of the savings required in the remaining months.

3.20 Furthermore 72% of the system efficiencies YTD plan have been delivered recurrently as at Month 10. This increases the risk in the underlying financial position of the ICS and is subject to ongoing work by providers to both recover the YTD shortfall and address the recurrent position.

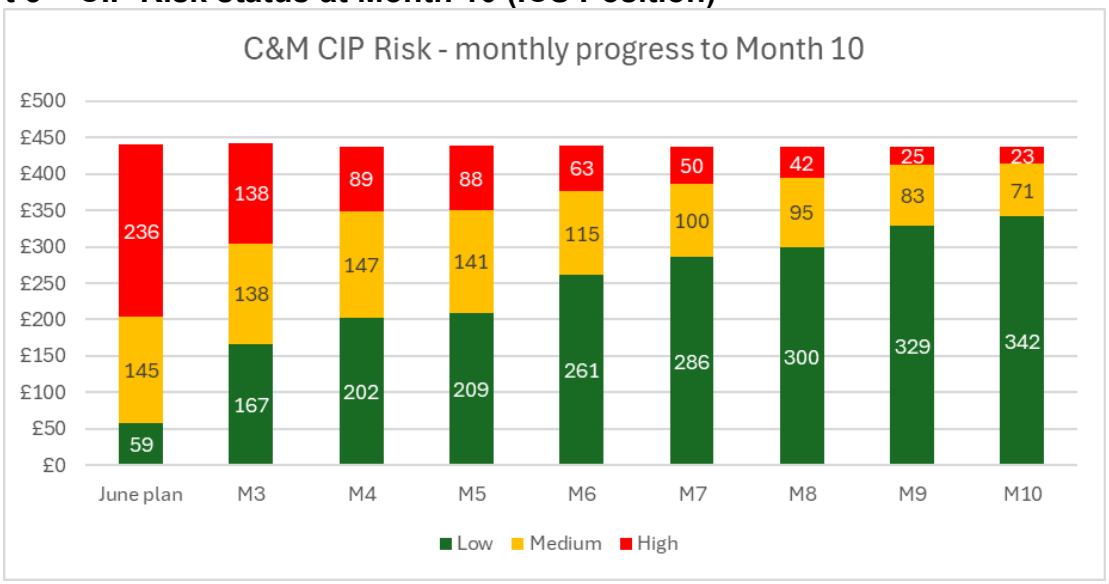
3.21 More detail on System efficiencies, by organisation, is included in **Appendix 6A**.

Table 10 – ICS M10 YTD Efficiency Delivery

Org	CIP delivery					CIP Recurrent / Non Recurent YTD			YTD CIP Profile as a % of FY CIP Plan	
	M10 YTD Plan £,000	M10 YTD Actual £,000	M10 YTD Variance £,000	M10 CIP actual as a % of Op Ex %	FY CIP Plan % of Op Ex %	M10 YTD Actual Recurrent £,000	M10 YTD Actual Non Recurrent £,000	M10 Actual Recurrent as a % of YTD plan %	M10 FOT £,000	M10 YTD CIP as a % of CIP FOT %
Alder Hey Children's	15,416	16,562	1,146	4.4%	4.6%	11,466	5,096	69%	19,950	72%
Bridgewater Community	4,855	2,831	(2,024)	3.2%	6.7%	824	2,007	29%	6,939	34%
Cheshire & Wirral Partnership	11,360	10,214	(1,146)	4.1%	4.7%	4,089	6,125	40%	13,913	63%
Countess of Chester Hospitals	15,593	9,042	(6,551)	2.7%	5.1%	9,042	0	100%	11,494	68%
East Cheshire Trust	8,623	8,623	(0)	4.3%	4.9%	3,850	4,773	45%	11,227	65%
Liverpool Heart & Chest	8,697	6,970	(1,727)	3.3%	4.5%	5,026	1,944	72%	10,644	54%
Liverpool University Hospitals	84,129	76,471	(7,658)	6.3%	8.3%	46,428	30,043	61%	114,600	53%
Liverpool Women's	4,650	5,309	658	3.4%	3.2%	2,023	3,286	38%	5,904	87%
Mersey Care	21,639	21,639	0	3.3%	3.5%	20,075	1,564	93%	25,967	75%
Mid Cheshire Hospitals	18,248	14,925	(3,323)	3.9%	4.9%	8,122	6,803	54%	22,437	57%
Mersey & West Lancs	35,881	38,215	2,334	4.7%	4.6%	28,381	9,834	74%	47,965	70%
The Clatterbridge Centre	8,334	8,334	(0)	3.2%	3.3%	3,904	4,429	47%	10,000	75%
The Walton Centre	7,111	7,111	0	4.1%	4.4%	6,529	582	92%	8,558	75%
Warrington & Halton Hospitals	14,084	13,068	(1,016)	3.8%	4.9%	10,364	2,704	79%	19,433	58%
Wirral Community	4,974	5,590	616	6.1%	5.8%	1,867	3,723	33%	6,275	73%
Wirral University Hospitals	21,801	21,801	(0)	4.8%	5.0%	15,572	6,229	71%	26,878	72%
TOTAL Providers	**285,394**	**266,703**	**(18,691)**	**4.1%**	**5.5%**	**177,561**	**89,142**	**67%**	**362,184**	**63%**
C&M ICB	59,288	54,647	(4,641)	0.8%	1.0%	54,647	0	100%	74,873	67%
TOTAL ICS System	**344,682**	**321,350**	**(23,332)**	**4.9%**	**6.1%**	**232,208**	**89,142**	**72%**	**437,057**	**61%**

3.22 **Chart 5** sets out the current risk and development status of efficiency schemes and how this has progressed since the June plan submission. As at Month 10 5% (£23m) of the CIP schemes are currently deemed high risk meaning there is still work to be undertaken the de-risk CIP delivery to support financial plan delivery. As part of the investigation and intervention Phase 2 work the CIP pipeline and delivery status of all CIP schemes is being reported and reviewed on a weekly basis for all providers. Further detail of the risk status of CIP at organisational level is included in **Appendix 6B.**

Chart 5 – CIP Risk status at Month 10 (ICS Position)



Productivity

3.23 The 2024/25 planning guidance set out an expectation for all providers, with a focus on the acute sector, to improve towards pre-pandemic levels (recognising potential adjustments for case mix change, structural factors and uncaptured activity). 'Implied Productivity Growth' of acute and specialist trusts is calculated by NHSE by comparing output growth (activity) to input growth (based on expenditure costs) against a baseline period. The measure examines the current year's YTD activity and costs with the same period in 19/20 and more recently, with 23/24. A negative value implies decreased productivity whilst positive implies productivity growth.

3.24 The most recently available comparative productivity data is from M6 24/25, and **Table 11** below sets out the aggregate position across all C&M acute and specialist providers compared to the national average. **Appendices 7A** sets out the position at a provider level.

Table 11 - Implied Productivity Growth M6

*Productivity Measure	C&M %	North West %	National Average %
Implied Productivity Growth M5 23/24 vs 19/20	-18.8%	-20.2%	-14.3%
Implied Productivity Growth M5 24/25 vs 23/24	0.2%	0.4%	1.6%
Implied Productivity Growth M6 23/24 vs 19/20	-18.9%	-20.2%	-14.3%
Implied Productivity Growth M6 24/25 vs 23/24	0.0%	0.5%	1.8%

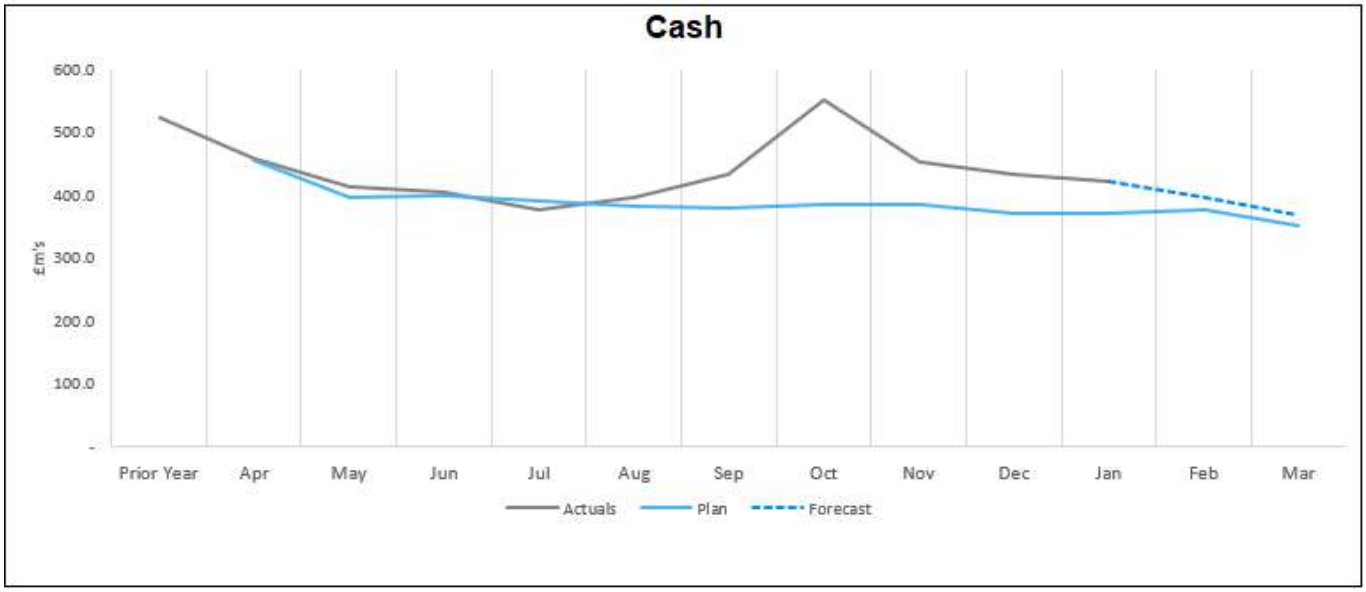
*acute providers only

3.25 Furthermore, the ICB has undertaken a series on provider CEO/CFO meetings that has reviewed a range of metrics under a Balanced Scorecard taking into account finance, WTE, balance sheet and productivity metrics. This scorecard focused on delivery of the year-end financial position, and the improvements required for 25/26. A paper was shared at the January FIRC with the detailed productivity metrics per organisation, with a summary of the key Model Hospital, productivity and weighted value activity metrics reported in **Appendix 7A and 7B.** NHSE are expected to issue a set of national and organisation specific productivity packs to support the 25/26 planning process.

Cash

3.26 The Providers' cash position at Month 10 was £422.5m, with the detail set out in **Appendix 8**. This is £98.1m lower than at the end of 2023/24 and includes £102.9m of external NHSE cash support received up to and including Month 10 supporting several acute organisations. Acute organisations with a planned deficit have received 10/12ths of the £150m deficit support funding in October which has driven the improvement in the cash position in the month of Month 7. **Chart 6** sets out the aggregated providers month on month cash balances up to Month 10.

Chart 6 – Aggregate Provider cash balances month on month



3.27 There are seven organisations that have formally received external cash support from NHSE up to Month 9 of 2024/25 to support their I&E deficit plans – Mersey and West Lancs Teaching NHS Trust, Mid Cheshire Hospitals NHST, Warrington & Halton Teaching Hospitals FT, Liverpool Women's NHS FT, Liverpool University Hospitals NHS FT, Countess of Chester Hospital NHS FT and Wirral Teaching Hospitals NHS FT. A further c£41m of external cash support is forecast to be required from NHSE in the remaining 2 months of the year.

3.28 **Table 12** below set out the aggregate provider cash balance at Month 10, the level of distress cash requests received by NHSE to date and the Month 10 average Better Payment Practice Code (BPPC) position across providers. The aggregate provider BPPC performance has deteriorated from an average number of 92.3% of bills paid within the 95% target at M12 2023/24 to an average number of 90.3% at Month 8. Further detail of BPPC performance by provider is set put in **Appendix 9.**

Table 12 – Provider Cash and BPPC Performance – Month 10

Org	Cash Balance			External Cash Support*		BPPC % of bills paid in target	
	2023/24 M12 Closing Cash Balance	2024/25 M10 Closing Cash Balance	Movement	Received as at M10	FOT	2024/25 M10 By number	2024/25 M10 By Value
	£m	£m	£m	£m	£m	%	%
TOTAL Providers	**520.6**	**422.5**	**(98.1)**	**102.9**	**144.1**	**90.3%**	**93.2%**

* External Cash support via NHS England's Revenue Support PDC process

3.29 The BPPC of WUTH is of particular system concern. The ICB has supported WUTH to date with £8m cash advance. This cash advance is to be repaid in March, and it is likely the trust will require further national support in March to ensure they have cash available to pay staff in March.

3.30 The review of the cash position by national team has focussed on cash requests above planned deficit levels, workforce and financial recovery trajectories being on track and working capital balances i.e. high levels of receivables.

3.31 The ICB has supported WUTH where possible but is constrained by our own levels of cash available. Cash can be transferred between NHS Providers, but this would be a PDC transfer and requires Board approval.

System Risks and Mitigations

3.32 Several risks have been reported through recent trust discussions and are subject to ongoing to monitoring and management by the respective organisations:

a. **Pay Award** – the final pay settlements for medical and agenda for change staff have been agreed and provider plans where set on the basis this would be fully funded. Providers are currently reporting a pay award gap of c£16m. NHSE have reviewed a targeted number of organisations who are reporting a material pressure from the pay award.

b. **Identification and delivery of recurrent CIPs** – this has been subject to weekly reporting as part of the PwC phase 2 governance process.

c. **Non-achievement of ERF / activity requirements** – Month 8 data has been made available from NHS England, indicating that C&M ICB is on plan at 114.7%. However, the overperformance lies more within the Independent Sector (136.5%) than C&M NHS Providers (111%). ERF funding has now been capped at M8 FOT, which means we need to manage activity over the next 2 months to this level.

d. **Inflation** – specifically; non-pay inflation for providers and prescribing and continuing care/packages of care for the ICB above national planning assumptions.

e. **Cost of out of area placements** arising from delayed transfers of care.

f. **Maintenance of core acute bed base year-round** – targeted improvement plan in development across the System in response to recommendations identified by National team.

g. **Industrial action disruption** – the plan assumes no further industrial action throughout the remainder of 24/25.

h. **Depreciation allocation** – There remains a link between depreciation expenditure in provider plans and a ringfenced allocation for increases depreciation from a baseline 22/23 position.

ICB Recovery Update

3.33 For the ICB the recovery programme targets consist of 3 main areas:

- Efficiency plans agreed as part of the plan.
- Stretch targets for Mental Health Pressures in A&E/Out of Area Placements, S117 Packages and Workforce agreed as part of the plan.
- Additional stretch targets identified for each programme.

3.34 The forecast savings against the combined recovery programme targets is £91.3m of which £73.7m relates to the efficiency plans agreed as part of the plan and £17.6m are additional savings identified by the programmes to contribute towards to recovery plan. **Table 13** sets out the latest position by programme.

Table 13 – ICB Recovery Programme Performance – Month 10

Programme Name	YTD			Forecast		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
All Age Continuing Health Care/Complex Care	21,125	18,338	(2,787)	36,465	33,237	(3,228)
Cheshire Urgent Care Improvement	4,137	3,633	(505)	4,965	4,359	(606)
Medicines Management	24,402	23,629	(773)	30,700	30,457	(243)
Mental Health System Flow	6,681	0	(6,681)	10,953	0	(10,953)
Optimising Patient Choice Independent Sector Value	0	2,300	2,300	1,800	2,625	825
Unwarranted Variation	433	610	177	520	825	305
Workforce Optimisation	8,270	8,270	0	10,924	10,924	0
Other	7,156	6,939	(217)	8,750	8,834	84
TOTAL	**72,204**	**63,718**	**(8,486)**	**105,077**	**91,261**	**(13,816)**

ICB Risk Adjusted Forecast

3.35 **Table 14** provides an updated summary of the ICB financial forecast for 2024/25 as at Month 10 and represents the latest most likely scenario.

Table 14 - ICB Forecast Risks and Mitigations

ICB Forecast Risk and Mitigation - Cheshire & Merseyside		
	£m	
ICB Planned Position +/-	62.3	
	Forecast Outturn	Risks
	£m	**£m**
CHC	-27.5	-4.0
MH Packages	-24.3	-1.4
Prescribing	-19.7	0.0
Other	32.0	-8.1
Total	**-39.5**	**-13.5**
Mitigations	**£m**	
Place Mitigations	9.5	
Medicines Management Recovery Programme	2.4	
Other Mitigations	9.1	
Total	**21.0**	
RISK ADJUSTED FORECAST	**30.3**	
RISK ADJUSTED VARIANCE TO PLAN	**-32.0**	

3.36 **Table 15** provides a summary of the mitigations by place. These include the following:

- Continued focus on reducing expenditure on packages of care through enhanced validation and review.
- Increased utilisation of estates void space.
- Recovery of further ERF for community services undertaking acute activity and challenge over-performance for non-ERF eligible activity e.g. outpatients.

Table 15 – Mitigations by Place

Area	Cheshire East £000's	Cheshire West £000's	Halton £000's	Knowlsey £000's	Liverpool £000's	Sefton £000's	St Helens £000's	Warrington £000's	Wirral £000's	Total £000's
Acute	0	0	30	0	0	0	679	60	0	769
Community	0	0	130	0	0	700	136	80	0	1,046
CHC	0	0	349	384	284	4,304	250	0	0	5,571
Mental Health Packages	551	0	0	0	0	0	0	0	0	551
Mental Health Contracts	0	0	0	0	0	0	0	0	0	0
Other Programme	0	0	0	0	20	240	0	0	0	260
Primary Care Delegated	0	0	78	0	0	0	0	0	0	78
Prescribing	0	0	0	0	0	0	0	0	125	125
Primary Care Other	0	0	0	172	300	574	23	0	0	1,068
	551	0	587	556	604	5,818	1,088	140	125	9,468

3.37 The ICB DOF continues to hold regular meetings with each Place finance lead to review the financial position including updated forecast outturn assessments and the outstanding mitigations being pursued by each place team.

ICS Risk Adjusted Forecast, including providers

3.38 The current Month 10 view of the forecast remains consistent with that reported at Month 9, as per below

Table 16 – risk adjusted forecast at M9 and M10

	Plan £m	Risk Adjusted FOT £m	Risk adjusted 'Gap to Plan' £m
Providers	(212)	(253)	(41)
ICB	62	30	(32)
Total ICS	(150)	(223)	(73)

3.39 There remain a number of non-recurrent transactions planned for month 12 which are set out in the table below and are reflected in chart 1.

3.40 These non-recurrent transactions are being monitored through direct meetings between the ICB CFO and each provider CFO. They are set out in the table below:

Description	**£m**	**Updated Risk Commentary**
LUHFT – Benefits arising from Liverpool Acute Trust collaboration	15.0	Medium Risk - Continue to be reviewed at meetings with LAAS providers. £5m now transacted, £11m associated with Estates harmonisation.
LUHFT – Legal Claim	27.3	High Risk, part of weekly review with LUHFT and regular update to NHW: NW
MWL Transaction Support from NHSE and own improvement	8.0	Low Risk - Continue to be reviewed at meetings with providers. MWL delivering this within YTD position and NHSE support confirmed
Wirral Community – Benefits arising from Wirral collaboration	3.5	Low Risk - Continue to be reviewed at meetings with providers.
Number of Trusts - Profile of CIP (WHH £7.7m, LUHFT £4m)	15.0	Low Risk - Continue to be reviewed at meetings with providers. CIP delivery improving
COCH – Thirlwall Enquiry Costs Funding	6.5	Low Risk - Funding to M8 confirmed.
TOTAL	**75.3**	

3.41 The system is still being asked to improve its outturn position and is working on additional mitigations.

Provider organisation opportunities

- Additional capital resource opportunities as agreed with NHSE. A number being transacted (M11)
- Review liabilities and deferred income across all organisations.

ICB opportunities

- Further support to areas of influenceable spend (Prescribing / All Age Continuing Healthcare) in support of recovery programme activities.

3.42 Current modelling of potential outturn ranges suggest possible delivery of an ICS position of c.£200m deficit compared to current outturn of £223m deficit as per Month 9. The highest risk element relates to the LUFT legal claim of £27m and timing / likelihood of confirmation within the financial year (for clarity – is assumed within the above figures and would be a further adverse variance should this not materialise)

Provider and Primary Care Capital

3.43 The 'Charge against Capital Allocation' represents the System's performance against its operational capital allocation, which is wholly managed at the System's discretion. For 2024/25 the System's Secondary Care Core allocation in 2023/24 is £258.4m, a Primary Care allocation of £4.7m, and a provider IFRS16 Operating Leases allocation of £40.0m. The plan submitted in June set out an overprogramming position against allocation of c£12m with plans to spend £315.0m with an expectation that the overprogramming position would be managed in year.

3.44 Tables 17 & 18 sets out the YTD Month 10 position capital expenditure against plan at a system level but also the ICB's primary care capital position. At Month 9 there is a £25.3m underspend against YTD plan, with a £22.3m forecast variance against full year plan largely in relation to additional spend forecast at the Mid-Cheshire Leighton site to address the ongoing RAAC programme and nationally approved revenue to capital schemes. The ICS has been provided with additional allocation by the national team to continue with the RAAC works. A reconciliation of the changes from Plan to FOT are set out in Table 19 below.

3.45 As reported at Month 7 the previous £12m overprogramming position at plan stage has been managed to £nil due to a review of capital lease expenditure and slippage of three contractually committed schemes into 25/26 across, therefore the system is now forecasting a compliant capital position for 2024/25.

3.46 At Month 10 providers have c.40% of capital expenditure to go in the final two months and is being closely monitored by individual organisations and the system. This is % profile is similar to the last two financial years and is expected to be managed.

Table 17 - System (Provider & ICB) - Charge against Capital Allocation M10

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT Year Ending £'000	Variance Year Ending £'000	%
System charge against allocation	228,891	203,589	25,302	315,026	337,305	(22,279)	-7.1%
Capital allocation					337,402		
Variance to allocation					97		
Allocation met					Yes		

Table 18 – ICB - Charge against allocation M10

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT Year Ending £'000	Variance Year Ending £'000	%
Cheshire And Merseyside ICB	228	228	(0)	4,698	4,698	-	0.0%
Capital allocation					4,698		
Variance to allocation					-		
Allocation met					Yes		

Table 19 – Reconciliation from ICS Capital Plan to ICS Capital FOT M10

	£,000	Comment
Capital Plan (submitted June 2024)	**315,026**	
Additions funded nationally		
Mid Cheshire RAAC	*24,682*	Funded by NHSE - priority
Wirral RAAC	*1,953*	Funded by NHSE - priority
Countess of Chester RAAC	*550*	Funded by NHSE - priority
Liverpool University RAAC	*2,100*	Funded by NHSE - priority
Mid Cheshire Digital	*3,000*	Bespoke - Rev to Cap M10
Wirral Sterlile Services	*2,000*	Bespoke - Rev to Cap M10
Reductions supporting £12m local overprogramming		
Review of IFRS16 leases	*(6,909)*	various trusts
Mersey Care - L2 scheme slippage	*(2,000)*	contractual spend now in 25/26
CWP - Mother & Baby Unit slippage	*(1,500)*	contractual spend now in 25/26
Alder Hey - various schemes slippage	*(1,500)*	contractual spend now in 25/26
Minor schemes	*(97)*	expected to reserve in M11
Capital FOT at M10	**337,305**	

3.47 **Appendix 10** sets out the detailed capital position M10 YTD and FOT by provider.

4. Ask of the Board and Recommendations

4.1 The Board is asked to note the financial position and metrics reported at Month 10 and the risks to delivery of the financial plan which are described in the paper.

5. Officer contact details for more information

Mark Bakewell
Interim Executive Director of Finance Cheshire and Merseyside ICB
mark.bakewell@cheshireandmerseyside.nhs.uk

Frankie Morris
Associate Director of Finance (Provider Assurance, Capital & Strategy)
Cheshire and Merseyside ICB
Frankie.Morris@cheshireandmerseyside.nhs.uk

Rebecca Tunstall
Associate Director of Finance (Planning & Reporting)
Cheshire and Merseyside ICB
Rebecca.Tunstall@cheshireandmerseyside.nhs.uk

6. Appendices

Appendix 1: Continuing Care and Complex Care Forecast Outturn by Place M10
Appendix 2: ICB Place Performance split by Programme Area M10
Appendix 3: Provider Income and Expenditure vs YTD Plan
Appendix 4: Agency Expenditure M10 YTD by provider
Appendix 5: Workforce Analysis M10 vs M12 trend and M10 Plan by Provider
Appendix 6A: System Efficiencies: Current Performance M10
Appendix 6B: System Efficiencies: Risk and Development of CIP Plan M10
Appendix 7A: Appendix 7A - Productivity Data – NHSE Model Hospital Reference Cost Index and Implied Productivity
Appendix 7B: Appendix 7B – Productivity - Value Weighted Activity
Appendix 8: Provider Cash at Month 10
Appendix 9: Provider BPPC at Month 10
Appendix 10: ICS Capital Expenditure YTD and FOT vs ICS Allocation at Month 10

Appendix 1

Continuing Care and Complex Care Forecast Outturn by Place as at 31st January 2025

Continuing Care M10 Forecast Variance (£'000)	Total	ICB Central	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
FYE of Packages 23/24	-3,868		1,329	5,810	-697	1,985	550	-6,379	-1,779	-234	-4,453
Prior Year Impact (relating to 23/24)	5,433		1,189	1,308	591	28	1,273	381	-340	524	478
Prior Year Impact (Budget Change)	-5,047		-1,156	-1,677	-405	322	1,178	-2,159	340	-401	-1,090
Volume above 4.3% (24/25)	-11,081		-1,147	-1,806	802	848	-8,962	-4,631	2,164	328	1,324
Price/Inflation above 1.9% (24/25)	4,481		-3,588	2,166	411	-555	6,750	2,941	-758	-763	-2,123
QIPP Delivered YTD (inherent in Price/Volume)	-10,920		-970	-700	-1,234	-977	-651	-1,763	540	-1,685	-3,481
Non Package Driven	-967		-719	-445	-493	381	-1,595	651	-348	143	1,458
Other Planning Adjustments	820		63	178	15	0	290	41	17	20	196
QIPP Underdelivery	-2,018		-1,010	-935	336	0	1,860	0	-2,363	151	-57
In Year Budget Changes	-3,776		391	257	-139	-313	-2,738	-1,410	17	278	-118
Other	33		0	0	4	-0	-0	0	28	0	-0
Grand Total	**-26,911**	**0**	**-5,618**	**4,157**	**-808**	**1,719**	**-2,046**	**-12,328**	**-2,482**	**-1,640**	**-7,865**

Complex Care (Packages) M10 Forecast Variance (£'000)	Total	ICB Central	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
FYE of Packages 23/24	-9,558		-1,332	367	-427	15	-5,255	-1,714	-1,427	268	-54
Prior Year Impact (relating to 23/24)	12,247		1,643	1,092	432	-159	3,191	2,756	546	351	2,396
Prior Year Impact (Budget Change)	-11,686		-1,669	-825	-483	159	-2,957	-2,259	-557	-367	-2,729
Volume above 4.3% (24/25)	-13,891		-1,106	-1,204	-398	-497	-6,364	-1,590	-1,521	78	-1,288
Price/Inflation above 1.9% (24/25)	-603		681	-4,303	-535	-1,295	4,071	1,493	797	416	-1,927
QIPP Delivered YTD (cannot be split price/volum	-3,920		0	-14	-577	0	-1,188	-791	0	-504	-846
Non Package Driven	2,736		281	719	-14	117	549	-52	-38	1,132	42
Other Planning Adjustments	955		0	0	-0	81	-2	-3	-1	898	-18
QIPP Underdelivery	-1,053		-268	-0	106	0	-817	0	0	-73	0
In Year Budget Changes	483		-28	55	65	0	1,514	-0	50	-1,153	-20
Other	0		-0	0	0	0	-0	0	0	0	-0
Grand Total	**-24,291**	**0**	**-1,798**	**-4,114**	**-1,832**	**-1,579**	**-7,259**	**-2,160**	**-2,150**	**1,045**	**-4,444**

Appendix 2

ICB Place Performance split by Programme Area as at 31st January 2025

ICB CENTRAL	C&M ICB Default - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	448	443	5	436	430	6
Community	14	14	(0)	17	17	(0)
CHC	(7)	(7)	(0)	(7)	(7)	(1)
Mental Health - Packages of Care	0	0	(0)	0	0	(0)
Mental Health - Contracts	52	52	1	63	62	1
Other Commissioned Services	1	1	0	2	1	0
Other Programme	31	31	1	38	37	1
Reserves	2	0	2	9	8	1
Primary Care - Delegated GP	0	1	(0)	0	1	(1)
Primary Care - Delegated Other	246	246	(0)	305	305	0
Prescribing	11	12	(0)	15	15	0
Primary Care - Other	3	1	1	4	2	2
Specialised Commissioning	514	507	6	615	607	8
Sub Total - Programme Expenditure	**1,316**	**1,300**	**16**	**1,495**	**1,477**	**18**
Running Costs	41	41	0	49	49	(0)
TOTAL EXPENDITURE	**1,357**	**1,342**	**16**	**1,544**	**1,526**	**18**
Surplus / (Deficit) Plan	*159*	*0*	*159*	*191*	*0*	*191*
Sub Total - Net Surplus / (Deficit) Reported	***1,516***	***1,342***	***175***	***1,734***	***1,526***	***208***

CHESHIRE EAST	Cheshire East Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	350	350	0	422	421	0
Community	77	75	2	92	90	2
CHC	65	71	(5)	78	84	(6)
Mental Health - Packages of Care	19	21	(2)	23	24	(2)
Mental Health - Contracts	47	47	(0)	57	57	(0)
Other Commissioned Services	2	2	0	2	2	0
Other Programme	1	1	0	2	1	0
Reserves	(2)	0	(2)	(3)	0	(3)
Primary Care - Delegated GP	69	69	(0)	80	80	(0)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	60	62	(2)	71	74	(2)
Primary Care - Other	15	14	1	18	17	1
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**703**	**711**	**(8)**	**841**	**851**	**(9)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**703**	**711**	**(8)**	**841**	**851**	**(9)**
Surplus / (Deficit) Plan	*(43)*	*0*	*(43)*	*(52)*	*0*	*(52)*
Sub Total - Net Surplus / (Deficit) Reported	***659***	***711***	***(52)***	***789***	***851***	***(61)***

NHS
Cheshire and Merseyside

CHESHIRE WEST	Cheshire West Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Outturn £'m	Variance £'m
Acute	359	358	1	432	431	1
Community	57	58	(1)	68	69	(0)
CHC	54	51	3	65	61	4
Mental Health - Packages of Care	19	22	(3)	23	27	(4)
Mental Health - Contracts	50	51	(1)	60	61	(1)
Other Commissioned Services	2	2	0	2	2	0
Other Programme	1	1	0	1	1	0
Reserves	(2)	0	(2)	(3)	0	(3)
Primary Care - Delegated GP	66	65	0	76	76	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	58	59	(2)	69	71	(2)
Primary Care - Other	14	14	1	17	16	1
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**678**	**681**	**(3)**	**811**	**815**	**(4)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**678**	**681**	**(3)**	**811**	**815**	**(4)**
Surplus / (Deficit) Plan	*(36)*	*0*	*(36)*	*(43)*	*0*	*(43)*
Sub Total - Net Surplus / (Deficit) Reported	***642***	***681***	***(39)***	***768***	***815***	***(47)***

HALTON	Halton Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Outturn £'m	Variance £'m
Acute	140	140	0	169	168	0
Community	33	33	(0)	39	40	(0)
CHC	15	15	(1)	18	19	(1)
Mental Health - Packages of Care	8	9	(2)	9	11	(2)
Mental Health - Contracts	21	21	(0)	25	25	(0)
Other Commissioned Services	1	1	(0)	1	1	(0)
Other Programme	1	1	0	1	1	0
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	24	24	0	27	27	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	23	23	(1)	27	28	(1)
Primary Care - Other	4	3	0	4	4	0
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**268**	**270**	**(2)**	**321**	**323**	**(2)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**268**	**270**	**(2)**	**321**	**323**	**(2)**
Surplus / (Deficit) Plan	*(8)*	*0*	*(8)*	*(9)*	*0*	*(9)*
Sub Total - Net Surplus / (Deficit) Reported	***260***	***270***	***(10)***	***312***	***323***	***(12)***

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KNOWSLEY	Knowsley Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Outturn £'m	Variance £'m
Acute	180	179	0	216	216	1
Community	52	52	(0)	62	63	(1)
CHC	14	13	1	16	15	2
Mental Health - Packages of Care	6	8	(1)	7	9	(2)
Mental Health - Contracts	30	30	(0)	36	36	(0)
Other Commissioned Services	1	1	0	1	1	0
Other Programme	3	3	0	4	4	0
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	37	37	0	43	43	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	30	31	(1)	36	38	(2)
Primary Care - Other	2	2	0	3	3	0
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**355**	**356**	**(1)**	**426**	**427**	**(1)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**355**	**356**	**(1)**	**426**	**427**	**(1)**
Surplus / (Deficit) Plan	*10*	*0*	*10*	*12*	*0*	*12*
Sub Total - Net Surplus / (Deficit) Reported	***365***	***356***	***9***	***438***	***427***	***11***

LIVERPOOL	Liverpool Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Outturn £'m	Variance £'m
Acute	582	581	1	700	699	1
Community	116	116	(0)	139	139	(0)
CHC	56	57	(1)	66	68	(2)
Mental Health - Packages of Care	25	31	(6)	31	38	(7)
Mental Health - Contracts	95	96	(1)	114	115	(1)
Other Commissioned Services	3	3	0	4	4	0
Other Programme	8	8	(0)	10	10	(0)
Reserves	(0)	0	(0)	0	0	(0)
Primary Care - Delegated GP	98	98	(0)	115	115	(0)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	85	89	(3)	102	106	(4)
Primary Care - Other	25	24	1	30	29	1
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**1,093**	**1,102**	**(9)**	**1,311**	**1,323**	**(13)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**1,093**	**1,102**	**(9)**	**1,311**	**1,323**	**(13)**
Surplus / (Deficit) Plan	*9*	*0*	*9*	*11*	*0*	*11*
Sub Total - Net Surplus / (Deficit) Reported	***1,102***	***1,102***	***(0)***	***1,321***	***1,323***	***(2)***

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SEFTON	Sefton Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Outturn £'m	Variance £'m
Acute	300	299	2	362	360	2
Community	79	78	1	95	94	1
CHC	35	46	(11)	42	54	(12)
Mental Health - Packages of Care	16	18	(2)	20	22	(2)
Mental Health - Contracts	46	46	(0)	55	56	(0)
Other Commissioned Services	1	1	0	1	1	0
Other Programme	3	2	0	3	3	0
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	45	45	(0)	53	54	(0)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	49	50	(1)	59	60	(1)
Primary Care - Other	10	10	0	12	12	0
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**585**	**595**	**(10)**	**703**	**714**	**(11)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**585**	**595**	**(10)**	**703**	**714**	**(11)**
Surplus / (Deficit) Plan	*(9)*	*0*	*(9)*	*(11)*	*0*	*(11)*
Sub Total - Net Surplus / (Deficit) Reported	***576***	***595***	***(19)***	***692***	***714***	***(22)***

ST HELENS	St. Helens Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Outturn £'m	Variance £'m
Acute	203	203	0	245	245	0
Community	47	46	1	57	55	1
CHC	22	25	(3)	27	29	(2)
Mental Health - Packages of Care	18	19	(2)	21	23	(2)
Mental Health - Contracts	30	30	(0)	35	36	(0)
Other Commissioned Services	1	1	0	1	1	0
Other Programme	3	3	0	4	4	0
Reserves	0	0	0	1	0	1
Primary Care - Delegated GP	37	36	0	43	43	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	34	36	(1)	41	43	(1)
Primary Care - Other	5	4	0	6	5	0
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**401**	**403**	**(3)**	**481**	**484**	**(3)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**401**	**403**	**(3)**	**481**	**484**	**(3)**
Surplus / (Deficit) Plan	*(9)*	*0*	*(9)*	*(11)*	*0*	*(11)*
Sub Total - Net Surplus / (Deficit) Reported	***391***	***403***	***(12)***	***470***	***484***	***(14)***

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WARRINGTON	Warrington Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Outturn £'m	Variance £'m
Acute	204	204	0	246	245	1
Community	37	37	0	44	44	(0)
CHC	26	28	(2)	31	33	(2)
Mental Health - Packages of Care	10	10	1	12	11	1
Mental Health - Contracts	29	29	0	35	35	0
Other Commissioned Services	1	1	0	1	1	0
Other Programme	1	1	0	2	1	0
Reserves	1	0	1	2	0	1
Primary Care - Delegated GP	35	35	0	41	41	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	32	33	(2)	38	40	(2)
Primary Care - Other	5	5	0	6	6	0
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**382**	**382**	**0**	**459**	**458**	**1**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**382**	**382**	**0**	**459**	**458**	**1**
Surplus / (Deficit) Plan	*(4)*	*0*	*(4)*	*(5)*	*0*	*(5)*
Sub Total - Net Surplus / (Deficit) Reported	***378***	***382***	***(3)***	***454***	***458***	***(4)***

WIRRAL	Wirral Place - Month 10 Position			Annual	M01 to M12 Forecast	
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Outturn £'m	Variance £'m
Acute	353	351	1	425	423	2
Community	76	74	2	91	89	2
CHC	57	62	(5)	68	76	(8)
Mental Health - Packages of Care	21	24	(3)	25	30	(4)
Mental Health - Contracts	53	54	(1)	64	65	(1)
Other Commissioned Services	1	1	0	1	1	0
Other Programme	0	0	0	0	0	0
Reserves	0	0	0	(0)	(0)	0
Primary Care - Delegated GP	60	61	(1)	71	71	(1)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	61	64	(4)	73	77	(5)
Primary Care - Other	10	9	1	12	11	1
Specialised Commissioning	0	0	(0)	0	0	(0)
Sub Total - Programme Expenditure	**691**	**700**	**(10)**	**829**	**842**	**(14)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**691**	**700**	**(10)**	**829**	**842**	**(14)**
Surplus / (Deficit) Plan	*(17)*	*0*	*(17)*	*(21)*	*0*	*(21)*
Sub Total - Net Surplus / (Deficit) Reported	***674***	***700***	***(27)***	***808***	***842***	***(34)***

Appendix 3: Provider Income and Expenditure vs YTD Plan

	Income - Month 10 YTD			Total Pay - Month 10 YTD			Non Pay - Month 10 YTD			Other Operating Items			Income YTD Variance	Pay YTD Variance	Non Pay YTD Variance	Other Operating YTD Var	TOTAL YTD variance to plan
	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	%	%	%	%	%
Alder Hey Children's	348,174	363,519	**15,345**	(226,753)	(226,619)	**133**	(113,797)	(129,355)	**(15,558)**	(6,130)	(6,917)	**(787)**	4.4%	0.1%	-12.0%	-11.4%	-0.3%
Bridgewater Community	82,501	84,743	**2,242**	(56,667)	(60,985)	**(4,318)**	(24,540)	(26,089)	**(1,549)**	150	(45)	**(195)**	2.7%	-7.1%	-5.9%	-430.9%	-2.8%
Cheshire & Wirral Partnership	236,030	239,881	**3,851**	(186,840)	(189,580)	**(2,740)**	(46,698)	(48,379)	**(1,681)**	(1,501)	(709)	**792**	1.6%	-1.4%	-3.5%	111.7%	0.0%
Countess of Chester Hospitals	302,571	320,108	**17,537**	(224,109)	(226,556)	**(2,447)**	(85,372)	(103,459)	**(18,087)**	(2,009)	(1,643)	**366**	5.8%	-1.1%	-17.5%	22.3%	-3.0%
East Cheshire Trust	178,598	185,715	**7,117**	(122,692)	(129,022)	**(6,330)**	(60,216)	(61,964)	**(1,748)**	(1,902)	(1,263)	**639**	4.0%	-4.9%	-2.8%	50.6%	-0.2%
Liverpool Heart & Chest	202,802	217,885	**15,083**	(95,509)	(99,472)	**(3,963)**	(95,073)	(106,592)	**(11,519)**	(729)	(386)	**343**	7.4%	-4.0%	-10.8%	88.9%	-0.3%
Liverpool University Hospitals	1,023,420	1,075,361	**51,942**	(713,430)	(744,453)	**(31,024)**	(357,119)	(382,300)	**(25,181)**	(20,190)	(18,251)	**1,939**	5.1%	-4.2%	-6.6%	10.6%	-1.0%
Liverpool Women's	142,071	141,739	**(332)**	(92,721)	(91,339)	**1,382**	(57,422)	(58,733)	**(1,311)**	(1,944)	(1,657)	**287**	-0.2%	1.5%	-2.2%	17.3%	0.9%
Mersey Care	607,803	637,516	**29,713**	(468,885)	(480,983)	**(12,098)**	(129,450)	(148,044)	**(18,594)**	(4,278)	(3,299)	**979**	4.9%	-2.5%	-12.6%	29.7%	0.0%
Mid Cheshire Hospitals	352,593	356,313	**3,720**	(251,870)	(252,004)	**(134)**	(107,886)	(111,808)	**(3,922)**	(4,438)	(4,486)	**(48)**	1.1%	-0.1%	-3.5%	-1.1%	-0.4%
Mersey & West Lancs	783,246	790,986	**7,740**	(528,110)	(529,750)	**(1,640)**	(248,080)	(253,175)	**(5,095)**	(25,530)	(21,187)	**4,343**	1.0%	-0.3%	-2.0%	20.5%	0.5%
The Clatterbridge Centre	242,522	254,669	**12,147**	(92,776)	(95,221)	**(2,445)**	(146,708)	(158,578)	**(11,870)**	(2,390)	(218)	**2,172**	5.0%	-2.6%	-7.5%	997.7%	0.0%
The Walton Centre	159,037	168,701	**9,664**	(81,833)	(83,829)	**(1,996)**	(72,452)	(80,305)	**(7,853)**	(318)	173	**491**	6.1%	-2.4%	-9.8%	-283.6%	0.4%
Warrington & Halton Hospitals	305,060	311,732	**6,672**	(224,491)	(232,613)	**(8,122)**	(89,958)	(93,351)	**(3,393)**	(3,807)	(2,903)	**904**	2.2%	-3.5%	-3.6%	31.1%	-0.5%
Wirral Community	87,324	88,862	**1,538**	(64,064)	(65,741)	**(1,677)**	(20,532)	(20,452)	**80**	(566)	(503)	**64**	1.8%	-2.6%	0.4%	12.7%	0.0%
Wirral University Hospitals	427,231	423,354	**(3,877)**	(298,826)	(308,742)	**(9,916)**	(130,376)	(126,401)	**3,975**	(4,416)	(4,016)	**400**	-0.9%	-3.2%	3.1%	10.0%	-2.4%
TOTAL Providers	**5,480,983**	**5,661,085**	**180,102**	**(3,729,575)**	**(3,816,910)**	**(87,335)**	**(1,785,679)**	**(1,908,985)**	**(123,307)**	**(79,998)**	**(67,309)**	**12,689**	**3.3%**	**-2.3%**	**-6.9%**	**15.9%**	**-0.3%**

Appendix 4 – Agency Expenditure M10 YTD by provider

Agency Costs YTD and FOT	YTD Plan	YTD Actual	YTD Variance	Forecast Outturn Plan	Forecast Outturn Forecast	Forecast Outturn Variance	YTD agency as a % of YTD pay costs	FOT agency as a % of FOT pay costs
	£m	£m	£m	£m	£m	£m	%	%
Alder Hey Children's	(0.5)	(1.2)	(0.7)	(0.6)	(1.3)	(0.7)	0.5%	0.5%
Bridgewater Community	(1.3)	(1.7)	(0.3)	(1.5)	(1.7)	(0.2)	2.7%	2.5%
Cheshire & Wirral Partnership	(7.2)	(7.1)	0.1	(8.3)	(8.7)	(0.4)	3.7%	3.9%
Countess of Chester Hospitals	(4.1)	(3.7)	0.4	(4.9)	(4.4)	0.5	1.6%	1.6%
East Cheshire Trust	(6.1)	(5.1)	1.0	(7.3)	(6.6)	0.7	4.0%	4.4%
Liverpool Heart & Chest	(0.8)	(0.4)	0.3	(0.9)	(0.8)	0.1	0.4%	0.6%
Liverpool University Hospitals	(8.8)	(9.4)	(0.6)	(10.0)	(11.7)	(1.7)	1.3%	1.3%
Liverpool Women's	(1.1)	(0.6)	0.5	(1.4)	(0.7)	0.6	0.7%	0.6%
Mersey Care	(15.0)	(13.3)	1.8	(18.0)	(15.5)	2.6	2.8%	2.7%
Mid Cheshire Hospitals	(7.2)	(10.1)	(2.9)	(8.5)	(12.4)	(3.9)	4.0%	4.1%
Mersey & West Lancs	(14.9)	(19.1)	(4.2)	(17.9)	(21.9)	(4.0)	3.6%	3.4%
The Clatterbridge Centre	(0.6)	(1.1)	(0.4)	(0.7)	(1.3)	(0.6)	1.1%	1.2%
The Walton Centre	0.0	(0.6)	(0.6)	0.0	(0.8)	(0.8)	0.8%	0.8%
Warrington & Halton Hospitals	(6.2)	(2.9)	3.3	(7.3)	(3.4)	3.9	1.2%	1.2%
Wirral Community	(0.4)	(0.6)	(0.2)	(0.5)	(0.7)	(0.2)	0.8%	0.9%
Wirral University Hospitals	(3.5)	(8.5)	(5.0)	(4.2)	(10.1)	(5.8)	2.7%	2.8%
TOTAL	**(77.8)**	**(85.4)**	**(7.6)**	**(92.0)**	**(101.9)**	**(9.9)**	**2.2%**	**2.3%**

C&M Annual Agency Ceiling	**(120.6)**
Forecast Variance to Ceiling	**18.7**

Appendix 5 – Workforce Analysis M10 vs M12 trend and M10 Trajectory Plan by Provider

NHS
Cheshire and Merseyside

	2023/24	2024/25									M10 Variance		2024/25	
Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M3 Actual	M4 Actual	M5 Actual	M6 Actual	M7 Actual	M8 Actual	M9 Actual	M10 Actual	M1 to M10 Trend	M10 Variance from plan trajectory favourable / (adverse)		M12 Plan (March 25)	M10 Actual vs M12 Plan
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%	WTE	WTE
Alder Hey Children's	**4,368**	4,326	4,334	4,292	4,310	4,400	4,418	4,383	4,426		(129)	-3.0%	4,273	(152)
Bridgewater Community	**1,434**	1,447	1,454	1,445	1,459	1,476	1,471	1,458	1,444		37	2.5%	1,479	35
Cheshire & Wirral Partnership	**4,072**	4,017	4,000	3,967	4,032	4,041	4,014	4,042	4,050		(22)	-0.5%	4,028	(22)
Countess of Chester Hospitals	**4,886**	4,809	4,829	4,829	4,848	4,841	4,842	4,826	4,864		(58)	-1.2%	4,764	(100)
East Cheshire Trust	**2,675**	2,633	2,656	2,697	2,660	2,668	2,641	2,625	2,672		(30)	-1.2%	2,625	(47)
Liverpool Heart & Chest	**1,912**	1,898	1,886	1,889	1,887	1,915	1,904	1,899	1,912		(24)	-1.3%	1,880	(31)
Liverpool University Hospitals	**15,448**	15,041	15,228	15,170	15,128	15,153	15,119	15,136	15,104		(421)	-2.9%	14,601	(503)
Liverpool Women's	**1,687**	1,717	1,715	1,748	1,760	1,783	1,784	1,767	1,772		(8)	-0.5%	1,764	(8)
Mersey Care	**11,623**	11,091	11,244	11,286	11,475	11,419	11,474	11,478	11,616		(352)	-3.1%	11,263	(352)
Mid Cheshire Hospitals	**5,687**	5,398	5,429	5,428	5,380	5,455	5,455	5,441	5,529		(174)	-3.2%	5,350	(179)
Mersey & West Lancs	**10,614**	10,478	10,556	10,551	10,547	10,694	10,621	10,642	10,575		40	0.4%	10,564	(11)
The Clatterbridge Centre	**1,893**	1,920	1,896	1,906	1,930	1,921	1,926	1,922	1,931		(28)	-1.5%	1,907	(24)
The Walton Centre	**1,562**	1,570	1,552	1,600	1,608	1,608	1,614	1,588	1,604		(46)	-2.9%	1,559	(46)
Warrington & Halton Hospitals	**4,786**	4,637	4,657	4,615	4,707	4,699	4,658	4,639	4,653		(78)	-1.7%	4,559	(94)
Wirral Community	**1,560**	1,567	1,566	1,564	1,568	1,570	1,581	1,568	1,560		(44)	-2.9%	1,512	(48)
Wirral University Hospitals	**6,258**	6,300	6,350	6,315	6,344	6,358	6,301	6,360	6,336		(82)	-1.3%	6,227	(109)
C&M Providers Total	**80,465**	**78,849**	**79,352**	**79,303**	**79,645**	**80,002**	**79,822**	**79,773**	**80,046**		**(1,420)**	**-1.8%**	**78,354**	**(1,692)**
by Sector														
Acute	50,353	49,296	49,704	49,604	49,616	49,868	49,637	49,668	49,731		(804)	-1.6%	48,688	(1,043)
Specialist	11,423	11,431	11,382	11,436	11,495	11,628	11,645	11,559	11,645		(234)	-2.1%	11,384	(262)
Community / MH	18,689	18,123	18,265	18,263	18,534	18,506	18,539	18,546	18,669		(382)	-2.1%	18,282	(387)
TOTAL Providers	**80,465**	**78,849**	**79,352**	**79,303**	**79,645**	**80,002**	**79,822**	**79,773**	**80,046**		**(1,420)**	**-1.8%**	**78,354**	**(1,692)**

Appendix 6A - System Efficiencies: Current Performance M10

NHS
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Org	CIP delivery													CIP Recurrent / Non Recurent YTD			YTD CIP Profile as a % of FY CIP Plan	
	M10 YTD Plan	M10 YTD Actual	M10 YTD Variance	M2 CIP actual as a % of Op Ex	M3 CIP actual as a % of Op Ex	M4 CIP actual as a % of Op Ex	M5 CIP actual as a % of Op Ex	M6 CIP actual as a % of Op Ex	M7 CIP actual as a % of Op Ex	M8 CIP actual as a % of Op Ex	M9 CIP actual as a % of Op Ex	M10 CIP actual as a % of Op Ex	FY CIP Plan % of Op Ex	M10 YTD Actual Recurrent	M10 YTD Actual Non Recurrent	M10 Actual Recurrent as a % of YTD plan	M10 FOT	M10 YTD CIP as a % of CIP FOT
	£,000	£,000	£,000	%	%	%	%	%	%	%	%	%	%	£,000	£,000	%	£,000	%
Alder Hey Children's	15,416	16,562	1,146	2.3%	2.4%	2.8%	3.2%	3.7%	3.7%	3.9%	4.3%	4.4%	4.6%	11,466	5,096	69%	19,950	72%
Bridgewater Community	4,855	2,831	(2,024)	1.2%	1.6%	1.7%	1.9%	2.7%	2.6%	2.6%	2.9%	3.2%	6.7%	824	2,007	29%	6,939	34%
Cheshire & Wirral Partnership	11,360	10,214	(1,146)	2.7%	2.9%	3.1%	2.8%	3.4%	3.4%	4.0%	3.9%	4.1%	4.7%	4,089	6,125	40%	13,913	63%
Countess of Chester Hospitals	15,593	9,042	(6,551)	0.1%	0.7%	1.4%	1.6%	1.8%	1.9%	2.4%	2.6%	2.7%	5.1%	9,042	0	100%	11,494	68%
East Cheshire Trust	8,623	8,623	(0)	2.0%	2.0%	2.5%	2.8%	3.0%	3.4%	3.8%	4.1%	4.3%	4.9%	3,850	4,773	45%	11,227	65%
Liverpool Heart & Chest	8,697	6,970	(1,727)	1.9%	2.3%	2.5%	2.6%	2.9%	2.9%	3.0%	3.0%	3.3%	4.5%	5,026	1,944	72%	10,644	54%
Liverpool University Hospitals	84,129	76,471	(7,658)	4.3%	4.4%	4.6%	5.0%	5.3%	5.2%	5.5%	5.6%	6.3%	8.3%	46,428	30,043	61%	114,600	53%
Liverpool Women's	4,650	5,309	658	1.2%	1.6%	2.5%	3.8%	3.8%	3.5%	3.5%	3.7%	3.4%	3.2%	2,023	3,286	38%	5,904	87%
Mersey Care	21,639	21,639	0	3.5%	3.4%	3.4%	3.4%	3.4%	3.3%	3.3%	3.3%	3.3%	3.5%	20,075	1,564	93%	25,967	75%
Mid Cheshire Hospitals	18,248	14,925	(3,323)	2.3%	2.5%	2.7%	3.0%	3.2%	3.3%	3.7%	3.8%	3.9%	4.9%	8,122	6,803	54%	22,437	57%
Mersey & West Lancs	35,881	38,215	2,334	2.9%	3.2%	3.6%	3.8%	4.0%	4.2%	4.4%	4.6%	4.7%	4.6%	28,381	9,834	74%	47,965	70%
The Clatterbridge Centre	8,334	8,334	(0)	3.3%	3.4%	3.3%	3.3%	3.3%	3.2%	3.2%	3.2%	3.2%	3.3%	3,904	4,429	47%	10,000	75%
The Walton Centre	7,111	7,111	0	4.1%	4.3%	4.3%	4.3%	4.3%	4.2%	4.1%	4.2%	4.1%	4.4%	6,529	582	92%	8,558	75%
Warrington & Halton Hospitals	14,084	13,068	(1,016)	1.7%	2.0%	2.5%	2.8%	3.0%	3.3%	3.6%	3.7%	3.8%	4.9%	10,364	2,704	79%	19,433	58%
Wirral Community	4,974	5,590	616	2.4%	4.0%	4.1%	3.8%	3.9%	4.6%	5.5%	5.5%	6.1%	5.8%	1,867	3,723	33%	6,275	73%
Wirral University Hospitals	21,801	21,801	(0)	3.1%	3.1%	2.7%	2.4%	4.3%	4.4%	4.5%	4.6%	4.8%	5.0%	15,572	6,229	71%	26,878	72%
TOTAL Providers	**285,394**	**266,703**	**(18,691)**	**3.0%**	**3.3%**	**3.5%**	**3.5%**	**4.0%**	**4.0%**	**4.3%**	**4.4%**	**4.1%**	**5.5%**	**177,561**	**89,142**	**67%**	**362,184**	**63%**
C&M ICB	59,288	54,647	(4,641)	0.6%	0.6%	0.6%	0.6%	0.6%	0.8%	0.8%	0.8%	0.8%	1.0%	54,647	0	100%	74,873	67%
TOTAL ICS System	**344,682**	**321,350**	**(23,332)**	**3.7%**	**3.8%**	**3.9%**	**4.1%**	**4.2%**	**4.3%**	**4.5%**	**4.7%**	**4.9%**	**6.1%**	**232,208**	**89,142**	**72%**	**437,057**	**61%**

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Appendix 6B - System Efficiencies: M10 Risk and Development of CIP Plan

	Month 10 (end of Jan 26) assessment									% of CIP High Risk
	CIP RISK				CIP DEVELOPMENT					
	Low £m	Medium £m	High £m	Total £m	Fully £m	In Progress £m	Opportunity £m	Unidentified £m	Total £m	%
Alder Hey Children's	19.2	0.6	0.2	**19.9**	18.9	1.0	0.0	0.0	**19.9**	1%
Bridgewater Community	3.1	0.8	3.1	**6.9**	3.9	0.0	0.0	3.1	**6.9**	44%
Cheshire & Wirral Partnership	12.2	0.4	1.3	**13.9**	12.2	0.4	0.0	1.3	**13.9**	9%
Countess of Chester Hospitals	11.3	0.2	0.0	**11.5**	11.4	0.0	0.1	0.0	**11.5**	0%
East Cheshire Trust	9.5	1.1	0.6	**11.2**	11.2	0.0	0.0	0.0	**11.2**	5%
Liverpool Heart & Chest	5.2	3.3	2.1	**10.6**	8.5	0.8	1.4	0.0	**10.6**	20%
Liverpool University Hospitals	97.2	13.1	4.3	**114.6**	111.2	0.5	3.0	0.0	**114.6**	4%
Liverpool Women's	5.7	0.2	0.0	**5.9**	5.8	0.1	0.0	0.0	**5.9**	0%
Mersey Care	12.2	13.8	0.0	**26.0**	10.3	15.6	0.0	0.0	**26.0**	0%
Mid Cheshire Hospitals	19.8	0.2	2.4	**22.4**	22.0	0.4	0.1	0.0	**22.4**	11%
Mersey & West Lancs	42.6	5.3	0.0	**48.0**	39.4	7.9	0.7	0.0	**48.0**	0%
The Clatterbridge Centre	10.0	0.0	0.0	**10.0**	10.0	0.0	0.0	0.0	**10.0**	0%
The Walton Centre	8.3	0.3	0.0	**8.6**	6.6	2.0	0.0	0.0	**8.6**	0%
Warrington & Halton Hospitals	17.0	0.0	2.5	**19.4**	16.4	2.6	0.5	0.0	**19.4**	13%
Wirral Community	6.3	0.0	0.0	**6.3**	6.3	0.0	0.0	0.0	**6.3**	0%
Wirral University Hospitals	26.6	0.2	0.1	**26.9**	22.2	4.6	0.1	0.0	**26.9**	0%
C&M ICB	36.2	31.9	6.8	**74.9**	74.9	0.0	0.0	0.0	**74.9**	9%
Total	**342.3**	**71.4**	**23.4**	**437.1**	**391.0**	**36.0**	**5.8**	**4.4**	**437.1**	**5%**

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Appendix 7A - Productivity Data – NHSE Model Hospital Reference Cost Index and Implied Productivity

	Info from Model System / Model Hospital (Not checked for data quality)								Other NHSE Productivity Measures		
Org Name	Updated: Capped theatre utilisation - weekly	ALOS for elective admissions (days) - rolling 6 months	Updated: ALOS for emergency admissions (days) - rolling 6 months	Updated: % of elective admissions with the length of stay > 6 days	Updated: % of emergency admissions with the length of stay > 6 days	Day case rates for BADCS procedures (3mths to month end)	Updated: % outpatient DNAs	Updated: % of OP appts performed virtually (SUS) - Weekly	Reference Cost Index 23/24	Implied Productivity 24/25 M6 vs 19/20	Implied Productivity 24/25 M6 vs 23/24
ENGLAND AVERAGE	**79.9%**	**3.0**	**10.4**	**9.4%**	**21.1%**	**84.5%**	**6.8%**	**18.2%**	**100**	**-14.3%**	**1.8%**
Alder HeyChildren's NHS Foundation Trust	80.9%	3.9	8.5	15.5%	10.1%	90.8%	9.5%	20.8%	104	-19.3%	3.9%
Countess ofChester Hospital NHS Foundation Trust	#N/A	2.7	12.1	9.8%	21.1%	85.9%	6.4%	17.7%	99	-16.2%	4.8%
East Cheshire NHS Trust	84.1%	3.2	11.3	7.9%	32.3%	86.8%	4.1%	10.8%	118	-21.9%	4.3%
Liverpool Heart and Chest Hospital NHS Foundation Trust	86.6%	5.1	8.7	28.4%	23.7%	0.0%	7.7%	31.7%	102	-20.8%	0.4%
Liverpool UniversityHospitals NHS Foundation Trust	78.3%	4.6	12.5	18.4%	21.1%	85.1%	10.1%	15.6%	110	-23.6%	-0.6%
Liverpool Women's NHS Foundation Trust	73.4%	1.6	4.6	1.7%	7.4%	88.2%	9.5%	26.8%	111	-25.8%	8.4%
Mid Cheshire Hospitals NHS Foundation Trust	73.8%	3.0	10.3	9.9%	18.4%	87.7%	5.8%	15.6%	104	-19.8%	2.1%
Merseyand West Lancashire Teaching Hospitals NHS Trust	75.7%	3.4	11.6	12.5%	16.5%	82.4%	8.2%	12.2%	#N/A	-14.8%	-4.4%
The Clatterbridge Cancer Centre NHS Foundation Trust	#N/A	10.4	14.2	28.6%	41.3%	92.7%	2.6%	25.3%	113	8.5%	7.6%
The Walton Centre NHS Foundation Trust	78.5%	4.0	23.0	11.5%	50.3%	23.3%	6.9%	30.8%	117	0.7%	4.6%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	76.7%	2.5	11.8	6.1%	31.7%	84.6%	8.2%	17.5%	#N/A	-31.8%	-8.7%
Wirral UniversityTeaching Hospital NHS Foundation Trust	#N/A	3.2	10.5	8.8%	22.9%	79.9%	7.4%	14.2%	83	-6.0%	6.8%
Bridgewater CommunityHealthcare NHS Foundation Trust									119		
Cheshire and Wirral Partnership NHS Foundation Trust									115		
MerseyCare NHS Foundation Trust									93		
Wirral CommunityHealth and Care NHS Foundation Trust									99		
Cheshire and Merseyside ICB/ICS	**78.4%**	**3.8**	**11.6**	**14.1%**	**20.8%**	**84.4%**	**7.3%**	**17.4%**	**103**	**-18.9%**	**0.0%**

Appendix 7B – Productivity - Value Weighted Activity

SUS (est)	31-Mar-24	17-Nov-24	24-Nov-24	01-Dec-24	08-Dec-24	15-Dec-24	22-Dec-24	29-Dec-24
NORTH WEST	**113.7%**	**108.2%**	**107.8%**	**108.3%**	**108.8%**	**110.2%**	**119.4%**	**121.0%**
LANCASHIRE AND SOUTH CUMBRIA ICB	107.2%	112.0%	112.2%	111.6%	111.3%	112.2%	119.8%	120.0%
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	113.4%	124.6%	124.0%	122.7%	124.1%	124.9%	132.9%	131.4%
EAST LANCASHIRE HOSPITALS NHS TRUST	44.3%	100.1%	102.0%	103.4%	104.3%	106.5%	113.0%	112.3%
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	118.4%	119.9%	117.7%	116.2%	114.6%	113.8%	127.4%	130.3%
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	147.3%	106.1%	107.6%	107.1%	106.0%	106.7%	109.7%	108.3%
GREATER MANCHESTER ICB	110.2%	104.3%	105.4%	106.0%	108.9%	110.3%	118.8%	120.9%
BOLTON NHS FOUNDATION TRUST	104.9%	124.3%	128.7%	129.4%	130.6%	141.5%	151.7%	154.8%
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	106.4%	100.0%	100.8%	101.0%	106.2%	107.6%	116.6%	119.1%
SALFORD ROYAL NHS FOUNDATION TRUST	104.7%	102.6%	103.8%	107.0%	108.9%	110.1%	117.5%	120.3%
STOCKPORT NHS FOUNDATION TRUST	104.3%	100.8%	99.9%	102.1%	101.0%	102.0%	112.9%	116.2%
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	103.3%	107.5%	112.2%	110.9%	115.3%	117.2%	122.2%	122.1%
THE CHRISTIE NHS FOUNDATION TRUST	97.8%	106.7%	100.3%	96.6%	98.8%	99.6%	105.9%	114.4%
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	106.2%	104.8%	107.8%	103.7%	103.7%	103.4%	112.8%	113.4%
CHESHIRE AND MERSEYSIDE ICB	117.5%	109.2%	106.2%	107.2%	106.0%	108.4%	119.9%	121.9%
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	121.1%	123.9%	121.8%	125.3%	125.6%	130.8%	146.8%	144.0%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	134.6%	71.3%	60.7%	51.1%	54.4%	56.1%	56.8%	62.0%
THE WALTON CENTRE NHS FOUNDATION TRUST	126.5%	116.2%	110.9%	113.0%	109.9%	124.7%	135.6%	138.7%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	116.3%	100.3%	99.5%	98.7%	100.2%	106.7%	119.6%	123.9%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	115.3%	107.4%	103.9%	92.2%	83.0%	83.7%	94.3%	105.6%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	115.1%	101.1%	99.5%	105.4%	105.4%	107.2%	114.8%	115.2%
EAST CHESHIRE NHS TRUST	102.3%	92.6%	92.8%	97.0%	95.8%	109.9%	112.4%	110.6%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	110.1%	124.1%	121.7%	121.6%	123.2%	124.2%	147.6%	148.4%
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	109.7%	109.7%	106.1%	109.3%	110.6%	109.8%	126.5%	127.0%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	113.3%	109.1%	102.9%	101.9%	102.6%	101.1%	108.2%	114.0%
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	129.3%	115.8%	113.8%	117.8%	116.5%	127.1%	138.8%	138.7%
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	154.7%	111.4%	108.0%	111.5%	109.1%	111.6%	119.7%	118.8%

* **Value Weighted Activity** – calculation utilises average tariff and represents performance for Provider across ALL commissioners, not just C&M ICB (therefore does not map to ERF performance

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Appendix 8: Provider Cash at Month 10

Org	Cash Balance			Operating Days Cash - Trend										External Cash Support*		BPPC % of bills paid in target	
	2023/24 M12 Closing Cash Balance	2024/25 M10 Closing Cash Balance	Movement	2023/24 M12	24/25 M3	24/25 M4	24/25 M5	24/25 M6	24/25 M7	24/25 M8	24/25 M9	24/25 M10	Trend	Received as at M10	FOT	2024/25 M10 By number	2024/25 M10 By Value
	£m	£m	£m	Days	Days	Days	Days	Days	Days	Days	Days	Days		£m	£m	%	%
Alder Hey Children's	78.3	56.1	(22.1)	63	52	47	52	50	43	46	53	53		0.0	0.0	93.3%	91.8%
Bridgewater Community	17.3	7.5	(9.9)	51	53	52	50	38	31	33	33	29		0.0	0.0	98.2%	98.2%
Cheshire & Wirral Partnership	28.1	32.2	4.1	27	32	33	31	39	41	40	42	44		0.0	0.0	95.8%	93.0%
Countess of Chester Hospitals	12.3	4.1	(8.2)	8	4	2	10	7	14	10	6	4		13.6	13.8	95.2%	95.2%
East Cheshire Trust	17.9	12.3	(5.6)	21	18	18	13	14	24	24	22	20		0.0	0.0	93.3%	91.3%
Liverpool Heart & Chest	43.2	42.8	(0.4)	59	63	65	68	71	58	66	65	62		0.0	0.0	97.2%	98.1%
Liverpool University Hospitals	40.6	5.5	(35.2)	9	10	5	1	4	9	6	5	2		30.0	57.0	76.8%	91.3%
Liverpool Women's	2.0	6.8	4.8	3	7	4	2	6	27	28	16	15		7.0	7.0	93.5%	95.2%
Mersey Care	72.9	58.7	(14.2)	29	27	26	36	38	28	32	30	29		0.0	0.0	95.4%	96.1%
Mid Cheshire Hospitals	16.4	35.7	19.3	11	13	13	18	25	31	27	31	34		19.7	19.7	94.5%	94.4%
Mersey & West Lancs	24.7	3.4	(21.3)	8	1	2	2	2	13	1	2	1		17.0	17.0	84.3%	92.0%
The Clatterbridge Centre	74.3	73.3	(1.0)	130	93	81	90	91	85	91	89	85		0.0	0.0	97.9%	98.9%
The Walton Centre	51.6	57.8	6.2	69	119	108	113	105	100	99	106	111		0.0	0.0	93.1%	93.4%
Warrington & Halton Hospitals	17.6	13.6	(4.1)	12	6	10	5	6	20	15	15	14		12.1	14.9	87.0%	92.9%
Wirral Community	12.7	9.2	(3.5)	33	45	41	49	55	28	31	37	37		0.0	0.0	91.9%	95.2%
Wirral University Hospitals	10.6	3.5	(7.1)	6	3	3	3	1	5	2	2	3		3.5	14.8	57.8%	74.6%
TOTAL Providers	**520.6**	**422.5**	**(98.1)**	N/A	N/A	N/A	N/A	N/A	N/A	**16**	**16**	**17**		**102.9**	**144.1**	**90.3%**	**93.2%**

* External Cash support via NHS England's Revenue Support PDC process

Appendix 9: Provider BPPC at Month 10

Better Payment Pratice Code (BPPC)	BPPC % of bills paid within 95% target – By Number										BPPC % of bills paid within 95% target – By Value									
	2023/24 M12 %	24/25 M3 %	24/25 M4 %	24/25 M5 %	24/25 M6 %	24/25 M7 %	24/25 M8 %	24/25 M9 %	24/25 M10 %	Trend	2023/24 M12 %	24/25 M3 %	24/25 M4 %	24/25 M5 %	24/25 M6 %	24/25 M7 %	24/25 M8 %	24/25 M9 %	24/25 M10 %	Trend
Alder Hey Children's	94.0%	92.6%	93.0%	93.4%	93.0%	93.3%	93.4%	93.6%	93.3%		92.9%	91.4%	91.0%	91.3%	91.4%	91.9%	92.0%	92.2%	91.8%	
Bridgewater Community	96.2%	96.6%	97.2%	97.5%	97.8%	98.0%	98.1%	98.2%	98.2%		96.8%	97.3%	97.7%	98.0%	98.3%	98.3%	98.4%	98.5%	98.2%	
Cheshire & Wirral Partnership	97.7%	94.6%	95.4%	95.7%	96.0%	95.9%	95.9%	96.0%	95.8%		97.1%	93.2%	93.5%	94.1%	94.2%	92.3%	92.9%	93.3%	93.0%	
Countess of Chester Hospitals	86.3%	95.7%	95.8%	95.6%	95.3%	95.2%	95.1%	95.1%	95.2%		89.1%	95.7%	95.9%	95.5%	95.6%	95.4%	95.7%	95.1%	95.2%	
East Cheshire Trust	94.9%	94.0%	94.6%	92.1%	91.7%	93.1%	93.3%	93.6%	93.3%		95.4%	93.3%	93.9%	92.8%	92.8%	92.0%	92.0%	91.0%	91.3%	
Liverpool Heart & Chest	96.4%	97.0%	96.9%	97.1%	97.2%	97.1%	97.2%	97.3%	97.2%		97.0%	97.1%	97.2%	97.4%	97.6%	97.8%	98.0%	98.0%	98.1%	
Liverpool University Hospitals	82.1%	76.6%	76.1%	76.9%	75.6%	76.3%	76.0%	76.8%	76.8%		92.8%	91.3%	91.4%	91.8%	91.7%	91.6%	91.5%	91.4%	91.3%	
Liverpool Women's	91.1%	92.2%	92.5%	92.9%	92.8%	93.5%	93.7%	93.7%	93.5%		93.6%	95.1%	95.1%	93.9%	94.7%	94.9%	95.3%	95.0%	95.2%	
Mersey Care	95.2%	95.2%	95.3%	95.3%	95.2%	95.3%	95.5%	95.4%	95.4%		93.0%	96.3%	96.1%	96.2%	96.1%	96.1%	96.1%	96.0%	96.1%	
Mid Cheshire Hospitals	88.6%	93.2%	93.4%	93.9%	94.1%	94.4%	94.3%	94.5%	94.5%		92.8%	93.2%	93.7%	94.1%	94.1%	94.4%	94.6%	94.4%	94.4%	
Mersey & West Lancs	90.2%	83.8%	82.6%	82.5%	82.4%	83.2%	83.8%	84.0%	84.3%		92.6%	92.4%	93.2%	92.6%	92.1%	92.4%	91.8%	91.8%	92.0%	
The Clatterbridge Centre	97.6%	97.8%	98.0%	97.8%	97.9%	97.8%	97.9%	97.9%	97.9%		99.3%	98.9%	99.1%	99.1%	99.3%	99.2%	99.1%	99.0%	98.9%	
The Walton Centre	90.4%	93.5%	93.9%	93.8%	93.5%	93.4%	93.2%	93.1%	93.1%		92.5%	94.9%	94.8%	94.2%	94.2%	94.1%	94.3%	94.0%	93.4%	
Warrington & Halton Hospitals	91.5%	91.8%	87.4%	86.8%	88.0%	87.7%	86.7%	86.6%	87.0%		91.4%	91.2%	89.2%	90.3%	90.7%	90.0%	91.3%	92.3%	92.9%	
Wirral Community	91.6%	92.4%	92.1%	92.1%	92.5%	92.6%	92.3%	92.2%	91.9%		93.4%	93.4%	94.1%	94.2%	94.0%	94.8%	95.2%	95.0%	95.2%	
Wirral University Hospitals	92.3%	74.2%	60.3%	52.3%	47.1%	48.6%	52.6%	54.8%	57.8%		95.1%	87.0%	81.9%	76.7%	74.5%	71.8%	73.1%	73.6%	74.6%	
Average C&M Providers	**92.3%**	**91.3%**	**90.3%**	**89.7%**	**89.4%**	**89.7%**	**89.9%**	**90.2%**	**90.3%**		**94.0%**	**93.9%**	**93.6%**	**93.3%**	**93.2%**	**92.9%**	**93.2%**	**93.2%**	**93.2%**	

Appendix 10: Provider Capital Expenditure YTD and FOT vs ICS Allocation at Month 10

NHS
Cheshire and Merseyside

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT Year Ending £'000	Variance Year Ending £'000	Variance Year Ending %	Spend YTD as % of FOT
Alder Hey Children'S NHS Foundation Trust	10,057	10,076	(19)	16,923	15,775	1,148	6.8%	64%
Bridgewater Community Healthcare NHS Foundation Trus	3,796	1,697	2,099	4,467	4,460	7	0.2%	38%
Cheshire And Wirral Partnership NHS Foundation Trust	6,881	4,407	2,474	7,866	6,366	1,500	19.1%	69%
Countess Of Chester Hospital NHS Foundation Trust	69,061	55,399	13,662	77,750	78,755	(1,005)	-1.3%	70%
East Cheshire NHS Trust	5,591	4,833	758	6,222	7,204	(982)	-15.8%	67%
Liverpool Heart And Chest Hospital NHS Foundation Trus	5,755	4,942	813	7,811	7,811	-	0.0%	63%
Liverpool University Hospitals NHS Foundation Trust	30,153	28,280	1,873	59,398	51,758	7,640	12.9%	55%
Liverpool Women'S NHS Foundation Trust	4,859	2,503	2,356	5,035	5,035	-	0.0%	50%
Mersey Care NHS Foundation Trust	25,909	18,642	7,267	36,254	34,503	1,751	4.8%	54%
Mid Cheshire Hospitals NHS Foundation Trust	11,876	30,370	(18,494)	13,553	41,234	(27,681)	-204.2%	74%
Mersey and West Lancashire Teaching Hospitals NHS Tr	22,385	13,233	9,152	28,256	28,256	-	0.0%	47%
The Clatterbridge Cancer Centre NHS Foundation Trust	6,322	6,218	104	11,110	11,410	(300)	-2.7%	54%
The Walton Centre NHS Foundation Trust	4,794	3,588	1,206	6,890	8,390	(1,500)	-21.8%	43%
Warrington And Halton Teaching Hospitals NHS Foundati	7,918	5,797	2,121	9,470	9,670	(200)	-2.1%	60%
Wirral Community Health And Care NHS Foundation Trus	3,347	3,774	(427)	6,453	5,156	1,297	20.1%	73%
Wirral University Teaching Hospital NHS Foundation Trus	9,959	9,602	357	12,870	16,823	(3,953)	-30.7%	57%
Total Provider CDEL	**228,663**	**203,361**	**25,302**	**310,328**	**332,607**	**(22,279)**	**-7.2%**	**61%**

ICS Capital allocation	**332,704**
Variance to allocation	97
Allocation met	Yes

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Integrated Performance Report

Agenda Item No: ICB/03/25/08

Responsible Director: Anthony Middleton: Director of Performance and Planning

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

Integrated Performance Report

1. Purpose of the Report

1.1 To inform the Board of the current position of key system, provider and place level metrics against the ICB's Annual Operational Plan.

2. Executive Summary

2.1 The integrated performance report for March 2025, see appendix one, provides an overview of key metrics drawn from the 2024/25 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

2.2 For metrics that are not performing to plan, the integrated performance report provides further analysis of the issues, actions, and risks to delivery in section 5 of the integrated performance report.

3. Ask of the Board and Recommendations

3.1 The Board is asked to note the contents of the report and take assurance on the actions contained.

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

5.1 The Integrated Performance report is considered at the ICB Quality and Performance Committee. The key issues, actions and delivery of metrics that are not achieving the expected performance levels are outlined in the exceptions section of the report and discussed at committee.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: Tackling Health Inequalities in access, outcomes and experience
Reviewing the quality and performance of services, providers and place enables the ICB to set system plans that support improvement against health inequalities.

Objective Two: Improving Population Health and Healthcare
Monitoring and management of quality and performance allows the ICB to identify where improvements have been made and address areas where further improvement is required.

Objective Three: Enhancing Productivity and Value for Money
The report supports the ICB to triangulate key aspects of service delivery, finance and workforce to improve productivity and ensure value for money.

Objective Four: Helping to support broader social and economic development
The report does not directly address this objective.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 The integrated performance report monitors the organisational position of the ICB, against the annual delivery plan agreed with NHSE and national targets.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
The integrated performance report provides organisational visibility against three key quality and safety domains: safe and effective staffing, equity in access and equity of experience and outcomes.

Theme Two: Integration
The report addresses elements of partnership working across health and social care, particularly in relation to care pathways and transitions, and care provision, integration and continuity.

Theme Three: Leadership
The report supports the ICB leadership in decision making in relation to quality and performance issues.

9. Risks

9.1 The report provides a broad selection of key metrics and identifies areas where delivery is at risk. Exception reporting identifies the issues, mitigating actions and delivery against those metrics. The key risks identified are ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience, which all correspond to Board Assurance Framework Risk P5.

9.2 Additionally, waits for cancer and elective treatment, particularly due to industrial action and winter pressures within the urgent care system could result in

reduced capacity and activity leading to poor outcomes, which maps to Board Assurance Framework Risk P3.

10. Finance

10.1 The report provides an overview of financial performance across the ICB, Providers and Place for information.

11. Communication and Engagement

11.1 The report has been completed with input from ICB Programme Leads, Place, Workforce and Finance leads and is made public through presentation to the Board.

12. Equality, Diversity and Inclusion

12.1 The report provides an overview of performance for information enabling the organisation to identify variation in service provision and outcomes.

13. Climate Change / Sustainability

13.1 This report addresses operational performance and does not currently include the ambitions of the ICB regarding the delivery of its Green Plan / Net Zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 Actions and feedback will be taken by Anthony Middleton, Director of Performance and Planning. Actions will be shared with, and followed up by, relevant teams. Feedback will support future reporting to the Q&P committee.

15. Officer contact details for more information

15.1 Andy Thomas: Associate Director of Planning:
andy.thomas@cheshireandmerseyside.nhs.uk

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

27th March 2025

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

ACUTE TRUSTS		SPECIALIST TRUSTS		COMMUNITY AND MENTAL HEALTH TRUSTS		KEY SYSTEM PARTNERS	
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT	AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT	BCHC	BRIDGEWATER COMMUNITY HEALTHCARE NHS FT	NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
ECT	EAST CHESHIRE NHS TRUST	LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT	WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT	CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
MCHT	MID CHESHIRE HOSPITALS NHS FT	LWH	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	MCFT	MERSEY CARE NHS FT	**OTHER**	
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT	TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT	CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT	OOA	OUT OF AREA AND OTHER PROVIDERS
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	TWC	THE WALTON CENTRE NHS FT				
WHH	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT						
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT						

Key:

Data formatting

	Performance worse than target
	Performance at or better than target
*	Small number suppression
-	Not applicable
n/a	No activity to report this month
**	Data Quality Issue

C&M National Ranking against the 42 ICBs

≤11th	C&M in top quartile nationally
12th to 31st	C&M in interquartile range nationally
≥32nd	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

C&M National Ranking against the 22 Cancer Alliances

≤5th	C&M in top quartile nationally
6th to 17th	C&M in interquartile range nationally
≥18th	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

Notes on interpreting the data

Latest Period: The most recently published, validated data has been used in the report, unless more recent provisional data is available that has historically been reliable. In addition, some metrics are only published quarterly, half yearly or annually - this is indicated in the performance tables.

Historic Data: To support identification of trends, up to 13 months of data is shown in the tables, the number of months visible varies by metric due to differing publication timescales.

Local Trajectory: The C&M operational plan has been formally agreed as the ICBs local performance trajectory and may differ to the national target

RAG rating: Where local trajectories have been formalised the RAG rating shown represents performance against the agreed local trajectories, rather than national standards. It should also be noted that national and local performance standards do change over time, this can mean different months with the same level of performance may be RAG rated differently.

National Ranking: Ranking is only available for data published and ranked nationally, therefore some metrics do not have a ranking, including those where local data has been used.

Target: Locally agreed targets are in **Bold Turquoise**. National Targets are in **Bold Navy**.

Integrated Quality & Performance Report – Interpreting SPC Charts:

NHS Cheshire and Merseyside

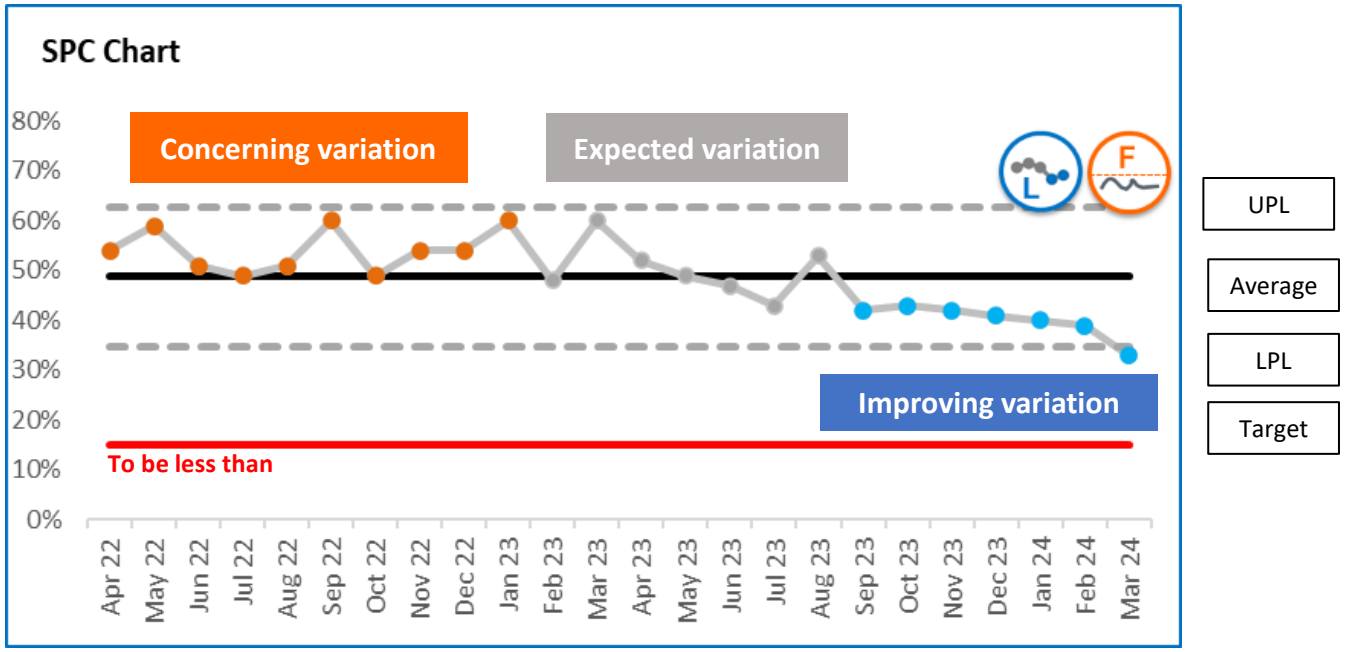
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated, and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



UPL

Average

LPL

Target

The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Integrated Quality & Performance Report – Interpreting summary icons:

NHS Cheshire and Merseyside

These icons provide a summary view of the important messages from SPC charts

	Variation / performance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening or has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening or has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is the target will be achieved or missed at random.	Consider whether this is acceptable and, if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Feb-25	68.1%	71.9%	72.1%	71.1%	72.7%	74.4%	74.3%	72.9%	72.3%	72.4%	71.4%	72.9%	73.1%	79.2%	78% by Year end	71.9%	73.4%	22/42
	Ambulance category 2 mean response time	Feb-25	00:43:30	00:29:31	00:24:49	00:33:02	00:34:47	00:37:59	00:24:58	00:38:08	00:56:23	00:52:34	01:06:45	00:52:51	00:38:28	-	00:30:00	00:35:44	00:35:40	-
	A&E 12 hour waits from arrival	Feb-25	16.7%	15.7%	15.8%	16.8%	15.8%	15.6%	15.5%	16.6%	17.0%	15.7%	18.3%	18.3%	17.4%	-	-	14.3%	11.3%	39/42
	Adult G&A bed occupancy	Feb-25	95.9%	96.0%	95.3%	95.8%	95.9%	95.5%	94.9%	95.6%	96.3%	96.5%	96.0%	97.4%	97.2%	95.0%	92.0%	94.6%	94.3%	31/42
	21+ day Length of Stay	Feb-25	1,396	1,413	1,303	1,379	1,364	1,321	1,349	1,371	1,362	1,326	1,474	1,532	1,495	0	-	-	-	-
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Feb-25	19.8%	20.1%	21.6%	21.8%	21.3%	21.5%	19.9%	19.6%	20.4%	21.7%	19.5%	22.7%	21.6%	13.0%	*	15.2%	13.1%	42/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jan-25	3,736	2,195	2,324	2,331	2,285	2,098	1,972	985	1,091	1,093	1,282	1,167		0	-	2,250	15,568	-
	Number of 52+ week RTT waits, of which children under 18 years.	Feb-25	1,497	1,446	1,471	1,505	1,542	1,493	1,295	1,029	1,063	886	902	922	919	1,381	-	n/a	n/a	-
	Total incomplete Referral to Treatment (RTT) pathways	Jan-25	371,542	365,756	367,759	369,179	368,967	370,607	372,357	369,065	367,350	366,053	361,746	358,637		374,565	-	1,045,487	7,463,403	-
	Patients waiting more than 6 weeks for a diagnostic test	Jan-25	10.7%	10.0%	10.2%	10.0%	10.1%	9.0%	10.1%	8.8%	7.2%	6.9%	10.3%	11.2%		10.0%	10.0%	17.3%	22.8%	3/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Dec-24	69.0%	75.4%	70.9%	71.8%	72.1%	75.9%	74.6%	73.0%	73.8%	75.9%	74.9%			72.3%	85.0%	72.8%	71.3%	9/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Dec-24	93.2%	92.4%	91.8%	95.4%	94.5%	94.8%	94.3%	93.3%	94.6%	94.2%	95.5%			96.0%	96.0%	93.2%	91.5%	15/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Dec-24	74.8%	76.0%	71.3%	71.4%	73.8%	74.1%	73.2%	71.4%	73.3%	75.4%	75.5%			75.5%	77% by Year end	78.4%	78.1%	30/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028**. (rolling 12 months)	Oct-24	58.3%	58.9%	59.9%	58.2%	58.0%	58.7%	62.0%	60.1%	63.2%					70.0%	75% by 2028	-	59.3%	12/42
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Dec-24			20,330	20,435	20,425	20,600	20,565	20,670	20,905	21,070	21,230			21037		53900	591368	-
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Nov 24 YTD	76%	78%	78%	78%	78%	76%	75%	73%	75%	76%	78%			60.0%	60.0%	64.0%	62.1%	15/41
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Dec 2024	57.8%			55.0%			52.0%			52.0%				-	60.0%	56.0%	59.0%	35/42
	Dementia Diagnosis Rate	Jan-25	66.8%	67.0%	67.0%	67.2%	67.4%	67.7%	67.6%	67.4%	67.6%	67.4%	67.3%	67.2%		66.7%	66.7%	70.0%	65.4%	16/42
	CYP Eating Disorders Routine	Dec-24	95.0%	94.0%	79.0%	79.0%	71.0%	79.0%	77.0%	79.0%	84.0%	87.0%	89.0%			95.0%	95.0%	83.0%	81.9%	17/40
	CYP Eating Disorders Urgent	Dec-24	100.0%	100.0%	42.0%	-	27.0%	57.0%	73.0%	85.0%	90.0%	86.0%	81.0%			95.0%	95.0%	76.0%	80.8%	19/32
	CYP 1+ Contacts - % LTP trajectory achieved	Dec-24	-	-	93.0%	92.0%	92.0%	93.0%	91.0%	92.0%	92.0%	93.0%	92.0%			100.0%	100.0%	109.0%	97.0%	22/42
	Perinatal Access - % LTP trajectory achieved	Dec-24	-	-	118.0%	119.0%	120.0%	122.0%	123.0%	125.0%	127.0%	128.0%	130.0%			100.0%	100.0%	107.0%	96.0%	5/42
	Talking Therapies completing a course of treatment - % of LTP trajectory (YTD)	Dec-24	-	-	100.0%	98.6%	93.6%	93.0%	93.0%	93.1%	95.0%	94.0%	92.0%			100.0%	100.0%	88.0%	96.0%	23/42
	Talking Therapies Reliable Recovery	Dec-24	45.0%	48.0%	48.0%	46.0%	41.0%	47.0%	46.0%	46.0%	48.0%	48.0%	45.0%			48.0%	48.0%	45.0%	46.8%	13/42
	Talking Therapies Reliable Improvement	Dec-24	66.0%	66.0%	66.0%	67.0%	50.0%	66.0%	65.0%	65.0%	66.0%	66.0%	65.0%			67.0%	67.0%	65.0%	66.9%	32/42
Note/s	* no national target for 2024/25 ** Wirral data missing for 30 November so 28 November used instead																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Jan-25	100	100	95	95	100	100	95	90	85	85	85	80		60	-	260	1,845	23/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Dec 24 YTD	76.0%	91.4%	3.1%	7.3%	12.0%	17.7%	23.9%	30.2%	38.2%	46.8%	54.1%			51.0%	**75%** by Year end	56.1%	52.8%	11/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Jan-25	82.9%	80.0%	84%	87%	85%	84%	86%	85%	86%	83%	84%			70.0%	**70.0%**	88.0%	93.0%	21/42
	Virtual Wards Utilisation	Jan-25	48.4%	56.5%	41%	39%	70%	67%	62%	74.6%	93.2%	75.2%	69.2%	94.7%		80.0%	**80.0%**	66.7%	78.2%	9/42
	Community Services Waiting List (Adults)	Jan-25	40,486	45,682	48,213	53,285	49,459	54,375	54,021	54,830	48,815	48,663	50,574	50,937				101,920	769,457	-
	Community services Waiting List (CYP)	Jan-25	19,897	20,826	21,954	24,712	25,209	25,378	24,426	23,542	21,747	22,890	22,834	23,164				45,929	289,261	-
	Community Services – Adults waiting over 52 weeks	Jan-25	265	274	289	308	329	359	382	433	435	411	234	164		67		914	10,468	-
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Jan-24	90.0%	95.0%	81.0%	81.0%	80.0%	79.0%	77.0%	82.0%	82.0%	83.6%	74.0%	77.0%		100.0%	**100.0%**	83.0%	79.0%	25/42
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Jan-24	923,844	924,609	926,008	926,012	926,430	928,591	928,716	929,187	929,958	930,608	931,583	932,555		986,184		2,635,531	18,143,666	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Jan-24	319,483	320,222	322,008	323,306	323,089	325,212	325,733	326,939	327,934	328,920	330,131	330,646		327,915		1,009,570	7,074,655	-
	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Dec-24	109.2%	92.8%	122.2%	106.9%	94.0%	109.0%	94.8%	93.7%	111.6%	97.6%	106.8%			-	-	107.5%	109.7%	-
	Percentage of appointments made with General Practice seen within two weeks	Dec-24	90.6%	90.1%	88.9%	89.7%	89.5%	89.8%	90.1%	90.0%	88.8%	89.2%	90.3%			85.0%	**85.0%**	83.9%	82.7%	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Sep-24	7.27%	7.19%	7.22%	7.17%	7.12%	7.08%	7.07%	7.06%						10.0%	**10.0%**	-	7.62%	-
	Total volume of antibiotic prescribing in primary care	Sep-24	1.040	1.033	1.04	1.04	1.04	1.04	1.03	1.02						0.871	**0.871**	-	1.00	-
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)***	Q2 24/25	262.8		244.4			222.0								-	-	219.1	176.8	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Nov-24	92.7%	93.4%	93.1%	93.4%	93.3%	93.0%	93.3%	93.3%	93.2%	93.2%				-	-	92.3%	93.0%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)***	Q2 24/25	531.5		535.3			526.1								-	-	478.0	452.2	-
Note/s	* no national target for 2024/25 *** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National crtieria which systems need time to adopt and validate.																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q2 24/25	69.6%		65.8%			65.6%								77.0%	80.0%	66.52%	66.8%	29/42
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies	Q2 24/25	61.9%		62.2%			62.3%									65.0%	61.1%	62.36%	19/42
	Smoking at Time of Delivery	Q2 24/25	7.3%		7.3%			6.8%									<6%	6.8%	5.60%	30/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Jan-25	14.1%	13.9%	13.9%	13.8%	13.7%	13.6%	13.7%	13.7%	13.6%	13.6%	13.5%	13.5%		12.0%	12.0%	-	12.7%^	-
Continuing Healthcare	Standard Referrals completed within 28 days	Q3 24/25	62.40%		71.70%			64.70%			73.10%					>80%	>80%	81.3%	75.5%	29/42
	% DST's (Decision Support Tool) completed that were in Hospital	Q3 24/25	0.00%		0.00%			0.00%			0%					<15%		0.0%	0.0%	1/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	25.33		28.75			29.15			27.18					<18		23.05	17.29	36/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	47.04		51.69			53.36			53.85					34.0		47.82	33.97	39/42
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q3 24/25	1.2		0.7			1.1			0.9					2.5	2.5	0.6		
	Still birth per 1,000 (rolling 12 months)	Oct-24	2.67	2.95	2.78	2.58	2.83	2.71	2.45	2.48	2.60					-	-	-	3.8	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare associated)	12 months to Dec 24	582	608	636	655	655	694	710	726	738	755	778			439	439	2238	11717	-
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Dec 24	788	812	816	823	810	813	813	817	829	831	821			518	518	2259	14602	-
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Sep-24	1.006	1.001	0.998	0.993	0.999	0.991	0.992	0.988						0.887 to 1.127 *		-	1.000	-
	Never Events	Feb-25	1	3	4	2	2	1	1	1	0	3	0	6	1	0	0	-	-	-
Workforce / HR (ICS total)	Staff in post	Jan-25	73,344	73,267	73,078	73,011	72,945	72,909	73,039	73,548	73,910	74,068	74,101	74,208		71,994	-	198,623	-	-
	Bank	Jan-25	5,881	6,086	5,230	5,262	4,833	5,339	5,255	5,122	5,084	4,868	4,848	5,000		3,246	-	16,424	-	-
	Agency	Jan-25	1,187	1,279	1,209	1,088	1,072	1,104	1,009	932	1,009	886	824	838		980.8	-	4,206	-	-
	Turnover	Dec-24	11.1%	11.2%	11.3%	11.2%	11.3%	11.0%	11.0%	10.9%	10.9%	10.8%	10.7%			13.0%	-	12.3%	-	-
	Sickness	Dec-24	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%			6.2%	-	5.9%	5.04%	37/42

Note/s

* National average upper and lower control limits (UCL and LCL) for SHMI across all non-specialist trusts. This gives an indication of whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, for C&M was as expected when compared to the national baseline. This "rate" is different to the SHMI "banding" used for trusts on slide 8, therefore a comparison cannot be drawn between the two.
^ National figure is the latest ONS figure from 2022. local data is directly from GP systems. this has been reviewed against historic ONS data for LA's and the variation ranges from -0.9% to +5.9%
# Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected
** -From December 2023 this metric is now available at ICB level, previously this was only reported at Cancer Alliance level. historical data has been updated

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Dec-24	-79.8	-61.5	-98.7	-	-68.8	-101.0	-138.0	-166.9	-108.5	-112.9	-129.5	-129.7	-109.7	-62.4	↗	0.0	0.0	0.0
	Financial position £ms (ICS) VARIANCE	Dec-24	-57.8	-50.5	-98.7	-	-19.1	-16.5	-38.5	-48.5	-48.8	-51.4	-67.4	-61.2	-47.3		↗			
	Efficiencies £ms (ICS) ACTUAL	Dec-24	302.7	334.4	388.6	-	41.9	64.7	92.3	119.9	156.4	192.9	235.3	276.6	321.3	344.7	↗	439.9	434.9	-5.0
	Efficiencies £ms (ICS) VARIANCE	Dec-24	56.3	-16.8	-0.1	-	-15.2	-13.1	-20.2	-26.6	-25.0	-26.7	-22.5	-20.7	-23.4		↘			
	Capital £ms (ICS) ACTUAL	Dec-24	115.3	153.6	267.3	-	N/A	39.5	65.6	81.8	97.1	121.7	145.0	170.0	204.1	228.7		310.3	332.6	-22.3
	Capital £ms (ICS) VARIANCE	Dec-24	49.7	51.8	1.1	-	N/A	3.9	11.3	13.6	26.8	28.3	28.2	32.1	24.6					

ICB Mental Health (MH) and Better Care Fund (BCF) Overall Financial Position:

Category	Metric	Latest period	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Vs Target expenditure (Current)	Vs Target expenditure (Previous)	Dir. Of Travel
Finance	Mental Health Investment Standard met/not met (MHIS)	Nov-24	Yes	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Yes**	**Yes**	↔
	BCF achievement (Places achieving expenditure target)	Nov-24	9/9	9/9	9/9	-	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	**9/9**	**9/9**	↔

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Urgent care	4-hour A&E waiting time % waiting less than 4 hours)	Feb-25	61.9%	50.5%	59.1%	74.3%	66.7%	74.1%	79.4%	87.7%	-	88.4%	-	-	-	-	-	-	-	73.1%
	A&E 12 hour waits from arrival	Feb-25	25.1%	13.8%	16.8%	24.0%	24.0%	16.0%	18.8%	0.2%	-	**	-	-	-	-	-	-	-	17.4%
	Adult G&A bed occupancy	Feb-25	98.7%	95.8%	95.0%	96.3%	96.5%	97.6%	98.3%	-	84.2%	61.5%	95.6%	91.0%					-	97.2%
	21+ day Length of Stay (ave per day)	Feb-25	139.3	67.4	165.6	212.2	160.7	566.1	316.9	2.8	12.9	0.0	27.9	33.5						1,495
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Feb-25	24.1%	17.2%	20.6%	16.5%	25.0%	23.0%	21.9%										-	21.6%
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jan-25	170	15	285	88	129	312	143	8	6	0	0	1			2	-	43	1,167
	Number of 52+ week RTT waits, of which children under 18 years.	Feb-25	155	10	126	136	58	34	97	300	0	2	0	1						919
	Total incomplete Referral to Treatment (RTT) pathways	Jan-25	33,615	12,931	37,696	47,362	33,755	70,629	77,156	21,619	5,798	16,676	771	15,564			57	-	-	358,637
	Patients waiting more than 6 weeks for a diagnostic test	Jan-25	17.0%	5.7%	7.0%	14.2%	13.2%	8.9%	6.4%	2.5%	8.6%	30.6%	0.0%	1.4%	28.5%	0.0%	-	-	-	11.2%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Dec-24	74.9%	78.1%	72.5%	72.2%	78.5%	78.3%	75.7%	-	78.7%	36.2%	79.7%	100.0%	88.4%				-	74.9%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Dec-24	94.1%	98.7%	85.3%	82.5%	97.3%	94.0%	87.1%	100.0%	100.0%	71.8%	99.0%	100.0%	94.4%				-	95.5%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Dec-24	83.1%	84.1%	73.8%	71.8%	73.8%	72.0%	78.2%	95.2%	72.7%	70.8%	87.5%	100.0%	83.1%				-	75.5%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Aug-24	61.7%	63.0%	61.2%	57.4%	58.5%	68.8%	59.7%	-	58.1%	71.3%	41.8%	-	100.0%	-				63.2%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Dec-24			Mental Health service providers only												78.0%	82.0%	-	78.0%
	CYP Eating Disorders Routine	Dec-24								79%							92.0%	100.0%		89.0%
	CYP Eating Disorders Urgent	Dec-24								79%							-	100.0%		81.0%
	CYP 1+ Contacts - % LTP trajectory achieved	Dec-24	Just number available/ no target																	92.0%
	Perinatal Access - % LTP trajectory achieved	Dec-24	Just number available/ no target																	130.0%
	Talking Therapies completing a course of treatment - % of LTP trajectory	Dec-24	Just number available/ no target																	92.0%
	Talking Therapies Reliable Recovery	Dec-24															47.0%			45.0%
	Talking Therapies Reliable Improvement	Dec-24															65.0%			65.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Dec-24	75.0%	87.0%	86%	Community Service Providers only									83.0%	90.0%	84.0%	-	78%	84.3%
	Virtual Wards Utilisation	Feb-25	100.0%	110.0%	89.6%	95.0%	81.3%	75.0%	104.2%	81.3%										73.5%
	Community Services Waiting List (Adults)	Jan-24	0	4,459	4,687	454	-	-	413	0	131	-	-	-	3,293	4,333	17,930	3,660	11,577	50,937
	Community services Waiting List (CYP)	Jan-24	1,167	743	1,573	5,055	-	-	847	5,448	0	-	-	-	3,776	766	756	310	2,723	23,164
	Community Services – Adults waiting over 52 weeks	Jan-24	0	22	3	0	-	-	0	0	3	-	-	-	20	0	0	33	83	164
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Health Inequalities & Improvement	Smoking at Time of Delivery (NEW) data only available at ICB/Place level																			
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	24/25 Q3	0.0	1.5	0.0	1.4	1.7		0.0			0.6								0.9
	Still birth per 1,000 (rolling 12 months)	Oct-24	2.09	1.62	3.57	1.74	2.79	-	1.77	-	-	3.48	-	-						2.60
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Dec 24	(91 vs 56)	(22 vs 6)	(51 vs 31)	(164 vs 71)	(93 vs 36)	(209 vs 133)	(107 vs 85)	(13 vs 0)	(4 vs 2)	(1 vs 0)	(14 vs 13)	(9 vs 6)						778
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Dec 24	(62 vs 35)	(43 vs 27)	(49 vs 24)	(107 vs 53)	(94 vs 54)	(253 vs 165)	(165 vs 121)	(12 vs 8)	(6 vs 6)	(4 vs 5)	(19 vs 10)	(7 vs 10)						821
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Sep-24	0.9290	1.2192	0.9174	0.9767	1.0318	0.9587	1.0256											0.988
	Never Events (rolling 12 month total)	12 Months to Feb 25	2	0	0	0	3	2	3	3	1	3	0	4	0	0	0	0	1***	22
Workforce / HR (Trust Figures)	Staff in post	Jan-25	4,542	2,407	4,996	5,899	4,241	14,029	9,654	4,258	1,841	1,701	1,899	1,510	1,413	1,508	10,521	3,788	-	74,208
	Bank	Jan-25	299	205	431	385	366	971	735	157	66	63	22	89	17	46	937	212	-	5,000
	Agency	Jan-25	24	60	101	52	46	104	185	11	4	9	11	5	14	6	157	50	-	838
	Turnover	Dec-24	11.8%	10.1%	8.9%	9.6%	10.2%	10.4%	9.8%	9.7%	11.7%	10.6%	9.8%	12.0%	10.2%	10.0%	12.9%	12.4%	-	10.7%
	Sickness (via Ops Plan Monitoring Dashboard)	Dec-24	6.0%	5.7%	5.1%	6.1%	5.8%	6.2%	4.0%	5.6%	5.2%	6.0%	4.7%	5.7%	6.0%	6.5%	7.8%	6.2%	-	5.6%
Finance	Overall Financial position **Variance** (£m)	Jan-25	-2.63	-0.32	-0.38	-9.42	-3.94	-2.32	5.35	-0.87	-0.06	0.03	0.00	0.31	-3.82	0.00	0.00	0.22	-29.40	-47.25
	Efficiencies (Variance)	Jan-25	-6.55	-0.00	-3.32	-0.00	-1.02	-7.66	2.33	1.15	-1.73	0.66	-0.00	-0.00	-2.02	0.62	0.00	-1.15	-4.70	-23.39
	Capital (Variance)	Jan-25	13.18	0.76	-18.64	0.36	2.12	1.87	9.15	-0.02	0.81	2.36	0.10	1.09	2.10	-0.43	7.27	2.47	0.00	24.57
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. *** Independent Providers / Other providers 1 at Spire Murrayfield # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																			

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours)	Feb-25	55.9%	60.8%	25.7%#	56.5%	75.1%	72.5%	78.4%	74.5%	63.8%		73.1%	79.2%	78% by Year end
	Ambulance category 2 mean response time	Feb-25	00:38:55		00:40:01	00:35:20	00:37:29	00:39:16	00:37:25	00:37:47	00:39:53		00:38:28		00:30:00
	A&E 12 hour waits from arrival	Feb-25	15.6%	21.6%	21.3%	21.8%	12.2%	22.7%	14.4%	22.9%	15.1%		17.4%	-	-
Planned Care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jan-25	491		86	109	191	48	57	63	122		1,167	0	-
	Total incomplete Referral to Treatment (RTT) pathways	Jan-25	105,238		51,778	28,422	60,669	28,121	23,647	21,201	39,561		358,637	374,565	-
	Patients waiting more than 6 weeks for a diagnostic test	Jan-25	12.3%		13.7%	10.7%	10.6%	8.4%	8.0%	14.2%	9.5%		11.2%	10.0%	10%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Dec-24	74.9%	74.0%	71.8%	84.1%	77.5%	89.8%	74.1%	73.2%	65.0%		74.9%	72.3%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Dec-24	91.3%	91.2%	90.2%	95.5%	96.6%	96.2%	93.6%	94.0%	91.7%		95.5%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Dec-24	77.6%	79.8%	71.4%	77.0%	69.9%	79.0%	81.1%	76.9%	75.2%		75.5%	75.5%	77% by Year end
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Dec-24	4,015		2,060	1,390	6,475	1,075	1,825	1,014	3,630		21230		
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Dec-24	84.0%		69.0%	90.0%	83.0%	53.0%	60.0%	-	63.0%	64.0%	78.0%	60.0%	60.0%
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Dec 2024	51.0%		50.0%	58.0%	54.0%	47.0%	57.0%	60.0%	43.0%	59.0%	52.0%	-	60.0%
	Dementia Diagnosis Rate	Jan-25	66.8%		66.4%	71.6%	67.8%	67.4%	62.5%	67.1%	67.10%		67.2%	66.7%	66.7%
	CYP Eating Disorders Routine	Dec-24	100.0%		100.0%	97.0%	80.0%	95.0%	95.0%	96.0%	61.0%	75.0%	89.0%	95.0%	95.0%
	CYP Eating Disorders Urgent	Dec-24	90.0%				80.0%						81.0%	95.0%	95.0%
	CYP 1+ Contacts - % LTP trajectory achieved	Dec-24	70.0%		90.0%	126.9%	98.2%	145.3%	95.2%	65.9%	86.2%		92.0%	100.0%	95.0%
	Perinatal Access - % LTP trajectory achieved	Dec-24	144.0%		124.3%	131.0%	115.6%	138.2%	137.3%	117.4%	119.6%	145.8%	130.0%	100.0%	100.0%
	Talking Therapies completing a course of treatment - % of LTP trajectory	Dec-24	99.0%		123.3%	77.7%	87.9%	109.3%	86.5%	65.2%	64.4%	75.6%	92.0%	100.0%	100.0%
	Talking Therapies Reliable Recovery	Dec-24	47.0%		39.0%	40.0%	47.0%	48.0%	50.0%	47.0%	40.0%	46.0%	45.0%	48.0%	48.0%
	Talking Therapies Reliable Improvement	Dec-24	67.0%		65.0%	61.0%	64.0%	63.0%	72.0%	63.0%	65.0%	71.0%	65.0%	67.0%	67.0%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. # Potential data issue at Wirral Cummunity Health which recorded no patients seen within 4-hours														

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Dec-24	10		10	5	15	5	10	20	10		80	-	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Dec 24 YTD	53.9%		59.8%	48.0%	52.9%	51.4%	64.9%	55.3%	48.7%		54.1%	51.0%	75% by Year end
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Jan-25	84.0%		88.1%	80.2%	74.8%	76.2%	92.3%	91.4%	84.5%	95.7%	84.3%	70.0%	70.0%
	Virtual Wards Utilisation Number only	Feb-25	67	67	38	26	42	42	6	15	10		313		
	Community Services Waiting List (Adults) - data only available at ICB/Provider level												50,937		
	Community services Waiting List (CYP) - data only available at ICB/Provider level												23,164		
	Community Services – Adults waiting over 52 weeks - data only available at ICB/Provider level												164		
Primary Care	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Dec-24	109.0%	107.7%	105.3%	112.9%	102.3%	101.3%	109.9%	107.6%	110.4%		106.8%	-	-
	Percentage of appointments made with General Practice seen within two weeks	Dec-24	90.2%	88.6%	89.7%	87.9%	92.5%	89.8%	91.5%	84.1%	92.8%		90.3%	85.0%	85.0%
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Sep-24	6.63%		9.15%	6.21%	7.15%	5.66%	6.46%	5.94%	7.66%		7.06%	10.0%	10.0%
	Total volume of antibiotic prescribing in primary care	Jun-24	0.93		1.12	0.95	1.05	1.18	1.19	1.08	1.10		1.04	0.871	0.871
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q2 24/25	172.4	204.0	218.0	166.7	286.5	238.9	293.1	229.0	189.2		222.0	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Nov-24	89.9%	89.8%	93.9%	94.5%	95.8%	94.5%	95.5%	94.6%	92.6%		93.2%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q2 24/25	507.8	533.4	447.1	375.8	761.5	540.6	623.8	469.4	475.9		526.1	-	-
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National crtieria which systems need time to adopt and validate.														

4. Place Aggregate Position

NHS Cheshire and Merseyside

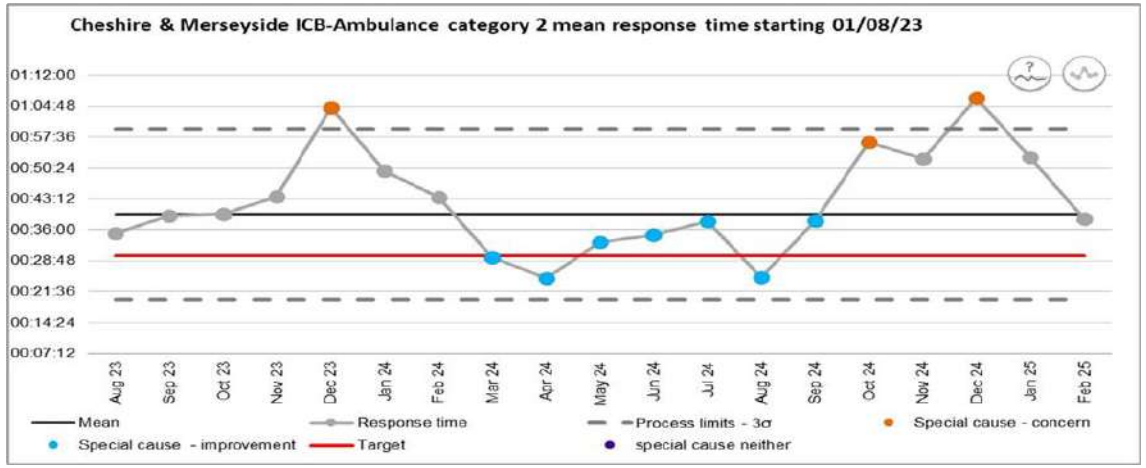
Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q2 24/25	66.8%		64.2%	64.4%	66.8%	65.2%	61.9%	68.1%	63.7%		65.6%	77.0%	80.0%
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies	Q2 24/25	61.5%		65.4%	60.5%	64.3%	61.7%	62.7%	62.1%	60.2%		62.3%		65%
	Smoking at Time of Delivery	Q2 24/25	5.4%		7.4%	6.9%	5.9%	9.8%	8.5%	11.5%	5.3%		6.8%		<6%
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Jan-25	11.08%	11.95%	13.88%	9.36%	15.97%	13.15%	16.56%	17.02%	13.22%		13.5%	12%	12%
Continuing Healthcare	Referrals completed within 28 days	Q3 24/25	81.3%		80.1%	90.2%	66.9%	69.7%	97.1%	80.0%	75.0%	56.9%	73.10%	>80%	>80%
	% DST's (Decision Support Tool) completed that were in Hospital	Q3 24/25	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.00%	<15%	
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	18.46		23.62	19.06	25.51	40.20	17.01	21.66	62.29	81.90	27.18	<18	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	61.9		74.3	42.5	46.4	24.2	27.4	44.7	59.6	85.2	53.85	34	
Quality & Safety	Still birth per 1,000 - data only available at ICB/Provider level														
	Healthcare Acquired Infections: Clostridium Difficile - Place totals	12 months to Dec 24	(211 Vs 156)		(166 Vs 131)	(70 Vs 45)	(144 Vs 172)	(38 Vs 47)	(65 Vs 47)	(44 Vs 33)	(52 vs 100)		778	439	439
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Dec 24	212		122	76	159	67	79	40	74		821	518	518
Finance	Overall Financial position Variance (£m)	Jan-25	-8.4	-3.3	-9.5	0.4	-9.1	-2.7	-0.7	-1.8	-9.9		15.6	0.0	0.0
	Efficiencies (Variance)	Jan-25	-0.6	-0.9	-0.8	1.2	-2.3	-0.8	0.3	0.5	-1.3		0.0	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	Jan-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Jan-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	9/9	9/9
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories **** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is different to the NHS Oversight Framework indicator used in the ICB table														

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (Feb-25)	00:38:28	National Ranking	n/a
ICB Trend (Feb-25)			Improved



Issue

- C&M not meeting CAT 2 ambulance response time of 30 mins.

Action

- **March Sprint:** All providers have bid for strategic development funds for a 'March Sprint' approach to rapid improvement to expedite initiatives. Plans are focused on further capacity for call before convey, SDEC, frailty services, additional triage/handover staffing, senior clinical decisions in ED and speciality senior in reach, as well as development of Rapid Assessment and Treatment and Fit to Sit models.
- **Ambulance Ambitions for Q4:** In line with the 'March Sprint' for delivery of 30 min Cat 2 performance for year-end 2024/25, NHSE has set, and the ICB and providers have agreed, to site level ambitions for Q4. Looking ahead to 25/26, NHSE have proposed additional stretch targets and implementation of ambulance rapid release which will involve a review of NWAS and system escalation policies.
- **Call before convey:** Continued implementation of 'call before convey' for each locality, in collaboration with ECIST and ICB admission avoidance at scale group to redirect patients to alternatives to ED. Latest updates:
- Liverpool – pathway established via Mersey Care SPA service with missed opportunity audits taking place in month to further refine the pathway.
- Mid and East Cheshire – Pilot launched on 10th March, for Mid Cheshire only. East start date TBC. Initial data suggests approx. 3-5 calls per day (over 65s only) but with a good deflection rate (c. 75%)
- MWL – pilot launched on 17th March at Whiston via existing MDT hub, with wrap-around MDT support from community teams
- COCH – pathway now embedded as BAU, with c. 70% deflection rate for the target cohort, and a clear reduction in over 65 attendances and conveyances, as well as impact on local CAT2 mean response time.
- Wirral – pathway embedded, and review took place on 14th March to consider next steps (see above)
- Warrington – lower volume and deflection rate than other pilots. Reviews taking place to understand why and what actions can be taken to rectify

Delivery

- As at 19th March, 10 of the 11 sites had exceeded the local ambitions for ambulance handover including Countess of Chester by 26 minutes 28 seconds and Arrowe Park by 24 minutes and 38 seconds.
- Acute sites below ambition: East Cheshire (- 10mins 58 seconds)
- Warrington, during the month of March now have a current average handover time of 14 minutes 50 seconds (variance of 8 minutes 55 seconds) from their November baseline (23.45)

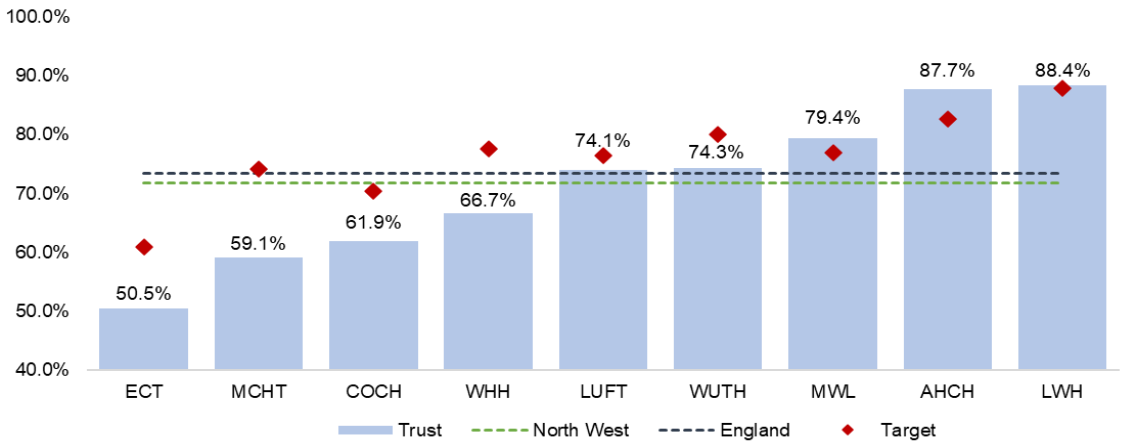
5. Exception Report – Urgent Care

Cheshire and Merseyside

A&E 4 hour waits from arrival

Latest ICB Performance (Feb-25)	73.1%	National Ranking	22/42

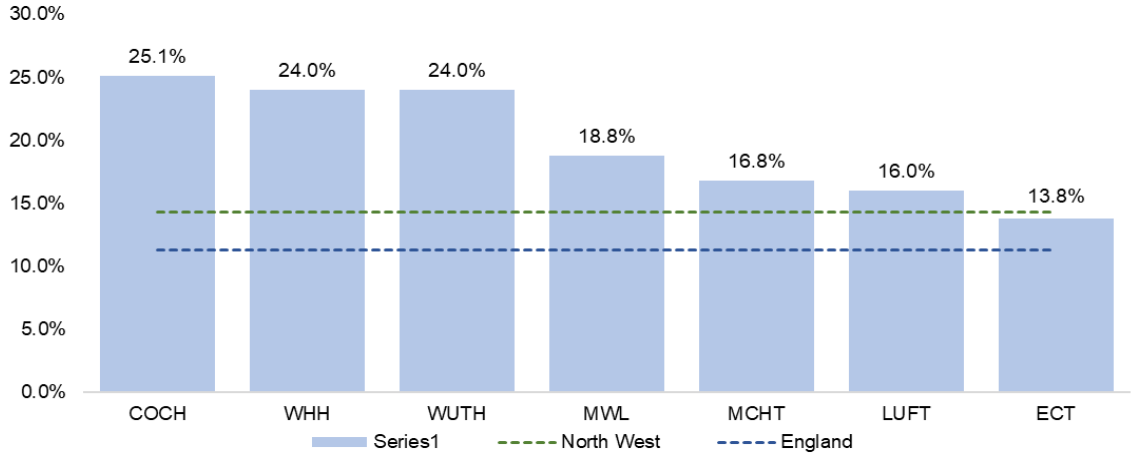
Provider Breakdown (Feb-25) — Improved



A&E 12 hour waits from arrival

Latest ICB Performance (Feb-25)	17.4%	National Ranking	39/42

Provider Breakdown (Feb-25) — Improved



Issue

- Cheshire and Merseyside performance is 6.1% below the in-year trajectory to achieve the 78% March 2025 ambition. At the same time 17.4% of patients were delayed over 12 hours compared to the North West average of 14.3% and the England average of 11.3%.

Action

- ECIST is working with C&M Emergency Departments through the Tier 1 Rapid Improvement Offer with a focus on reducing the number of patients waiting over 12 hours in department. This offer has been extended until the end of March, and engagement is ongoing with Trusts to develop further offers of support.
- In line with the 'March Sprint' approach, the ICB has allocated strategic development funds (March only) towards patient facing services to support pathway co-ordination or streaming across all sites, e.g., 4hr guardians, discharge coordinators in ED and increased nursing staffing to support SDEC.
- During March, Arrowe Park are piloting use of their CDU to reduce long waits in ED for patients that could be treated within an ED SDEC area along with a dedicated 4 hour ED tracker to remove delays ensuring timely flow through ED
- Warrington are increasing their streaming numbers from ED to reduce ED occupancy and improve 4 hour performance
- Royal Liverpool have increased their AMU consultant workforce Monday to Friday by 1 WTE
- Whiston & Southport have deployed a 7 day '4 hour guardian' in ED to improve performance against 4 hour standard

Delivery

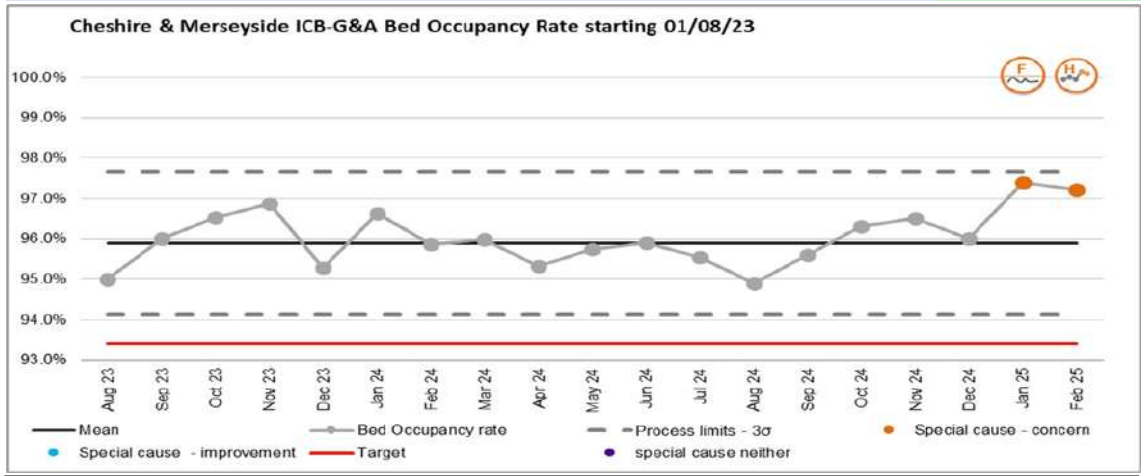
- C&M is adopting a recovery approach to UEC in 2024/25 and is committed to achieving 78% by the end of 2024/25 and a reduction in 12 hour waits

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (Feb-25)	97.2%	National Ranking	31/42
ICB Trend (Feb-25)	Improved		



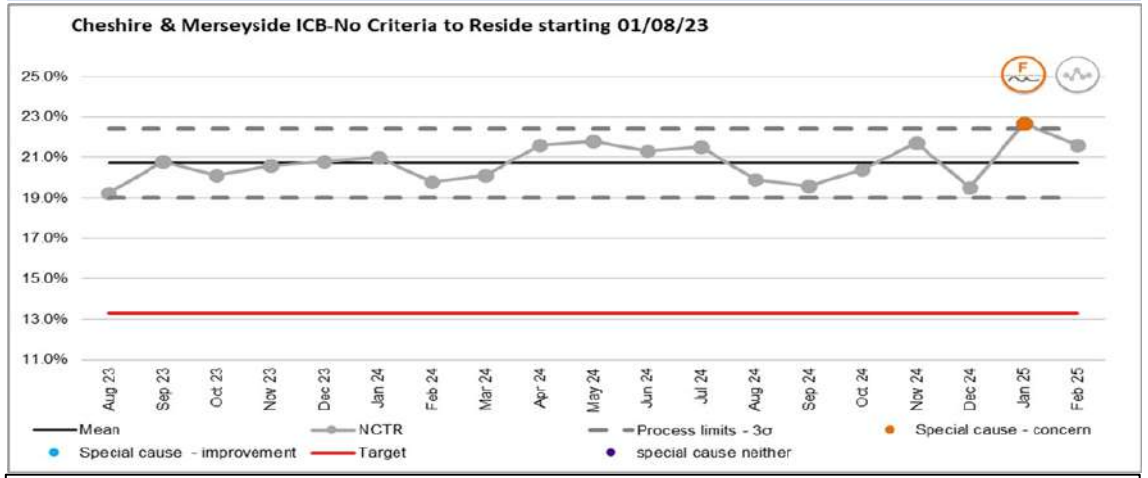
Issue
- Bed occupancy remains high across the system at 97.2%

Action
- Tier 1 Rapid Improvement Offer ongoing - focus on improving ward-based processes to increase discharges (overall number and earlier times of day)
- Discharge monitoring embedded within operational rhythm of the SCC and discharge ambitions set within weekend planning process
- OPEL 2024/6 implementation - opportunity to ensure all data is refreshed and includes escalation beds. Next steps to relaunch system wide OPEL action cards, supporting system wide approach to de-escalation of operational pressures, by 31March.
- Wirral and SCC are running a lunch and learn event sharing their progress and best practice around the development of local escalation triggers aligned to OPEL.

Delivery
- Within the recovery approach to UEC in 2024/25, the ICB is committed to a reduction in bed occupancy as a key metric.

No Criteria To Reside (NCTR)

Latest ICB Performance (Feb-25)	21.6%	National Ranking	42/42
ICB Trend (Feb-25)	Improved		



Issue
- NCTR is at 21.6%, substantially higher than England (13.1%) and North West (15.2%), with no special cause variation.

Action
- NCTR remains a challenge although slight improvement in February. Actions taking place:
- Wirral - HomeFirst: Enhanced Joint working between HF and Dom Care – with trusted assessment model implemented. Milestones set for May 2025 for Pathway 1 NCTR to be below 30 with improved throughput and flow through HF and improved capacity to support hybrid packages. Full launch of discharge pathway filter (piloted since Dec 24) for April 25 deliverables/outcomes shift in activity – reduction in P3 and P2 discharges.
- Mid Cheshire – have deployed in March a discharge intensive support squad to increase discharges, unblock delays and provide clinical check and challenge around decision making.

Delivery
- Within the recovery approach to UEC in 2024/25, the ICB is committed to a reduction in long LOS and NCTR as a key metric.

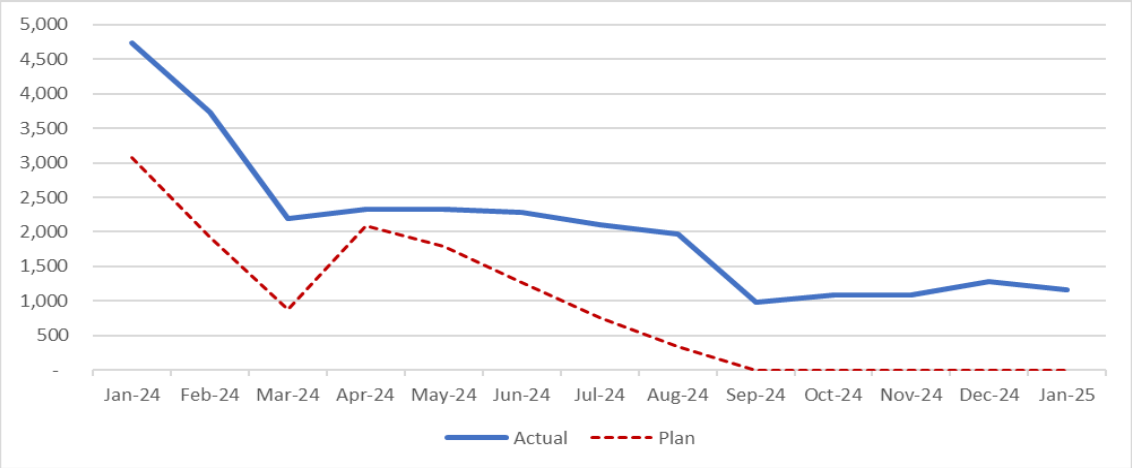
5. Exception Report – Planned Care

Cheshire and Merseyside

ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Jan-25)	1,167	National Ranking	n/a

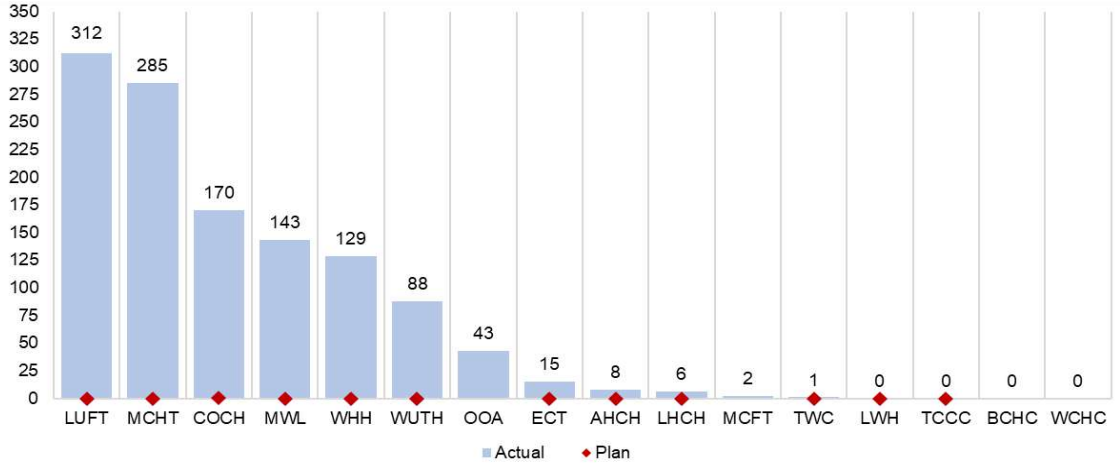
ICB Trend (Jan-25) — Improved



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Jan-25)	1,167	National Ranking	n/a

Provider Breakdown (Jan-25) — Improved



Issue

- Challenges remain in clearing 65 week wait patients, given patient choice and complexity issues. 3 providers at March month end.
- 904 patients reported 65-week breaches at end of February, largely sitting within Mid Cheshire where we have seen increase in reported position, LUFT and MWL. For March, the system is currently predicting 476 breaches with 233 being capacity breaches, 87 complex patients and 129 choice related delays and 27 corneal grafts. For April the system is predicting 239 of which 69 capacity, 110 choice and 52 complex.
- The CYP 52WW ambition is currently underperforming against trajectory , however overall numbers have largely reduced – there are currently 959 CYP waiting over 52 weeks – we are predicting this to reduce to 412.

Action

- Provider action plans have been received for the continued reduction of long waits and there is weekly reporting in support of this, with plans and performance reviewed during regular trust Patient Tracking List (PTL) meetings, and additional support agreed and provided where needed.
- The elective programme is working closely with providers to ensure that mutual aid and operational tactical measures are explored and expedited. C&M currently have 8 active mutual aid requests within Hysteroscopy & Biopsy, Oral & Max Fax, Plastics, General Surgery, Vascular, T&O, Gynae, and pain.
- Validation SDF funding was allocated and utilised per Trust supported by improvement trajectories. This has shown an improvement year to date of 13.5% for 12-weeks, 22.6% for 26-weeks and 14.7% for 52-weeks. Further discussions are underway around how the national validation sprint will be implemented across C&M.
- At MCHT, there are significant pressures within Cardiology, Rheumatology and T&O. The trust is subject to additional oversight from NHS England, with daily support in place from CMAST.
- At LUHFT, ENT and Oral and Maxillofacial Surgery are the most challenged specialties. An outsourcing contract is in place, with patients are being transferred and these numbers now decreasing.
- At COCH, ENT insourcing has been approved and is having an impact, with no capacity breaches reported, and the Trust have now mobilised for paediatric to deliver the CYP 52WW ambition.

Delivery

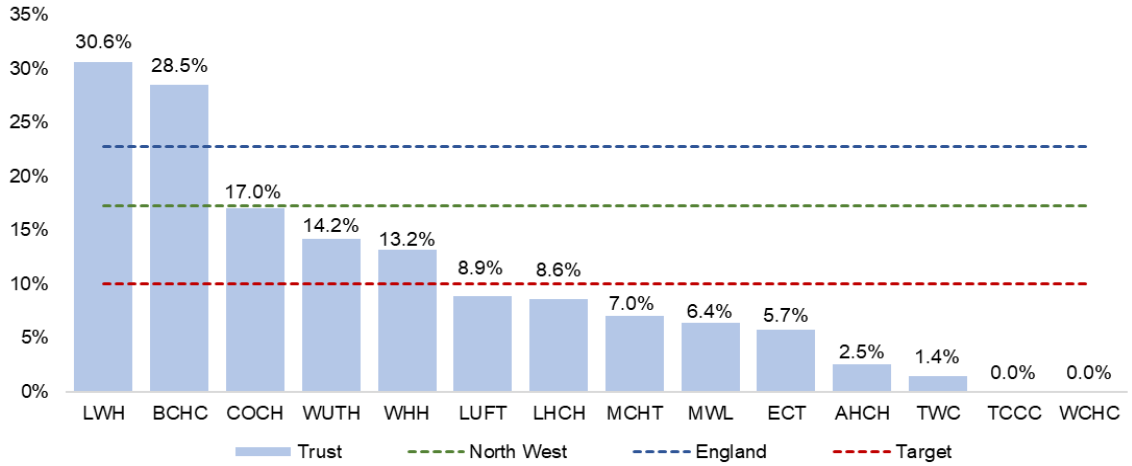
- There is a continued focus on eradicating 65 week waits and to model the delivery of 52 and 18 weeks for future planning.
- The team are currently working through improvement schemes to deliver 65% with a focus on annual planning for 2025/26 and implementation of the elective reform plan.
- Working towards the ICB ambition of zero CYP patients waiting over 52 weeks by the 31st March 2025. This remains on plan with some risks across East Cheshire and Alder Hey.

5. Exception Report – Diagnostics & Cancer

NHS Cheshire and Merseyside

Patients waiting more than 6 weeks for a diagnostic test

Latest ICB Performance (Jan-25)	11.2%	National Ranking	3/42
Provider Breakdown (Jan-25)			Deteriorated



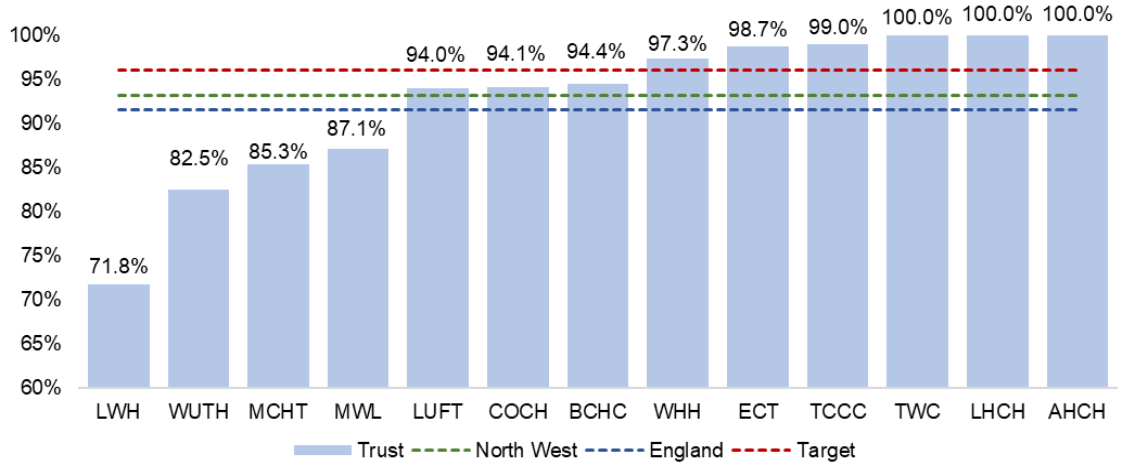
Issue
- C&M is not yet achieving the 95% diagnostic performance target. The figure of 88.8% is 4th amongst a potential 42 ICBs nationally for January 2025.

Action
- Deterioration in performance for January is largely driven by capacity issues in NOUS (LWH, WUTH and COCH) and ECHO (LUFT) tests across the system.
- Trusts are being supported through the Mutual Aid process to utilise system wide capacity available for both NOUS and ECHO at:
  - Paddington CDC are supporting Countess of Chester Hospital for NOUS
  - Paddington CDC are supporting Wirral University Hospitals for NOUS
  - Liverpool Heart and Chest Hospital are supporting Liverpool University Hospitals for ECHO
- Additional activity for NOUS and ECHO has been included in the CDC activity plans for 25/26 to ensure system capacity is available for these tests and plans submitted from providers are being reviewed by the Diagnostic Programme Performance team to ensure adequate provision for 25/26

Delivery
- C&M expects to achieve the 95% performance target by the end of March 2025. The latest Waiting List Minimum Dataset (WLMDS) data submitted by Trusts on the 09/03 displays C&M performance at 93.9% of patients seen within 6 weeks.

Patients commencing first definitive treatment within 31 days of a decision treat

Latest ICB Performance (Dec-24)	95.5%	National Ranking	15/42
Provider Breakdown (Dec-24)			Improved



Issue
- C&M not yet achieving the 96% 31-day combined standard required however, the figure of 93.5% is 8th amongst Cancer Alliances and 15th amongst ICBs in this latest month.

Action
- Those providers not yet achieving the 31-day standard are surgical treatment providers.
- Capacity and demand exercises for 25/26 are necessary to address this and short-term investment is already being made by the Cancer Alliance in key areas, confirmed by the performance forum, an example of this is the SNLB camera service at MWL.
- Improvement plans for each provider are either in place or under development for 25/26 These are included in the operational improvement plan to be submitted to NHSE as part of alliance assurance.

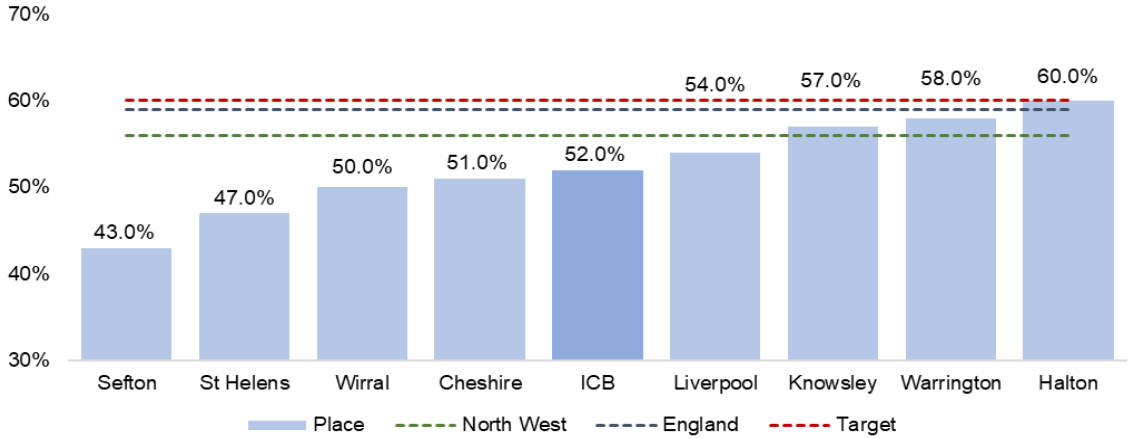
Delivery
- C&M expects to meet the 96% performance standard by the end of Q4 24/25 because the specific areas of 31-day breaches are identified and are targeted with improvement plans.

5. Exception Report – Mental Health

NHS Cheshire and Merseyside

People with SMI receiving a full annual physical health check

Latest ICB Performance (Q3-24/25)	52.0%	National Ranking	35/42
Place Breakdown (Q3 – 24/25)			No Change



Issue

- C&M is not achieving the minimum 60% target for all 6 health checks. Changes to SMI health check QOF payments for GPs and GP Collective Action may have further impact
- Only Halton is currently meeting the minimum 60% national target for all 6 SMI Health checks

Action

- The ICB Board received a deep dive into PH in SMI at the November 2024 Public Board meeting.
- All Places have access to the new BI report which allows information at GP practice level.

Delivery

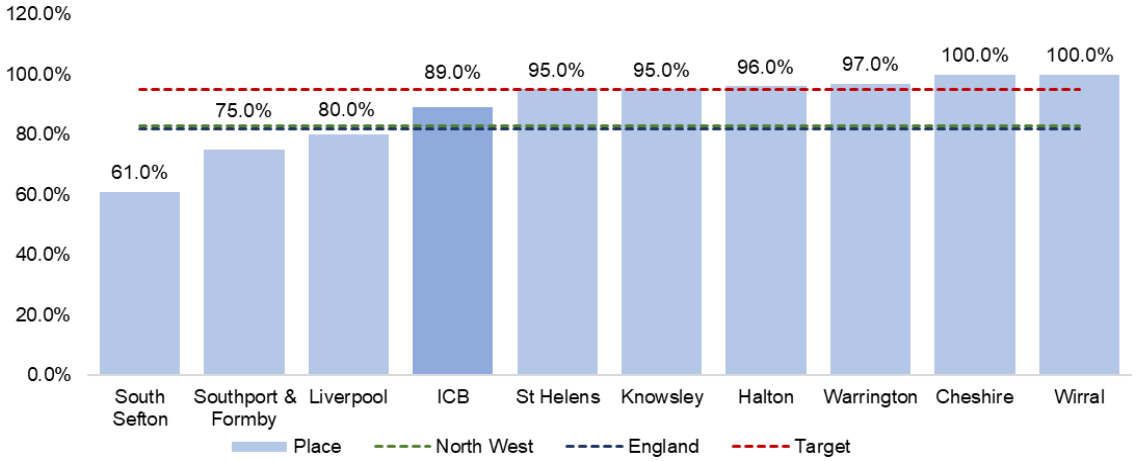
- Support is being offered to practices which are not meeting targets.
- All places have a local SMI steering group where performance is managed and local improvement initiatives are developed.
- Historic annual data indicate a downward trend through the year with a surge in Q4 which minimises the opportunity of follow-up on non-attendance. There is a risk this trend may not be repeated this year because of QOF income protection based on last year's activity, which was below target.

5. Exception Report – Mental Health

NHS Cheshire and Merseyside

CYP Eating Disorders Routine

Latest ICB Performance (Dec-24)	89.0%	National Ranking	17/40
Place Breakdown (Dec-24)			Improved



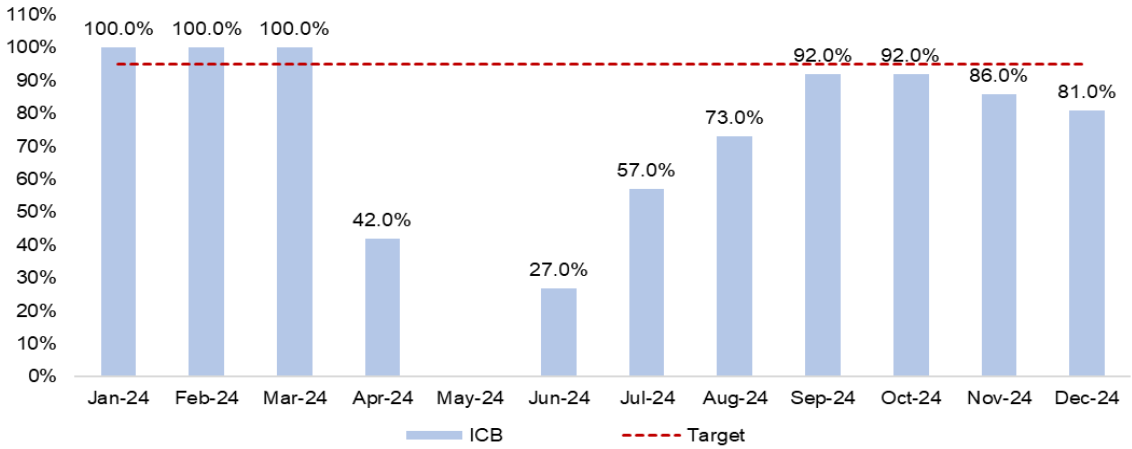
Issue
- Nationally published data shows that performance has improved from 87% in Nov 2024, however, the routine waiting time standard for CYP Eating Disorders (target 95% seen within 4 weeks) is not being achieved.
- Data quality issues still exist in the MHSDS, predominantly at Alder Hey.

Action
- C&M providers are being supported by the C&M Mental Health Programme Team to address data quality issues in the MHSDS, to ensure that all activity and performance is accurately reflected going forwards.
- Work is also underway to review how pathways can be improved across community eating disorder teams to provide more effective and efficient care.

Delivery
- Providers continue to monitor service waits locally – local data indicates that the routine standard has ranged between 77% and 88% for Southport & Formby, Liverpool and Sefton with all breaches being due to patient choice.

CYP Eating Disorders Urgent

Latest ICB Performance (Dec-24)	81.0%	National Ranking	19/32
ICB Trend (Dec-24)			Deteriorated



Issue
- The reported data shows C&M not achieving the urgent waiting time standard for CYP with Eating Disorders (target 95% seen within 1 week). However, data quality issues are ongoing, and the number of urgent referrals made is small, leading to significant changes in % variation when breaches occur.

Action
- C&M providers are being supported by the C&M Mental Health Programme Team to address data quality issues in the MHSDS, to ensure that all activity and performance is accurately reflected going forwards.

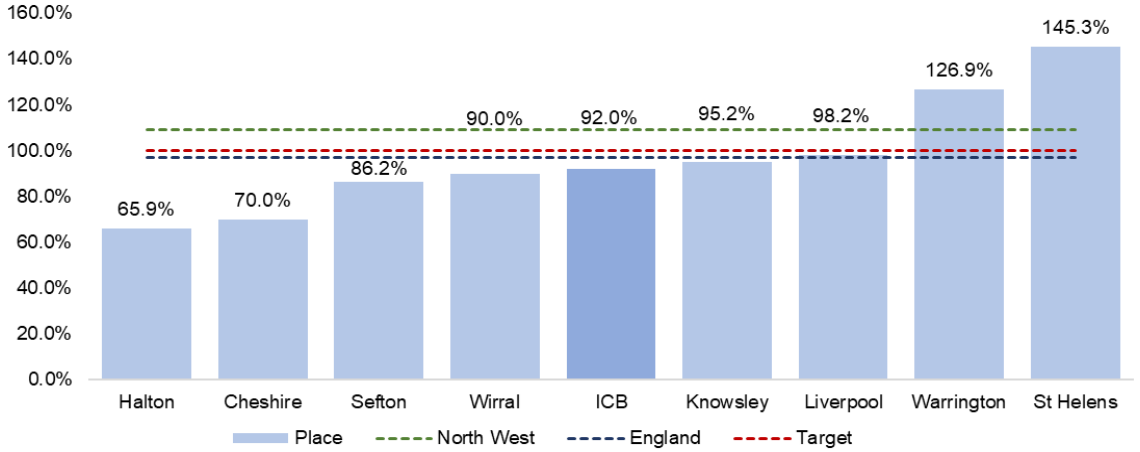
Delivery
- Providers continue to monitor service waits locally - local data shared at weekly divisional meetings indicates 98% - 100% of urgent are being seen, above the 95% target.

5. Exception Report – Mental Health

NHS Cheshire and Merseyside

CYP 1+ Contacts: % LTP trajectory achieved

Latest ICB Performance (Dec-24)	92.0%	National Ranking	22/42
Place Breakdown (Dec-24)			Deteriorated



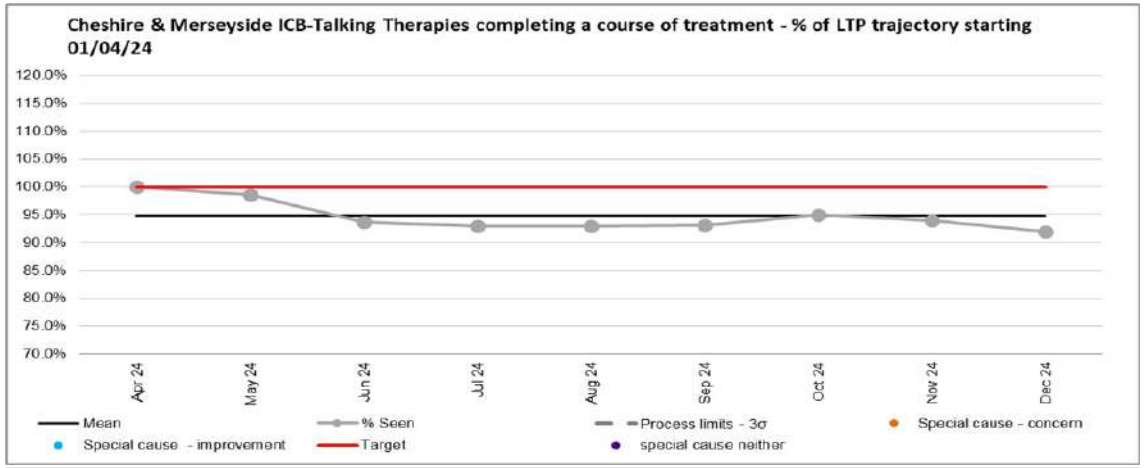
Issue
- There has been a 1% deterioration in access rates reported this month and access remains below target by circa 3,000 CYP
- Not all VCSE services are able to flow data to the national dataset so this activity is not captured in its totality.

Action
- Roll out of 5 new wave 11 MH in school teams will support increased access over the coming months (Liverpool, South Sefton, Cheshire, Wirral & Knowsley)
- C&M CYP Access Development Workstream reviewing trajectories at sub-ICB level to identify actions to address downward trends in Cheshire.
- Good practice is being shared across Places.
- Place level improvement plans will be shared with CYP Committee in March 2025.

Delivery
- There has been no significant change in overall C&M access rates during 2024, however there is more significant variance in place level trends

Talking Therapies completing a course of treatment - % of LTP trajectory

Latest ICB Performance (Dec-24)	92.0%	National Ranking	23/42
Place Breakdown (Dec-24)			Deteriorated



Issue
- The number of people completing a course of treatment has reduced from 92% of LTP target in Nov 2024 to 75% in Dec 2024. However, this seasonal variation reflects the trend reported in recent years.

Action
- Significant workforce expansion is underway aligned with additional funding committed via the Autumn Statement for a 5 year period
- Additional trainee therapists have started in post with a further cohort due to start in March 2025
- A single Cheshire and Merseyside Service Specification has been developed to ensure consistency of delivery best on good practice
- A “readiness for therapy” video has been developed to minimise the number of people not completing their course of treatment

Delivery
- Trajectories have been set at place level and shared with each of C&M’s five talking therapy providers and activity will be monitored at this level

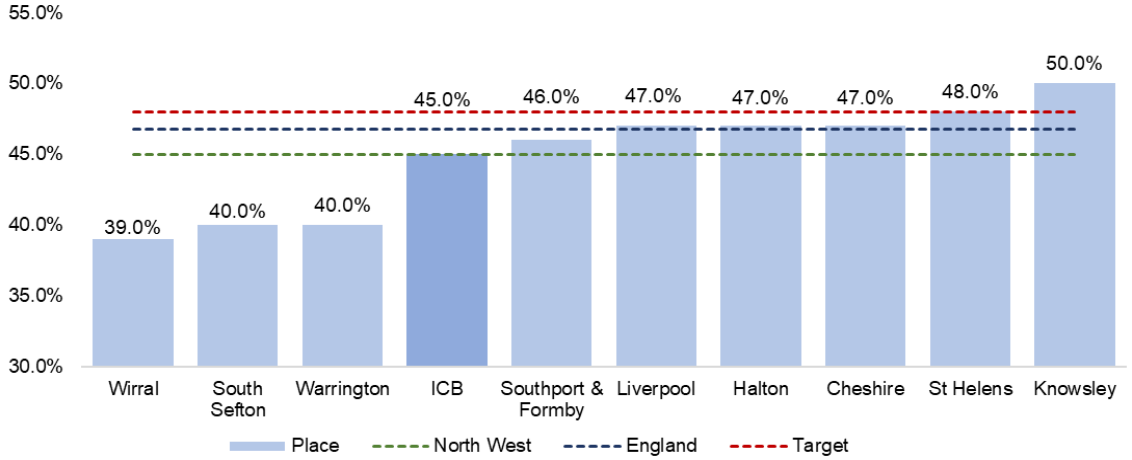
5. Exception Report – Mental Health

NHS Cheshire and Merseyside

Talking Therapies Reliable Recovery

Latest ICB Performance (Dec-24)	45.0%	National Ranking	13/42

Place Breakdown (Dec-24) — **Deteriorated**



Issue
- There has been a 3% deterioration in performance since Nov 24 resulting in C&M not achieving the 48% reliable recovery target this month

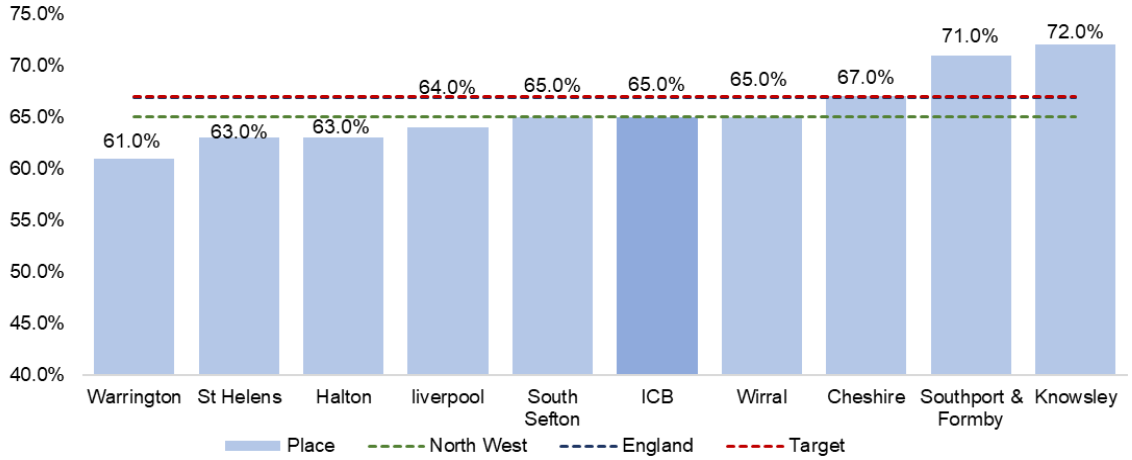
Action
- Further work taking place locally on workforce modelling in the absence of a national tool
- Single Cheshire and Merseyside service specification developed to facilitate consistency across services
- Planning to rebalance the ratio of low intensity to high intensity therapists to improve reliable recovery and reliable improvement rates, aligned with national guidance

Delivery
- St. Helen's and Knowsley places have both achieved reliable recovery targets for Dec 24, having been below target in the previous month
- Liverpool rate has remained static at 47% and is the only place to have not achieved reliable recovery rates in any month of this financial year
- All other places meeting are below target for December, however, reliable recovery rates have been achieved on a variable basis throughout the year

Talking Therapies Reliable Improvement

Latest ICB Performance (Dec-24)	65.0%	National Ranking	32/42

Place Breakdown (Dec-24) — **Deteriorated**



Issue
- C&M ICB is 2% below the national metric for reliable improvement. This is a 1% deterioration since Nov 2024.

Action
- The C&M Talking Therapies Steering Group and Workforce Group continue to focus on actions required to achieve national metrics. These actions include a review of data with service providers.
- A "readiness for therapy" video has been developed to increase reliable improvement and reliable recovery rates

Delivery
- Liverpool and Knowsley have been consistently below target this year. However, in Dec, Knowsley reliable improvement rates increased from 60% to 72%, achieving the target for the first time. Reliable improvement rates have fluctuated in other places, however, Warrington rates have previously been consistently high but experienced a 12% drop this month which is reflective of last year's trend
- Performance is expected to improve in future months.

5. Exception Report – Learning Disabilities

NHS Cheshire and Merseyside

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Jan-25)	80 *	National Ranking	23/42
Place Breakdown (Jan-25)			Improved

Issue

- There were 83 adult inpatients, of which 46 are Specialised. Commissioning (Spec Comm) inpatients commissioned by NHSE, and 37 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 60 or fewer by the end of Q4 2025

Action

- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 83 adults, 10 individuals are currently on Section 17 Leave. There have been discharges during Q3, but it is expected that some of the existing section 10 individuals will be discharged in Q4 pending MOJ Clearance.
- Data quality checks continue to be completed on Assuring Transformation to ensure accuracy.
- Weekly C&M system calls ongoing to address Delayed Discharges with Mersey Care and CWP.
- Housing Lead continues to work to find voids which can accommodate delayed discharges.
- Desk top reviews take place to address section 17 leave progress.

Delivery

- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2024/25, where the target is 60. Over the latest 12-month period, the adult inpatient cohort has reduced by 261 (76%) from 342 to 82 but Autism admissions continue to increase.

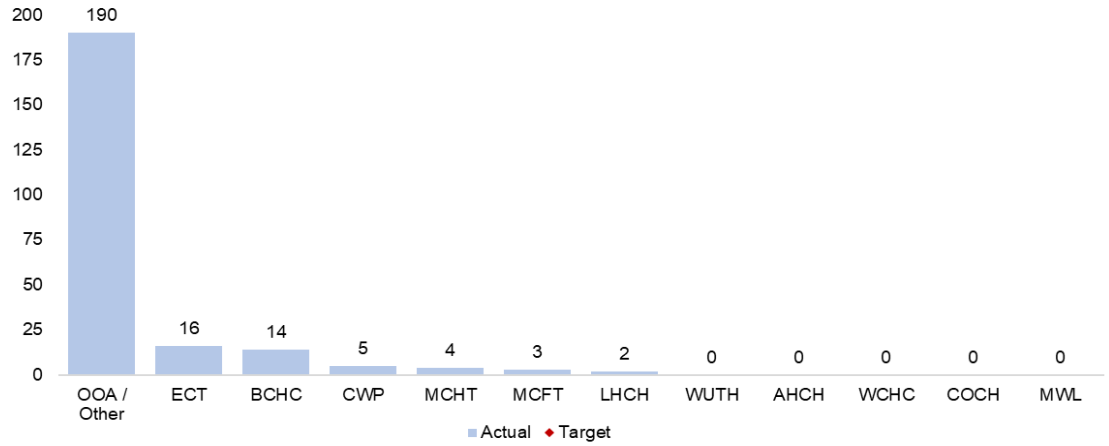
** Data rounded up/down to nearest 5: therefore, Place subtotals may not add up to the ICB total*

5. Exception Report – Community

NHS Cheshire and Merseyside

Community Services – Adults waiting over 52 weeks

Latest ICB Performance (Dec-24)	234	National Ranking	n/a
ICB Trend (Dec-24)			Improved



Issue

- OOA/other waits relate predominantly to a single provider, HCRG Care Group.
- HCRG Care Group has its head office in C&M but delivers services nationally. The over 52 week waits relate to non-C&M patients for services provided by HCRG Care Group elsewhere in the UK.
- The ICB has an ENT and Dermatology contract with HCRG for services provided in the Wirral area, but these waits do not refer to this contract.

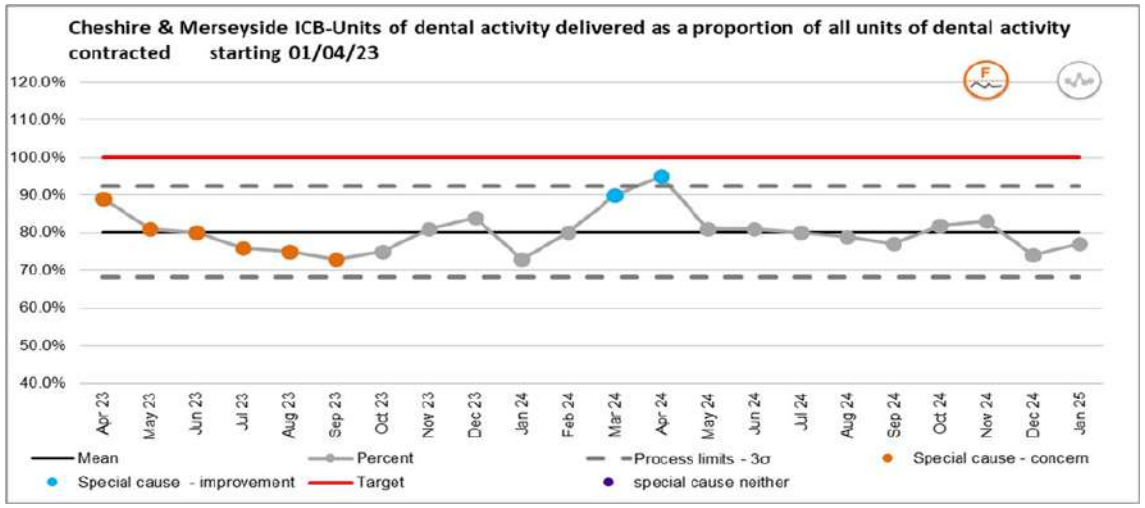
Action

- There is a piece of work ongoing with the provider collaborative and the Business intelligence team looking at HCRG data quality and validation in conjunction with NHS England.

5. Exception Report – Primary Care

NHS Cheshire and Merseyside

Units of dental activity delivered as a proportion of all units of dental activity contracted			
Latest ICB Performance (Jan-25)	77.0%	National Ranking	25/42
ICB Trend (Jan-25)			Improved

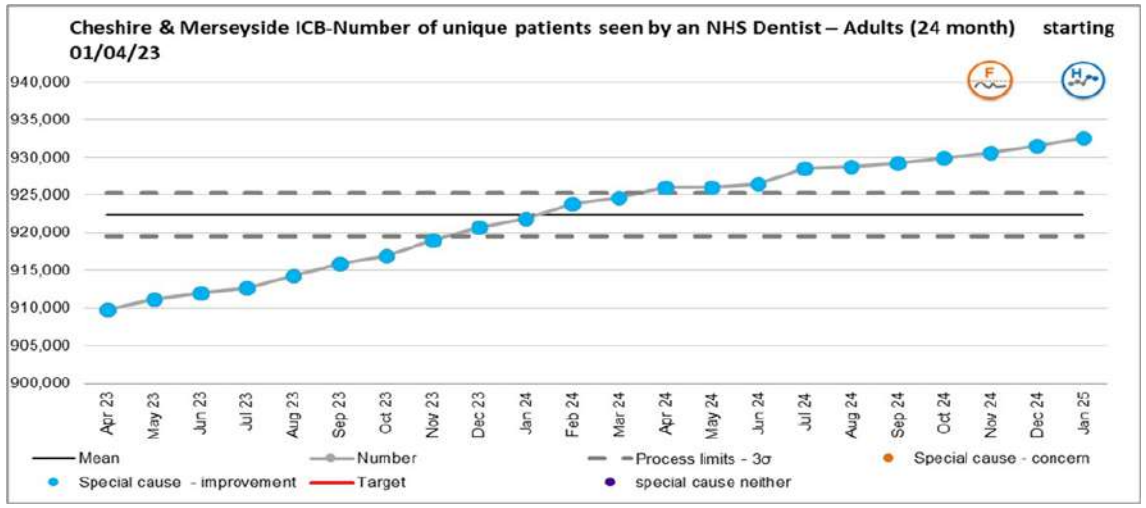


Issue
- C&M does not currently meet the 100% target.

Action
- Consideration will be given to reallocation of UDA's subject to ICB approval
- Guidance issued on urgent care national programme that will see an increase in activity
- C&M allocation is an additional 46k for urgent care appointments for 25/26
- Support practices who a) are struggling b) have the ability to over perform and do more

Delivery
- Fluctuations in delivery of target are expected throughout the year such is the nature of national contract.

Number of unique patients seen by an NHS Dentist – Adults			
Latest ICB Performance (Jan-25)	932,555	National Ranking	n/a
ICB Trend (Jan-25)			



Issue
- C&M does not currently meet the target.

Action
- Continue to support network of providers to see new patients who require an NHS dentist
- Local plan for 2025/26 approved by Primary Care Committee with continued focus on routine access.
- New patient premium will cease in 25/26 but activity to be factored into local improvement plan for 25/26.

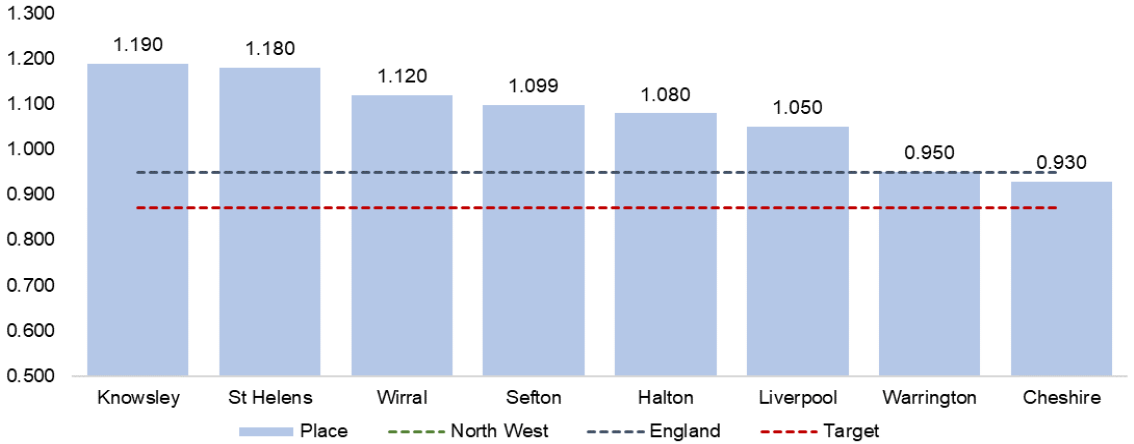
Delivery
- Commissioners are using flexible commissioning arrangements to improve activity**.**
- 1 post filled so far as part of Golden Handshake scheme. 7 C+M practices have been allocated funding.
- Review current data versus delivery to ensure alignment with vulnerable groups and health inequalities.

5. Exception Report – Primary Care

NHS Cheshire and Merseyside

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Sep-24)	1.02	National Ranking	n/a
Place Breakdown (Sep-24)			Deteriorated



Issue
- C&M does not currently meet the target set for the volume of prescribing of antibiotics.

Action
- All Places working with primary care on cascading of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- Results from recurrent UTI reviews completed across C&M audit to be shared with urology network for review and support with ongoing advice as needed.
- Agree a quarterly AMR Place update for AMR place leads to submit to and inform AMR report to Q&P Committee.
- Places have agreed to utilise PISCES audits in incentive schemes and Place MMT workplans with 5/7 prescribing and STAR PU being included in incentive schemes to improve appropriate prescribing at place.
- Penicillin de-labelling continues to be a priority, consideration to a single penicillin de-labelling inbox to aid system approach across C&M to ensure penicillin de-labelling actions are completed and patient records updated appropriately in primary care.

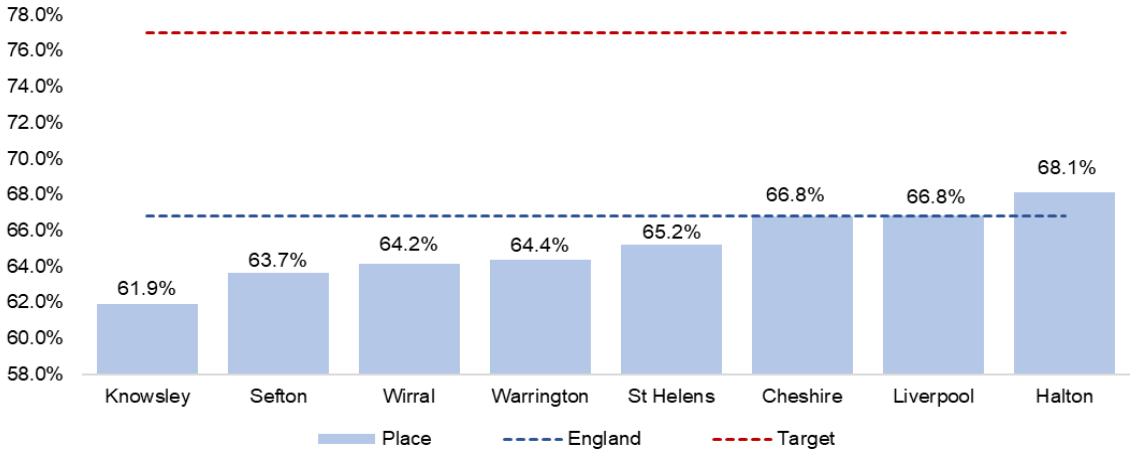
Delivery
- Analysis to continue with Q3 2024/25 data at Place and ICB level to inform areas to focus at Place and C&M level.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

% of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold

Latest ICB Performance (Q2-24/25)	65.6%	National Ranking	29/42
Place Breakdown (Q2-24/25)			Deteriorated



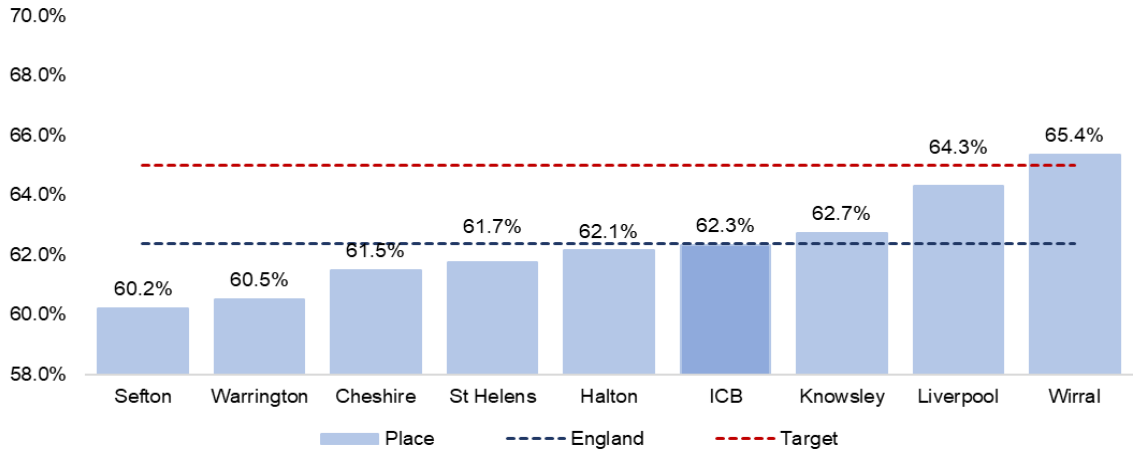
Issue
- Considerable variation in C&M, reductions in capacity & funding continue to affect performance; C&M does not currently meet the national target ambition.

Action
- Forum now established and has met to collaborate across C&M on Health Checks
- Governance in place to oversee hypertension case finding pilots in optometry with leadership being provided by the Population Health team. Patient pathway has been developed and is currently being shared for consideration and support by Local Medical Committees and Local Optometry Committees
- The Health Inequalities blood pressure optimisation project is underway, with 2 practices complete and 12 more going through the on-boarding process. Evaluation will be undertaken Q1 25/26

Delivery
- CVDP SRO, Programme lead and CVDP Board is the vehicle to coordinate C&M wide NHS activity alongside local Place CVD Prevention plans.
- The role of primary care in achieving this ambition is key.

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies

Latest ICB Performance (Q2-24/25)	62.3%	National Ranking	19/42
Place Breakdown (Q2-24/25)			Improved



Issue
- Considerable variation in C&M, reductions in capacity & funding continue to affect performance; C&M does not currently meet the national target ambition.

Action
- A clinically led lipid management group has been established to consider a range of lipid management matters and to ensure lipid management opportunities are being explored along the pathway
- Work with system wide laboratory process has begun to establish a consistent approach when the new global bloods system goes live
- As the Familial Hypercholesteremia is now recurrently funded by the ICB, this provides an opportunity to embed FH service into wider Lipid Management services.

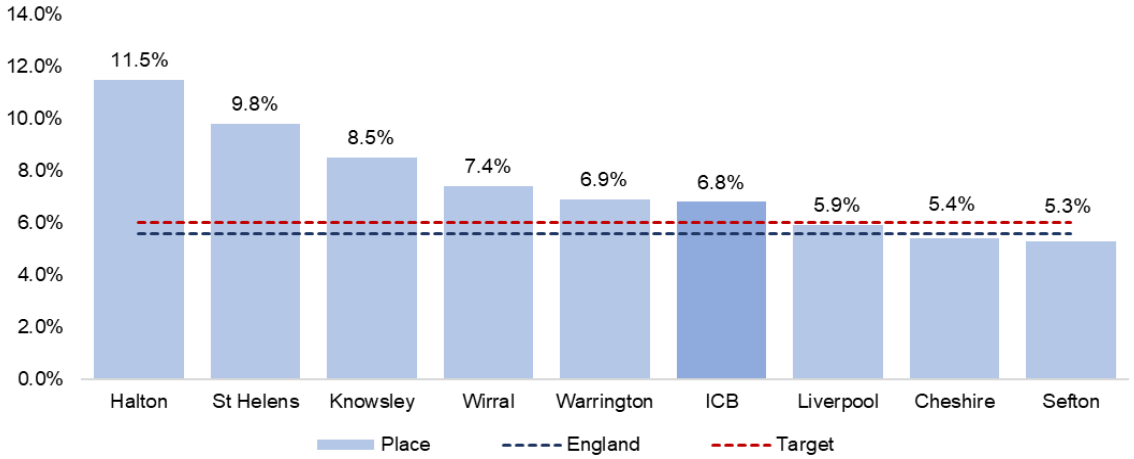
Delivery
- CVDP SRO, Programme lead and CVDP Board is the vehicle to coordinate C&M wide NHS activity alongside local Place CVD Prevention plans.
- The role of primary care in achieving this ambition is key.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

Smoking at Time of Delivery

Latest ICB Performance (Q2-24/25)	6.8%	National Ranking	30/42
Place Breakdown (Q2-24/25)			Improved



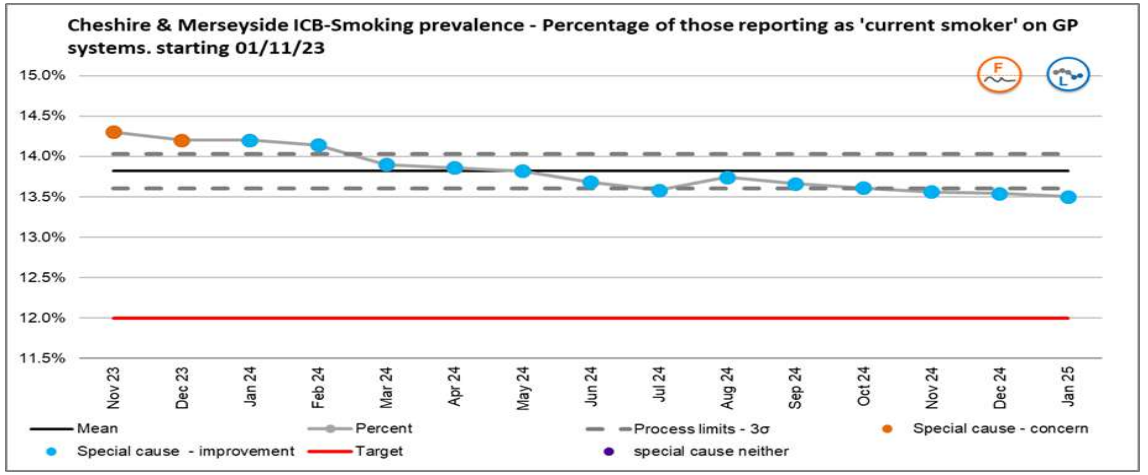
Issue
- Cheshire and Merseyside's (C&M) smoking at time of delivery continues to be higher than the England average, rates also vary significantly by place.

Action
- Work is ongoing with providers to discuss their readiness to implement the swap to stop initiative across all maternity services in C&M.
- The All Together Smokefree programme has commissioned a company to develop key marketing messages for C&M and this will include stories of pregnant women's quitting journeys.

Delivery
- Currently SATD continues to improve each quarter with the ongoing ambition that C&M will reach the England average by the end of the financial year.

Percentage of those reporting as 'current smoker' on GP systems

Latest ICB Performance (Jan-25)	13.5%	National Ranking	n/a
ICB Trend (Jan-25)			No Change



Issue
- Radically reducing smoking prevalence remains the single greatest opportunity to reduce health inequalities and improve healthy life expectancy in Cheshire and Merseyside (C&M).

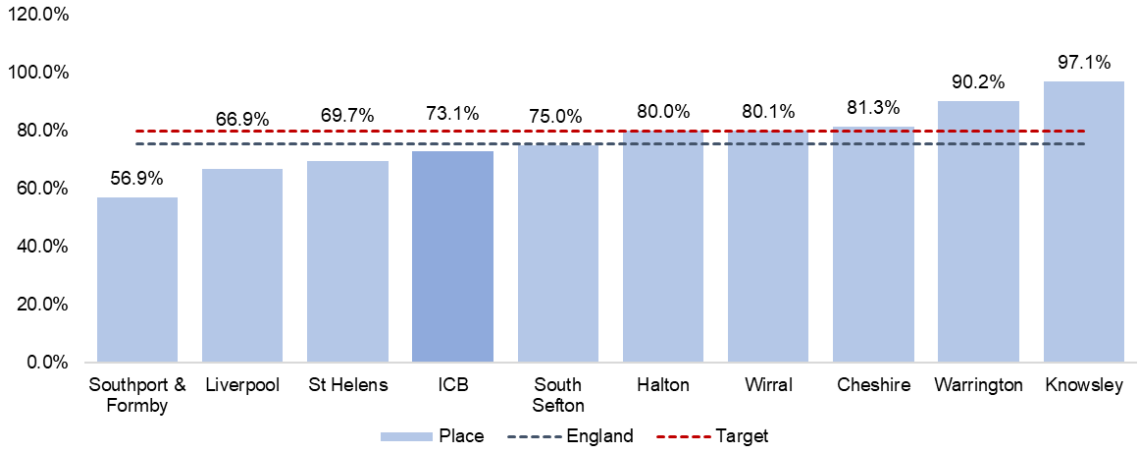
Action
- A campaign to launch the new public facing branding "Smoking Ends Here" on No Smoking Day (12 March 2025) has been developed.
- Insight work has been commissioned to provide a segmentation of the Cheshire and Merseyside smoking population.
- The All Together Smokefree programme has successfully recruited into the programme team to deliver the ambitious targets across C&M

Delivery
- Smoking prevalence continues to decline in C&M but requires a continued Whole System Approach to ensure progress is maintained.

5. Exception Report – Continuing Healthcare

Standard Referrals completed within 28 days

Latest ICB Performance (Q3-24/25)	73.1%	National Ranking	29/42
Place Breakdown (Q3-24/25)			Improved



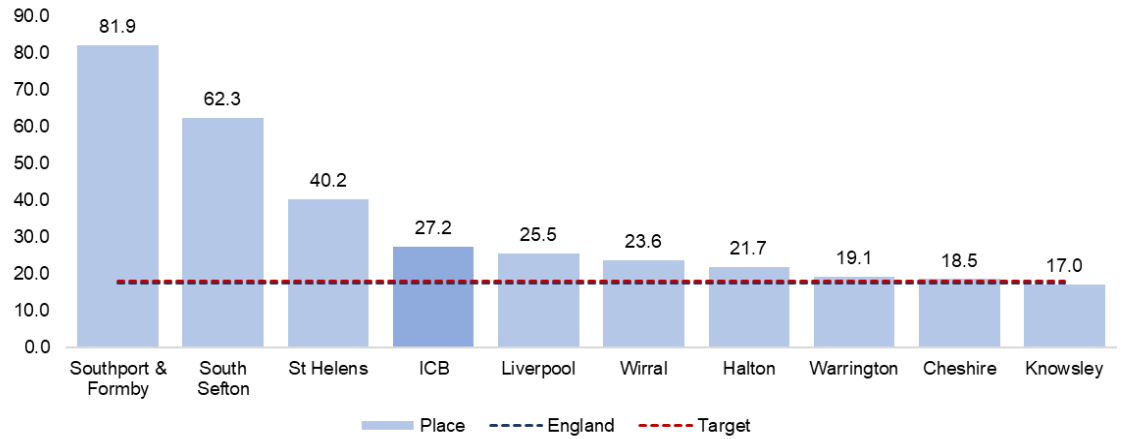
Issue
- Cheshire and Merseyside ICB is not currently meeting the NHS England KPI for Standard CHC referrals to be completed within 28 days.

Action
- A review of AACC delivery across C&M has taken place to develop a single structure and improve consistency and capacity across the 9 sub-locations. This includes the in-housing of Liverpool and Sefton place-based teams, which are the main outliers for this metric.
- Additional scrutiny of the in-housed service has enabled allocated senior clinical resource to daily management of 28 day / long waits.

Delivery
- The ICB delivery is slightly below the quarterly trajectory agreed with NHS England. The Q3 projection was ≥75% to 77.9% although an overall improvement is being seen..

Number eligible for Fast Track CHC per 50,000 population *

Latest ICB Performance (Q3-24/25)	27.18	National Ranking	36/42
Place Breakdown (Q3-24/25)			Improved



Issue
- Cheshire and Merseyside ICB currently has a higher conversion rate for the number of people eligible for Fast Track per 50,000 population than the national position.

Action
- NHS C&M ICB are producing a suite of supportive policies and procedures to support teams in delivering consistent delivery and application of NHS CHC across the C&M system. Some are already operational and published whilst others are in various stages of ratification and development.
- The main impact upon this metric is with the place teams that are, or were, outsourced; in-housing will enable improved scrutiny over delivery.

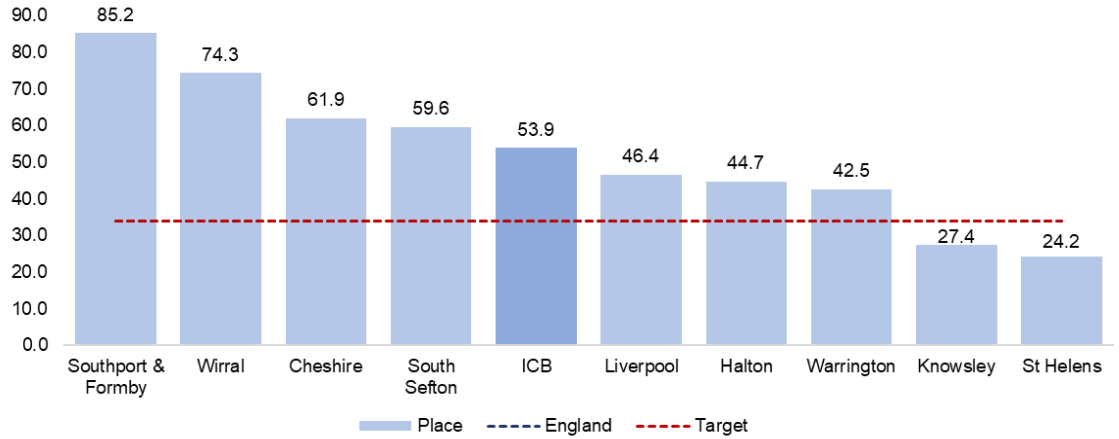
Delivery
- A focused piece of work in Liverpool and Sefton through outsourcing of Fast Track reviews as well as the implementation of the revised structure should ensure that only those individuals who are eligible for Fast Track are in receipt of the funding.

**snapshot at end of quarter*

5. Exception Report – Continuing Healthcare

NHS Cheshire and Merseyside

Number eligible for standard CHC per 50,000 population *			
Latest ICB Performance (Q3-24/25)	53.85	National Ranking	39/42
Place Breakdown (Q3-24/25)			Improved



Issue

- Cheshire and Merseyside ICB currently has a higher conversion rate for the number of people eligible for CHC per 50,000 population than the national position.

Action

- The main outliers for this metric are Southport and Formby, Wirral, Cheshire and Sefton. Sefton, Southport and Formby are still fairly recently in-housed teams and some positive action has been seen within other metrics.

Delivery

- Delivery is not expected to be improved significantly within this financial year but the Management of Change and consistent application of processes is intended to support a revised position over the financial year of 25/26. (Figures may also be impacted by demographics.)

**snapshot at end of quarter*

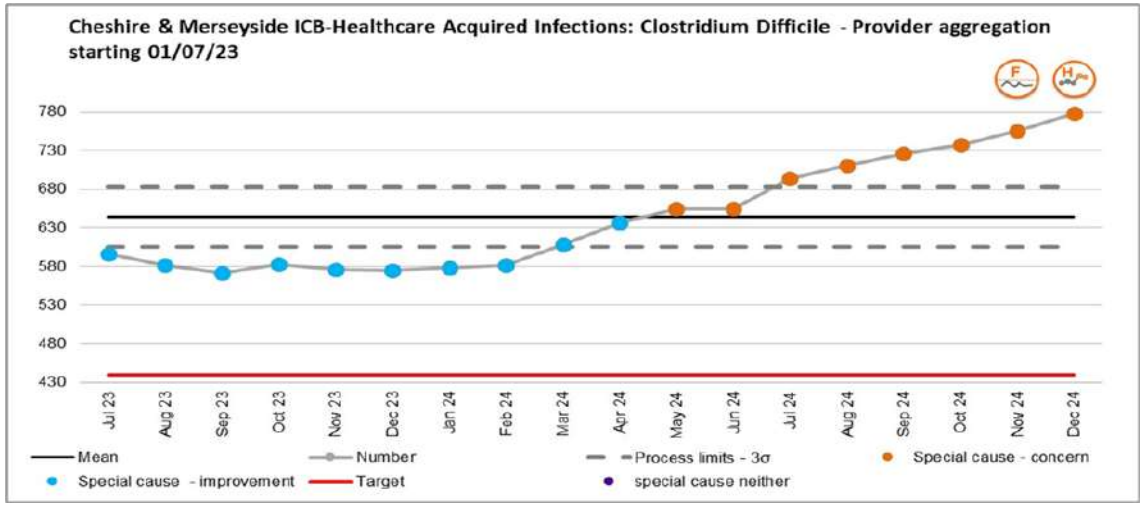
5. Exception Report – Quality

NHS Cheshire and Merseyside

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (12 months to Dec-24)	778	National Ranking	n/a

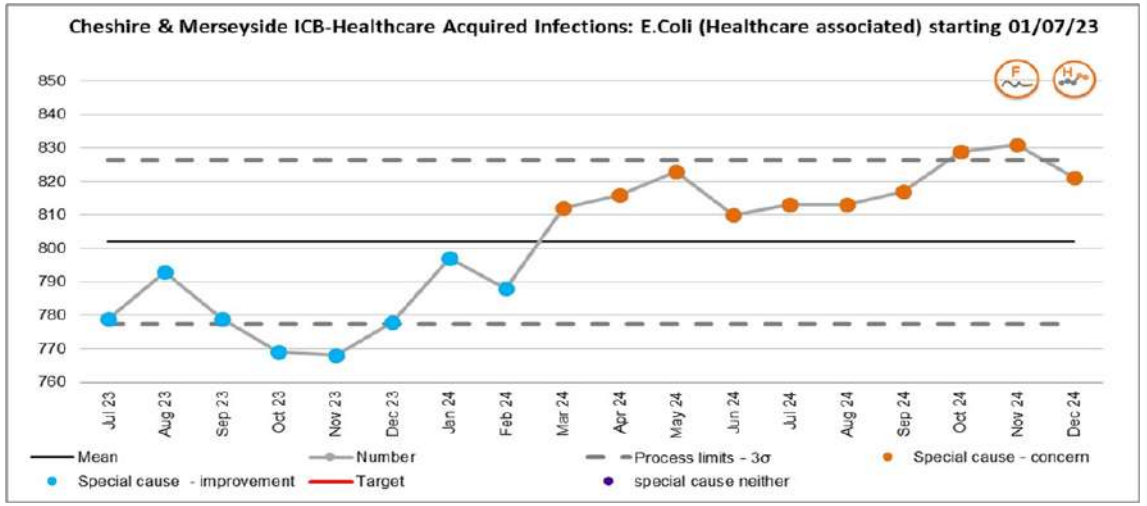
Provider Breakdown (rolling 12 months to Dec-24)



Healthcare Acquired Infections: Clostridium E.Coli (Hospital onset)

Latest ICB Performance (12 months to Dec-24)	821	National Ranking	n/a

Provider Breakdown (rolling 12 months to Dec-24)



Issue

- The C&M rate of CDI continues to increase across a range of providers with six providers seeing an increase in (CDI) healthcare associated infections based on a rolling 12 months. The greatest increase has been seen with WUTH who are a recognised outlier noted nationally and remaining a focus of quality contract discussions. Increases have also been seen at LUFT, COCH, ECT, MWL and CCC.
- The January data released but not included within this pack observes some improvement to 772, however rates continue to increase at WUTH and MWL.
- The C&M rate of E.Coli has reduced into December data, this is despite increases in WUTH, WHH and MWL.

Action

- There has been a newly established HCAI Review Group to increase oversight with regards to HCAI rates and actions being taken to reduce. All providers with increased rates of HCAI are supported with regular discussions through the quality contract meetings to seek assurance and challenge progress.
- The development of a CDI improvement programme via CMAST has been shared with all acute Trusts to implement key actions.
- Place-based teams are seeking to understand positive learning from providers with low outlier positions.

Delivery

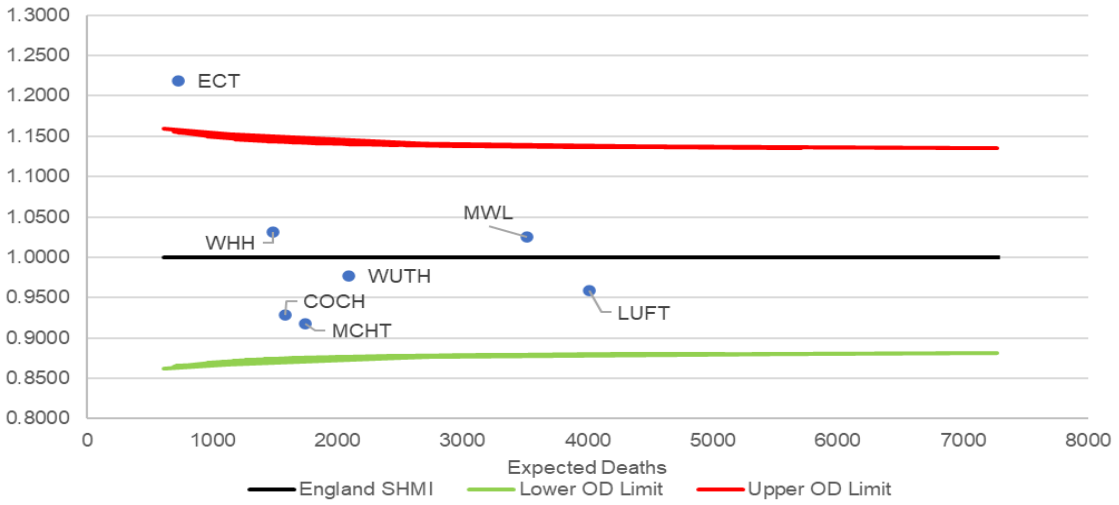
- CDI rates are expected to show a reduction in the January data, E. Coil rates have reduced to December and a further reduction is expected from the newly released January data.

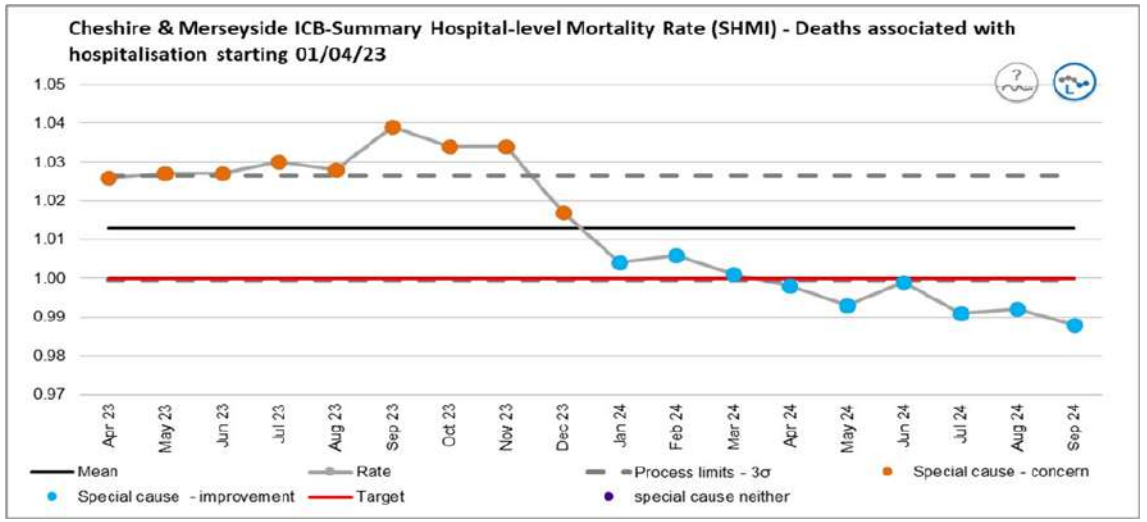
5. Exception Report – Quality

NHS Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Sep-24)	0.988	National Ranking	n/a
Provider Breakdown (Sep-24)*			Improved





Issue
- C&M trusts are within expected tolerances except ECT, with a current value of 1.2192 against the upper control limit for ECT of 1.1445.

Action (ECT only)
- The trust has moved to quality improvement phase of quality governance/escalation.
- Scrutiny continues between the ICB and trust in board-to-board meetings and system oversight reviews ensuring the optimal support is in place to bring about best patient outcomes.
- Following the meeting of ICB and trust execs and board, further developed improvement plans and support have been agreed and a detailed timetable of support and assurance created.
- Early indication of improved rates of hospital acquired infection will not be reflected in SHMI, but monthly reporting scrutinised by trust and ICB Medical Directors.

Delivery
- Some CRAB metrics have shown positive improvement, although not yet defined as sustained.
- The improvement culture in the trust is palpably improved and a Board to Board review in November has led to next steps including a review using HSMR+ that has demonstrated a significantly frail elderly population and clear improvement in mortality when measured the HSMR+ methodology. It is not yet into the normal range and thus oversight continues.

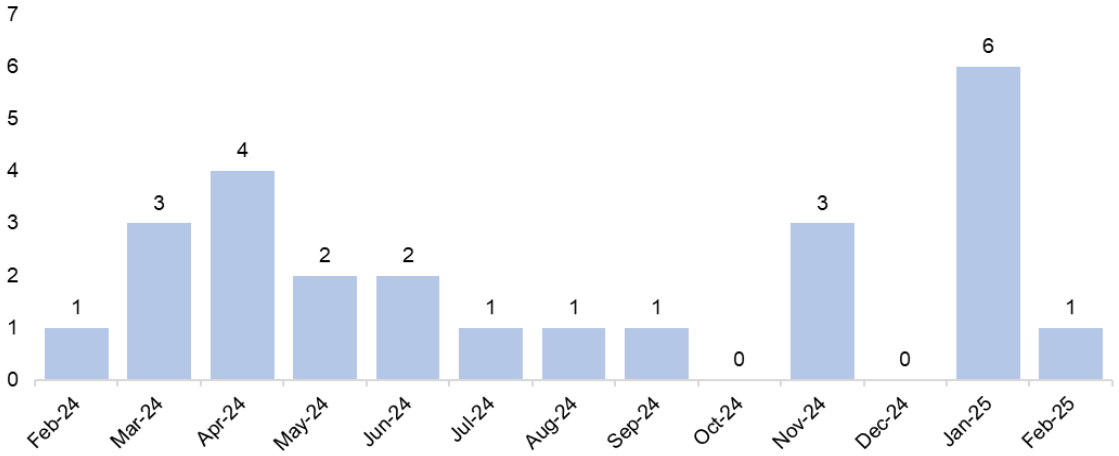
** OD, overdispersion, adds additional variance to the standard upper and lower control limits*

5. Exception Report – Quality

NHS Cheshire and Merseyside

Never Events

Latest ICB Performance (Feb-25)	1	National Ranking	n/a
ICB Trend (Feb-25)			Improved



Issue

- C&M have had 23 Never Events over the last 12 month rolling period, which continues to demonstrate a reduced rate from previous years, however the spike in January to 6 cases has made a specific impact.
- Whilst 6 cases in January represents a spike in rates, there are no initially obvious patterns with all cases at different trusts. All three related to surgical safety; 2 wrong implants, 3 wrong site and 1 retained object.

Action/s

- All incident will be reviewed via the newly formed Safety Standards for Invasive Procedures Group and learning shared across the system.

Delivery

- There have been 6 Never Events in January as a significant spike that will be discussed further on completion of provider patient safety Incident Investigations.

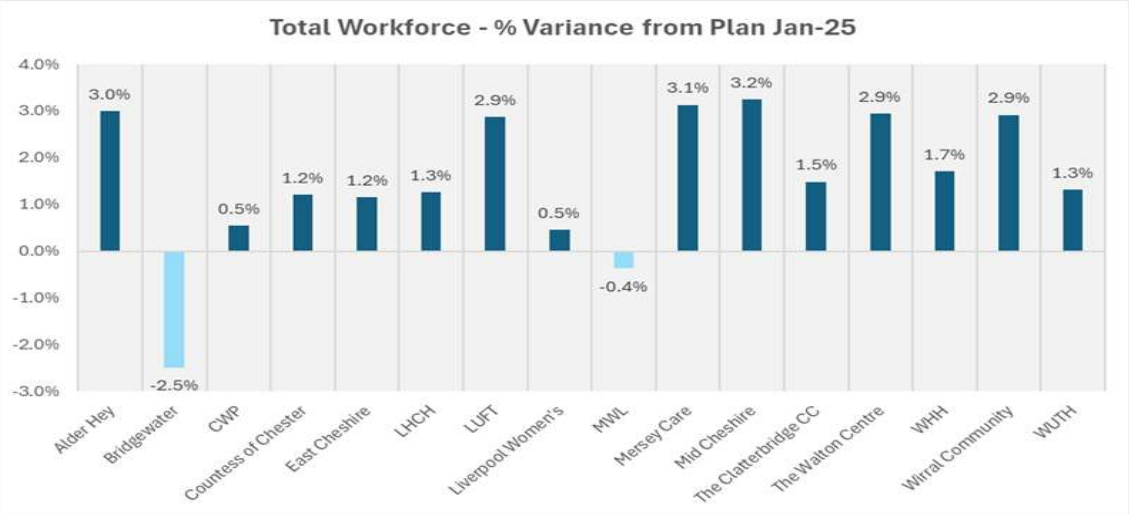
5. Exception Report – HR/Workforce

Cheshire and Merseyside

Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PWRs

C&M ICB Performance (Jan-25)	1.8%

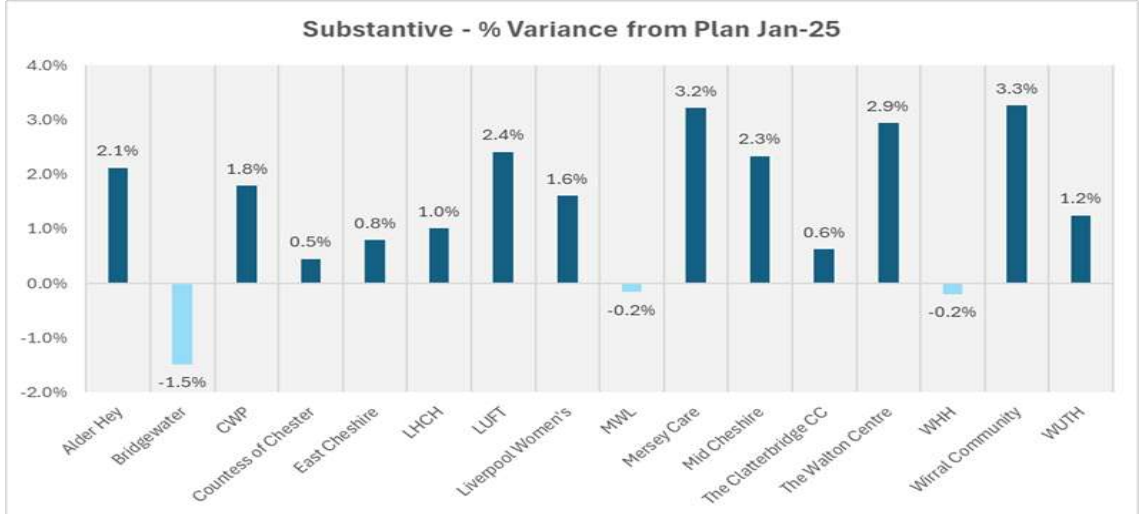
Provider Breakdown (Jan-25)



Substantive Variance from Plan % - via PWRs

C&M ICB Performance (Jan-25)	1.6%

Provider Breakdown (Jan-25)



Issue

- In Jan-25, fourteen of the sixteen C&M Trusts reported their total workforce WTEs were above their plan as at M10, with a C&M variance from plan of +1.8% (1,419 WTE).
- Thirteen of sixteen C&M Trusts reported substantive staff in post numbers higher than that forecast in their operational workforce plans (as re-submitted on 4th October 2024). The total system performance was a variance from plan of +1.6%. At a system level, substantive staffing increased by 108.5 WTE / 0.1% from the previous month.

Action

- NHS C&M co-ordination of operational (annual) workforce plans has been initiated – with a key focus on productivity & efficiency opportunities in temporary staffing & corporate services NHS C&M is supporting Trusts with their workforce, activity & finance triangulation.
- All Trusts have in place vacancy authorisation processes – which will be reviewed in line with the published 25/26 Operational Planning Guidelines (NHSE). Greater scrutiny of workforce and pay costs data at organisational and system level is now taking place. The workforce WTE monitoring dashboard is shared with Trusts monthly – for review and feedback; where individual performance can be interrogated in terms of WTE numbers & assumptions for the coming quarter / financial year.

Delivery

- NHSE C&M co-ordination of operational (annual) workforce plans has been instigated – with key lines of enquiry being developed as the plans iterate throughout Feb/March.
- Proactive monitoring of workforce data & proposed actions now takes place with Trust Chief People Officer & workforce/resourcing teams as part of the C&M Trust PDN Network focussed workstream on workforce planning.

Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

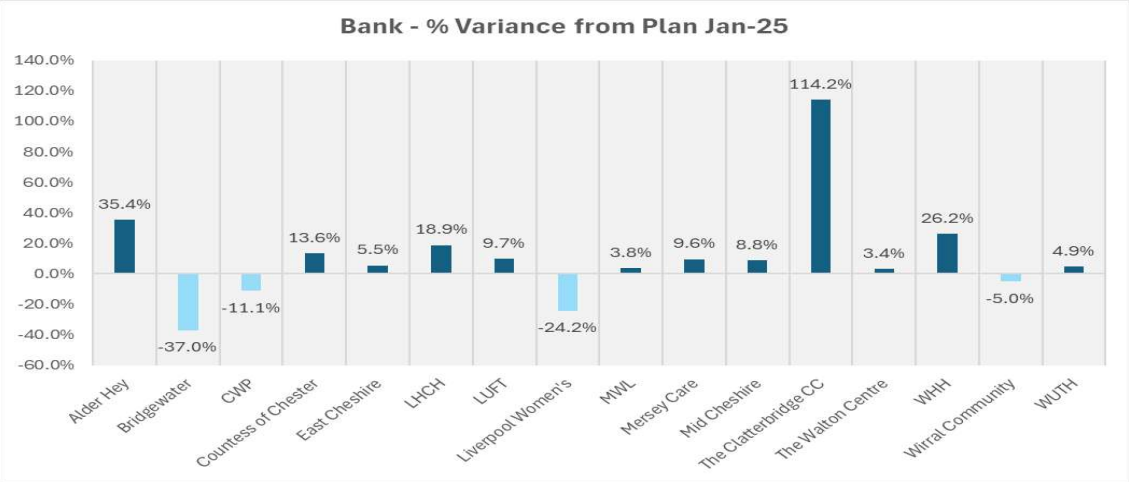
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Bank Variance from Plan % - via PWRs

C&M ICB Performance (Jan-25)	8.2%

Provider Breakdown (Jan-25)



Issue

- Twelve of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of Jan-25. The total system performance was a variance from plan of +8.2%.
- At a system level, the total bank usage increased by 124.9 WTE / 2.6% from the previous month.

Action

- All Trusts are reviewing their internal workforce resourcing processes & specific organisational actions around temporary staffing data & premium costs (WTEs Utilised and Rates Charged) which continues to be a focus for all Trusts, as part of the 25/26 planning process.

Delivery

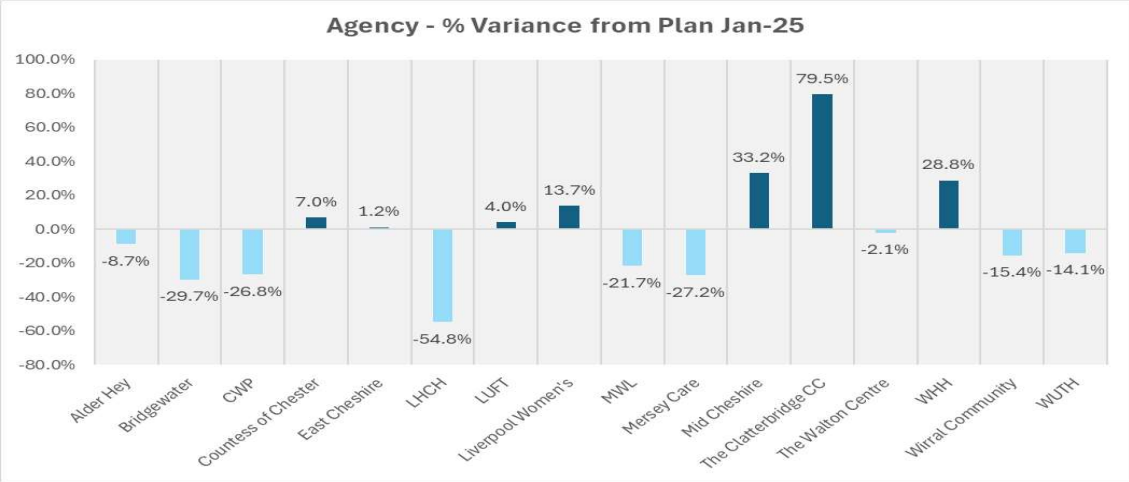
- Proactive monitoring of workforce data & proposed actions/controls with Chief People Officers C&M Trust PDN Network focussed workstream – ongoing KLOE's and 25/26 plan reviews incorporate reviews of 24/25 performance against plan.

Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

Agency Variance from Plan % - via PWRs

C&M ICB Performance (Jan-25)	-10.9%

Provider Breakdown (Jan-25)



Issue

- Nine of sixteen C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for the month of January. The total system performance was a variance from plan of -10.9%.
- At system level, Agency usage increased by 13.7 WTE / 1.7% from the previous month.

Action

- Temporary staffing data (Agency Spend & Off Framework Usages) is being reviewed across all Trusts in C&M – in line with their 25/26 Operational Plan submissions & assumptions.

Delivery

- Proactive monitoring of workforce data & proposed actions/controls with Chief People Officers C&M Trust PDN Network focussed workstream – in Mar-25 and objectives for 25/26 to be reset.
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework and Agency Spend data (by staff group) is shared monthly with additional input provided by NHSE North West.

Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

5. Exception Report – Finance

Overall Financial position Variance (£m)

Latest ICB Performance (Jan-25)	-47.3	National Ranking	n/a

Provider Breakdown (Jan-25)

Issue

- The ICS reports a YTD deficit of £109.7m as at Jan-25 which represents a £47.3m adverse variance to plan. Within that, the ICB position is a YTD surplus of £22.5m which is an adverse variance of £29.4m compared to the £51.9m YTD surplus plan.
- The system variance from plan has improved during the month by £13.8m.
- The adverse variance on provider positions (£17.8m) is driven by industrial action and associated lost income, undelivered CIP, ERF underperformance, costs associated with the Thirlwall Inquiry and the Wirral Cyber attack and a shortfall in pay award funding.
- The net unmitigated ICS risk was reported at month 10 as £77m (£32m ICB and £45m providers) – this is the risk that would need to be mitigated in order to deliver the planned system position.

Action

- Investment decisions to be taken to improve position non-recurrently.
- Review investments and uncommitted reserves.
- Review forecasts and methodologies.

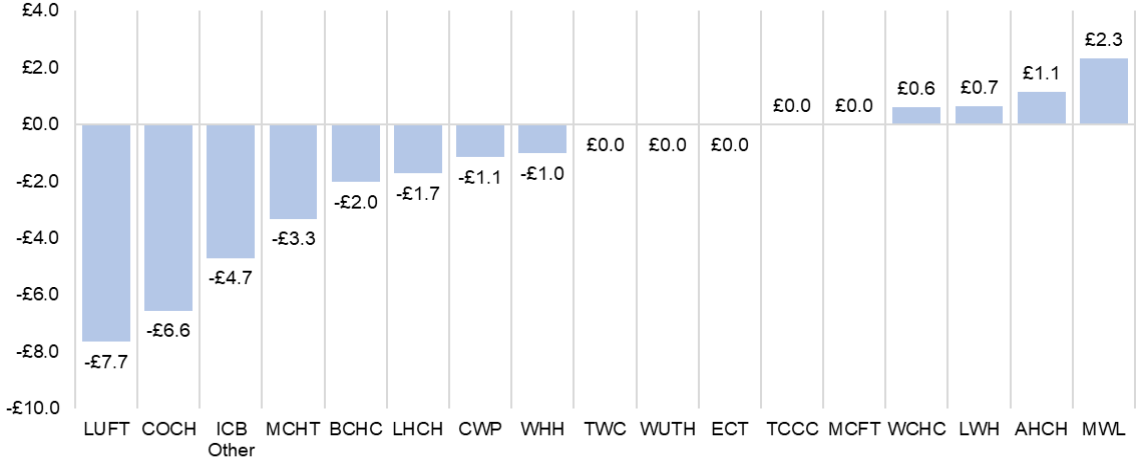
Delivery

- System reported a forecast in-line with plan to NHSE for M10 but £109.7m YTD deficit would need to be recovered in final 2 months of the year to deliver a balanced system position.

Efficiencies Variance (£m)

Latest ICB Performance (Jan-25)	-23.4	National Ranking	n/a

Provider Breakdown (Jan-25)



Issue

- ICS efficiencies - £321.3m achieved as at M10 – a £23.3m shortfall against the plan.
- System is forecasting that it will deliver £435m of the £440m efficiency target – as part of the strategy to deliver the most favourable position possible by the end of the year.
- Recurrent Efficiency plans are forecast to slip by £111.7m within provider organisations. This will be offset by non-recurrent measures this year but has implications for 2025/26 plans.

Action

- Expenditure controls in place including additional vacancy controls.
- Place focus on delivering additional mitigations where slippage occurs
- ICB on track to remain within running cost allowance following 20% reduction in allocation in 2024/25 – with a further 10% reduction in 2025/26

Delivery

- Review continuously as part of the monthly reporting process throughout 2024/25 financial year.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Report of the ICB Directors of Place

Agenda Item No: ICB/03/25/09

Responsible Director: Carl Marsh (ICB Place Director – Warrington)
Alison Lee (ICB Place Director – Knowsley)

Report of the ICB Directors of Place

1. Purpose of the Report

1.1 The purpose of the paper is to provide Board members with an overview of key areas of focus and delivery being undertaken at Place within the Integrated Care System.

1.2 The paper provides insight into the activities of each Place, based on these agreed key themes and areas of focus.

1.3 This paper is a regular update to the Board with regards to Place work, providing assurance to the Board on how teams are working towards the delivery of the Integrated Care System (ICS) objectives by working with partners locally to improve health and wellbeing of the local population.

2. Executive Summary

2.1 This report provides an overview of activities being undertaken at Place level describing the arrangements which support the Integrated Care Board (ICB) strategic priorities.

2.2 The report provides further detail on key aspects of each Place's operational activities, describing key features where local teams work in partnership with partners and stakeholders in support of delivery of the organisation's objectives.

2.3 Further insight is provided within the report across focus areas including Place partnership development, Place risks, action on health inequalities, patient discharge and flow, primary care network development, provider market development, strategic issues as applicable to each place, children and young people's issues and use of resources.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- Consider the contents of the report and the work being undertaken at Place to support delivery of the ICB strategic objectives.
- Note the progress being made in each of the sections as described within this report and areas of good practice.
- Note the relevant risks and issues as contained in this report that are captured as part of the ICB risk management approach and are monitored through the Risk Committee on a regular basis.

4. Place Partnership Development

Key areas of focus for recent and upcoming Place Partnership meetings include:

4.1 **Cheshire East**

Our most recent Place Partnership Board was held in January 2025. The meeting was held as a workshop focusing on Special Educational Needs and Disabilities (SEND) and working more effectively across the system to provide services to children and young people with special educational needs and their families. The workshop included representatives from the ICB, various providers and the local authority, as well as the local Parent Carer Forum.

At the next meeting in March 2025, further focus will be given to this area.

4.2 **Cheshire West**

Our most recent Place Partnership Committee was held early January 2025. The agenda included a spotlight on one of our Community Partnerships, which highlighted some of the key successes over the last year. In addition, the Committee received presentations from the local authority regarding Children's Services and the recent August Inspection of Local Authority Children's Services (ILACs); an update on the Adult Social Care Strategy and preparation for the forthcoming Care Quality Commission (CQC) inspection and an update from our partners in Mid Cheshire Hospitals Trust around the Healthier Futures (New Hospital) programme.

An update on a proposed Joint Intelligence Board across Cheshire West & Chester was presented to Place Committee, which was strongly supported by members as an opportunity to make the most of the available intelligence, capacity, and expertise as well as more effective prioritisation.

Cheshire West's Quality Team are also working collaboratively with colleagues from the ICB, social care, local authority and NHS providers to further develop Delegated Healthcare Tasks guidance (issued by Department of Health & Social Care, November 2024), and provide a local structure which will form a more robust framework in the local governance for delegated healthcare and improve care delivery for Cheshire and Merseyside patients.

The next meeting in March 2025 will focus on the updated and streamlined joint place transformation programme which will be implemented over two years, along with an update on the proposals for a pooled budget for the Better Care Fund.

4.3 **Halton**

At the last One Halton Partnership Board meeting in February 2025, the Board received a presentation, update and follow up discussion on the "Data Into Action" programme. The Board considered the opportunities to be pursued in Halton and some further follow up meetings have been held since. Further discussions with the programme to consider next steps will take place.

The Board also received presentations and updates on progress regarding Same Day Access to Primary Care and Long-Term Conditions Management programmes.

A discussion was held on the recent Neighbourhood guidance and its aims and ambitions which had been nationally published, and the Board agreed to set aside time for further discussions at its next meeting.

4.4 **Knowsley**

The February 2025 meeting was the first Board chaired by James Duncan the new Chief Executive of Knowsley Council. The focus was on urgent care. One of the items was a proposal to improve the health of people who are housebound. The proposal came from a Primary Care Network Clinical Director who has visited many people at home to administer covid and flu vaccinations.

The March 2025 meeting is our annual review and priority setting for 2025/26.

4.5 **Liverpool**

At the One Liverpool Partnership Board meeting held on 12 February 2025, the Board received a presentation/update on the Neighbourhood Partnership Model and an overview of the 2025/26 NHS Planning Guidance. The focus of the meeting was dedicated to the Liverpool Health and Wellbeing Board review conducted by the Local Government Association, which is nearing its conclusion. The findings and recommendations of the review will influence the strategic direction, governance and membership of the Health and Wellbeing Board, ensuring partners continue to work together effectively to improve the health and wellbeing of the citizens of Liverpool. The outcome of the review will also have a significant impact on the agenda and planning of the One Liverpool Partnership Board as it prepares for 2025/26 and beyond.

4.6 **St Helens**

The Skills Academy took a step closer to completion with the Council's Cabinet agreeing to the release of funding to Mersey and West Lancashire Trust (MWL) to award the contract to their preferred supplier. We expect the work to commence shortly with a completion date of July 2025.

The St Helens Live Well Directory has been launched and currently has 900 pages of information, services, and organisations to enable people to live well. This is an invaluable resource for social prescribers and organisations across the borough.

The February 2025 Partnership Board had a performance focus, bringing partners up to speed regarding public health and NHS key indicators, planning guidance and financial position. The content of the presentations provides a precursor to the April 2025 Board which will be run as a workshop to refocus and reshape our approach to the Place priorities.

4.7 **Sefton**

Response to the Southport Major Incident:

The partners in Sefton continue to work collectively in response to the Southport Major Incident. The extensive multiagency response and recovery cell remains in place with the ICB leading on the activation of the Cheshire and Merseyside Psychological Support Plan following a Major Incident Plan led by the Associate Director of Quality and Safety Improvement for Sefton Place. Support is available via the local authority website 'Southport Together' which includes the emotional and mental health offer of support

https://www.sefton.gov.uk/southport-together/.

The trial of the perpetrator of the Southport attacks commenced on 20 January 2025 with sentencing on 23 January 2025. A Public Inquiry into the incident was announced on 21 January 2025.

Communication mechanisms have been put in place, with family liaison officers to support any victims or witnesses who have chosen to access private therapy provision, and the clinical reference group have created a guide to ensure anyone who does choose private therapy, understands how to check out efficacy of the service through professional registration checks.

Mutual aid has been sourced from Mersey Care to support mental health matters and prioritise the increase in referrals since the trial.

The Associate Director of Quality and Safety Improvement has submitted a report to ICB Executive Director of Nursing and Care to provide an update and assurance on the Psychological Care Co-ordination Group on 6 February 2025. The report recommended that ICB and council leadership consider longer-term resource requirements necessary for Southport to support Sefton Place to manage all the concurrent processes of psychological support, Public Inquiry and Local Safeguarding Child Practice Review (LSCPR) through capacity. Capacity of leadership needs consideration. ICB Place does not have any additional resources solely dedicated to management of the incident. A full update was also given to the Sefton Council leadership on 26 February 2025.

Healthy Neighbourhoods:
Sefton Place is keen to accelerate its development of neighbourhood working considering the new planning guidance. Many of the key components of the model are already in place in Sefton. Our two large PCNs, whose localities are coterminous with our Integrated Care Teams working at a neighbourhood level of 30-50,000 patients and are at the forefront of innovations in working with a range of place partners and local communities to offer care in an integrated way. For example, both PCNs have Complex Lives programmes which involve NHS, local authority, and voluntary sector partners to shape the service to meet the needs of vulnerable groups within the population. Both data-led risk stratification and knowledge of local patient need is used to offer a range of bespoke services for different cohorts and our Integrated Care Teams, co-ordinated by Mersey Care colleagues, ensure a multi-disciplinary team approach, where required. Our work on urgent and emergency care connects to our community neighbourhood approach through the development of our Home First model as part of our Better at Home Programme – an integrated approach delivered with Sefton Council. A key priority for development will be ensuring an all-age approach, improving connectivity between all services and community support in our neighbourhoods.

Along with system partners, we are completing a self-assessment of our current position in relation to the guidelines, with a view to develop a development plan, owned and overseen by the Sefton Partnership Board and would be keen to be an accelerator site to further our development.

4.8 **Warrington**

The partnership has restated its commitment to addressing poverty and raising awareness about the challenges faced by residents. This was demonstrated by the recent Poverty Conference held on 4 February 2025 at Warrington Wolves. The conference brought together local organisations, charities, businesses, and educational institutions to discuss these issues and explore solutions.

The conference served as a platform for listening to local people with lived experience, fostering partnership collaboration, and sharing ideas. It also provided an opportunity to showcase data highlighting the daily challenges faced by many residents.

Several key pledges were made during the conference, some are summarised below into themes that will guide future action:

- Listening more attentively to the needs of communities
- Understanding the realities faced by the people we serve
- Emphasising person/family-centred approaches
- Working collaboratively across communities
- Building on the existing community ethos.

The conference culminated in the introduction of the Warrington Poverty Truth Commission. This initiative seeks to involve people with lived experience of poverty in decision-making to address the underlying causes of poverty. The aim is to create a collaborative platform where both community and civic leaders work together to find solutions.

The Poverty Truth Commission will be launched in Spring 2025. The first step will involve recruiting Community Commissioners (individuals with lived experience of poverty) to share their stories and inform decision-making. Civic Commissioners, including leaders from the council, health services, businesses, and the voluntary sector, will also be involved.

4.9 **Wirral**

The Partnership Board meetings of 23 January 2025 and 20 February 2025 included updates on:

- Dentistry
- Quality and Performance Report
- Place Finance Report incorporating Pooled Fund update
- Wirral Health and Care Plan Programme and Workforce Programme
- Wirral Place Review
- Wirral Health and Care Plan Programme Delivery Dashboard
- Unscheduled Care Improvement Programme
- Supporting Groups Chairs' Reports
- Oversight of All Age Continuing Care (AACC) and Complex Care in Wirral
- NHS Operational Planning Guidance 2025/2026 - implications for Wirral Place

The next meeting will take place on 27 March 2025.

5. Place Risks and actions to address

5.1 The top five risks common across places and key actions being taken to address them are set out in Table One.

Table One

Rank	Risk	Key Actions
1	**Performance:** Urgent care flow / no criteria to reside	Current controls include daily collaborative discharge monitoring and escalation, system winter plans and additional capacity, and admissions avoidance services. Further action and initiatives are being developed and progressed through the urgent care recovery programme.
2	**Quality:** Neurodevelopmental assessment delays	Current controls include the assessment framework, performance monitoring of commissioned providers, clinical networks, SEND improvement plans, and quality and performance reporting. Key further action underway to develop joint and strategic approach to commissioning for Autism and ADHD.
3	**Quality:** Reduced standards of care	Current controls include key policies and standards, incident reporting and harm review process, standard contracts, System Quality Group, and quality dashboard reporting. Key further actions planned include development of UEC patient safety principles, development of primary care quality forum and strengthening of host commissioner arrangements.
4	**Primary Care:** GP collective action	Current controls include EPRR, escalation and reporting and local place responses. Further work is underway looking at the potential impact on other healthcare services – in particular our urgent & emergency care services; to determine if there are specific additional risks associated with collective action.
5	**Quality:** Safeguarding Services capacity	Current controls include working across place footprints and prioritising statutory duties. Key further action includes the commencement of a talent pipeline / career path for Designated Nurses.

5.2 The scoring and distribution of significant common risks across the nine Places is illustrated in the heat map (Figure One) and may indicate where further action is required in a particular place/s to strengthen the effectiveness of an existing control or to implement additional controls.

5.3 In addition, there is a significant risk in Halton and Wirral that the health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services, currently rated as extreme (16).

Figure One

Risk ID	Risk Title	Current Risk Score									
		ICB Wide	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
F8/9	As a result of increasing demands, inflationary pressures, and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties.	16	12	12	12	8	12	12	8	4↓	16
PC8	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services.	16	12	12	9	12	12	16	12	6↓	15
QU04	Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm	16	16	12	8	3	12↓	9	9	9	8
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	20	16	12	12	8	16	16	20	16	16
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	20↑	9	4	12	12	16	16	6	6↓	20↑
T2	Limited Access to Specialist Weight Management Services across Cheshire and Merseyside and non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drug / Specific Place Risks in relation to potential loss of existing services	16			9		20		16		
PF1	Common place risk in relation to urgent care flow / 'no criteria to reside'	20	12	20		9	20		16	16	20

6. Action on Health Inequalities at Place

6.1 Cheshire East

No significant update to provide.

6.2 Cheshire West

The Cheshire and Merseyside Health Inequalities fund is being utilised to support mental health and crisis interventions for children, young people, and their families. In addition, a new programme of work has been stepped up to work across Place partners to carry out joint interventions to improve primary, secondary and tertiary prevention of cardiovascular diseases. This work will focus primarily on those communities/cohorts facing the biggest health inequalities.

Primary care funding has been prioritised from March 2025 to support one GP and one nurse session per month to identify patients experiencing health inequalities and identify potential interventions to maximise health outcomes.

6.3 Halton

Halton's National Institute for Health and Care Research (NIHR) funded Research Ready Community Project was featured as a winner of the conference abstract competition at the Royal Society of Medicine's "Tackling Health Inequalities: Health is Wealth" conference on 28 January 2025. A poster was created about the work and presented to conference participants during the intervals between keynote speakers. Senior representatives of NIHR viewed the poster presentation and as a direct result have awarded the project an additional £7500 for 2024/25, with the promise of support for a larger research grant in April.

Halton's Core20PLUS5 Connector Project continues to support a broad range of projects. Some of our female Connectors are supporting colleagues from Cheshire and Merseyside Women's Health and Maternity Programme, to organise an International Women's Day event at Runcorn Shopping City on 7 March 2025. The Connectors remain in high demand, with other projects such as vaccine awareness and health literacy potentially developing.

6.4 Knowsley

Residents from Kirkby in Knowsley have created a brand-new cookbook with a Mediterranean-inspired diet to help try and curb the issue of obesity and its associated health risks, such as fatty liver disease.

The cookbook is a collaboration between nutrition students from Liverpool John Moores University, local community groups and doctors and patients from the Millbrook Medical Centre in Kirkby. The cookbook is backed by leading liver specialists from Aintree hospital.

https://www.knowsleynews.co.uk/kirkby-fights-back-against-obesity-with-new-community-created-cookbook/

Dementia Diagnosis:
There have been improvements in rates of dementia diagnosis, from 59.5% to 63.6% between December 2023 and December 2024.

Learning Disabilities (LD) Annual Health Checks (AHCs):
Up to the end of January 2025, learning disabilities health checks are at 74% compared to 65% in the same period in 2023/24. Practices with 50% or less compliance are offered support from Mersey Care NHS Foundation Trust.

6.5 **Liverpool**
Work has commenced on integrating the new 'Tier Two' Weight Management programme with the city's diabetes service, whilst achievement of GP specific targets for Long Term Conditions has also seen a slight increase.

Severa UK has been working closely with Picton Primary Care Network (PCN) in support of International Women's Day on 8 March 2025 – raising awareness of bowel/breast/cervical cancer and the importance of screening to a targeted group of women. A Directed Enhanced Service (DES) is also currently awaiting implementation to support PCNs with cancer screening planning for 2025/26.

Progress with the BLINX PACO Pilot continues to gather pace. Clinical Safety DCB1060 (a clinical risk management standard that NHS organisations use to ensure the safety of health IT systems) has been completed at ICB level, whilst two Liverpool practices have now gone live with the 'Digital Front Door' programme – enabling patients to access online consultations, book appointments and access information. Feedback from patients in relation to their experience in relation to 'Digital Front Door' has so far been very positive.

Liverpool continues to maintain a strong focus on the development of the 'Proactive Care' model to tackle health inequalities in the city. The North Mersey Diabetes Review is making good progress, whilst analysis of population health data continues to shape priority areas for delivery.

The development and promotion of ORCHA (Organisation for the Review of Care and Health Apps) also continues to make an impact on local population health. Colleagues from Liverpool City Council, public health and the ICB have met to discuss using the ORCHA platform to raise awareness of the 'Lower My Drinking' app. Plans are also being formulated to explore how ORCHA could be integrated with remote Telehealth consultations as a digital support resource.

Following the publication of NHSE's Neighbourhood Health Guidelines 2025/26, Liverpool Place will work with system partners to undertake an assessment of current plans against these components to agree an action plan, ensuring delivery of the six core components.

6.6 **St Helens**

The Inequalities Commission met on 14 January 2025 with Carole Hassan as our new Independent Chair. Since then, we have continued to support our three main areas of Best Start in Life, food poverty and fuel poverty.

Family hubs have been delivering Pregnancy and Beyond multi-agency antenatal classes and providing free dental care to under 2s in Smile Squad sessions, in collaboration with the Liverpool School of Dentistry.

Work is ongoing to understand the infant feeding experiences of St Helens families, and a new Talking Pants programme has been launched to teach professionals how to discuss abuse and consent in a child-friendly manner. We have also helped to promote the recent CHAMPS Child Poverty Report and provided information to an upcoming child poverty task force.

We have 12 food pantries open supporting thousands of individuals throughout 2024, and the Affordable Warmth and Welfare Team continues to secure benefit gains and arrears, emergency fund interventions, heating improvements and insulation measures for hundreds of vulnerable residents. We have also distributed 8,000 Winter Well packs, with a further 3000 packs distributed by partners, providing hundreds of residents with free vitamin D tablets.

Inequalities funding from the ICB has been distributed to several organisations supporting our Best Start work. This includes the YMCA Youth Bursaries project, which has already provided £8504 to support children and young people to access sport and leisure activities that they would otherwise be unable to afford, including fishing, football, rugby, horse riding, dance, and yoga. Many of these young people were not only facing financial difficulties, but had also experienced issues such as social anxiety, domestic violence, ADHD, learning difficulties, eviction, and caring responsibilities for a parent with long term illness.

On Friday 21 March 2025 we will be holding our next workshop with IVAR, which will focus on loneliness, social isolation, and stigma. This promises to be an exciting interactive session, in which we will challenge ourselves to promote access to services for those groups who might be harder to reach and will learn from one another to support all St Helens services to improve. We want as much engagement as possible - please contact alicelacey@sthelens.gov.uk to secure a spot on the workshop.

6.7 **Sefton**

National Hydration Pilot – Scale and spread regionally:

The Hydration Team continue focusing on the roll out of care home training and UTI prevention and are expanding the intervention across Cheshire East and West, Halton, Liverpool, and St Helens. The team has shared resources northwest wide via IPC programmes.

The team were recognised as 'Team of the Quarter' and presented at the We Are One session on 26 February 2025.

The team continues to support the scale and spread of the training and resource materials across Cheshire and Merseyside ICB. Workforce contracts extended to the end of March 2025. A full business case is being prepared to support scale and spread in view of the pilot findings supporting several recovery programmes including urgent care, hospital admission avoidance and care home quality improvements.

6.8 **Warrington**

As set out above, Warrington Poverty Conference took place on 4 February 2025 with a wide range of stakeholder organisations. This provided a staging point and commitment from organisations to take forward plans around establishing a local 'Poverty Truth Commission.' Warrington Place will work together, listen to our residents, create solutions, and support each other across all areas of our community to make lasting change and improve people lives for the better.

6.9 **Wirral**

Macmillan Wirral Integrated Cancer Service, a three-year pilot funded by Macmillan, has undertaken engagement and co-production in readiness of the launch of the Wirral Integrated Cancer Service.

The work, led by One Wirral Community Interest Company (CIC) provides a foundation for providing patients diagnosed with cancer, a robust pathway offer that meets their needs and can be personalised through a holistic needs assessment and care plan which then links to assets and services in the community to fulfil their needs.

The service's mission statement reads "Through innovation and collaboration, we will transform the cancer journey into a seamless experience, empowering people with choice, reducing disparities and improving connections between services to ensure the person's needs are at the heart of everything we do."

The engagement and co-production work comprised surveys and focus groups, along with three dedicated co-production events. The work attracted input and conversations with both patients and professionals, with over 100 people becoming involved.

The work has provided a wealth of information that is still being worked through; however, through the surveys and workshops it is clear that patients require more support throughout the pathway. Patients expressed shock at diagnosis, the need for emotional preparation, more information and support about impact of treatment and medication, particularly regarding long term medication effects, incontinence and erectile disfunction and possible surgical complications. Support for practical needs, for example prosthetics, diet, symptom management, alongside support for the impact on mental health and financial support.

This coproduction work will provide a foundation for the service to target its resources to achieve the greatest outcomes for patients. The service, due to

launch in April 2025, will initially focus on newly diagnosed breast cancer patients prior to rapidly rolling out to other tumor groups.

The service has established links with many of Wirral community organisations who have pledged their support for the service and are willing to work in partnership with the service to provide a comprehensive offer to patients.

Progress will be monitored closely by Macmillan who hope that this will be a flagship service that will be emulated for cancer patients across England.

7. Patient Discharge and Flow

7.1 **Cheshire East and Cheshire West**

Following the establishment of NHS Cheshire and Merseyside's Urgent and Emergency Care Recovery Programme, Cheshire East and West are working together as a single Cheshire Urgent and Emergency Care Recovery Programme. The key stakeholders include the three acute Trusts, community services, primary care, NWAS, local authorities, voluntary sector and the ICB Place teams.

The programme is aligned to the three thematic areas of Admission Avoidance, In-hospital Patient Flow and Discharge (known as Home First).

The Admission Avoidance workstream has seen good progress with the roll out of the 'Steady on Your Feet' platform to support falls prevention, roll out of the Head Injury pathway, maximising use of UCR/Virtual Wards and increasing focus on advanced care planning. In addition, 'Call before Convey' has been piloted in Cheshire West, where 66% of calls have been diverted from an admission. This is now being rolled out across Cheshire East Trusts.

Within the acute Trusts, work is progressing across four key workstream areas: front door/Emergency Department, ward processes, escalation management and site flow, discharge co-ordination/tracking.

In relation to Discharge; within Cheshire West the Community Response Hub model has been rolled out across the borough supporting discharge of Pathway 1 patients, as the default being Home First. There is a recognised gap however in Pathway 2 (bedded intermediate care) capacity. In Cheshire East, the Discharge to Assess model has been reviewed/refined with an options appraisal undertaken, with a view to potentially shifting some resource from Pathway 2 to Pathway 1.

7.2 **Halton**

Halton has seen a significant increase in the number of patients being discharged on a social care pathway which has resulted in an increased No Right to Reside position.

Discharges have remained consistent and there has been available capacity to support the patients after discharge but there have been issues with processes to enable more timely discharges both from the hospital and community side. Urgent work is being undertaken to address this.

The process of direct referrals to intermediate care services continues to be further embedded and refined to reduce the need for social work assessment on the acute ward and the new trusted assessor is supporting with the review of patients seeking long term placements.

Oakmeadow, the Halton intermediate care unit, had an outbreak of norovirus during February 2025 and was closed to admissions for two weeks. An additional four intermediate beds were block purchased at a local care home until the end of March 2025.

The Call Before Convey pilots with the ambulance service is resulting in more calls to the community response team and more conveyances to the UTCs, avoiding the need for attendance at the Emergency Department.

The Urgent Community Response (UCR) team is also reviewing all ambulance conveyances from the intermediate care unit to determine if there is a cohort of patients that could be maintained in the unit with additional support.

7.3 **Knowsley**

Additional discharge capacity has been created to deliver an improved trajectory non-criteria to reside patients – which we are on track to achieve.

We have also reviewed and 'flexed' the criteria for Intermediate Care to include patients who have been delayed for a long-term placement or to allow home changes to be made. This has led to increased utilisation and a reduction in Pathway 2 delays.

7.4 **Liverpool**

Following the challenging winter period, the North Mersey Urgent and Emergency Care (UEC) Recovery Programme continues to maintain robust oversight in relation to performance against key metrics and delivery of improvement actions.

Acute Discharge - 14+ Length of Stay (LOS) has seen an increase in occupancy, although the metric remains outside of the upper control limit. The number of patients with 21+ day LOS has decreased and is now reporting within the mean average range, whilst 60+ day continues to increase weekly and is now reporting outside of the upper control limit. As at 4 March 2025, No Criteria to Reside (NC2R) performance was at 23.4%.

Ongoing improvement actions include MRI capacity and demand analysis and audits of common referral delays. New 'fast-track' referral documentation has also been implemented across the North Mersey footprint with an agreed data specification now used for these referrals and end of life care within the acute setting. P2 Pathway (bed-based reablement) reviews are to be completed by all stakeholders and providers have been asked to review delays at each hub.

Admission Avoidance – NWAS (North West ambulance Service) Conveyances volumes to Type 1 remain around the mean (indicating normal variation). Conveyances for ages 65+ have been reported below the mean for three consecutive weeks since the beginning of February 2025. Work is ongoing to reverse the decline in UCR referrals from NWAS crews. Other improvement

actions which were highlighted in February 2025 included the development of simplified communications on community services for NWAS crews. ECIST (Emergency care Intensive Support Team) is also supporting reviews of patients referred under 'Call Before Convey' (CB4C) test of change, whilst system provider partners continue improvement work in relation to NWAS referrals (which have reduced since CB4C implementation).

7.5 **St Helens**

A project is underway with Mersey Care NHS Foundation Trust to recruit a Later Life and Memory Service (LLAMS) in-reach Advanced Nurse Practitioner that will be based in the Emergency Department at Whiston and track patients that have been admitted. This is funded through Better Care Fund Discharge monies from St Helens, Knowsley, and Halton. The post holder will complement the work of the frailty in-reach and social work team in the Emergency Department and search for opportunities to turn patients around in the department with follow up from LLAMS in the community.

There are planned changes to the discharge tracking list approach in Whiston. The current approach relies heavily on daily meetings and a lengthy Wednesday meeting. Following a workshop in February 2025, this will be modified with the Trust developing smarter ways to get assurance and updates from social care colleagues. St Helens IDT and Urgent Care Commissioners were involved in the workshop.

Admissions Avoidance opportunities through the UCR (Urgent Community Response Team) remain satisfactory. The Cheshire and Mersey Business Intelligence Team are developing a local UCR dashboard for Cheshire and Merseyside which will provide further data about UCR outcomes, referral sources etc. There is a target of 157 referrals per 100k of population with an aim to increase referrals from paramedics. The St Helens UCR performance against this target is best in Mersey West Lancashire footprint with range of 129 and 167 referrals per 100k population based on Q3 data. UCR improvement work across the Mersey West Lancashire footprint takes place in the Admission Avoidance UEC programme. There is work to do regarding increasing referrals from care homes and NWAS and a targeted communications plan is in development.

Whiston are developing their 'Call Before Convey' model as a pilot further to the NHSE SPOA guidance. This is being led by the MHLDC Provider Collaborative.

Regarding care homes, there remains much variation in how they manage falls and falls risk. A pilot took place in November and December 2024, and it was concluded that many homes pick up their own resident from the floor, however homes with 'long arm owners/managers' tended to have policy that unwitnessed falls require a 999 call. There is a clear need to develop falls pick up training and standardise care home falls policies where practicable, this in turn will reduce demand on the UEC system. The Long Lie and Head Injury Protocol are now successfully embedded in care homes and welcomed by NWAS.

Procurement for the Brookfield clinical cover will conclude soon with a paper coming to PLT (Protected Learning Time) on 20 March 2025.

Innovative Admission Avoidance project will commence by end of March with PCN Frailty Teams using frequent flyer information from the Care Home Dashboard. There are 20 patients in our care homes with five or more Emergency Department attends in the past 12 months and the teams will work proactively with them and feed back to commissioners any themes or key learning. The Caldicott Guardian and ICB Medical Director approve this approach.

7.6 **Sefton**

Sefton Health and Social Care are working in partnership to manage the market and are beginning the development of an integrated brokerage function commencing with NHS D2A (Discharge to Assess) placements moving to be manually brokered by the local authority outside the use of the ADAMS DPS system. Aligned pricing to local authority standard rates and capped Length of Stay (LOS) are expected to result in a cost saving both during the D2A placement and impacting too positively cost of long-term care. Forecasts are currently being modelled by both local authority and NHS finance teams. Pending ICB approval, Go Live is planned for Quarter of 2025 with further transfer of NHS brokerage activity to the local authority during 2025/26.

Several service developments are underway to support discharge:

The Home First service went live on 27 January 2025 in the North using new processes and team integration from therapy and reablement from two organisations (Mersey Care Foundation Trust (MCFT) and Sefton New Directions (SND)) into a single delivery model. The service aim is to provide rehab, reablement and care to either remain or return home following hospital admission.

The first four weeks activity and outcomes included:

- 26 referrals, eight discharges, 96% seen within 24hrs of referral (one delay due to family preference), case mix of three therapy only, 11 reablement only and 10 mixed interventions. All patients had a formal review in 24hrs and 72hrs as per model target. Average length of stay 11.4 days (target 14-21 days). Average calls per day prescribed by the Transfer of Care Hub (TOCH) prior to Home First was 2.58 per day (49 call per day for 19 patients). All were discharged as independent with no ongoing care needs. Alternative to reablement (high-cost domiciliary care) for North Sefton has significantly reduced since Go Live, only one within the four weeks and reduced cost of circa £20k saving per week.
- Planned admission avoidance pathway in development for Home First with 1 April 2025 Go Live in the North.
- Planned development of Home First Model in South commenced.

There is increased utilisation and throughput of community beds at Chase Heys supporting Pathway 2 discharges through an agreed test of change with all partners. The change went live on 10 December 2024 involving admission decisions through the Transfer of Care Hub (TOCH), therapy or reablement offer on-site over seven days a week, capped Length of Stay (LOS) at 14 days, community therapy MCFT therapy resource used to enhance Home First. Resulting in:

- Length of Stay reduced from baseline in reablement beds.

- Skill mix achieved with caseload sharing and transfers between SND reablement and Mersey and West Lancs Hospital (MWL) therapy.
- Broader scope of criteria, increasing acuity inclusive of dementia and delirium – cases managed and discharged without incident from unit.
- 100% occupancy during January 2025 with increased throughput seen to date.

Changes in Adult Social Care (ASC) continue and include:

- Additional assessment staff commenced at ASC front door.
- Work completed on remit of new staff team (all new referrals into ASC to be assessed by First Contact Team).
- Commencement of Partners in Change work at the front door of ASC to look at how a “three conversation model” can improve outcomes for individuals and reduce bureaucracy.
- Continued engagement with key stakeholders, including People First, Older Persons Forum and internal workforce and name decided as First Contact Team.
- MDT Daily huddles commenced to ensure appropriate pathways for individuals, working well.

7.7 **Warrington**

Progress continues to be made in all workstreams towards delivering the opportunities identified from the Newton Europe diagnostic work, with some of the indicators continuing to make progress. Most notably:

- Continued reduction in the average time spent on the corridor per patient.
- SAPIT (Summary Acute Provider Indicator Table), a tool used in the NHS to provide urgent and emergency care metrics, identifies Warrington to be in the least challenged quartile nationally for the percentage of the population attending the Accident and Emergency Department.
- Continued increased utilisation of the Urgent Community Response (UCR) Service in the community compared to previous years.
- Continued increase in the utilisation of the Frailty Virtual ward over the 80% standard.
- Sustained utilisation of the ARI (Acute Respiratory Infection) Virtual Ward.
- Discharges before midday increased in January and February 2025 compared to the same months last year.
- Achieving a reduction in complex discharges addressing the Newton Diagnostic challenge of reducing over prescribing of care.

We have bid and been successful in securing additional funding to improve the 4-hour Accident and Emergency standard in the month of March. We have used this funding to allocate additional medical and nursing staff to SDEC (hospital based same day emergency care) into the evening to increase our ability to stream more patients from the front door (triage) to the Emergency Department SDEC pathway.

All workstreams are intended to improve urgent and emergency care outcomes for the whole population. However, there is a particular focus throughout for our most vulnerable population with frailty syndromes of falls, immobility, delirium, incontinence, and side effects of medication.

Activities and interventions that have driven these improvements include:

- Engagement sessions with primary care, increasing referrals to UCR.
- Ongoing Call Before Convey Test of Change with NWAS, Urgent Community Response and Frailty Assessment Unit.
- Continued focus on the Transfer of Care to minimise complex discharge delays from the point No Criteria to Reside is recorded.
- New task finish groups established under the Discharge Improvement Group workstream to develop new activities to further reduce delay days spent in hospital.

Workstreams are now focusing on the 2025/26 workplan including activities and success measures to deliver a continued improvement in system performance.

7.8 **Wirral**

Wirral Place is working with partners to develop a joint working agreement to support Pathway 1 discharges. This includes Wirral Community Healthcare NHS Trust Home First service and the domiciliary care service commissioned by Wirral Borough Council. In recent weeks there have been some bottlenecks in the availability of Pathway 1 care.

Wirral has been working to enhance proactive care for frailty patients in the Hoylake and Meols PCN area, this involves work between the PCN and Wirral Community Healthcare NHS Trust supporting frailty management and chronic disease management.

For frailty this entails identifying patients with moderate/severe frailty and developing a care plan using Comprehensive Geriatric Principles (CGA). Early evidence is showing a 15% reduction in GP appointments and 25% emergency admissions.

Wirral Place has jointly worked with Wirral Borough Council to submit the BCF for 2025/26.

8. Primary Care Network Development

8.1 **Cheshire East**

General practice in Cheshire East has in some ways led the way on collective action owing to many of our practices being larger and more cohesive.

There are few apparent significant implications from the taking of collective action to date.

More positively, local GPs are continuing their work to develop a GP Federation (a provider collaborative for GP primary care) with work on proposed governance due to be completed in the next month or so.

8.2 **Cheshire West**

There are nine PCNs geographically aligned to our Care Community Team and Community Partnership geographies. The only difference is that three Chester PCNs are working as one Community Partnership. This helps support alignment with local authority ward profiles

Good relationships are in place between GP practices, PCNs and the ICB with regular practice manager and PCN clinical director forums well attended. We also hold GP collaborative events monthly with representatives from all practices as an opportunity to focus on areas of development, in addition to providing an update on Place transformation work and recovery programmes.

We have also developed a primary/secondary care interface meeting with practices that face the Countess of Chester, with a separate meeting organised for those that face Mid Cheshire Trust. Challenges include the ongoing levels of demand faced by primary care as well as the financial implications of inflationary pressures.

The primary care team have worked collaboratively with PCNs to utilise System Development Funding towards recovery priorities. PCNs stood up additional on the day 'urgent' appointments in primary care from November 2024 to February 2025, with more than 2248 additional appointments provided per month.

To date, Cheshire West has four PCNs who have achieved all three pillars of the Capacity and Access Improvement Plan for Modern General Practice Access (this equates to 19 practices). A summary of achievement against each indicator is below:

- Better Digital Telephony: five PCNs (22 practices)
- Simpler Online Requests: five PCNs (22 practices)
- Faster Care Navigation: four PCNs (19 practices)

If carried out properly, the support level framework conversation is a powerful tool to engage with practices and help them to understand their strengths, weaknesses and challenges which will in turn help support them to provide the best access and care possible for their patients. The visits undertaken by the primary care team have been extremely valuable - both for the practices and the team. A wide range of excellent work has been identified as part of these conversations, and the primary care team have been sharing this good practice across the 43 practices to encourage wider adoption and resolve issues identified. 33 practices have had Support Level Framework visits to date with a further two scheduled for March 2025.

8.3 **Halton**

At the February 2025 Primary Care Commissioning Group, PCNs provided an update on a range of development projects, some of which were resourced via 2024/25 Primary Care Service Development Funding:

Runcorn PCN:

- PCN development session to support the transition of leadership, new Clinical Director, GP Education Director and PCN Lead Nurse. The purpose of the session is to develop a shared vision and agree priorities for 2025.
- Establishment of nurse leadership, educational planning and oversight for nursing teams within PCN service delivery and to promote nurse retention, whilst also supporting the Place Primary Care Workforce Group.
- Chronic Kidney Disease care improvement project to increase identification and improve monitoring.
- Planning for a vaccination and immunisation workshop to scope the potential for collaborative working across the network.

Widnes PCN:

- Continued implementation of the cardio renal metabolic (CRM) conditions improvement work, which includes the development of a patient support group.
- Support provided by the cancer care coordinators to improve screening uptake across the PCN.
- Mobilisation of Blinx PACO to support the implementation of the Modern General Practice Access Model across the PCN and improve access for patients.

In addition, PCNs continue to support the One Halton Place based partnership transformation programmes, taking a leading role in the development of the Same Day Primary Care and Long-Term Condition Management neighbourhood working programmes.

Following the launch of the 2025/26 Neighbourhood Health Guidelines (NHSE) the Place Primary Care Leadership team, including the PCNs, are to undertake a review of our approach to integrated neighbourhood working, utilising the self-assessment developed in Sefton Place. The review will support a refresh of our plans and ensure the continued strategic alignment of resources at a PCN and practice level, e.g., informing the finalisation of the Local Enhanced Services specifications for 2025/26.

8.4 **Knowsley**

We are working with our clinical leads to re-specify the Primary Care Local Quality Incentive Scheme for 2025/26. The scheme will cover six key improvement areas with specific and measurable deliverables for participating practices.

We have commissioned an externally led review of Primary Care Network maturity, completed by MIAA (Mersey Internal Audit Agency). We are supporting the networks to access performance data to identify areas of unwarranted variation and potential for schemes that will support a reduction in health inequalities.

The Primary Care Networks are also supporting the developing model for neighbourhood health. We have held a series of workshops with colleagues from community and mental health providers and the local authority.

8.5 **Liverpool**

The city's PCNs continue to contribute to numerous Liverpool system meetings, pilots and initiatives. Seven Liverpool PCNs have been awarded a total of £22k to undertake initiatives aimed at improving winter vaccination uptake. Schemes were targeted at groups/communities with lower uptake and will be evaluated during March and April 2025 to measure their impact and identify best practice to be shared. Data shows that flu vaccine uptake for over 65s has decreased by 4% (which is in line with national reporting) although a greater gap in uptake has been reported by Anfield and Everton PCN.

A total of 52 Liverpool Practices are taking part in the Binx PACO pilot (funded by ICB GPIT resilience funding) to test software to support modern general practice models. Progress with the roll out has been slower than expected as practices take time to develop their 'digital front door' and embed the new software, however feedback from practices has been extremely positive with 10 practices across Cheshire and Merseyside going live in February 2025 with support from ICB Digital Team and iMerseyside also in place. As part of this pilot, all PCNs have been offered Digital Clinical Safety Training.

8.6 **St Helens**

Changes to the GP Contract in 2025/26:

Details of the new contract have been published and primary care will see an increased investment into General Practice that will reduce bureaucracy and help GPs commit to greater continuity of care and supporting the health and wellbeing of patients.

In 2025/26 the Additional Roles Reimbursement Scheme (ARRS) will increase in flexibility to support PCNs to respond to their local workforce requirements, this will support further development of our PCNs and enable the recruitment of practice nurses who will be added to the ARRS scheme from April 2025. Following publication of the contract, practices will be issued with a contract variation to sign up to. The primary care team will support the implementation of the contract and ongoing monitoring of the contract requirements.

Research in Primary Care:

A St Helens Place application has been approved for 2024/25 Research Capability Funding (RCF); St Helens has been awarded a fixed amount of £3,624.00.

St Helens Research and Innovation Academy is in development and aims to build on existing infrastructure and successes to establish a leading centre for healthcare research and innovation. By leveraging local and regional resources, the Academy will enhance engagement, capacity, and impact, addressing health inequalities and improving outcomes for the St Helens population. This initiative will align with the Cheshire and Merseyside Integrated Research and Innovation System (C&M IRIS) strategy, ensuring a coordinated approach to health research and innovation across the region.

We will use the funding to host our first showcase and networking events to highlight ongoing research and innovation projects across the borough. These

events will provide a platform for researchers, clinicians, and voluntary sector organisations to connect, share successes, and inspire new collaborative initiatives. Through these events, the Academy will strengthen its role in driving collaborative and impactful research aligned with local health priorities.

Supporting Winter:
St Helens practices have participated in a winter quality improvement project which is designed to encourage practices to consider prioritising clinical reviews of our most vulnerable and at-risk patients before the winter surge, and give them best opportunity to avoid an admission, as well as easing some of the expected winter pressures felt within General Practice.

Care Quality Commission (CQC):
At the latest inspection, CQC found that one of our practices had made significant improvements and its overall rating, as well as the areas of safe, responsive, and well-led, have improved from 'Inadequate' to 'Good'. The ratings for effective and caring have gone up from 'Requires Improvement' to 'Good'.

Access:
We are continuing to support the delivery of Modern General Practice and target support to practices based on their ability to improve access and offer a good overall experience for patients. PCNs/practices continue to make improvements.

Cervical Screening:
The primary care team has been working with public health colleagues to pilot the Cervical Screening Project in Quarter 4, where the mobile clinic will visit community locations in the borough for people to be able to have their cervical screening appointments. The hope is that this removes barriers for women and makes screening appointments more accessible.

GP Collective Action:
There are few apparent significant implications from the taking of collective action to date. We have seen some withdrawal of co-operation with shared prescribing initiatives. The consultation on changes to the GP contract for 2025/26 has now concluded.

Throughout the contract consultation, we understand that the engagement with GPC England has been positive and constructive and that they are supportive of the contract changes.

8.7 **Sefton**
On 18 February 2025, South Sefton Primary Care Network (PCN) and NHS Cheshire and Merseyside were visited by senior leaders of the NHS England national and regional team to hear about the collaborative work they are doing following the PCN of the Year 2024 award win for South Sefton at the General Practice Awards in December 2024.

The NHSE National Group Director of Primary Care and Community Services, Keira Moulds, Deputy Director, GP Contract, Incentives and Planning, Linda Charles-Ozuzu, Regional Director of Commissioning, and Steven Colfar, Deputy Director of Nursing met with Deborah Butcher, Sefton Place Director, NHS Cheshire and Merseyside,

Tracy Jeffes, Interim Associate Director for Transformation and Partnerships for Sefton, NHS Cheshire and Merseyside Tom Knight, Associate Director of Primary Care, NHS Cheshire and Merseyside, Rachel Stead, Strategic PCN Manager and Dr Craig Gillespie, Clinical Director of South Sefton PCN.

The day started with an overview from Sefton Place and the PCN to set the scene, including an introduction to the ACES (Adverse Childhood Experiences) programme and mental health services. They also heard about the regeneration of the Strand Shopping Centre in Bootle which was very welcomed.

The next stop was Cambridge Family Wellbeing Centre to meet representatives from the voluntary community faiths sector, further education services and mental health services. The NHSE team then heard from some of the ACES participants who were mid-way through the programme to talk about their experiences and the impact the support they have had on them.

The final stop was the PCN's business hub where they met Dr Craig Gillespie and other PCN staff members, including those who support the Acute Respiratory Hub, Enhanced Health at Home and Care Home Programmes, the Women's Health Hub, the vaccination team, and the Learning Disability Health Check Programmes. All of whom described the success of collaborative working.

Alex Morton from NHSE national said: "Reflecting on a fantastic day in Sefton, I'm incredibly grateful for the opportunity to connect with local teams and see firsthand the great work happening. It was invaluable to hear about what's working well, the challenges you face, and the innovative ideas you're putting into practice. A special thanks to the ACE programme service users for sharing their powerful stories and to the PCN team for their insights. I'm leaving Sefton with a deep sense of trust, great relationships and community - Sefton is lucky to have such dedicated and passionate people making a real difference!"

Dr Craig Gillespie, Clinical Director of South Sefton PCN, said: "We were delighted to welcome our NHSE colleagues to South Sefton and share the fantastic collaborative work taking place across our network. It was a great opportunity to showcase the dedication of our colleagues and partners in delivering innovative, patient-centred neighbourhood health care.

"We also welcomed the chance to discuss the challenges facing General Practice and explore future opportunities for PCN innovation. We're incredibly proud of what we've achieved so far and look forward to building on this progress."

Women's Health Hub:
Services continue to develop across Sefton to reflect the requirements of the national Women's Health Hubs core specification. This includes increasing access to long-acting reversible contraception (LARC) in the community with a focus on its use for non-contraceptive reasons e.g., to manage gynecological or menopause symptoms.

Menopause services are becoming more accessible and connected. For example, Liverpool Women's Hospital is now offering community-based menopause clinics at May Logan Centre. This service is closer to home for South Sefton patients and helps to address long waiting times for services in the hospital setting. There is also a HRT prescribing service led by clinical pharmacists and a five-week lifestyle course.

Work with partners continues to gather momentum to extend the women's health offer across the borough.

8.8 **Warrington**

Warrington has 26 practices which make up our five PCNs. The PCNs and their Clinical Directors are well embedded within the Warrington Together system and are working collaboratively with each other and with partners.

Following the development of Primary Care Network Estates Strategies, Warrington Place has worked with GB Partnerships on a Place estates prioritisation exercise. Prioritisation has now been agreed by the Warrington Senior Leadership Team aligning projects to Warrington Place priorities.

The Estates Capital Funding process is also now open, the NHSE national estates team have secured several capital routes for primary care. The process has been streamlined to allow practices to initially apply on one simplified expression of interest (EOI) document, for all their estate's improvements/projects/schemes for 2025/26 and years 2-5. This process has been split into two stages:

- Firstly, the schemes will be assessed against the NHS General Medical Service - Premises Cost Directions 2024 to ensure that they meet the criteria for a grant to be offered and that all the relevant information has been submitted.
- Secondly, schemes will be submitted to the Integrated Care Board/the NHSE national estates team for final approval.

Warrington Place Primary Care Transformation Team is engaged with practices to develop plans and Warrington practices submitted a total of 13 expressions of interest from 11 Practices. Seven of these EOIs have now progressed to stage two.

8.9 **Wirral**

Wirral has six PCNs. Work is underway amongst the PCNs' Digital Transformation Leads on enabling use of CIPHA information to inform population health priorities.

Healthwatch Wirral are continuing to gather patients' insights and intelligence on Primary Care Enhanced Access and Access Recovery Plans with interim reporting due shortly.

Refinement of a Quality Scorecard is being concluded in conjunction with Place quality and safety team colleagues. This builds upon an existing scorecard that is produced for ICB System Primary Care Committee and will be included in the Place Primary Care Group agenda.

9. Provider Market Development / Strategic Initiatives

9.1 **Cheshire East**

Sustainable Hospital Services is the name of the programme that describes East

Cheshire Trust's work principally with Stockport Foundation Trust to address some of their challenges around service sustainability.

Since the case for change was supported by a wide range of partners, progress has been made in some areas (for example maternity); less progress made in others.

The original case for change has now been refreshed. The Trust has identified a new preferred option which was discussed with ICB Executives before Christmas. The planning and financial implications will be addressed as part of our preparatory work for 2025/26.

The 'Healthier Futures' is the name of the programme that will deliver a new Leighton Hospital. The strategic outline case - supported by this Board in September - is now subject to some revision and will be returning, likely to the March 2025 Board. Meanwhile, work proceeds towards presenting an outline business case in Autumn 2025. This is a very significant programme for us, with potentially wide-ranging implications. It is important that the hospital is 'right sized', and that any assumptions about wider place transformation are aligned to the resources necessary to deliver them.

9.2 **Cheshire West**

Regarding Healthier Futures (described above), Cheshire East acts as the 'lead' Place but, as Mid Cheshire also serves the Cheshire West population, members of the Cheshire West Place team are included in regular updates and membership of the Transformation Group developing the model of care.

In relation to the care home market, the Place quality and transformation teams work with colleagues in the local authority to support providers through regular provider forums, addressing queries and signposting to further support. The local authority led brokerage service is currently being evaluated to understand the impact for both the ICB and the local authority on reducing discharge delays as well as managing package costs.

9.3 **Halton**

No further update since last briefing.

9.4 **Knowsley**

Medicines Management:

Trurapi switches: Knowsley have led the way with a biosimilar switch to improve cost efficiency when prescribing certain insulins. Knowsley will take part in a national webinar sharing the success and encouraging others to follow.

'Only Order What You Need' roll out: Knowsley Medicines Management Team Technicians are now ready to start the 'Only Order What You Need' audit. This involves speaking to patients aged 70+years via telephone and asking them about their current creams / emollients. The aim of the audit is to conduct a technical review of their emollient creams / ointments whilst considering other items and opportunistically de-prescribe items no longer required.

End-of-Life Continence Project: The Knowsley Medicines Management Team

Care Home Team have had a successful bid for a project involving the review of Urology appliances used by Knowsley Care Home patients to ensure cost effective appliances are being prescribed and ordering is appropriate.

9.5 **Liverpool**

The Liverpool Clinical Services Review (LCSR) has identified opportunities to improve population health outcomes, enhance the quality and experience of patient care and support financial and clinical service sustainability through systematic collaboration in Liverpool. In response to these findings, NHS Cheshire and Merseyside ICB requested the establishment of a joint committee, the 'Liverpool Adult Acute and Specialist Providers (LAASP).' This committee includes five acute and specialist trusts in Liverpool: Liverpool University Hospitals NHS FT (LUHFT), Liverpool Heart and Chest NHS FT (LHCH), The Clatterbridge Cancer Centre NHS FT (CCC), The Walton Centre NHS FT (TWC), and Liverpool Women's NHS FT (LWH); with the unifying aim to improve patient care and outcomes whilst creating a sustainable healthcare system.

LAASP published its case for change in January 2025 and the document sets out the partnership's aims to enhance the quality and efficiency of healthcare delivery in Liverpool by adopting a 'unified approach' to providing acute and specialist care that is responsive to the evolving needs of the city's population. Over the next three years, the LAASP Joint Committee will oversee the integration of the five trusts into the University Hospitals of Liverpool Group (UHLG). This presents multiple opportunities for patients, their families, and staff to benefit from closer collaboration through LAASP and University Hospitals Liverpool Group (UHLG).

9.6 **St Helens**

Care Communities:

The PCNs are also instrumental in development of the care communities, with some real successes developing in this area:

- North PCN have now evaluated their January Care Community meeting on primary school non-attenders, with clear actions and learning which is being shared with partners. Initial feedback suggests that school attendance has started to improve in some of the cases discussed.
- Newton and Haydock PCN had their first Care Community meeting about school non-attenders in February 2025, with a focus on high schools. They discussed 12 children from both a proactive and reactive list (one referral came into the Care Community via a Health Visitor). They are in the process of evaluating this and planning their next cohort of complex patients for their next meeting in May 2025.
- Central PCN are planning their first Care Community meeting on 2 April 2025 where they will also discuss primary school non-attenders from five different schools.
- South PCN have now agreed based on learning from the other PCNs to plan their first Care Community meeting in April, focusing on high school non-attenders. Their Clinical Director is also keen to address populations within the Core 20 plus remit.

9.7 **Sefton**

No update.

9.8 **Warrington**

Integration

Bridgewater Community Healthcare NHS Foundation Trust (BCH) and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) are joining forces and working as one to improve healthcare services for our communities.

Governance arrangements have been established, including joint exec-to-exec meetings, joint Board meetings, and the creation of a steering group made up of senior representatives from both Trusts as well as system partner organisations. Initial communications have taken place internally and externally, with further routine communications and engagement activity being planned to ensure all parties feel informed and involved.

A programme has been established, called Better Care Together, which has seen the creation of eight workstreams. Each workstream has a named responsible officer from each organisation, and all have developed initial priorities for the coming six, 12 and 24 months. A steering group has also been developed to ensure key partners are involved in shaping the approach.

A key workstream is the integration of clinical services clinical pathways. An initial workshop has been held, that included key partners, at which the following services were prioritised:

- Starting Well - women, children's and family services
- Ageing Well
- UEC and discharge
- Long term conditions and prevention

An options appraisal process has also commenced, which aims to identify options, including legal mechanisms, to bring both organisations together to support and enable integration. Partners are involved in this process.

9.9 **Wirral**

Crisis Bed Redesign work:

Transformation of our existing adult crisis step down beds (also known as ERB beds) after visit undertaken to YMCA in Liverpool where they have a collaborative model with Merseycare on one site; mini-working group established between Wirral and Cheshire Places – the aim is to redeploy existing resource spent across Cheshire and Wirral.

Thorn Heys:

Appropriate Places of Care (APOC). Disused building owned by Cheshire and Wirral Partnership (CWP) to be used for a potential APOC provision. Plan is to continue developing the business proposal with further finance information.

Integrated Housing Pilot with Magenta Housing Association:

One patient is in a property, another two patients are being prepared for the next available property. The pilot is now at the stage for ongoing management between CWP and Magenta Housing Association, but all patients being considered for this project are to be agreed by the ICB to ensure it is hitting the priorities of the ICB to around financial recovery and reducing out of area placements.

Talking Therapies:
ADHD assessment pilot evaluation and potential investment/expansion - link to overall ADHD LEAP pathway.

10. Children and Young People (CYP)

10.1 **Cheshire East**
At our January 2025 Place Partnership Board, we held a session exclusively focused on children and young people with special educational needs and disabilities (SEND). This is part of preparatory work for an anticipated inspection.

10.2 **Cheshire West**
In alignment with the development of the Cheshire and Merseyside children and young people pathway for neurodiversity, work has commenced on reviewing the early help offer and how this could be further expanded in 2025/26. In addition, discussions with the local authority have commenced as to how a multidisciplinary team for neurodiversity could be delivered across partners to provide a single point of contact for schools/SENCOs.

Demand for assessment and diagnosis for ADHD/Autism continues to be high with significant waiting lists. Some additional Transforming Care funding has been secured to undertake a waiting list initiative for those awaiting assessment.

We are also continuing to work with the local authority on supporting prevention of adverse mental health in children and young people and their families.

10.3 **Halton**
In response to Halton families raising that they would like more information about Tics and Tourette's, Halton and Warrington Places have arranged for Tourette's Action to provide three online workshops during March 2025 (one for parents and carers; one for health and social care professionals and one for education professionals).

A workshop was undertaken in February 2025 to consider MDT arrangements that will be needed to support children and young people that receive a neurodevelopment needs assessment profile when the "Portsmouth Model" pilot commences. The workshop clarified the role of the MDT and shaped further planning that will be required to implement an MDT around the children with profiles.

The Halton Place team has agreed with Halton Borough Council to undertake a focused piece of work on children and young people's emotional health and wellbeing. This will seek to better understand need and the current and future provision required to meet that need. Halton will work with those Places that are meeting the children and young people access target to inform its own improvement actions. Halton Borough Council have introduced a "Thrive" offer in schools that will support with early intervention and should help prevent escalating need for some children. These contacts do not count towards Halton contact

activity but do support meeting children and young people emotional health and wellbeing needs.

10.4 **Knowsley**

Safeguarding Children:

An Ofsted Inspection of Knowsley Local Authority Children's Services took place between 18-29 November 2024. A summary of the report findings is below.

- The impact of leaders on social work practice with children and families: Inadequate.
- The experiences and progress of children who need help and protection: Inadequate.
- The experiences and progress of children in care: Requires Improvement to be Good.
- The experiences and progress of care leavers: Inadequate.
- Overall effectiveness: Inadequate.

The ICB are part of the improvement board set up because of the inspection.

10.5 **Liverpool**

During Children's Mental Health week (3-9 February 2025) more than 300 children and young people took to the stage of St George's Hall Concert Room for Liverpool's tenth annual 'NOW Festival' (https://www.liverpoolcamhs.com/children-young-people/now-festival-celebrates-ten-years/)

Over three evenings, audiences were treated to powerful performances revisiting themes from previous years, including education, violence prevention, belonging, and Adverse Childhood Experiences (ACEs) - all through a mental health lens. This is a jointly funded placed-based collaboration between the ICB (Liverpool Place), Liverpool City Council, Liverpool Learning Partnership and Violence Reduction Partnership (VRP) and led through the children and young people Mental Health Partnership. The positive impact on improving awareness of mental health and access to services has been evidenced over the last 10 years https://nowfestliv.com/

As part of the work to improve support for children and young people with complex and multiple needs, Liverpool City Council have recently submitted an application to source capital funding for an Appropriate Place of Care (APOC). This has been supported by the ICB and wider mental health partners. Work to strengthen mental health pathways and improve access for transgender children and young people, or those questioning their gender, has been developing with the local offer now defined and promotional material produced (which will be disseminated widely). Workforce development and awareness about children and young people's mental health continues to focus on the local offer and a range of topics. The most recent development, 'Emotionally Based School Avoidance' has been very well attended. Although demand continues to be high across all children and young people's mental health services, access is improving and we continue to exceed our target for 2024/25.

Alder Hey's Neurodiversity (ASD/ADHD) Transformation Programme is continuing across Liverpool and Sefton, with additional funding sourced through

Transforming Care to help manage waiting lists across both areas. Further funding was also secured to develop waiting list workshops with children and young people and families to improve engagement and awareness about the local offer across Liverpool and Sefton. Spectrum Gaming has also recently been commissioned (in partnership with St Helens Place) to provide an additional offer to children and young people known to the Dynamic Support Keyworkers.

In response to the newly published national guidelines on the development of Neighbourhood MDTs for children and young people, Liverpool Place has met with key partners to explore how the guidance can be evaluated and mobilised in the coming months. These discussions included a consideration of best practice models that already exist and collaboration with the VCSE.

The children and young people asthma diagnostics pilot is currently working well within one PCN, and there are plans to extend this across the city. In response to the new NICE Asthma Diagnostic Guidelines, work is underway to implement a consistent, measurable model of care between primary and secondary care.

There is also a North Mersey focus on paediatric UEC systems, with a view to improving the flows throughout primary care and alleviating the pressure in the acute sector.

10.6 **St Helens**

Tackling Health Inequalities:

The Warm Homes for Young Lungs Project will be delivered from Parr Children's Centre every six weeks from the 15 April 2025. This is to provide equity of service, as we know from consultation conducted by the Family Hubs, that 50% of the Parr residents decline to leave Parr to attend appointments and Parr is one of St Helen's most deprived wards.

The Warm Homes for Young Lungs offer includes a children's respiratory clinic which is by invitation to appointment only and patients are identified using the CIPHA (Combined Intelligence for Population Health Action) system. It also offers patients access to the affordable warmth team, Breathe Buddies and Healthy Air for Healthy Lungs team. The offer at Parr expands on this to also include Social Prescribers and smoke free homes, and all except from the clinic will be available as a drop in for residents.

Maternity:

A new Maternity Alliance group has been set up to address the factors reported in the CDOP (Child Death Overview Panel) report, services are brought together to develop actions for improvement to the offers made and a marketplace event is being planned for April 2025 to be held at Lowe House Health Hub.

Cheshire and Merseyside (C&M) Neurodiversity Workstream:

C&M ICB Commissioning Intentions for NDP shared with Place leads who are now socialising this with wider partners. Work is ongoing in St Helens to prepare locally for adopting Profiling Tool. St Helens is also leading on developing a Digital Solution for neurodiversity with a draft specification prepared and being used to consult with various stakeholders. Exploratory conversations between St Helens ICB team, Mersey Care NHS Foundation Trust and Mersey and West

Lancashire Trust on commissioning intentions for a single provider pathway.

Transforming Care Programme (TCP):
Intensive Support Function (ISF) which will provide targeted support to children and young people on the Dynamic Support Database (DSD) is mobilising and set for an initial launch in Q1 2025/26; the intention for the service is to go live in phases, testing and changing initially to inform the eventual full-service model. No St Helens children and young person on the DSD have been admitted to hospital and thus far being supported in the community - in February partners from the St Helens TCP group undertook a Lessons Learned session on a case study and identified a series of recommendations that will be shared with system partners.

Wellbeing in Schools:
Carr Mill Primary School have recently been awarded the SEL (Social Emotional Learning) Worldwide Model School Status for their implementation of PATHS (Promoting Alternative Thinking Strategies) as well as a Gold Award Standard for Mental Health in Schools. Lyme Primary have also achieved the SEL Worldwide Model School Status for their implementation of PATHS within Q4 2024/25.

10.7 **Sefton**

Support for Ofsted re-inspection by Safeguarding Children's Partnership:
Preparation for Ofsted re-inspection has commenced in Sefton, following a series of monitoring visits. In April 2024, the Minister for Children Families and Wellbeing directed the local authority to act on the report and recommendations from Sefton's Commissioner for Children's Services. There is a requirement of the partnership to address four recommendations as part of the Ministerial directive.

The partnership is meeting monthly to review data and Annex A submissions, in preparation for the next full inspection now anticipated in March 2025.

A presentation was shared at Sefton Delivery Group on 18 February 2025 to highlight inspection process, key lines of enquiry and expectations of staff once inspection is announced.

The Associate Director of Quality and Safety Improvement reported into the Improvement Board on 27 February 2025 on progress made in addressing multi-agency audit findings by partners on themes relating to harm outside the home, step up and step down and pre-birth assessments. The commissioner advised Ofsted is conducting a site visit on 6 March 2025, so can expect re-inspection from 10 March 2025.

SEND Inspection:
Sefton are anticipating a SEND inspection before the end of Q2 2025/26. In 2016 Sefton historically was rated as Inadequate, a notice of improvement was received in 2019 due to lack of progress against actions. The notice of improvement was lifted in June 2021 following significant progress made to evidence improvements.

Sefton Place are supporting the partnership with preparations for SEND

inspection. Partnership governance and reporting arrangements are in place with Place leads reporting into the SEND Improvement Board (SENDCIB) supporting the inspection preparedness meetings with evidence against the SEF and Annex A.

10.8 **Warrington**

Warrington received visits from the DFE/NHSE in November 2024 and subsequently OFSTED in December 2024 to review progress against SEND recovery plans following the 2023 SEND Inspection. The ICB and Warrington Borough Council, in partnership with Warrington Parents and Carers, provided a detailed overview of progress against plans and improvements made to the respective bodies. Overall feedback was positive and highlighted by the DFE as remarkable given the challenges education, health and care faced against the backdrop of significant increase in demand.

Warrington's Complex Needs Hub is planned scheduled for a phased opening in March 2025 and is the first of its type across Cheshire and Merseyside, supporting the wider plans for 'Appropriate Places of Care' for our most vulnerable children and young people.

Warrington Place continues to be on target for 2024/25 to meet the nationally mandated NHSE 'Access and Wait Time Standards' for children and young people's mental health services.

Work is ongoing with Bridgewater Community Healthcare Trust to improve access and wait times to diagnoses and treatment for children and young people on the Neurodevelopmental Pathway. Plans are in place to support the risk stratification of the current wait list and harm reviews are undertaken to ensure that risks are mitigated, and patients prioritised for assessment. Appropriate support is provided to ensure that patients and families/carers are supported whilst waiting.

10.9 **Wirral**

Children and young people neurodevelopment:

A three-year plan has been developed to support the reduction of waiting times and ensure a needs led and multi-disciplinary approach to triage and assessments. A multi-disciplinary neurodevelopment team is being developed which includes community paediatricians, specialist nurses and speech and language therapists.

The new model recognises the importance of early identification of needs and provision of support. A new Profiling Tool, developed by Portsmouth Neurodevelopment Service, is being rolled out nationally. Wirral are an early adopter of the Profiling Tool and are currently in phase one of the roll-out working with schools and early years settings across Wirral with full implementation planned during 2025. The tool supports early identification and help for children and young people presenting with neurodevelopmental needs.

11. Use of Resources

11.1 **Cheshire East**

At the end of Month 10, Cheshire East Place reported a deficit of £51.7m, which is £8.4m more than the planned deficit of £43.3m. The predicted deficit at the end of the financial year is £61.4m, which is a £9.4m adverse variance to the planned deficit of £52m. Note that there is £800k improvement than the previously reported period.

In terms of spending that can potentially be influenced, continuing healthcare is our principal focus. We have identified cost improvement opportunities by reducing the number of one-to-one packages of care, and by a more robust approach to price negotiation and this is continued to be delivered by the teams alongside actively working in conjunction with the broader recovery programme in this area. At the same time, demographic pressures remain, and it is important that budgets are set at a realistic Place appropriate level.

Cheshire East Place has delivered £6.7m worth of savings compared to the £7.3m that was included as part of the financial plan, of which £6.7m is recurrent. However, it should be noted that Cheshire East Place has delivered all these savings recurrently and is forecasting that £8.7m of the £13.2m planned savings target will be delivered recurrently by the end of the financial year, with a further £3.3m delivered non-recurrently.

11.2 **Cheshire West**

At the end of Month 10, Cheshire West Place reported a deficit of £38.9m, which is £3.3m over the planned deficit of £35.6m.

The predicted deficit at the end of the financial year is £47.0m, which represents a £4.3m adverse variance to the planned deficit of £46.7m. A review of potential risks and mitigations has identified a potential further net deterioration of £1.6m, and therefore the risk adjusted forecast outturn is a projected deficit of £48.6m which is a £5.9m adverse variance to plan.

Cheshire West Place has delivered £6.0m worth of savings year to date compared to the £6.9m year to date that was included as part of the financial plan. However, it should be noted that Cheshire West Place is indicating that £8.0m savings will be delivered by the end of the financial year. Additional recovery plans are also being developed to mitigate the known risks but there remains a risk that these may not be fully mitigated.

11.3 **Halton**

At the close of Month 10, Halton reported a year-to-date deficit of £9.6m (representing a £1.6m adverse variance from plan), with a forecast outturn deficit of £11.7m (a £2.4m adverse variance from the full-year plan). The main drivers of this adverse financial performance continue to be cost pressures within:

- All Age Continuing Healthcare - particularly in relation to adult fully funded and fast-track packages which jointly account for £1.7m and £2.1m of the year-to-date and forecast outturn overspend.
- Mental health packages of care - specifically in respect of Mental Health Act placements (where the forecast outturn overspend has increased to £1.6m from £1.3m in Month 8) and complex Learning Disability packages (which

remains forecast to outturn at £0.6m over-budget).

- Prescribing – where prescribing cost are now projected to exceed budget by £0.8m.

In addition, Halton's revised position in terms of further risks not included within the reported positions has improved from £0.7m net risks in Month 8 to £0.1m net mitigation at the end of Month 10. This has largely been afforded by further management of local risks in relation to required SEND, Community Paediatrics and Paediatric Speech and Language Therapy services improvement measures as well as principal mitigations such as the expected Section 75 Pooled Budget underspend (estimated at £0.3m), in-year savings on the transfer of Learning Disability Nursing (£0.13m) and projected savings from the Prescribing Waste Mitigation initiative (£0.2m).

As previously, the scope for identifying further cost saving opportunities likely to have an in-year impact significantly diminishes towards the close of the financial year. The focus of the Halton Place team for the remainder of the financial year therefore remains on containing the outturn position currently forecast against further demand/acuity cost pressures, including through robust validation/ challenge of invoices received and close working with Halton Borough Council in respect of joint and aligned budgets.

11.4 **Knowsley**

At the end of Month 10 (January 2025), Knowsley reported a surplus of £9.2m, which is a £0.7m adverse position to the planned surplus of £9.9m for periods to date.

The predicted surplus at the end of the financial year is £11.2m, which is £0.7m below the planned surplus of £11.9m.

Knowsley has delivered £3.1m worth of efficiency savings, in line with the planned levels to date, and projections are that the full efficiency plan (£3.4m) will be delivered by the end of the financial year.

11.5 **Liverpool**

At the end of Month 10, Liverpool Place deficit was £0.222m which is £9.064m above the planned surplus of £8.842m and reflects an adverse position.

The predicted deficit at the end of the financial year is £1.939m, which is £12.549m above the planned surplus of £10.6m. A review of potential risks and mitigations are being reported in the financial position for Month 10.

Liverpool Place has delivered £7.2m worth of savings compared to a plan of £9.8m. Liverpool Place is indicating a slight underachievement of £0.587m of the full efficiency plan of £11.9m will be delivered by the end of the financial year.

11.6 **St Helens**

At the end of Month 10, St Helens Place reported deficit was £11.9m, which is a £2.7m adverse position to the planned deficit of £9.3m.

The predicted deficit at the end of the financial year is £14.5m, which is £3.4m

adverse to the planned deficit of £11.1m. This is a slight deterioration from the position reported at Month 8 by £0.2m, mainly due to increasing adult CHC costs.

However, the net of potential risks and mitigations has improved by £0.4 but still shows a potential further net deterioration of £1.5m to that position – primarily related to the GP prescribing budget and increasing CHC costs, and therefore the risk adjusted deficit is projected to be £16.0m.

For the 5% planned cost reductions, St Helens Place has delivered £3.3m worth of savings compared to a plan of £4.1m, which is an adverse variance of £0.7m. This adverse position is mainly related to AACC savings plans due to staff shortages and IT system transition. The St Helens team are continuing to try and identify further cost reduction opportunities as part of the financial recovery and hope to report an improved position as the year progresses.

11.7 **Sefton**

At the end of Month 10, the Sefton Place financial position was a deficit of £17.2m which is £9.4m above the planned deficit and reflects an adverse position.

The predicted deficit at the end of the financial year is £18.7m which is £9.9m above the planned deficit of £10.5m. A recovery plan which identified cost reductions of £12m was agreed and implemented during the year, £4.7m recovery savings have been achieved to date but there is further work required to address the remaining savings required. Cost pressures also continue to increase, which impacts the overall financial recovery.

The overall financial position is significantly overspent compared to plan and remaining recovery savings identified will not reduce expenditure sufficiently to deliver the agreed financial plan.

In respect of the agreed efficiency target included in the financial plan for 2024/25, Sefton Place has reported £5m worth of savings within the Month 10 position and is on target to achieve the full efficiency plan of £7.795m by the end of the financial year.

11.8 **Warrington**

At the end of Month 10, Warrington Place's reported deficit was £3.4m, which is £0.4m favourable to the planned deficit of £3.8m for periods to date.

The predicted deficit at the end of the financial year is £4.0m, which is £0.6m below the planned deficit of £4.6m. At this stage of the financial year, risks against the forecast outturn position are balanced with mitigating measures to provide assurance on delivery.

Warrington Place has delivered £4.8m worth of efficiency savings year to date, compared to a plan of £3.7m (£1.1m favourable). With anticipated annual savings of £5.9m against a plan of £4.5m (£1.4m favourable).

11.9 **Wirral**

At the end of Month 10, Wirral Place deficit was reported as £26.8m which is £9.5m above the planned deficit of £17.3m and reflects an adverse position.

The predicted deficit at the end of the financial year is £34.4m which is £13.7m above the planned deficit of £20.7m.

Wirral Place has delivered £6.5m worth of savings compared to a plan of £7.3m which is an adverse variance of £0.8m. Wirral Place is predicting that £8.6m worth of savings will be delivered before the year end compared with a plan of £8.8m, which equates to an adverse variance of £0.2m.

12 Officer contact details for more information

Mark Wilkinson, Cheshire East Place Director
Mark.Wilkinson@cheshireandmerseyside.nhs.uk

Laura Marsh, Cheshire West Place Director (Interim)
Laura.Marsh@cheshireandmerseyside.nhs.uk

Anthony Leo, Halton Place Director / Acting Liverpool Place Director
Anthony.Leo@cheshireandmerseyside.nhs.uk

Alison Lee, Knowsley Place Director
Alison.Lee@cheshireandmerseyside.nhs.uk

Deborah Butcher, Sefton Place Director
Deborah.butcher@cheshireandmerseyside.nhs.uk

Mark Palethorpe, St Helens Place Director
Mark.Palethorpe@sthelens.gov.uk

Carl Marsh, Warrington Place Director
Carl.Marsh@cheshireandmerseyside.nhs.uk

Simon Banks, Wirral Place Director
Simon.Banks@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Cheshire and Merseyside Cancer Alliance Update Report

Agenda Item No: ICB/03/25/10

Responsible Director: Professor Rowan Pritchard-Jones, Medical Director

Cheshire and Merseyside Cancer Alliance Update Report

1. Purpose of the Report

1.1 To update the Board on the Cheshire and Merseyside Cancer Alliance's progress to improve cancer outcomes for the population, and to present a summary of the Alliance's workplan for 2025/26.

2. Executive Summary

2.1 Cheshire and Merseyside Cancer Alliance oversees the improvement of cancer outcomes for the population of Cheshire and Merseyside on behalf of the ICB.

2.2 In recent years, cancer outcomes have improved at a faster rate in Cheshire and Merseyside than for England as a whole. Just five years ago, early stage diagnosis rates for our population were amongst the lowest in the country. Now they are amongst the best. Cancer survival rates in Cheshire and Merseyside have historically lagged behind the England average, but they are now significantly above.

2.3 Cancer waiting times are coming down too. Cheshire and Merseyside has some of the shortest referral to treatment times for cancer in England.

2.4 But there is still more work to be done. We are still some way off meeting the national ambition to diagnose 75% of all cancers at an early stage by 2028. Cancer survival rates, whilst comparing well to England, compare less well internationally. And cancer incidence is higher in our population than the national rate, meaning that more people get cancer in Cheshire and Merseyside in any given year per 100,000 population. Indeed, if our incidence rate was the same as England's, 2,000 fewer people would get cancer in Cheshire and Merseyside each year. Our higher incidence is highly likely to be linked to our region's high levels of deprivation and suggests a greater need to focus on prevention as well as earlier diagnosis and treatment.

2.5 This report explores cancer outcomes in greater detail and also provides a summary of the Cancer Alliance's workplan for the year ahead.

3. Ask of the Board and Recommendations

3.1 The Board of NHS Cheshire and Merseyside is asked to:

- note the contents of this report and
- support the continued efforts of all system partners, coordinated by the Cancer Alliance, to further improve outcomes for cancer patients.

4. Officer contact details for more information

Jon Hayes, Managing Director, Cheshire and Merseyside Cancer Alliance

John McCabe, Medical Director, Cheshire and Merseyside Cancer Alliance

Cancer Report

Cheshire and Merseyside Cancer Alliance

NHS Cheshire and Merseyside
Board Meeting
27th March 2025

Cheshire and Merseyside Cancer Alliance

NHS

Contents

1. Executive Summary

Cheshire and Merseyside Cancer Alliance oversees the improvement of cancer outcomes for the population of Cheshire and Merseyside on behalf of the ICB.

In recent years, cancer outcomes have improved at a faster rate in Cheshire and Merseyside than for England as a whole. Just five years ago, early stage diagnosis rates for our population were amongst the lowest in the country. Now they are amongst the best. Cancer survival rates in Cheshire and Merseyside have historically lagged behind the England average, but they are now significantly above.

Cancer waiting times are coming down too. Cheshire and Merseyside has some of the shortest referral to treatment times for cancer in England.

But there is still more work to be done. We are still some way off meeting the national ambition to diagnose 75% of all cancers at an early stage by 2028. Cancer survival rates, whilst comparing well to England, compare less well internationally. And cancer incidence is higher in our population than the national rate, meaning that more people get cancer in Cheshire and Merseyside in any given year per 100,000 population. Indeed, if our incidence rate was the same as England's, 2,000 fewer people would get cancer in Cheshire and Merseyside each year. Our higher incidence is highly likely to be linked to our region's high levels of deprivation and suggests a greater need to focus on prevention as well as earlier diagnosis and treatment.

This report explores cancer outcomes in greater detail and also provides a summary of the Cancer Alliance's workplan for the year ahead.

2. Introduction

Cheshire and Merseyside Cancer Alliance (CMCA) is an NHS organisation that brings together healthcare providers, commissioners, patients, cancer research institutions and voluntary and charitable sector partners to improve cancer outcomes for our local population, including the Isle of Man[1].

The Alliance is funded by, and accountable to, the national cancer programme within NHS England. The Alliance is hosted by The Clatterbridge Cancer Centre NHS Foundation Trust on behalf of NHS England and the Cheshire and Merseyside integrated care system.

Our four main responsibilities are

1. To deliver the NHS Long Term Plan objectives for cancer, including the ambition that, by 2028, 75% of cancers will be diagnosed at stages 1 and 2

2. To reduce unwarranted variation in care, access, patient experience and outcomes

3. To improve performance against cancer waiting times standards

4. To support innovation and safeguard the long-term sustainability of cancer services

The Alliance was established in 2017 and has developed into one of the most mature cancer alliances in England, with an experienced central team, clear governance and a robust organisational structure. The Alliance provides system leadership for cancer – coordinating, supporting and amplifying the work of the local NHS and partner organisations.

This report provides an update on the Alliance's progress to improve cancer outcomes, patient experience and operational performance. It also presents a brief summary of the key priorities within the Alliance's workplan for the NHS planning year commencing on 1st April 2025.

The year ahead presents both opportunities and challenges for the Cancer Alliance. The publication of the Government's 10-year plan for health is due in the spring, and a commitment has been made

[1] The Isle of Man is a self-funding member of the Cancer Alliance. The island's health services are independent of the NHS but look to Cheshire and Merseyside for specialist cancer services and service improvement advice.

to publish a new national strategy for cancer shortly afterwards. This is encouraging and signals an ongoing commitment to maintain a focus on improving cancer outcomes as a key NHS priority.

However, the national funding available to cancer alliances in 2025/26 will be 25% less than was available in the previous year.

Whilst the reduction in funding presents challenges, the stability and maturity of Cheshire and Merseyside Cancer Alliance will allow it to continue to drive forward improvements in cancer outcomes in line with current national objectives, albeit with some risks to the pace of delivery.

The last twelve months have seen many positive achievements, and important milestones have been met. Most notably, for the first time ever, Cheshire and Merseyside's long-term cancer survival rate has surpassed the national average. Early-stage diagnosis of cancer also continues to improve, and CMCA is rolling out the new national lung cancer screening programme faster than any other area in the country.

The Alliance won two prestigious national awards in 2024. In September, CMCA's community partnerships programme was crowned Community Care Initiative of the Year at the HSJ Patient Safety Awards. This initiative is a partnership with local Community and Voluntary Service organisations, engaging communities through grassroots organisations to increase awareness of early diagnosis of cancer and increase uptake of cancer screening programmes.

In November 2024, the education and career framework developed for the cancer assistive and supportive workforce (such as cancer support workers) won another HSJ award for the Workforce Initiative of the Year.

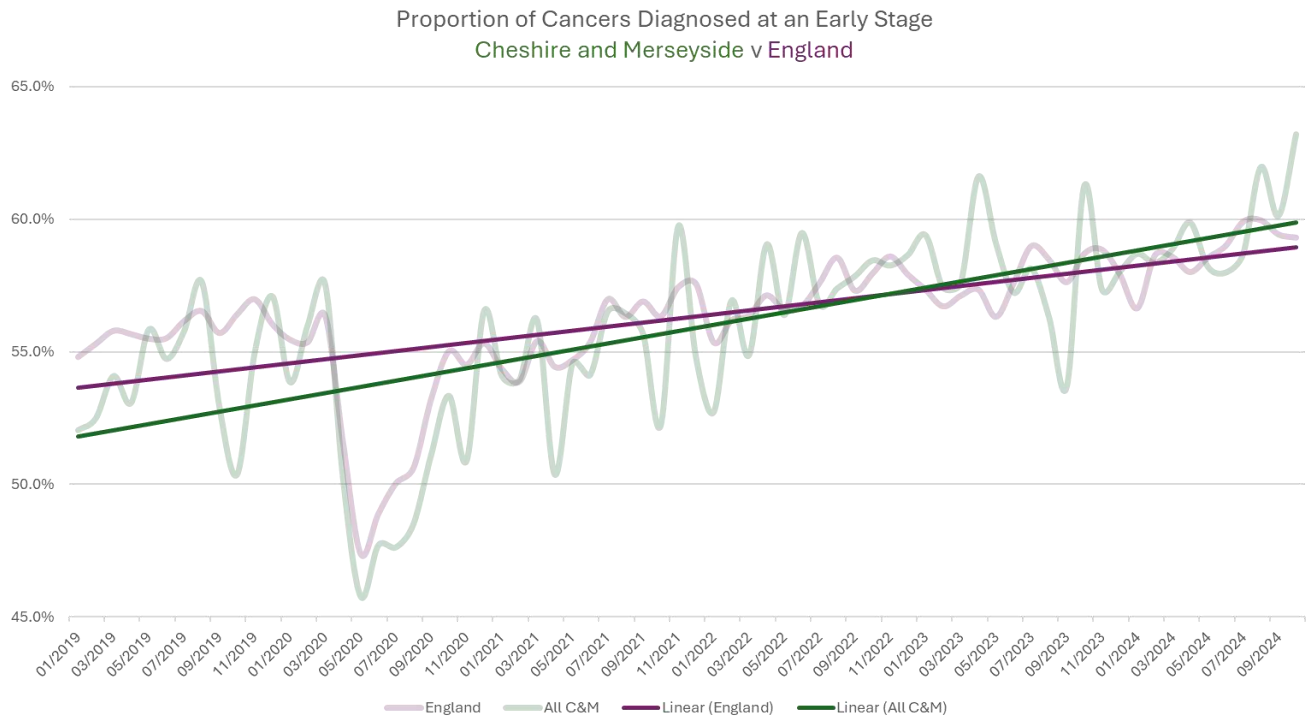
At the Cancer Alliance board meeting on 17th March 2025 board members thanked Dr Liz Bishop for her leadership of the Alliance as chair of the board and senior responsible officer (SRO). Dr Bishop, who is the chief executive of The Clatterbridge Cancer Centre NHS Foundation Trust and Liverpool Heart and Chest NHS Foundation Trust, is retiring from the NHS at the end of March. The board welcomed Joan Spencer, interim chief executive of The Clatterbridge Cancer Centre, as the Alliance's new chair and SRO.

3. Cancer Outcomes

3.1. Early Diagnosis of Cancer

The NHS Long Term Plan[2] set an ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 would rise to 75%. In 2018, the year before the Long Term Plan was published, early diagnosis rates in Cheshire and Merseyside were significantly below the national average. Out of 21 cancer alliances in England, Cheshire and Merseyside had the second lowest proportion of cancers diagnosed at stages 1 and 2.

In recent years, early diagnosis rates have improved at a faster pace in Cheshire and Merseyside than in many other parts of the country. CMCA is now ahead of the England average and ranks 8th best out of 21 cancer alliances. For the latest three month period (Q3 2024) CMCA's early diagnosis rate for all cancers combined was 60.9%, compared to England at 59.7%.



For the four most common cancers, CMCA has significantly better early diagnosis rates for breast (88.8%) and lung (43.2%) compared to England, and statistically similar rates for colorectal (46.7%) and prostate (55.4%).

[2] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

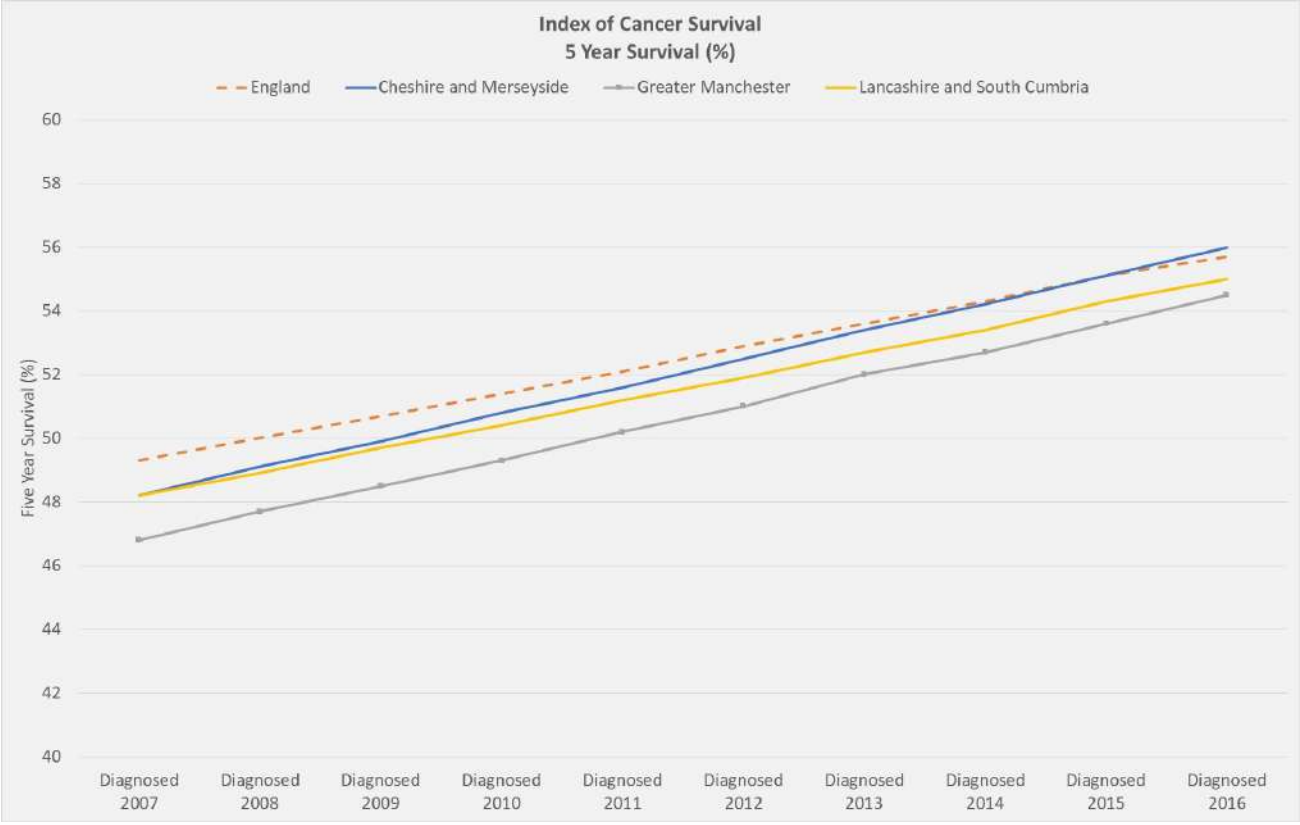
Cheshire and Merseyside's progress on early diagnosis is attributed to the introduction of lung cancer screening, improved surveillance of individuals at high risk of cancer, and successful awareness campaigns and community action.

The Alliance is currently refreshing its early diagnosis strategy with the intention of maintaining progress towards meeting the 75% ambition for 2028.

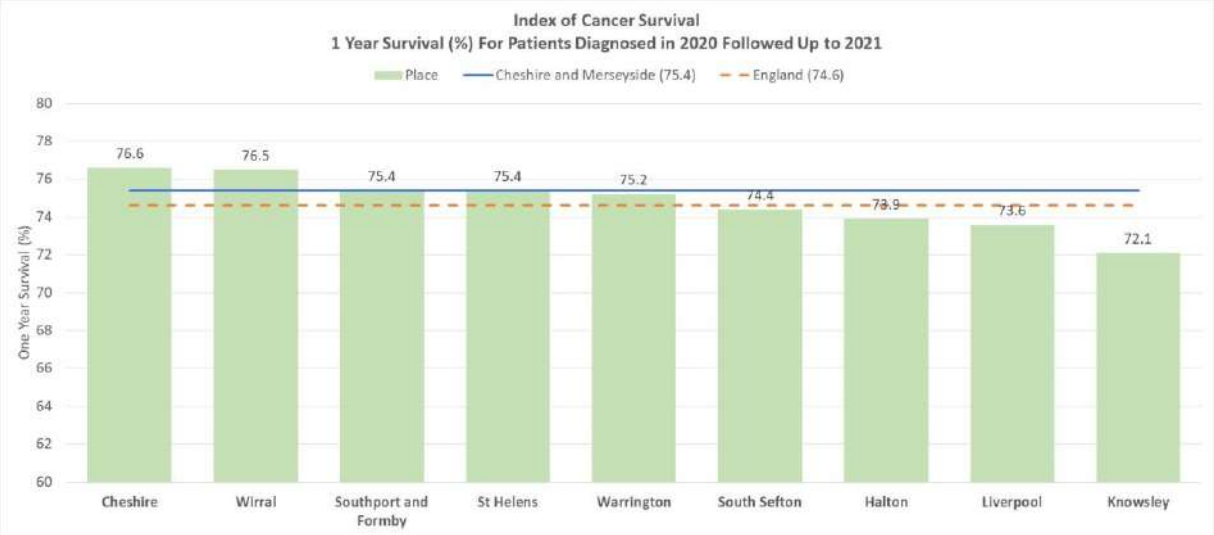
3.2. Cancer Survival

Historically, cancer survival rates in Cheshire and Merseyside have been significantly poorer than the national average. Other parts of the North West and the north of England have also experienced below-average survival rates.

However, Cheshire and Merseyside's survival rates have been improving marginally faster than the England average. One-year cancer survival in CMCA surpassed the national average several years ago, and the latest data show that five-year cancer survival is now also above the national average.



Whilst one-year and five-year survival rates are now better in Cheshire and Merseyside than the England average, there is variation across the nine former-CCG footprints. Patients diagnosed in 2020 and followed-up in 2021 in Cheshire, Wirral, Southport and Formby, St Helens and Warrington had one-year survival rates above the national average, whereas those living in South Sefton, Halton, Liverpool and Knowsley had rates lower than England. Since 2020, significant efforts have been made to address inequalities in these areas. The greatest improvements in early diagnosis have occurred in these neighbourhoods and this is expected to translate into improved survival rates shortly.

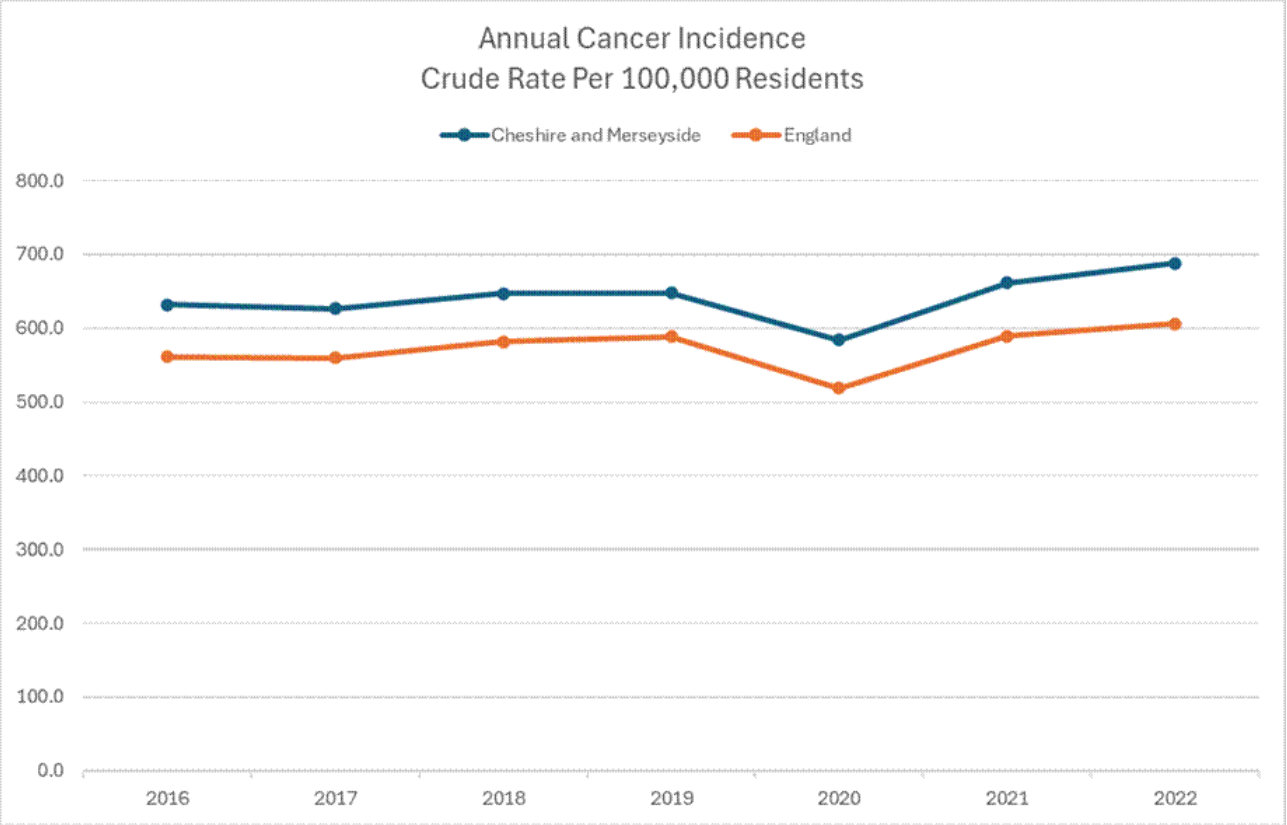


Nationally, survival rates are poorer for cancers of the brain, lung, liver, pancreas, stomach and oesophagus. Locally, one-year survival rates for liver, lung, pancreas and stomach are higher in our region than the England average, with oesophageal and brain cancers being about the same. At the present time, our population's five-year survival rates for the six less-survivable cancers are almost identical to the rates seen across England as a whole.

3.3. Cancer Incidence and Prevalence

Whilst local early diagnosis and survival rates have improved over recent years and are now ahead of the England average, it remains a fact that proportionately more people are diagnosed with cancer in Cheshire and Merseyside than across the country as a whole.

Cancer incidence, as measured by the number of people diagnosed with cancer each year per 100,000 residents, is approximately 10% higher in CMCA. This gap has largely remained unchanged for a decade.



In 2022, there were 17,556 confirmed cancer cases in Cheshire and Merseyside. If the non-standardised incidence rate was the same as England, there would have been 15,460. In other words, an annual excess incidence of approximately 2,000 cases per year.

The causes of this excess incidence will be multiple but is almost certainly linked to higher levels of deprivation. Twenty-three percent of neighbourhoods in Cheshire and Merseyside are in the 10% most deprived neighbourhoods in England.

Relatively high incidence combined with improving survival rates is leading to a growth in the number of people living with a cancer diagnosis. It is estimated that there are 111,000 people living with cancer in Cheshire and Merseyside, up from 100,000 five years ago and predicted to be 124,000 by 2040.

4. Patient Experience and Health Equity

For the second year running, patients in Cheshire and Merseyside rated their cancer care higher than anywhere else in England, giving an average score of 9.01 out of 10.

The Cancer Alliance has a dedicated health inequalities and patient experience team who ensure that patients' and carers' voices are heard and their experiences inform the design, delivery and improvement of cancer services.

The Alliance has an active programme to recruit and support patient representatives from diverse backgrounds. Individuals are able to contribute in different ways. We have around 50 patient representatives who attend Alliance meetings and work alongside project managers and clinical teams to advise and inform service improvement activities. Others volunteer as members of our Readers' Panel who read draft patient information documents and comment on readability. And we have a number of Storytellers who are helping us to build a library of lived experiences to share with staff at the beginning of meetings and events to ensure that patients remain at the centre of our thoughts and work.

Each year the Cancer Alliance holds a series of roadshows in various busy locations such as shopping centres and car boot sales to speak to a wider cross-section of the public to gather their views on various aspects cancer. In 2024, the roadshows visited six locations across Cheshire and Merseyside and spoke to several hundred members of the public, 239 of whom completed a survey. The results from the survey included the following headlines:

- 71% said that they would go to a GP as their first place for health advice
- 86% said that they had all of their questions answered at their last GP appointment
- 85% said that they would be willing to travel to be seen sooner
- 89% said that they would attend a lung health check as part of the lung cancer screening programme if invited

Listening to the experiences of members of our community is key to identifying and understanding health inequalities. However, all too often health and social care staff lack the confidence to address inequalities – and often believe that it is someone else's job, not theirs. For this reason, the Cancer Alliance has developed the 123 Approach which provides training, resources and support to empower staff to take a bite-sized approach and 'change one thing'.

Since its launch in 2024, CMCA's 123 Approach has been adopted by 41 NHS trusts and 12 cancer alliances.

5. Operational Performance and Patient Safety

Performance against the national cancer waiting times standards improved through 2024/5 compared to the previous year. Cheshire and Merseyside's performance against the 31 day and 62 day standards is amongst the best in England.

Between April and December 2024, average 62 day performance in Cheshire and Merseyside was 74.9%, significantly above the England average of 68.0% and the national planning expectation of 70% by March 2025, although below the 85% constitutional standard.

For the same period, C&M's performance against the 31 day standard was 94.0% compared with England's 91.1%.

Performance was more challenged, however, against the 28 day faster diagnosis standard. Between April and December 2024, average 28 day performance in C&M was 73.6% compared with 76.1% nationally.

Standard	C&M April – Dec 2024	England April – Dec 2024	C&M/England comparator
28 day faster diagnosis std	73.6%	76.1%	-2.5%
62 day cancer waiting times std	74.9%	68.0%	6.9%
31 day cancer waiting times std	94.0%	91.1%	2.9%

A comparison of treatment activity between the 12 months up to December 2024 and the previous 12-month period shows growth across all modalities. The number of first definitive surgical treatments rose by 7%, radiotherapy treatments rose by 6% and systemic anti-cancer treatments (including chemotherapy) were 6% higher than the previous 12 months.

The volume of urgent suspected cancer referrals, however, reduced by 1%, with a significant reduction in lower gastrointestinal referrals since the successful introduction of faecal immunochemical testing (FIT) masking a rise in referrals for other suspected cancers especially skin.

Over the last 18 months, the Alliance has developed a process to receive and review patient safety incidents that involve cancer patients, to identify and share learning across cancer teams. This process is coordinated with NHS Cheshire and Merseyside's patient safety team and complements the national patient safety incident response framework (PSIRF).

6. Work Programme 2025/26

Each year, the Cancer Alliance oversees a comprehensive portfolio of programmes designed to reduce cancer inequalities and improve overall cancer outcomes. The NHS operational planning guidance sets out objectives for cancer annually and the Alliance responds by constructing a detailed plan which is signed off by NHS England North West Region and the national cancer programme within NHSE.

The sections below provide a brief summary of the key elements of the Cancer Alliance's delivery plan for 2025/6.

6.1. Performance Improvement

In-depth review methodology, developed by CMCA, will continue to be used across providers to clearly identify pathway delay reasons. Improvement plans in a common format have been developed for each provider and include performance improvement actions across all tumour sites and headline standards. Tumour-site trajectories have been developed which aggregate up to the agreed trust trajectories supplied as part of the 2025/26 operational planning.

A Cancer Intelligence Strategy has been developed across Cheshire and Merseyside which will use ICB data warehousing to build all system cancer reporting and include new data flows at patient level to link diagnostic waiting lists and cancer patient tracker lists (PTL) for the first time in real time. This will begin to be operationalised with initial use cases by Q4 and will allow predictive modelling and analysis to support the use of community diagnostic centres (CDCs) for cancer pathways, single-queue diagnostics (in collaboration with Greater Manchester Cancer Alliance) and responsive capacity planning. This strategy will also support activities such as enhanced case finding to support primary care to improve early diagnosis and population characterisation and segmentation to ensure intelligence-driven performance and early diagnosis interventions.

6.2. Early Diagnosis and Prevention

Whilst good progress has been made to improve early diagnosis rates across Cheshire and Merseyside there is still considerable work to be done to meet the national ambition of diagnosing 75% of cancers at stage 1 or 2 by 2028.

In 2025/26 the Alliance will continue to roll out the lung cancer screening programme (LCS, formerly known as targeted lung health checks, TLHC). The programme will extend to north Sefton

this year, and then to Cheshire in 2026/7 to complete full population roll-out well ahead of the national target (2029).

To improve lung cancer detection in non-smokers, CMCA has commissioned the Liverpool Lung Project to undertake a feasibility study into the development of a risk stratification tool for the identification of lung cancer in this population. This project will both review existing datasets and review factors in newly diagnosed patients across Cheshire and Merseyside. Between 10% and 15% of all UK lung cancers occur in non-smokers and this population is currently not included in the lung cancer screening programme. This will be a two-year project commencing in April 2025; however, it is planned that within the year, the project will provide the Cancer Alliance with useful intelligence on incidence and clustering of these cancers to allow for the planning of interventions and future potential case-finding programmes to ultimately improve detection in this population.

Through 2024/25, a primary care data dashboard has been developed which allows, for the first time, local services and system leaders to see and triangulate key cancer incidence, early detection and prevention metrics, in real time, down to an LSOA or PCN level. This is fed by data derived from GP systems and as such, provides a rich source of intelligence. A widespread engagement programme has been undertaken across Cheshire and Merseyside to introduce the use of this dashboard at PCN and system level, and several projects for early adopters have been funded. Through 2025/26, the following priorities driven by this dashboard will be delivered:

1. Phase 3 and Phase 4 to be launched including extensive additions to available data including staging data, health inclusion groups, referral dynamics, faecal immunochemical test data, lung cancer screening programme data, linked conditions and if possible, HPV status.
2. Dashboard intelligence will be strongly embedded across all CMCA programmes and decision making.
3. Additional “early adopter” projects will be supported and funded to help build a repository of projects and resources for the Cancer Academy.
4. Intelligence will be used to develop internal insight work across Cheshire and Merseyside.
5. Intelligence will be used to identify deficiencies in GP coding and projects supported to improve this.

Following a very positive evaluation of the CMCA programme for developing local, Place-based GP leadership in cancer, we will continue to fund each Place with a strategic GP cancer lead to maximise effectiveness of programmes in each Place.

As in previous years, they will be the key link between Place and CMCA and will be instrumental in helping us to develop relevant resources to support and influence PCNs to implement DES early cancer specification.

Through 2024/25, CMCA has developed the capacity and infrastructure of its screening and HPV immunisations programme team to support the NHSE regional commissioning team and local partners to deliver plans to increase uptake and coverage of regional cancer screening programmes and HPV vaccination into targeted cohorts. This has led to CMCA developing a three-year flexible plan to support screening by utilising its existing well-established relationships with PCNs and wider system partners to provide a coordinating function to bring the right partners together with the right intelligence to share learning across the system to support improvement work.

Our timely presentation community partnerships workstream aims to directly engage with high-risk groups and communities identified as facing the most significant challenges to early diagnosis. It is doing this by working with all eight Community and Voluntary Services (CVS) organisations across the nine Places of Cheshire and Merseyside. Each of these organisations has been commissioned by the Alliance to provide community engagement roles (dedicated Social Action Leads), with allocated enablement funding to support grassroots organisations to raise awareness of early signs and symptoms of cancer and improve earlier presentation of cancer, including through screening uptake.

Specific projects will be undertaken this year based on data, targeting the most socio-economically deprived 20% of the population, including a focus on sharing learning across the Cancer Alliance. Ongoing quantitative and qualitative evaluation metrics will be delivered by the Alliance's business intelligence team.

In partnership with the Health Equalities Group we will continue to engage in a whole systems approach to promoting, encouraging, and empowering people to have healthier lifestyles, reducing obesity as a risk factor for cancer and improving outcomes following cancer diagnosis. A three-to-five-year strategic plan has been developed and some direct intervention work with under-represented groups is taking place. Key workstreams have been agreed for the following year.

6.3. Faster Diagnosis

The Alliance's faster diagnosis programme supports providers with service improvement activities to improve productivity, efficiency and patient experience across urgent suspected cancer pathways, driving forward delivery of the 28 day and 62 day cancer waiting times standards.

NHS England has instructed cancer alliances to focus upon four priority pathways, namely urological, gynaecological, breast and skin. CMCA will also work with providers on lung, lower gastro-intestinal, haematological, liver, pancreas, oesophago-gastric and head and neck cancers, as these have been identified as local priorities.

The Alliance works closely with the Cheshire and Merseyside Diagnostics Programme and, as part of an ongoing collaboration, there will be a focus on optimising the use of community diagnostic centres for cancer pathways in 2025/6.

6.4. Treatment Variation

To maximise cancer outcomes (including long term survival) it is essential to ensure that all patients are offered the best and most appropriate treatment for their condition. National and local clinical audits and Get it Right First Time (GiRFT) reports have identified priority areas to focus on to reduce unwarranted variation in treatment.

During 2025/26, the Alliance will focus on supporting providers to improve if they are not currently meeting the following standards:

- **Lung**: 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 receiving systemic anti-cancer therapy (SACT).
- **Bowel**: 50% of stage III colon cancer patients receiving adjuvant chemotherapy following major resection.
- **Primary Breast**: 25% of primary breast cancer patients receiving immediate reconstruction following a mastectomy
- **Ovarian**: 80% of women with stage 2 to 4, or unstaged ovarian cancer receiving treatment (any type)
- **Pancreatic**: 65% of patients with non-metastatic pancreatic cancer (stages 1-3) and 35% of patients with metastatic (stage 4) pancreatic cancer receiving disease targeted treatment
- **OG**: Reduce the number of patients with OG cancer waiting more than 62 days from referral to first disease-targeted treatment.
- **Non-Hodgkin Lymphoma**: Reduce the number of patients with high-grade NHL waiting more than 62 days from referral to starting chemotherapy.

6.5. Urgent Cancer Care

The Alliance's Urgent Cancer Care Strategy 2024-2028 outlines the plan to transform urgent cancer care (UCC) across the region. UCC is an important element of many cancer patients' journeys, addressing the unplanned care needs of patients who become unwell due to a new emergency diagnosis of cancer, side effects of cancer treatment, or worsening symptoms related to cancer progression and other comorbidities.

CMCA's vision and mission for transforming UCC is to ensure that all cancer patients in Cheshire and Merseyside with urgent care needs receive timely, effective, and equitable treatment. The goal is to seamlessly integrate oncology and urgent care teams, enhancing outcomes through education, advanced protocols, and continuous data-driven innovation. By bridging the gap between unplanned urgent care and planned cancer treatment, CMCA aims to ensure clinical safety and improve patient experience.

By 2028, we plan to have achieved the following objectives:

- Increase cancer referrals into same day emergency care (SDEC) and community care services.
- Reduce emergency department (ED) attendance, ensuring patients with the greatest need can quickly access high quality emergency care.
- Avoid admissions with short length of stay (0-3 days) and ensuring timely discharge for patients who need hospitalisation.
- Introduce service standards, regional performance metrics, and workforce education for UCC.
- Agree and implement an overarching governance structure within and across organisations to ensure sustainable change.

The increasing need for UCC aligns with the UEC system's transformation, aiming to reduce bed occupancy and waiting times. CMCA is the first alliance in the country to acknowledge UCC as a priority, develop a strategy and fund a UCC improvement programme.

6.6. Living With and Beyond Cancer

Each year in Cheshire and Merseyside, more than 17,000 people are diagnosed with cancer. Each of these patients requires care and support through their diagnosis, their first and subsequent treatments and, in many cases, for many years beyond. There are approximately 111,000 people in Cheshire and Merseyside living with and beyond cancer, and this number is predicted to increase to nearer 124,000 by 2040.

In 2025/26, the Alliance will focus on embedding local accountability arrangements for personalised care interventions and personalised stratified follow-up (PSFU) pathways, and drive forward sustainable improvement plans for psychological support, cancer prehabilitation, and behaviour change initiatives to increase physical activity as key contributors to better patient outcomes.

6.7. Workforce and Education

In 2024 CMCA won a national award for its leadership of the Aspirant Cancer Career Education and Development programme (ACCEND). In 2025/6 the Alliance will continue to embed the ACCEND framework across all providers, ensuring standardisation of roles and job descriptions, and consistent access to educational resources to support the cancer workforce including nurses, allied health professionals and support workers. CMCA's Cancer Academy will be the central platform for cancer education in the region.

The Alliance will complete a workforce modelling project with the aim of describing what a high functioning cancer services team looks like within all Cheshire and Merseyside providers, resulting in the production of a service specification with recommendations linked to the Long Term Workforce Plan. CMCA will continue to engage our future workforce via the Inspiring the Future Workforce project. The Alliance will target areas of deprivation to engage with young people to highlight cancer careers whilst also focusing efforts on areas of the workforce with high levels of attrition.

CMCA's primary care programme will continue to work closely with the Cancer Academy to build on the work done through 2024/25 to develop and deliver high quality primary care education events and resources around the early diagnosis of cancer, based on identified local priorities and changing national guidance (e.g. NG12 guidance).

This will include developing a series of educational webinars and events relevant to primary care delivered through a high impact, high quality platform, the scoping of education for other primary care roles (including dentistry and pharmacy), commissioning and delivering lifestyle medicine events as part of the wider CMCA prevention strategy and scoping of alternative means for delivery of education.

Following comprehensive scoping that has been undertaken throughout 2024/25, a workstream to develop a new model of education for GP registrars around early cancer diagnosis will be concluded with the model co-developed with local medical schools and other key stakeholders.

6.8. Innovation

CMCA's innovation programme aims to identify, implement and evaluate innovations that support better cancer outcomes and improved productivity. By connecting the Alliance to both local and national innovation ecosystems, the programme fosters collaboration and development of new system relationships. It is a partnership with Health Innovation Northwest Coast (HINWC), with

shared posts and resources. The programme has outlined priorities for 2025/26 and is in the process of finalising a joint innovation strategy and framework in collaboration with HINWC, expected to conclude in Q1 2025//26. The programme will focus on the following core aims:

- Reducing health inequalities.
- Supporting early cancer detection and rapid diagnosis.
- Enabling a shift from hospital-based care to community care.
- Facilitating the transition from analogue to digital solutions.

Key priorities for the programme are likely to include:

- Continued delivery and evaluation of innovation projects initiated in 2024/25
- Utilising linked data sets to identify individuals with learning difficulties and their carers who have not accessed screening services. This will enable tailored support for cancer screening through community-based partners.
- Establishing an economic analysis approach for innovative projects to support adoption and spread of innovations. The initial focus will be on evaluating the CURE smoking cessation programme which has now been tested in outpatient settings.
- Delivering a Cheshire and Merseyside wide project to link cancer datasets to enable improved management and outcomes. The initial focus will be on linking datasets related to metastatic breast cancer and those patients accessing urgent care services. This initiative is part of a wider cancer intelligence strategy.
- Implementing a new digital messaging integration tool for inter-hospital specialist cancer advice and referrals.
- Implementing digital tools to improve urgent cancer care across Cheshire and Merseyside, including digital referral and triage solutions.

The programme will also explore, assess, and support the development of emerging ideas, such as capillary blood testing to enable more efficient and effective cancer treatment, and exploring the shift from hospital-based to community care, starting with lower gastro-intestinal cancers.

6.9. HIV and Cancer

Individuals living with HIV have an elevated risk of cancer. CMCA will continue work that was commenced in 2024/25, working with specialist oncology teams to undertake an audit of experiences of cancer care for people who have a dual diagnosis of cancer and HIV, developing an action plan and educational resources to improve the quality of their care and overall compliance with European AIDS Clinical Society (EACS) guidelines.

The Alliance will also undertake work to improve cancer prevention and early diagnosis in the HIV community with a particular emphasis around HPV driven cancers, focussing on education and uptake of the HPV vaccine.

6.10. Genomics

CMCA will continue to support providers to adopt best-practice across cancer pathways, and continue working closely with the North West Genomics Medicines Service Alliance (GMSA) and Genomic Laboratory Hub (GLH) to drive improvement. The Alliance works closely with the C&M pathology network, and a shared workplan is in development. CMCA will also continue to build on the work of the Improving Molecular Pathways and Cancer Turnaround Times (IMPACTT) project, supporting Cheshire and Merseyside laboratories to adopt best-practice, and supporting the removal of logistical barriers to timely care.

7. Recommendations

The Board of NHS Cheshire and Merseyside is asked to note the contents of this report and support the continued efforts of all system partners, coordinated by the Cancer Alliance, to further improve outcomes for cancer patients.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Liverpool Adult Acute & Specialist Providers (LAASP) Case for Change

Agenda Item No:

Responsible Director: Graham Urwin, ICB Chief Executive
James Sumner, University Hospitals of Liverpool (UHL) Group Chief Executive
Liz Bishop, Clatterbridge & Heart & Chest Chief Executive
Jan Ross, The Walton Centre Chief Executive

Liverpool Adult Acute & Specialist Providers (LAASP) Case for Change

1. Purpose of the Report

1.1 In a letter issued in July 2024, the Chief Executive of the NHS Cheshire and Merseyside (ICB) called for closer and shared working arrangements between the five Liverpool Adult Acute & Specialist Providers (LAASP).

1.2 One of the asks for the LAASP trusts was to define their case for change, in particular to be able to capture the clinical and financial opportunities to work differently across the five trusts.

1.3 Agreeing the LAASP Case for Change is one the LAASP Joint Committee's 24/25 strategic priorities and in recognition of this the Joint Committee commissioned PwC in September 2024 to support the development of the Case for Change.

1.4 This report summarises the LAASP Case for Change document (enclosed) and provides recommendations for the Board of NHS Cheshire and Merseyside.

2. Executive Summary

What is LAASP?

2.1 In July 2024 the LAASP Joint Committee was formed to allow the five LAASP trusts to work more closely together and to continue to deliver previously agreed recommendations from the Liverpool Clinical Services Review.

2.2 The LAASP Joint Committee aims to unify strategic activities and governance across Liverpool's five trusts. It leads on strategic decisions, financial planning, corporate services, and the development of a five-year strategy for transforming adult acute and specialist care. Additionally, it works closely with the NHS University Hospitals of Liverpool Group (UHLG) Board to implement the UHL hospital group model.

2.3 Since forming in July, the LAASP Joint Committee has agreed a roadmap that defines the order the LAASP trusts will join the UHL Group and eight priority programmes of work (the LAASP Portfolio), each led by an Executive from one of the five trusts.

2.4 The LAASP Portfolio is intended to provide the delivery infrastructure to support the design and implementation of the UHL Group and the findings of the LAASP Case for Change.

2.5 From April 2025, the LAASP Joint Committee will receive formal delegation (where required) from the LAASP trusts in order to deliver the objectives of the LAASP Programmes.

2.6 The LAASP Joint Committee will also oversee the process for the five LAASP Trusts joining the University Hospitals of Liverpool Group (UHLG) in line with the agreed UHLG Roadmap.

Moving Towards the UHL Group Model

2.7 Establishing the University Hospitals of Liverpool Group is one of the key priorities for the LAASP Joint Committee.

2.8 In July 2024, the LAASP Joint Committee and LAASP Trust Boards agreed a roadmap or sequencing for the order the LAASP trusts will establish and then individually join the UHL Group.

2.9 The UHL Group was established via a Joint Committee between Liverpool University Hospitals (LUHFT) and Liverpool Women's Hospital (LWH) in November 2024.

2.10 The next steps on the roadmap are Liverpool Heart and Chest (LH&C) joining in 2025/26, The Walton Centre Foundation Trust (TWC) in 2026/27 and The Clatterbridge Cancer Centre (CCC) in 2027/28.

The LAASP Case for Change

2.11 The work to develop the Case for Change has been undertaken through a number of engagement interviews with senior stakeholders and clinicians across the five LAASP trusts and partners, an extensive documentation review, a weekly task and finish group and engagement with the LAASP Joint Committee and LAASP Portfolio Board.

2.12 The Case for Change is not a strategy, nor is it an implementation plan, rather it is intended to clearly state the case for working together differently and the areas that as LAASP we must transform.

2.13 The LAASP Case for Change describes that we must work collaboratively as one to improve patient experience, clinical pathways and to move our system to a position of financial stability.

2.14 The Case for Change concludes: "we can do better for the patients that we serve:

- Clinically, our organisational boundaries are impacting on the care we provide in several pathways, e.g. women's services, cardiology and stroke and impacting on how patients experience our services.
- Financially, our emerging group has a significant financial risk that needs to be managed and operating at scale through LAASP can contribute towards mitigating those risks in the long term.
- We now need to develop a comprehensive programme of work to simplify how our clinical and corporate services are delivered in the future."

3. Case for Change Headlines & Critical Success Factors

Five Ways LAASP Must Change

3.1 Over the next three years, the LAASP Joint Committee will oversee the integration of the five trusts into the University Hospitals of Liverpool Group (UHLG). This presents multiple opportunities for patients, their families, and LAASP staff to benefit from closer collaboration through LAASP and UHLG. The Case for Change draws out five areas for LAASP to focus on moving forwards:

Clinical Pathways and Patient Experience

3.2 There is significant scope to enhance coordination and expertise sharing between Trusts by establishing formal pathways for joint patient care initiatives.

3.3 The Case for Change has not exhaustively reviewed all clinical pathways but identifies examples where we LAASP can improve moving forwards, including: closer collaboration between gynaecology, anaesthetic and surgical teams at Royal Liverpool Hospital and LWH; building upon the Liverpool Cardiology Partnership's work to optimise and align cardiology pathways and streamlining thrombectomy and thrombolysis pathways for stroke patients.

3.4 This will reduce fragmentation and variation for patients while standardising referral pathways, developing shared protocols and formalising effective informal pathways that currently exist.

3.5 In addition, any future clinical service transformation must be enabled by the introduction of a single Electronic Patient Record (EPR) to streamline workflows and support decision-making across LAASP organisations and allow trusts to improve clinical safety and patient communication.

Workforce

3.6 More can be done for the c. 22,000 staff to consistently attract, retain and nurture the very best talent. The Case for Change identifies that we LAASP can maintain and improve staff satisfaction by offering clear progression pathways with a focus on creating 'Liverpool Careers', attracting top national talent and investing in advanced skill development.

3.7 LAASP can contribute to long-term financial sustainability in areas such as harmonising bank and agency staff terms, conditions and management and through standardising rate cards.

Clinical Support and Diagnostic Services

3.8 All LAASP trusts have clinical support services and diagnostic services. Streamlining and transforming diagnosis and treatment models is fundamental to achieving the three shifts set out in the NHS 10 Year Plan. There is now an opportunity for LAASP to do this together to improve the management of our 18-week referral to treatment (RTT) pathway, align pharmacy provision, and expand Medicines Optimisation programmes.

Research, Development, Innovation and Commercialisation

3.9 Across LAASP there are existing examples of excellence in research, innovation and commercialisation across our trusts, however collective scale is not being utilised, and trusts can compete for funding.

3.10 The Case for Change clearly recommends that research and commercial opportunities are exploited across LAASP by leveraging a larger patient base and workforce to establish a unified research network, drive clinical innovation, and strengthen the value proposition for grants and academic recruitment.

Corporate Services

3.11 In addition to implementing a shared Electronic Patient Record, much more can be done with LAASP Corporate services and assets. Working across the five trusts presents an opportunity for reducing duplication by consolidating business functions, leveraging economies of scale, e.g. in procurement, and optimising use of available estates by taking a strategic approach based on clinical need.

Our Financial Opportunity

3.12 Forming LAASP can unlock significant financial opportunities, cost savings and additional income streams.

3.13 The Case for Change conservatively estimates that implementing the opportunities set out above could yield a gross financial benefit of £49-90m over the next three to five years.

Critical Success Factors

3.14 Implementing our Case for Change will require significant investment, leadership and programme management to deliver. The Case for Change defines a number of implementation Critical Success Factors:

- **Patient and staff involvement** – including diverse perspectives in shaping the partnership and future planning
- **Governance structures** – driving and delivering on a shared vision with structures that promote shared ownership and risk
- **Brand identity and culture** – developing a strong brand for UHL Group whilst leveraging existing hospital brands in order to attract the best talent and bring in investment
- **Estates and capital optimisation** – adopting a collaborative approach to capital planning, guided by need, to maximise use of our estates
- **Digital enablement** – investing in our digital capabilities, such as a single EPR, to optimise workflows and communications as a group

Fig 1.1 LAASP implementation Critical Success Factors

4. Ask of the Board and Recommendations

4.1 **The Board is asked to:**

- note the progress made to establish the LAASP Joint Committee, the LAASP Portfolio of delivery programmes and the LAASP Case for Change.

- **approve** the Case for Change document and support the LAASP Joint Committee to implement the LAASP Portfolio including development of a Strategic Outline Case (SOC) and LAASP Financial Sustainability Plan (FSP).

5. Reasons for Recommendations

5.1 Following support and guidance from the ICB, significant progress is now being made with the LAASP collaboration and integration agenda.

5.2 Continued support from the ICB will allow LAASP to continue this trajectory which will in time improve the quality and safety of services for our patients, make the UHL Group a career destination of choice for our staff and make a significant contribution to the Liverpool and Cheshire and Merseyside financial challenge.

6. Officer contact details for more information

Tim Gold, Group UHL Chief Transformation Officer & LAASP Portfolio Senior Responsible Owner (SRO)

7. Appendices

Appendix One: LAASP Case for Change

NHS Liverpool Women's NHS Foundation Trust
NHS Liverpool Heart and Chest Hospital NHS Foundation Trust
NHS Liverpool University Hospitals NHS Foundation Trust
NHS The Walton Centre NHS Foundation Trust
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Liverpool Adult Acute and Specialist Providers (LAASP)

Case for Change

January 2025

Contents

Foreword

The Liverpool Clinical Services Review, conducted in January 2023, identified opportunities to improve health outcomes, enhance the quality and experience of care, and support financial and clinical service sustainability through systematic collaboration in Liverpool. In response to these findings, NHS Cheshire and Merseyside Integrated Care Board (C&M ICB), requested the establishment of a joint committee, the 'Liverpool Adult Acute and Specialist Providers (LAASP)'. This committee includes five acute and specialist trusts in Liverpool: Liverpool University Hospitals NHS FT (LUHFT), Liverpool Heart and Chest NHS FT (LHCH), The Clatterbridge Cancer Centre NHS FT (CCC), The Walton Centre NHS FT (TWC), and Liverpool Women's NHS FT (LWH); with the unifying aim to improve patient care and outcomes whilst creating a sustainable healthcare system.

The purpose of this document is to clearly state that, as LAASP, we must now work differently to improve patient experience, clinical outcomes and move our system to a position of financial stability. It is not a strategy or an implementation plan, but instead outlines the unprecedented scale of opportunities that lie ahead of us as LAASP with ~£2.2bn revenue and over 22,000 staff. In developing this document, we engaged with more than 40 stakeholders over six weeks and used insights from interviews, supplemented with document reviews and data analysis, to identify where change would benefit patients, staff, the city, and the wider health system.

We have a unique opportunity to reshape clinical pathways to better meet the current and increasingly complex future needs of our populations. This collaboration is not just about addressing fragmented pathways and reducing duplication in current service delivery or reducing our financial deficit; it is about working together to create a sustainable healthcare system, focused on clinical excellence that prioritises the needs of our patients rather than the limitations of the current system infrastructure. By taking collective accountability, adopting a shared approach to risk and establishing our shared electronic patient record (EPR) we can optimise resources and create a group that is both efficient and equitable.

We are committed to working collaboratively to enhance the acute care and specialist services we provide within Cheshire and Merseyside. Operating as one through LAASP will allow us to develop a common strategy, shared decision-making and simplify our contracting arrangements for acute care and specialised commissioning.

We recognise broader demand, workforce, and financial pressures impacting the quality and effectiveness of patient care, requiring a whole-system response. Challenges include patient flow in the acute system, with a significant number of LUHFT beds occupied by patients who no longer meet residency criteria. We will work with our system partners in these areas, while taking collective responsibility as LAASP for the patients under our care.

As leaders of our five hospitals, we commend the LAASP Case for Change, a document that marks the start of our collaborative journey, not its conclusion. As we move forward, we invite continued engagement and feedback as we further define the opportunities. Together we can shape the future of acute and specialist healthcare in Liverpool and the wider population we serve.

[signature here]

Kathy Doran
Chair of CCC

[signature here]

Max Steinberg
Chair of TWC

[signature here]

David Flory
*Chair of UHL**

[signature here]

Val Davies
Chair of LHCH

[signature here]

Jan Ross
CEO of TWC

[signature here]

James Sumner
*CEO of UHL**

[signature here]

Liz Bishop
CEO of CCC and LHCH

Note: *LUHFT and LWH became the NHS University Hospitals of Liverpool (UHL) Group on 1 November 2024

1. Executive Summary

1.1 Introduction and strategic context

This case for change highlights the opportunities presented by integrating five acute and specialist trusts across Liverpool under the Liverpool Adult Acute and Specialist Providers (LAASP) partnership. The participating trusts are Liverpool University Hospitals NHS FT (LUHFT), Liverpool Women's NHS FT (LWH), Liverpool Heart and Chest NHS FT (LHCH), The Clatterbridge Cancer Centre NHS FT (CCC), and The Walton Centre NHS FT (TWC).

Liverpool is the **third most deprived local authority** in England, with deepening inequalities: 1 in 4 people aged 20 and above are projected to be living with a major illness by 2040[1]

As anchor institutions, our trusts play a pivotal role in the local community. The LAASP partnership aims to enhance the quality and efficiency of healthcare delivery in the city by adopting a unified approach to providing acute and specialist care that is responsive to the evolving needs of Liverpool's population.

This collective effort is driven by an understanding that the future of healthcare delivery requires innovative and collaborative solutions to meet patients at their point of need. This aligns with national priorities, such as the *2024 Darzi Report*[2], which advocates for better integrated care, and with the government's call to action to reshape the NHS through the *10 Year Health Plan*[3].

1.2 Overview of current state

The challenges faced by our communities are significant, with rising service demand and cost pressures outpacing budgets, creating a challenging financial landscape for NHS organisations nationwide.

Diagnostic testing access

Despite these pressures, in Cheshire and Merseyside we continue to deliver improvements, including the **fastest growth in diagnostic testing access nationally**, significant progress in reducing long waits for planned care, and strong performance exceeding England and North-West averages for 31-day and 62-day cancer waiting time standards[4].

We are making progress in Liverpool and the broader Cheshire & Merseyside region, but further improvements are needed to improve the experience of patients. Many still face challenges accessing care across the five trusts, often perceiving services as disconnected. Common concerns include a lack of coordination between trusts; long waiting times and delays; poor communication; and difficulty navigating between our Trusts for different parts of their care journey[5]. Challenges also exist within our clinical pathways, where our organisational boundaries can lead to disconnected care in areas such as Women's Health, Cardiac Services, and Stroke Medicine. This causes unwarranted variation in the quality of care delivered to patients and in their health outcomes.

Staff satisfaction and recruitment are also significant concerns for some trusts within LAASP. Many staff members feel disconnected and under pressure, highlighting the need for a supportive environment to enable them to work at their best, with greater opportunities for professional development.

£88.7m Planned group deficit across LAASP for FY 24/25[6]

The scale of our combined planned deficit suggests our current way of operating is unsustainable and requires rethinking to achieve long-term financial sustainability and create a more resilient workforce.

Whilst there are collaborative efforts in diagnostics, and good examples of innovation within our trusts - including strong staff-led initiatives in research and development - there is still significant potential for greater achievements through a more joined-up approach.

1.3 Summary of key opportunities

Over the next three years, the LAASP Joint Committee will oversee the integration of the five trusts into the University Hospitals of Liverpool Group (UHLG). This presents multiple opportunities for patients, their families, and our staff to benefit from closer collaboration through LAASP and UHLG:

Clinical Pathways and Patient Experience

- Enhance coordination and expertise sharing between our Trusts by establishing formal pathways for joint patient care initiatives, such as the collaboration between gynaecology and surgical teams at Royal Liverpool Hospital and LWH

Sources: 1) Liverpool City Council, *State of health in the city: Liverpool 2040*, 2024 ; 2) UK GOV *Independent Investigation of the NHS in England*, 2024; 3) UK GOV *Change NHS: help build a health service fit for the future;* 4) NHS Cheshire and Merseyside *Joint Forward Plan – NHS Delivery Plan*, 2024; 5) LUHFT patient and public engagement; 6) NHS Provider Finance Returns

1. Executive Summary

1.3 Summary of key opportunities cont.

- Build upon the Liverpool Cardiology Partnership's work to optimise and align cardiology pathways. This will reduce fragmentation and variation for patients while standardising referral pathways, developing shared protocols and formalising effective informal pathways that currently exist
- Streamline thrombectomy and thrombolysis pathways by enhancing in-hospital coordination through stroke nurse-led processes, reducing unnecessary steps, and adopting integrated workforce models to improve patient flow
- Integrate digital systems across LAASP, introducing a single Electronic Patient Record (EPR) to streamline workflows and support decision-making between back-office operations and front-line workers, improving clinical safety and patient communication

Workforce

- Maintain and improve staff satisfaction by offering clear progression pathways with a focus on creating 'Liverpool Careers', attracting top national talent and investing in advanced skill development
- Harmonise bank and agency staff terms, conditions and management to support long-term financial sustainability

Clinical Support and Diagnostic Services

- Streamline diagnostic and treatment models, aligning existing pharmacy services, and expanding Medicines Optimisation programmes

Research, Development, Innovation and Commercialisation

- Scale research and commercial opportunities by leveraging a larger patient base and workforce to establish a unified research network, drive clinical innovation, and strengthen the value proposition for grants and academic recruitment

Corporate Services

- Reduce duplication by consolidating business functions, leveraging economies of scale, e.g. in procurement, and optimise use of estates by taking a strategic approach based on clinical need

1.4 Summary of financial opportunity*

Forming LAASP could unlock significant financial opportunities for our trusts through cost savings and the potential to generate additional income streams.

To estimate these, opportunities were calculated across four areas**:

1) **Clinical Pathways**
2) **Workforce**
3) **Corporate and Shared Services**
4) **Research, Development, Innovation and Commercialisation**

£49 – 90m Is the estimated gross annual financial opportunity from the formulation of LAASP***

The majority are expected to arise from more efficient clinical pathways within and across our organisations **(approximately £19 - 29m)** and savings in bank spend **(approximately £13 - 28m).**

For these opportunities to be fully realised, LAASP will need to mature as group. Therefore, we assume that the total annual financial opportunity will be realised after three to five years.

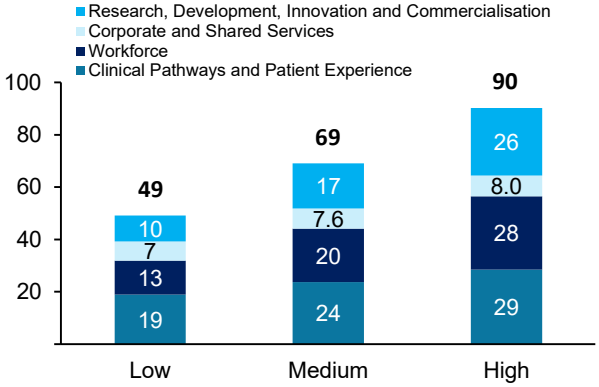


Figure 1.4.1: *Annual financial opportunity associated with LAASP (£m)*

1.5 Next steps

As we move forward, several **critical success factors** will guide our efforts:

- **Patient and staff involvement** – including diverse perspectives in shaping the partnership and future planning
- **Governance structures** – driving and delivering on a shared vision with structures that promote shared ownership and risk
- **Brand identity and culture** – developing a strong brand for UHL Group whilst leveraging hospital brands that our patients recognise
- **Estates and capital optimisation** – adopting a collaborative approach to capital planning, guided by need, to maximise use of our estates
- **Digital enablement** – investing in our digital capabilities, such as a single EPR, to optimise workflows and communications as a group

We will now be embarking on a period of engagement with our staff and patients to develop our LAASP Strategic Case and Financial Sustainability Plan that will expand on the opportunities in this document and chart our implementation journey. By uniting our trusts, we can leverage our expertise and resources to achieve improved outcomes, financial sustainability and a better experience for our patients and their families.

Note: *More detail on how the financial opportunities were estimated can be found in the 'Financial opportunity' sub-section at the end of each section of the report. ** The financial opportunities identified here represent areas with the strongest evidence base; however, they do not encompass all potential financial benefits for LAASP. *** Financial opportunities are presented as gross rather than net benefits as they do not account for the costs associated with the formation of LAASP. As there are different scenarios and therefore costs associated with how LAASP will be established, costs have been omitted from the analysis.

2. LAASP Overview

565,000
patients served across Liverpool

2-3.5million
patients served across a wider catchment spanning Cheshire and Merseyside, North Wales, Isle of Man, and the wider North-West region[1-6]

**Graphic locations not exhaustive, illustrative to demonstrate geographically co-located trusts*

The Clatterbridge Cancer Centre NHS FT

Sites: Aintree, Liverpool and Wirral Cancer Centre

Services: Inpatient cancer care, Radiotherapy, Chemotherapy, Gene therapy, Palliative and Supportive care

Staff: ~1,920[3]

Beds: 103[10]

Revenue: £294.2 million[3]

The Walton Centre NHS FT

Sites: Aintree (The Walton Centre Main building and Sid Watkins building)

Services: Neurology, Stroke services, Rehabilitation, Neurosurgery, Spinal Surgery, Pain Management

Staff: ~1,500[9]

Beds: 192[9]

Revenue: £198.7 million[5]

Liverpool Heart and Chest Hospital NHS FT

Sites: Liverpool Heart and Chest Hospital

Services: Cardiothoracic Surgery, Cardiology, Respiratory, Diagnostic Imaging

Staff: ~1,939[6]

Beds: 181[6]

Revenue: £244.4 million[6]

Liverpool University Hospitals NHS FT

Sites: Royal Liverpool University Hospital, Aintree University Hospital, Broadgreen Hospital, Liverpool University Dental Hospital (Merged in 2019)

Services: Surgery, Anaesthetics, Critical Care, Head and Neck, Acute and Emergency Medicine, Diagnostics and Support Services, Specialist Medicine

Staff: ~15,000[2]

Beds: 1570[11]

Revenue: £1.28 billion[2]

Liverpool Women's NHS FT

Sites: Crown Street (incl. The Hewitt Fertility Centre and Liverpool Centre for Genomic Medicine), Aintree

Services: Maternity, Gynaecology, Neonatal Care, Fertility, Genomics

Staff: ~1,780[4]

Beds: 138[12,13]

Revenue: £149.3 million[4]

~ £2.2 billion
total LAASP revenue

~22,139
members of LAASP staff

2,184
total beds

3/5 trusts rated **outstanding or good**

LHCH voted the **TOP place to work** in the country[7]

Walton Centre winner of **NHS Parliamentary Award**[8]

Sources: 1) Liverpool Women's NHS FT; 2)The Liverpool University Hospitals NHS FT Annual Report 23/24; 3) The Clatterbridge Centre NHS FT Annual Report 23/24; 4) The Liverpool Women's NHS FT Annual Report 23/24; 5) The Walton Centre NHS FT Annual Report 23/24; 6) The Liverpool Heart and Chest NHS FT Annual Report 23/24; 7) NHS Staff Survey 2023; 8) The Walton Centre NHS FT Specialist neuroscience Trust wins NHS Parliamentary Award (Oct 2024) ; 9) NHS The Walton Centre; 10) CQC CCC; 11) CQC LUHFT; 12) CQC Liverpool Women's NHS FT Evidence Appendix, 2018, 13) CQC Liverpool Women's NHS FT, 2024

2. LAASP Overview

The city of Liverpool has a unique configuration of acute and specialist trusts which stand as pillars of acute and specialist care for 565,000 residents in Liverpool and a wider population of 2.8 million across Cheshire and Merseyside (C&M). Some hospitals provide specialised services that cater to regional and national needs. For example, The Walton Centre serves a patient population of approximately 3.5 million from C&M, Lancashire, Greater Manchester, the Isle of Man, and North Wales. Together, our trusts serve a diverse and often complex population, with needs that are exacerbated by the social determinants of health. We also manage a combined annual income of approximately £2.2 billion, representing a significant resource pool to support healthcare delivery across the region.

Collectively, we employ a workforce of 22,139 dedicated staff, spanning a wide range of medical, clinical and operational roles that are essential to delivering high-quality care and the best patient experience. Our workforce also includes a mix of bank and agency staff, with 6% of total workforce expenditure allocated to bank staff and 1.1% to agency staff (year-to-date, Month 7)[1] to help support service delivery and maintain flexibility across our operations.

2.1 Our local population

In North Mersey, 53% of our population live in the top 20% most deprived areas of England. Four in every 10 children under the age of 16 live in poverty. On average, men will spend 21% of their lives in poor health, rising slightly to 24% for women[15].

In Liverpool, we see the real impact of significant health challenges on the lives of our community. Many people suffer from chronic conditions, with our biggest killers being cancer, cardiovascular disease, and respiratory disease, leading to frequent hospital visits and affecting quality of life. Marked health inequalities are evident from birth in Liverpool, with people in our most deprived areas living eight years fewer than most people in affluent areas[2]. Minority ethnic groups also experience higher rates of long-term conditions, including coronary heart disease, diabetes, and asthma[3].

Long-term unemployment in our community is **7.5%**[4] (vs the national average of **4.3%**[5])

Liverpool is the **3rd** most deprived local authority in the UK and **63%** of Liverpool residents are living in areas ranked among the most deprived in England[6]

Looking ahead, projections indicate that by 2040, 37% of women in Liverpool will suffer from obesity[7]. The number of people with major illness (two or more long term conditions) is set to increase by between 33,000 and 38,000 people[6], with the overall number of health conditions projected to rise by 54%[6].

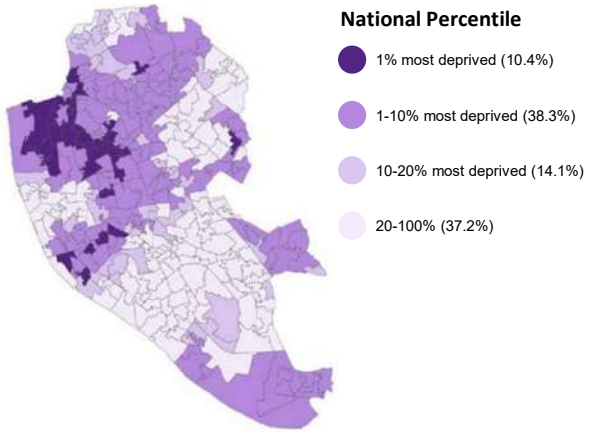


Figure 2.1.1: *Heat map of deprivation in Liverpool, 2023 (using IMD 2019)[3]*

These realities shape the lives of the people we care for, highlighting the importance of having a joined-up approach to addressing these challenges and improving health and well-being across our communities.

2.2 Strategic context

National landscape:

The NHS continues to operate under intense pressure.

Referral to treatment (RTT) figures show:
6.34m patients are awaiting treatment, of which
3.1m have been waiting over 18 months[8,9]

Furthermore, the demand for Emergency Department (ED) services surpasses the available capacity. In July 2024, the total number of attendances at A&E departments was more than 2.3m, which is an increase of 5.5% compared to July 2023[10]

Sources: 1) NHS Provider Finance Returns; 2) NHS *One Liverpool Strategy 2019-2024; 3)* Liverpool City Council, *State of health in Liverpool 2040,* 2024; 4) Liverpool City Council, Labour Market Headline Indicators, 2024; 5) ONS, Unemployment, 2024; 6) Liverpool City Council, State of health in the city: Liverpool 2040, 2024; 7) UHLG Public Health Internal Analysis; 8) Data from October 2024; 9) BMA, NHS Backlog Data Analysis, 2024; 10) NHS England, A&E July 2024 Statistical Commentary, 2024; 11) NHS Providers, 2024 12) DHSC, The government's 2023 mandate to NHS England 13) NHSE, Financial Performance update, 2024 14) NHS England Reforming elective care for patients, 2024; 15) NOMIS, English Housing Society and Office for Health Improvement & Disparities. Public Health profiles https://phe.org.uk

2. LAASP Overview

The financial outlook for 2024/25 is pressured with NHSE's total revenue allocation only rising by 0.2% in real terms, placing demands on trusts to identify unprecedented levels of efficiency savings this year as high as 5-6% [11] in some cases (significantly above the efficiency target of 2.2% set by the government)[12].

This highlights the need to think differently about how healthcare is delivered to achieve longer-term financial sustainability.

Citizens and NHS staff have been called to inform the government's *10 Year Health Plan* which seeks to reshape healthcare in the UK through three shifts in care: from analogue to digital; from hospital to community; and from treatment to prevention. In alignment with the elective care reform plan, change is needed to meet the 18-week standard for RTT and transform elective care by March 2029[14]. This change is needed to meet the evolving holistic needs of patients and alleviate pressure on the entire system.

2.2 Strategic context cont.

As acute and specialist care providers, we have a key role to play that requires transforming how and where we deliver our services. Central to this is aligning with the priorities outlined in the *2024 Darzi Report*[1], which emphasises the urgent need for integrated care delivery models, greater collaboration between providers, and greater focus on patient-centred care. By working together, the LAASP partnership aims to sustainably realise this vision, whilst prioritising addressing health inequalities and supporting the goals of the *Core20PLUS5* framework[2]. The *NHS Workforce Plan*, focuses on expanding and nurturing a diverse and skilled healthcare workforce. We recognise that our staff reflect the communities we serve, and in this context, we are committed to fostering a culture of support, continuous development and advanced practice.

Regional landscape

The C&M ICB vision is *"we want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer".* Working alongside the wider integrated care partnership, C&M ICB has four key aims: (1) tackle inequalities in outcomes, experience and access; (2) improve outcomes in population health and healthcare; (3) enhance productivity and value for money; and (4) help the NHS support broader social and economic development.

In C&M, there are two provider collaboratives: 'Cheshire and Merseyside Acute and Specialist Trust (CMAST)' and 'Mental Health, Learning Disabilities and Community Collaborative (MHLDC

These collaboratives have been formalised and encouraged by the Health and Care Act 2022, which removed barriers to collaboration that previously existed. The CMAST collaborative is home to our five LAASP trusts alongside eight further C&M trusts and has an overarching aim to support delivery and service improvement for patients across the system by reducing unwarranted variation and maximising equity of access. CMAST have agreed areas of focus and delivery with C&M ICB which also align with national priorities, including elective recovery and transformation, increasing diagnostic activity and capacity, as well as clinical pathway reviews and efficiency at scale.

2.3 Our local priorities

As individual trusts, we have been key partners in the development and delivery of the 'One Liverpool strategy' (2019-2024). Collaborating with primary care networks, the City Council, voluntary and community organisations, and other partners to improve the health and wellbeing of people living in Liverpool.

In July 2024, the LAASP Joint Committee was formed to strengthen collaboration and advance delivery recommendations from the Liverpool Clinical Services Review. The Committee aims to unify strategic activities and governance across our five trusts.

Starting in April 2025, the LAASP Joint Committee will receive formal delegation from the LAASP Trusts to lead on the development of a five-year strategy for transforming adult acute and specialist care. Its responsibilities will also include shared financial planning, the shared delivery of a LAASP EPR solution and further development of corporate and shared services. The LAASP Joint Committee will also oversee the process for the five LAASP trusts joining the University Hospitals of Liverpool Group (UHLG) over the next three years.

As LAASP Trusts, we are also full committed to supporting wider NHS Cheshire & Merseyside and priorities, including: the Women's Hospital Services in Liverpool Programme, Women's Health Hubs, Liverpool Centre for Cardiovascular Science (LCCS), and the Cheshire and Merseyside Cancer Alliance.

Sources: 1) UK GOV *Independent Investigation of the NHS in England,* 2024 2) NHS England, *Core20Plus5 (adults) ; 3)* NHS C&M, Women's Hospital Services, 2024 ; 4) NHS C&M, Improved Access to Reproductive Healthcare for Women in Liverpool, 2024; 5) Local Gov Association, Setting up a Network of Women's Health Hubs, 2022; 6) Liverpool Health Partners, Cardiovascular Disease, 2019; 7) Liverpool Health Partners, How to Collaborate; 8) C&M Cancer Alliance, Screening; 9) Champs Public Health Collaborative, *Cancer Screening*

2. LAASP Overview

2.2 Strategic context cont.

As acute and specialist care providers, we have a key role to play that requires transforming how and where we deliver our services. Central to this is aligning with the priorities outlined in the *2024 Darzi Report*[1], which emphasises the urgent need for integrated care delivery models, greater collaboration between providers, and greater focus on patient-centred care. By working together, the LAASP partnership aims to sustainably realise this vision, whilst prioritising addressing health inequalities and supporting the goals of the *Core20PLUS5* framework[2]. The *NHS Workforce Plan*, focuses on expanding and nurturing a diverse and skilled healthcare workforce. We recognise that our staff reflect the communities we serve, and in this context, we are committed to fostering a culture of support, continuous development and advanced practice.

Regional landscape

The C&M ICB vision is *"we want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer".* Working alongside the wider integrated care partnership, C&M ICB has four key aims: (1) tackle inequalities in outcomes, experience and access; (2) improve outcomes in population health and healthcare; (3) enhance productivity and value for money; and (4) help the NHS support broader social and economic development.

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2.3 Our local priorities

As individual trusts, we have been key partners in the development and delivery of the 'One Liverpool strategy' (2019-2024). Collaborating with primary care networks, the City Council, voluntary and community organisations, and other partners to improve the health and wellbeing of people living in Liverpool.

In July 2024, the LAASP Joint Committee was formed to strengthen collaboration and advance delivery recommendations from the Liverpool Clinical Services Review. The Committee aims to unify strategic activities and governance across our five trusts.

Starting in April 2025, the LAASP Joint Committee will receive formal delegation from the LAASP Trusts to lead on the development of a five-year strategy for transforming adult acute and specialist care. Its responsibilities will also include financial planning and further development of corporate and shared services. The LAASP Joint Committee will also oversee the process for the five LAASP trusts joining the University Hospitals of Liverpool Group (UHLG) over the next three years.

There are ongoing programmes of work that will continue to drive and support as LAASP, such as:

Women's Hospital Services in Liverpool Programme[3]:

Led by NHS Cheshire and Merseyside, this initiative aims to develop a sustainable model for maternity and gynaecology services, focusing on quality and safety, with community feedback.

Women's Health Hubs[4,5]:

Established by Liverpool's primary care networks, local NHS, and City Council, these hubs offer integrated healthcare services, improving access to reproductive health for women in Liverpool.

Liverpool Centre for Cardiovascular Science (LCCS)[6,7]:

A research collaboration focused on improving cardiovascular health through research, education, and clinical practice in the Liverpool City Region.

Cheshire & Merseyside Cancer Alliance[8,9]:

Aims to enhance cancer services and outcomes, including the Targeted Lung Health Checks for high-risk individuals and various cancer screening improvement projects.

LAASP Digital and Data Programme:

Initiated in December 2024, the Digital and Data Programme aims to establish LAASP as a digital exemplar within the NHS, including the delivery of flagship digital programmes e.g. a LAASP single EPR

Sources: 1) UK GOV *Independent Investigation of the NHS in England,* 2024 2) NHS England, *Core20Plus5 (adults) ; 3)* NHS C&M, Women's Hospital Services, 2024 ; 4) NHS C&M, Improved Access to Reproductive Healthcare for Women in Liverpool, 2024; 5) Local Gov Association, Setting up a Network of Women's Health Hubs, 2022; 6) Liverpool Health Partners, Cardiovascular Disease, 2019; 7) Liverpool Health Partners, How to Collaborate; 8) C&M Cancer Alliance, Screening; 9) Champs Public Health Collaborative, *Cancer Screening*

3. Clinical Pathways and Patient Experience

Across Liverpool and the wider C&M region, there is a significant opportunity to improve patient outcomes and experiences by strengthening collaboration across clinical pathways. Operating as LAASP will provide us with the ability to take joint responsibility for the entire patient pathway for the first time. This alignment will enable us to define shared goals and work collaboratively to strategically redesign pathways where needed. By improving flow between our sites and standardising operating procedures, we can eliminate unwarranted variation in care delivery and improve equity of access to high quality care for our population. Working as one group also allows us to reimagine how we care for our patients, many of whom have complex needs. Through better coordination and fewer, better-planned interactions, we can greatly improve their overall experience of healthcare.

In this section we will explore examples of pathways: women's health; cardiac services; and stroke services / neurology, as indicators of where collaboration could further enhance care delivery and benefit our population. It should be noted that these three pathways are not exhaustive, and opportunities not exclusive, as other opportunities may exist in other specialties.

3.1 Overview of current state in women's health

As outlined in the Gynaecology and Maternity Hospital Services in Liverpool Case for Change[1], the current organisation of hospital-based gynaecology and maternity services in Liverpool does not provide women and their families with the best possible care and experience.

Unlike most other specialist centres in England, LWH's main site, Crown Street, is 'isolated' from our acute hospitals. This separation limits LWH's ability to manage acutely ill patients, patients with complex surgical needs, or patients with significant medical co-morbidities as there are limited acute and emergency hospital services available on site. In emergencies, vulnerable patients need to be transferred by ambulance to other local hospitals such as the Royal Liverpool Hospital (RLH) (1.3 miles away) or Aintree University Hospital (AUH) (6.8 miles away) at high clinical risk:

148 Clinical incidents between 2022-2024 that were caused in full or in part by women's services being provided on a separate site[1]

60% Maternity bookings each year are women with complex needs, and often require ambulance transfers (220 annually)[1]

50% Transfers are for emergency or life-threatening situations[1]

Additionally, gynaecology and maternity services are not available at our acute hospital sites within Liverpool. This is despite over 2,000[1] pregnant women or those with gynaecology conditions presenting annually at the RLH or AUH A&Es. As a result, these women require transfers to LWH and unnecessary delays in treatment.

Women using gynaecology and maternity services in Liverpool versus other parts of England are at a significant disadvantage. The poor configuration of services is compounding the gender and health inequalities across North Mersey, adding to an already challenging picture to the provision of care.

75% Maternity and emergency gynaecology patients have at least one risk factor, such as deprivation, adverse life experiences, diverse needs, or protected characteristics[2]

Where our patients face a higher risk of poor outcomes due to complexities associated with health inequalities, our services are less well equipped to care for them.

In 2022, NHS C&M commissioned the Liverpool Clinical Services Review, which identified resolving challenges in women's hospital services as one of three urgent priorities. To address this, the Women's Services Committee was established under the ICB to oversee the development of a safe and sustainable future care model for women's services in Liverpool.

Since this, significant progress has been made, including:

- Joint operating lists for complex gynaecology care, with weekly operating sessions at RLH for patients needing critical or specialist surgical support
- Joint outpatient appointments and weekly MDTs with LUHFT specialists

However significant risks remain, including the lack of co-located women's services with specialist surgical, medical and support teams, which poses a safety challenge. While staff work to manage risks in the short term, the growing complexity of patients and rising co-morbidities threaten the long-term sustainability of care and increase avoidable risks. Additionally, the pressures on staff are significant, with 25% seeking trauma-based psychological support in the past 18 months[1].

3.2 Opportunities in women's health

Operating as a group offers an exciting and unprecedented opportunity to take collective ownership of Women's Services in Liverpool. It will enable us to take a strategic approach towards the configuration of Women's Services across all our hospital sites and work towards addressing the five risks outlined in the Gynaecology and Maternity Hospital Services in Liverpool Case for Change[1].

Sources: 1) Gynaecology and Maternity Hospital Services in Liverpool – Case for Change, 2024; 2) UHLG Public Health Internal Analysis

3. Clinical Pathways and Patient Experience

3.2 Opportunities in women's health cont.

Building on successful joint initiatives

Good practice already exists within LAASP through strong informal relationships between teams across our hospitals. Operating as one group will enable us to formalise these existing relationships and scale best practices through shared learning:

- Maternal medicine clinics running in partnership with specialist input from other trusts such as TWC provide coordinated, multi-specialty care for women with complex medical needs

- Joint care currently provided informally at RLH, through close partnerships between gynae-oncology and surgical teams (including general surgery, urology and colorectal teams) at LUHFT

Addressing clinical safety and governance

While Crown Street remains isolated in the short term, formalised clinical risk and governance structures between sites is an effective way to enhance clinical safety and optimise care. One key area where this has been particularly impactful is the shared provision of anaesthetic cover:

- At LWH, a Task and Finish Group has been established to explore a potential model for RLH to take over anaesthetic cover, highlighting how joint governance structures can address safety concerns effectively

The ability to draw on RLH's clinical staffing infrastructure makes certain that there are no gaps in anaesthetic support, even during high-demand periods, creating a safer environment for patients. Furthermore, this shared model exemplifies how challenges related to co-location can be effectively managed when resources and expertise are pooled.

Reducing risk through optimising infrastructure and co-location of services

In 2022, 70% of the standards and specifications that LWH could not meet were due to being on an isolated site.[1] 94% of these can be fully met by co-locating with adult acute services.[1] In the short term, targeted efforts to co-locate such as shared waiting lists offer an interim solution:

- Weekly operating sessions have been established at the RLH for complex gynaecology patients likely to require critical care and / or surgical support from other specialities e.g. colorectal surgery and urology.

Data-driven tools can also be leveraged to enhance clinical oversight and support timely decision-making. For example, the potential use of live dashboards to monitor women presenting with gynaecological problems in ED.

Over the longer term, operating as a group will allow us to strategically assess how our collective estates landscape can be optimised to co-locate women's services with acute and emergency services. This will help us to reduce clinical risk and the associated impact this has on our workforce's wellbeing, in addition to providing more appropriate care for our patients with complex needs. It will also enable us to meet service quality standards and specifications, preventing the loss of specialised services from Liverpool and C&M more widely.

3.3 Current state in cardiac services

Our current setup of cardiology services - two distinct general cardiology services within LUHFT (RLH and AUH), and specialist services at the LHCH – contributes to duplication, unwarranted variation and fragmentation across cardiac pathways, including Acute Coronary Syndrome (ACS) and arrhythmia. For patients this can introduce treatment delays and different experiences of care depending on their entry point into the system.

Moreover, C&M benchmarks poorly in some national cardiac indicators, including percutaneous coronary intervention (PCI) treatment for 100% Non-ST-elevation myocardial infarction (NSTEMI) patients within 72 hours.

26% C&M NSTEMI patients receive PCI within 72 hours vs a national median of 65%[2]

Sources: 1) Gynaecology and Maternity Hospital Services in Liverpool – Case for Change, 2) LCHC internal analysis

3. Clinical Pathways and Patient Experience

3.3 Current state in cardiac services cont.

Cardiac pathways differ in Liverpool to other parts of the country, as cardiology teams at LUHFT do not undertake certain procedures. For example, patients needing PCI must be referred by LUHFT (RLH or AUH) and transferred to LHCH. This creates more opportunity for delays at various stages throughout the pathway than at other trusts in the country, as depicted in figure 3.3.1 below:

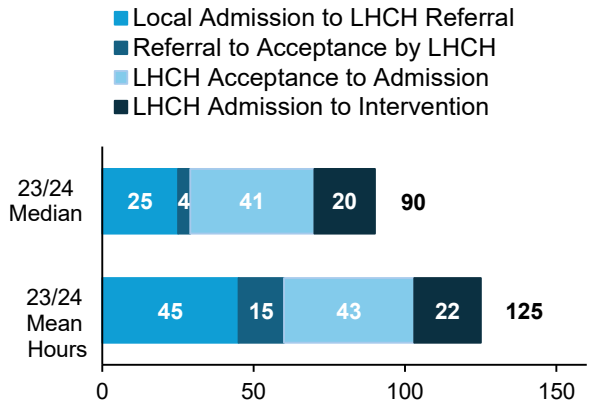


Figure 3.3.1: *Median and mean hours patients receiving PCI intervention spend in each stage of the NSTEMI treatment pathway at LHCH FY23/24*

The difference between the median and mean time to treatment in Figure 3.3.1 highlights how some patients experience extensive delays at each stage.

Differences in diagnostic models, referral pathways, and patient management between the cardiology teams introduces unwarranted variation in the length of time it takes for patients to receive PCI treatment as depicted in Figure 3.3.2 below.

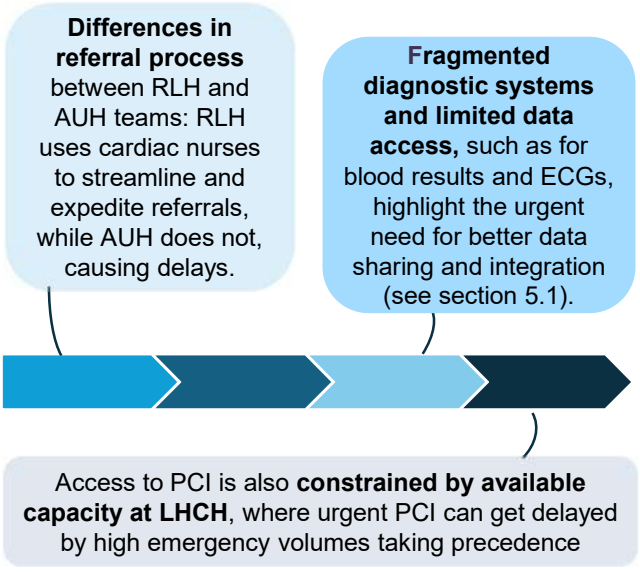


Figure 3.3.2: *Challenges along each stage of the NSTEMI treatment pathway. (Stages as depicted in figure 3.3.1)*

These challenges also extend beyond ACS, affecting heart failure and complex procedures, arrhythmia and pacing, and heart valve and endocarditis pathways. LHCH serves as the central provider for the management of complex devices and valve disease, and patients currently need to be transferred from acute hospitals to LHCH for these complex services.

Pacing and device implantation is currently limited to AUH, with no current plans to expand capacity at RLH. This creates variation in patient experience and delays in care depending on whether the patient presents at RLH and needs to be transferred to AUH for treatment or presents at AUH directly. This also continues to strain resources at AUH, adding to the increasing demand pressures as a major trauma centre.

LHCH frequently provides pacing support to AUH in cases of acute need, but this is through an informal pathway which creates inconsistent support. Whereas heart failure management is more distributed, with significant work happening at both AUH and RLH, however the withdrawal of funding for virtual wards has left gaps in continuity of care.

The Liverpool Cardiology Partnership

Launched in 2021, the partnership has made significant strides in enhancing cardiology care across Liverpool and the C&M region by unifying services across trusts. While UHLG plays a key role, it does not manage ACS care for the entire C&M region.

This highlights the importance of not only seizing opportunities to improve outcomes for Liverpool patients but also making sure that care is enhanced for those across the C&M region.

3.4 Opportunities in cardiac services

Single cardiology service to improve alignment and reduce duplication

Building on the foundation of the Liverpool Cardiology Partnership, establishing a single, unified cardiac service across Liverpool could further improve our collective efficiency by reducing duplication of activity across sites.

Moreover, operating as one single UHLG cardiology service will enable us to strategically optimise care pathways to cater to patient needs and demand rather than organisational boundaries.

This means making best use of our collective resources to deliver a standardised level of cardiac coverage and care to patients regardless of location.

3. Clinical Pathways and Patient Experience

3.4. Opportunities in cardiac services cont.

Standardising ACS management to reduce service variation in cardiology services across Liverpool

Becoming one unified cardiac service will serve as a platform to scale already successful initiatives and standardise service delivery by levelling up to best practice:

- Successful implementation of standardised emergency department admission to referral procedure
- Building on existing practices at RLH, a successful pilot of chest pain specialist nurses in AUH was rolled out
- Extended criteria for direct conveyance to LHCH – previously limited to STEMI patients, this approach now includes high-risk NSTEMI patients, allowing them to be conveyed directly

Investing in the entire ACS pathway across the region is essential to facilitating timely, high quality equitable care for our patients regardless of their entry point into the system. By creating a unified approach, we can reduce variability across sites and improve the outcomes for all patients with ACS across the region.

It is important that this effort goes beyond Liverpool to include Cheshire and Merseyside. This will help create a smooth and efficient care pathway that improves results for all patients in the region.

Optimising and enhancing integration across all cardiac pathways

The potential benefits of operating as one group can also be seen across other cardiac pathways, including heart failure (HF), arrhythmias, and device management.

- A shared protocol for the use of isoprenaline has been developed to optimise the medical management of arrhythmia. This protocol reduces the need for temporary wires and aims to minimise variation in care across the city

Building on best practices from existing efforts, such as shared cardiology diagnostics, standardised heart valve clinics, and the expansion of virtual heart failure wards, working within a group structure could accelerate progress.

Through shared responsibility of demand and greater alignment strategically, unwarranted variation of care and gaps in services provision could be further reduced.

- Closer collaboration between LUHFT and LHCH would streamline and formalise pacing pathways. This would enhance transparency in referrals for pacing and alleviate some of the pressure on Aintree
- A shared investment in cardiac catheterisation lab capacity could address gaps in services such as emergency pacing, or elective pacemaker implantation. This would support successful implementation of the C&M catheterisation strategy

Moreover, it creates opportunities to move beyond the limitations of care provision as it currently is today to tackle more complex challenges, such as:

- Implementing a single rota for 24/7 cardiology imaging
- Establishing a unified EPR (electronic patient record) system, paving the way for more streamlined and efficient care.

3.5. Current state in stroke services / neurology

With the consolidation of care at the Aintree site through the Mersey Stroke Assessment Centre, our stroke services across the region have improved. However, there are still areas where we can refine pathways to enhance efficiency and patient outcomes.

With stroke incidence rising in our local population, demand for services like thrombectomy is increasing. Currently, we provide thrombectomies for approximately 6% of stroke patients presenting to Aintree, but we aim to expand this to 10%-15%[1], which would increase survival rates by providing more patients access to this life-saving procedure.

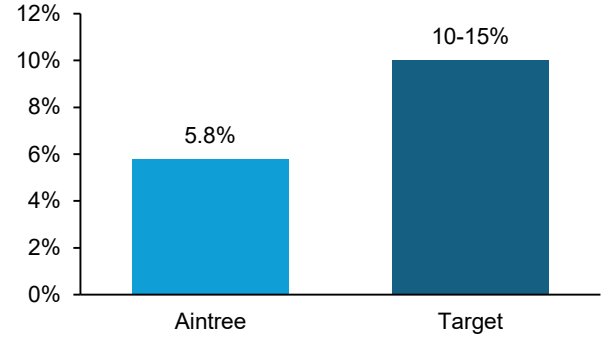


Figure 3.5.1: *% of patients presenting who received thrombectomy vs national target*

Sources: 1) Interviews with LAASP Staff

3. Clinical Pathways and Patient Experience

3.5. Current state in stroke services / neurology cont.

To achieve this, we need to address challenges such as reliance on phone calls to transfer patients at RLH to AUH for thrombolysis, or patients at RLH or AUH to The Walton Centre (TWC) for thrombectomy. These intermediary steps introduce delays and prevent patients from receiving timely and effective care.

Currently, the referral process for thrombectomies requires a stroke physician to contact a registrar at TWC for approval, who then coordinates with interventional neuroradiology to deliver the procedure. This creates an additional unnecessary administrative step. Furthermore, each site transfer is logged as a separate admission, inflating readmission rates. These inefficiencies present clear opportunities to streamline the process, reduce handoffs and improve overall care coordination.

By consolidating stroke care onto the Aintree site, we have transformed outcomes, with SSNAP† scores improving from grade Bs and Cs to consistent As[1], making our stroke service one of the best in the country.

The success of the Mersey Stroke Assessment Centre demonstrates what we can achieve through collaboration.

This has been achieved by working together to better organise services, using the same workforce in a more coordinated way. Building on this momentum, there are further opportunities to enhance pathways and support our patients to receive even better care.

3.6 Opportunities in stroke services / neurology

We have the potential to deliver enhanced stroke care by leveraging a dedicated and motivated workforce. By working together with aligned incentives we can meet growing demand for thrombectomies, streamline stroke pathways to achieve targets, and expand thrombectomy services to ultimately improve patient care, outcomes and experiences.

Streamlining the thrombectomy and thrombolysis pathways to reach local and national targets

To address out-of-hospital delays and optimise in-hospital processes streamlining thrombectomy and thrombolysis pathways is required.

By introducing a team of specialist stroke nurses who can work across sites, perform a single assessment, and organise these interventions, we could cut unnecessary steps and improve coordination

Transitioning the coordination of A&E referrals from a neurology registrar to a stroke nurse would further streamline the process

A single workforce model comprising of stroke nurses and appropriately trained medical staff (stroke doctors or neurologists) could also enhance pathway efficiency, with interventional neuroradiologists performing the procedures

By addressing these areas, we can improve patient flow, reduce treatment delays, and enhance both efficiency and patient outcomes.

Expanding thrombectomy services to increase capacity and meet demand

Expanding thrombectomy services is another critical area where integrated approaches could address capacity constraints and support growing demand. Working in a group structure would allow for provision of the necessary infrastructure and shared resources, for example, estate expansion and recruitment of scrub nurses and operating department practitioners (ODPs), to sustain growth in case numbers.

It is also possible to enhance access and reduce treatment times while maintaining procedure delivery at TWC, which benefits from its close connection to AUH. By integrating our trusts, we can optimise care pathways, streamline resources, and uphold consistent care standards.

Addressing these needs will be critical to meeting the target of treating 10-15% of stroke patients via thrombectomies[2] while improving outcomes for patients presenting with other acute neurological symptoms requiring further investigation.

Sources: 1) Aintree University Hospital Internal Analysis; 2) Interviews with LAASP Staff;; Notes: † SSNAP is a national clinical audit designed to measure the quality and organisation of stroke care across hospitals in England, Wales, and Northern Ireland. The program evaluates various aspects of stroke care, including the timeliness and effectiveness of treatment, patient outcomes, and overall service quality.

3. Clinical Pathways and Patient Experience

Anna's Story

Anna was taken directly to Surgical Emergency Ambulatory Care (SEAC). The partnership between Aintree Hospital and The Walton Centre was excellent. She underwent three scans at Aintree before being transferred for her procedure, which was successful.

Due to the rapid response and effective treatment, Anna made a smooth recovery and was quickly able to return to her active lifestyle.

3.7 Further clinical opportunities

The pathways and services reflected in this section are examples of how operating as a collective could help to overcome significant challenges in our care delivery and improve the experiences of our patients. As we move forwards with the LAASP Strategic Case, we will explore these potential opportunities, which include cancer services, outpatients, and urgent and emergency care. Our existing lung cancer model, which includes the targeted lung health check programme led by C&M Cancer Alliance and LHCH, shows early data indicating increasing survival rates. This model could be replicable in other specialties and designed to minimise multiple visits.

Outpatient services across all our trusts present a significant opportunity for modernisation by making them uniformly more patient-focused. This includes transforming follow-up care for chronic diseases and ambulatory care to better meet patient needs.

Same-day care could be aligned to the national direction to shift care from hospitals to the community with LAASP clinicians providing the required oversight and expertise

Additionally, consolidating, standardising and digitising booking processes across LAASP, offers the potential to achieve operational efficiently at scale. This transformation within outpatients alone could greatly improve patient experiences of disconnection and deliver substantial financial benefits.

Having a single EPR across trusts also presents an opportunity to improve patient experience.

All information across the five trusts available on one trusted system would enable clinicians to manage patients using the latest available patient data in acute care, facilitating delivery of more holistic patient centred care

Enhanced data visibility would strengthen LAASP-wide understanding and management of demand and capacity. This improvement could create opportunities for more effective care coordination, particularly for patients with co-morbidities. For example, it could enable the scheduling of appointments around other care they are receiving within LAASP, minimising the number of visits. It would also allow for optimisation of staff workflows, improving overall efficiency.

John's Story

After being hit by a car, John was rushed to Aintree Hospital as a trauma call. He couldn't feel or move anything from the waist down. A CT scan revealed a fracture at the top of his spine, but nothing lower down to explain his symptoms.

The doctor tried contacting the specialists at The Walton Centre repeatedly, but no one responded. Whilst John waited he became more unwell. The doctor eventually got through to The Walton Centre, but John was kept at Aintree, where his condition worsened.

Through collaborating, the 'No Criteria to Reside' challenge can continue to be addressed through admission avoidance and improved patient flow. Specialist in-reach and direct admissions could reduce unnecessary stays, while virtual wards and rapid diagnostics support timely community care.

3.8 Financial opportunity

Clinical costs

By considering the average cost of delivering similar services elsewhere in the country (utilising the 2023/24 National Cost Collection Index (NCCI))[1] we have evaluated the cost performance of LAASP trusts for inpatient services compared to other group trusts. Taking the net inpatient opportunity from LAASP having the same inpatient services NCCI as the comparators, we developed three scenarios:

1) **Low:** Assume LAASP achieves 50% of net opportunity
2) **Medium:** The average of the low and high scenario
3) **High:** Assume LAASP achieves 75% of net opportunity

It is estimated that the formation of LAASP, in a three-to-five-year horizon, could result in a total recurring opportunity of approximately **£19m – 28.5m.**

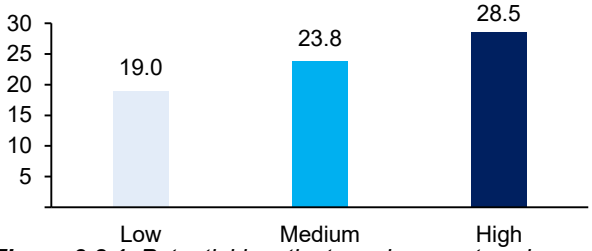


***Figure 3.8.1**: Potential inpatient services cost savings across LAASP with low, medium and high scenarios (£m)*

Sources: 1) NHS England *National Cost Collection for the NHS 2023/24* 2) NHS Cheshire and Merseyside Balance Scored Card – 2024/25, 2025

4. Workforce and Staff Experience

The workforce is at the heart of delivering exceptional healthcare within the NHS. Operating as a group will provide greater consistency in staff support, foster shared learning opportunities, and enrich our workplace culture to one where everyone feels valued and empowered. By leveraging the collective strengths of our trusts and the added flexibility of group collaboration, we can address workforce challenges more effectively and create a supportive environment that benefits patients, staff, and local communities.

Our vision is to position Liverpool as a leading destination for attracting high-quality talent and providing unmatched opportunities for staff development. By reducing variations in experiences across our trusts, we aim to promote consistently high satisfaction levels for all staff, regardless of their workplace.

4.1 Overview of current state

Our clinical workforce, which represents our largest staff group, faces key challenges related to staff satisfaction and access to learning and development opportunities. At the same time, we have heard concerns about insufficient training and career development opportunities for non-clinical staff, who play an equally crucial role in the success of our services.

Whilst specialist trusts are performing well – achieving a leaver rate of **10.8%**, significantly below the national average of 16.2%[1] – there are still large variations in staff satisfaction across our other trusts

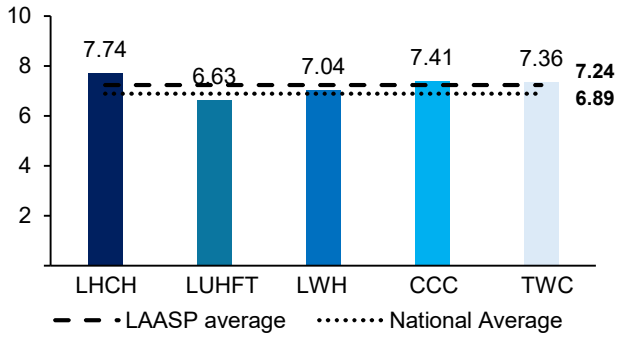


Figure 4.1.1: *Staff engagement score (1-10) by trust (2023)*

Disparities in engagement levels highlight the importance of addressing varying staff experiences to sustain a consistently motivated workforce. Similarly, access to training and career development remains inconsistent, with trainee feedback revealing dissatisfaction. Concerns include reluctance to recommend placements, with some considering leaving the training programme entirely.

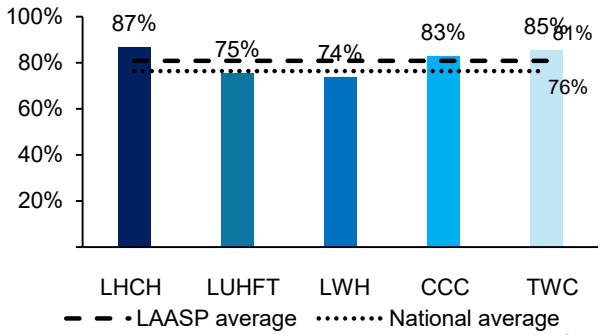


Figure 4.1.2: *Trainee survey overall experience (%) by trust (2023)*

Furthermore, as a group LAASP has spent an average of 6% and 1.1%[2] of total overall workforce spend year to date (month 7) on bank and agency staff, respectively. However, spending on bank and agency staff varies across the trusts and is suggested to be exacerbated by competition for the same staff groups. This competition has led to unwarranted pay rate escalations, and potentially greater variability between our trusts.

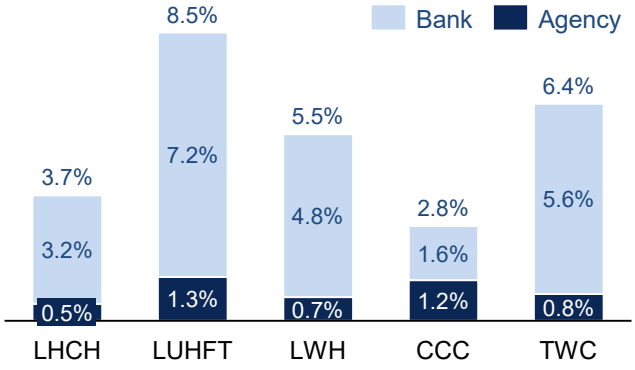


Figure 4.1.3: *Difference in bank/agency spend as a proportion of total staff spend FY24/25 YTD Month 7*

4.2 Key opportunities

The LAASP group will enable us to operate as one Liverpool workforce, offering unique flexibility and variety to attract and retain high quality staff. Through our collective scale, we could create new training opportunities, enhance demand and capacity management, and harmonise management of bank and agency staff.

Attracting and retaining talent

Attracting and retaining talent is essential for strengthening our workforce and ultimately delivering high quality care for our patients. Our specialist trusts have already achieved significant success in this area. By collaborating as LAASP, we can build on these strengths to offer a broader range of opportunities, making us an attractive destination for top-tier professionals. This would support staff to access all modalities across trusts rather than limiting expertise to certain modalities in individual trusts.

By establishing a 'Liverpool Careers' approach across our trusts we could break down organisational barriers and help to address workforce challenges.

Sources: 1) NHS Staff Survey 2023; 2) NHS Provider Finance Returns

4. Workforce and Staff Experience

4.2 Key opportunities cont.

For example, in response to a national shortage of sonographers, we could introduce rotational contracts across our trusts, providing flexibility and broadening opportunities for staff development.

By adopting and scaling this shared workforce vision we could implement rotational roles and shared contracts in a wide range of areas, improving staff satisfaction and increasing workforce flexibility to meet service demands more effectively.

Additionally, trusts across the country are piloting the NHS Digital Staff Passport service[1], which allows employees to move seamlessly between trusts by reducing administrative barriers and enhancing flexibility

This system streamlines onboarding, enabling staff to begin work sooner, reducing rota gaps, lowering reliance on agency workers, and simplifying rota management.

Operating together as LAASP also positions us to attract and retain ambitious professionals seeking dynamic and fulfilling career paths. We can provide more opportunities for career progression and involvement in innovative projects or research than possible as individual trusts alone. Furthermore, we have greater scope to offer flexible working arrangements and initiatives that support work-life balance, aligning with the priorities of a modern and evolving workforce.

While there is an ambition to develop a dynamic new brand for Liverpool Place, it is equally important to preserve the existing strengths that contribute to high staff satisfaction and positive patient experiences. Our unified identity should build on these strengths, instil pride, and inspire a dedicated workforce committed to our shared success, whilst evolving to reflect our collective vision.

New training opportunities through scale

As a group we can offer trainees easier access to diverse learning and development opportunities, exposure to specialties and associated experiences that may not be available within a single trust.

This would particularly benefit Portfolio Pathway doctors by offering tailored training routes to develop expertise in targeted areas while benefiting from mentorship and diverse experiences across trusts.

By working alongside senior staff and educators from various specialities across trusts, trainees can expand their knowledge and build their portfolios with greater ease. Additionally, they can gain access to learning procedural skills unique to each of the specialist trusts, which would otherwise be unavailable without a collaborative approach.

Enhanced demand and capacity management

As one group, we can align workforce supply more effectively with population health needs, ensuring that the right resources are deployed to the right areas at the right time. This strategic alignment reduces gaps in staffing, minimising the need for costly, short-term solutions such as agency or bank staffing. Furthermore, a shared understanding of demand trends and capacity constraints across the system enables proactive workforce planning, fostering greater consistency and sustainability in staffing levels.

Demand and capacity modelling at a higher level also offers advantages over individual trust-level analysis.

Sources: 1) NHS England *Digital Staff Passport*, 2024

4. Workforce and Staff Experience

4.2 Key opportunities cont.

Different techniques (e.g., System Dynamics, Discrete Event Simulation, and Agent Based Modelling) are typically used for modelling systems at the level of complexity seen at a system or regional level, compared to an individual trust[2].

These methods encourage organisations across a system to collaborate more effectively, fostering an integrated approach to addressing short- and long-term challenges[1].

Harmonising bank and agency management

A uniform approach to bank and agency management presents a significant opportunity to increase our purchasing power and negotiate the best agency rates for all. Aligning pay structures will also allow us to mitigate inflationary pressures caused by our trusts competing for the same staff groups reducing financial inefficiencies such as overpaying for agency staff, or duplicating efforts to attract the same pool of staff.

Adopting one approach to bank and agency management will also create opportunity to implement smart data systems that improve data visibility, unlocking opportunities to make both strategic and day to day data informed decisions that benefit the Group, such as easily identifying particular staff groups across the trusts where there is overreliance on bank or agency staff.

4.3 Financial opportunity

The formation of LAASP represents an opportunity to improve ways of working, boost staff satisfaction, and enhance employment opportunities across trusts - all of which serve to improve staff retention and reduce the costs associated with staff replacement.

Numerous case studies provide evidence that initiatives targeted at improving ways of working, staff engagement, and career development result in a reduction of annual leaver rates of **0.5–2.4%**[3,4]

… and evidence suggests the cost of replacing a doctor is **£297,500**[5] and the cost of replacing a nurse is **£13,600**[6] (adjusted for inflation).

Bank spend

To estimate the financial opportunity of a reduction in bank spend due to the formation of LAASP, we compared the LAASP trusts' bank spend as a proportion of staff spend to national benchmarks[1].

As shown in figure 4.3.1, the majority of LAASP trusts, except for LUHFT and TWC, are below the national lower quartile. Therefore, we developed three scenarios:

Low: Assume LUHFT bank spend proportion is reduced to national median

Medium: The average of the low and high scenario

High: Assume LUHFT and TWC bank spend proportion is reduced to the national lower quartile

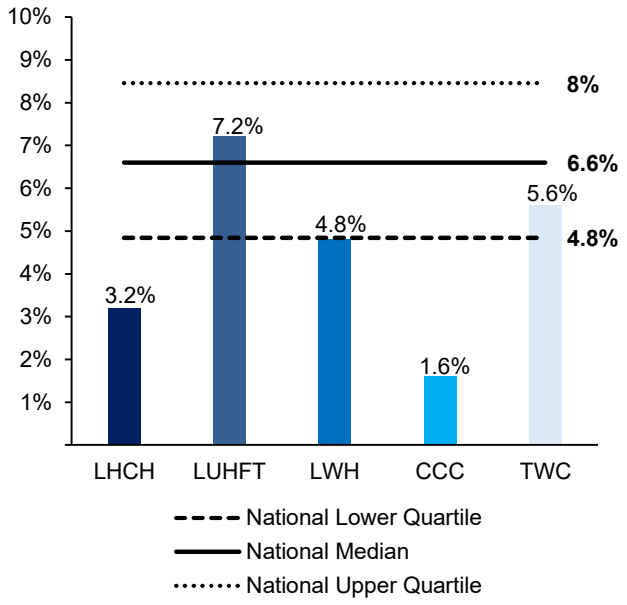


Figure 4.3.1: *LAASP Bank spend as a proportion of staff spend (%)*

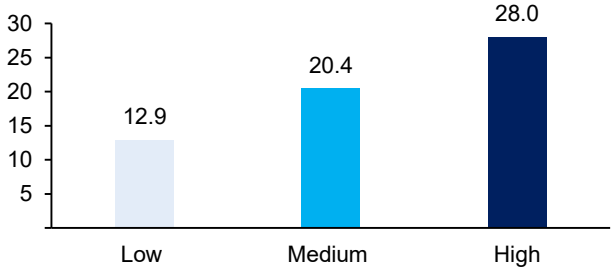


Figure 4.3.2: *Low, medium and high LAASP bank spend opportunity (£m)*

£13 – 28m is the estimated bank spend opportunity from the formulation of LAASP (in a 3-5 year horizon)

Sources: 1) NHS England, *NHS providers: trust accounts consolidation (TAC) data publications*, 2022-23; 2) NHS England *Demand and Capacity*, 2024; 3) NHS Employers, *Improving retention through staff engagement: and Do OD case study*, 2024; 4) NHS Employers, *Supporting staff to work for longer*, 2020; 5) British Medical Association, *When a doctor leaves: tackling the cost of attrition in the Uk's health services*, 2024; 6) NHS Shared Business Services, *Improving staff retention with workforce analytics*

5. Clinical Support and Diagnostic Services

Clinical support and diagnostic services are the backbone of our health services, providing the foundation for accurate diagnoses, effective treatments, and seamless patient journeys. While we have already made significant progress in enhancing these services, operating as a group presents an exciting opportunity to further align our efforts and reduce duplication. By working together, we can streamline pathways and optimise our resources, creating more efficient and coordinated experiences for both patients and staff.

5.1 Overview of current state

The delivery of clinical support and diagnostic services across Liverpool and the wider C&M system faces several challenges that affect operational efficiency, resource utilisation, and ultimately patient care. Significant progress has been made through collaborative efforts and integration – helping our five trusts to perform well against the national average. However, the variation across providers as shown in figure 5.1.1 highlights opportunities for improvement.*

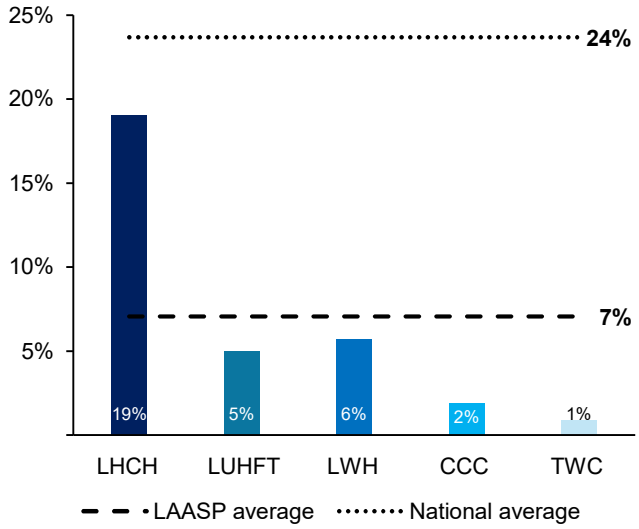


***Figure 5.1.1**: Average percentage of patients waiting 6+ weeks (Oct 23 - Sept 24) for diagnostic test by provider*

Significant progress has been made in integrating diagnostics across sites, including the AUH-RLH merger, which has reduced fragmentation and duplication for patients. Merging processes, legislation, and waiting lists has led to reduced wait times, improved DMO1 compliance, increased accessibility, more research activity, and greater patient choice. Workforce benefits include lower turnover and vacancy rates, driven by enhanced career progression and job satisfaction.

CMAST Diagnostic Programme

Imaging and pathology networks now fall under the broader CMAST Diagnostic Programme, which unites various diagnostic networks, including endoscopy, Community Diagnostic Centres (CDCs), and primary care diagnostics. This comprehensive approach highlights the system's commitment to enhancing diagnostic services.

However, gaps remain, particularly in areas like Cardiology where greater integration could unlock further efficiencies. For instance, while both LHCH and RLH use the Integrated Clinical Environment (ICE) system for pathology, data from one trust is not visible to the other, creating gaps in patient management[1].

CAMRIN

Established in 2012, the Cheshire and Merseyside Radiology Imaging Network (CAMRIN) is a partnership of 12 NHS trusts within C&M ICS, aiming to improve services for patients and staff through large-scale change programmes. CAMRIN reprocured a single Radiology Information System (RIS) and Picture Archiving Communications System (PACS) software[2]. This has allowed the imaging network to deploy AI solutions across the network, progressing the digital maturity of the network to 'thriving'.

However, the lack of shared access to blood results via ICE, and particularly the absence of ECGs in cardiology, continues to hinder effective patient management by leaving clinicians without a complete picture.

The benefits of collaboration are also evident within the trusts of LAASP. For example, **Liverpool Clinical Laboratories (LCL)**, established through the collaboration of LUHFT, LWH, and LHCH, has significantly improved productivity.

Similarly, closer alignment of pharmacy services could optimise resources. Currently, Broadgreen Hospital and LHCH operate separate physical pharmacy units and Electronic Prescribing and Medicines Administration (EPMA) systems, despite being in close proimity[1]. Aligning these services presents an opportunity to optimise space and avoid unnecessary duplication.

Significant progress has also been made in Medicines Optimisation across several services within LAASP, such as the impactful work undertaken in LUHFT's medicines safety improvement programmes

Sources: 1) Interviews with LAASP Staff; 2) NHS C&M *Radiology Imaging Network*, 2024 Notes: * Whilst recognising that different diagnostic tests have different performance times across the clinical specialities that could also contribute to variation.

5. Clinical Support and Diagnostic Services

5.2 Key opportunities

These initiatives focus on enhancing systems and processes to promote greater safety and quality, achieving better patient outcomes through targeted quality improvement efforts

The collaborative work fostered by CMAST and within Liverpool has demonstrated tangible benefits, yet digital systems remain a critical limitation to further progress.

Back-office systems are becoming linked, but fragmented digital systems at the front line continue to impede clinicians' ability to deliver care effectively.

By building on the strong foundations laid by CMAST and within Liverpool so far, there is significant opportunity to address current gaps and establish LAASP as a leader in integrated diagnostic and clinical support services.

Streamlined diagnostic and treatment models

Joint working across the trusts drives and streamlines pathways such as the 18-week referral to treatment (RTT) by optimising resource allocation and introducing innovative solutions.

Pooling diagnostic assets, such as imaging equipment and laboratory facilities, and designing solutions to work at scale, helps address backlogs and directs capacity where it is needed most

Coordinated efforts will enable smoother transitions between diagnostic and treatment stages while minimising delays.

Innovations like **rapid near-patient testing**, **shared diagnostic hubs** and **virtual consultations** enable faster and more accurate diagnostics, while services that can be more community-based such as phlebotomy bring essential diagnostics closer to patients, supporting the shift of care from hospitals to communities.

Aligning pharmacy services

Collaborative efforts to align pharmacy services, such as between Broadgreen and LHCH, can maximise existing resources, reduce redundancy of assets and infrastructure, and eliminate the need for duplicative investments.

Scaling best practices, such as CCC's pharmacy subsidiary PharmaC, for better contract management, could also further enhance service quality and outcomes.

Leveraging group-scale capabilities, such as having specific dispensing contracts across LUHFT, can drive efficiency and standardise high-quality care delivery

Developing and scaling Medicines Optimisation

By collaborating across trusts, we can develop streamlined and robust improvement plans for Medicines Optimisation, scaling these efforts to achieve the greatest impact across LAASP.

We can establish LAASP-wide clinical guidance and medicines management standards, e.g., ensuring uniformity in how controlled drugs are managed, administered, and delivered

Sources: 1) The Clatterbridge Cancer Centre Internal Insights

5. Clinical Support and Diagnostic Services

5.2 Key opportunities cont.

Centralising these processes under a unified corporate structure will help standardise practices, driving consistency and excellence across all services. Operating as a group also allows us to pool resources, advocate for equitable funding for critical services such as radio-pharmacy, and manage these services more efficiently.

Scaling diagnostic excellence

The Cheshire and Merseyside Diagnostics Programme

Hosted by CCC since 2021[1], this programme has significantly improved diagnostic capacity and patient outcomes.

With performance increasing from **79% to 91%** against the six-week waiting time standard[1], the delivery of operational advancements such as 10 Community Diagnostics Centres (CDCs) performing over **500,000 additional tests** annually[1], and spearheading national innovations in echocardiography AI, intelligent liver function testing, and unified pathology systems, the programme has established itself as a **leader in diagnostics delivery**.

The Diagnostics Programme is set to deliver further opportunities, such as **benefits of up to £16m per annum** for a Pathology 3 Hub Target Operating Model and has secured £1.2m to revolutionise digital pathology and deliver faster biopsy turnaround times[1]

Building on the strong foundation of the C&M Diagnostics Programme, we can unlock future opportunities across LAASP and the wider C&M region. For instance, by using the increased capacity of the two CDCs in Liverpool, we could collectively commit to phasing out reliance on the independent sector, except where patient choice dictates. Additionally, we could aim to see all patients within 24 hours, where appropriate, to prevent emergency admissions or attendances - shifting our focus from sickness to prevention.

Another example is jointly bidding for the PET CT contracts, taking a Liverpool system-led approach to enhance service provision and reduce waiting times, which particularly impacts cancer performance

A combined NHS bid would support this service to be NHS-led, benefiting the wider geography and reinforcing integrated care delivery

Integrating digital systems

While ongoing collaboration has driven significant progress, a critical opportunity lies in better linking digital diagnostic systems to enhance the delivery of care and move our system from analogue to digital.

The great work of CMAST has laid a strong foundation, but by collaborating further, it allows us to implement a single laboratory information system across LAASP, revolutionising how diagnostic tests and results are requested, accessed, and utilised.

The C&M Diagnostics Programme has also found **benefits of £10m over 10 years for LIMS** (laboratory information management system) implementation[1]

Through having a unified LIMS system, clinicians across the network would be able to seamlessly request and review diagnostic tests and results, regardless of their or their patient's location.

By fully integrating a unified LIMS across LAASP, we can support seamless cross-trust collaboration, empower clinicians with real-time access to data, and create a more connected, efficient, and responsive healthcare ecosystem

By investing in these areas all trusts can be digitally connected, enabling further integration among pathology labs and aligning with the strategic intent for improved collaborative care models.

Sources: 1) The Clatterbridge Cancer Centre Internal Insights

6. Research, Development, Innovation and Commercialisation

Our commitment to high-quality research within each of the five trusts is beyond question, as demonstrated by our performance and strong partnerships. We believe collaborating as LAASP can enhance the impact of our research and commercial activities. Together, we can accelerate the development of innovative tools and practices by our talented staff and maximise commercial opportunities to optimise patient care.

6.1 Overview of current state

In Liverpool and the wider Cheshire and Merseyside system, we continue to have a strong research infrastructure being home to two National Institute for Health and Care Research (NIHR) funded Clinical Research Facilities (CRF).

We currently work successfully together to deliver our Liverpool CRF across LUHFT, CCC and LHCH, which was instrumental in responding to the COVID-19 pandemic. Further, LUHFT and CCC are affiliated with the Liverpool Experimental Cancer Medicine Centre (ECMC[1]).

As LAASP we all bring distinct expertise and growing strengths in research and innovation.

Across our trusts, we have a **growing number of research staff**, a **diverse portfolio of clinical trials**, and **meaningful collaborations with academic institutions** both locally (The Liverpool Centre for Cardiovascular Science) and nationally (CCC's participation in a cancer specific Biomedical Research Centre (BRC) with The Royal Marsden and City University of London).

Despite investments and collaborative efforts, participation in clinical trials within Liverpool is **lower than Core City peers** per 100,000 of the population[2]

Increasing research participation among under-represented, socially deprived groups in Liverpool would generate findings more applicable to the local population.

Despite strong partnerships with Liverpool universities and support from Liverpool Health Partners, recruitment of academics and researchers is hampered by limited support packages.

Additionally, the largely independent nature of current research activities restricts our ability to scale initiatives and secure larger grants[2].

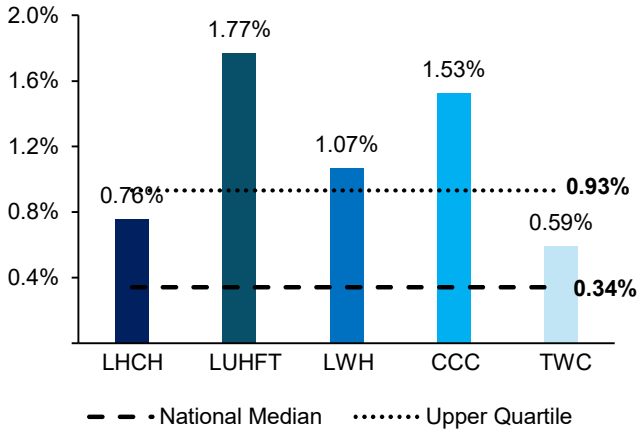


***Figure 6.1.1**: LAASP R&D income as a proportion of total income across trusts 2022-2023 (%)*

Our trusts currently engage in varied commercial activities, but there's significant potential for expansion. Without a unified approach, leveraging a broader patient base, enhancing workforce capacity, and collaborating effectively on large-scale commercial and research opportunities remain constrained.

Commercial Research Delivery Centre (CRDC)

The new Commercial Research Delivery Centre, **hosted by the University Hospitals of Liverpool Group (LUHFT and LWH combined)**, offers Cheshire and Merseyside communities early access to cutting-edge commercial research, alongside the indirect benefits of additional income and prestige the initiative will bring.

As one of 20 CRDCs nationwide[3], the centre's establishment highlights how size, scale, and effective collaboration can attract significant NIHR grants.

6.2 Key opportunities

Scaling research and securing grants

By uniting our efforts, we can leverage a broader patient base, enhancing the scale and impact of clinical trials.

Sources: 1) ECMC Network, Liverpool 2) NHS C&M, *Liverpool Clinical Services Review,* 2023; 3) C&M NHS, *NHS University Hospitals Liverpool Group named as one of 20 UK Commercial Research Delivery Centres*, 2024

6. Research, Development, Innovation and Commercialisation

6.2 Key opportunities cont.

This would position us to attract larger funding opportunities, including NIHR grants, and allows us to compete with larger institutions.

Collaboration would also provide access to additional workforce capacity, enabling research nurses and teams to be deployed more effectively across trusts. Specialised areas such as neurosciences, cancer, and head and neck research offer avenues for targeted growth, supported by Liverpool's recognised strengths in these fields.

A unified research network can create a more compelling value proposition for fellows, professors, and academics, supported by innovative fellowship programmes and stronger ties with Liverpool's research universities

By fostering a nurturing environment that recognises individual trust contributions, we can retain the unique appeal of our trusts' brands, while benefiting from the impact of a larger group.

Aligning academic research with local population need

Creating a united interface and more standardised ways of working will enable us to deepen our relationships with Liverpool universities.

Enhanced integration with universities encourages access to better academic support and strengthens our bids for BRC status

It will also enable us to strategically align collective research priorities with our local population needs, from neurodegenerative diseases to cardiovascular medicine, fostering partnerships that are academically and clinically impactful.

Fostering clinical innovation

We have the potential to build on strong pockets of culture that support and celebrate grassroots innovation empowering clinicians to drive impactful ideas forward.

Developing a clear, standardised innovation framework will empower clinicians to bring their ideas to an innovation hub for evaluation, acceleration, and commercialisation.

Example: *At CCC, a clinical director developed a groundbreaking molecular test to accurately predict mortality in palliative care patients[1].*

By identifying specific metabolites that emerge before traditional diagnostic markers, this innovation enables more predictive and personalised patient care. This showcases how organic clinician-driven ideas can be transformed into impactful solutions.

Identifying and scaling commercial opportunities

As LAASP, our specialisation and scale position us to dynamically generate revenue beyond the NHS. A structured approach will help us identify and scale successful initiatives within the group.

Example: *At TWC specialised spinal surgery has enabled a lucrative partnership with a leading IT services and consulting firm. By licensing long-term outcome data from their database, the trust generates £125k annually[1].*

This model developed organically, demonstrating how clinical data can be effectively monetised while contributing to ongoing research and innovation.

Long-term contracts with industry leaders will allow us to secure funding, develop products collaboratively, and establish clinical programmes directly sponsored by industry partners.

Example: *LHCH has established a long-term contract with a medical devices company to purchase their products over several years[1]. In return for this multi-year commitment, the medical devices company provided support for capital investment.*

Alongside similar agreements with other medical devices firms, the trust has been able to foster symbiotic relationships where lead clinicians can collaborate on product development and clinical programmes sponsored by the industry.

Strong relationships such as LHCH's with a medical devices company, or CCC's with a pharmaceutical company offer a strong foundation from which the group can build their commercial approach at scale.

Sources: 1) Interviews with LAASP staff

6. Research, Development, Innovation and Commercialisation

6.3 Financial opportunity

The formation of LAASP creates an avenue for our trusts to increase income streams by leveraging our scale to consistently capitalise on commercial opportunities. This could also be beneficial for the wider Cheshire & Merseyside region. To illustrate this, we estimated the financial opportunity across three different income streams:

1) Research and Development Income (R&D)

2) Education and Training (E&T)

3) Private Patient Income (PP)

By evaluating LAASP trust income streams as a proportion of total income, we compared this against national benchmarks. Each of our trusts have variation in the levels of income from R&D, E&T and PP that each respectively drive their total income. Taking a blended view across the three income streams helps to account for the difference in how each trust operates and generates income.

To estimate the financial opportunity, unique scenarios had to be developed for each income stream (as shown in Table 6.3.1). This is due to variance in performance. For example, all LAASP trusts' income proportions for R&D are greater than the national median, whilst for PP, all income proportions are only greater than the lower quartile.

Scenario	R&D	E&T	PP
Low	Assume LAASP achieve 75% of additional income from income proportion equal to CCC (1.7%)	Assume income proportion equals national lower quartile	Assume income proportion equals national median
Medium	Average of low and high scenario	Assume income proportion equals national median	Average of low and high scenario
High	Assume LAASP achieve 75% of additional income from income proportion equal to LUHFT (1.9 %)	Assume income proportion equals national upper quartile	Assume income proportion equals national upper quartile

***Table 6.3.1** Financial opportunity scenarios*

We estimate that the formation of LAASP could result in a total opportunity size of **£10 - 26m** in recurring annual additional income across LAASP 3-5 years after formation.

Opportunity	Low	Medium	High
R&D	3.8	4.6	5.3
E&T	4.9	8.5	13.4
PP	1.2	4.2	7.1
Total	**10.0**	**17.2**	**25.8**

***Table 6.3.2** LAASP additional income opportunity (£m)*

7. Corporate and Shared Services

To improve efficiency, productivity, and collaboration across Liverpool, we see significant opportunities in corporate and shared services within LAASP to tackle operational inefficiencies and financial challenges. This understanding stems from the work of CMAST's efficiency at scale initiatives, like Health Procurement Liverpool and unified payroll systems. We aim to build on these efforts, enhance efficiencies at the Liverpool level, and leverage collective expertise across the acute and specialist trusts while maintaining high service quality.

7.1 Overview of current state

Of the five trusts, LWH is the only trust with costs above the national median. However, there is significant variation in the costs of the corporate functions overall and for specific functions. Within LAASP, LWH has the highest costs of c.£6m per £100m of income and LUHFT has the lowest with corporate costs of c.£4m per £100m[1] income, which are further broken down in figure 7.1.1 below.

Furthermore, there is duplication of specific fixed costs services, such as within HR, Finance, Governance and Risk functions. Through the efficiency at scale programme by CMAST, there is a specific focus on better understanding the cost drivers to improve understanding of productivity within trusts.

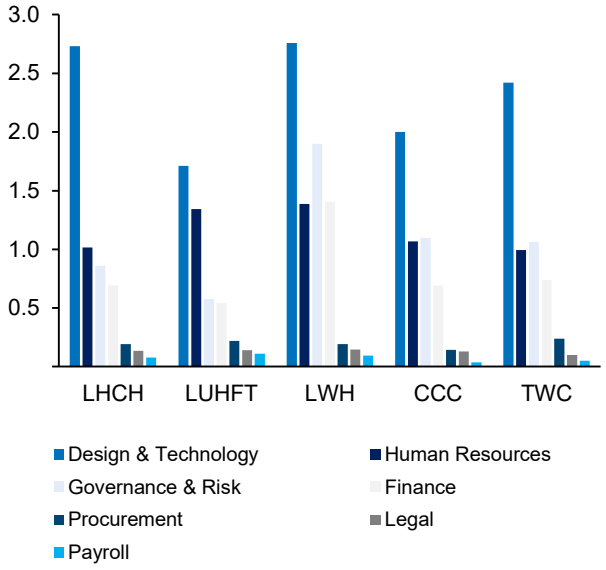


Figure 7.1.1: *Corporate services total cost breakdown per £100m income by trust*

7.2 Key opportunities

While we already work together to deliver many services, closer partnership can help standardise processes and reduce duplication.

Reducing unnecessary duplication

By working collectively, we can consolidate functions and processes where necessary, leading to cost savings and more efficient operations. Preliminary analysis suggests opportunities within digital services, HR processes, finance, legal services, and governance functions.

Within HR, training of Radiologists is conducted at each trust and could instead be arranged and coordinated by one department to reduce costs

Economies of scale

We can leverage our collective size to achieve economies of scale. This will enhance our purchasing power, for example allowing us to negotiate better procurement rates with suppliers for medical equipment and pharmaceuticals, thereby reducing per-unit costs.

Larger contract opportunities with service providers can lead to more favourable terms and reduced operational costs, ultimately freeing up resources to be reinvested in patient care

7.2.1 Enablers

Operating as a unified group will allow us to fully leverage three key enablers - digital, estates & facilities and finance, to drive meaningful improvements in all aspects of patient care.

Digital

We have a significant opportunity to enhance interoperability among our digital systems, currently fragmented with over ten different Patient Administration Systems (PAS) and EPR systems, hindering effective information sharing. By integrating these services, aligned with the national shift from analogue to digital, we can innovate care delivery and elevate digital capabilities across all organisations.

Shared digital platforms, such as converged EPR, referral, and EPMA systems, improve care coordination and patient management, facilitating seamless care transitions and reducing errors.

Additionally, integrated services support system-wide population health management, demand/capacity modelling, and business intelligence, providing critical insights for targeted interventions and efficient resource allocation.

Estates and facilities

Estate strategy and master planning is a key pillar within the LAASP delivery structure. By working as a group, we can make more efficient use of our joint estate, taking a strategic approach based on patient and clinical need to optimise the use of estates and

Sources: 1) CMAST Internal Analysis

7. Corporate and Shared Services

7.2.1 Enablers cont.

capital expenditure. This also provides an opportunity to align investment with clinical pathway transformation, identifying suitable and under-utilised space across the city.

Since 2016, while the NHS estate has grown by **3%**, patient attendances have risen by **11%**[1], highlighting the need for efficient space management to meet rising demand and provide a safer and more compliant care environment for patients

The condition and functionality of NHS estates are often constraints for NHS trusts, with significant investment required to modernise and make ageing premises fit-for-purpose. However, within LAASP, most of the trusts occupy relatively modern estate with 67% of CCC estate and c.80% of RLH, within the LUHFT estate, constructed in the last 10 years[2]. This allows for targeted investment in other areas of need and further development of the combined estate.

The C&M efficiency-at-scale programme identified significant costs in facilities like cleaning and catering, presenting opportunities for innovative approaches, such as the PropCare subsidiary established by CCC.

Recognising the critical role of estates in group operations, a dedicated project will establish a baseline assessment of estates across LAASP, providing a strong foundation for future planning.

Finance

Pooling capital resources enables us to enhance financial planning and resource allocation, allowing for strategic investments in infrastructure and technology

This approach promotes the efficient use of funds to support long-term healthcare improvements. Furthermore, collaboration enables us to better share and manage financial risks, particularly in areas where cost drivers span multiple organisations. By working collectively, we can tackle financial challenges more effectively and prioritise allocating resources where they are needed most.

7.3 Financial opportunity*

There is significant variation in corporate services costs across trusts. The formation of LAASP represents an opportunity to reduce variance and overall corporate services costs through the standardisation and sharing of services and processes. Following the Model Hospital's opportunity methodology, we estimated the cost savings opportunity across corporate functions:

- Digital and technology
- Finance
- Payroll
- HR
- Procurement
- Governance & Risk
- Legal

We developed three opportunity scenarios:

1) Low:

- If cost > National lower quartile, assume opportunity target = National lower quartile
- If cost > National median, assume opportunity target = National median
- If cost > National upper quartile, assume opportunity target = National upper quartile

2) Medium: Average of low and high scenario

3) High:

- If cost > National lower quartile, assume opportunity target = National lower quartile
- If cost > National median, assume opportunity target = National median
- *If cost > National upper quartile, assume opportunity target = National median*

We estimate that LAASP could have an annual recurring opportunity of approximately **£7 - 8m** in corporate services costs.

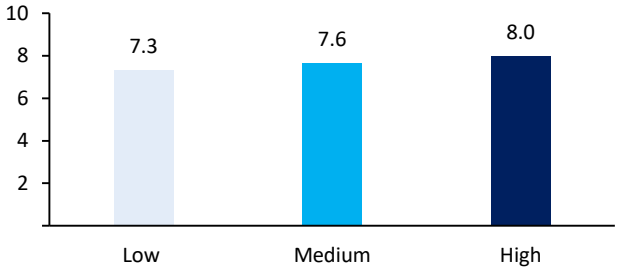


Figure 7.3.1: *LAASP annual corporate and shared services financial opportunity (£m)*

Sources: 1) NHS England *Delivering productivity through the NHS estate*, 2024; 2) NHS England *Estates Returns Information Collection 2023-24 Site data*, 2024
Notes: * Whilst there will be financial opportunities within estates following the formation of LAASP, these opportunities have not been calculated due to limitations in data availability.

8. Financial Sustainability

We have a collective responsibility to design our services around the healthcare needs of the population. As the prevalence of comorbidities continues to rise, LAASP has an opportunity to shape services to better meet the needs of our patients. Operating within a financially challenged regional and national NHS environment, we need to think differently about how to make best use of our collective resources to sustainably deliver healthcare to people in Liverpool.

8.1 Overview of current state

The five trusts within LAASP are currently operating within a significantly challenged financial environment across the NHS and Cheshire & Merseyside Integrated Care System (ICS).

As of 30th November 2024 (Month 8), the ICS is reporting a YTD deficit of £113m against a planned YTD deficit of £61.5m resulting in an adverse YTD variance of £51.5m[1].

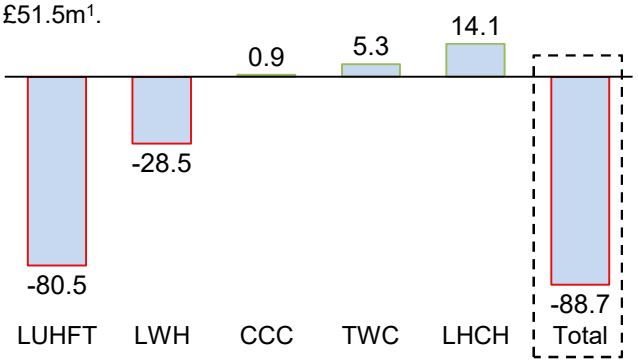


Figure 8.1.1: *FY24/25 financial plans submitted by each of the 5 trusts and the total deficit (£m)*

The financial picture across the trusts varies, as outlined in figure 8.1.1 above, with the majority of £88.7m planned group deficit sitting with LUHFT. At Month 6, LUHFT are also the only trust out of the 5 to have a Risk Adjusted FOT that is £18.3m worse than Plan at £98.8m[1].

In year financial performance against plan at Month 8 is also varied across the trusts, with LUHFT and LHCH £7m and 0.4m[1] behind plan respectively, CCC on plan and TWC and LWH 0.4m and 0.9m[1] ahead of plan.

8.2 Financial opportunity

Alongside opportunities to improve patient experience, clinical quality and staff experience, there are meaningful financial opportunities associated with the five hospitals working closely together within a group structure which have been explored throughout this document. These are just an indicative sample of the true scale of opportunities that working as a group could enable.

Figure 8.2.1 shows how the LAASP financial opportunities identified within this report could bring the combined group into a more financially sustainable position, with a total estimated annual recurrent financial opportunity of **£49-90m**.

The majority of these benefits are expected to come from clinical pathway efficiencies (approximately £19-29m) and a reduction in temporary staffing costs (approximately £13-28m).

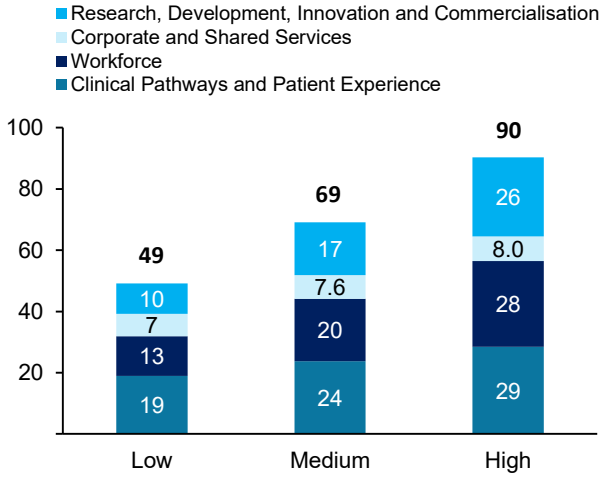


Figure 8.2.1: *Cumulative financial opportunity identified with the formation of LAASP (summary of report analysis, non-exhaustive) (£m)*

Our analysis into clinical pathway efficiencies focused on inpatient services so represents only a portion of the total clinical opportunity. Recent C&M ICB analysis of reference costs across all health services suggests a total financial opportunity of approximately **£160m,** indicating further opportunities in Outpatients, Emergency Care and other areas. Further work is needed to evaluate the full financial opportunity within LAASP health services.

Sources: 1) Provider PFRs

9. Conclusion and Next Steps

This document outlines the potential opportunities of working together as five trusts within LAASP, focussing on aligning our ways of working and integrating the services we provide to ultimately improve the healthcare experiences and health outcomes of people in Liverpool.

However, we recognise that we cannot accomplish this without working more closely with our system partners, and there is more we could achieve as a group through further conversations. As we move forward, the case for change will guide our efforts to create detailed business cases that will explore how we can deliver more cohesive, efficient, and patient-centred acute and specialist care.

9.1 Further work

Following development of our Case for Change we will now be embarking on a period of engagement with our staff and patients to develop our **LAASP Strategic Case** and **Financial Sustainability Plan** that will expand on the opportunities in this document and chart our implementation journey. We will develop a financial framework that will reflect how the group could 'act as one' with a unified approach.

9.2 Critical success factors

As we design our future state and further identify the changes and improvements that will benefit our patients, staff and wider healthcare system, there are considerations that are critical to our success:

Patient and staff involvement	The voices of those we serve are central to our design and planning, as is understanding and including the diverse perspectives of our workforce. We will create a range of opportunities to gather insights and feedback to shape our future work and provide the necessary support to guide any changes.
Our governance structures	Working collectively requires alignment at all levels - a shared vision, objectives and goals. To address the opportunities and challenges outlined in our case for change, we will establish a robust programme structure and leverage leadership from across our organisations. We will also delegate the decision-making authority and resources to the LAASP Programme to drive the success of our work.
Our brand identity and culture	It is crucial that in developing a group identity, we build on the strengths of our existing individual brands to enhance the value of LAASP as a collective. There are strong, attractive cultures across our trusts, and our aim is to learn from and amplify what makes the trusts within LAASP a great place to work and receive care.
Estates and capital optimisation	Effective use of our collective estate is vital and depends on strategic alignment across all our trusts. We will adopt a collaborative approach to capital planning, making sure that investment is guided by patient and clinical needs, whilst identifying opportunities to maximise the efficiency and use of our estate.
Digital enablement	A unified digital approach is essential to delivering an outstanding experience for our patients and reducing complexity for our staff. We will invest in our digital capabilities such as a single EPR, convergence and greater interoperability across our organisations, to optimise our workflows and communication as a group.

9.3 Conclusion

In conclusion, the development of our Case for Change has highlighted that we can do better for the patients that we serve.

From a clinical perspective, our organisational boundaries are impacting the care we provide across several pathways, including but not limited to women's services, cardiology and stroke, while also influencing how patients experience our services.

Financially, our emerging group faces significant financial risks that require effective management. Operating at scale through LAASP offers an opportunity to mitigate these risks over the long term.

To address these challenges, we must now develop a comprehensive programme of work to simplify the delivery of our clinical and corporate services, supporting a more efficient and effective future.

Appendix A: Financial Opportunities Summary

A detailed summary of the financial opportunities* outlined in this report:

		Annual Opportunity Within 3 - 5 Years (£m)**		
Report section	**Description**	**Low**	**Medium**	**High**
Clinical Pathways & Patient Experience	Reduction in Elective, Non-Elective: Long Stay and Non-Elective: Short Stay costs	19.0	23.8	28.5
Workforce & Staff Experience	Reduction in bank spend, aligned to the median and upper quartile national spend	12.9	20.4	28.0
Research, Development & Innovation and Commercialisation	Increase in Trust income from RD&I and Commercial routes in line with the national and upper quartile medians	3.8	4.6	5.3
	Increase in trust income from Education and Training	4.9	8.5	13.4
	Increase in Private Patient income	1.2	4.2	7.1
Corporate and Shared Services	Reduction in trust spend on Corporate and Shared Services in line with the national and upper quartile medians	7.3	7.6	8.0
Total		**49.2**	**69.1**	**90.3**

Notes: *The financial opportunities identified here represent areas with the strongest evidence base; however, they do not encompass all potential financial benefits for LAASP. They are presented as gross rather than net benefits as they do not account for the costs associated with the formation of LAASP. As there are different scenarios and therefore costs associated with how LAASP will be established, costs have been omitted from the analysis. **Sum of opportunities and the total may differ due to rounding

Appendix B: Financial Opportunities Methodology

The following the section outlines the methodology and assumptions used to estimate the financial opportunities across the four following areas:

1) **Clinical Pathways**
2) **Workforce**
3) **Research, Development, Innovation, and Commercialisation**
4) **Corporate and Shared Services**

It is important to note across all of these areas that the financial opportunities are calculated at a high level and will require further refinement through future work as opportunity areas are developed in detail.

Financial Opportunity Assumption

The estimated financial opportunities are presented as annualised figures and represent what can be achieved once LAASP attains a suitable level of maturity, which we anticipate will occur within 3 to 5 years of all members joining LAASP (allowing for time to implement the necessary changes and initiatives to fully unlock these opportunities).

1) Clinical Pathways*

To estimate the financial opportunity within clinical pathways, we compared the weighted average of the LAASP Trusts' National Cost Collection Index (NCCI) for inpatient services (see Table B1.1) against suitable trust comparators to determine if there was variation and, therefore, an opportunity to reduce costs. Comparators were selected based on having similar sizes, structures, and specialisms to the structure if LAASP and their NCCIs are shown alongside in Table B1.2.

LAASP trusts	Elective Inpatients NCCI	Non-Elective Inpatients: Long Stay NCCI	Non-Elective Inpatients: Short Stay NCCI
LHCH	94	104	102
LUHFT	87	109	91
CCC	155	157	157
LWH	111	114	121
TWC	110	114	120
Weighted Average	96	111	99

Table B1.1: *LAASP NCCI average for Inpatient Services (23/24)*

Comparator trusts	Elective Inpatients NCCI	Non-Elective Inpatients: Long Stay NCCI	Non-Elective Inpatients: Short Stay NCCI
Barts Health NHS Trust	113	83	76
Guy's & St. Thomas' NHS Foundation Trust	115	138	136
Imperial College Healthcare NHS Trust	101	90	88
Manchester University Foundation Trust	105	112	111
Northern Care Alliance NHS Foundation Trust	114	93	90
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	90	87	89
Weighted Average	106	98	101

Table B1.2: *Comparator trust NCCI average for Inpatient Services (23/24)*

LAASP's weighted average NCCI is approximately 10% lower than the comparator for Elective Inpatients, but it is 12% higher for Non-Elective Long-Stay and 1% higher for Non-Elective Short-Stay. To estimate the opportunity, the percentage variation in NCCI was applied to the LAASP trusts' NCCIs. From this, we calculated the potential revised costs of inpatient services.

Continued on next page

Notes: * Sum of opportunities and the total may differ due to rounding

Appendix B: Financial Opportunities Methodology

1) Clinical Pathways cont.

As shown in Table B1.3, the net opportunity across LAASP trusts equalled £38 million. However, given NCCI represents a 'whole cost' measure (with a portion of overheads assigned to clinical activities), we do not believe it is appropriate to take 100% of this opportunity. To be conservative, we have therefore developed three scenarios to estimate the total LAASP opportunity:

1) **Low scenario**: Assume LAASP achieves 50% of the opportunity
2) **Medium scenario**: Assume average of low and high scenarios
3) **High scenario:** Assume LAASP achieves 75% of the opportunity

From this, we estimate the financial opportunity for LAASP trusts in clinical pathways to be approximately from £19 to £28.5 million.

Trust	Financial opportunity (at 100%)
LHCH	0.8
LUHFT	32.1
CCC	0.8
LWH	4.0
TWC	0.3
Total	38.0

Table B1.3: *LAASP inpatient services net opportunity (£m)*

Trust	Low	Medium	High
LHCH	0.4	0.5	0.6
LUHFT	16.0	20.1	24.1
CCC	0.4	0.5	0.6
LWH	2.0	2.5	3.0
TWC	0.1	0.2	0.2
Total	19.0	23.8	28.5

Table B1.4 *LAASP annual financial opportunity (£m)*

Appendix B: Financial Opportunities Methodology

2) Workforce

To estimate the financial opportunity within the workforce, we compared the bank spend as a proportion of staff spend for LAASP trusts against trusts nationwide. Using data from Trust Accounts Consolidation (TAC) 22/23, we calculated the national lower quartile (4.8%), median (6.6%), and upper quartile (8.5%), as shown in Figure B2.1. When comparing LAASP trusts to the national benchmark, excluding LUHFT and TWC, the bank spend proportion for these trusts is below the national lower quartile.

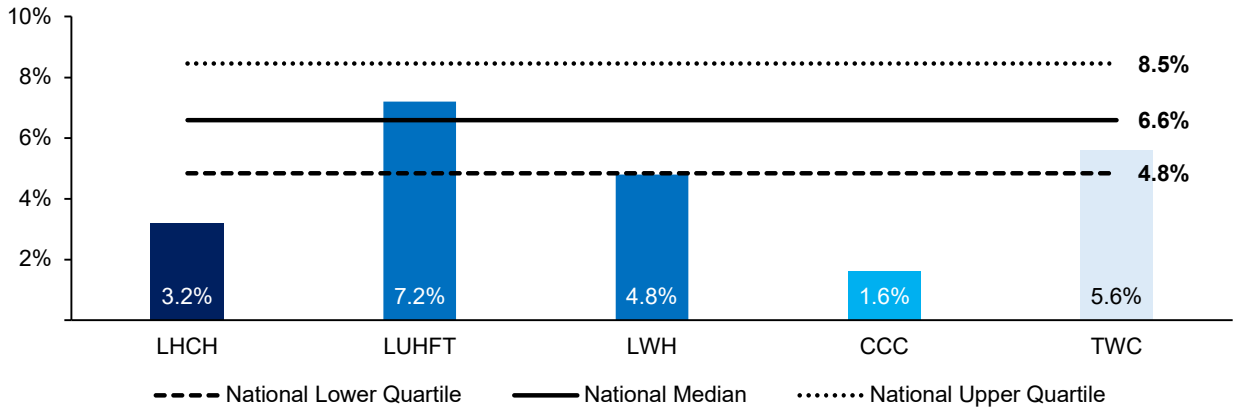


Figure B2.1 *LAASP annual bank spend as a proportion of staff spend (%) (22/23)*

To estimate the financial opportunity, we developed three scenarios:

1) Low: Assume LUHFT's bank spend proportion is reduced to the national median.

2) Medium: The average of the low and high scenarios.

3) High: Assume the bank spend proportion for LUHFT and TWC is reduced to the national lower quartile.

Applying the updated bank proportion from each scenario to the total staff spend, we estimate the financial opportunity for LAASP trusts in workforce management to be approximately **£13 - 28m**.

Trust	Low	Medium	High
LHCH	0.0	0.0	0.0
LUHFT	12.9	20.4	27.9
LWH	0.0	0.0	0.1
CCC	0.0	0.0	0.0
TWC	0.0	0.01	0.03
Total	12.9	20.4	28.0

Table B2.2 *LAASP bank spend savings (£m)*

Appendix B: Financial Opportunities Methodology

3) Research, Development, Innovation, and Commercialisation

To estimate the financial opportunity within Research, Development, Innovation, and Commercialisation, we estimated the potential additional income that trusts could generate from the formation of LAASP. Therefore, three income streams were chosen:

1) Research and Development (R&D)
2) Education and Training (E&T)
3) Private Patient (PP)

To account for the different sizes of trusts, we chose to compare income streams as a proportion of total income against trusts nationwide (See Tables B3.1 and B3.2).

Trust	R&D	E&T	PP
LHCH	0.8%	1.3%	2.0%
LUFHT	1.9%	3.9%	0.1%
LWH	0.9%	4.1%	2.9%
CCC	1.7%	1.4%	1.5%
TWC	0.6%	2.1%	0.1%

Table B3.1: *LAASP commercial income as a proportion of total income (23/24)*

Trust	R&D	E&T	PP
National Lower Quartile	0.2%	2.2%	0.04%
National Median	0.3%	2.7%	0.2%
National Upper Quartile	0.9%	3.4%	0.5%

Table B3.2: *National benchmarks of commercial income as a proportion of total income (22/23)*

As shown above, there is significant variation in income streams across trusts. LUHFT ranks highest for R&D, and LWH for E&T as well as PP. To estimate the financial opportunity across each trust, we followed a similar methodology to that used by Model Hospitals. Using national benchmarks, we estimated the additional income LAASP trusts could generate if their commercial income streams, as a proportion of income, were equal to the national benchmarks.

However, LAASP trusts' performance against the national benchmarks varies considerably for each income stream. For example, for R&D, all the LAASP Trusts have an income proportion above the national median. On the other hand, for E&T, three trusts (LHCH, CCC, and TWC) have income proportions below the national lower quartile. It was therefore necessary to develop different estimation scenarios for each income stream, as shown below in Table B3.3.

Scenario	R&D	E&T	PP
Low	Assume LAASP achieve 75% of additional income from income proportion equal to CCC (1.7%)	Assume income proportion equals national lower quartile	Assume income proportion equals national median
Medium	Average of low and high scenario	Assume income proportion equals national median	Average of low and high scenario
High	Assume LAASP achieve 75% of additional income from income proportion equal to LUHFT (1.9 %)	Assume income proportion equals national upper quartile	Assume income proportion equals national upper quartile

Table B3.3: *Financial opportunity scenarios*

Appendix B: Financial Opportunities Methodology

3) Research, Development, Innovation, and Commercialisation cont.

With the developed scenarios, it was then possible to estimate the financial opportunity across trusts for each income stream (see Tables B3.5/6/7). As shown in Table B3.4, we estimate a total financial opportunity of **£10 – 26m**. The largest opportunity lies within E&T, with a total opportunity of **£5 – 13m**.

Scenario	R&D	E&T	PP	Total
Low	3.8	4.9	1.2	10.0
Medium	4.6	8.5	4.2	17.2
High	5.3	13.4	7.1	25.8

Table B3.4: *LAASP additional income opportunity (£m)*

Trust	R&D	E&T	PP	Total
LHCH	1.5	2.2	0.0	3.7
LUFHT	0.0	0.0	1.1	1.1
LWH	0.8	0.0	0.0	0.8
CCC	0.0	2.4	0.0	2.4
TWC	1.5	0.3	0.1	2.0
Total	3.8	4.9	1.2	10.0

Table B3.5: *Low Scenario – Additional income opportunity by trust (£m)*

Trust	R&D	E&T	PP	Total
LHCH	1.7	3.4	0.0	5.1
LUFHT	0.0	0.0	3.7	3.7
LWH	0.9	0.0	0.0	0.9
CCC	0.3	3.8	0.0	4.1
TWC	1.7	1.3	0.5	3.5
Total	4.6	8.5	4.2	17.2

Table B3.6: *Medium Scenario – Additional income opportunity by trust (£m)*

Trust	R&D	E&T	PP	Total
LHCH	1.9	5.0	0.0	6.9
LUFHT	0.0	0.0	6.2	6.2
LWH	1.1	0.0	0.0	1.1
CCC	0.5	5.8	0.0	6.3
TWC	1.9	2.6	0.9	5.4
Total	5.3	13.4	7.1	25.8

Table B3.7: *High Scenario – Additional income opportunity by trust (£m)*

Appendix B: Financial Opportunities Methodology

4) Corporate and Shared Services

To estimate the financial opportunity within corporate and shared services, we followed the methodology of Model Hospitals and evaluated the variation in the cost of corporate functions across trusts and how it compared to national benchmarks. As shown in Table b4.1 below, there is significant variation in corporate function costs per £100 million income across each trust.

Trust	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll
LHCH	0.7	0.2	0.9	0.1	1.6	1.0	0.1
LUHFT	0.5	0.2	0.6	0.1	1.5	1.3	0.1
LWH	1.4	0.2	1.9	0.1	1.9	1.4	0.1
CCC	0.7	0.1	1.1	0.1	1.2	1.1	<0.1
TWC	0.7	0.2	1.1	0.1	1.7	1.0	0.1
National Lower Quartile	**0.5**	**0.1**	**0.6**	**0.1**	**1.4**	**1.0**	**0.1**
National Median	**0.6**	**0.2**	**0.8**	**0.1**	**1.7**	**1.3**	**0.1**
National Upper Quartile	**0.7**	**0.3**	**1.1**	**0.2**	**2.2**	**1.6**	**0.1**

***Table B4.1**: Corporate and shared services cost per £100m income (£m)*

Exploiting the variation in cost per £100m we developed three scenarios:

1) **Low:**
   - If cost > National lower quartile, assume opportunity target = National lower quartile
   - If cost > National median, assume opportunity target = National median
   - If cost > National upper quartile, assume opportunity target = National upper quartile
2) **Medium:** Average of low and high scenario
3) **High:**
   - If cost > National lower quartile, assume opportunity target = National lower quartile
   - If cost > National median, assume opportunity target = National median
   - If cost > National upper quartile, assume opportunity target = National median*

From the scenarios, we estimated the financial opportunity across corporate functions. We estimate that the formation of LAASP could result in a reduction in Corporate and Shared Services costs of **£7 – 8m**, with the largest opportunities existing within Governance and Risk **(£2.4m)** and Finance **(£1.5 – 1.9m**). A break down of opportunity by trust can be found in Tables B4.3/4/5.

Scenario	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll	Total
Low	1.5	0.3	2.4	0.6	1.2	1.2	0.2	**7.3**
Medium	1.7	0.3	2.4	0.6	1.2	1.2	0.3	**7.6**
High	1.9	0.3	2.4	0.6	1.2	1.2	0.4	**8.0**

***Table B4.2**: LAASP corporate and shared services total opportunity (£m)*

*The LWH Governance and Risk benchmark was kept as the national upper quartile. As a women's hospital, LWH faces high costs incurred by negligence claims for example. that would not likely reduce through the formation of LAASP.

Appendix B: Financial Opportunities Methodology

4) Corporate and Shared Services cont.

Trust	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll	Total
LHCH	0.2	0.1	0.1	0.1	0.4	0.0	<0.1	0.9
LUHFT	0.1	0.1	0.0	0.5	0.6	0.9	0.1	2.2
LWH	1.0	0.1	1.2	0.0	0.2	0.2	<0.1	2.6
CCC	0.2	0.0	0.7	0.1	0.0	0.1	0.0	1.1
TWC	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.5
Total	**1.5**	**0.3**	**2.4**	**0.6**	**1.2**	**1.2**	**0.2**	**7.3**

Table B4.3: *Low scenario – Corporate and shared services opportunity by trust (£m)*

Trust	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll	Total
LHCH	0.2	0.1	0.1	0.1	0.4	0.0	<0.1	0.9
LUHFT	0.1	0.1	0.0	0.5	0.6	0.9	0.3	2.3
LWH	1.1	0.1	1.2	0.0	0.2	0.2	<0.1	2.7
CCC	0.2	0.0	0.7	0.1	0.0	0.1	0.0	1.1
TWC	0.1	0.0	0.4	0.0	0.0	0.0	0.0	0.6
Total	**1.7**	**0.3**	**2.4**	**0.6**	**1.2**	**1.2**	**0.3**	**7.6**

Table B4.4*: Medium scenario – Corporate and shared services opportunity by trust (£m)*

Trust	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll	Total
LHCH	0.2	0.1	0.1	0.1	0.4	0.0	<0.1	0.9
LUHFT	0.1	0.1	0.0	0.5	0.6	0.9	0.4	2.4
LWH	1.2	0.1	1.2	0.0	0.2	0.2	<0.1	2.8
CCC	0.2	0.0	0.7	0.1	0.0	0.1	0.0	1.1
TWC	0.2	0.0	0.4	0.0	0.0	0.0	0.0	0.7
Total	**1.9**	**0.3**	**2.4**	**0.6**	**1.2**	**1.2**	**0.4**	**8.0**

Table B4.5*: High scenario – Corporate and shared services opportunity by trust (£m)*

Appendix C: List of Abbreviations

Abbreviation	Full Description
ACS	Acute Coronary Syndrome
BRC	Biomedical Research Centre
C&M	Cheshire and Merseyside
CAMRIN	Cheshire and Merseyside Radiology Imaging Network
CCC	The Clatterbridge Cancer Centre NHS FT
CMAST	Cheshire and Merseyside Acute and Specialist Trusts
CRDC	Commercial Research Delivery Centre
CRF	Clinical Research Facilities
D&T	Digital and Technology
E&T	Education and Training
ECG	Electrocardiogram
ECMC	Experimental Cancer Medicine Centre
ED	Emergency Department
EPMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Record
FSP	Financial Sustainability Plan
HF	Heart Failure
ICB	Integrated Care Board
ICE	Integrated Clinical Environment
ICS	Integrated Care System
LAASP	Liverpool Adult Acute and Specialist Providers
LCCS	Liverpool Centre for Cardiovascular Science
LCL	Liverpool Clinical Laboratories
LHCH	Liverpool Heart and Chest Hospital NHS FT
LIMS	Laboratory Information Management System
LUHFT	Liverpool University Hospitals NHS FT
LWH	Liverpool Women's Hospital NHS FT
MDT	Multidisciplinary Team
MHLDC	Mental Health, Learning Disabilities and Community Collaborative
NCCI	National Cost Collection Index
NIHR	National Institute for Health and Care Research
NSTEMI	Non-ST-elevated Myocardial Infarction
PACS	Picture Archiving and Communication System
PAS	Patient Administration System
PCI	Percutaneous Coronary Intervention
PHM	Population Health Medicine
PP	Private Patient
R&D	Research and Development
RIS	Radiology Information System
RLH	Royal Liverpool Hospital
RTT	Referral to Treatment
SSNAP	Sentinel Stroke National Audit Programme
STEMI	ST Elevated Myocardial Infarction
TWC	The Walton Centre NHS FT
UHL/UHLG	University Hospitals of Liverpool Group
YTD	Year to Date

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Report on the October/November 2024 public engagement on Improving Hospital Gynaecology and Maternity Services in Liverpool

Agenda Item No: ICB/03/25/12

Responsible Directors: Christine Douglas, Director of Nursing and Care
Fiona Lemmens, Associate Medical Director,
Clare Powell, Programme Director

Report on the October/November 2024 public engagement on Improving Hospital Gynaecology and Maternity Services in Liverpool

1. Purpose of the Report

1.1 The Board approved the Hospital Gynaecology and Maternity Services in Liverpool case for change on 9 October 2024.

1.2 Following the approval of the case for change, a six-week public engagement entitled *Improving Hospital Gynaecology and Maternity Services in Liverpool* launched on 15 October 2024, and ran until 26 November 2024.

1.3 An independent organisation, Hood & Woolf, was commissioned to collect questionnaire feedback during the engagement, then analyse the findings of the engagement as a whole and produce a report presenting the outcomes. This paper presents the resulting engagement report.

1.4 The Board is asked to note the report, and acknowledge that the findings will be used to inform the forthcoming options process.

1.5 The publication of these Board papers marks the point at which the report was first shared in the public domain. Supporting communications have been issued to coincide with this.

2. Executive Summary

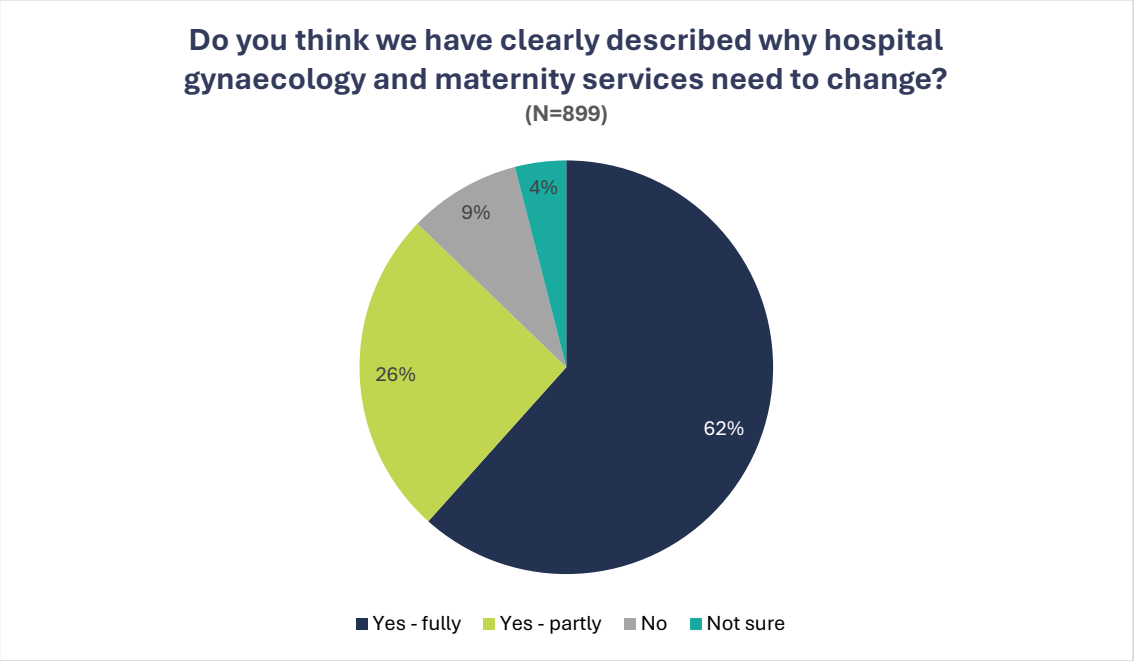
2.1 The public engagement asked people to reflect on the case for change, and indicate what was most important to them in relation to the future of gynaecology and maternity services. People also had an opportunity to share their own experiences of care.

2.2 The main mechanism used to collect feedback during the engagement was a questionnaire, which was completed by 913 individuals. This included a series of quantitative and qualitative questions, the findings from which have been analysed in the report. The questionnaire was available online, but also as a printed version and in alternative languages and formats on request. A telephone number was provided for those who preferred to talk through the questionnaire.

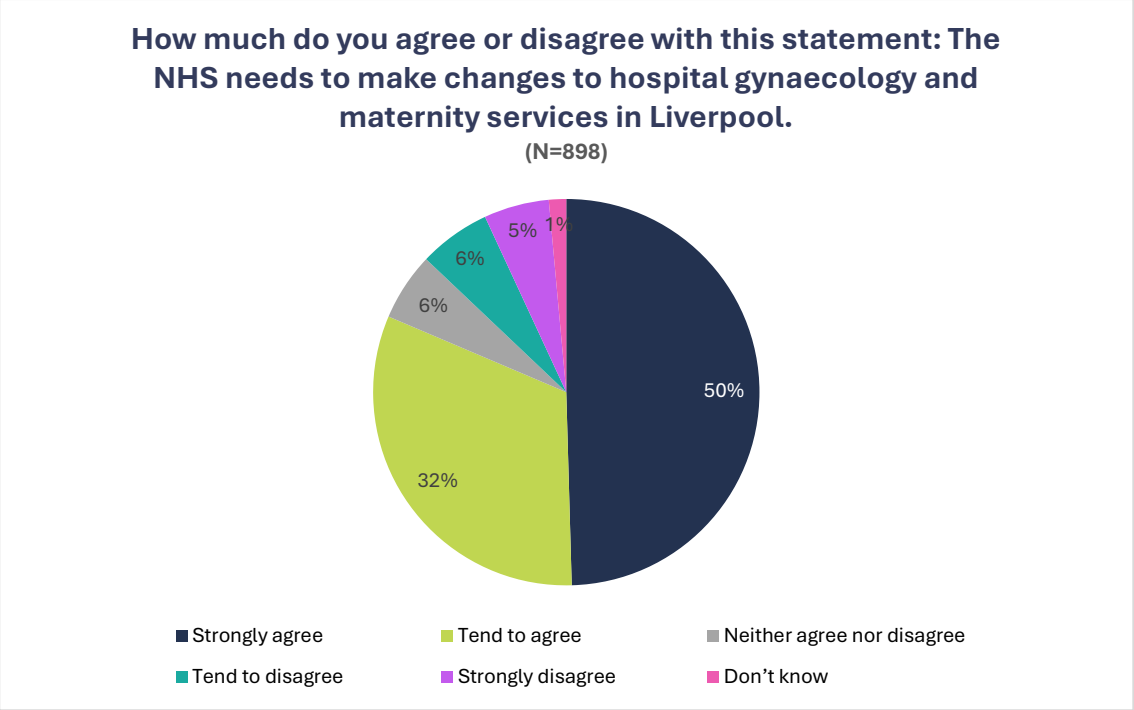
2.3 Six engagement events took place during the six-week period – two online and four in-person – which were attended by a total of 71 individuals. Notes were taken by facilitators during table discussions at these events, and the themes that arose are set out in the report.

2.4 Six VCFSE (voluntary, community, faith and social enterprise) organisations were commissioned to carry out additional, targeted activity. This approach was designed to improve the reach of the engagement, utilising existing community channels and networks. The main requirement for the six organisations was to promote the engagement and encourage further questionnaire completions, but they also held separate discussions to facilitate this work.

2.5 The majority of questionnaire respondents (62%) agreed that NHS Cheshire and Merseyside had fully described why hospital gynaecology and maternity services need to change. A further 26% agreed that the organisation had partly described the reasons. However, 9% said it had not been clearly described why these services need to change, and 4% said they were unsure.



2.6 Questionnaire respondents were asked to what extent they agreed or disagreed with this statement: “The NHS needs to make changes to hospital gynaecology and maternity services in Liverpool.” Among those who answered, 82% agreed with the statement (50% strongly agreed and 32% tended to agree), 11% disagreed (6% tended to disagree, 5% strongly disagreed), and 6% neither agreed nor disagreed.



2.7 Questionnaire respondents were also asked to indicate whether they had used gynaecology and maternity services, and where this was the case, provide further details in subsequent questions. This generated a substantial amount of feedback, both positive and negative, about people's experiences, which the report outlines.

2.8 The questionnaire asked people to answer a number of equalities monitoring questions. An overview of the demographic characteristics of those who responded to the questionnaire is set out in the report.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- Acknowledge the engagement report.
- Acknowledge that communications have been issued to mark the publication of the engagement report, aimed at both 'closing the loop' for people who took part in the process, and providing a wider update on next steps for the programme.
- Acknowledge that the engagement report findings will be used to inform the next stage of the Women's Hospital Services in Liverpool programme, and in particular the options process.
- Acknowledge that the formal engagement process that took place in autumn 2024 only reflects the first stage of involving people in the

programme, and that there is an ongoing need to ensure there is capacity and resource to deliver this as work continues.

4. Reasons for Recommendations

4.1 Involving the public is a legal duty for ICBs, as set out in the National Health Service Act 2006, as amended by the Health and Care Act 2022, Section 14Z45. Failure to meet involvement duties presents the risk of future legal challenge.

4.2 However, beyond our statutory duties, effective involvement helps us to develop better, more effective services. Ensuring that we harness the insights and experience of those who use and depend on our local NHS is an integral part of the service change process.

4.3 The future of women's services in Liverpool is a long-standing issue, which has attracted high levels of interest, and generated debate amongst sections of the public and stakeholders. It's important that we continue to keep people informed about the status of this work, and create mechanisms for ongoing engagement, to enable us to hear from people across our diverse communities.

5. Background

5.1 Planning for public engagement was undertaken through the Women's Hospital Services in Liverpool (WHSIL) Communications and Engagement Group, which reports to the WHSIL Programme Board. The group includes representation from the NHS trusts involved in the programme and local Healthwatch organisations.

5.2 The engagement plan was shared with the WHSIL Programme Board, before being approved by the Women's Services Committee on 13 September 2024.

5.3 Comprehensive communications were issued to launch the engagement on 15 October 2024. A dedicated programme website www.GynaeandMaternityLiverpool.nhs.uk went live on the first day or the engagement period, and a toolkit was cascaded to partner organisations, encouraging them to promote the opportunity to take part using their own channels.

5.4 A Lived Experience Panel for the programme was set up during summer 2024, aimed at those with experience of gynaecology and maternity services. The panel provided feedback on engagement materials and the questionnaire. Initial headlines from the engagement report were shared with panel members who took part in the group's March 2025 meeting.

5.5 Six engagement events took place during November 2024 – two online, and four face-to-face. A total of 71 individuals attended, with a number of people

joining more than one session. During the events, some attendees questioned why more people had not taken part, and whether the events had been adequately promoted. More than twelve times as many people chose to complete an engagement questionnaire as attended an event, but both opportunities were advertised simultaneously, so it is likely that personal preference was a factor in people's decision to take part.

5.6 Some of the views raised at engagement events related to wider concerns about the NHS, rather than specific issues around gynaecology and maternity care. All event participants were asked to complete the engagement questionnaire, but facilitators also took notes during table discussions. Some attendees queried whether this feedback would be adequately recorded. To make the process clearer, and aid consistent recording of views, it is suggested that in the future all feedback collection could take place via the questionnaire. In this scenario, events would act as a mechanism for promoting the involvement opportunity and answering any questions that people might have, rather than primarily collecting views. This is one of a number of learnings from the process that will be used to inform future involvement activity, which also include:

- holding early briefing sessions with wider partners to provide an overview of the engagement, and discuss how organisations can help share information with their staff and communities.
- using unique QR codes for each different engagement material/type of activity, so that their effectiveness can be more accurately tracked.
- exploring making information available to support staff in helping promote the opportunity to get involved to patients and the public.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: Tackling Health Inequalities in access, outcomes and experience
Public involvement is a key part of the Women's Hospital Services in Liverpool (WHSIL) programme. Ensuring that we hear the voices of our communities, including those who experience health inequalities, allows us to understand more about the issues and barriers faced by people when accessing services, which can in turn inform the plans we put in place to address them.

Objective Two: Improving Population Health and Healthcare
By listening to people, we can help to ensure that the services we have in place better meet their needs, supporting improved experience and outcomes.

Objective Three: Enhancing Productivity and Value for Money
Services that are co-produced with those who use and depend on them, and therefore better meet their needs, are a better use of NHS resources.

Objective Four: Helping to support broader social and economic development
While this report does not directly relate to this objective, it should be noted that on an individual level, being involved can reduce isolation, increase confidence and improve motivation towards wellbeing.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 Delivery of actions around communications and engagement, and compliance with statutory guidance on working in partnership with people and communities, is a focus area within the Annual Delivery Plan. Putting in place arrangements to support meaningful involvement helps us to meet legal requirements and ensure that the voices of our population are embedded in our work.

7.2 Addressing the challenge facing women's services in Liverpool was one of three critical priorities identified in the Liverpool Clinical Services review, which is a core area of focus in the Liverpool Place Plan. It's important that we have a robust involvement approach to support the Women's Hospital Services in Liverpool Programme.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
Involvement activity helps us to "actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes", as highlighted in the 'equity in experiences and outcomes' quality statement (QS5) within theme one.

Theme Two: Integration
The paper does not link to this theme.

Theme Three: Leadership
The 'partnerships and communities' quality statement (QS14) within theme three highlights the importance of engaging "…with people, communities and partners to share learning with each other that results in continuous improvements to the service".

9. Risks

9.1 The ICB has a legal duty to make arrangements so that people are appropriately involved in planning, proposals, and decisions regarding NHS services. This requires us to assess the need for public involvement, and plan and carry out involvement activity. If these duties are not met, there is a risk of challenge and/or failure to pass NHS England (NHSE) assurance process, in addition to the wider risks to the quality of the process itself.

9.2 The period of public engagement held in autumn 2024 is part of mitigation against two risks which currently appear on the Women's Hospital Services in Liverpool programme risk register:

- WSC 1A: If communication about the case for change for women's hospital services in Liverpool is insufficient or ineffective, it could lead to a lack of public and / or stakeholder engagement with the process which will negatively impact on outcomes.

- WSC 1B: Ineffective public and patient involvement in the women's services programme could lead to challenge and/or failure to pass NHSE assurance processes.

9.3 It should be noted that the first of the government's four tests for service change is strong public and patient engagement, and stage two of NHSE's assurance gateway will include a detailed examination of public and patient engagement activity.

10. Finance

10.1 A budget for the delivery of engagement activity, including analysis and reporting, was identified in July 2024. Use of this budget is reported through the Women's Services Committee.

11. Communication and Engagement

11.1 The autumn 2024 engagement was a key milestone in the overall communications and engagement approach for the programme. However, there is an ongoing requirement to involve people as work continues.

11.2 Alongside wider public communications and engagement, the Lived Experience Panel is seen as a key mechanism for harnessing the insights of those who have used services. The intention is to continue to develop and grow the panel over the coming months, including opening up recruitment so that new members can join.

12. Equality, Diversity, and Inclusion

12.1 Our public involvement duty also has links with separate duties around equalities and health inequalities (section 149 of The Equality Act 2010 and section 14Z35 of the National Health Service Act 2006). As part of our work, we need to involve people with protected characteristics, social inclusion groups and those who experience health inequalities.

12.2 NHS Cheshire and Merseyside commissioned six VCFSE organisations to facilitate direct engagement with communities during the autumn 2024 public engagement. The projects that this funded included a focus on: pregnant women, mums, parents & families; those who are experiencing/have experienced homelessness, the South Asian community; and Syrian, Yemeni, Somali, and Kurdish communities. Further details are set out in the engagement report.

12.3 A short report into equalities considerations arising from the engagement report is currently in development, and will be presented to the Women's Services Committee at its next meeting.

13. Climate Change / Sustainability

13.1 This report does not link to the Green Plan/Net Zero obligations.

14. Next Steps and Responsible Person to take forward.

14.1 The WHSIL Programme Board will be responsible for the next steps via the Programme Director.

14.2 In relation to the comments about individual experiences of care received as part of the engagement, the Liverpool Women's Hospital Patient Experience and Involvement Group will review this, and report through trust governance structures, as is the case for other patient feedback.

15. Officer contact details for more information

Helen Johnson, Head of Communications and Engagement, NHS Cheshire and Merseyside, helen.johnson@cheshireandmerseyside.nhs.uk

16. Appendices

Appendix One: Engagement Report - Improving Hospital Gynaecology and Maternity Services in Liverpool

HOOD & WOOLF

Improving hospital gynaecology and maternity services in Liverpool

Engagement report for NHS Cheshire and Merseyside Integrated Care Board

March 2025

Hood & Woolf Ltd.

Golden Cross House
8 Duncannon Street
London, WC2N 4JF

Contents

1 Executive summary

1.1 Introduction

The NHS is looking at hospital gynaecology and maternity services in Liverpool.

The organisation leading this work is NHS Cheshire and Merseyside Integrated Care Board (ICB), which is responsible for planning healthcare services in the area.

Currently, most of these services happen at Liverpool Women's Hospital, which means they are separate from other hospital services, and NHS Cheshire and Merseyside is concerned that this can sometimes create issues and delays with care.

The NHS is committed to finding a long-term solution that will improve the quality and safety of hospital gynaecology and maternity services, giving patients the best experience, wherever they are being treated. Although these issues have been discussed in the past, this is a new process aimed at addressing the problems as they stand today.

The public engagement detailed in this report was part of a new programme of work, but it follows earlier conversations with the public about women's hospital services in Liverpool.

This report summarises feedback received from a public engagement period which ran from 15 October until 26 November 2024.

The primary purpose of the engagement was to ask people to share their views on women's hospital services and respond to the newly-developed case for change for these services.

1.2 Overview of who responded

913 people completed a questionnaire during the engagement period in order to share their views. Of these, 229 indicated that they were a healthcare or social care professional, although many completed the questionnaire to share their experiences of having been a patient.

Among those who provided information on ethnicity, the majority identified as White (72%). The largest proportion of respondents was aged between 30 – 49 (59%), with 28% aged 50 or older and 11% under 30. In terms of gender, the majority of respondents identified as female (88%), with males representing 9%. A small number identified as non-binary. For more information about the demographics of respondents, see section 5.

In addition to the questionnaire, feedback was received from people attending public listening events, and by email or social media. For more information about how the engagement period was promoted and about the respondents, see section 3.

1.3 People's views on the case for change

Awareness and understanding

The majority of questionnaire respondents (62%) agreed that NHS Cheshire and Merseyside had fully described why hospital gynaecology and maternity services need to change. A further 26% agreed that the organisation had partly described the reasons.

However, 9% said the organisation had not clearly described why these services need to change, and 4% said they were unsure.

Overall agreement on the need for change

Respondents were asked to what extent they agreed or disagreed with this statement:

> *"The NHS needs to make changes to hospital gynaecology and maternity services in Liverpool."*

Among the 898 participants who answered, there was a broad consensus regarding the need to make changes to hospital gynaecology and maternity services:

- 82% agreed with the statement (50% strongly agreed and 32% tended to agree)
- 11% disagreed (6% tended to disagree, 5% strongly disagreed)
- 6% neither agreed nor disagreed

1.4 How people have experience of hospital gynaecology and maternity services

Experience of current services

Questionnaire respondents who had experienced hospital gynaecology or maternity services, or knew someone who had, were asked to rate their experience, or that of the person close to them, of these services.

Of the 794 people who responded:

- 56% reported a positive experience (31% described it as positive and 25% as very positive)
- 25% reported a negative experience (11% rated their experience as negative and 14% as very negative)
- 18% reported a neutral experience
- 1% reported that they didn't know

People who had direct experience of hospital gynaecology or maternity services (or had a close relative or friend who had used them) were invited to provide more information about these experiences.

This was an open question, and feedback revolved around four key themes:

- Staff attitude and compassion
- Maternal and neonatal care quality
- Access and waiting times
- Staffing and expertise

Whether people felt disadvantaged when using the services

Questionnaire respondents were asked whether they, or someone close to them, felt disadvantaged when using hospital gynaecology or maternity services. Of the 788 people who responded:

- 62% responded that they had not felt or observed some form of disadvantage
- 21% indicated that they had felt or observed some form of disadvantage
- 17% were unsure

From their responses, four key themes emerged, highlighting the specific ways they or their loved ones felt disadvantaged in accessing or receiving care. These were:

- Staff attitude and compassion
- Discrimination and bias
- Patient autonomy and being treated with respect
- Consistency and standards of care

People completing the questionnaire were also invited to give their thoughts on the challenges facing these hospital services in Liverpool in a free text box. Five key themes emerged from respondents' reflections:

- Waiting times for treatment and delays with appointments
- Staff compassion and competence
- Facilities, environments and locations
- Patient autonomy and being treated with respect
- Specialised care and follow-up services

Future priorities

Questionnaire respondents were asked to identify the three most important factors to them when considering the future of hospital gynaecology and maternity services in Liverpool.

Five broad themes emerged in the feedback which, understandably, echo feedback provided elsewhere in the questionnaire. The five key themes were:

- Patient experience
- Accessibility and equity of care
- Waiting times and reducing appointment delays
- Patient safety

- Staff compassion and competence

A range of views were also expressed at the public listening events (see section 6), by correspondence and emails (see section 7), social media (see section 8), and by petition (see section 9).

2 Introduction

The NHS is looking at hospital gynaecology and maternity services in Liverpool.

The organisation leading this work is NHS Cheshire and Merseyside, which is responsible for planning healthcare services in the area.

Currently, most of these services happen at Liverpool Women's Hospital, which means they are separate from other hospital services, and NHS Cheshire and Merseyside is concerned that this can sometimes create issues and delays with care.

The NHS is committed to finding a long-term solution that will improve the quality and safety of hospital gynaecology and maternity services, giving patients the best experience, wherever they are being treated. Although these issues have been discussed in the past, this is a new process aimed at addressing the problems as they stand today.

The public engagement detailed in this report was part of a new programme of work, but it follows earlier conversations with the public about women's hospital services in Liverpool.

During 2015, Liverpool Women's NHS Foundation Trust held a 'Summer of Listening', involving both public and staff engagement, to help inform the development of its 'Future Generations' clinical strategy.

In June 2016, NHS Liverpool Clinical Commissioning Group (CCG), which was responsible for planning local hospital services, undertook patient, public, staff and stakeholder engagement as part of a review of women's services and neonatal care. This set out the reasons why change was required for these services, and invited people's views, thoughts, and feedback.

The insights gathered were used to develop a 'pre-consultation business case', which included a proposal for a new Liverpool Women's Hospital alongside an adult acute hospital, but this plan did not move forward because funding wasn't available.

In July 2022, NHS Cheshire and Merseyside took over the CCG's responsibilities for commissioning (buying) healthcare services. Starting the same month, it oversaw the Liverpool Clinical Services Review, which looked at how all of Liverpool's hospitals could work better together to improve care for patients.

The review identified resolving the challenges facing women's hospital services in the city as one of three urgent priorities. And, as a result, NHS Cheshire and Merseyside established the Women's Hospital Services in Liverpool programme, to oversee the development of a safe and sustainable future care model.

The engagement set out in this report was led by NHS Cheshire and Merseyside. Planning for it included representatives from:

- Liverpool Women's NHS Foundation Trust* (which manages Liverpool Women's Hospital)
- Liverpool University Hospitals NHS Foundation Trust* (which manages Aintree University Hospital, Broadgreen Hospital, Liverpool University Dental Hospital and the Royal Liverpool University Hospital)
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Alder Hey Children's NHS Foundation Trust

On 1 November 2024, Liverpool Women's NHS Foundation Trust and Liverpool University Hospitals NHS Foundation Trust became part of NHS University Hospitals of Liverpool Group.

Planning also included representatives from three local Healthwatch organisations:

- Healthwatch Knowsley
- Healthwatch Liverpool
- Healthwatch Sefton

In addition, NHS Cheshire and Merseyside set up a 'Lived Experience Panel'. This comprises around 30 people with experience of using hospital gynaecology and / or maternity services in Liverpool, whether as a patient, family member or carer.

Members of the panel provided feedback on both the summary information booklet published for the engagement, and the questionnaire used to enable people to share their views. NHS Cheshire and Merseyside remains grateful for their invaluable experience and ongoing input.

NHS Cheshire and Merseyside's Board approved a 'case for change' for these important services on 9 October 2024, and a six-week period of public engagement launched the following week, on 15 October 2024.

Previous conversations around hospital gynaecology and maternity care in Liverpool provided an important foundation, but it's important to note that this engagement was not a continuation of an earlier process.

NHS Cheshire and Merseyside were mindful that, not only had a significant period of time passed since people last had an opportunity to share their views on women's services, the engagement described in this report also asked people to respond to a newly-developed case for change, reflecting the situation as it stands today.

The public engagement exercise described in this report did not set out any proposals for services. While a number of people who responded to the questionnaire and attended listening events made specific comments about the location of services, the case for change did not set out any potential options for the future.

NHS Cheshire and Merseyside will use the views on women's health services in Liverpool shared during this engagement period – including people's experiences of them, their views on change, and what is important to them about the future of these

services – to inform what happens next, including the development of any proposals for how hospital gynaecology and maternity services could look in the future.

Views, insights and feedback gathered by NHS Cheshire and Merseyside during the engagement period – for example notes from listening events – were anonymised (with the exception of a letter from a local MP) and then provided, otherwise unedited, to Hood & Woolf to draft this independent report.

Where feedback is verbatim, such as responses to questions in the questionnaire, it appears in quotation marks throughout the report against a blue background.

> *"Direct quotations are presented in this format against a blue background."*

Feedback that has been received in note form, for example from notes of listening event discussions, is not in quotation marks.

> *Feedback received in note form is presented in this format against a green background.*

The direct feedback included in the report is illustrative of the points raised – it is not intended as a comprehensive inventory of all feedback received. All the feedback received during the engagement period will be supplied, anonymised, to NHS Cheshire and Merseyside.

Where percentages are used, these have been rounded up or down to the nearest 1%. As a result, on occasion, totalled percentages may not equal exactly 100%. On some questions in the questionnaire, respondents could select more than one answer, which will result in some totals being more than 100%.

A note on language

It's not only people who identify as women (or girls) who use women's health services. Like NHS Cheshire and Merseyside, we use the terms 'woman' and 'women's health' in this report to include trans men and non-binary individuals assigned female at birth who also access these services.

Thank you

NHS Cheshire and Merseyside would like to thank everyone who took the time to share their views during the engagement period.

3 An overview of this engagement

3.1 Promotion to patients, people and communities

Pre-consultation engagement plan

A pre-consultation engagement plan was developed to support the period of engagement and was approved by NHS Cheshire and Merseyside's Women's Services Committee in September 2024. 'Pre-consultation engagement' is a commonly used term in NHS service change, but NHS Cheshire and Merseyside used 'public engagement' to describe the process, as it was felt this was more accessible and less likely to cause confusion.

A wide range of mechanisms were used to share information, promote the engagement period, and encourage as many people as possible to take part. These included:

Website

A dedicated website for the Women's Hospital Services in Liverpool programme – www.GynaeandMaternityLiverpool.nhs.uk – launched on the first day of the engagement period.

This set out the context of the programme, including supporting information, and also included the summary case for change booklet, the full technical case for change document, and a range of videos with clinicians setting out some of the current clinical challenges.

Over the six-week engagement period, the website was visited by a total of 7,656 unique users, with a total of 15,056 page views and 46,090 actions taken (such as downloads or clicks to another link).

The website will remain live as work on the programme continues. Visitors to the site can sign up to join the Virtual Reference Group to receive further news and updates by email.

Engagement materials

The main case for change booklet (also known as the summary information booklet) and engagement questionnaire were produced in English (available online, and printed on request), and translated into 16 additional languages.

An Easy Read version of the summary information booklet and questionnaire were also made available on the website, and a British Sign Language (BSL) summary video was produced, highlighting key points from the case for change and details of the public engagement. These were made available on the programme website, and also shared directly with relevant organisations.

Communications toolkit

A communications toolkit was cascaded to a wide range of public sector organisations and community partners in Liverpool, Sefton, and Knowsley.

This included all NHS provider trusts and local authorities within Cheshire and Merseyside, GP practices, Healthwatch organisations, and council for voluntary services (CVS) organisations.

The toolkit – which contained content which could be easily shared to promote the engagement – was also made available on the resources page of the programme website, so that it was widely accessible.

Attendance at external meetings and events

In addition to six NHS-led public engagement sessions (see section 5 for further details), NHS Cheshire and Merseyside offered to attend existing stakeholder and community group meetings, to provide a briefing on the case for change and explain how people could share their views on the issues facing hospital gynaecology and maternity services.

This offer was taken up by a number of groups and organisations, including Healthwatch Liverpool Community Engagement Board and Sefton CVS. The engagement was also promoted at a health fair that formed part of the Liverpool University Hospitals NHS Foundation Trust and Liverpool Women's NHS Foundation Trust Annual Members' Meeting, and at an event held by One Knowsley, an independent social infrastructure body for the borough.

Media promotion

Four press releases were issued to regional and local media during the course of the engagement period. This resulted in a number of pieces of coverage, across the following outlets:

> *BBC Radio Merseyside, BBC North West Today, BBC North West Tonight, ITV Granada Reports, Liverpool Echo, BBC Online, Capital FM Liverpool, LBC, Radio City Liverpool, The Guide Liverpool, and the Health Service Journal.*

Social media promotion

In addition to organic (unpaid) social media posts across NHS and partner accounts, a ten-day social media advertising campaign was run through Meta (Facebook and Instagram), towards the end of the engagement period.

This specifically targeted women in Knowsley (focused around the Kirkby area), Liverpool and south Sefton.

This enabled NHS Cheshire and Merseyside to focus on groups that were under-represented at the mid-point review of the engagement period (see section 4). These

were those aged 18 – 29, and those aged 55+. The promotional social media activity was later extended to include those aged 30 – 54.

The campaign generated 5,718 'click-throughs' to the programme website, and had an approximate reach (the estimated number of people who saw the social media content) of 237,566.

3.2 Promotion to NHS staff

The NHS organisations involved in the programme shared information about the opportunity to take part in the engagement using a range of existing internal communications channels, including all-staff emails, bulletins and briefing sessions.

Liverpool Women's NHS Foundation Trust also held an online listening event for staff, aimed at supplementing the trust's ongoing communications about the issues affecting gynaecology and maternity services. The session was focused on briefing staff members who were newer to the trust, but all staff were invited to attend and ask questions. A total of 25 colleagues joined, and the session was recorded and shared with all staff, so that those who could not attend were able to watch it back at a later date.

3.3 Methods of providing feedback

The engagement period was designed so that people could share their views using a variety of methods, including by:

- Completing a questionnaire online, or completing and returning a hard copy
- Attending one of six listening events
- Emailing engagement@cheshireandmerseyside.nhs.uk
- Post
- Telephone

3.4 Summary of overall responses

During the engagement period, people took part in a variety of ways to share their views and experiences of hospital gynaecology and maternity services in Liverpool, their thoughts on the challenges it faces, and what was most important to them for those services in the future. These comprised:

- 913 people who completed the online questionnaire
- 13 who shared their feedback by email
- 1 who shared their feedback by letter
- 71 members of the public who attended events
- 25 NHS staff from Liverpool Women's Hospital who attended a separate listening event
- 74 people who shared thoughts on social media

Respondents came from a range of demographic backgrounds. Specific actions were taken to ensure feedback was obtained by a wide range of people who access and use these services. However, it's important to note that the feedback contained in this report cannot be generalised to the population served by the services in question. That is to say, those who took part were self-selecting and some groups will be over or under-represented as a result.

The full case for change document published as part of this engagement includes demographic information for people using Liverpool Women's Hospital services. This information has not been reproduced here as, while NHS Cheshire and Merseyside was keen to hear from those individuals during this engagement period, it also wanted to seek views from a wider range of people.

4 Questionnaire methodology

4.1 Questionnaire design

The questionnaire aimed to enable people to share their views on, and experiences of, hospital gynaecology and maternity services as easily as possible.

No questions were mandatory, which meant that participants could choose not to answer any that didn't apply to them, or where they did not want to provide feedback. Importantly, this means that where percentages are provided throughout this report, they refer to the proportion of respondents who answered that question.

The questions were carefully selected to generate a range of both quantitative and qualitative feedback.

The quantitative data provides a basis for numerical comparison, while the qualitative feedback, such as people's thoughts and experiences, means we could hear from people directly in their own words. We use these answers to identify any key themes across all the responses, and use direct quotations of people's specific feedback to highlight themes, opinions, and views.

The qualitative feedback was analysed using a structured thematic coding approach. The themes that emerged from this analysis are presented with the most commonly mentioned first within the relevant sections of this report.

The main body of the questionnaire asked about people's views and experiences of gynaecology and maternity services.

The remainder of the questionnaire was dedicated to asking respondents about themselves, for example whereabouts they live and where they work (if they are a healthcare or social care professional).

The final section contained equalities monitoring questions. These ask about people's characteristics (such as their age, gender, religion, relationship status, and if they have any disabilities).

In order to measure the effectiveness of promotional activity, identify any gaps in responses, and ensure that responses were received from a diverse range of people, a mid-point review was built into the engagement period. As a result of this, a number of actions were put in place, including targeting of specific groups, both using social media and though promotion to relevant organisations and community networks.

5 Responses and findings from the questionnaire

5.1 Overview of who responded

Number of responses

913 people completed the questionnaire during the engagement period. Some questionnaires were completed online, and others were completed as paper versions then inputted into the online system by NHS Cheshire and Merseyside staff or VCFSE (voluntary, community, faith or social enterprise) representatives. See section 10 for more information about the engagement undertaken by VCFSE organisations.

Of the 913 respondents, 229 indicated that they were a healthcare or social care professional – although they did not necessarily work in or alongside gynaecology or maternity services, and many completed the questionnaire to share their experiences of having been a patient.

Of those who completed hard copies, a number were translated into English from another language. Some of the translations were undertaken by NHS Cheshire and Merseyside, and some were undertaken by VCFSE organisations. Of the languages translated from NHS Cheshire and Merseyside, 13 were completed in Arabic, five in Farsi, two in Polish, and one each in Hungarian, Pashto, and Somali.

Six people who completed the questionnaire ticked the box to say they were responding on behalf of an organisation, but then gave no further details indicating the name or type of organisation. We have included these responses and they have been treated as individual responses.

A full breakdown of the demographic information for questionnaire respondents can be found in Appendix A. This also includes how people found out about the questionnaire, and the level of engagement material they had read before responding.

Key demographic information

The map below plots the postcodes of respondents to the questionnaire, and is colour-coded by number of people who participated who live in that area.

Where people live

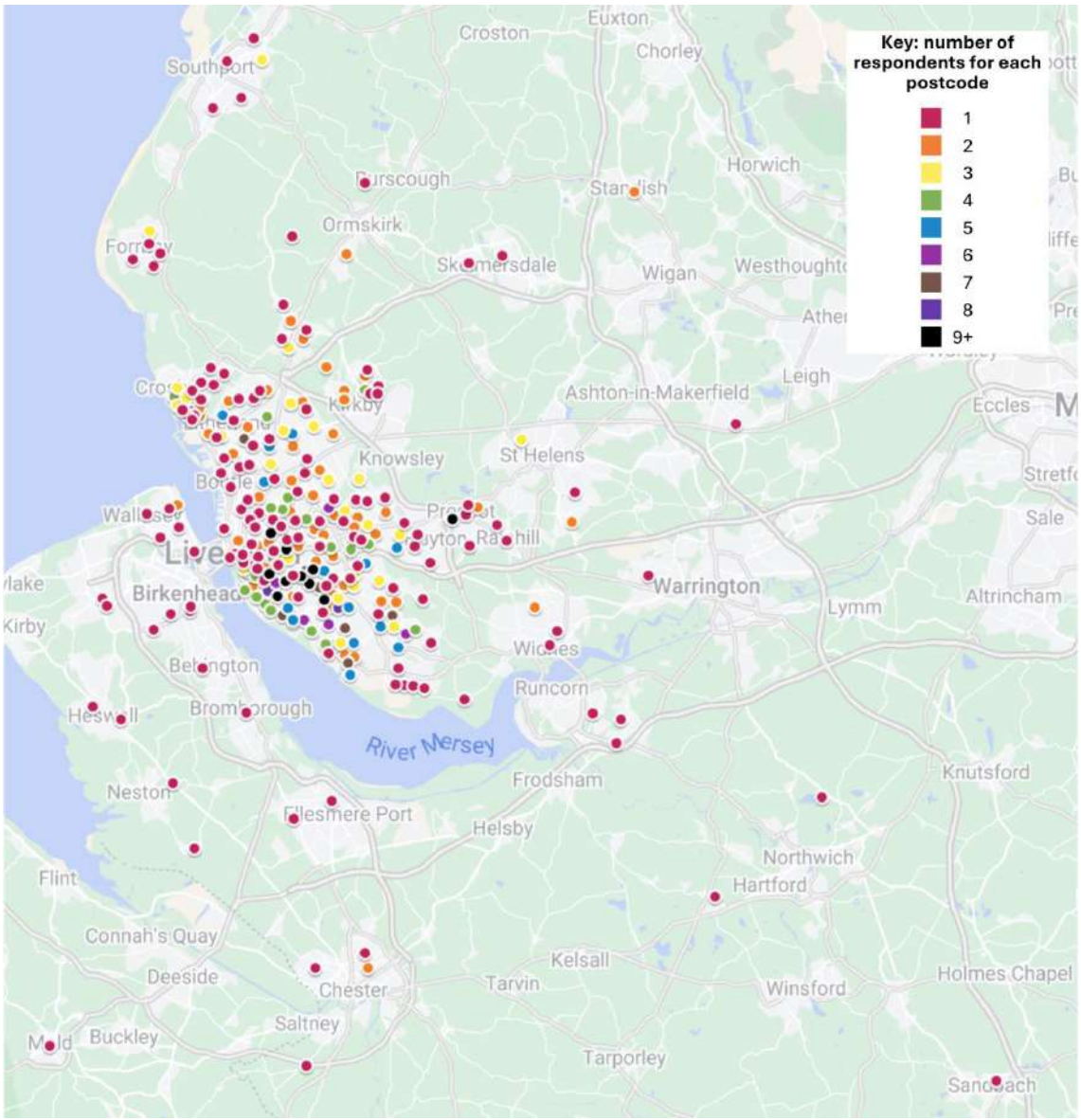


Figure 1: What is the start of your postcode?

Almost three quarters of respondents – 71% – live in Liverpool, while 12% live in Sefton, and 7% in Knowsley. Smaller proportions live in Wirral (3%), and Cheshire West, St Helens, Halton, Cheshire East, and Warrington (each with 1% or less).

Ethnicity

Among those who provided information on ethnicity, the majority identified as White (72%). The majority were English / Welsh / Scottish / Northern Irish / British, who accounted for 67% of respondents.

Other notable groups included individuals of Asian / Asian British backgrounds, who collectively represented 15%, with significant numbers identifying as Bangladeshi (6%) Indian (5%), and Pakistani (3%).

Respondents from Black / African / Caribbean / Black British backgrounds made up 3%, while smaller percentages identified as Mixed / Multiple ethnic groups or other ethnic categories.

Age

The largest proportion of respondents was aged between 30 – 49 (59%), with 28% aged 50 or older and 11% under 30.

Gender

In terms of gender, the majority of respondents identified as female (88%), with males representing 9%. A small number identified as non-binary.

Healthcare or social care professionals

26% of respondents indicated that they worked in healthcare or social care, although they did not necessarily work in or alongside gynaecology or maternity services, and many shared their experiences of being a patient.

A full breakdown of the demographic information for questionnaire respondents can be found in Appendix A.

5.2 Awareness and understanding

Respondents were asked to if they thought NHS Cheshire and Merseyside had clearly described why hospital gynaecology and maternity services need to change. The possible responses they could provide were:

- Yes – fully
- Yes – partly
- No
- Not sure

The majority of respondents (62%) agreed that NHS Cheshire and Merseyside had fully described why hospital and gynaecology and maternity services need to change. A further 26% agreed that the organisation had partly described the reasons.

However, 9% said the organisation had not clearly described why these services need to change, and 4% said they were unsure (see Chart 1).

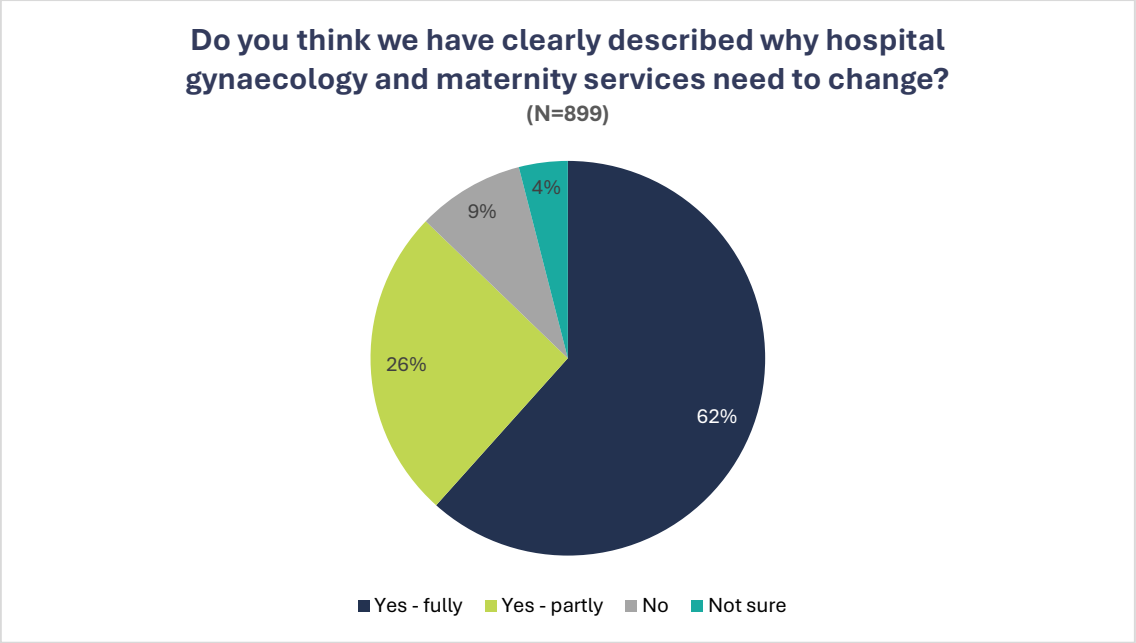


Chart 1: Do you think we have clearly described why hospital gynaecology and maternity services need to change?

Further analysis showed that those who responded that NHS Cheshire and Merseyside had fully or partly described why hospital gynaecology and maternity services need to change were far more likely to agree than to disagree that there is a need for change (93% vs 53% respectively). This group were also more likely to describe their experience of the services as negative than positive (91% vs 85%).

In contrast, those who felt that NHS Cheshire and Merseyside had not clearly described why hospital gynaecology and maternity services need to change were more likely to disagree than to agree that there is a need for change (37% vs 4% respectively), and were more likely to describe their experiences of services as positive rather than negative (11% vs 6%).

Demographic analyses revealed that:

- Healthcare and social care professionals were more likely than the public to respond that NHS Cheshire and Merseyside had clearly described why hospital gynaecology and maternity services need to change (92% vs 86%).
- Younger respondents tended to be more likely to state that the organisation had fully described why hospital gynaecology and maternity services need to change than older respondents: those aged 30-39 (65%) and those aged 40-49 (66%) were more likely than those aged 50+ (56%) to feel the case for change had been fully explained.
- Currently or recently pregnant people were more likely to respond that NHS Cheshire and Merseyside had described why hospital gynaecology and maternity services need to change (93%) compared to non-pregnant people (85%).

Those who partially agreed or did not agree that the case for change had been made were asked how they thought the information could be made clearer. 39% responded that there was not enough information, while 21% said there was too much information.

21% also said that the way the content is laid out made it difficult to read, and 14% said there was too much jargon. 4% said they did not like the design (see Chart 2).

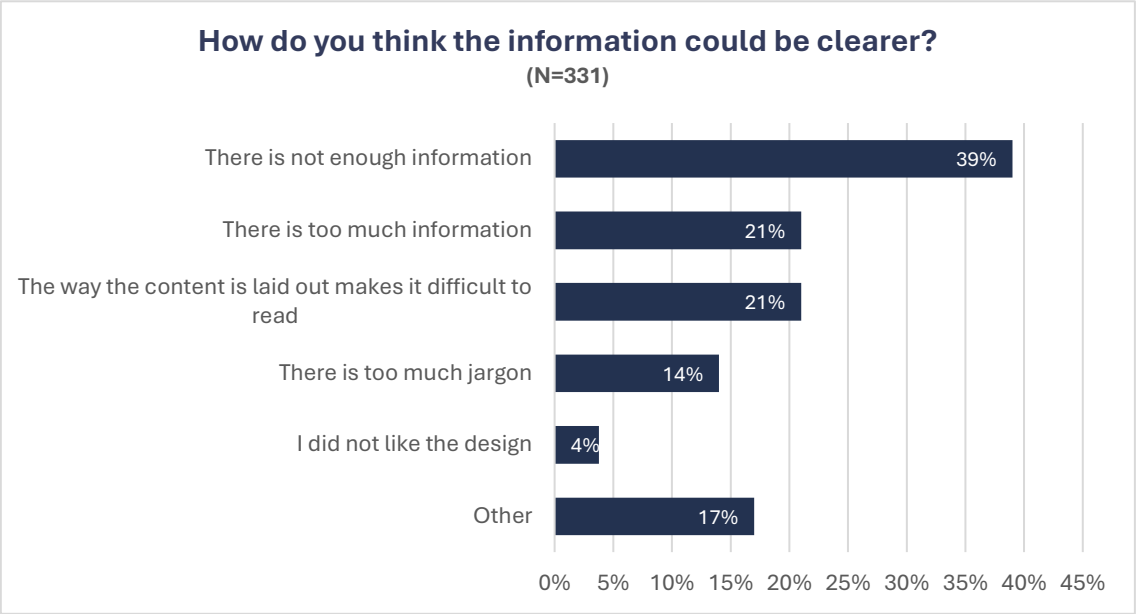


Chart 2: How do you think the information could be clearer?

Of the 17% who responded 'Other', many perceived the content as biased, citing that it focused primarily on the negative aspects of current provision without presenting the benefits, a balanced view, or sufficient evidence:

> *"The information is presented in a biased fashion which is designed to create prejudice against retention of the Crown Street site."*

> *"The information is not neutral but is making it seem as if a move is the only possible answer."*

> *"The content focuses on the negative issues and not on the bigger picture of why those issues are happening at this time of underfunding in the whole of the NHS."*

Accessibility challenges were also highlighted, including difficulties in locating the summary information booklet online. Additionally, some respondents identified a lack of detail in the materials, with feedback including:

> *"The information is not clear and doesn't cover all the issues."*

> *"The arguments given ignore important relevant information, alternative views, and public opinions."*

5.3 Overall agreement on the need for change

Respondents were asked to what extent they agreed or disagreed with this statement:

> *"The NHS needs to make changes to hospital gynaecology and maternity services in Liverpool."*

The possible responses people could provide were:

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Among the 898 participants who answered, there was a broad consensus regarding the need to make changes to hospital gynaecology and maternity services: 82% agreed with the statement (50% strongly agreed and 32% tended to agree), while 11% disagreed (6% tended to disagree, 5% strongly disagreed) and 6% neither agreed nor disagreed (see Chart 3).

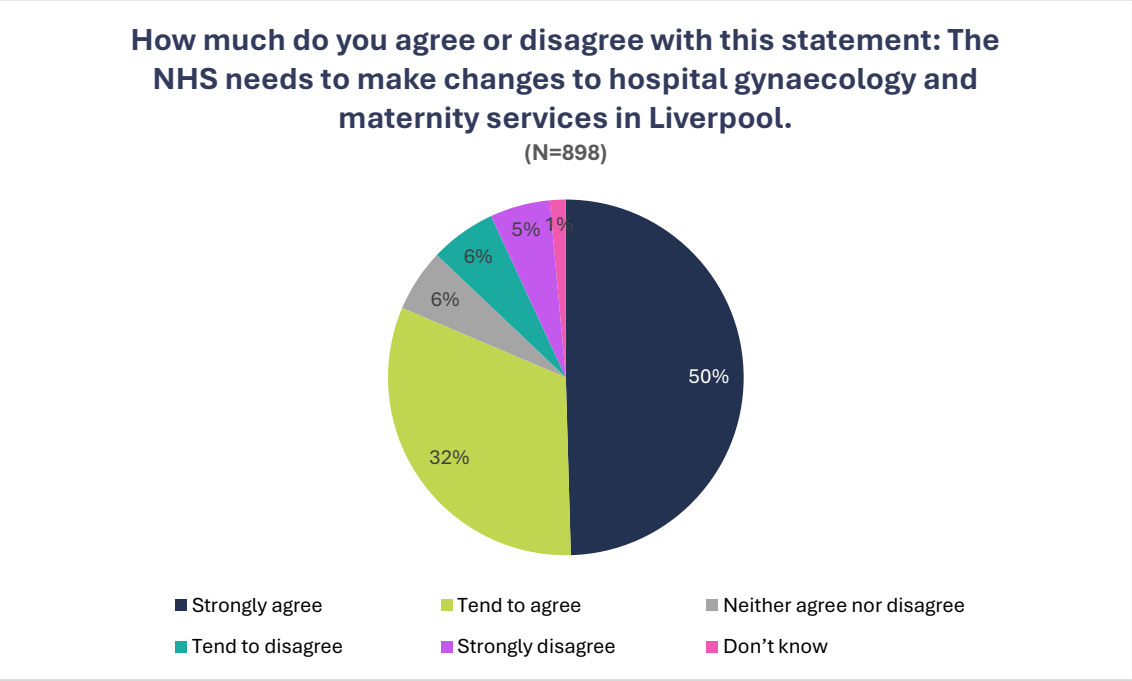


Chart 3: How much do you agree or disagree with this statement: The NHS needs to make changes to hospital gynaecology and maternity services in Liverpool

As already noted in section 4.2, people's experience of the services appears to relate to their agreement with the need for change, and how clear they think the case is for making changes.

For example, 98% of those who had a negative experience of care agreed with the need for change, vs 72% of those who had a positive experience.

Among those who felt the case for change was fully made, 92% agreed with the statement, compared with 75% of those who said the case is partly made, and only 41% of the group who didn't believe the argument had been made at all.

Overall, 93% of professional respondents agreed with the statement, which was significantly greater than the proportion of the general public who felt this way (77%).

5.4 How people have experience of hospital gynaecology and maternity services

As part of the questionnaire, people were asked:

> *"Have you, or someone close to you, used hospital gynaecology and / or hospital maternity services in Liverpool?"*

Respondents could select multiple options to reflect their own experiences, those of close family or friends, and / or if they worked in or alongside these services. 894 people answered the question, broken down as follows:

- 50% reported that they had used hospital gynaecology services
- 42% reported that they had used hospital maternity services
- 25% reported that someone close to them had used hospital gynaecology services
- 26% said that someone close to them had used hospital maternity services
- 9% reported working in or alongside hospital gynaecology and maternity services
- 9% wanted to share their views despite not having personal or close contact with these services.

A further 1% indicated they were responding on behalf of an organisation, however they did not provide details when prompted. Their responses have been treated as being from an individual and included in the analysis.

5.5 Experience of current services

Respondents who had experienced hospital gynaecology or maternity services, or knew someone who had, were then asked to rate their experience, or that of the person close to them, of these services. The possible responses they could provide were:

- Very positive
- Positive
- Neutral
- Negative
- Very negative
- Don't know

Of those who answered, 56% reported a positive experience: 31% described it as positive and 25% as very positive.

Neutral responses accounted for 18%, indicating mixed or average experiences. Negative feedback was reported by 25% of respondents: 11% rated their experience as negative and 14% as very negative (see Chart 4).

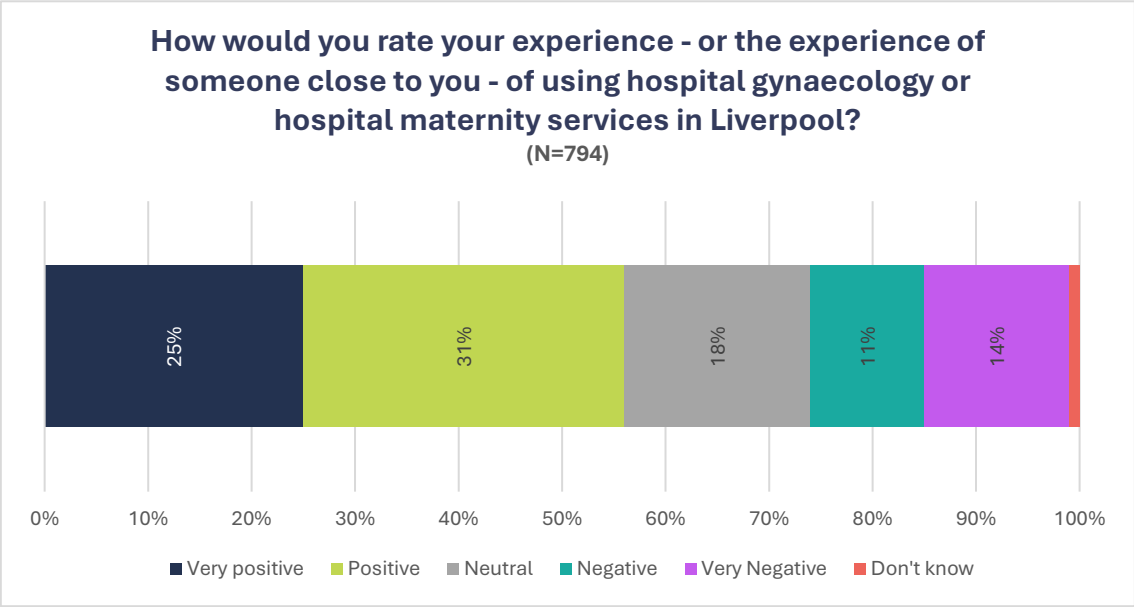


Chart 4: How would you rate your experience – or the experience of someone close to you – of using hospital gynaecology or hospital maternity services in Liverpool?

As noted in section 4.2, positive experiences of services were associated with a lower likelihood of agreeing with the need for change or feeling an adequate case for change had been made. For example:

- Those who reported positive experiences of services were much more likely to disagree (88%) with the case for change than to agree (49%) with it. Additionally this group were more likely to feel the case for change had not been clearly explained (70% vs 54% who felt it had).
- Older respondents were more likely to report very positive service experiences than younger people: those aged 50+ were more likely (41%) to report very positive experiences than those aged under 30 (18%), 30-39 (18%) and 40-49 (18%).
- Pregnant and recently pregnant individuals were more likely to report higher positive experiences of services (62%) compared to those who were not (55%).
- Healthcare and social care professionals were more likely than the public to describe their experiences of the services as negative (31% vs 23%).

People were then asked:

> *"Please tell us more about your (or their) experiences – both the things that went well, and the things that could be improved."*

People who had direct experience of hospital gynaecology or maternity services (or had a close relative or friend who had used them) were invited to provide more information about these experiences. This was an open question, and feedback revolved around four key themes:

- Staff attitude and compassion
- Maternal and neonatal care quality
- Access and waiting times
- Staffing and expertise

Staff attitude and compassion

The most common theme among the responses for this question was staff attitude and compassion. Within this, the proportion of responses that were positive and negative in nature were closely matched, with negative sentiment slightly higher.

In the main, where people's experience had been negative, respondents described staff being rude, not listening to concerns or reported being made to feel as though they couldn't ask for help once they were on the maternity ward.

> *"The nurses performing gynaecological services could have better people skills and not be so cold and robotic to talk to."*

> *"I didn't feel like a person when I was getting seen when I had a miscarriage."*

Some respondents described having received good quality care during their operation or birth but felt their experience on the ward was significantly less good.

> *"Little support morning after [C-]section [caesarean] and poor wound care [after a] hysterectomy this year. Dr / recovery care good. Ward care not great, would not like to become seriously ill at the hospital as don't have the staff / facilities to care for. Good and bad staff everywhere but I believe [a] lot of improvement can be made in patient care."*

> *"The aftercare on the ward (we stayed for five days) was absolutely horrendous - rude staff, no support, tell you you're being dramatic, make you seem like an inconvenience for ringing the buzzer for help, no help or information with what was happening with my sick baby. Was ignored and sent home with mastitis."*

A number of respondents felt that this attitude stemmed from staff being overwhelmed and the unit understaffed, and there was a sense that some staff had become desensitised to women's experiences.

> *"Staff should remember it may be their day job but to some patients this episode of care may be [the] most terrifying and stressful thing they have ever done. Please don't desensitise to that."*

In terms of positive experiences, there were some examples of compassion and understanding from staff, including how integrated working benefits patients.

> *"Initial admin and referral took a long time but once I was actually seen by a clinician, I was able to be properly diagnosed and treated for the first time in ten years. I have seen multiple specialists on site and my treatment is rare and complex so managed by a team. They work together to provide ongoing care and my condition is properly managed for the first time ever … I have been able to achieve things in my life that I never thought possible when my condition was unmanaged. I couldn't praise the team at the Women's highly enough for how professional, caring, and efficient they are."*

Maternal and neonatal care quality

The second most common theme expressed for this question was maternal and neonatal care quality. Within this, the proportion of responses that were positive and negative in nature were again closely matched, with negative sentiment again slightly higher. There were, however, examples of fantastic care and patients who felt that their experience was exceptional.

> *"This year I had my first child at the Women's Hospital. From my scans, being induced, checking in at 4am, having to stay overnight to wait for a delivery suite to have my waters broken and finally giving birth naturally I thought the hospital was brilliant."*

> *"Caring, dedicated staff. Emergency access went well. Beds available when required (no waiting). Access to top surgeons / consultants. Prompt appointments."*

The negative comments highlighted some concerns around safety and procedures. A number of respondents described experiencing the loss of a baby and then being located near to new mothers.

> *"My partner developed diabetes whilst pregnant, towards the end of her pregnancy she had trouble feeling the baby move and kick she was worried and went to the hospital only to be turned away three times as there was no one to see her as a result the baby was stillborn and she had to give birth to a 10lbs 11 baby boy, she was then taken to a ward where women were having healthy babies and left."*

> *"The Trust is more concerned about midwifery retention as opposed to dealing with poor practice or serious professional misconduct. Maternity … needs a massive improvement plan."*

Some respondents' experiences were, at least in part, due to needing to be transferred from Liverpool Women's Hospital elsewhere:

> *"I didn't feel safe when I was in the hospital as it wasn't explained to me, I was hurried into an ambulance and taken to [the] Royal for emergency surgery, it was stressful and I had to leave my baby behind, I didn't know who was going to look after him, I didn't know if I was going to live or die, so many things was going round in my head."*

Others felt that their experiences of poor care were not down to the location of services, but the standard of care they received:

> *"My daughter has given birth to three children from 2010 to 2017 and treated for one miscarriage. In my opinion the service provided for all three births and miscarriage was poor … Also a friend has life limiting injuries following a gynaecological procedure resulting in receiving large compensation. I think there have been fundamental problems with the service for years which is nothing to do with co-location. It has to be poor management from the top of the organisation."*

Access and waiting times

The third most common theme from responses for this question related to access and waiting times. More than half of the respondents shared negative experiences, with many describing waiting times to access services that were significant, and impacting on other areas of their lives.

> *"Transparency on waiting times has not been there, I have been told by different professionals that my wait wouldn't be more than a couple of months but this is not the case, expectations are not being managed."*

> *"Despite hours of distress chasing up, I've been told there is a long undefined waiting list with people in front?! I struggle to see how any service cannot know what timescales are involved."*

> *"Delay in results. Delay in reading scans. Delay in waiting for an appointment after GP has referred to gynaecologist."*

Staffing and expertise

The theme of staffing and expertise saw almost half of respondents express a negative view, around three in ten responding neutrally, and around a quarter sharing positive responses. Those that were positive highlighted the skill of staff and the impact that this had on the patient experience.

> *"I have had four recurrent miscarriages one in the second trimester and had a full-term birth. I've always found staff to be knowledgeable and skilled. Having the recurrent miscarriage department helped us so much."*

> *"Personally I have had some very good care at the colposcopy clinic with adaptations made for my previous experiences of sexual trauma."*

However, there were recurrent mentions of the lack of staffing and the impact that this has on patient care.

> *"There is never enough staff or if there are they are either too tired or not wanting to engage. The staff who did help were brilliant and really did go above and beyond which is why I think it may just be overstretched services."*

There were also some concerns raised about the skills and expertise of staff, both in maternity and gynaecology.

> *"Important health screenings did not pick up that their baby was in fact suffering during the pregnancy and such they lost their baby at 37 weeks gestation. Multiple opportunities to identify issues were missed."*

The remaining responses covered themes of scheduling and communication, specialist support services, postnatal care and mental health support, facilities and equipment and administration and record keeping.

5.6 Whether people felt disadvantaged when using the services

Respondents were asked whether they, or someone close to them, felt disadvantaged when using hospital gynaecology or maternity services. Of the 788 participants who answered, 62% responded that they had not felt or observed some form of disadvantage, 21% indicated that they had, and 17% were unsure (see Chart 5).

Further analyses showed:

- Those with a disability were more likely to report experiencing or observing disadvantage (27%) compared with those who did not report having a disability (17%).
- Younger people aged under 30 were more likely to report that they had experienced or observed disadvantage (31%) compared with those aged 50 and over (15%).
- People who were White were more likely to report not experiencing or observing disadvantage (64%) than those from any other ethnic background (55%).

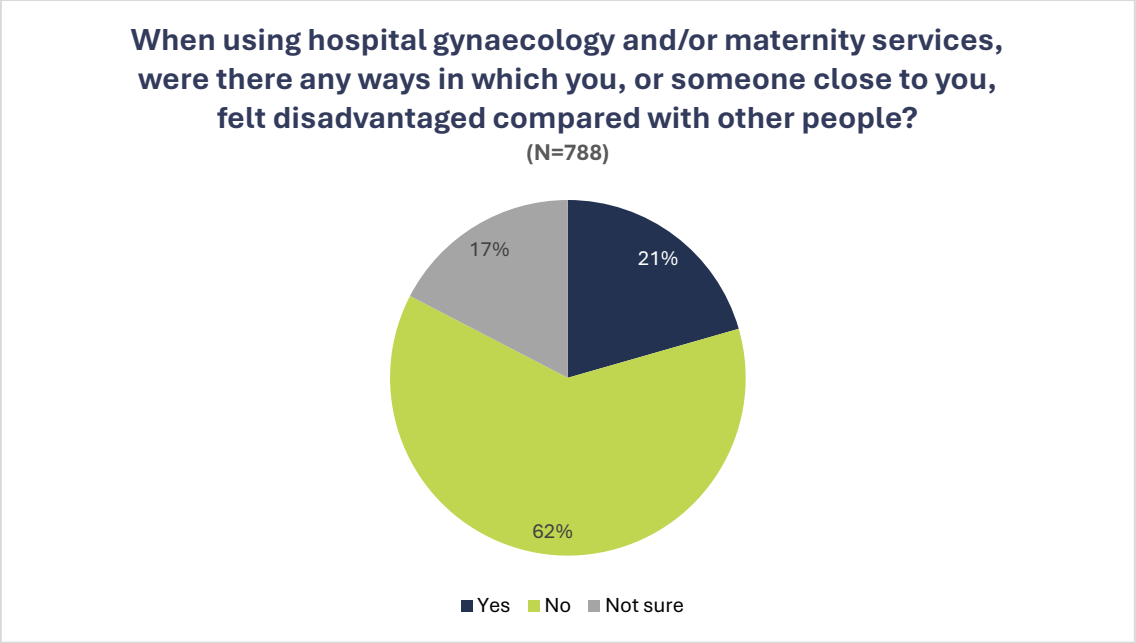


Chart 5: When using hospital gynaecology and/or maternity services, were there any ways in which you, or someone close to you, felt disadvantaged compared to other people?

Those who answered 'Yes' to experiencing or observing a disadvantage when using hospital gynaecology or maternity services were invited to provide further comment.

From their responses, four key themes emerged, highlighting the specific ways they or their loved ones felt disadvantaged in accessing or receiving care. These were:

- Staff attitude and compassion
- Discrimination and bias
- Patient autonomy and being treated with respect
- Consistency and standards of care

Staff attitude and compassion

The most prominent theme focused on patients sharing their experiences of staff attitude and compassion.

Some patients said they didn't feel listened to and that the concerns of their relatives were not taken seriously. Others described feeling their care was not as good as that provided to patients who complained:

> *"During maternity services, if you didn't call for a midwife and kick up a fuss you were ignored for hours on end during induction. Junior doctors appeared inexperienced and lack compassion. Serious errors were made in my care and nobody spoke to me about it until just before they discharged me."*

> *"Those who shouted loudest were seen quicker."*

> *"Not listened to: I was talked down to, shouted at almost because I was scared."*

> *"Partner's concerns were not listened to. A concern repeated by others who gave birth at Liverpool Women's Hospital (including friend who is themselves a medical doctor)."*

> *"My wife's gynaecological issues were not taken seriously as I believe the hospital disadvantaged her on timescales and the fact it wasn't pregnancy related."*

> *"... as a woman with [a rare condition] I face constant stress and triggers in the NHS. I'm constantly being asked questions that I shouldn't be asked e.g. about periods, contraception whilst trying to conceive, chances of being pregnant ... I wouldn't mind but every day I was having to re-explain again and again to a different nurse about my situation. It's as if there is no note keeping system whatsoever. The communication at the Women's Hospital is horrific."*

> *"I felt disadvantaged in that I was unable to advocate for myself due to my mental state. When I had the same experience the second time but had my husband with me, my care was hugely improved."*

One patient described how they felt patronised:

> *"As a first time mum, I was patronised by the staff for attempting to advocate for myself and my care until I just gave up."*

Another described how her daughter was expected to perform tasks beyond their physical capacity after surgery.

> *"My daughter and daughter-in-law could not walk after surgery but were expected to care for their babies just like mums who could get out of bed."*

Discrimination and bias

The second most common theme in respondents' comments to this question was discrimination and bias, with many sharing that they felt they had experienced discrimination while being cared for:

> *"[I experienced] heteronormativity."*

> *"The hospital kept me waiting longer than white patients. They also were rude to me."*

> *"Being a person of colour."*

> *"As a black woman I have often been dismissed with regards to my symptoms."*

Others felt discriminated against because they could not be seen by a female doctor or helped by a female interpreter:

> *"Not having access to female doctors."*

> *"Wanting female doctors or female interpreters for cultural reasons were not accommodated."*

> *"As a Muslim woman, I always request a female gynaecologist / doctor / nurse etc. which wasn't always available."*

Patients also reported issues with interpreters, saying they were ineffective in facilitating understanding. Others felt their cultural and religious needs were overlooked or misunderstood:

> *"... language needs are not met and staff don't always respect culture and treat them with care."*

> *"... I don't have great English, on one occasion the nurse stopped the interpreter and asked me to talk directly with her, as the nurses knew the interpreter wasn't doing a good job."*

> *"Feel staff don't understand my culture and religion needs. They need to understand how things are different from me compared to other women who are English or those women who are more modern."*

Patient autonomy and being treated with respect

The third most common theme among responses to this question focused on respondents' experiences of autonomy and being treated with respect. These included comments around a lack of privacy, respect or feeling listened to:

> *"Just being Muslim, [I] needed more privacy on ward when breastfeeding."*

> *"Less respect because I am overweight."*

> *"As I was not prioritised, felt like I had to plea my case to be referred to in the first place but also gain another appt."*

Some of the key issues highlighted included patients saying they did not experience clear communication from staff and that there was inadequate explanation of procedures, leading to confusion and distress.

> *"Lack of information of the procedure / process. Terrible attitude of ward staff. Theatre staff uninformed and ignored patient privacy and dignity."*

> *"Not getting the right support for interpreters or the doctors and nurses treating them with disrespect. At one you used to get gowns for examination, now you have to just put your knickers down for examination. It's not nice to have to do that."*

> *"Things were not explained properly about the procedure by the doctor. The doctors put a coil in without telling me, without my consent, are they allowed to do this. I'm trying to get this removed but the GP won't help me. I don't know where to go for this."*

Some neurodivergent individuals, and those with a mental health condition, highlighted the absence of tailored support, saying this added to their distress and impacted their health:

> *"Being neurodivergent, I found it extremely overwhelming as so much went wrong. This caused great distress. For anyone typical, this would not have been such an awful experience. I completely felt unheard and ignored."*

> *"It was my daughter in law that felt disadvantaged because of her mental health ... not because of staff... more to do with lack of facilities for husband to be able to give her the necessary support."*

Consistency and standards of care

The fourth most common theme centred on people's experiences of the consistency and standards of care they received. Some of the negative experiences shared in the responses included patients saying that they felt staff were dismissive of their health conditions.

> *"Poor understanding of ADHD [attention deficit hyperactivity disorder] in adult women and the impact of ADHD medication on anaesthesia. Consequent[ly] mental health issues are being poorly handled."*

> *"I am an amputee and this led to the surgeon thinking my pain was related to being disabled. Ultrasound confirmed otherwise."*

> *"Treatment not at the expected standard, patient deteriorated due to not being listened to. Subsequent admission to another trust following discharge."*

Other patients described long waits for pain relief, scans, or procedures, believed age and gender were barriers to accessing care, or described challenges in attending appointments, citing issues such as inconvenient scheduling and services not being co-located.

5.7 The challenges for hospital gynaecology and maternity services in Liverpool

People were invited to give their thoughts on the challenges facing these hospital services in Liverpool in a free text box. Five key themes emerged from respondents' reflections:

- Waiting times for treatment and delays with appointments
- Staff compassion and competence
- Facilities, environments and locations
- Patient autonomy and being treated with respect
- Specialised care and follow-up services

Waiting times for treatment and delays with appointments

Waiting times for treatment and delays with appointments were the most prominent issue cited by respondents to this question. The majority shared experiences of long delays waiting for care and appointments, and called for urgent action to reduce these, improve waits for follow-up care, and address the existing backlog. Some patients described delays of a year or more:

> *"Waiting times are a huge issue. I originally waited 14 months for a gynaecology appointment only to have been referred to the incorrect service and to be put back to the start of the list. I waited an additional four months for the correct service."*

> *"It took five years for me to get an appointment with a consultant in the Women's and when I finally attended said appointment the way in which I was treated was honestly disgusting ..."*

> *"Living with prolapse for 12 months without any support or appointment is disgusting. I am only a young woman in my 30s. My whole life has been on hold because [I'm] waiting for an appointment!"*

> *"The wait lists are unacceptable. I'm 18 months overdue for my follow-up appointment. Women's gynaecology issues are not treated with the same respect as any issues men have reproductively."*

Staff compassion and competence

Staff compassion and competence was the second most common theme to emerge from people's responses, with over half the responses negative in sentiment, just over a quarter neutral, and fewer than one in five positive.

Where patients shared negative experiences, these tended to focus around feeling unheard, overlooked, and unsupported. Patients highlighted issues such as perceived

understaffing, lack of empathy, inadequate aftercare, and poor communication, which left many feeling vulnerable and neglected:

> *"I don't know who is training the staff at the Women's but they need to take a long look at themselves. I have chronic pain due to ongoing gynae problems since I was 12 (I'm 53 now) and have never felt less welcome or less cared about than at the Women's. I called once to ask about a referral and after a 30-minute wait then a five-minute call was in absolute tears. Crying on the phone. So I don't bother telling my GP anything anymore and will probably die early rather than be an inconvenience."*

> *"I was in hospital having a baby in June 2024 and got treated different coz I was in a hostel and my baby was going into temporary foster care. This made me feel unwelcome."*

One patient described experiencing very different levels of care within two different settings:

> *"Not currently delivering a service with safe staffing levels. I found when I had my baby earlier this year at the women's to be with an excellent theatre team with the C-section and excellent care for my baby in NICU [the neonatal intensive care unit]. I was disgusted with the treatment I received on the maternity ward afterwards."*

Despite this, patients did share examples of excellent care and treatment from staff, expressing their gratitude and recognising that some challenges are more widespread than Liverpool alone:

> *"Having been a patient of Liverpool Women's for the last 13 years, I couldn't fault the hospital and truly believe without their care I would have died … I think it's the waiting times that need to be addressed but this is widespread across the whole NHS."*

Facilities, environments and locations

A number of patients spoke about the challenges with facilities and environments as they are currently. For most, this related to the location of where services are provided from:

> *"It's unacceptable to have someone get two buses to a hospital that does not serve the north part of Liverpool."*

> *"I feel strongly that patient safety will be hugely affected if it is allowed to remain a physically separate site. The convenience for some of having a women's hospital in current location / set up is far outweighed by the significant risk posed by separating this from acute emergency teams with skill sets, equipment and staff in time critical scenarios."*

> *"Failure to locate these services on a site with other adult services was a mistake that needs reversing urgently."*

However, others felt that it was important that the services remain separate:

> *"It is really important that women have this separate service. We don't want to be dragged through big busy hospital environments to have our babies. Birthing babies is a very natural process and a relaxed environment is really important to facilitate this."*

> *"Keep the women's hospital on the site."*

Some spoke about what the current site lacked, in terms of other services:

> *"Better access to lab facilities to prevent delay with results."*

> *"If I were to require pregnancy care, or a surgical gynaecology procedure, I would actively avoid being under Liverpool Women's Hospital with its current set up … I would want to be cared for at a hospital where I know that other services and specialties (e.g. general surgery, critical care, transfusion lab) are available on the same site should they be required."*

Others shared their experiences of travelling to use the current services."

> *"Car parking is awful."*

> *"Some people cannot afford to travel to the Women's as it is not an easy hospital to attend if you use public transport."*

Patient autonomy and being treated with respect

The fourth key theme that emerged from responses to this question was patient autonomy and being treated with respect, with the majority of comments reflecting negative experiences of care and treatment, a third neutral in tone, and a much smaller proportion highlighting instances of exceptional care and positive experiences.

> *"Staff need to be monitored properly and should take things more seriously – nobody ever even looked at my birth plan and one midwife was awful to me."*

Others described distressing situations and lack of empathy:

> *"When being treated for fertility issues including a miscarriage I had to sit and wait with pregnant mothers and be surrounded by baby clothes sales."*

> *"Doctors are very dismissive and I've been laughed at by male doctors – more empathy and respect is needed."*

Specialised care and follow-up services

Many patients also reflected on the importance of specialised care and follow-up services, emphasising that having various services located together would help provide improved care and stop the need for women to be transferred to other sites for treatment, away from their babies.

> *"Maternity services need to be physically on the same site as other acute medical services with direct access to critical care, blood bank, interventional radiology and cardiology."*

> *"Expectant mothers with complications or life-threatening issues and mothers who have given birth who have health issues should be able to have the care they need whilst remaining with their babies."*

> *"I am a health professional at another trust and have witnessed the issues caused by patients having to be transferred to other hospital sites when complications occur. I had considered having my baby at another hospital where care could be provided should complications arise because I was worried I would have to be transferred to another hospital for potential surgical complications etc."*

One patient raised concerns about delayed reproductive health support for cancer patients:

> *"My sister has breast cancer and obviously her fertility has been affected by it. It has taken her five years of back and forth with GPs and appointments to finally be seen by the Women's only to confirm her menopause has begun due to the cancer treatment.*
>
> *"This is so ridiculously obvious, if a young woman is being treated for cancer, there should be an automatic link to her reproductive health at the Women's to keep track of this."*

Patients also criticised the lack of coordination, and their experiences of poor communication, between hospitals. This was particularly true of those with complex cases who required input from multiple clinical specialties:

> *"The engagement between hospitals is terrible … Despite repeated attempts by [doctors], nurses and consultants … it took two weeks to get a 3-way catheter delivered from the Liverpool Royal team. Which meant that my mum's bladder remained full of blood from a bleeding tumour for two whole weeks … The staff at Liverpool Women's went above and beyond but the urology team at Liverpool Royal were non-existent …"*

> *"It will be really good to have more joined up services, clearer pathways and safer care – can't happen soon enough."*

The remaining responses covered themes including integration and coordination of care, the quality of communication and information, emergency and critical care response, maternity and postnatal care, and mental health and emotional support.

5.8 Future priorities

Respondents were asked to identify the three most important factors to them when considering the future of hospital gynaecology and maternity services in Liverpool.

Five broad themes emerged in the feedback which, understandably, echo feedback provided elsewhere in the questionnaire. The five key themes were:

- Patient experience
- Accessibility and equity of care
- Waiting times and reducing appointment delays
- Patient safety
- Staff compassion and competence

Patient experience

The predominant theme that respondents prioritised was patient experience. This theme encompassed a number of areas.

Improvements to pain management

Respondents described the need for pain management to be taken more seriously and for pain medication to be provided more quickly, both for those in labour and for those managing a health condition.

> *"Be compassionate to patients who suffer pain."*

> *"Pain management while we are on the waiting list. Gynaecological pain is debilitating."*

Better understanding of women's health and a holistic approach to care

Some respondents described a feeling that women's health issues weren't widely understood, and wanted to see a more holistic approach. There was a sense among some that this would provide a more joined-up service by treating the whole person.

> *"To have an accessible holistic and [person-]centred approach which having community gynaecologists helped to achieve."*

> *"A holistic approach to services for women rather than artificially separating gynaecological health from childbirth."*

The option of being able to see a female clinician / nurse / midwife

Some respondents outlined the importance of maintaining a female only environment which they felt contributed to a better patient experience. Linked to this was the ability to be able to choose to see a female professional as part of their care.

> *"Being in a female only environment."*

> *"Care for individual needs of women depending on their age, culture, language and preference for female doctors."*

Greater cultural awareness

Some respondents described the need for more cultural awareness as impacting on their experience of care. Some respondents reported being treated differently as a result of cultural differences.

> *"Recognise that women from different backgrounds will present their symptoms differently, need to be aware of cultural differences."*

Conviction that services should all remain at Liverpool Women's Hospital

Many of the comments in response to this question took the opportunity to object to services potentially moving away from the Crown Street site. Others highlighted that the hospital has historic status within the city and should not be taken away.

> *"The hospital ought to stay on the Crown Street Site."*

> *"The situation in Liverpool must be seen in the context of the national crisis in gynaecology and maternity services. In this time of crisis it would be wrong to move women's services from the Crown Street site. Liverpool Women's Hospital is an iconic hospital."*

Accessibility and equity of care

The second most highly rated priority for the future was accessibility and equity of care. This included a strong desire for services to be delivered locally. Transport was also highlighted as an area of importance, with respondents indicating that any move of services should ensure continued access to transport links and parking.

> *"Hospital services are easily accessible for transport / parking etc – this is not possible at the Royal Liverpool Hospital."*

> *"Gynaecology should be in a main hospital. With easy access from all over the city."*

Others expressed accessibility in terms of convenient appointment times as well as locations.

> *"Care around the clock – appointments out of hours for those who work and don't want to take time out for appointments. Appointments in different venues across the city."*

Waiting times and reducing appointment delays

People's third most common priority for the future was waiting times and appointment delays.

Many people spoke of having to wait a long time for appointments:

> *"Significant reduction in waiting times."*

> *"Keep the speed of being seen especially when in for urgent reasons."*

As with earlier in the report, some spoke of waiting more than a year for treatment:

> *"Actually getting an appointment and being seen, I personally have been waiting nearly three years for a laparoscopy."*

Others said that co-ordination, communication, and short notice periods were issues with appointments currently:

> *"Difficult to contact via telephone. Waiting times too long and hard to speak to relevant people."*

> *"Easier to make appointments."*

There were a number of references to delays for urgent appointments and some respondents elaborated on the toll this was taking on individuals.

> *"Those who have bleeds in early pregnancy … at weekends or out of hours should be able to access a scan in the emergency department even if it is just to check the baby's heartbeat as well as an examination. It should not have an extensive waiting time. Instead, women are told to go home and booked in for a scan sometimes two to three days later."*

Patient safety

The fourth most common priority was patient safety. This included having access to the appropriate specialists and having care available at the right time, especially in an emergency.

> *"Everything needs to be in one place and everyone needs to have access to the doctors or emergency care when needed and not put their life in danger."*

> *"Ability to safely and effectively deal with the ever increasing complexities in maternity care."*

Staff compassion and competence

Staff compassion and competence was prioritised by almost the same number of respondents as patient safety. The issue of cultural awareness and sensitivity was also raised here, in relation to staff behaviours:

> *"Culture and religion is understood by staff in hospitals, some of them are racist when they see you with [a] headscarf."*

> *"Patient to feel respected, heard and cared for through compassion, staff tend to be rude especially if you're brown or have a headscarf on."*

Others spoke about the need for high levels of competence:

> *"Appropriately trained staff with a high standard of purposefully rota'd skill mix for support and exposure to experience."*

Also within this theme there was a sense that women need to be listened to more. Respondents described staff dismissing their concerns or not taking their views seriously:

> *"For women to be listened to and for there to be more support for women and their needs. People need to understand women know their own bodies."*

> *"That doctors listen to their patients instead of jumping to conclusions."*

> *"Sexist / misogynistic attitudes to be identified and addressed in all professionals / ancillary staff so that women and girls feel listened to and respected at every stage of their care."*

> *"To be listened to as a human being, not a number, and feel like I matter."*

Among the remaining areas of importance to respondents, funding and resources stood out in prominence. Among those who prioritised funding and resources, almost all mentioned the need for more staff, including doctors, nurses and gynaecologists.

6 Responses and findings from listening events

6.1 Public listening events arranged by NHS Cheshire and Merseyside

NHS Cheshire and Merseyside held six listening events during the engagement period: four face-to-face and two online. These were held at different times of day, and the face-to-face events in a variety of locations, to enable as many people as possible to attend.

Seventy-one people attended the events overall. This number does not include several people who attended more than one event. While we recognise the strength of feelings expressed on local NHS services, where themes have been repeated from event to event, we have aimed to reflect these accurately in this summary, while avoiding duplication.

Twenty-nine attendees completed equalities monitoring information. While care should be taken in interpreting percentages of a small number of respondents, of these:

- 73% were White English / Welsh / Scottish / Northern Irish / British
- 15% were White Irish
- 4% were White other
- 4% were Black/African/Caribbean/Black British: African
- 4% preferred not to say
- 4% selected 'other'

In contrast to the questionnaire, the vast majority of attendees were older, with 82% aged 65 and over.

In terms of religious beliefs, 68% responded that were not religious, 29% that they were Christian, and 4% preferred not to say. 78% identified as female, 19% as male and 4% as gender non-conforming. A full breakdown of the demographic information for event attendees, as well as questionnaire respondents, can be found in Appendix A.

The feedback in this section was sourced from notes taken at each event, and so has not been presented as direct quotes.

Kirkby Christian Fellowship, Old Rough Lane, Northwood, Kirkby

The first event, held on 7 November from 10.30am – 12.30pm, was attended by 21 members of the public.

Feedback from discussions included that the case for change felt 'one-sided' and would benefit from a wider range of evidence, as well as that more investment was needed in NHS women's services generally.

One attendee asked about other ideas from around the country, while another felt that examples of care in London did not translate well to Liverpool because of perceived greater spending on the NHS in the capital.

Some felt Liverpool Women's Hospital should be left 'as it is':

> *Nonsense to leave an NHS building given the state of other NHS buildings.*

> *Look for solutions that don't involve closing the Women's.*

> *Invest more money.*

> *There seems to be money available for development of some hospital units / services but not maternity.*

However, others agreed with the idea of looking at where services are provided from:

> *It's frustrating that services were removed from Aintree all those years ago when local people had campaigned for them to remain. A service returning to Aintree University Hospital would be great for the women of Kirkby.*

> *The location of the Women's [Crown Street] is difficult for transport [from Kirkby].*

> *Over 60 years' access to a range of local maternity provision has been eroded in spite of a growing and developing population in Kirkby.*

Others described how their care at Liverpool Women's Hospital fell short of their expectations:

> *I would be happy to have a dedicated maternity / gynaecology service as a satellite in this area.*

> *I didn't have good care at the Women's.*

> *I had to travel to the Women's A&E because the nature of my condition could not be dealt with at Aintree. There were long waits when I arrived and it was a poor service.*

Bridge Chapel, Morris Hall, Heath Road, Liverpool

The second event, held on 14 November from 2pm – 4pm, was attended by 18 members of the public.

Some attendees spoke about whether it would be possible to introduce an intensive care unit into Liverpool Women's Hospital, some felt that a decision on the future shape of services had already been made, and some asked if there was a case for improving services at the hospital rather than the possibility of moving them:

> *There are thousands of procedures and births that are successful at Liverpool Women's Hospital, most women with higher risks are already known about and therefore their treatment should be able to be planned for.*

> *There is [a] case for rethinking how this whole issue is looked at. Staffing and logistics is the real issue that needs to be addressed, not a relocation of services or a closure.*

Others discussed the case for change in the context of opportunities and pressures at other local hospitals:

> *The Royal is already over-subscribed with bed management issues, there is no space for any other patients.*

> *The Royal is very small – acute medical emergencies should be managed on site at the Women's.*

> *Why did Aintree maternity close? Should we just re-open that?*

> *Why didn't the new Royal include maternity and gynaecology in the rebuild?*

Some participants felt there was a lack of clarity as to which services are currently co-located, and which would need to be in the future:

> *It's impossible to have all services in every hospital – so we have to accept that there will always be some need to move patients between hospitals. Isn't that always going to happen?*

> *Trauma / major incident is at Aintree – if women's services move to the Royal, wouldn't some specialisms still be elsewhere?*

Others felt that co-locating services would be 'going back to what used to happen' and asked how people could have confidence in decision-making this time, while some felt that the challenges set out in the case for change could be addressed through more funding for maternity care.

Quaker Meeting House, 22 School Lane, Liverpool

The third event, held on 20 November from 6.30pm – 8.30pm was attended by 14 members of the public.

Feedback included that people did not agree with the problems outlined around transferring people for specialist care, and that there are other hospitals that aren't co-located with a wider range of services in the area. As with other events, some attendees expressed a desire not to change the services at Liverpool Women's Hospital, to invest more money into gynaecology and maternity services and staff, and raised concerns about privatisation.

Some argued that co-location does not guarantee services will always be safe, while some said that services need developing at Liverpool Women's Hospital rather than moving:

> *The case for change seems to mainly rest on the idea that co-location is safer for patients, but lots of tragedies still happen on sites that are co-located too … co-location isn't the answer to everything.*

> *There is a real need to further develop the specialist care that women can receive, why is this not possible?*

> *The services need development rather than any relocating.*

> *Ambulances should be allocated to the hospital for potential emergencies.*

However, others said that the situation in Liverpool was not acceptable:

> *Services should be accessible at the point of need for all patients – shouldn't just be accepted that in Liverpool we pass women around the system, or send them elsewhere for care.*

Some attendees asked where services could be moved to in order to achieve co-location, how this would benefit those using them, or whether the national context is being borne in mind:

> *Don't want this process to result in a poorer version of the care provided to women now, based at the Royal – needs to be better for women, and NHS has some work to do to demonstrate how any change would be better.*

> *The situation taking place in the background around women's services and the crisis across the country is not being taken into account.*

The Lake House Waterloo, Crosby Coastal Park, Liverpool

The fourth event, held on 22 November from 10.30am – 12.30pm, was attended by 16 members of the public, including a member of staff from Healthwatch Sefton.

Feedback from table discussions included:

> *A query on whether a crash team or intensive care unit could be located at Liverpool Women's Hospital to mitigate some of the risks of not being co-located with other services.*

> *A desire to understand what services would be needed at Liverpool Women's Hospital to enable services to remain on site, and whether these would be costed as an option.*

> *That the hospital was a specialist centre of excellence, important for research, and that moves to co-locate services would be going backwards.*

Several attendees questioned whether the case for change was impartial and felt it only presented the case for making changes to services, or was one-sided. Others felt that moving women's services to an acute hospital would create new challenges:

> *There's no bed space, so there's corridor care, long ambulance queues and overstretched staffing. Co-location would just create a new set of problems, even if beds were ringfenced for maternity and gynaecology care. Even on some large acute sites, such as Aintree University Hospital, there is a certain amount of distance between sites.*

Another said that her recent experience of being transferred from Liverpool Women's Hospital to Royal Liverpool University Hospital after being admitted for a gynaecology procedure was calmer than when she gave birth at Fazakerly Hospital 25 years ago and needed to wait for emergency surgery in the same hospital:

> *Unplanned care is never 'instant' – regardless of location, it always takes some time to arrange.*

> *Liverpool Women's Hospital gynaecology A&E services is a 'jewel in the crown' and should be better promoted … as it's a great service for women, but many people don't know it's there.*

Others echoed this by reflecting, for example, an experience of poor care after they'd been transferred from Liverpool Women's Hospital, and one of being cared for at Aintree University Hospital with a 'gynaecology team on standby'. One participant added that:

> *The issue isn't really about Liverpool Women's Hospital, it's a great facility – it's just about the lack of co-location … there is no perfect solution as you can never have 'everything' on one site.*

In discussing the future, themes included:

> *Keeping maternity and gynaecology services all in one place, don't split them up by moving maternity but leaving gynaecology where it is.*

> *Don't lose what's good about the care at Liverpool Women's Hospital in these discussions.*

> *Solve the finances and bottlenecks rather than moving the site.*

> *Accessibility is really important – it's not very easy to get to the current site for women from north of Liverpool, transport links to the current site really aren't great. So there is an inequality of access in that.*

Online engagement events

NHS Cheshire and Merseyside also held two online engagement events: one on 4 November, between 6pm and 8pm, and one on 13 November, between 10am and 12noon. Each event was attended by eight members of the public.

As with the face-to-face events, there was concern that the case for change felt one-sided, lacked evidence, or expressed confusion around the possible future of the Liverpool Women's Hospital building. Others disagreed, however:

> *I don't know anyone who wouldn't agree that there is a case for change. It is very clear from the presentation.*

Others said that the case for change had given them information that they did not have before being cared for there:

> *What do patients know about the care that they can get before they come in? I didn't have a clue that I would have to be moved if I experienced any major complications. I understand that there is a need for balance that people need to have confidence rather than be scared, but I still think I would have rather known some more.*

One asked for more information about the impact of any changes on those with protected characteristics:

> *There needs to be more information about other protected characteristics that will be impacted by change- Liverpool has the UK's 10th largest gay and lesbian population and the UK's 13th largest trans population.*

Others said that it was important that staff using digital systems at different hospital sites in the city can access the same information, and there was also feedback around the need to reduce waiting times.

As with the feedback from some of the face-to-face events, some felt that some of the issues presented, such as those around recruitment or patient transfers, were not specific to Liverpool Women's Hospital.

Staff event for NHS colleagues at Liverpool Women's Hospital

Liverpool Women's NHS Foundaton Trust also held an online listening event to enable their staff to share their views and feedback on the case for change.

25 members of staff attended the event, which was also recorded and shared afterwards, for those who wanted to attend but were unable to.

While this was not formally commissioned as part of the programme of engagement by NHS Cheshire and Merseyside, it nevertheless gave those colleagues an opportunity to share their views, which have been reflected below.

During the event, a matron fed back that:

> *The 'wrap around' care provided at Liverpool Women's Hospital is not as good as other organisations, and there is a tendency for teams to care for patients with complex conditions as best they can, before calling for specialists externally.*

> *The member of staff also felt that if the hospital was on the same site as other clinical specialties, the tendency would be to bring in other teams much earlier, because it would be easier to get that help.*

This view was supported by a consultant in maternity who fed back that Liverpool Women's Hospital 'feels different' to others she has experienced training and working in, and offers a different focus in training, specific to the clinical context of the hospital. She identified a risk in recruitment as a result, with NHS colleagues who have trained elsewhere potentially finding working in Liverpool unattractive, because of the unique way services are organised.

One staff member shared her experiences of being cared for by the gynaecology service as a patient. She described how:

> *Because there were complications, it took considerable effort to manage her condition between Liverpool Women's NHS Foundation Trust and Liverpool University Hospitals NHS Foundation Trust.*

> *It took a lot of extra time to organise her care for staff, additional logistics, and caused unnecessary stress to her experience as a patient. She said she would have felt less anxious if the services she needed had been available on the same site.*

Another member of staff asked what was new this time around, in terms of the process of looking at these services, and whether there was a risk that the teams repeat the process and engagement of previous years, and it result in anxiety for staff but not materialise in change.

Those leading the event also took a quick poll of attendees, which showed:

- 17 out of 25 (68%) felt comfortable with the case for change and felt they recognised the issues presented in it
- The same number felt broadly supportive of the case for change
- There was about a 50 / 50 split in terms of whether colleagues would feel comfortable explaining the key issues in the case for change to their patients, family, and friends

7 Feedback from correspondence, emails, and telephone calls

7.1 Feedback from correspondence

NHS Cheshire and Merseyside received one piece of correspondence in response to the case for change, which was from the MP for Liverpool West Derby. The Member of Parliament sets out his view that "Liverpool Women's Hospital and all its services must remain at Crown Street".

The MP describes how he believes "maternity services require a significant increase in funding … and the shortages of specialist staff are not caused by Liverpool Women's being one mile from the Royal, but by fundamental problems with workforce planning nationally."

He also asks for clarity about future proposals for the services, and cites "long waiting times in Liverpool's accident and emergency departments".

7.2 Feedback from emails

NHS Cheshire and Merseyside received 13 responses by email during the engagement period. Of these, 11 correspondents disagreed with what they perceived as a proposed closure of the Liverpool Women's Hospital. Some wanted more information than is currently available:

> *"Where will our babies be born? It is nonsense to expect people to agree to this engagement without these key issues being mentioned. Will gynaecology remain with maternity? Will all the other services remain? Will it remain a maternal medicine centre? Will it still be a tertiary hospital treating patients other hospitals cannot manage?"*

Others linked the location of the current hospital to inequality:

> *"This location was chosen as part of the attempts to re-build and reconcile with the L8 community, the black L8 community in particular … How can you as the ICB responsible for making these decisions affecting the future of the Women's Hospital seriously suggest that it's destruction as an integrated specialist women's hospital, a central part of Liverpool's oldest black community, at the heart of one of the poorest areas of the city, could somehow contribute to equality?"*

Some expressed gratitude and praised the quality of care at Liverpool Women's Hospital, while others shared concerns that the quality of care would not be replicated if the services were to move to other sites:

> *"I would like you to know I wholeheartedly support Liverpool Women's Hospital. My son was born there, my wife's life was saved there. My best*

> *friend received life-saving care there. My family would literally not exist without the care they gave us. Please, please, please, leave it alone."*

> *"If it was to move into an all-encompassing hospital, we wouldn't get this service and culture to helping women. Look to why it was built in the first place. I would dare say you wouldn't get the same facilities anywhere now. Even in the new Royal hospital. Women have far more complications and need dignity in being looked after. I went to A&E in the Royal, bleeding and in pain and was left to sit there for all to gawk at. I know I wouldn't have had that in the Women's. Please, please do not close this hospital!!!"*

As with some of the feedback from the listening events, others linked the case for change to wider perceived issues around funding and privatisation:

> *"Make birth safer for all. Bring back fully staffed services. End cuts and privatisation."*

> *"At the engagement meeting, it was clear that those attending from the local community were concerned about the unacknowledged but powerful contexts that have brought us to this position: underfunding, understaffing, privatisation."*

> *"Rather than laying waste to local skills, expertise, knowledge and resources by closing this hospital, the ICB might consider channelling their energies into discussions which will secure the future of Liverpool Women's Hospital."*

> *"Identifying appropriate funding sources to make improvements to the estate and increasing staffing to safe levels is possible and is necessary."*

However, another fed back that they had felt this side-tracked from the specific conversations that were intended around gynaecology and maternity care:

> *"I recognise I may have been one of very few people attending [an engagement event] not part of 'Save Liverpool Women's Hospital' and while they are a fantastic cause, I did feel as though they focused most of their time on that particular topic than the issue as a whole."*

7.3 Feedback via telephone calls

No feedback on the case for change was received via telephone.

Members of the Patient Advice and Liaison Service (PALS) team at Liverpool Women's Hospital NHS Foundation Trust provided a telephone contact point for people to call with any questions/feedback about the engagement, and to request materials in other formats or languages. This was staffed from Monday to Friday, 9.30am – 4.30pm.

The team logged a total of three calls about the engagement, including two requests for printed versions of the questionnaire, and one asking about registration for the engagement events.

8 Feedback from social media

This chapter summarises the comments and feedback on social media during the engagement period.

8.1 Facebook

During the engagement period, 55 comments from 38 individuals were received on posts from the NHS Cheshire and Merseyside account.

A number of these comments were expressing uncertainty over the future of Liverpool Women's Hospital, with many users debating whether the facility is closing or merging with another hospital. Commenters also questioned the adequacy of the new Liverpool Royal Hospital, with concerns that the facility does not have enough capacity to support maternity and gynaecological services.

> *"The new Royal is not big enough for sick people, never mind maternity and gynae. I think it should be left alone."*

> *"There are already a few hundred fewer beds in Liverpool Royal Hospital now, never mind using some for maternity and gynae. No wonder there's never a shorter waiting list—it's the problem of fewer beds."*

Many comments highlighted delays in medical appointments, particularly for gynaecological care and follow-ups. Across these comments there is a recurring theme of frustration with waiting times for NHS services.

> *"Still waiting for a 6-month follow-up appointment..... 18 months and counting."*

> *"2-year wait to see a gynaecologist, let you know then."*

Additionally, several commenters describe negative experiences with maternity care, ranging from staff attitudes to hygiene concerns.

> *"First time around they nearly killed me—very bad clinical neglect...7 years later, knowing this, all went perfectly and I couldn't fault them."*

> *"Terrible, I'm suffering every day with pain, and they lost my referral and still waiting to be seen."*

> *" When my wife was having my son, the midwife came damn close to killing the pair of them. The staff are arrogant beyond belief, not to mention it's a dirty hospital...seriously, just take a moment to take a proper look, I have been to African villages with better hygiene."*

Commenters also discussed structural changes in the NHS, questioning why NHS services have been organised as they currently are.

> *"Maternity, children's, cancer care should be within a main hospital like it used to be, and more local hospitals built. They've knocked down large local hospitals and replaced them with small ones not capable for the amount of patients that need them."*

A significant portion of the comments received expressed concerns about immigration, and demographic changes. A few comments touched on broader societal issues, including government decisions and media coverage.

8.2 X formerly Twitter

During the engagement period,15 tweets from multiple users highlighted dissatisfaction with the case for change.

Many users expressed scepticism about whether public feedback would be genuinely considered. Issues raised included a lack of transparency, and claims that decisions were predetermined.

> *"@C_MPartnership plan to bury 75k signatures along with our Women's Hospital! They don't care what we think & their sham 'engagement' with scraps of paper is a con."*

> *"Great turnout today of local Kirkby residents & NHS campaigners—challenged @C_MPartnership & LWH reps to explain their 'case for change' but they couldn't. There's no convincing argument in their document."*

> *"@NHSCandM solution is to close the dedicated, safe women's hospital so that the safety of women/babies can be brought down to unsafe levels everyone else experiences #LevellingDown."*

Commenters were directed by the NHS Cheshire and Merseyside social media accounts to complete the online questionnaire.

9 Petitions

A petition entitled 'Save Liverpool Women's Hospital' was set up on the 38 Degrees online platform nine years ago.

At the time of writing, the 38 Degrees petition has been signed by 45,460 signatures, however those involved with the Save Liverpool Women's campaign have reported that the figure has now reached 76,000, when paper-based petition signatures are included.

This will be taken into account, along with all other feedback arising.

The petition statement is below:

> *"Save Liverpool Women's Hospital*
>
> *"Save the Liverpool Women's Hospital. No closure. No privatisation. No cuts. No merger. Reorganise the funding structures not the hospital. Our babies and mothers our sick women deserve the very best.*
>
> *"Why is this important?*
>
> *"All the maternity and women's health provision of Liverpool was pulled into this one site. It's a much loved hospital. It provides crucial specialised care and the daily joy of new babies. #one born. The driving force for closure is a clumsy funding structure not the needs of women and babies. The alternative of wards in the new Royal is not an equivalent.*
>
> *"This is a modern hospital on a good site. Our taxes built it for our babies and for our women."*

In addition, during the engagement period, 438 pre-printed postcards were received. The postcards had been pre-populated with NHS Cheshire and Merseyside's address, and each included the signatories' name and address. Some were received individually, and some were received together within the same envelope.

The pre-printed postcard message is below:

> *"Save Liverpool Women's Hospital 2024. I say no to the ICB proposals of October 2024. This is my response to the 'engagement' with the public. No to closing or dispersing the services of Liverpool Women's Hospital".*

10 Responses and findings from voluntary, community, faith, and social enterprise groups

NHS Cheshire and Merseyside invited voluntary, community, faith, and social enterprise (VCFSE) organisations to apply for funding to carry out engagement directly with communities. The aim was to broaden the reach of the engagement, enabling seldom-heard groups to share their views. A total of 12 organisations applied for funding and, following an assessment of these applications, six were taken forward. These were:

- Blackburne House Group
- Diverse Active
- Syrian British Cultural Centre
- The Whitechapel Centre
- Women's Health Information and Support Centre
- Women Reach Women

While engagement materials were provided by NHS Cheshire and Merseyside, organisations were encouraged to engage on them using methods and channels that are most accessible and relevant to the communities they work with.

The VCFSE organisations were asked to support and encourage individuals to complete the questionnaire, which was made available in hard copy and responses translated where necessary.

Where it was felt more effective in enabling people to have their say, organisations could also hold singular or group conversations with people, and report on these separately.

For the purposes of this report, where individuals have completed the questionnaire, their responses are included in the questionnaire findings above. This chapter summarises feedback that VCFSE organisations gathered through individual conversations and / or focus groups, which was detailed in reports provided to NHS Cheshire and Merseyside.

NHS Cheshire and Merseyside would like to thank the VCFSE groups that took part in helping their communities share their views on these important issues.

10.1 Blackburne House Group

Blackburne House Group is a Liverpool-based charity that supports the development of local, and often vulnerable, women. It has a core focus on education, particularly in sectors in which women are still under-represented.

The charity reported that they had engaged 221 people during the engagement. This includes people who completed a questionnaire, and those who had their say in a focus

group or as part of their classroom activity. The organisation 'engaged with women across a wide age range, from young to old, and from ethnically diverse backgrounds'.

> *"The vast majority of those consulted expressed feeling safe and valued in their interactions with the hospital's gynaecological and maternal care services. However, some voiced frustration, particularly about the review of services that were implemented over 30 years ago, which they believe continue to meet essential needs effectively."*

In line with views expressed earlier in the report, feedback reflected the drawbacks of not having co-located services. However, among focus group respondents, there was "strong support for maintaining a women-only hospital" and "the need for an embedded A&E facility."

> *"Some women expressed a strong belief in the absolute necessity of having a women-only hospital. However, they also acknowledged the absence of an Accident and Emergency (A&E) department and emphasised the importance of embedding such a facility within the Women's Hospital."*

On similar lines, "concerns were raised about the potential reintegration of services into general hospitals, with older women citing this as a wasteful reversal of progress."

The inconsistency of quality of care across Liverpool and surrounding areas was raised, in the context of women perceiving a higher quality of care at Liverpool Women's Hospital than they now receive locally.

> *"... several women who previously used the hospital and can no longer access it due to residing on the Wirral compared their experiences with Wirral-based hospitals, often describing them as significantly worse in terms of care and overall experience."*

Experiences around "challenges in accessing abortion services" were also shared by several women.

> *"Within focus groups, some women raised concerns about accessing abortion services at the Women's Hospital. They shared personal experiences, or those of friends, highlighting the challenges and barriers encountered in this area. They emphasised the importance of including abortion services in any future review or planning to ensure that these essential services are accessible and meet the needs of all women."*

Lastly, some women felt they had been discharged quicker than they would have liked after giving birth.

> *"... many women repeatedly expressed a desire for longer hospital stays following childbirth. The suggested timeframes varied, with women advocating for stays ranging from two to five days, emphasising the need for adequate recovery time and support during the postpartum period."*

10.2 Diverse Active

Diverse Active is a community interest company which supports pregnant women, mothers, fathers, and families across Merseyside to improve their health and wellbeing.

During the engagement period, they enabled 196 "pregnant women, mums and health professionals" to share their views in individual conversations, and 12 people took part in small focus groups.

The organisation described how "everyone we spoke to understands the case for change and agreed that changes need to be made to improve the quality and safety of gynaecology and maternity services in Liverpool."

The priority areas which were raised throughout the engagement they undertook were:

- communication and information
- staff and staff training
- integrated care
- future plans

Communication and information

Diverse Active found "people highlighted multiple issues with communication throughout their experiences of both gynaecology and maternity. Almost everyone we spoke with had experienced poor communication in some form."

> *"The attendee received a scan invitation and a phone call from another community midwife weeks later to ask "how the pregnancy was progressing" after [her] baby had died, leading [to] exacerbated upset and trauma."*

> *"There was also an additional issue beforehand following a scan, with a delay to the results meaning that scan results confirming "baby was ok" arrived after baby has passed."*

Another described a lack of information at the start of her pregnancy.

> *"Who should I tell/contact? What do I need to do? How can I check if everything is ok/what is normal? Did not know who to contact for support in early pregnancy if experience pain or bleeding. Could communication around this be improved?"*

Diverse Active also found that "many attendees reported that health professionals assumed understanding and used terminology they were unfamiliar with, leaving them confused."

> *"Attendees reported not feeling confident to ask questions as they didn't want to feel stupid and that the midwife didn't seem to have time to listen / explain . . . Pregnancy is a special time, however it often comes with lots of*

> *stress and anxiety, people look to midwifes/health professionals for reassurance. Unfortunately, many felt they didn't get the support / service they expected."*

Staff and staff training

The organisation reported that "the number and standard of staff was a huge talking point during all conversations, most with varying experiences. Most reported that they had seen staff "doing their best" however, it was visible that they were overstretched creating fears about the standard of care."

> *"Midwives at Liverpool Women's were typically being stretched to 11 women to their usual eight due to shortage of staff meaning that the midwives were not being able to fulfil their role to a good standard without having to [do] extra work after their hours and felt they were achieving bare minimum each time."*

> *"My anaesthetist was awful whilst administering epidural, saying she needed to be away in another surgery in five minutes, making me feel as though I was not important, serious lack of patient care."*

> *"When coming round from anaesthetic, I overheard a staff member saying he'd been on shift for 16 hours, which is terrifying and traumatic, knowing I was at risk."*

> *"I overheard staff saying that they were actively turning away women in active labour due to staff shortages and bed shortages."*

People also discussed "feeling that lots of people in Liverpool have old fashioned opinions and that people don't want to understand differences, referencing transgender and people of different sexualities, and that they may get treated differently."

Diverse Active reported that "people overall felt like staff were doing a good job, consistently going 'above and beyond' to ensure safety / do their job, however, everyone felt that they need more support and help to do their jobs more effectively."

Integrated care

The organisation noted that "there was full support for better integrated care and services working better together as highlighted in the booklet and information on the website" and that "ensuring better access to all services for everyone is a priority."

Future plans

The organisation also reported that "people want to know 'The Truth' about what is happening and if decisions have already been made … One person referenced the

previous engagement circa 2016 and asked 'what is different now, and why didn't anything change then?'".

Diverse Active also reported that people had questions over the funding for any changes, the timeframe, and logistics.

> *"Many people feel they have been here before with rumours over several years and the previous engagement. People we spoke to understand the pressing need for change and would like to see some action and movement on the back of the engagement to improve services and safety."*

10.3 Syrian British Cultural Centre CIC

The Syrian British Cultural Centre CIC (community interest company) encourages cultural exchange and fosters understanding among residents, providing a wide range of activities and events, including art classes, music sessions, and cultural workshops.

The organisation's engagement for this project targeted underserved communities, including Syrian, Yemeni, Somali, and Kurdish women, addressing linguistic, cultural, and accessibility barriers.

A total of 118 women participated in this engagement, representing diverse backgrounds, including 67 women of Arab ethnicity and 19 Kurdish women.

A variety of methods were employed to maximise participation and inclusivity, including face-to-face sessions, focus groups for discussions, WhatsApp groups for outreach and reminders, and home visits for women with disabilities.

Community feedback on key areas

The majority of participants had direct experience with hospital gynaecology and maternity services in Liverpool, with 78% of women having used or currently using gynaecology services, and 7% having had experience of maternity services. Additionally, 9% of women reported that someone close to them had used gynaecology services, and 5% of women knew someone who had accessed maternity care.

The experiences of participants varied. 26% of women described their experience as positive and 14% as very positive. However, a significant proportion – 41% of women – reported a neutral experience, and 14% had a negative experience. 3% described their experience as very negative.

Concerns around fairness in accessing care were also raised, with 10% of women feeling that they had been disadvantaged compared to others. In contrast, 82% stated they did not feel disadvantaged, and 8% were unsure.

When asked whether they agreed with the need for change in hospital gynaecology and maternity services, an overwhelming majority – 92% – strongly agreed, while 6% tended to agree. Only 3% were unsure or did not express an opinion.

The overarching themes that the participants raised are set out below.

Language barriers and access to information

Language barriers emerged as one of the most pressing issues, with participants highlighting the lack of interpreters and translated materials as significant obstacles to accessing care.

Many women were unaware of their right to request interpreters, or of the full range of services available to them, leaving them feeling disempowered. This led to confusion and stress, particularly during critical appointments where understanding medical advice was essential.

> *"I had to rely on my young daughter to translate for me during appointments, which was embarrassing and uncomfortable."*

> *"I found it challenging to fill out forms that were only available in English, which delayed my registration and caused frustration."*

> *"My mother wasn't aware of the availability of free translation services, which limited her ability to communicate her medical concerns effectively."*

> *"There's no translated information about treatment options, and that prevented me from making informed decisions about my care."*

Participants expressed frustration over the lack of clear and accessible information about services.

> *"The absence of clear communication left me uncertain about the next steps in my treatment, which caused unnecessary stress."*

Cultural sensitivity

Many participants reported that the lack of cultural sensitivity among healthcare staff often left them feeling uncomfortable or excluded. Specific examples included those which highlighted the importance of privacy and dignity during examinations, the absence of female healthcare professionals, which was a priority for several women, and broader lack of understanding around the participants' religion.

> *"The medical staff didn't seem to understand my cultural need for modesty during examinations, which made me feel uneasy."*

> *"I felt excluded because there wasn't a female doctor available for my gynaecology appointment, and it was against my beliefs to be examined by a male."*

> *"The lack of understanding of my religious practices during my stay made me feel like my needs weren't valued."*

Group-specific insights

Syrian and Yemeni women: These groups stressed the importance of having access to translation services and strongly preferred female interpreters to ensure they felt comfortable and had effective communication.

Kurdish women: Participants from the Kurdish community highlighted the need for culturally sensitive staff who could understand and accommodate their specific cultural needs.

Somali women: This group reported a notable lack of trust in the healthcare system, citing past negative experiences and a perceived lack of effort to address community-specific concerns. They also advocated for community-based solutions to bridge gaps in trust and accessibility.

10.4 The Whitechapel Centre

The Whitechapel Centre is a homeless and housing charity for the Liverpool region. The team work with people who are sleeping rough, living in hostels or struggling to manage their accommodation.

The organisation reported engaging more than 50 people, of which 30 were from across three hostels it operates in the region. It listened to those with differing support needs and those for whom English is not their first language, including families seeking asylum.

They also engaged people through various support groups. This involved assisting their clients to read the engagement materials, understand them, and then support them to complete hard-copy questionnaires which were subsequently inputted online. This means that the responses from these individuals have been included in section 4 of this report. The summary feedback states that "on the whole, feedback regarding the services was mixed to negative, many respondents had good experiences while in hospital services but found post-natal support in the community to be lacking.

"Some respondents had negative experiences of services, with the main feedback we received in these cases being that they often felt unheard, talked over or misunderstood by medical staff. Several respondents had major negative experiences with services and felt very strongly that services needed to change … Many respondents indicated fear at having to return to or use services at the Women's after reading the case for change documents".

10.5 Women's Health Information and Support Centre

The Women's Health Information & Support Centre (WHISC) is a charity which aims to improve the health and wellbeing of women and their families throughout Liverpool and the surrounding areas.

During the engagement period, the charity held three face-to-face events, engaging with 40 women in total and encouraging women to complete the survey.

10.6 Women Reach Women CIC

Women Reach Women CIC (community interest company) is dedicated to improving the health, wellbeing, and empowerment of Black, Asian, and minority ethnic women. The organisation works through a combination of research, education, engagement and advocacy to address the unique challenges faced by women from diverse backgrounds.

The organisation used "bi-lingual advisors with local knowledge [who] played a key role in building trust and credibility among participants ... For participants who might have been hesitant or unfamiliar with formal healthcare discussions, the bi-lingual advisors acted as a bridge, making the sessions more accessible."

The organisation targeted residents from Wavertree, Toxteth, Greenbank, Kensington and Princess Park, and also included a number of male respondents. They supported 116 respondents to complete hard copy questionnaires, and then entered these into the online survey. This means their individual responses have been included in section 4 of the report.

Women Reach Women found that "most participants who completed the surveys were positive about the proposed changes, but several shared personal experiences that highlighted the urgent need for improvement, particularly in emergency care."

> *"For example, individuals spoke about the distress caused by being transported by ambulance to another hospital for emergency surgery, and the long-term trauma of being separated from their babies during such a critical time. These stories strongly resonated with the case for change and emphasized the need for improvements in healthcare practices, especially for women facing emergencies."*

Barriers to accessing care

The team noted that "many participants shared troubling stories of poor interpreter performance, with some healthcare professionals even stopping interpreters from speaking and communicating directly with patients instead."

Respondents also spoke of long waiting lists leading to delayed treatment, and "participants [emphasising] the importance of having female healthcare professionals available to meet religious and cultural requirements for women."

Specialist care

Women Reach Women said that "though the majority of participants supported the proposed changes, many emphasised that the Women's Hospital is what makes Liverpool unique compared to other hospitals in the country. The specialised care and

sense of community at the Women's Hospital were viewed as critical factors in improving patient experiences."

The report also described people's views that, while Liverpool Women's Hospital has neonatal critical care, even with more emergency services brought onto the site, some babies who need surgery might still need to be transferred to Alder Hey Children's Hospital.

> *"Some participants suggested bringing more specialist doctors to the hospital and increasing funding to enhance its services. Others highlighted that while embedding emergency care services within the hospital may improve accessibility for women, the issue of neonatal babies requiring emergency care still remains. These cases would require transfer to Alder Hey, presenting similar risks for the babies."*

Future plans

As with Diverse Active, Women Reach Women reported that "many participants expressed concern that the case for change had not clearly outlined what would happen to the hospital's services or where they would be located. There was a strong interest in knowing what the next steps would be, with people eager for updates and clarity."

Communication

Also, in line with previous feedback throughout the engagement period, the organisation found "there was also a general sentiment of frustration regarding communication in healthcare."

> *"Many participants felt their concerns were not always listened to by doctors and that there was a lack of clear communication about their care."*

11 Next steps

The feedback outlined in this report will be used to inform the next phase of the Women's Hospital Services in Liverpool programme.

In March 2025, the report will be received by the Women's Hospital Services in Liverpool Programme Board, the group managing the development and delivery of the programme, before being presented to the Women's Services Committee of NHS Cheshire and Merseyside.

Subject to the committee's recommendation, the report will then be presented to the Board of NHS Cheshire and Merseyside when it meets at the end of March 2025.

Under the guidance of the Programme Board, the engagement findings will be used to inform the process of developing potential options for how services could look in the future, which is expected to take place during spring / summer 2025, and will also involve the programme's Lived Experience Panel.

NHS Cheshire and Merseyside will share further information as this work progresses. To keep up-to-date, visit www.GynaeandMaternityLiverpool.nhs.uk and sign up for NHS Cheshire and Merseyside's Virtual Reference Group.

Appendices

Appendix A: Demographic information – questionnaire respondents and event attendees

Appendix B: Promotional material to support the engagement activity

Appendix C: Engagement questionnaire

Appendix A: Demographic information

Demographic information from questionnaire respondents

Information collected from the questionnaire has been collated to provide a detailed overview of respondents' demographics.

Where people live

Almost three quarters of respondents – 71% – live in Liverpool, while 12% live in Sefton, and 7% in Knowsley. Smaller proportions live in Wirral (3%), and Cheshire West, St Helens, Halton, Cheshire East, and Warrington (each with 1% or less) (see Chart 6).

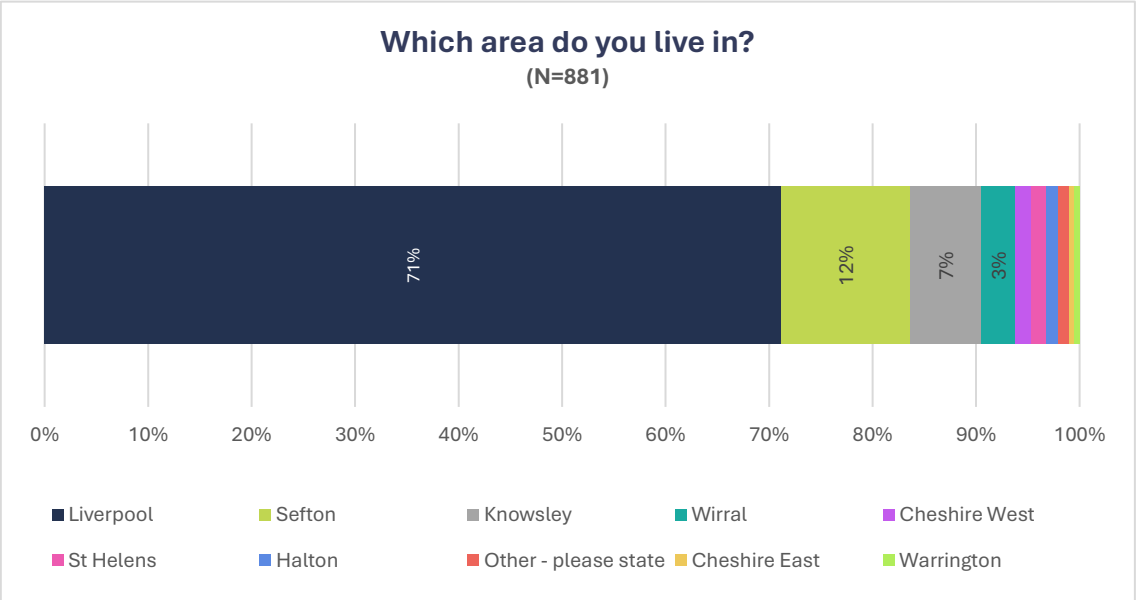


Chart 6: Which area do you live in?

Ethnicity

Among those who provided information on ethnicity, the majority identified as White (72%). The majority were English / Welsh / Scottish / Northern Irish / British, who accounted for 67% of respondents (see Chart 7).

Other notable groups included individuals of Asian / Asian British backgrounds, who collectively represented 16%, with significant numbers identifying as Bangladeshi (6%) Indian (5%), and Pakistani (3%).

Respondents from Black / African / Caribbean / Black British backgrounds made up 4%, while smaller percentages identified as Mixed / Multiple ethnic groups or other ethnic categories.

Those who identified as Arab constituted 1%, and 2% of respondents did not disclose their ethnic background.

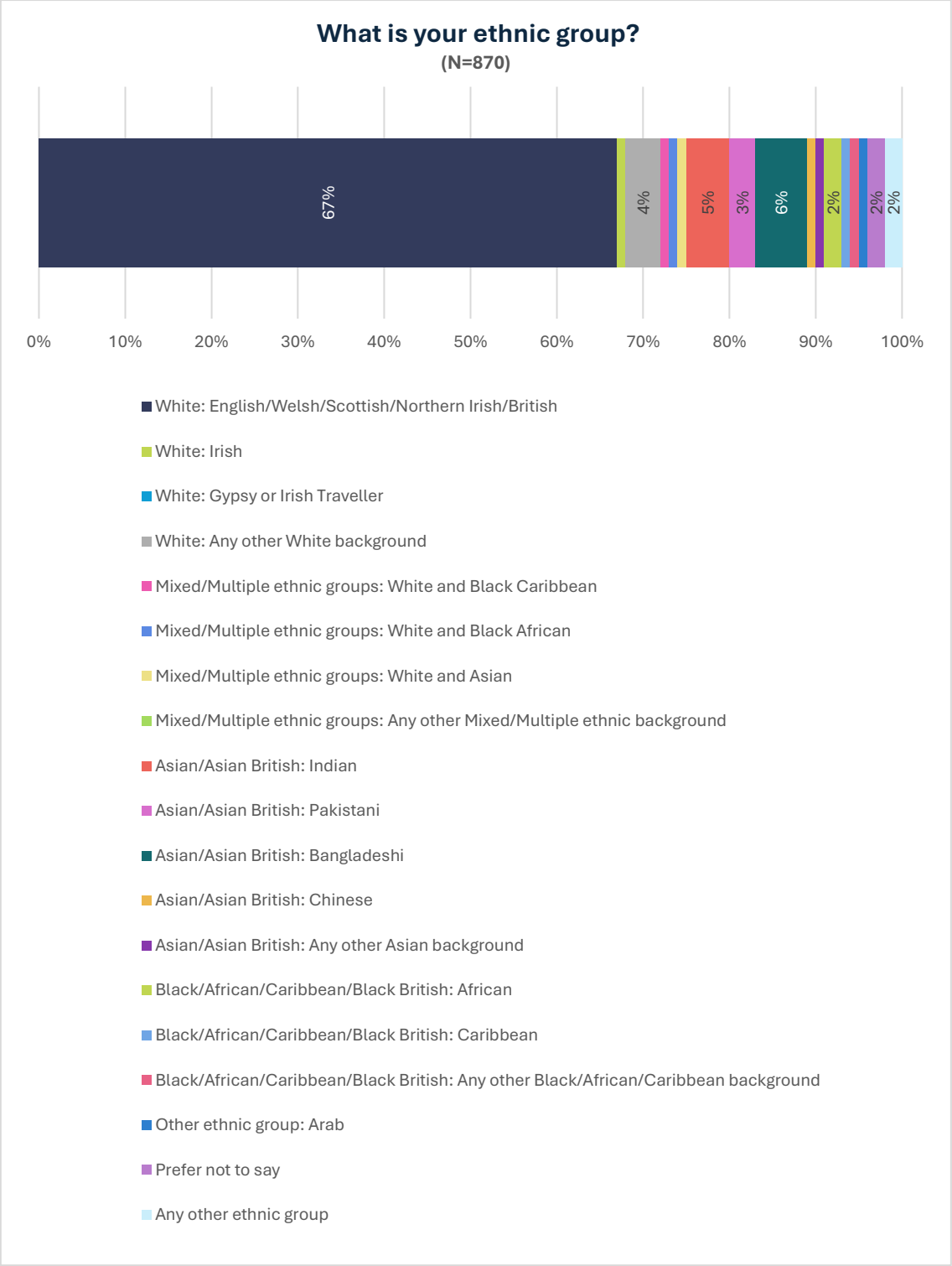


Chart 7: What is your ethnic group?

Age

The largest proportion of respondents was aged between 30 – 49 (59%), with 28% aged 50 or older and 11% under 30 (see Chart 8).

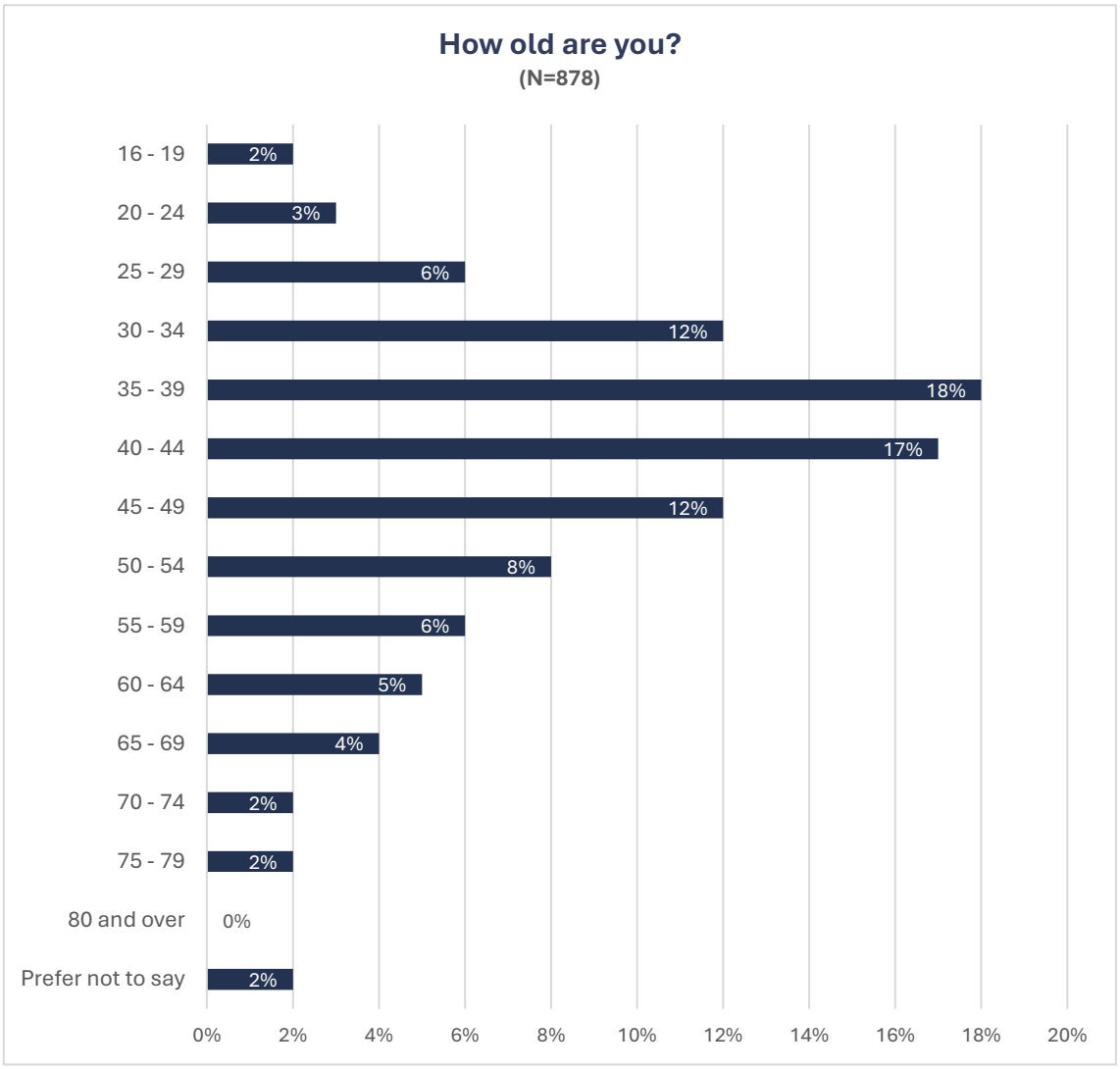


Chart 8: How old are you?

Religion

Religious belief also varied widely among participants. Christianity was the most commonly identified belief, with 44% of respondents associating with it, while 31% stated they had no religion, and 15% identified as Muslim.

Other faiths, including Buddhism, Sikhism, Hinduism, and Judaism, were represented to a lesser extent, collectively making up about 7%. A small percentage (4%) of respondents chose not to disclose their religious beliefs (see Chart 9).

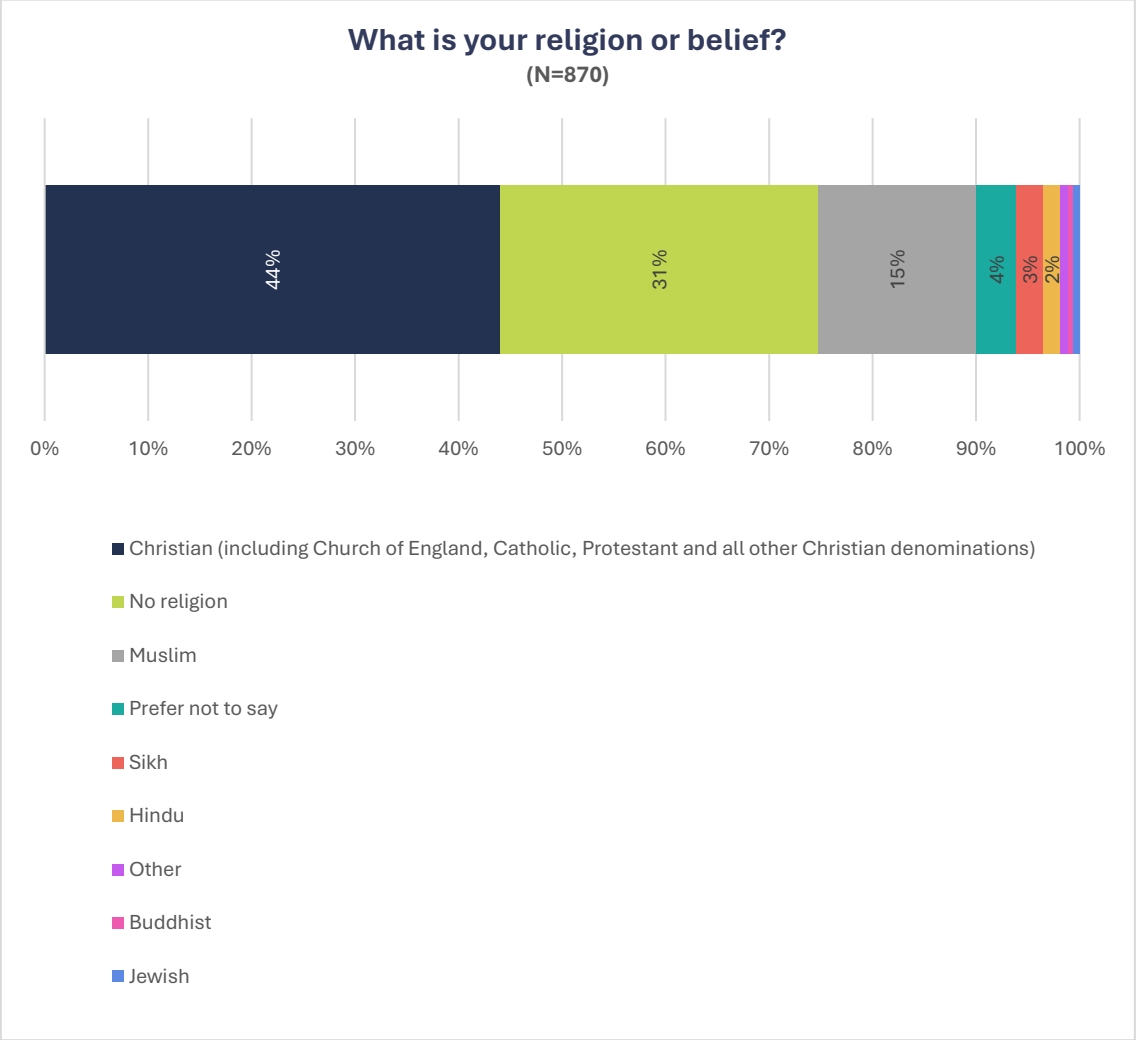


Chart 9: What is your religion or belief?

Gender and sexual orientation

In terms of gender, the majority of respondents identified as female (88%), with males representing 9%. A small number identified as non-binary (see Chart 10).

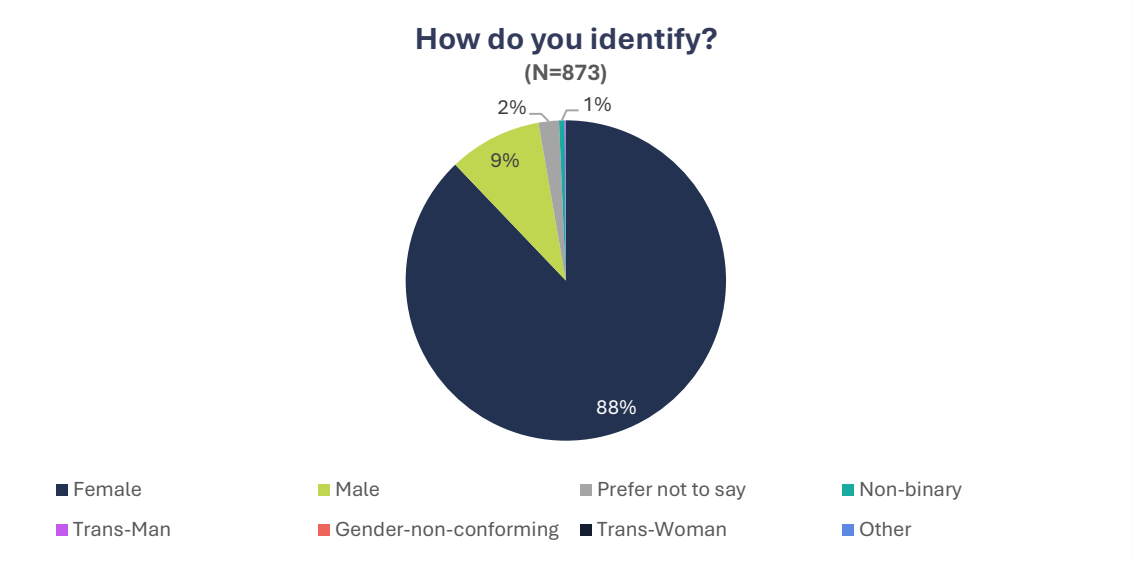


Chart 6: How do you identify?

Regarding sexual orientation, 86% of respondents identified as heterosexual, while the remainder included individuals identifying as lesbian, gay, bisexual, asexual, or other orientations (8%), with 6% opting not to disclose this information (see Chart 11).

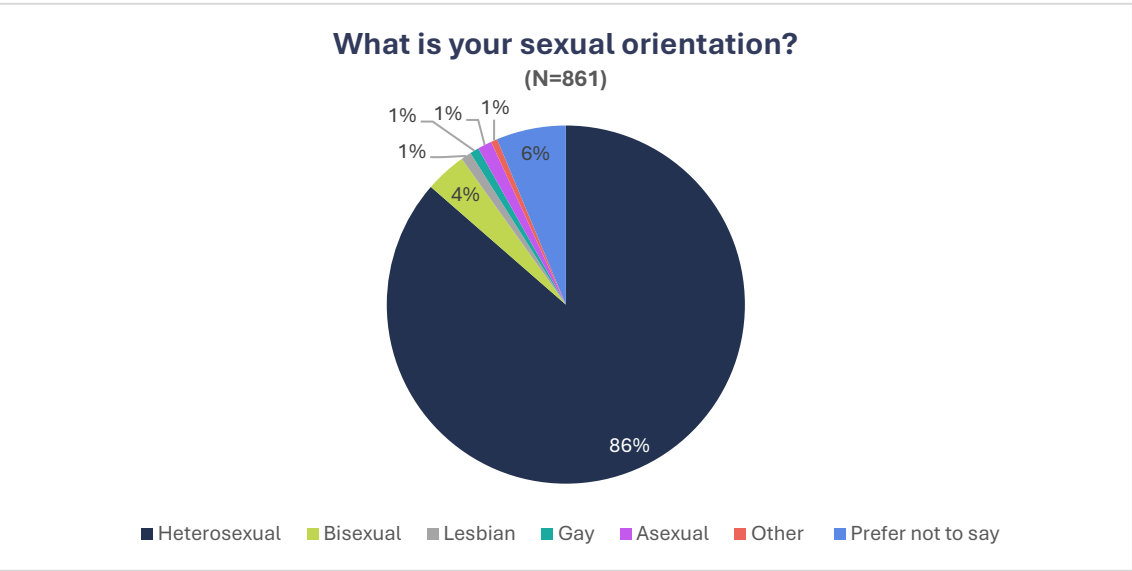


Chart 11: What is your sexual orientation?

Relationship status

Relationship status showed that over half of respondents were married (54%), while 18% were single and 15% were living with a partner. Smaller proportions reported being in a civil partnership (2%), divorced (4%), separated (1%), or widowed (2%) (see Chart 12).

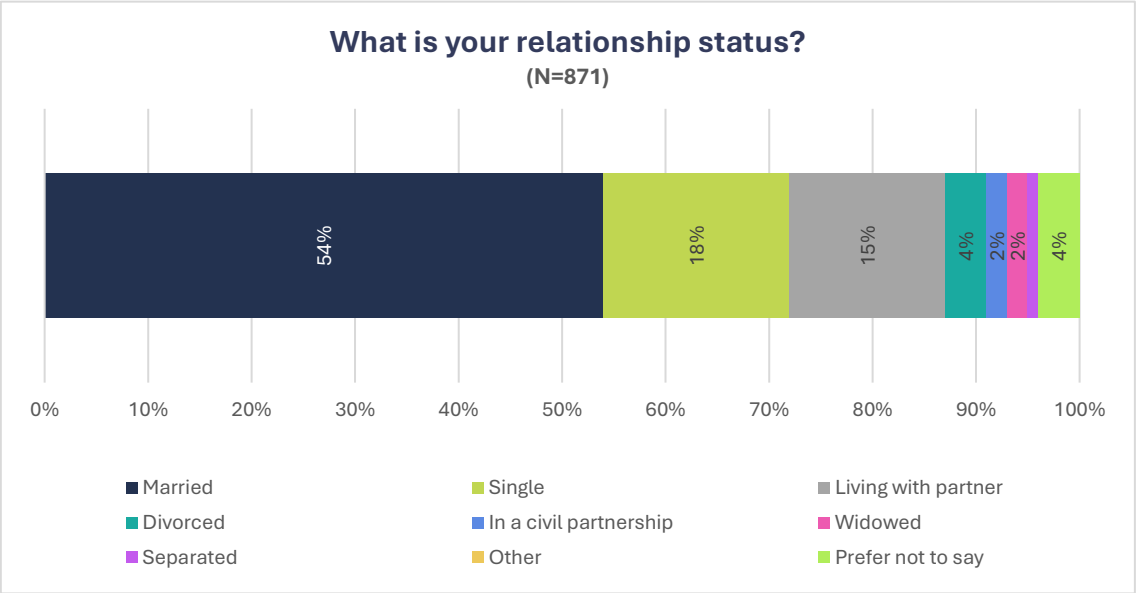


Chart 12: What is your relationship status?

Disability

Health-related questions revealed that 58% of people did not consider themselves to have a disability. 14% reporting long-term illnesses (such as cancer, diabetes, or COPD), 13% reported having a mental health condition and 10% reported a physical disability (see Chart 13).

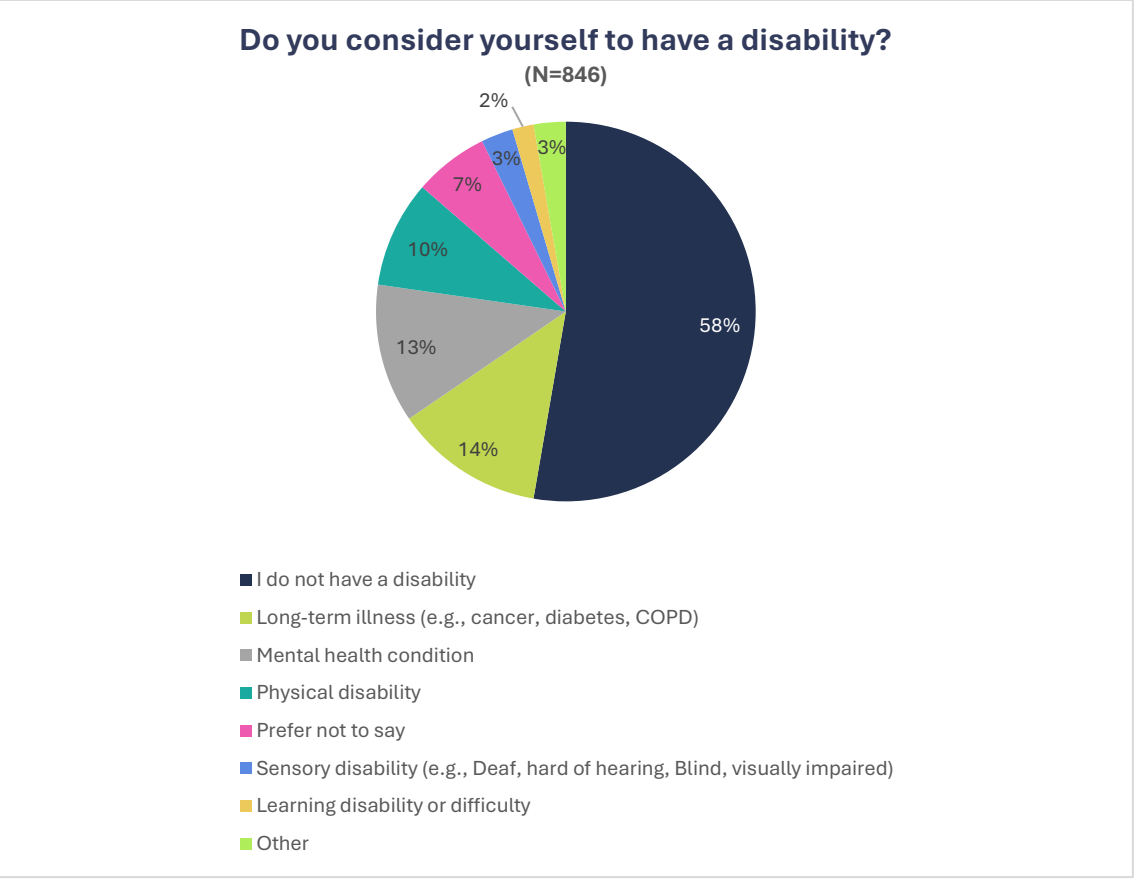


Chart 13: Do you consider yourself to have a disability?

29% of respondents reported limitations in day-to-day activities due to a health problem or disability which has lasted, or is expected to last, at least 12 months. This included 9% of respondents who reported that they were 'limited a lot' (see Chart 14).

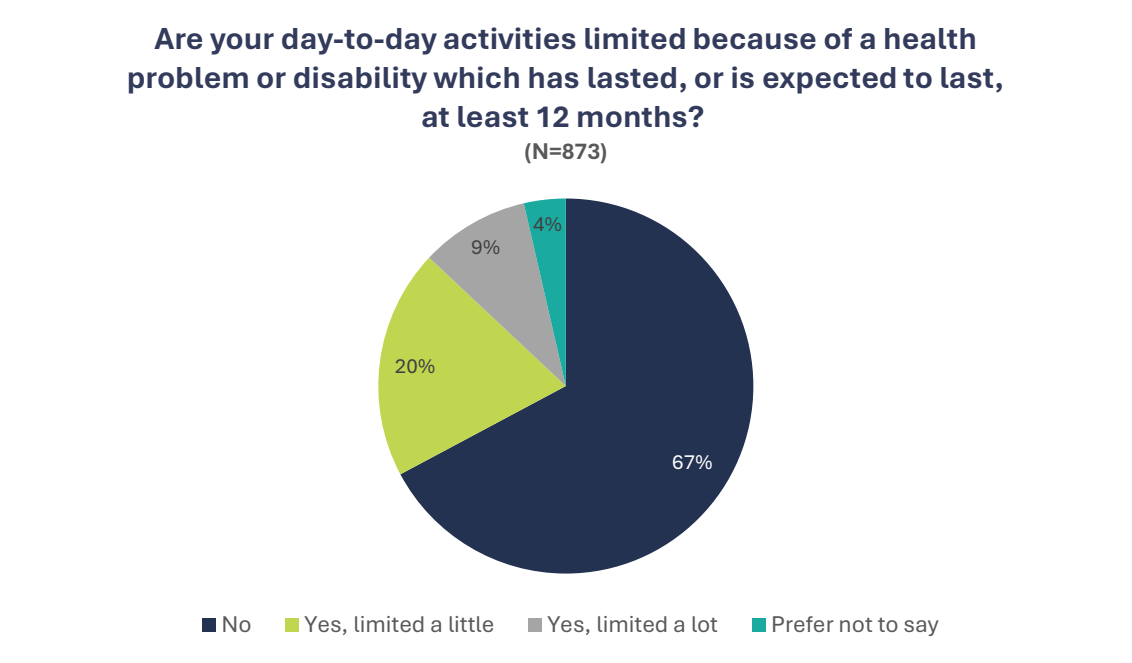


Chart 14: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

Carer responsibilities

26% of respondents indicated that they care for someone, with 13% caring for young people (aged under 24), 10% caring for older adults (aged 50 and over), and 3% caring for adults aged 25 to 49 (see Chart 15).

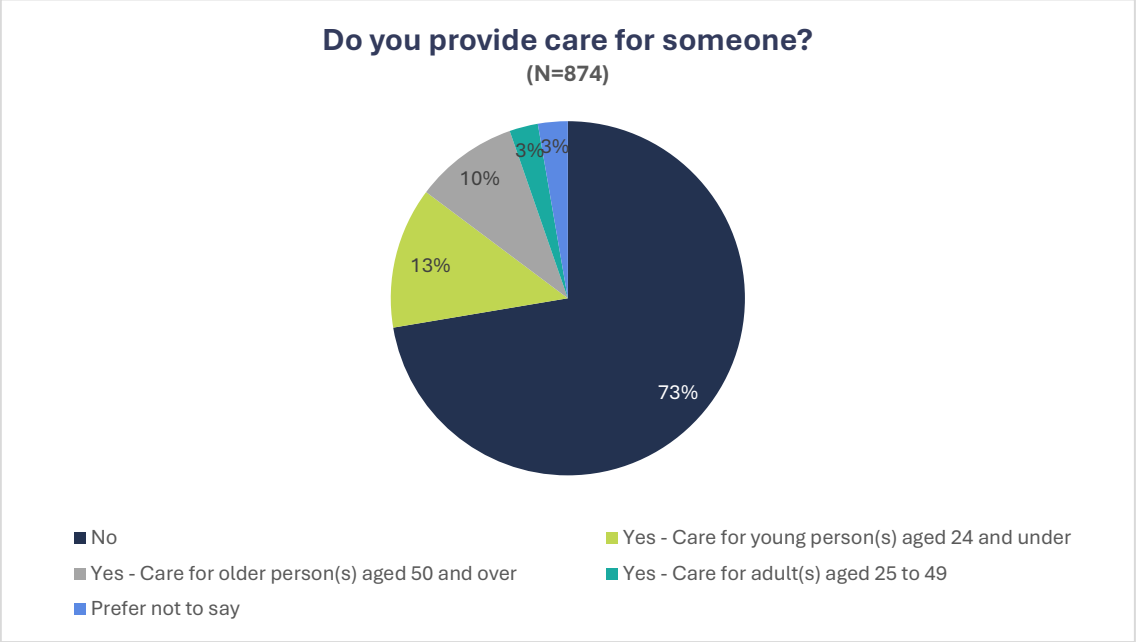


Chart 15: Do you provide care for someone?

Pregnancy and child birth

Pregnancy and childbirth data showed that 6% of respondents were pregnant at the time of the survey, and 7% had given birth within the past six months (see Charts 16 and 17).

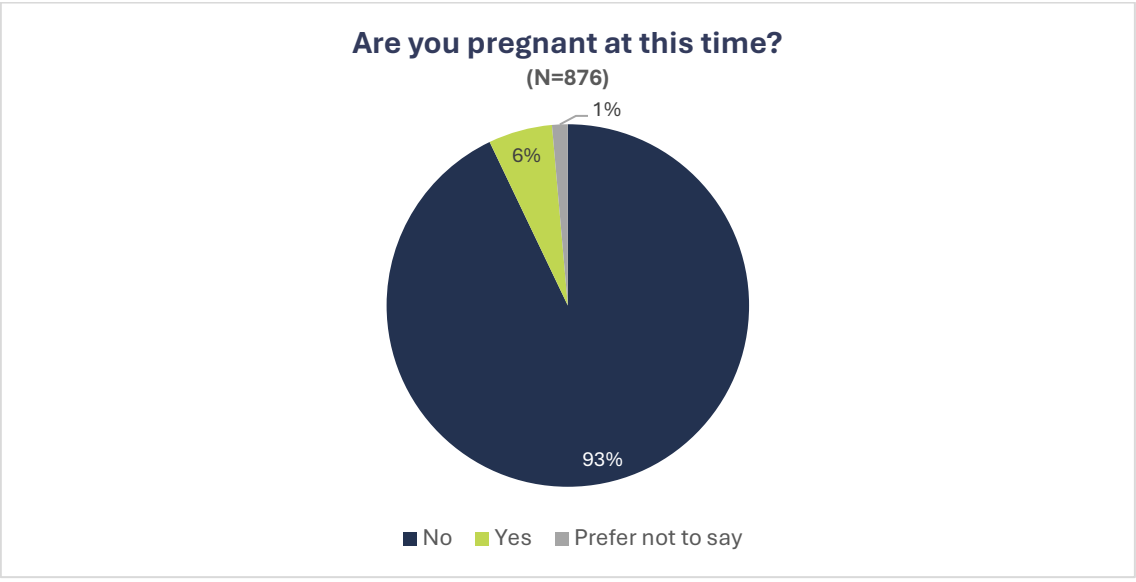


Chart 16: Are you pregnant at this time?

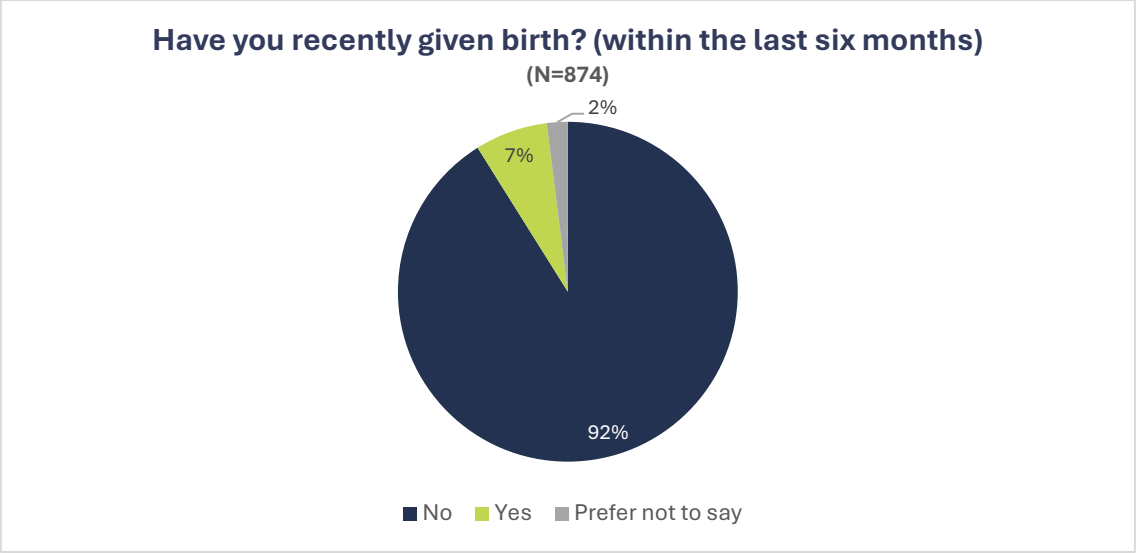


Chart 17: Have you recently given birth? (within the last six months)

Armed forces service

1% of respondents reported that they had served in the armed forces (see Chart 18).

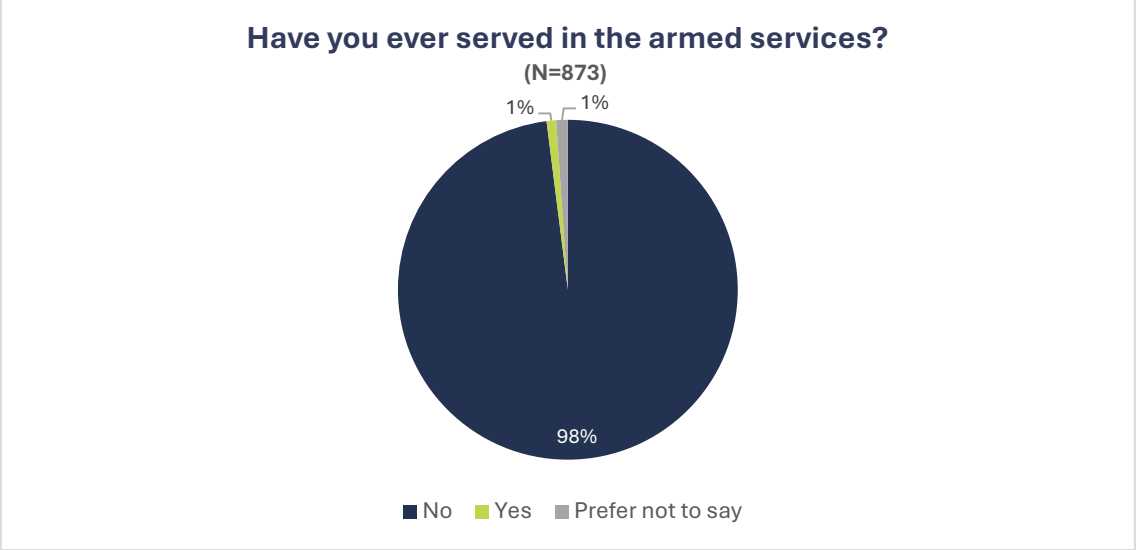


Chart 18: Have you ever served in the armed services?

Healthcare or social care professionals

26% of respondents indicated that they worked in healthcare or social care.

Among the professionals who provided further information about their workplace:

- 22% work at Liverpool University Hospitals NHS Foundation Trust
- 11% in GP practices
- 9% at Liverpool Women's NHS Foundation Trust
- 8% at Mersey Care NHS Foundation Trust
- 5% at Mersey and West Lancashire Teaching Hospitals NHS Trust
- 5% at NHS Cheshire and Merseyside

Smaller numbers of respondents indicated employment at a variety of other organisations, such as Alder Hey Children's Hospital NHS Foundation Trust (4%), independent health or social care providers (2%), and The Clatterbridge Cancer Centre NHS Foundation Trust (2%) (see Chart 19).

19% of professionals selected 'Other' and specified a wide range of roles and workplaces. These included colleagues from other NHS organisations, care homes, universities, primary care, private health practices, and those who are retired.

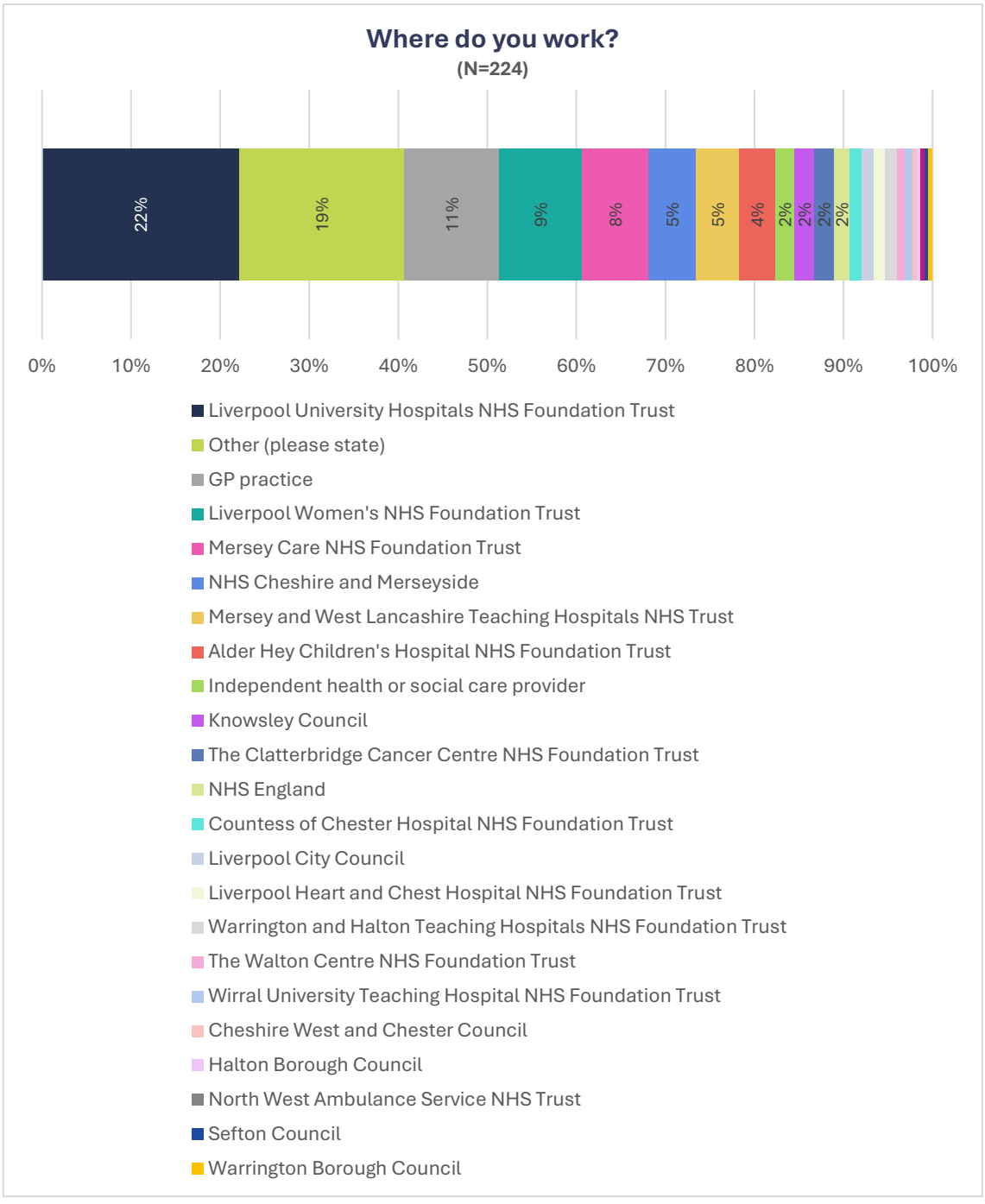


Chart 19: Where do you work?

How people found out about the questionnaire

Respondents were asked how they found out about the questionnaire.

Community or voluntary sector organisations was the most prominent source, mentioned by 51% of participants, followed by social media (32%), email or text message from the NHS (12%), and word of mouth (9%) (see Chart 20).

NHS websites accounted for 5%, local media such as newspapers and radio also for 4%, and leaflets or flyers for 3%.

A smaller number of respondents mentioned a Healthwatch organisation, or from a hospital volunteer, while a few indicated they did not know.

Within the 'Other' category, selected by 4% of respondents, people cited a number of different sources including their workplace and people campaigning for NHS services.

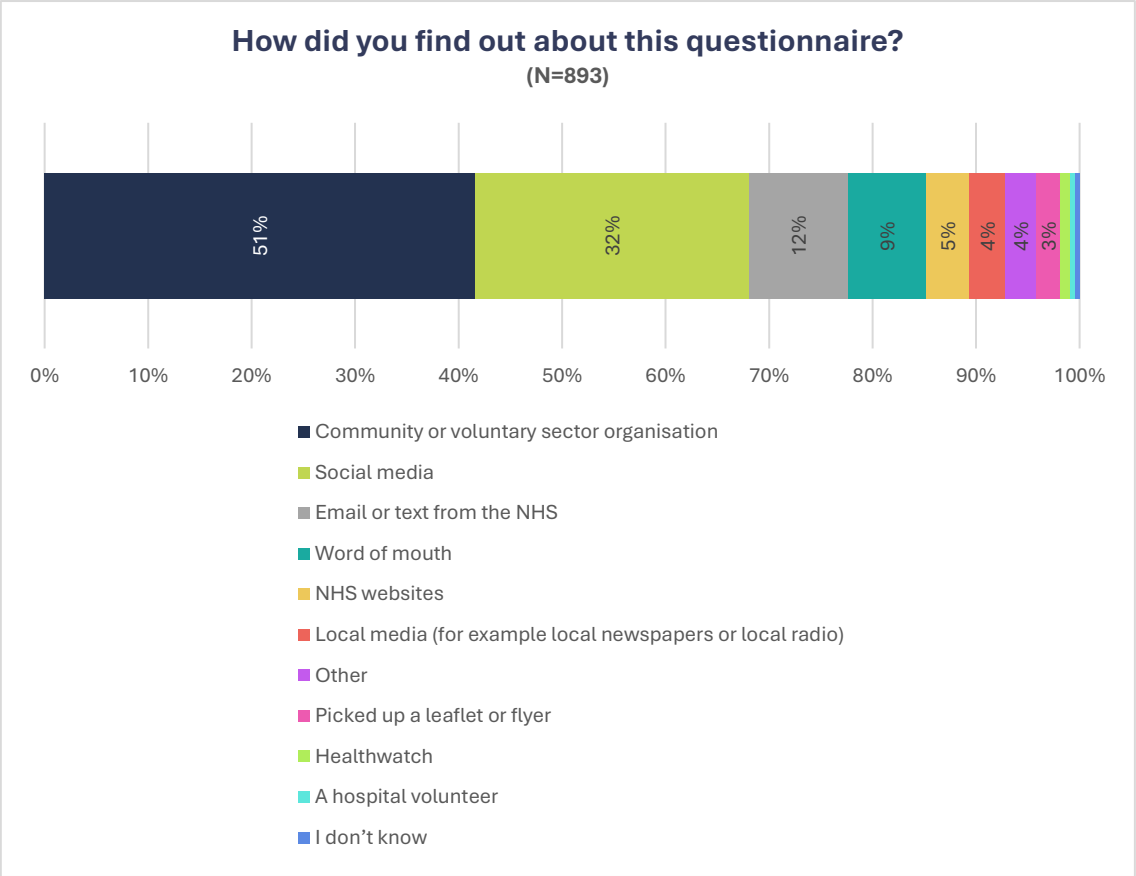


Chart 20: How did you find out about this questionnaire?

The numbers of people who accessed the engagement materials

The majority of respondents (64%) reported having read the 'Improving hospital gynaecology and maternity services in Liverpool' booklet. Additionally, 22% of respondents had engaged with the Easy Read version of the booklet, while a similar

proportion (22%) had visited the website www.GynaeAndMaternityLiverpool.nhs.uk for further information (see Chart 21).

A smaller percentage (9%) indicated that they had attended or were planning to attend one of the engagement events scheduled for November. Meanwhile, 6% had read the full case for change document, which consisted of more than 90 pages.

Among the respondents, 8% stated that they had not engaged with any of the provided resources.

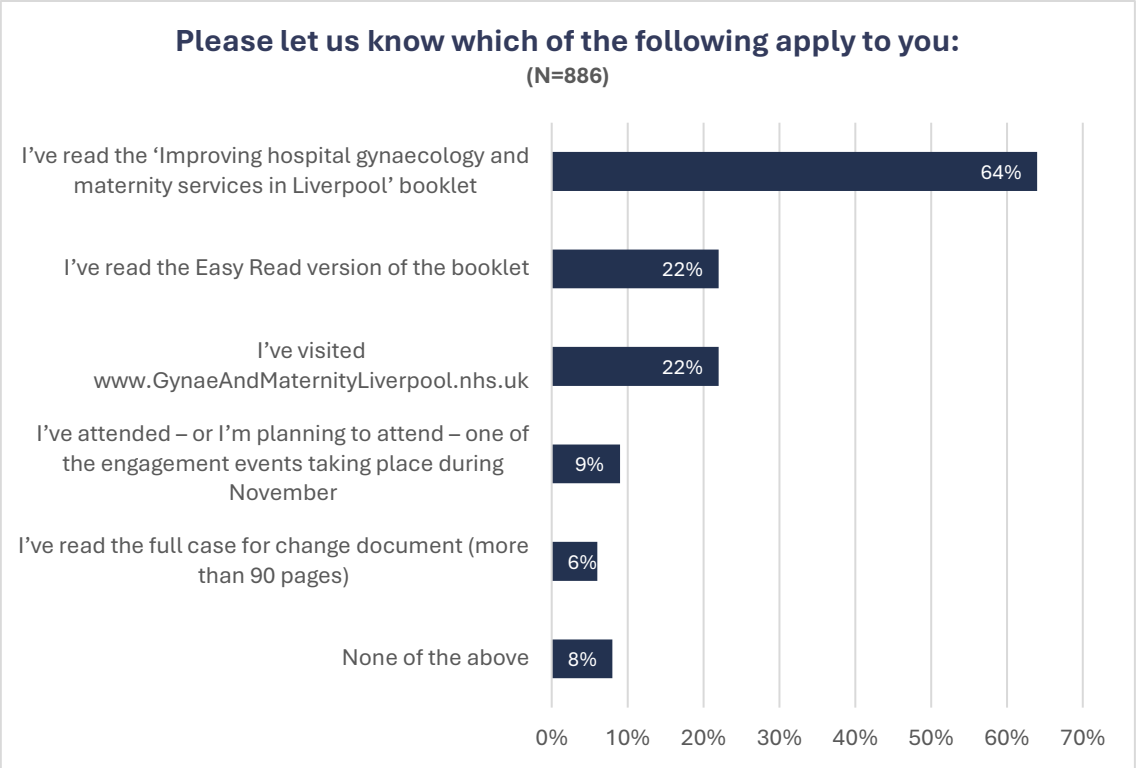


Chart 21: Please let us know which of the following apply to you

Demographic information from events

Seventy-one people attended the events overall, although several people actively involved in campaigning for NHS services locally attended more than one event.

Twenty-nine attendees completed equalities monitoring information. Of these:

- 73% were White English / Welsh / Scottish / Northern Irish / British
- 15% were White Irish
- 4% were White other
- 4% were Black/African/Caribbean/Black British: African
- 4% preferred not to say
- 4% selected 'other'

In contrast to the questionnaire, the vast majority of attendees were older, with:

- 4% aged 81 and over
- 30% aged 75 – 80
- 33% aged 71 – 74
- 15% aged 65 – 70
- 4% aged 45 – 54
- 7% aged 25 – 34
- 7% preferred not to say

In terms of religious beliefs, 68% responded that were not religious, 29% that they were Christian, and 4% preferred not to say.

78% identified as female, 19% as male and 4% as gender non-conforming.

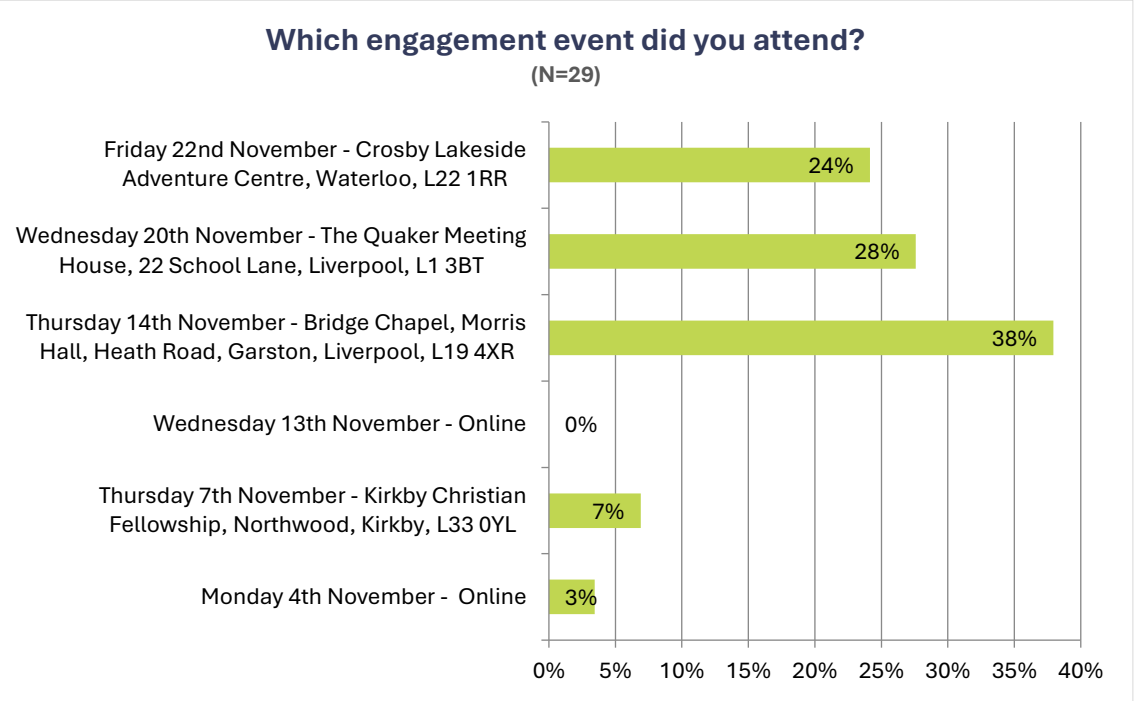


Chart 22: Which engagement event did you attend?

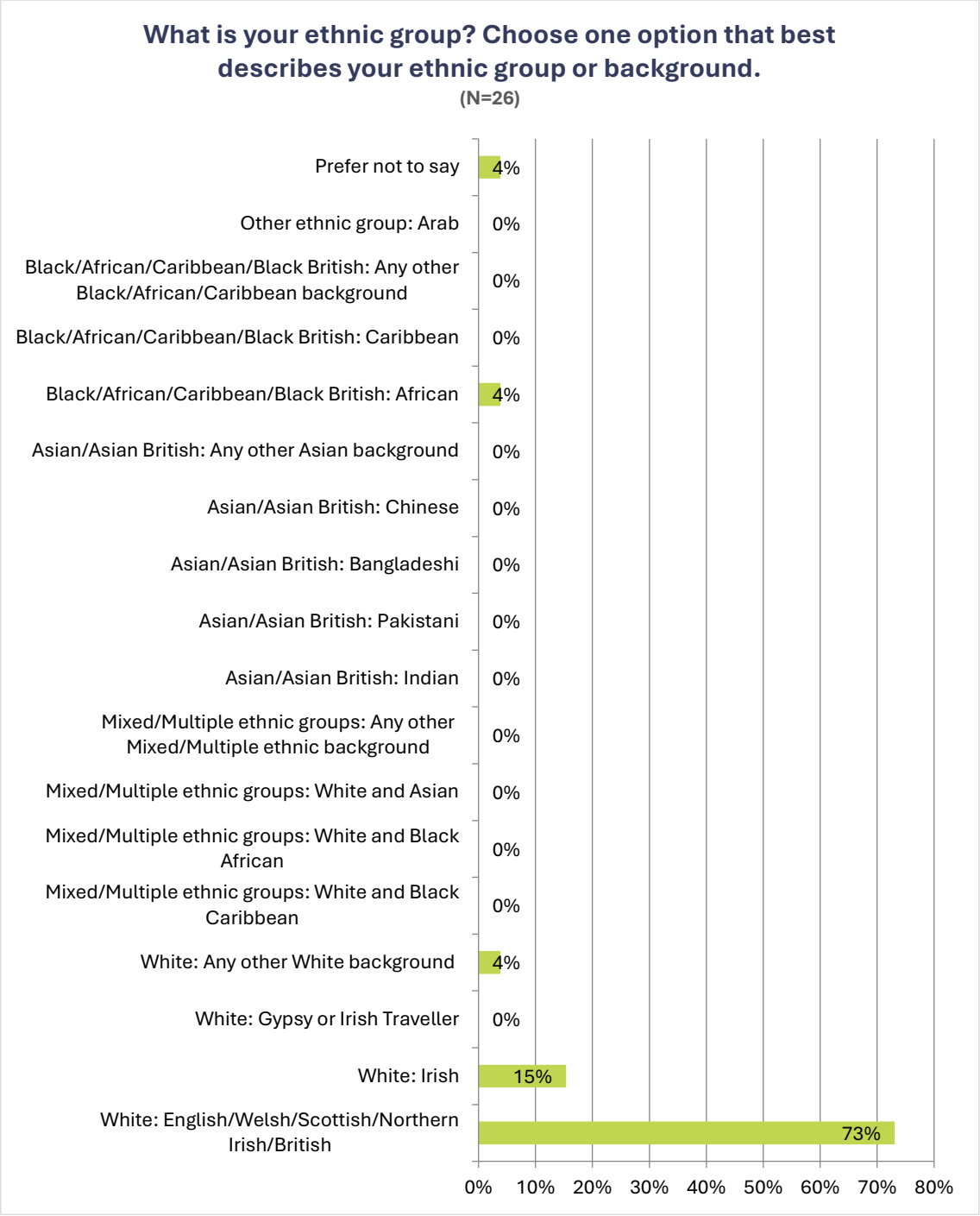


Chart 23: What is your ethnic group? Choose one option that best describes your ethnic group or background.

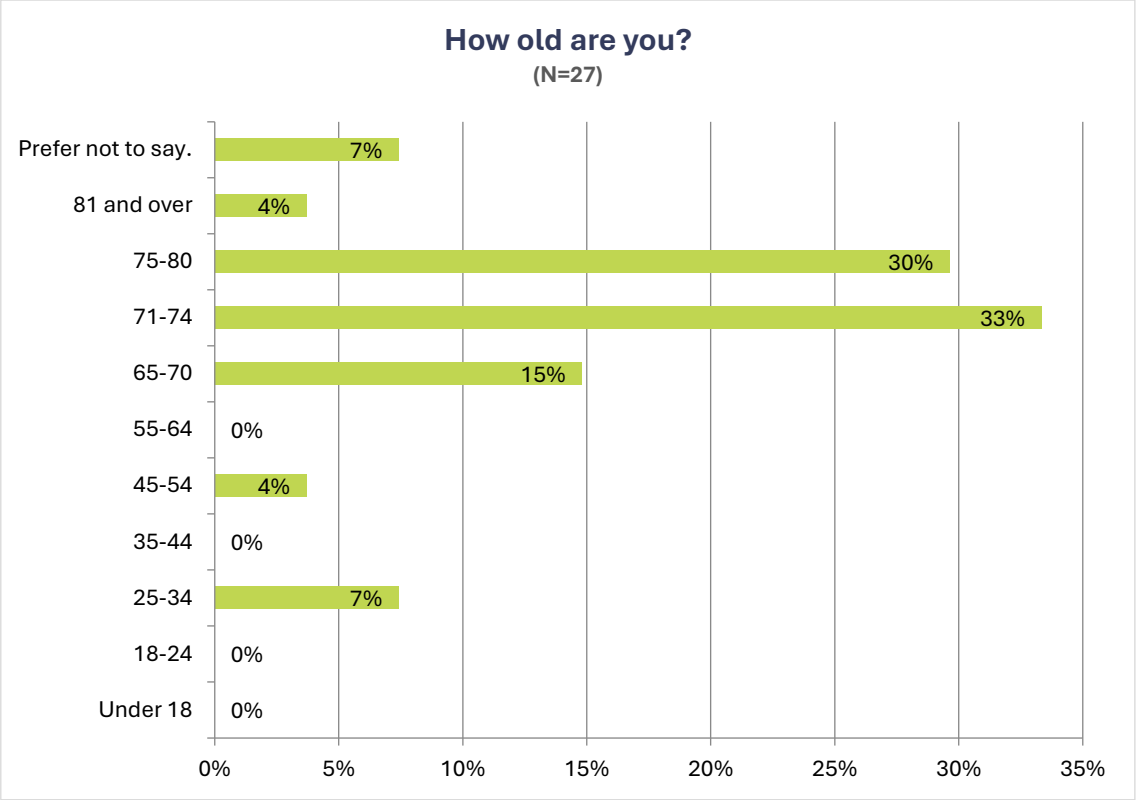


Chart 24: How old are you?

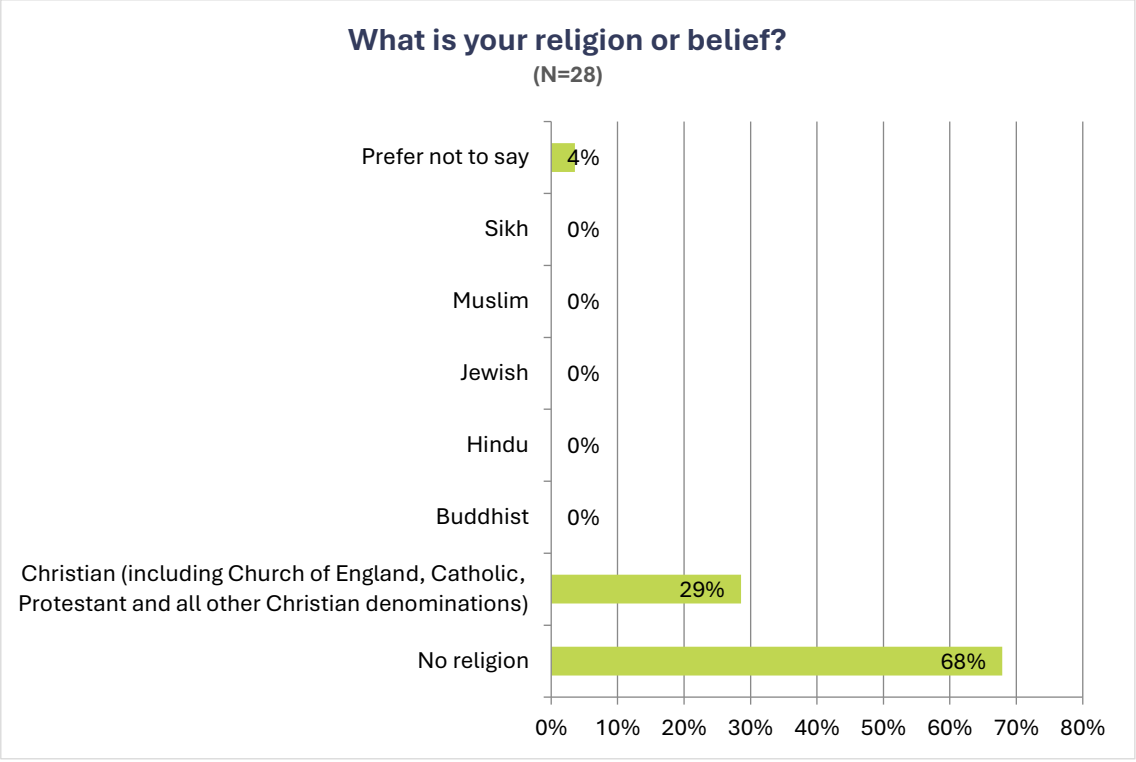


Chart 25: What is your religion or belief?

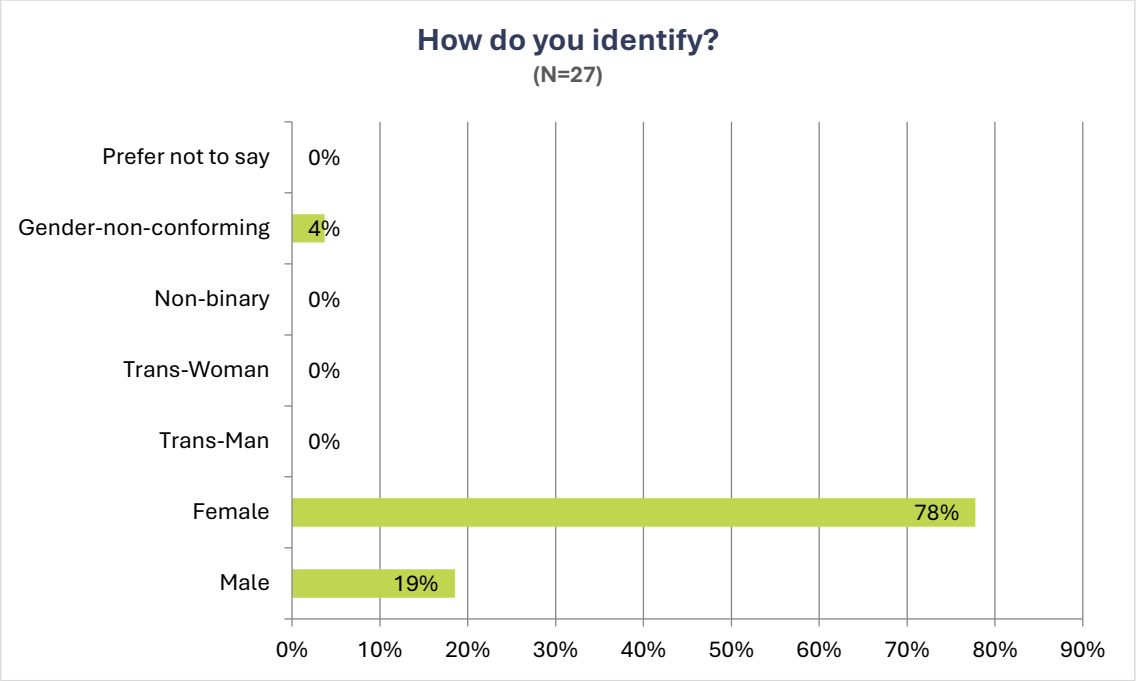


Chart 26: How do you identify?

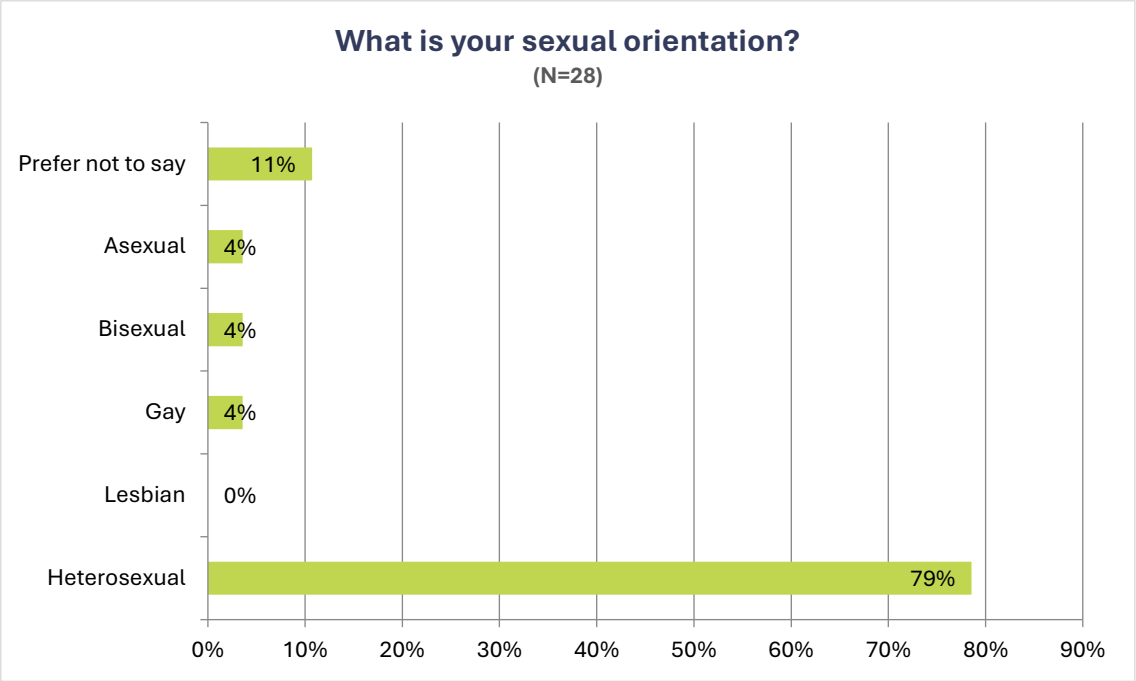


Chart 27: What is your sexual orientation?

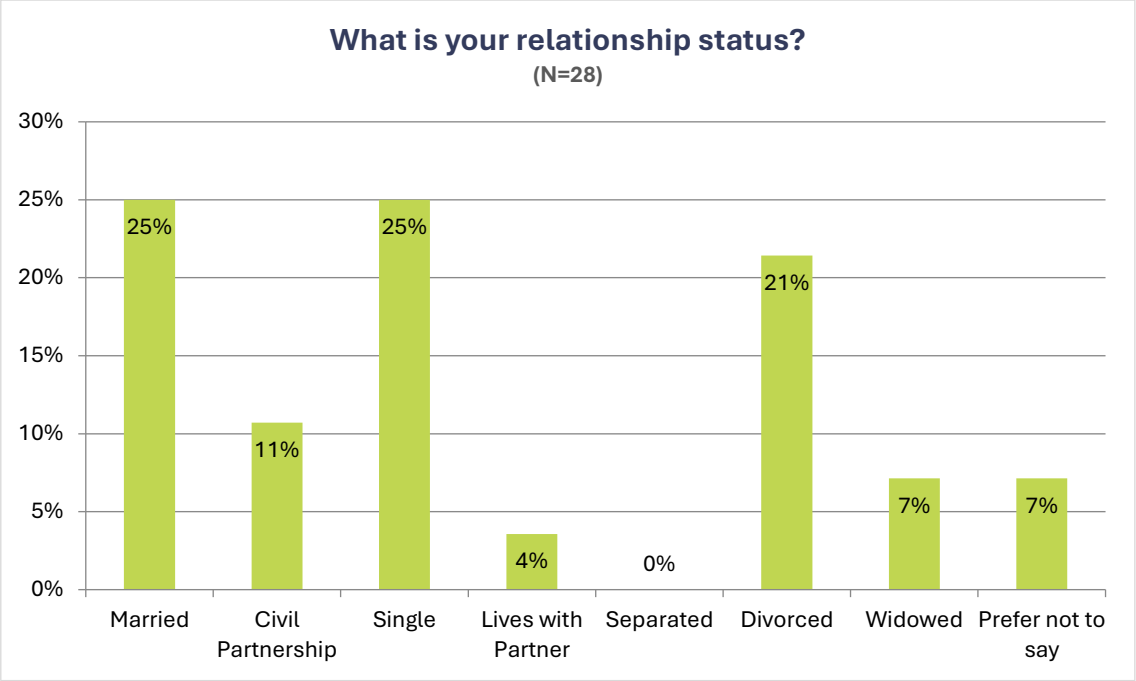


Chart 27: What is your relationship status?

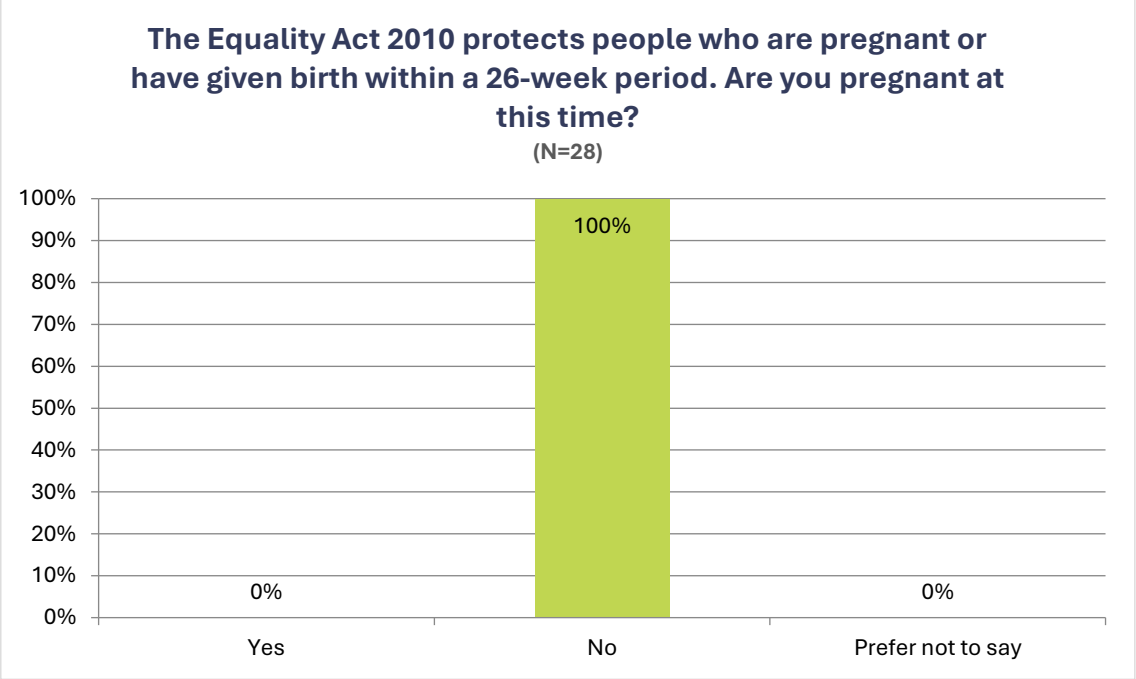


Chart 28: Are you pregnant at this time?

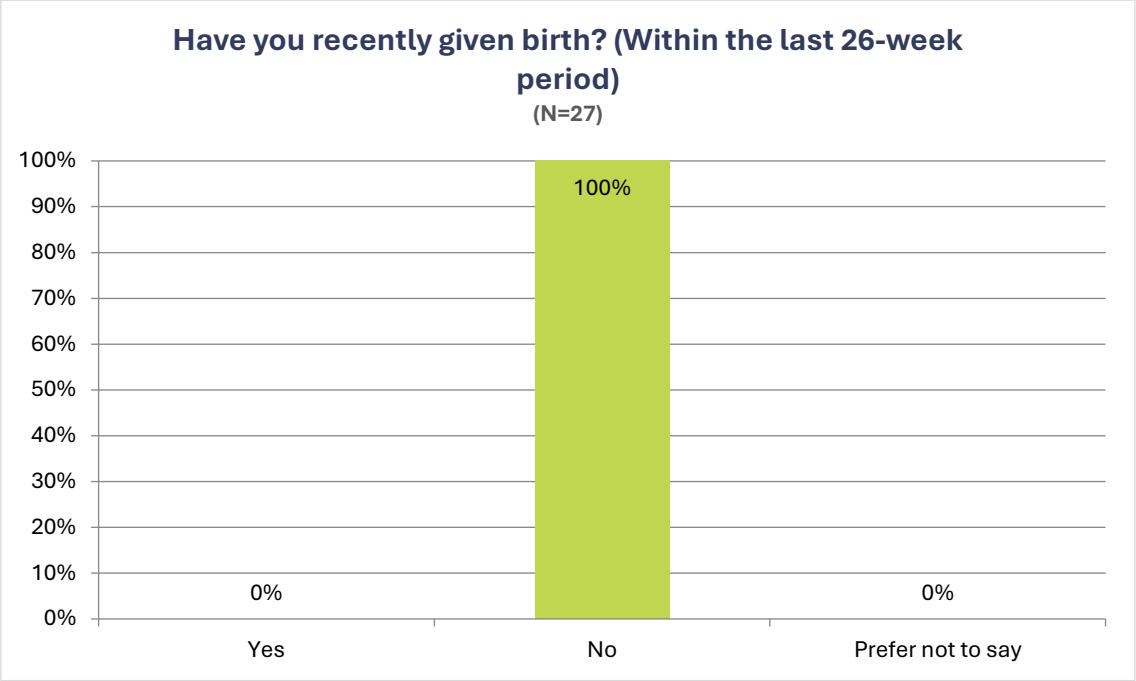


Chart 29: Have you recently given birth? (Within the last 26-week period)

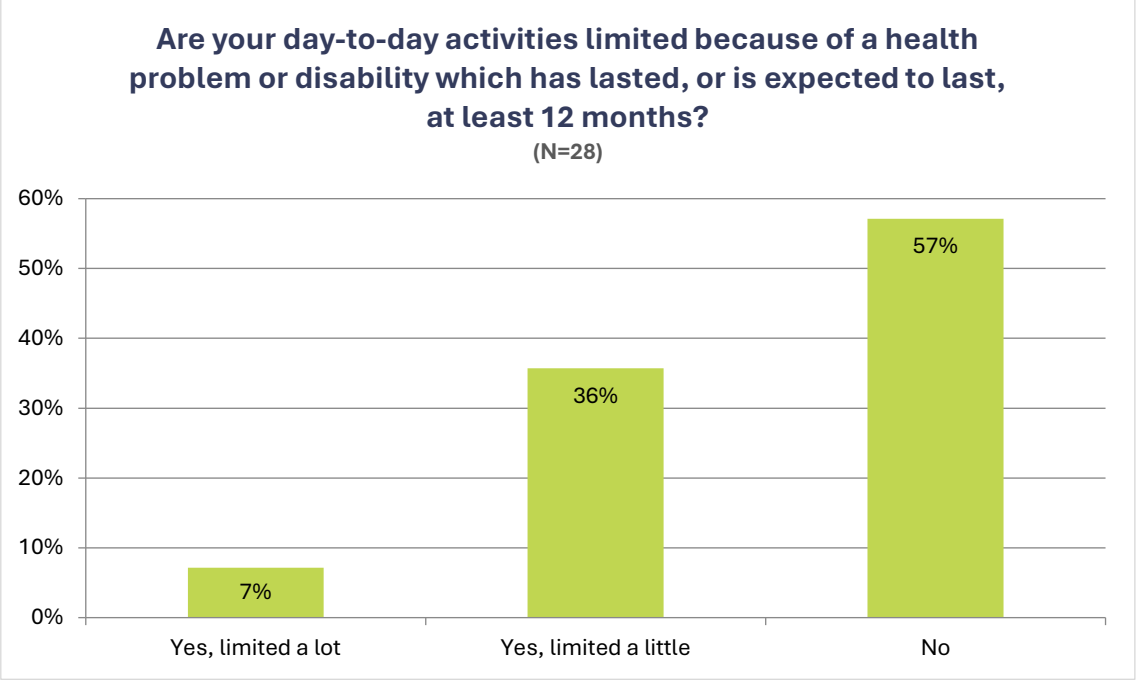


Chart 30: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

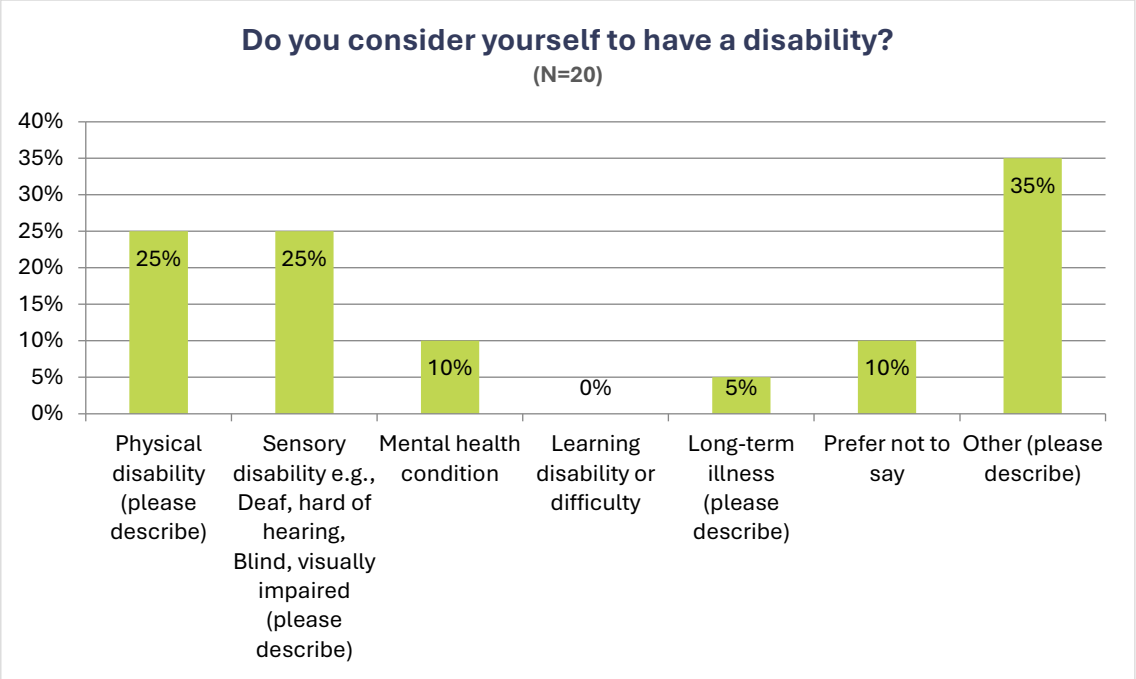


Chart 31: Do you consider yourself to have a disability?

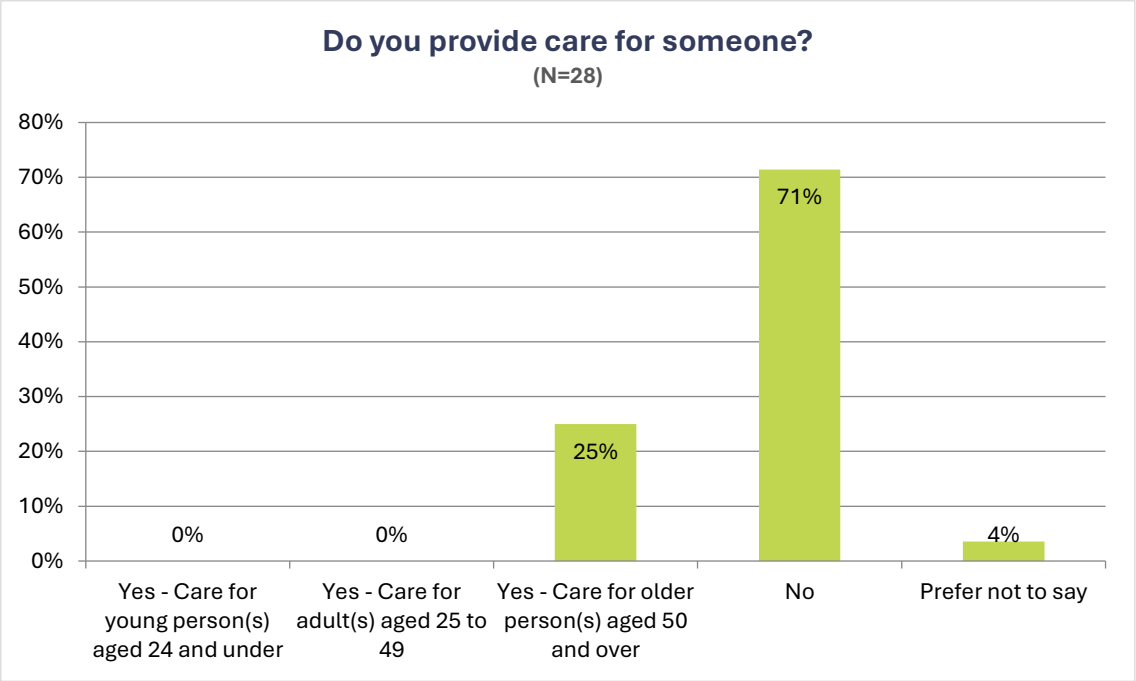


Chart 32: Do you provide care for someone?

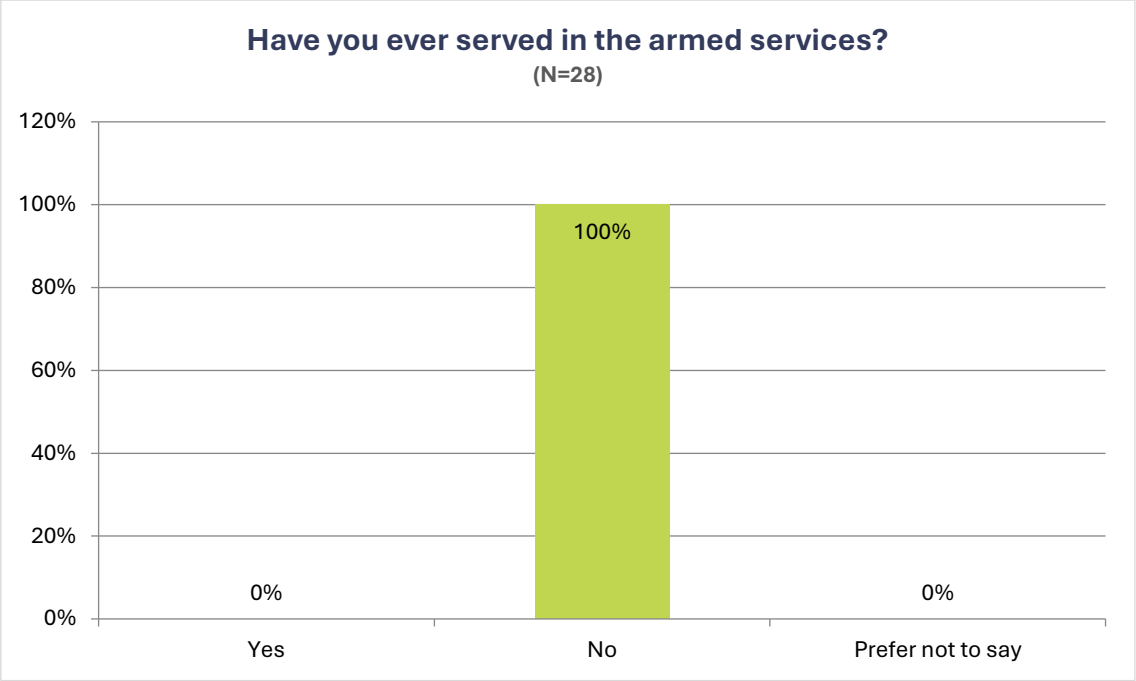


Chart 33: Have you ever served in the armed services?

Appendix B: Promotional material to support the engagement period

A range of promotional material was created to promote and support the engagement period, including posters, flyers, and summary information booklet:

Appendix C: Engagement questionnaire

Improving hospital gynaecology and maternity services in Liverpool

About this questionnaire

The NHS in Cheshire and Merseyside is looking at hospital gynaecology (care relating to any functions and diseases affecting the female reproductive system) and hospital maternity (care provided during pregnancy, delivery, and after birth) services in Liverpool.

The majority of this care happens at Liverpool Women's Hospital. Although maternity and gynaecology care also takes place at other local hospitals, including Whiston Hospital, Ormskirk Hospital, or Wirral Women and Children's Hospital (Arrowe Park), we aren't looking at those services in this piece of work.

You should read the *Improving hospital gynaecology and maternity services in Liverpool* booklet before answering this questionnaire.

You can find the booklet at www.GynaeAndMaternityLiverpool.nhs.uk where you'll also find details of six engagement events that we will be holding during November 2024.

If you would like this questionnaire, or the booklet, in a different language or another format, such as Easy Read or large print, call 0151 702 4353 (Monday to Friday, between 8.30am and 4pm) or email engagement@cheshireandmerseyside.nhs.uk.

Please return this questionnaire by

Tuesday 26th November 2024.

How will my information be used?

NHS Cheshire and Merseyside Integrated Care Board, the organisation that plans health services for our area, has appointed an independent company, Hood & Woolf Ltd., to manage this questionnaire and report on the responses. Responses made in a personal capacity will remain anonymous and you will not be identifiable. Responses made in an official capacity (for example if you are responding on behalf of an organisation), may be attributed.

All the questions are optional, and all information you provide will be processed by the independent company in accordance with the latest data protection guidance. Information will only be used to share your views on hospital gynaecology and maternity services in Liverpool, and any personal information which could identify you will be kept for no more than one year. Please visit www.hoodwoolf.co.uk/privacy-policy for more information.

Section 1 – Your views about the case for change

After reading the information in the ***Improving hospital gynaecology and maternity services in Liverpool*** summary booklet, please answer the following questions.

1. **Do you think we have clearly described why hospital gynaecology and maternity services need to change?** Please tick one box only.

Yes – fully	
Yes – partly	
No	
Not sure	

If you answered Yes – fully please go to question 2.

If you answered Partly, No, or Not sure, **how do you think the information could be clearer?** Please tick all boxes that apply.

There is too much jargon	
The way the content is laid out makes it difficult to read	
There is too much information	
There is not enough information	
I did not like the design	

Other (please specify):

2. **How much do you agree or disagree with this statement:**

The NHS needs to make changes to hospital gynaecology and maternity services in Liverpool.

Please tick one box only. You'll have a chance to explain more about your answer in question 5.

Strongly agree	
Tend to agree	
Neither agree nor disagree	
Tend to disagree	
Strongly disagree	
Don't know	

3. **Thinking about the future of hospital gynaecology and maternity services in Liverpool, what are the three most important things to you?**

One:
Two:
Three:

4. **Is there anything else you would like to say about the challenges for hospital gynaecology and maternity services in Liverpool?** Please answer in the box below.

Section 2 – Your experiences

5. **Have you, or someone close to you, used hospital gynaecology and/or hospital maternity services in Liverpool?** The majority of this care happens at Liverpool Women's Hospital – we aren't referring to maternity and gynaecology services that take place at other local hospitals including Whiston Hospital, Ormskirk Hospital, or Wirral Women and Children's Hospital (Arrowe Park). Please tick all boxes that apply.

I have used/am using hospital gynaecology services in Liverpool	
I have used/am using hospital maternity services in Liverpool	
Someone close to me has used/is using hospital gynaecology services in Liverpool	
Someone close to me has used/is using hospital maternity services in Liverpool	
I work in – or alongside – hospital gynaecology and/or maternity services in Liverpool	
I want to share my views, but I haven't had experience of these services in Liverpool	
Not applicable – I am providing a response on behalf of an organisation	

6. **If you have had experience, how would you rate your experience – or the experience of someone close to you – of using hospital gynaecology or hospital maternity services in Liverpool? Was it:**

   Please tick only one box, if applicable.

Very positive	
Positive	
Neutral	
Negative	
Very negative	
Don't know	

7. **Please tell us more about your (or their) experiences – both the things that went well, and things that could be improved.**

   Please answer in the box below and continue on an additional sheet if necessary.

   If you have a question or a concern about the care that you are currently receiving, please contact the hospital or organisation providing your care directly.

8. **When using hospital gynaecology and/or maternity services, were there any ways in which you, or someone close to you, felt disadvantaged compared with other people?** Please tick one box only if applicable.

Yes	
No	
Not sure	

9. **Please** tell us more about this in the box below:

Section 3 – About you

10. How did you find out about this questionnaire? Please tick all boxes that apply.

Email or text from the NHS	
Picked up a leaflet or flyer	
Social media	
NHS website	
A hospital volunteer	
Local media (for example local newspapers or local radio)	
Word of mouth	
Healthwatch	
Community or voluntary sector organisation	
I don't know	

If you found out somewhere else, please let us know where:

11. Please let us know which of the following apply to you:

I've read the 'Improving hospital gynaecology and maternity services in Liverpool' summary booklet.	
I've read the Easy Read version of the booklet	
I've visited www.GynaeAndMaternityLiverpool.nhs.uk	
I've attended – or I'm planning to attend – one of the engagement events taking place during November.	
I've read the full case for change document (more than 90 pages)	
None of the above	

12. If you are responding on behalf of an organisation, please tell us your name, job title, and which organisation you represent.

If you are providing your own personal response, please answer the questions below. They are optional, but they help us understand more about who we're reaching with our engagement activity.

13. What is the start of your postcode? (For example, L8 7 or L19 2)

☐☐☐☐☐■■

14. Which area do you live in?

Cheshire East
Cheshire West
Halton
Knowsley
Liverpool
Sefton
St Helens
Warrington
Wirral

Other – please state:

15. Are you a healthcare or social care professional?

Yes	
No	

If you are a healthcare or social care professional, where do you work?

If you'd like to be kept up to date with this work, please sign-up to the Virtual Reference Group at www.GynaeAndMaternityLiverpool.nhs.uk/get-involved/

Section 4 – Equality monitoring

We are asking these questions because we want to make sure that we have asked lots of different people for their views.

All the information that you give will be recorded and reported anonymously – it will never be used with your name or contact details. NHS Cheshire and Merseyside collect this as part of its duty under the Equality Act 2010.

Your data will be treated confidentially and stored in accordance with Data Protection law and Hood & Woolf Ltd.'s privacy notice at www.hoodwoolf.co.uk/privacy-policy/

You do not have to answer these questions if you do not want to.

16. **What is your ethnic group?** Choose one option that best describes your ethnic group or background.

White: English/Welsh/Scottish/Northern Irish/British	
White: Irish	
White: Gypsy or Irish Traveller	
White: Any other White background (please specify below)	
Mixed/Multiple ethnic groups: White and Black Caribbean	
Mixed/Multiple ethnic groups: White and Black African	
Mixed/Multiple ethnic groups: White and Asian	
Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background (please specify below)	
Asian/Asian British: Indian	
Asian/Asian British: Pakistani	
Asian/Asian British: Bangladeshi	
Asian/Asian British: Chinese	
Asian/Asian British: Any other Asian background (please specify below)	
Black/African/Caribbean/Black British: African	
Black/African/Caribbean/Black British: Caribbean	
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background (please specify below)	
Other ethnic group: Arab	
Prefer not to say	

Any other ethnic group (please specify below):

17. How old are you?

16 - 19		55 - 59	
20 - 24		60 - 64	
25 - 29		65 - 69	
30 - 34		70 - 74	
35 - 39		75 - 79	
40 - 44		80 and over	
45 - 49		Prefer not to say	
50 - 54			

18. What is your religion or belief?

No religion	
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	
Buddhist	
Hindu	
Muslim	
Sikh	
Prefer not to say	
Other (please specify):	

19. How do you identify?

Male		Non-binary	
Female		Gender-non-conforming	
Trans-Man		Prefer not to say	
Trans-Woman		Other (please specify):	
Non-binary			
Gender-non-conforming			

20. What is your sexual orientation?

Heterosexual		Prefer not to say	
Lesbian		Other (please specify):	
Gay			
Bisexual			
Asexual			

21. What is your relationship status?

Married	
In a civil partnership	
Single	
Divorced	
Living with partner	
Separated	

Widowed	
Prefer not to say	
Other (please specify)	

22. The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week period. Are you pregnant at this time?

Yes	
No	
Prefer not to say	

23. The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week period. Have you recently given birth? (within the last six months)

Yes	
No	
Prefer not to say	

24. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

Yes, limited a lot	
Yes, limited a little	
No	
Prefer not to say	

25. Do you consider yourself to have a disability? *(*The Equality Act 2010 states a person has a disability if they have a physical or mental impairment that has a 'substantial' and 'long-term' (more than 12 months) negative effect on your ability to do normal daily activities.

Physical disability	
Sensory disability (e.g., Deaf, hard of hearing, Blind, visually impaired)	
Mental health condition	
Learning disability or difficulty	
Long-term illness (e.g., cancer, diabetes, COPD)	

Prefer not to say	
Other (please specify):	

26. Do you provide care for someone? A carer is defined as anyone who cares, unpaid (or in receipt of Carer's Allowance, but not someone who is employed as a care professional), for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Yes - Care for young person(s) aged 24 and under	
Yes - Care for adult(s) aged 25 to 49	
Care for older person(s) aged 50 and over	

No	
Prefer not to say	

27. Have you ever served in the armed services?

Yes	
No	
Prefer not to say	

Please return your questionnaire to:

NHS Cheshire and Merseyside
920 Centre Park
Warrington
WA1 1QY

The closing date for us to receive your response is midnight on **Tuesday 26th November 2024**. Please allow enough time for your posted questionnaire to reach us.

Thank you very much for your time. We will use your feedback to help develop plans for how services might be delivered in the future.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

NHS Cheshire and Merseyside 2025-26 Joint Forward Plan (Annual Refresh)

Agenda Item No: ICB/03/25/13

Responsible Director: Clare Watson, Assistant Chief Executive

NHS Cheshire and Merseyside 2025-26 Joint Forward Plan (Annual Refresh)

1. Purpose of the Report

1.1 The ICB has a statutory duty to publish an updated version of our Joint Forward Plan by 31st March each year. This paper provides the Board with a copy of the proposed "light touch" refresh of the 2025/26 Cheshire and Merseyside Joint Forward Plan (JFP). This approach is in line with the suggested national approach with the intention to delay a full refresh until after the publication of the NHS 10 Year Plan expected later in 2025.

1.2 The summary document aims to provide clarity as to the headline priorities for Cheshire and Merseyside ICB in 2025-26

1.3 An update on plans to progress a full NHS Cheshire and Merseyside Integrated Care Board Annual Delivery Plan and associated Annual Tracker for the May ICB Board Meeting is also covered.

2. Executive Summary

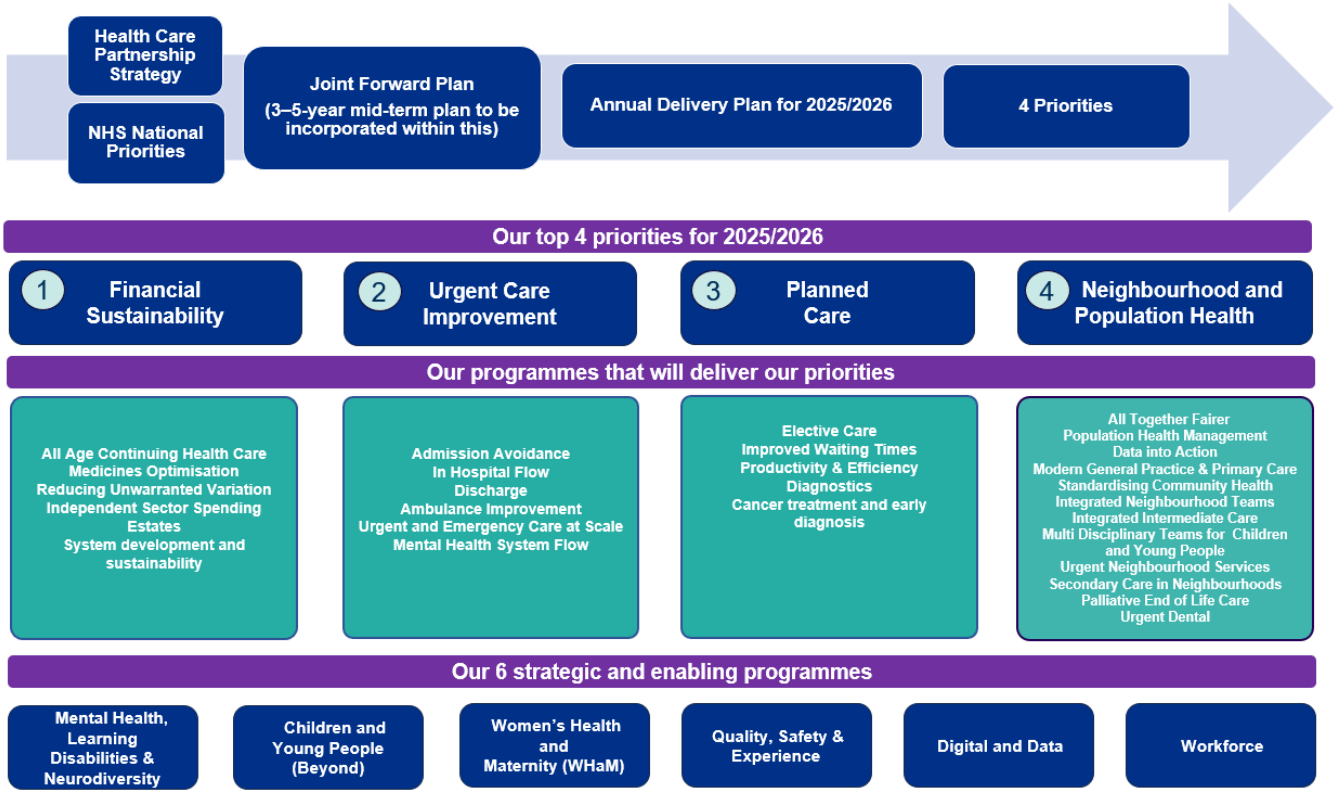
2.1 In recent years we have used our annually refreshed Joint Forward Plan to describe our key priorities. In line with the suggested national approach, in reflection of the NHS 10 Year Plan being expected to be published later in 2025, we are intending to delay re-publication of a full Joint Forward Plan until after this.

2.2 In order to provide clarity as to our priorities plans and approaches in 2025-26, we have developed a refreshed summary document (5 slides) this will subsequently be accompanied by a more detailed Annual Delivery Plan (around 15 published slides) and an Annual Delivery Plan tracker that will be presented to the May ICB Board Meeting.

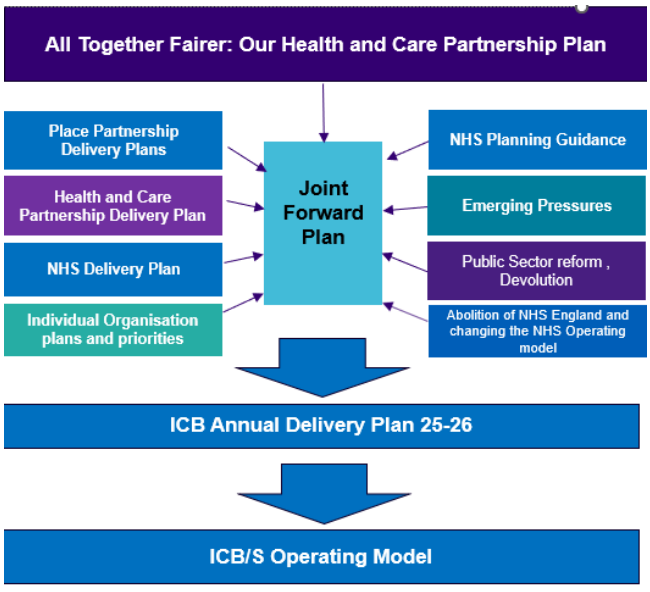
2.3 The publication of the Joint Forward Plan Refresh for 25-26 (see Appendix1) will be hosted on the ICB website and will consist of a front cover and 4 key slides (with live links maintained to the detail in our existing strategies and plans). These cover the following:

- an introduction outlining our current strategies and plans
- a summary of the 2025-26 NHS Operating Planning priorities
- an outline of the wider National Context and the three national shifts for the NHS
- our guiding principles for prioritisation
- a summary of our key priorities, strategic programmes and system enablers (See the Figure One).

Figure One



2.4 As part of our 2024-29 Joint Forward Plan we specifically focused on two areas ***Financial Sustainability*** and ***Urgent and Emergency Care***, we have identified two additional areas for 2025-26 ***Planned Care*** and ***Neighbourhood and Population Health*** these are supported by the 6 Strategic and Enabling programmes described in the table above. The 25-26 refresh reflects the following plans, priorities and system pressures:



2.5 We have also aligned our JFP refresh and the developing 25-26 Annual Delivery Plan to reflect our existing priorities, the three national shifts and the

NHS operational planning guidance to support delivery of our 4 strategic objectives.

2.6 The proposed ICB Annual Delivery Plan is in development which builds on the summary slide deck presented in appendix 1. This will include the key aspects of our annual operational, financial and workforce plans and is planned to be completed by the end of April and will be presented to board in May 2025.

2.7 The Annual Delivery plan will include an Annual Delivery Plan tracker – the tracker will provide the framework to monitor progress against our plans and will include detail on:

- Priority/programme area, reporting route and executive lead
- A summary of the key programme delivery areas
- Headline outcomes for each programme
- Agreed 2025/26 measures and defined metrics
- Quarterly trajectories (where it is feasible to measure in year)
- Identified Cash Releasing Efficiency Savings (CRES).

2.8 During 2025 we will more fully review our Joint Forward Plan to ensure our plans are fully responsive to the priorities and opportunities outlined in the NHS 10 Year Plan.

2.9 During 2024/25 the ICB invoked an interim operating model in response to the launch of the Recovery Programme. As we move towards 25/26, we are currently reviewing the substantive and interim operating models to ensure we are 'Fit for the Future' our revised model will need to support delivery of our Annual Delivery Plan. The review includes consideration of the recent announcements around NHS England being closed and brought back into the Department of Health and Social Care, the requirements for ICBs to significantly reduce their costs, the anticipated 10-year Plan, Local Authority Devolution, and the outcomes of a Local Authority Commissioned Report in relation to Place Based Working.

3. Ask of the Board

3.1 The Board is asked to**:**

- **Approve** the attached slide deck as our 2025-26 Joint Forward Plan refresh and pending any amends authorise its publication by 31 March 2025.

- **Endorse** the proposal to provide the Board with an NHS Cheshire and Merseyside Integrated Care Board Annual Delivery Plan and associated Annual Tracker for review and approval at the May 2025 ICB Board Meeting

- **Endorse** the proposal that during 2025 we will more fully review our Joint Forward Plan to ensure our plans are fully responsive to the priorities and opportunities outlined in the NHS 10 Year Plan*.

***Note-** the timescale for this will be reviewed once the publication of the 10-year plan is announced

4. Reasons for Recommendations

4.1 The 2024-29 JFP was developed following the nationally defined statutory and advisory requirements identified in the NHS England Guidance on developing the JFP. This has resulted in a significant amount of content and detail in our plans. A summary Annual Delivery Plan was developed that provided detail on the work taking place to progress the core JFP themes and outlining the main outcomes from each of the priority programmes, enabler functions and system development work the refresh provides an interim update pending publication of the 10-year plan.

4.2 The JFP refresh, and the proposed Annual Delivery plan are developed from discussions and insight from the ICB Executive Team, Programme Leads (including aligned NHS Clinical Networks), ICB/S Functional Leads, Place Partnerships, and alongside our system partners including the VCFSE sector, Providers and Provider Collaboratives. By aligning the development processes of NHS Cheshire and Merseyside, Health and Care Partnership and system partners we can maintain a consistent approach to planning across the system, which will help us by:

- proactively identifying and communicating the totality and alignment of all our plans both internally and externally
- prioritising plans and assigning financial resources across our system more effectively.
- provide cross ICB/S visibility of plans reducing duplication in plans and assigning our combined workforce more efficiently.
- aligning resources to support public engagement and co-production contained within plans.

5. Background

5.1 The JFP is a nationally mandated document which combines the Cheshire and Merseyside delivery plans to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of NHS resources.

5.2 Whilst the JFP covers a five-year period there is a statutory requirement to update and republish the plans each year, inevitably this annual update means the document focuses on the next 12 months and includes the key actions identified in our plans.

5.3 During 2024-25 a revised Health and Care Partnership Strategy was developed: ***All Together Fairer: Our Health Care Partnership Plan***. Due to the General and Local Elections this was only presented in August last year and signed off

in September 2024 as such the content still stands and provides detail on how we will work collectively as a system to address the social determinants of health and health inequalities.

5.4 The first Cheshire and Merseyside Joint Forward Plan (JFP) was approved by the ICB Board in June 2023 with a refresh in 2024. The NHS Delivery plan element of this was signed off by board in August 2024. A summary Annual Delivery Plan was also developed the intention is to produce an updated 25/26 version outlining our current priorities, anticipated outcomes, annual measures and defined metrics (the previous version was only signed off by the board in October 2024).

5.5 The plan also describes how we work as part of the wider system outlining how our core enabling strategies to enhance and support delivery.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: **Tackling Health Inequalities in access, outcomes and experience**

Objective Two: **Improving Population Health and Healthcare**

Objective Three: **Enhancing Productivity and Value for Money**

Objective Four: **Helping to support broader social and economic**

6.1 All of the above are core elements in the Joint Forward Plan and the proposed refresh, including the NHS Delivery Plan and proposed Annual Delivery plan, as well as the alignment of the Health and Care Partnership (HCP) Strategy with the All Together Fairer report.

6.2 The revised HCP strategic plan (***All Together Fairer: Our Health and Care Partnership Plan)*** reflects the 8 All Together (Marmot) Themes. All nine of our Cheshire and Merseyside Health and Wellbeing Boards have committed to the recommendations in ***All Together Fairer*** and form part of our ***Marmot Community***; our plans reflect the strong support, enthusiasm and shared ambitions of partners.We have summarised the recommendations into three principles.

- Shifting investment to Prevention and Equity
- Anti-Poverty Work
- Social Justice, Health and Equity in All We Do.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 As outlined this paper focuses on a refresh and fully reflects the current Joint Forward Plan and the associated NHS Annual Delivery Plan – a proposed NHS Cheshire and Merseyside Integrated Care Board Annual Delivery Plan has

been developed and will be completed for the May 2025 Board which will include enhance programme governance and reporting processes to ensure a robust delivery approach.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
Theme Two: **Integration**
Theme Three: **Leadership**

8.1 The key themes above are included in the Joint Forward Plan, NHS Delivery Plan and will be integral to the associated NHS Cheshire and Merseyside Integrated Care Board Annual Delivery Plan and Annual tracker.

9. Risks

9.1 The NHS Annual Delivery Plan has been mapped to the Board Assurance Framework. In addition, there are a range of related additional risks that are being considered.

9.2 That current plans do not provide sufficient detail or stretch in their timelines to fully assess progress, or it may be that the reporting regime is not robust enough to provide the necessary stretch or challenge it is anticipated that the production of the proposed Annual Tracker will reduce the risk.

9.3 The programme management resources to support this ongoing development need is limited and will need to be enhanced to support and assure delivery and an ongoing assessment of priorities and use of resources by the Executive Team and Board

9.4 Delivery of the requested 50% reduction in the running cost allocation will have a significant impact on the ICB's ability to deliver the Annual Delivery plan. This will become clearer as we begin to understand the details of the revised national operating model.

10. Finance

10.1 Financial planning for 2025/26 is reflected in the JFP refresh, Annual Delivery Plan with a continued focus on financial sustainability and the Recovery Programme and as one of our core strategies.

11. Communication and Engagement

11.1 Much of the content of the JFP and subsequently the NHS Delivery Plan has been developed through existing programmes, which have established mechanisms for engagement in developing the plans.

11.2 A public survey was undertaken in March/April 2023 to look at the content of the draft Interim Cheshire and Merseyside HCP Strategy, with the results assessed as part of developing the JFP. We have subsequently closed the loop on this and fed back via a 'you said we did' approach the majority of priorities have not changed.

11.3 A copy of the draft NHS Annual Delivery Plan will be shared with stakeholders during April and May 2025, feedback received will be incorporated into the final version. The plan will also be reviewed by the ICB corporate executive team and Place Directors.

12. Equality, Diversity and Inclusion

12.1 An overarching Equality Impact Assessment (EIA) has been completed for the previous JFP, NHS Delivery Plan and the Recovery Programme, individual EIAs will be produced as required to assess the impact of the individual programmes and plans, including the Recovery Programme.

12.2 A working group is currently reviewing and refreshing our EIA, and Quality Impact Assessment (QIA), policies and processes to support effective delivery of the changes that will be delivered through our Joint Forward Plan.

13. Climate Change / Sustainability

13.1 Climate change and sustainability are included as priorities in the ***All Together Fairer: Our Health and Care Partnership Plan*** and associated HCP delivery plan and as one of our headline ambitions.

14. Next Steps and Responsible Person to take forward

14.1 The ICB Strategy and Collaboration team will:

- finalise the content for the Joint Forward Plan refresh / to ensure all accessibility checks are complete prior to publication on the 31st of March 2025

- finalise the more detailed NHS Cheshire and Merseyside Integrated Care Board Annual Delivery Plan which sits behind the JFP refresh for presentation to board in May 2025, including engagement with stakeholders to develop this content.
- circulate and socialise the associated Annual Delivery Plan tracker engaging with programme and enabler leads to fully complete - this will provide the detail of delivery plans containing agreed outcomes, measures metrics and milestones of key priorities.
- in monitoring progress against the Annual Delivery Plan and associated Annual Tracker measures we will continue to link in with the review of our

substantive and interim operating models to ensure we are Fit for the Future our revised model will need to support delivery of our Annual plans. The review includes consideration of NHS England changes to its operating model, the anticipated 10-year Plan and the outcomes of a Local Authority Commissioned Report.

- following the above agree a consistent approach across our revised sub-committee structures to capturing delivery of plans, and progress in impacting the agreed outcomes, measures and defined metrics noting this will require additional programme management office support.
- during 2025 we will more fully review our Joint Forward Plan to ensure our plans are fully responsive to the priorities and opportunities outlined in the NHS 10 Year Plan.

15. Officer contact details for more information

Neil Evans, Associate Director of Strategy and Collaboration
(neil.evans@cheshireandmerseyside.nhs.uk or 07833685764)

Stephen Woods, Head of Strategy
(stephen.woods@cheshireandmerseyside.nhs.uk or 07813178150)

16. Appendices

Appendix One: Joint Forward Plan 2025-26 refresh

www.cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Cheshire and Merseyside

Joint Forward Plan

25/26 Integrated Care Board (ICB) Annual Delivery Plan

20/03/2025

Introduction

This Annual Delivery Plan builds from our existing strategic priorities described in our 2024-2029 Joint Forward Plan alongside newly prioritised areas to describe the priorities for NHS Cheshire and Merseyside Integrated Care Board (ICB) in 2025-26, and reflects:

- The Health and Care Partnership Strategy (All Together Fairer our Health and Care Partnership Plan) - published September 2024);
- Our nine Place based Health and Wellbeing Board Strategies;
- The 2025/26 NHS Planning Guidance, including the emerging themes of the 10 Year NHS Plan due to be published later this year
- Our 2024/25 NHS Delivery Plan
- Emerging service pressures not reflected in the current Joint Forward Plan.
- Wider Public Sector reform priorities emerging nationally e.g. devolution, role of the NHS in supporting wider government health missions including Get Britain Working, the need to focus on growing levels of multi-morbidity.
- How we configure the ICB/S Operating Model to deliver our plans.

During 2025 we will more fully review our Joint Forward Plan to ensure our plans are fully responding to the priorities and opportunities outlined in the NHS 10 Year Plan.

Our Mission:

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

We will do this through our Strategic Objectives:

- Tackling health inequalities in outcomes, experiences and access
- Improve outcomes in population health and healthcare
- Enhancing quality, productivity, and value for money
- Helping the NHS to support broader social and economic development

The 2025-26 NHS Planning Guidance

In line with the Government Mandate the number of national priorities in 25/26 have reduced from last year's guidance, focusing on a smaller set of headline ambitions and key enablers:

- Reducing the time people wait for elective care
- Improving Accident and Emergency A&E and ambulance response times
- Enhancing access to general practice and urgent dental care
- Improving mental health and learning disability services
- Improving access to Children and Young People's (CYP) mental health services
- Living within the budget allocated, reducing waste and improving productivity
- Maintaining collective focus on the overall quality and safety of services
- Addressing inequalities and shift towards prevention

The National Context

The latest review of the NHS by Lord Darzi has highlighted the need for:

- Simplifying and innovating care delivery for a neighbourhood NHS**, embracing multidisciplinary models** that bring together a **range of primary, community, mental health and wider services**
- NHS organisations **focusing on the patients and communities** they serve, with national organisations enabling and not distracting from this process
- Recognising that, as one example, people in the most deprived communities are far more likely to have multiple emergency admissions to hospital in the last year of their lives, but that the health service has a potentially huge role to play in **tackling wider socio-economic inequalities**, improving the quality of people's lives and economic prospects, at all stages of their lives.

The Fuller stocktake – a comprehensive review carried out in 2022, by Dr Claire Fuller

- Helping people to stay healthy for longer through a more **joined-up approach to prevention.**
- Providing more proactive, personalised and **multi-disciplinary care for people with more complex needs.**
- **Streamlining access** to care and advice to meet the needs of infrequent users of healthcare services.

Hewitt Review:

- Fewer central targets - resources based on the **needs of their local populations**
- Enabling a shift towards **upstream investment in prevention**
- Multi-year funding - systems can more **cohesively plan their local priorities**
- Payment mechanism flexibility **- flexibility to determine allocations**

Impact of the abolition of NHS England and changes to the NHS operating Model

The 3 Big Shifts:-

- Hospital to Community
- Sickness to Prevention
- Analogue to Digital

Neighbourhood Health Services

- During 2024 the Government commissioned the Darzi Review of the NHS and is now developing the 10 Year NHS Plan this builds on the existing national policy direction.
- NHS England are developing an updated Operating Model; they will publish a new NHS Improvement and Assessment Framework that will set out how NHS England will work with as well as assess the performance and capability of providers and Integrated Care Boards (ICBs).
- We have aligned our 25-26 Annual Delivery Plan to reflect our existing priorities the three national shifts and the NHS operational planning guidance to support delivery of our 4 strategic Objectives

In reviewing our plans and defining our priorities for 2025-26 we have applied a set of principles to guide us:

- Deliver financial savings through productivity reducing waste, focusing on opportunities related to efficiency at scale, corporate services and unwarranted variation.
- Any available growth funding will be protected to deliver the "neighbourhood health service" through community-based interventions and applying principles for mutual accountability for ensuring delivery of outcomes which support the three national shifts, to address health inequalities including priorities agreed by the HCP on wider determinants and improving access and outcomes in urgent care including mental health.
- Prioritisation of the local and national safety, quality and performance metrics
- Co-design solutions and plans with partners and our communities and consider the best design and delivery approaches:
  - Delivered at a whole Cheshire and Merseyside (C&M) or sub-C&M footprint to gain economies of scale and address, or avoid creating, unwarranted variation
  - Maximise local partnerships and assets to integrate joint commissioning e.g. with a local authority and/or our Voluntary, Community, Faith and Social Enterprise Sector at a Place or neighbourhood level.
  - Delegation of functions to partner organisations to lead delivery on behalf of the ICB e.g. Collaboratives, Alliances, Networks
- Detailed triangulation approach essential between Population Health / Finance / Workforce / Operational plans and ensure contracting approaches align with our commissioning plans including payment mechanisms and outcomes.
- Use clear change, continuous improvement and innovation methodologies

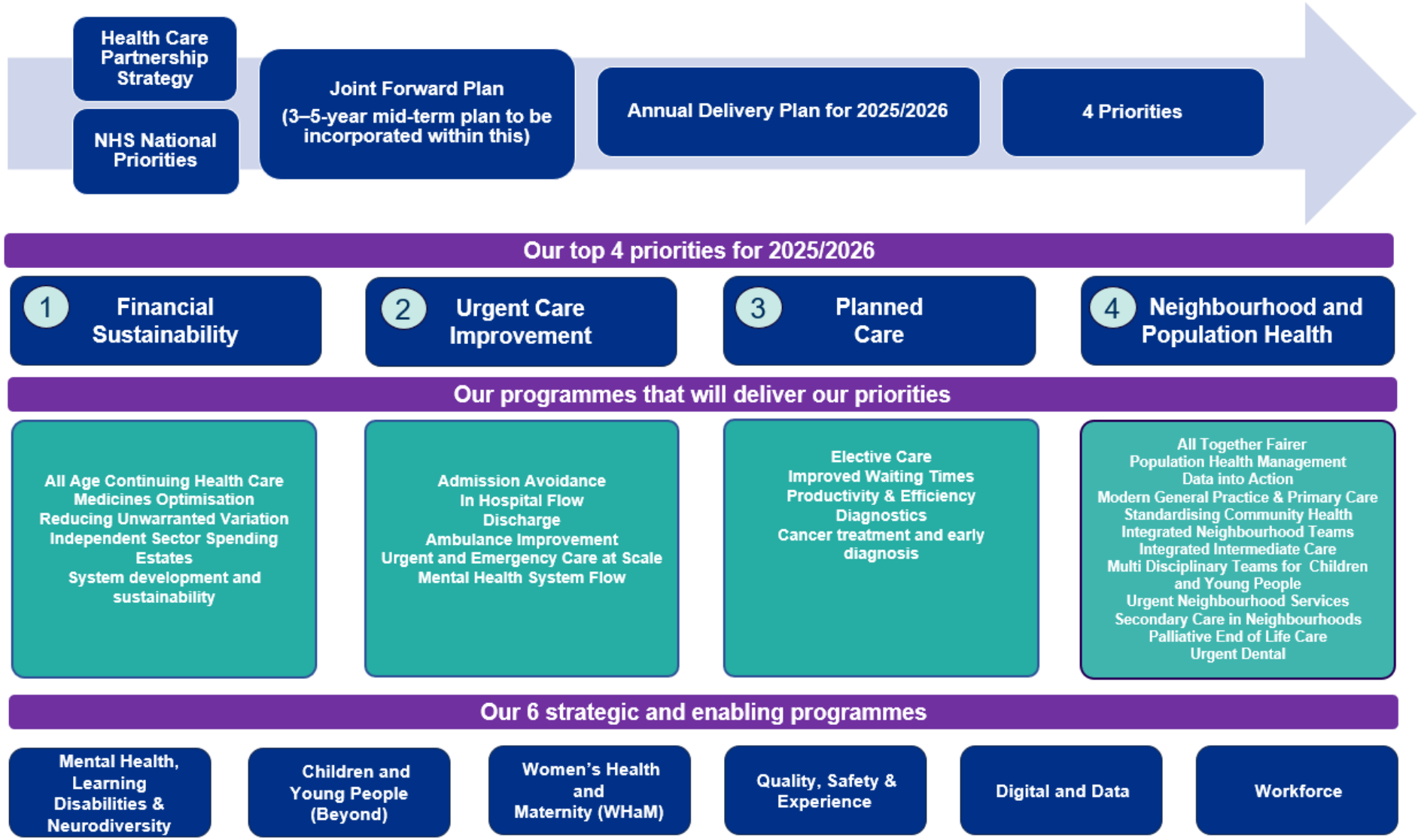
Determining our 25-26 priorities

As part of our 2024-29 Joint Forward Plan we prioritised a focus on two areas Financial Sustainability and Urgent and Emergency Care, we have identified two additional areas for 2025-26

1. **Financial Sustainability**
2. **Urgent Care Improvement**
3. **Planned Care**
4. **Neighbourhood and Population Health**

These are supported by 6 Strategic and Enabling programmes (see Table below)

Our priorities for 2025-26



Our strategic and enabling programmes

To support delivery of our 4 priorities we have defined additional strategic and enabling programmes further detail on these can be found by clicking the link below.

In line with the concept of a ***"self-improving system"*** described in the Hewitt Review we intend to develop our capabilities and be ambitious in developing our leadership, workforce and improvement approaches alongside our delivery plans.

To support this, we will focus on those areas that enable us to develop as a system.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

NHS Cheshire and Merseyside 2025/26 Financial Plan Update

Agenda Item No: ICB/03/25/14

Responsible Director: Mark Bakewell, Interim Executive Director of Finance

NHS Cheshire and Merseyside 2025/26 Financial Plan Update

1. Executive Summary

1.1 The purpose of this paper is to provide the Board with an update on the work that has been undertaken to develop the ICB financial plan for the 2025/26 financial year in accordance with national NHS England planning deadlines.

1.2 The paper provides an overview of the latest financial position reported to NHS England (NHSE) for C&M ICB as at 14th March 2025 with a focus on the ICB position including the key assumptions that underpin it, and the resulting financial risks.

1.3 Based on the assumptions as described within this paper as at 14th March 2025, the ICB is currently forecasting a **break even** position for the 25/26 financial year.

1.4 The wider ICS position is still being developed and will be shared once agreed in accordance with NHS England agreement. As at the 14th March there was a significant system gap with a final plan submission still expected by the end of March 2025 in line with national timescales.

1.5 The C&M system has been set a requirement to meet the maximum system deficit control total of £178m for the 25/26 financial year.

2. 2024/25 Background and Context

2.1 2024/25 has continued to be a significantly challenging year for the NHS financially. The economic situation has continued to be a difficult one with higher than anticipated inflation continuing to increase prices and ongoing industrial action by doctors and consultants impacting heavily on service costs and productivity. In Cheshire and Merseyside, the continuing urgent care challenges are also having an adverse impact on provider costs.

2.2 The ICS is forecasting to end the year with a forecast £196m deficit (based on month 11 reporting) which is an adverse £46m compared to an agreed deficit plan of £150m.

2.3 This report sets out the ICB planning assumptions for the 25/26 financial year and resulting financial position.

3. Revenue Resource Allocations 2025/26

3.1 C&M ICB's opening recurrent allocation for the 2025/26 financial year is £7.54bn. This is a net increase of £366m and consists of the following adjustments:

- Allocation growth £295m (to cover inflation / activity increases)
- Convergence (£29.3m) - due to being over target allocation – see below
- Running Cost Reduction (£3.4m) - to meet 30% running cost allocation reductions
- Discharge Funding £24.6m (now recurrent and added to baseline)
- Service Development Funding £79.9m (now recurrent and added to baseline)
- Other (Corneal Tissue – (£283k), Optical Coherence Tomography (OCT) – (£365k)).

	Programme £m	Delegated Primary Medical £m	POD £m	Specialised Commissioning £m	Running Costs £m	Total £m
Opening Recurrent Baseline	5,675,213	538,642	294,928	624,619	43,490	**7,176,892**
Growth (point 10-12)	248,007	16,644	10,234	19,581*	588	**295,054**
Convergence (points 13-15)	(29,616)	268		*netted off growth above at regional level		**(29,348)**
Running Cost Reduction (Point 16-17)					(3,480)	**(3,480)**
Discharge Funding (add to baseline)	24,644					**24,644**
Better Care Fund	848					**848**
Service Development Funding (add to baseline) (Point 18-19)	79,868					**79,868**
Other	(508)			(140)		**(648)**
Recurrent Baseline	**5,998,456**	**555,555**	**305,162**	**644,060**	**40,598**	**7,543,830**

Growth

3.2 The base growth funding represents the level of funding deemed by NHSE to be required for known cost pressures including inflation, demographic/population growth, non-demographic growth such as increased demand for services, or for national policy such as the Mental Health Investment Standard (MHIS) and the increased minimum investment to the Better Care Fund (BCF).

3.3 Base growth has been set at 4.4% to reflect the following:

- the cost uplift factor (CUF) for 2025/26 of 4.15%, including a 2.8% headline pay assumption and the impact of other pay-related cost pressures on NHS services. Net Cost Uplift Factor is 2.15%.
- the general efficiency requirement of 2.0%
- the Clinical Negligence Scheme for Trusts (CNST) increasing by 4.6%Better Care Fund (BCF) growth
- affordable activity growth, excluding emergency ambulance services.

3.4 The relative uplifts for each category are:

- Programme Allocation 4.37%
- Specialised Services 5.35%
- Primary Care Medical 3.09%
- POD 3.47%

Convergence

3.5 A consistent convergence policy applies across the ICB core programme, ICB specialised and ICB primary medical care. The convergence adjustment applied to an ICB depends on its distance from the target allocation. The maximum convergence for those ICBs outside 2.5% of their target allocation is +/-0.5%. The requirement is tapered such that convergence reduces as ICBs move closer to their target.

3.6 The net 'convergence' funding reduction of £29.3m is an adjustment to move the overall allocation over a period of time towards a defined 'target' allocation based on the assessed relative need of the population. This is commonly known as the 'distance from target' and consists of a reduction of £29.6m on ICB programme allocation and £0.3m increase on primary care medical allocation.

3.7 The relative changes are based on the below position:

	2024/25 Distance from Target	Convergence (capped at maximum 0.5%)	2025/26 Distance from Target (post convergence)
Programme	4.66%	-0.5%	4.13%
Specialised	6.67%	-0.33%	6.36%
Primary Care Medical	-0.23%	0.05%	-0.19%

Running Cost Reduction

3.8 Running Cost allocations are used to fund the administrative running costs of the ICB including staffing, estates, and other non-pay related costs.

3.9 The allocation reduction of £3.48m reflects the second year of the 30% real terms reduction required from 2023/24. Allocations have been updated to reflect the revised national insurance employers' contribution) to the value of £588k. However, the cost of the proposed pay award of 2.8% and incremental drift must be funded within existing running cost resources and is reflect within the CRES requirement for running costs.

3.10 Recent announcements (late march' 25) regarding further reductions to ICB management costs are not yet factored into the position and we await further guidance.

Service Development Funding (SDF)

3.11 For 2025/26, a proportion of SDF has moved to ICB core programme allocations (but has been subject to a reduction to support overall financial balance of national plans). Where funding has been transferred into ICB core programme allocations it is important to note that this is no longer ringfenced, and there are no additional performance requirements beyond those set out in the 2025/26 priorities and operational planning guidance.

3.12 Detail of updated allocations are included as part of Appendix One with corresponding expenditure assumptions included in below sections.

Non-Recurrent Allocations

3.13 Detail of updated non-recurrent allocations for 2025/26 totalling £524m are as per the below table with further narrative included for the key values below.

	Programme £m	Delegated Primary Medical £m	POD £m	Specialised Commissioning £m	Running Costs £m	Total £m
Recurrent Baseline	**5,998,456**	**555,555**	**305,162**	**644,060**	**40,598**	**7,543,830**
Elective Recovery Fund (Point 22)	258,041			38,374		**296,415**
COVID Testing	4,415					**4,415**
CDC Funding (point 23)	41,013					**41,013**
SDF	29,944					**29,944**
CEOV	(793)					**(793)**
Microsoft Licences	(1,297)					**(1,297)**
Deficit Repayment (point 24-26)	(29,472)					**(29,472)**
Deficit Support (point 27)	178,275					**178,275**
Community Lateral Flow Testing			505			**505**
Pay Other Income Support	5,187					**5,187**
Non-Recurrent Allocation 2025/26	**485,314**	**0**	**505**	**38,374**	**0**	**524,193**
Total ICB Allocation 2025/26	**6,483,770**	**555,555**	**305,667**	**682,434**	**40,598**	**8,068,023**

3.14 As above, this results in a total allocation for 2025/26 totalling £8.07bn are as per the above table with further narrative included for the key values below.

Elective Recovery Funding

3.15 Additional Elective recovery funding in 2025/26 has been distributed as set out below:

- Core elective recovery funding (separately identified) in ICB allocations and distributed on a fair share basis.
- Additional elective recovery funding has also been separately identified in ICB allocations and is distributed on a targeted basis. The distribution will be based on the forecast outturn for 2024/25 (at M8) with some limited adjustments for the impact of TIF schemes coming onstream.
- Additional allocation for specialised commissioning activity.

Community Diagnostic Centres

3.16 Where there are existing CDC schemes in place, ICBs will be allocated revenue funding for establishing and delivering activity in 2025/26, based on plans agreed with NHS England. This funding will be fixed and included in allocations, meaning it will not be updated in-year or subject to a ringfence.

Repayment of cumulative system overspends from prior years

3.17 Where systems are due to repay overspends that relate to a period before 2024/25 (for 2025/26 that relates to the system carry-forward position at 31 March 2024), the full value of the cumulative overspend will continue to be subject to repayment on the basis of the ICB and system finance business rules (repaid over a 3-year period, subject to an annual cap set at 0.5% of the 2025/26 recurrent ICB core programme allocation)

3.18 Where systems have achieved a breakeven position in 2022/23 and 2023/24, any net historical clinical commissioning group (CCG) overspend will be written off. Those systems which did not achieve this will have any historical overspend reinstated and will be subject to repayment, in line with the arrangements set out in the repayment section of the ICB and system finance business rules guidance, with repayments starting from 2025/26.

3.19 The Impact of the above rules for C&M given prior year financial performance result in the following values for each organisation are a 'call' on in-year allocations and within the maximum deficit control total.

Organisation	Debt Repayment £m
Liverpool University Hospitals	-0.2
Liverpool Women's	-2.8
Countess of Chester Hospitals	-3.1
East Cheshire Trust	-1.2
Mid Cheshire Hospitals	-2.9
Warrington & Halton Hospitals	-3.4
Wirral University Hospitals	-2.9
TOTAL Providers	**-16.5**
ICB	**-13**
Total ICS	**-29.5**

Deficit Support Funding

3.20 As in 2024/25, a non-recurrent deficit support revenue allocation will be issued to those systems with a deficit plan limit in 2025/26 that is equal to the size of the limit. Allocation of this within the system is still to be determined.

4. Expenditure Planning Assumptions

ICB Financial Plans

4.1 The starting point for 25/26 planning was use of the Month 8 (November) Forecast outturn expenditure values with further adjustments made for non-recurrent allocations / expenditure as appropriate to an adjusted baseline. It is estimated that this resulted in an underlying / exit run rate of £119m deficit.

4.2 Further adjustments have been made for subsequent material movements between Month 8 and Month 10 reporting periods and suggest an improvement in the exit rate of £33.7m recurrently.

4.3 The below planning assumptions have been used as the basis for the ICB expenditure plans for the 25/26 financial year. Further work is required to validate these assumptions within local 'place' arrangements (e.g. market rates as agreed with each local authority area) but are used as the basis for planning at an ICB level.

- Net CUF Uplift of 2.15% - consisting of 4.15% Gross Uplift less 2% efficiency as per National Planning Guidance
- BCF Total Growth is 1.7%, however minimum contribution to 'social care' growth is 3.9% within this.
- Mental Health Investment Standard requires additional investment in line with base growth assumptions of 4.4%.
- Ambulance Growth is funded but is being held centrally in line with revised national commissioning approach.
- No growth for secondary care activity, with a separate funding stream for elective recovery funding (albeit now capped at a maximum level per system).
- Funded Nursing Care Rate increase of 7.7% for 25/26
- No specific 'national' assumptions around additional investment in community / primary care to support the shift left of resources.
- Local Planning Assumptions for the following areas are as per the below table, however 'places' are still required to review assumptions including local inflation prices & growth rates.

	Net Inflation	Growth	Total
Continuing Care Services	4.11%	4.96%	9.08%
Mental Health Services - PACKAGES OF CARE	4.13%	4.58%	8.72%
Prescribing	0.09%	3.12%	3.22%

ICB Financial Plans

4.4 On the basis of the above and comparing against the 25/26 resource envelope, the ICB financial planning position for 2025/25 is currently set a **break-even** position with a summary of the ICB financial plan by spend area as per table below totaling £8.07bn

2025/26 ICB Expenditure Plan Summary

Total 'Revenue' Resource Available	8,068,023
Category	
Acute Services	3,228,428
Community Health Services	697,853
Continuing Care Services	489,906
Mental Health Services - PACKAGES OF CARE	223,259
Mental Health Services - CONTRACTS	503,273
Other Commissioned Services	15,710
Other Programme Services	61,991
Reserves / Contingencies	553,595
Delegated Primary Care - Medical	555,555
Delegated Primary Care - Community Dental	13,433
Delegated Primary Care - Primary Dental	151,095
Delegated Primary Care - Secondary Dental	40,352
Delegated Primary Care - Ophthalmic	28,438
Delegated Primary Care - Pharmacy	72,342
Delegated Primary Care - Property Costs	818
Prescribing	556,340
Primary Care - Other	109,283
Delegated Specialised Commissioning	725,755
Running Costs	40,597
Total Net Expenditure	8,068,023
	-
TOTAL Surplus/(Deficit)	0

4.5 Further description of the above expenditure areas are included in the below sections.

Acute Services

4.6 Acute services are by far the largest expenditure area for the ICB at circa £3.3bn. This includes services such as Emergency Departments (A&E), and Inpatient and Outpatient services for medicine and surgery. This also includes expenditure on Ambulance Services.

4.7 Price inflation for the majority of Acute and Ambulance Services is included in line with national planning net Cost Uplift Factor (CUF) at 2.15%.

4.8 It should be noted that there is a significant expectation with national planning guidance of increased productivity (circa 4%) alongside the 2% efficiency factor within the 'CUF'.

Community Services

4.9 This represents the cost of community-based services. These are services generally provided out in the community and in some cases in patients own homes. It includes costs such as District Nursing, Community Audiology and Optometry, Reablement Services, Termination of Pregnancy, Hospices and Palliative Care, Long Term Conditions services, Wheelchair Services, and Community Children's services.

4.10 Again, price inflation for the majority of Acute and Ambulance Services is included in line with national planning net Cost Uplift Factor (CUF) at 2.15%.

Mental Health Services (Contracts & Packages)

4.11 This represents expenditure on Mental Health, Learning Disability, Dementia and Autism services. It also includes individualised packages of care for these areas, and joint Section 117 Mental Health aftercare in the community packages with Local Authorities.

4.12 Mental Health is also subject to a national Mental Health Investment Standard (MHIS) whereby expenditure on Mental Health must increase in line with overall allocation growth either through inflationary increases or through additional investment.

4.13 2024/25 has continued to see significant growth in demand for individual mental health packages including those in the Community, but also for patients requiring acute Mental Health beds, for which a growing number have been met through Independent Sector providers. A summary position of 24/25 outturn is as per the below table:

Area	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral	Grand Total
Mental Health Placements in hospitals outside of area			484,420	2,981,528	2,395,987	3,688,428		0		9,550,363
Mental Health placements in supported living accommodation	1,000,660	454,112	0		1,369,008	1,333,045	0	0	979,927	5,136,752
S117 placement JF with LA	15,642,015	14,535,641	7,578,570	3,391,263	16,555,417	11,733,038	11,704,288	10,718,878	14,139,859	105,998,968
Mental Health Placements in hospitals in area	4,661,802	3,909,315	544,038	204,415	2,476,170	0	6,644,940	1,902,168	11,765,263	32,108,110
Learning Disability Placements	6,208,906	9,690,643	1,439,065	924,097	7,896,491	7,199,523	4,511,102	0	4,489,655	42,359,482
ABI	865,048	832,867	826,578	1,763,384	8,848,902	1,728,153	940,871	344,404	369,422	16,519,629
Grand Total	**28,378,431**	**29,422,577**	**10,872,670**	**9,264,687**	**39,541,975**	**25,682,187**	**23,801,200**	**12,965,450**	**31,744,126**	**211,673,305**

4.14 Price inflation for Mental Health Contracts is included in line with national planning net Cost Uplift Factor (CUF) at 2.15%. However, for packages of care price inflation of 4.15% is currently assumed (CUF excluding efficiency factor) pending agreement of uplifts at local level.

4.15 Activity growth for packages of care has been calculated at individual place level based on 2024/25 activity growth with an average growth of 10% included.

Continuing Healthcare Services

4.16 This represents the cost of Continuing Healthcare placements, including those on personal health budgets. It also includes the cost of Funded Nursing Care and CHC Assessment. CHC costs include costs of healthcare within Care Home, Home Care, and Supported Accommodation settings, as well as Day-care and associated transport costs.

4.17 Initiatives such as the Fair Cost of Care have significant impacts on costs within this sector, and due to the links between health & social care, uplifts on health need to align where possible to Local Authority social care uplifts. Prices within this sector continue to be heavily influenced by the National Living Wage and the Real Living Wage.

4.18 The below table shows the variance to budgeted levels of spend in the 24/25 financial year using information as at February 2025 and are as a result of both price and demand pressures and driven in particular by high ‘usage’ of fast track placements and 1:1 packages of care.

	Budget YTD (£000's)	Actual YTD (£000's)	Variance YTD (£000's)	Budget FOT (£000's)	Forecast FOT (£000's)	Variance FOT (£000's)
AACC	**368,473**	**397,927**	**(29,454)**	**403,580**	**435,248**	**(31,667)**

4.19 For 25/26, Price inflation for Continuing Care Contracts is included in line with national planning net Cost Uplift Factor (CUF) at 2.15%. However, for packages of care price inflation of 4.15% is currently assumed (CUF excluding efficiency factor) pending agreement of uplifts at local level.

4.20 Activity growth for packages of care has been calculated at individual place level based on 2024/25 activity growth with an average growth of 7% included.

4.21 CHC (and associated areas) will remain a key area of focus for the ICB in the 25/26 financial year with significant transformational changes required to embed the new operating model, standardise systems and process and continue to develop performance reporting arrangements.

Primary Care Services

4.22 This element relates to locally commissioned Primary care services including local enhanced services provided by GP Practices, Opticians and Pharmacies. This does not cover the main contracts with GPs, Dentists, Opticians and Pharmacies – these are covered by other budget lines noted further within this report.

Primary Care Prescribing

4.23 This relates to the cost of Prescribing, and the vast majority is for prescriptions issued by GP Practices, but a small element relates to the cost of prescriptions issued by other services.

4.24 The 2024/25 financial year has continued to see challenges within the prescribing budget driven through a number of factors including general price inflation, unavailability of cheaper drugs, supply chain issues, availability of costly new drugs, and general increases in patient demand and need for medicines.

4.25 A total net uplift of 3.22% has been provided for Prescribing increases to support further price and demand growth in 2025/26 based on horizon scanning undertaken by the Medicines Management team.

Primary Medical Care Services

4.26 This represents the costs relating to Primary Care Medical Services including the national GP Primary care contract costs, and schemes such as the Additional Roles Reimbursement Scheme (ARRS), and the Impact & Investment Fund.

4.27 Cost uplifts have been applied to Primary Care budgets per national guidance and plans assume full utilisation of the specific allocation provided for this area.

Delegated Pharmacy, Ophthalmic and Dental Services

4.28 This represents the costs relating to the primary care provision of NHS Pharmacy services, Ophthalmic Services, and Dental Services, sometimes referred to as POD services. This also includes the costs of Secondary Care dental services.

4.29 Cost uplifts have been applied to POD budgets per national guidance and plans assume full utilisation of the specific allocation provided for this area.

Running Costs

4.30 This represents the operating costs of the ICB including staffing, estates, and other non-pay related costs.

Specific investments

4.31 On the basis of the above planning assumptions and anticipated delivery of the Cash Releasing Efficiency Savings.. A small investment fund has been created in order to support a number of system risks / emerging pressures.

4.32 These schemes are still in development and will need to go through the appropriate system/ organisational governance but will result in an additional investment in the following areas during the 2025-26 financial year.

- Virtual Ward Expansion
- Elastometrics
- Digital System Investment
- Weight Management Services
- NDP / ADHD Waiting List
- Shared Care ADHD - investment in primary care
- ICS Strategic Programmes – LAASP / Shaping Care / Liverpool Womens / East Cheshire
- Appropriate Places of Care (invest to save)
- Oral Nutritional System Investment
- Elective Investment (demand management)
- CHC Admin System costs (project costs to get to a single system).

4.33 The ICB is making a targeted investment in 'Health Inequalities' within the 25-26 financial year from within its baseline allocations. Again, a number of these initiatives still require further approval and will need to go through the relative governance / sign off processes but support the organisations commitment to addressing health inequalities in line with its strategic plan.

Pay Costs	£918k
VSNW	£439k
Population Health (CHAMPS)	£1m
Smoke Free (at Scale)	£2.3m
Healthy Weight (at Scale)	£0.4m
Health & Housing (at Scale)	£80k
Place Based Schemes	£1.5m
Place Based (Non-rec pick up from 24/25)	£0.83m
Live Well Programme (Risk of lack of central coverage)	£1.0m
Total	**£8.5m**

*NB – Live Well Programme provisionally included, pending confirmation of separate national funding programme.

Cash Releasing Efficiency Savings (CRES)

4.34 NHS planning guidance assumes a minimum efficiency requirement of 2%, however as per above the ICB is starting 2025/26 from a significant recurrent underlying deficit position and must also offset the negative impact of 2025/26 convergence/ deficit repayment.

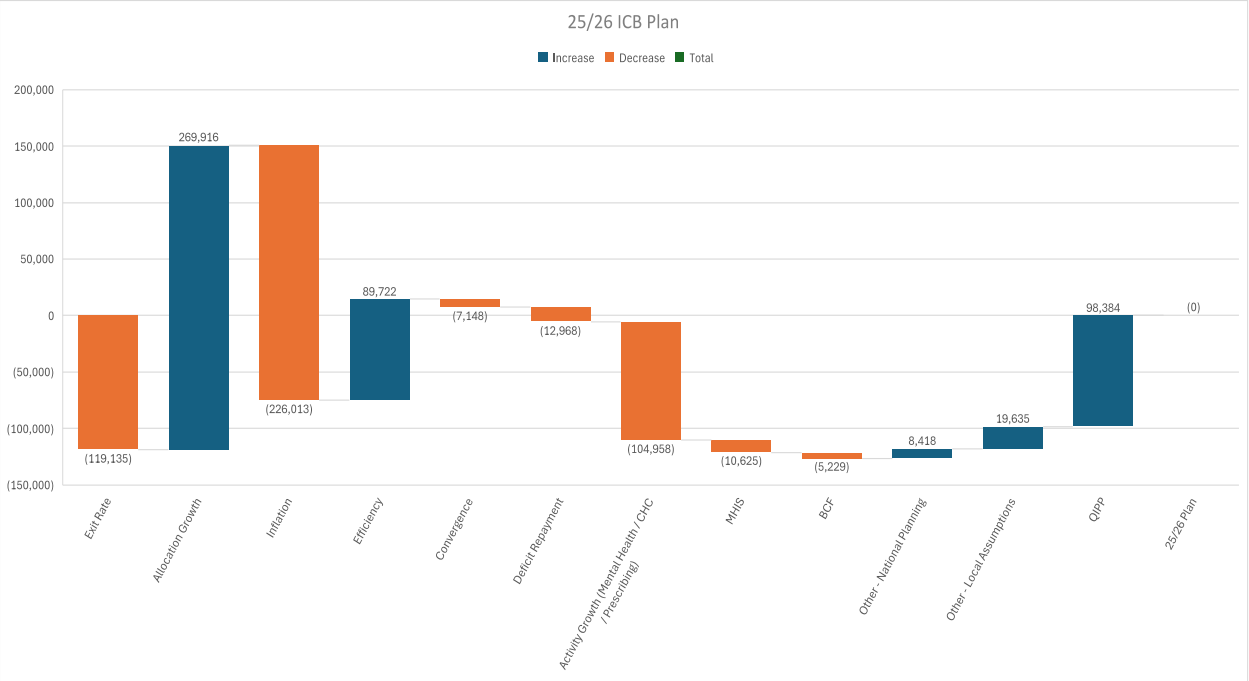
4.35 Current ICB plans include a savings target of £98.3m which equates to circa 5.8% of influenceable spend (as described as expenditure outside on NHS Block Contracts / activity related to Elective Activity) plus the required savings required for running costs.

25-26 CRES		Rationale
Continuing Health Care Savings	28,226	As identified by national benchmarking
Prescribing Savings (Multiple Areas)	10,000	As identified by Prescribing team
Prescribing Savings (Oral Nutritional Supplements)	6,293	As identified by Prescribing team
Demand Management / Activity Savings	20,000	Linked to Elective / System Activity Management Plan
Additional GP Prescribing savings (dependent upon TOM)	5,500	As identified by Prescribing team
High-Cost Drugs System Savings	8,000	As identified by Prescribing team
Mental Health Packages	11,982	5% CRES of anticipated 25-26 spend (in line with national expectations)
Other - Unwarranted Variation	4,500	As identified by Unwarranted variation group
	94,501	
Management Costs	3,883	NB 30% reduction currently being met by holding of vacancies
TOTAL	**98,384**	

4.36 A series of other demand management / cost avoidance activities are also planned for the 25-26 financial year in order to support delivery of the financial position and will help to constrain growth in expenditure and to realise opportunities as identified from the recent ICB recovery programme.

Change Category & Project Description	Cost avoidance £m	Non-cash releasing £m	Grand Total £m
Contract harmonisation		**10.01**	**10.01**
EBI Phase 2 and 3		10.00	10.00
Move to a single managed framework for primary care cabelling. GPIT capital monies. Capital investment plan		0.01	0.01
Redesign		**0.10**	**0.10**
Move from Dell to Lenovo laptops (captial monies but will get more for money and mitigate other price increases such as Windows 11)		0.10	0.10
Re-negotiated cost	**0.07**	**0.48**	**0.55**
Change of technical solution to provide E1 licences rather than E3 to mitigate Microsoft price increases as per recommendation by iMersey and ICB CTO	0.07		0.07
Reduction in activity for EBI 1A - 1D procedures		0.48	0.48
Grand Total	**0.07**	**10.59**	**10.65**

4.37 A bridge chart showing the relative movements between exit run and rate and impact of other assumptions are shown as per the below chart.



5. Capital Plans – Provider and ICB

5.1 A summary of the current system capital investment plan for 2025/26 is set out below but remains draft at this stage with a number of elements still a work in progress.

5.2 For 2025/26, the C&M ICS has been allocated £199.989m of capital resources to support day to day operational requirements and any locally agreed capital schemes. The resource has been allocated using a combination of depreciation costs / locally agreed priorities and prior commitments.

5.3 Plans continue to be developed but at the time of writing there remains around £19.2m to be allocated at this stage of the planning process.

5.4 Additional national allocations of £131m have been received for 2025-26 to reflect national priorities as per the above table. The basis for allocation is as per below

- Estates safety - £18m allocated using Significant and High-Risk backlog, with an additional allocation to address Maternity non-compliance in WHH.
- Diagnostics - £3.5m allocated to CDC, Audiology and Echo.
- Elective – £19.8m Schemes to improve productivity within the elective pathway.
- Urgent Pathway - £20m to address existing UEC projects.
- RAAC – £61.7m as per nationally determined schemes.
- Mental Health – £8.0m to support Reducing Out of Area placements.

6. Ask of the Board and Recommendations

6.1 The Board is asked to:

- **Note** the progress being made on both revenue and financial plans for 25/26 and the current forecast of a break even position for the ICB
- **Note** the requirement for the C&M system to meet the system control total of a maximum £178m deficit.
- **Note** that further updates will be provided to the ICB Board in line with planning requirements and will include a wider assessment of risks and mitigations in respect of delivery of the 25/26 ICS financial position.

7. Officer contact details for more information

Mark Bakewell
Interim Executive Director of Finance, Cheshire and Merseyside ICB
Mark.Bakewell@cheshireandmerseyside.nhs.uk

Frankie Morris
Associate Director of Finance (Provider Assurance, Capital & Strategy)
Cheshire and Merseyside ICB
Frankie.Morris@cheshireandmerseyside.nhs.uk

Rebecca Tunstall
Associate Director of Finance (Planning & Reporting)
Cheshire and Merseyside ICB
Rebecca.Tunstall@cheshireandmerseyside.nhs.uk

8. Appendices

Appendix One: SDF Allocations 2025-2026

Appendix One – SDF allocations 2025/26

		SDF transferring to core allocations
Community Health Services	Community Services Transformation	4,025
Children and Young People	CYP Transformation	1,086
Learning Disability & Autism	Community / Keyworkers	7,058
Learning Disability & Autism	Autism	213
Learning Disability & Autism	Hearing Screening	49
Maternity	Enhanced Continuity of Carer for deprived areas and BAME	886
Maternity	3 Year Delivery Plan	2,654
Maternity	Ockenden II Workforce	1,323
Mental Health	MH Adult Crisis	4,813
Mental Health	Children and Young People Mental Health including Eating Disorders	10,301
Mental Health	MH Adult Community	20,021
Mental Heath	Mental Health Support Teams in Schools (MHST)	11,514
Mental Heath	MHLDA Inpatient Quality - recurrent	2,069
Mental Heath	MHLDA Inpatient Quality - non recurrent	108
Other SDF	Adjustment to SDF baseline	0
Other SDF	Medical Examiners	2,647
Other SDF	Pay uplift	277
Primary Care	Primary Care Transformation	5,865
Primary Care	GPIT - Infrastructure and Resilience	606
Prevention & Long-Term conditions	Long Covid CYP	128
Prevention & Long-Term conditions	Prevention & LTC Universal Allocation	3,324
Prevention & Long-Term conditions	Prevention & LTC Targeted Allocation	903
Total of bundles		**79,868**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Supporting Care Leavers Into Employment

Agenda Item No: ICB/03/25/15

Responsible Director: Mike Gibney, Chief People Officer

Leading integration through collaboration

Supporting Care Leavers Into Employment

1. Purpose of the Report

1.1 This report addresses the issue of supporting care leavers into meaningful employment across NHS Cheshire and Merseyside. The report outlines current initiatives, challenges, and proposals for creating structured employment opportunities, strengthening workplace support, and ensuring leadership accountability to embed care leavers as a priority group in NHS workforce policies.

2. Executive Summary

2.1 NHS Cheshire and Merseyside is committed to ensuring care leavers have access to meaningful careers. Recent policy developments have reinforced the importance of corporate parenting, with the UK Government announcing that public bodies, including NHS organisations, will soon be legally required to uphold corporate parenting responsibilities. This new statutory duty mandates public sector employers to actively support care leavers' wellbeing, life chances, and career prospects by removing systemic barriers to employment and providing tailored workforce support.

2.2 As one of the largest employers in the region, NHS Cheshire and Merseyside recognises the significance of this change and is committed to embedding corporate parenting principles into its workforce strategy. This means proactively identifying and addressing challenges faced by care-experienced young people, ensuring equitable access to NHS careers, and fostering an inclusive working environment where care leavers can thrive.

2.3 **Understanding the Challenge**
Care leavers continue to face significant barriers, including disrupted education, financial hardship, and a lack of stable professional networks. Embedding targeted support within workforce strategies will foster a more inclusive NHS. Understanding the scale of the challenge is key to shaping effective interventions. The following data highlights the number of children in care and the proportion over the age of 16, indicating the potential workforce pipeline for NHS employment initiatives:

Region	Children in Care	Over 16 (%)	BAME (%)	White (%)	Male (%)	Female (%)
England	83,630	27%	29%	71%	57%	43%
Cheshire & Merseyside	5,510	27%	14%	86%	56%	44%

(Source: Explore Education Statistics, December 2024)

2.4 These figures reinforce the need for structured employment pathways and workforce policies that directly address the disadvantages faced by care-experienced young people. By embedding sustainable career support and development programmes, NHS Cheshire and Merseyside can play a leading role in improving employment outcomes for care leavers while strengthening workforce diversity and long-term sustainability.

2.5 **Current Initiatives**
Several programmes are already supporting care leavers into NHS employment:

- **Universal Family Programme** – A national scheme providing employment pathways, mentorship, and career support.
- **SPECTRA Partnership** – Recruiting 25 care leavers into NHS roles, with mentoring and career coaching.
- **Medical Student Mentoring** – Alder Hey-led programme supporting care-experienced medical students.
- **Helping Hands Programme** – Targeting young people at risk of becoming NEET with career guidance and skills training.

2.6 Despite progress, care leavers still face disadvantages in securing NHS roles due to:

- lack of formal recognition as a priority group.
- recruitment barriers, such as job criteria and reference requirements.
- limited structured support for career development and retention.

3. Ask of the Board/Committee and Recommendations

3.1 To address these challenges and meet the evolving corporate parenting duty, NHS Cheshire and Merseyside should with the support of the Board:

- **Recognise care leavers as a priority group in recruitment policies.**
- **Enable self-identification in the NHS Electronic Staff Record (ESR)** to track employment trends.
- **Strengthen recruitment pathways** with guaranteed interviews and ring-fenced placements.
- **Appoint an Executive Champion for Care Leavers** to lead workforce inclusion.
- **Expand mentorship and career coaching** to improve retention.
- **Advocate for national policy change** to formally recognise care leavers in NHS workforce planning.

3.2 By embedding these measures, NHS Cheshire and Merseyside will not only comply with its new corporate parenting responsibilities but also make significant positive strides in social responsibility, workforce diversity, and inclusion. These efforts will create sustainable, meaningful employment opportunities for care leavers while strengthening our workforce pipeline.

4. Reasons for Recommendations

4.1 The recommendations set out in this report are designed to embed a structured and sustainable approach to supporting care leavers into employment across NHS Cheshire and Merseyside. This aligns with the NHS's social value commitments, workforce diversity objectives, and obligations under the Children (Leaving Care) Act 2000 and the Care Leaver Covenant.

4.2 **Key Benefits of Approving the Recommendations**

- recognising care leavers as a priority group in workforce policies will ensure targeted employment support, creating fairer and more inclusive recruitment pathways. This will also strengthen NHS Cheshire and Merseyside's wider workforce strategy, addressing existing recruitment challenges by tapping into an underrepresented talent pool.

- appointing an Executive Champion for Care Leavers will provide clear leadership and accountability, ensuring that employment programmes for care leavers are implemented effectively and embedded within our workforce strategies. Without such leadership, efforts may lack strategic direction and consistency.

- developing new and existing programmes will enhance opportunities for care leavers, improving their employment outcomes and retention in NHS roles. This will help address workforce shortages and support long-term career development.

- introducing voluntary self-identification in the Electronic Staff Record (ESR) will enable better data monitoring to assess employment trends, measure progress, and inform future recruitment and workforce planning strategies. Without this, the NHS will lack visibility on the success and challenges of its care leaver employment initiatives. (Data collection will be voluntary, anonymised where necessary, and fully compliant with NHS Digital's workforce data security guidelines).

- endorsing national advocacy for care leavers to be recognised as a protected characteristic would create systemic change, influencing NHS policies to drive a more inclusive workforce agenda at both regional and national levels.

4.3 **Impact and Risks of Not Supporting the Recommendations**

- Care leavers will continue to face barriers to employment, limiting their access to NHS career pathways.

- NHS Cheshire and Merseyside will miss an opportunity to strengthen workforce diversity, potentially impacting its ability to attract and retain staff from underrepresented backgrounds

- Without strategic leadership and accountability, initiatives may remain fragmented, lacking sustainability and impact

- The absence of structured data collection (via ESR self-identification) will hinder the ability to measure progress and refine recruitment strategies

- NHS Cheshire and Merseyside will fall behind other regions in fulfilling its social value commitments, potentially affecting public perception and partnership opportunities.

4.4 By approving these recommendations, the Board ensures a coordinated and impactful approach to supporting care leavers into employment, reinforcing its position as a leader in workforce inclusivity and sustainability.

5. Background

5.1 At the request of the Board in the latter half of 2024 the People Team were asked to undertake a viability study for recognising Care Leavers as a protected characteristic and to report back finds and recommendations.

5.2 There are strong arguments on both sides regarding protected status—particularly given the significant challenges care leavers face in securing and sustaining meaningful employment. At present the Equality Act 2010 does not currently legislate care leavers. Unlike characteristics such as age, sex, or race, care leaver status is time-limited (e.g., it typically applies until the individual turns 25), which makes its inclusion as a protected characteristic problematic.

5.3 On a positive note, alternative mechanisms already exist to support care leavers without requiring legislative changes. Rather than creating a new protected characteristic, we believe the focus should be on strengthening existing policies and frameworks, such as: The Children (Leaving Care) Act 2000 and the Care Leaver Covenant, which require public sector bodies to provide additional support for care-experienced young people.

5.4 Positive action measures under the Equality Act, allowing NHS employers to prioritise care leavers in recruitment, apprenticeships, and mentoring programmes. Targeted recruitment strategies, such as ring-fenced job placements and guaranteed interviews, which can be implemented at the employer level without legal amendments

5.5 After evaluating the potential legal and operational challenges of protected status, we concluded that identifying care leavers as a priority group would be a more pragmatic approach at this time pending any changes to legislation in the future.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

6.1 The recommendations outlined in this paper directly support NHS Cheshire and Merseyside Integrated Care Board's (ICB) strategic objectives, ensuring that care leavers are recognised as a priority workforce group while strengthening NHS workforce sustainability and inclusion.

Objective One: Tackling Health Inequalities in Access, Outcomes, and Experience
Supporting care leavers into employment is a direct intervention to address health inequalities, ensuring equitable access to NHS careers for a group that faces systemic barriers. Care leavers experience poorer health outcomes, including higher rates of mental health challenges, unemployment, and socio-economic instability.

- By embedding structured employment pathways (e.g., apprenticeships, internships, and ring-fenced roles), the NHS removes barriers to employment and helps care leavers access stable income, career progression, and workplace support, which are key social determinants of health.
- Mentorship and career support programmes will improve employment experiences and retention, leading to better long-term outcomes for care leavers in NHS careers.
- Introducing voluntary self-identification in ESR will help monitor care leaver employment trends, ensuring that targeted interventions are effective in reducing inequalities in workforce representation.

Objective Two: Improving Population Health and Healthcare
By actively recruiting and supporting care leavers, the NHS workforce becomes more representative of the communities it serves, leading to better patient engagement and understanding of diverse needs.

- A diverse workforce strengthens patient care and engagement, ensuring that NHS staff reflect the communities they serve, including individuals from disadvantaged backgrounds.
- Care leavers often lack access to preventative healthcare and stable employment, both of which are critical for long-term health. By providing NHS employment opportunities, the ICB addresses social determinants of health, helping care leavers lead healthier, more stable lives.
- Supporting care-experienced medical students through the Atlas Mentoring Programme enhances the future clinical workforce, ensuring that NHS Cheshire and Merseyside develops a skilled, inclusive, and sustainable workforce to improve healthcare delivery.

Objective Three: Enhancing Productivity and Value for Money
Investing in structured employment and retention initiatives for care leavers can strengthen workforce supply, reduce staff turnover, and improve recruitment efficiency, contributing to NHS Cheshire and Merseyside's productivity and financial sustainability.

- Proactively hiring and supporting care leavers ensures a pipeline of skilled, motivated employees, reducing reliance on costly agency staff.
- Ring-fenced apprenticeships and recruitment pathways help fill entry-level vacancies efficiently, reducing time and resources spent on external recruitment.
- Providing mentoring, training, and workplace support for care leavers reduces turnover, ensuring that the NHS retains employees who might otherwise struggle to sustain long-term employment.
- Investing in pre-employment support (via SPECTRA, Atlas Mentoring, and Helping Hands) enhances job-readiness, reducing onboarding and training costs for NHS employers.

Objective Four: Helping to Support Broader Social and Economic Development

Embedding care leaver employment initiatives within NHS workforce policies aligns with the ICB's social value commitments, ensuring that the NHS plays a leading role in supporting disadvantaged groups into meaningful careers.

- As one of the largest employers in the region, NHS Cheshire and Merseyside has a responsibility to drive inclusive economic growth by improving employment access for underrepresented and socially disadvantaged groups, including care leavers.
- Providing structured career pathways for care leavers strengthens regional workforce resilience, ensuring that young people who might otherwise struggle to secure stable employment can access long-term careers within the NHS.
- By embedding social value commitments into workforce planning, the NHS enhances partnerships with local authorities, education providers, and third-sector organisations, supporting a collaborative approach to social and economic development.
- Advocacy for national recognition of care leavers as a protected characteristic supports broader policy change, ensuring that workforce inclusion remains a long-term national priority.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 The recommendations outlined in this report align closely with the objectives set forth in the NHS Cheshire and Merseyside Annual Delivery Plan. Below is an analysis of how each objective is addressed:

Objective One: Tackling Health Inequalities in Access, Outcomes, and Experience

By recognising care leavers as a priority group within workforce policies, the NHS actively addresses social determinants of health, providing equitable employment opportunities to a historically underserved population. This initiative directly contributes to reducing health inequalities by improving the socio-economic status of care leavers, which is a significant factor in health outcomes.

Objective Two: Improving Population Health and Healthcare
Integrating care leavers into the NHS workforce not only benefits the individuals but also enriches the organisation with diverse perspectives, leading to more culturally competent care. A workforce that reflects the community it serves is better equipped to address various health needs, thereby enhancing overall population health.

Objective Three: Enhancing Productivity and Value for Money
Investing in the employment and development of care leavers can lead to a more stable and committed workforce, reducing turnover rates and associated recruitment costs. This approach ensures value for money by cultivating talent from within the community and fostering employee loyalty.

Objective Four: Helping to Support Broader Social and Economic Development

7.2 As a major employer, the NHS has the capacity to influence social and economic factors in the region. By providing career opportunities to care leavers, the NHS supports social mobility and economic development, contributing to the broader well-being of the community.

7.3 In summary, the recommendations in this report are designed to align with and advance the strategic objectives of the NHS Cheshire and Merseyside Annual Delivery Plan, fostering a more inclusive, effective, and socially responsible healthcare system.

8. Link to meeting CQC ICS Themes and Quality Statements

8.1 The recommendations in this report directly support CQC Integrated Care System (ICS) themes by enhancing workforce quality, integration, and leadership across NHS Cheshire and Merseyside.

- **Quality and Safety** – Structured employment pathways for care leavers will improve workforce stability, diversity, and training, leading to safer, more effective patient care**.** A more inclusive workforce reduces staff turnover and enhances overall service quality**.**
- **Integration** – This initiative strengthens partnerships across NHS Trusts, Local Authorities, and education providers, ensuring a coordinated and sustainable approach to workforce planning. Embedding care leavers into NHS employment aligns with wider system integration goals**.**
- **Leadership** – The appointment of an Executive Champion for Care Leavers ensures strategic oversight and governance, positioning NHS Cheshire and Merseyside as a national leader in inclusive employment. This supports long-term workforce sustainability and policy influence**.**

8.2 These actions align with the CQC's vision for high-quality, integrated, and well-led health and care services, ensuring NHS Cheshire and Merseyside drives best practice in workforce inclusivity and social responsibility.

9. Risks

9.1 The recommendations in this report present some risks, but these have been identified and can be effectively mitigated:

Risk 1: Lack of Organisational Commitment – Without leadership backing, initiatives may not be prioritised.
Mitigation: Appointing an Executive Champion for Care Leavers ensures strategic oversight and sustained focus.

Risk 2: Insufficient Workplace Support – Care leavers may struggle without structured assistance.
Mitigation: Implementing mentorship and support programmes will help them integrate successfully and improve retention.

Risk 3: Data Privacy Concerns – Introducing voluntary self-identification for care leavers in ESR may raise confidentiality issues.
Mitigation: Ensuring compliance with data protection regulations and clearly communicating the purpose of data collection will encourage participation.

Risk 4 : Low Engagement from Care Leavers
Mitigation: Active outreach, mentoring, and ongoing feedback mechanisms to adapt initiatives based on care leaver experiences and needs.

9.2 These risks align with the ICB's Risk Management Strategy, supporting objectives around tackling health inequalities and workforce development.

10. Finance

10.1 Currently, we are operating within our existing financial envelope, utilising available resources within the ICB/ICS to support this initiative. We have received modest short-term funding from NHSE for the SPECTRA project, which is set to conclude in July 2025 after which time we will want to be self-sufficient in terms of sourcing candidates and the support we offer care leavers and hiring managers. Additionally, we receive some operational support for care leavers from The King's Trust and are actively exploring opportunities for a longer-term agreement, in addition we will look to our local authority colleagues to partner with us on a number of these initiatives.

11. Communication and Engagement

11.1 To ensure successful implementation, ongoing engagement is required with:

- **Hiring Managers** – To embed training and awareness programmes ensuring recruitment practices actively support care leavers.
- **Care Leavers** – Continued consultation to refine support mechanisms and assess the effectiveness of employment initiatives.
- **Wider NHS Staff** – Awareness campaigns to promote inclusive workplace cultures and mentoring opportunities for care-experienced employees.
- **ICB/ICS and National Policy Leads** – To advocate for national recognition of care leavers as a protected characteristic and ensure policy alignment.

12. Equality, Diversity and Inclusion

12.1 An Equality Impact Assessment (EIA) is recommended to ensure compliance with the Public Sector Equality Duty (PSED) under the Equality Act 2010. While care leavers are not a protected characteristic, they often belong to other disadvantaged groups, such as ethnic minorities or individuals with disabilities. We have conducted an assessment within the ICB and will take advice on an approach to a wider system impact assessment going forward.

13. Climate Change / Sustainability

13.1 There are no specific environmental sustainability considerations pertinent to this report.

14. Next Steps and Responsible Person to take forward

14.1 Subject to Board approval; recommendations will be disseminated to Trusts via the Chief People Officer network and wider ICS through the Care Leaver Stakeholder Group led by NHS Cheshire and Merseyside.

14.2 The following officers will oversee the implementation of agreed actions:

- Executive Champion for Care Leavers **(To Be Confirmed)** – Provides strategic leadership and accountability for the programme.
- Paul Martin, Head of Workforce Programmes, NHS Cheshire and Merseyside – Leads operational delivery of workforce policy changes.
- HR Leads from Cheshire and Merseyside NHS Trusts – Responsible for embedding recruitment adjustments and workforce inclusion measures.
- Dr Katherine Birch (Alder Hey Academy) and Dr Bryony Kendall – Provide academic and programme support for mentoring and training initiatives.

15. Officer contact details for more information

Paul Martin, Head of Workforce Programmes, NHS Cheshire and Merseyside
Dr Katherine Birch, Director, Alder Hey Academy
Dr Bryony Kendall, Named GP for Safeguarding, NHS Cheshire and Merseyside

NHS
Cheshire and Merseyside

Meeting Held in Public of the Board of NHS Cheshire and Merseyside

Held in Ballroom, Bootle Town Hall, Oriel Road, L20 7AE

Thursday 30th January 2025
9am-1.30pm

Unconfirmed Minutes

ATTENDANCE	
Name	**Role**
Members	
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Neil Large, MBE	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Ann Marr, OBE	Partner Member, Chief Executive, Mersey and West Lancashire Teaching Hospital NHS Trust (voting member)
Prof. Steven Broomhead, MBE	Partner Member, Chief Executive, Warrington Borough Council (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member, Chief Executive Office, Community Pharmacy Cheshire, and Wirral (CPCW) (voting member)
Dr Naomi Rankin	Partner Member, Primary Care (GP) Partner Member (voting member)
Andrew Lewis	Partner Member, Chief Executive, Liverpool City Council
Trish Bennett	Partner Member, Chief Executive, Mersey Care
Erica Morriss	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Mark Bakewell	Executive Director of Finance (Interim), Cheshire & Merseyside ICB (voting member)
Warren Escadale	Chief Executive, Voluntary Sector North West (Voting Member)
In Attendance	
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (Regular Participant)
Mike Gibney	Chief People Officer, Cheshire & Merseyside ICB (Regular Participant)
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (Regular Participant) *Joined at 12noon*

Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (Regular Participant)
Diane Blair	Chief Executive, Healthwatch Sefton
Professor Paul Kingston	Lead Chair of Research Committee, University of Chester
Alison Lee	Knowsley Place Director, Cheshire and Merseyside ICB
Anthony Leo	Halton & Liverpool Place Director, Cheshire and Merseyside ICB
Louise Robson	Chair, Health Innovation North West Coast (regular participant)
Megan Underwood	Board Administrator, Cheshire and Merseyside ICB
Laura Marsh	Cheshire West Place Director, Cheshire and Merseyside ICB – *for item ICB/01/25/25*
Deborah Butcher	Sefton Place Director, Cheshire and Merseyside ICB (until 11am)
Rachel Stroud	Strategic PCN Manager, South Sefton PCN -*for item ICB/01/25/04*
Dr Craig Gillespie	Clinical Director, South Sefton PCN – *for item ICB/01/25/04*
Christine Wee	CYP Clinical Lead – *for item ICB/01/25/25*
Dr Chris Pritchard	Adult ADHD Clinical Lead – *for item ICB/01/25/25*
Temitayo Roberts	Freedom To Speak Up Guardian, Cheshire and Merseyside ICB – *for item ICB/01/25/19*
Andrea Astbury	Data into Action Programme Director – *for item ICB/01/25/24*
Jim Hughes	Associate Director Digital and Data Strategy – *for item ICB/01/25/24*

Apologies	
Name	**Role**
Rev. Dr Ellen Loudon	Director of Social Justice & Canon Chancellor
Prof. Hilary Garratt, CBE	Non-Executive Director, Cheshire & Merseyside ICB (voting member)

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

ICB/01/2401 Welcome, Introductions and Apologies

All present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. Apologies for absence were noted as above.

The Chair welcomed Mike Gibney to his first ICB Board Meeting and highlighted that Dr Naomi Rankin had been appointed to the Board for a further three-year term.

ICB/01/25/02 Declarations of Interest

There were no declarations of interest made by Members on the agendas.

ICB/01/25/03 Chairs announcements

No announcements

ICB/01/25/04 Experience and achievement story – South Sefton Primary Care Network

Dr Craig Gillespie, Clinical Director and Rachel Stead, Strategic PCN Manager attended the meeting to present Primary Care Network of the Year.

South Sefton PCN was formed on 1st April 2022 and is made up of 19 GP practices. The PCN operates a neighbourhood structure, each with clinical leadership to align with integrated care teams. Neighbourhood priorities has been established via close collaboration with practices and partners and data into action.

Acute Respiratory Infection Hub launched in February 2023, over the last year over 35,000 patients have been treated. Scope has been increased to include a wider range of acute minor illnesses for patients aged two plus. The PCN are working with local pharmacy committee to maximise the benefit of Pharmacy First.

Enhanced Health at Home was established several years ago with some funding from the NHS, this supports the aims of the Sefton strategy by establishing a team focused on integration of services with the Sefton partnership, this is to enable older patients who want to live at home to remain to do so. Patients are contacted proactively and regularly by Care Co-ordinators and Social Prescribing Link Workers. Patients also remain well and avoid in-patient admissions or re-admission through proactive medication reviews and acute visiting service.

Learning disability health check team has now been established and their role is to support practices in visiting patients at home who have not attended surgery for their annual learning disability health check.

Medicines hub has been established within Sefton and in the first half of 2022/23 the team.

- Responded to 9,500 medicined queries including 400 calls to secondary care and 1,700 to patients.
- 6,600 post hospital discharge summaries.
- 822 structured medication reviews for patients at risk of harm from their combinations of medication.
- 2,267 medication reviews for patients at risk of gastric bleed.
- 924 reviews of controlled drug prescribing
- 1,006 medication reviews for new patients in Sefton.

For patients and general practice clinical pharmacists complete discharge reconciliations, this has now been taken away from the GP's.

The future plans for the PCN were highlighted to the Board – the PCN have completed a consultation process and consulting member practices and system partners about how general practice in south Sefton should evolve, the success of the PCN comes from having strong relationships with GP practices within the patch. The PCN have recently been through a consultation process which has lasted around 12 months, the PCN have engaged with Merseycare and Health Watch with regards to what patient priorities might be for primary care networks. The vision for further collaboration is wide and deep and recommendations will become the strategic plan for the next PCN period.

Core General Practice has been introduced which will retain list-based practice and autonomy, partnership model and multi-practice providers co-exist and are underpinned by PCN services. For those patients who are more complex, continuity was essential and important for those patients to see their own GP's. Unwell patients would benefit from continuity where possible and generally well patients would benefit from quick access – prioritised to be seen in acute and minor illness hub.

The future plans were highlighted as follows.

- Existing services are business as usual, developing a strong track record of effective delivery
- Ready for investment and opportunities for further system collaboration

The Chair congratulated Dr Craig Gillespie, Rachel Stead and team on winning PCN of the Year award.

The Board thanked Dr Craig Gillespie and Rachel Stead for their leadership on this piece of work, congratulations were noted on winning their award.

It was noted that the planning guidance being released aligned well with this piece of work, self-assessments will be completed following the publication of the planning guidance.

The Chair highlighted that it is important to understand the progression and the lessons learnt with a piece of work to come back to a future Board meeting.

Leadership Reports

ICB/01/25/05 Report of the ICB Chief Executive

The Chief Executive highlighted the following to the Board.

The Chief Executive noted that the Board were asked to approve the recommendation to progress the next layer of delegation of Specialised Commissioning Services from NHSE, when established ICB took responsibility for local commissioning budgets CCGs used to hold, NHSE retain certain budgets. The Board were asked to approve this.

New government – the good news was highlighted with regards to the Secretary of State releasing a capital grant at the end of December 2024. Once the money arrived with hospices this was effectively a revenue income stream to support hospices.

The Board were asked to note the devolution white paper as published, with this to be discussed further in the coming months. Cheshire and Warrington colleagues have received support to progress this further, once established the NHS will continue to adapt and evolve the new strategic footprint for the planning of all public services.

NHSE are required to publish an annual assessment of ICB performance, the framework was yet to be agreed, however, in future years it is to resemble more of a league table, for the time being a narrative based assessment has been published with the key messages being highlighted to the Board and the full report has been published on the website. The Chief Executive was content this was a reasonable assessment of where the ICB were on its journey, and this was discussed openly with NHSE.

The ICB were out to consultation on gluten free products and what this will look like, the consultation has been published on the website the Board were also consulting on a number of policies across the ICB to achieve standardisation where historically there would have been idiosyncrasies over nine CCG's which is now one single statutory organisation, it is important to ensure policies and procedures reflect this.

Flu vaccine data has been shared and over the last month there has been a substational spike in flu, from UK HSA weekly surveillance reports there have been numerous hospital healthcare based outbreaks of flu spreading although staff absence data only runs until September, December and January figures should show the impact of staff sickness, the low level of uptake of the flu vaccine will become apparent in staff sickness levels.

Trusts were given additional funding; data shows huge variation, overall, very low staff uptake. Social media has had a significant impact on the public's appetite to engage in vaccination programmes, in terms of looking forward the Board must be positioned in a different way. It was highlighted that all Trusts have the resources in place and the offer available to their staff.

From a provider point of view the low uptake of flu vaccine has been in relation to staff and publics choice, this spike has particularly difficult. The consequences of low uptake of flu vaccination were different this year compared to previous years. In terms of media and communications the organisations were working hard in ensuring their staff received the vaccination. Lessons on this are to be learnt and brought back to the Board with the Director of Population Health to lead on this.

The Director of Population Health noted that a behavioural insights piece of work was to commence with staff to be spoken to, to better understand barriers and myths to visit fears of flu and Covid being together and the impacts of social media. It was suggested this be a topic at the next Trust's Chair's meeting. Director of Population Health to bring insights and plans back to June's Board meeting.

It was stated that there was no information on flu vaccination uptake within primary care providers, specifically care homes and domiciliary providers – wider view to be incorporated into the report.

Cheshire and Warrington have been invited to submit an expression of interest to be part of the Government's devolution priority programme, 12 Places across England have submitted expressions of interest. This will be significant for the ICB as Mayors and future Mayors will prefer to have more involvement from May 2026 in Cheshire and Warrington this could have an impact on the footprint of the current ICB arrangements.

Specialised Commissioning report – a point was raised in relation to the distribution of services within the CHARTS programme of care and mental health and the separation of CAHMS across three levels of ICS, North-West level and super regional which was children, assurance is to be received that there was good coordination of CAHMS services across those three levels. The Assistant Chief Executive noted that this will be discussed as part of the Joint Committee and work was already ongoing in terms of lead provider collaborative, local group called Specialist Commissioning Operational Group (SCOG), and this looks at what is internally commissioned from Cheshire and Merseyside (C&M) and how this is shared with colleagues wider. Assurance will be provided through the joint committee and SCOG which will be reported through the strategic tracker. The essence of this is the ICB become the decision makers, there is specialist knowledge in how the services are managed, services were being retained of NHSE team whereby NHSE will work for ICB on those decision making parts but will continue to work for NHSE on those services NHSE are decision makers on.

Decision
The Board **approved** the variation to the Specialised Commissioning Delegation Agreement set out in Appendix Two.

Action – the Director of Population Health to lead on a piece of work in relation to behavioural insights on flu vaccination uptake and for wider view of primary care providers to be incorporated. Report to come back to June's Board.

ICB/01/25/06 Report of the ICB Director of Nursing and Care

For the month of January, the Director of Nursing report highlighted three key areas.

- Patient Safety Strategic Development
- Special Educational Needs and Disabilities (SEND) Co-Production Charter
- Maternity Services at East Cheshire Foundation Trust

Patient Safety Strategic Development – an integral part of the ICB role as a strategic commissioner is to keep those who use the services it commissions safe, protecting patients from avoidable harm. The World Health Organisation (WHO) estimates that 50% of harm within health care is avoidable and avoidable harm is one of the biggest causes of mortality in health services alongside an increase in subsequent morbidity and psychological harm for both population and those delivering health and care services.

The ICB has adopted the AQUA framework in developing its strategic approach to system safety. A change in culture will require a focus on continuous improvement using an iterative cycle of change and improvement. AQUA describes using existing tools in a consistent and collaborative way across the system. System level programme was being developed which will include aspects from the AQUA framework and will be developed into a system safety plan linked to the commissioning priorities and the work on continuous quality improvement.

Within the ICB a patient safety specialist community of practice has been established which provides a forum for ongoing support and a sharing of understand and opportunities for improvement. Providers within C&M were demonstrating considerable expertise and experience within this area and there was an opportunity to share best practice to scale and spread across the system.

Next steps are there is to be a further presentation delivered to the February Quality and Performance Committee on development of system safety plan and oversight and monitoring of this will continue within the committee, further update to come back to a future Board.

The SEND Co-Production Charter – this was established by parent carer forum in October 2023 and is chaired by the Director of Nursing as the ICB Executive Lead for SEND and the group meets on a bi-monthly basis. The meeting provides a platform for parents and carers from the nine Places across C&M to communicate directly with the Executive Lead on a regular basis. The meeting ensures an awareness of current issues impacting on children and young people with SEND and their families and provides a regular opportunity to share lived experiences of SEND across the patch.

The Co-Production Charter was attached as Appendix One and this was referred to at each meeting and would replace the traditional Terms of Reference (TOR) and Memorandum of Understanding. Instead, the charter is intended to be used at the beginning of each meeting with the 'we will' section acting as a benchmark for co-production within the meeting.

Maternity Services at East Cheshire Foundation Trust (ECFT) – this section outlines the oversight of maternity and neonatal services and provides historic information with regards to the development of Local Maternity and Neonatal System otherwise known as LMNS. Previously, East Cheshire has been overseen and supported by Greater Manchester's LMNS service, to continue to provide assurances to the maternity and neonatal services the Board would like to bring East Cheshire maternity and neonatal services into C&M's ICB to support and oversee the developments within East Cheshire, this is to commence from 1st April 2025 and discussions have been held with Greater Manchester's ICB with a meeting being held with the Trust to discuss this further.

A point was raised with regards to the finances and that a proportion of money being lost could be avoided with avoidable harm. A cost can attributed to a fall with the financial cost of a fractured neck of femur multiplied by the number of falls occur that result in a patient having a fractured neck of femur this cost could be saved by the work to prevent falls within hospitals and across the wider system. Often the reasons for patients falling links across the significant number of multiple medications some of which interact and are associated with blood pressure dropping. From looking into the data C&M, the system has a high number of prescribing both opioids and patients on between 10-20 or more medications at one given time. There is a programme of medicines optimisation, this was currently being done well within Sefton and this will contribute financially and reduce the risk of harm associated with this – this continues to be an area of focus and investment with the data of impact to continue being sourced.

Freedom to Speak to Up to be included within the safety plan.

Actions –

- **Director of Nursing and Quality to seek international data and report back to the Board in future meetings**

ICB/01/25/07 NHS Cheshire and Merseyside Finance Report Month 8

The Executive Director of Finance provided the Board with an update on Month 8 financial position with the following being highlighted.

As of Month 8 the ICS system is reporting a year to date deficit of £129.5m against a planned year to date deficit of £62.1m, resulting in an adverse year to date variance of £67.4m – 1.3% of allocation.

Within table 1 of section 2.6 the ICB were currently forecasting at the end of November, a forecast adverse variance of around £72m against the full year budget which results in a deficit of around £223m across both the ICB and NHS provider position. There was a small improvement between Months 7 and 8.

In terms of the year-to-date deficit position, this was consistent with previous months reported on the ICB side a combination of costs associated with continuing health care, mental health packages and prescribing costs. Within the ICB, there were a series of actions and mitigations underway to cattail and improve areas of focus through performance and this was being managed through the recovery committee process with a range of mitigations in place to improve this for the remainder of Quarter 3 and into Quarter 4.

With regards to provider financial performance, there was a combination of issues and costs associated with industrial action, pay award cost pressures, non-delivery of efficiency savings set out at the beginning of the financial year and several individual factors.

The ICB routinely monitor lots of information specifically around agency, workforce training and CIP delivery and cash which remains a challenge for several provider Trusts – important to ensure that as a system the pressures were mitigated.

The ICB were currently forecasting a risk adjusted position of £32m against its planned surplus of £62m, this will result in a £30m surplus at the end of the financial year.

It was reported that Month 9 does align with Month 8, this provides the ICB with a level of credibility that the forecast does remain true, however, improvements were looking to be made with partners across the system.

Updates will continue to be reported to the Finance Committee and to the Board during the remainder of the financial year, close conversations were ongoing with NHSE regarding forecast outturn position and available mitigations to close the gap on the financial position.

The Chief Executive noted that this financial year is expected to be last unusual year due to the way the NHS nationally managed resources off the back of the Covid campaign, next year during financial discussions there will be no money left for the systems. There have been pay disputes across each staff groups which was settled at levels beyond any contingency each ICB could have held – issues with inflation associated with world events and prices. A report is to be presented against an agreed plan of £150m deficit, the ICB regularly meeting with NHSE who have provided a number which would be the acceptable landing position for year-end – the same number has been provided to each ICB across the country. NHSE have agreed a target of £200m deficit, with two months remaining of the financial year £20m of improvement is to be sourced. There was a significant amount of work ongoing across the patch to source the final £20m.

The current financial year has had significant differences to previous financial years, the underlying position along with progress is to be improved.

Financial reporting is good; however, financial deficits question the quality and safety and patient care. The focus must be on community work given there were not enough hospital beds – in-year position and the target to be the focus for the next financial year.

Repayable – there are a set of rules within the operational guidance with this to be brought back to the next Board meeting as this will form a feature of next year's financial plan, it will be capped at a certain level around 0.5% of overall allocations, for next financial year around £30m will need to be repaid which will continue for several years. The level of spend will be higher than allocation with distance from target and convergence which will hamper the organisation moving forward.

Local level was currently seeking long term relationships as well as planning for longer term investments and dividends.

The Chair requested a medium-term financial plan be in place in a level of detail that provides the Board with a level of assurance.

3-year financial plan (medium term) to be the first iteration into the new financial year. Messages to be circulated to Trust Chief Executive's and Chairs with regards to the medium term, some organisations have 3-year financial plans in place with majority of Trusts looking to be back at pre-Covid financial plans.

The Board **accepted** the report.

ICB/01/25/08 Highlight report of the Chair of the ICB Finance, Investment and Resources Committee

An investment was being made to ring fence longer term digital aspirations and was around c£8m and was in relation to population health – data interaction, shared care records and research and innovation.

The Board **accepted** the report.

ICB/01/25/09 NHS Cheshire and Merseyside Integrated Performance Report

There have been several new additions added to the performance report following endorsement from the Quality and Performance Committee as part of the rolling development to improve visibility of all sectors – mental health, community, health inequalities indicators. Next steps will be to improve primary care visibility.

Urgent care – 92% of general acute bed occupancy has been achieved prior to the festive period – more beds had been opened than previously planned and non-criteria reside rate was the lowest for this year and an improvement from last year. Over that December period certain parts of the system felt pressures emerging which was mainly as a result acuity there was a peak just into January with seasonal flu and other aspects, which resulted in a slow-down in discharges between Christmas and New Year. During the week commencing 6th January three critical incidents declared across the patch – Liverpool St Helens and Wirral, in line with normal emergency procedures systems converged to co-located and implemented measures to address the challenges. Steps involved a high number of patients being cared for in corridors, there long waits within A&E departments with patients being discharged to social care settings temporarily prior to transfer to suitable settings – those settings were of high acuity as opposed to low.

There was a notable change in public behaviour with a drop in walk-in attendances and a significant drop in low acuity within those A&E departments over the time of the critical incidents and there has been no bounce back of those A&E departments. By 10th January all 3 systems had met the criteria to deescalate the incidents, by 13th January the positions had been maintained and formal decision was taken to step the incidents down, Category 2 response time for ambulance calls were at 35 minutes, NWAS support was overwhelming and put out double crews during the critical incidents and allocated their resources accordingly. Peak of winter has now passed, however, remains a challenging period across sectors.

The ICB and partners are expected to face challenges during the month of March specifically with four-hour A&E standards of 78% being delivered and Category 2 ambulance response calls.

The Board will be provided with regular updates through appropriate committees.

Response stage – individual support stood up across each of the incidents, exceptional ways of working, deferring elective care ensuring doctors and nurses could be moved around to other parts of the hospital. Ongoing narrative is those patients who are on the floor at home and the importance of ensuring ambulances are sent out to those patients in a timely manner. The triumvirate of care is also important, those senior doctors, nurses and operational colleagues come together, regular meetings have been held to objectively measure where the risk is within the system – high risk health within A&E departments. The ability to better share risk requires the triumvirate to drive those changes through, step one risk was formally measured now how to share and mitigate the risk, the stepwise plan is that this is taken into one of the single organisations to test this through, rapid cycles of change and improvement working with one trust which then moves to up to the entire system, conversations have been held with the national team who have expressed intense interest when raised at a national

meeting each system has the same challenge – the ICB were looking to lead the way on this and will keep Board informed on the lessons learnt and how to make this stick to share risk.

Report is developing well with a significant amount of data included, dedicated time to look at performance report to understand the next stage of the development. The Board were supportive of discussing this further at February's Development Board.

The Board **accepted** the report.

ICB/01/25/10 Highlight report of the Chair of the ICB Quality and Performance Committee

Hospice provision – the report covered the 11 adult hospices, one children's hospice and one infant/baby hospice within the system. It was identified that there was variation within funding arrangements with all hospices relying on additional charitable funds to deliver their services. The services vary and were mostly limited-service specifications allowing hospice provision to fluctuate without contractual oversight.

The report also highlighted proposed changes to the Terms of Reference (TOR) for the Committee which were being recommend for approval by the Board.

The Board **approved** the recommended changes to the Committee TOR.

ICB/01/25/11 Consolidated report of the ICB Directors of Place

Place Partnership Boards are held regularly, with a whole range of topics being discussed, support for local authority colleagues in terms of CQC inspections that have taken place or yet to take place, how to work with social care colleagues.

In terms of health inequalities there was a wide range of activity within these spaces – health inequalities around mental health and how the health inequalities funds were being used within this space. Knowsley and Wirral have reported on progress in relation to severe mental health annual mental health checks with significant progress being made on this.

Patient discharge and flow – significant amount of partnership work is ongoing in Places specifically with the local authorities.

Children and young people – this topic has received a significant amount of attention within the partnership boards, there was a recovery programme within this space. Knowsley were currently working on section 75 for children and young people. Work was progressing with commissioners from both the ICB and the local authority to understand and agree priorities for the borough.

The psychological support and recovery as part of the Southport incident was highlighted to the Board, within the report there was a paragraph highlighting the outstanding psychological support for those families who were affected. Substantive item has been deferred to a future Board meeting. In terms of outlining recovery priorities in relation to Southport major incident, an appropriate accessible effective family led support for children and their families to ensure easy access to full graduated offer to practice psychological support, ensure resilience was being built within communities and community leadership to deal with long term impact and hate crime councils were leading on that piece of work with partners, mitigate short term impacts and ensure long term successive regeneration projects and the wider Southport economy and the impact of the incident building in a memorial. A strategic framework has been developed off the back of the major incident following in-depth and sensitive discussions with those affected.

In terms of current position, a council cabinet paper that was discussed at a cabinet meeting in January and will be circulated with the minutes for the Board and a local child safeguarding practice review will be taking place in February.

In terms of assurance from Sefton Place and Sefton Council, the public were continuing to receive support for those affected by the events on 29th and 30th July.

Integrated communications plan was in place to ensure information was disseminated to the public. Alder Hey, NHS colleagues, primary care, Merseycare were thanked for their continued support.

The Chair highlighted that reports that have been presented recently by Place Directors highlight the significant improvement in intelligence and highlighting the overall good work taking place in all nine Places. The Chair requested a better understanding of the metrics, the variation and the performance both population level and processes received, overall, this is an informative report and helps the Board understand what is going on at a Place level.

The Board **accepted** the report.

ICB Committee AAA Reports – matters of escalation and assurance

ICB/01/25/12 Highlight report of the Chair of the ICB Remuneration Committee

The Remuneration Committee received a report on the appointment of the new Chief Executive, the Committee approved the proposed salary range for the Chief Executive position and agreed the establishment and composition of the appointments panel to oversee and support the Chair in the appointment process.

The Board **accepted** the report.

ICB/01/25/13 Highlight report of the Chair of the ICB Audit Committee

Audit Committee was on track with nothing specific to highlight.

The Board **accepted** the report.

ICB/01/25/14 Highlight report of the Chair of the ICB System Primary Care Committee

Primary Care meeting was held in December, there was a robust primary care workforce discussion on the pressures and how they were being managed.

New agenda items were being added to the Primary Care Committee and they were highlighted as follows.

- Primary Care digital strategy updates
- Strategic estates
- Freedom to Speak Up

Review of current primary care access is to be undertaken with Healthwatch attending in February and to come to Board in March.

The Board **accepted** the report.

ICB/01/25/15 Highlight report of the Chair of the ICB Women's Hospital Services in Liverpool Committee

The Terms of Reference have had their annual review, and the Board was asked to approve the amendments made within the TOR.

The Board **accepted** the report.

The Board **approved** the amendments to the Committee TOR.

ICB/01/25/16 Highlight report of the Chair of the ICB Strategy and Transformation Committee

The Board **received** the highlight report of the ICB Strategy and Transformation Committee with the following being highlighted.

A detailed updated was received on the work progressing on specialised commissioning and some key disease group areas, the importance of looking at the whole pathway became apparent.

The ongoing work within integrated neighbourhood health and current position of community services which provides a good baseline for plans in the future.

The Board **accepted** the report.

ICB/01/25/17 Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership (HCP)

The Health and Care Partnership received a good presentation from the Police and Crime Commissioners in relation to service violence prevention. It was recognised by members that a partnership approach was required to address serious violence via a public health approach including undertaking early prevention work with identified vulnerable individuals at risk of criminality.

Health and housing partnership was launched which covered a whole range of areas.

Draft green plan was received and is to be discussed at Board in March, this will now commence moving through internal governance processes.

The Board **accepted** the report.

ICB Business Items and Strategic Updates

ICB/01/25/18 NHS Cheshire and Merseyside Freedom to Speak Up Update

NHSE outlined its expectations of ICB's and ICSs in relation to Freedom to Speak Up and they are working with the National Guardian's Office.

The ICB were advised that arrangements should be put into place in place for system partners and primary care by 2026 and work was currently underway to provide assurance on this area.

Updates were made regularly to People and Audit Committee explaining the organisations responsibilities in relation to FTSU and setting out the intended approach to developing FTSU arrangements across the ICB and progress made against those plans.

The ICB submitted a self-assessment and reflection tool in January 2024 with assessment attached within Appendix One. The self-assessment is to be repeated in January 2026 to show an improved position.

Several areas for improvement were identified and actions have been taken to address these. Good progress has been made in developing internal FTSU arrangements and updates were now reported through People Committee, with an annual report on effectiveness of arrangements presented to Audit Committee.

Current reporting for 2024/25 was 29 having previously been none, the number of FTSU cases reported has increased steadily since the recruitment of the FTSU Guardian lead who has continued to raise the profile of FTSU across the ICB.

The FTSU Guardian Lead was looking at how to make different routes clearer of speaking up – icon to be on the desktop so staff can click on the icon.

Since the recruitment of the FTSU Guardian Lead, a significant amount of work has been undertaken to promote FTSU – roadshows and highlighting to staff the importance of being able to speak up. There is limited resource from NHSE and have asked the ICB to look at the following: organisation, primary care – supporting primary care and helping support wider system.

The FTSU Guardian was thanked for the significant amount of work that had been undertaken.

The Board **accepted** the report.
The Board **noted** and **endorsed** the action plan.

ICB/01/25/19 NHS Cheshire and Merseyside ICB Board Assurance Framework and Corporate Risk Register 2024-25 Quarter Three Update

There were currently 10 principal risks including, one critical risk, five extreme risks and four high risks. Of those, seven were at the agreed target for 2024/25 and the focus will be on assurance that controls remain effective and on continuing to progress actions to further mitigate the risk over the longer term. The remaining three were above the agreed target or 2024/25. Despite the actions being taken, it was anticipated that reductions in P3 and P5 will take longer to achieve and therefore revisions to the current year targets were proposed.

Since November, P3 around finances and ICSs ability to achieve statutory duty has been reduced from critical to extreme.

Quarter 4 Board Assurance Framework (BAF) is to be presented at May's Board which will complete the 2024/25 financial year alongside the BAF for 2025/26 and for this to form framework for Board development.

The Director of Finance highlighted that the risk description was not clear with a mix of ICS and ICB and wording, i.e., statutory and break even. Provider Trust do not have same statutory duty and have going concern.

Elective care – likelihood and impact score to be amended. The Board accepted this, and changes will be made accordingly.

It was noted that this to be discussed through CMAST.

The Chair expressed his thanks to the Assistant Chief Executive and Associate Director of Corporate Affairs and Governance for the report.

The Board **accepted** the report.

The Board approved the Q3 Board Assurance Framework

ICB/01/25/20 NHS Cheshire and Merseyside ICB Corporate Risk Register 2024-25 Quarter Three Update

The 15 risks were detailed within Appendix 1 of the report, four were critical and 11 were extreme and summarised within the report.

Since November, several risks have been escalated and will be discussed through Quality and Performance Committee.

The Board **accepted** the report.

The Board approved noted the ICB Corporate Risk Register.

ICB/01/25/21 Reforming Elective Care for Patients in Cheshire and Merseyside

The Department for Health and Social Care and NHSE published reforming elective care for patients on 6th January 2025, the national plan sets out the following key commitments.

- NHS will meet 18-wek standard by March 2029
- By March 2026 the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally.
- Each Trust will be expected to achieve sufficient increases annually to reach 92% in 2029.

Initial assessment of the ask in terms of forthcoming expectation of delivering 65% RTT performance is the system currently sit at 57%, within this it has expectations that if one Trust is delivering the standard there is still an expectation, they will receive 5% improvement from where they currently are.

In terms of the maths, based on waiting list size c43,000 would need to be treated, last year there was a change of 7,000.

The elective reform plans were highlighted within the report. Over the last several weeks, CMAST have been taken the opportunity down to a granular opportunity with the ICB working to bridge this gap. This is purely dependent on financial allocations with some this unknown, cap for ERF is likely to continue into next financial year.

Previously providers were assured that by completing extra activity the provider would be financially remunerated for this.

Productivity is to improve be and higher up on the agenda, further work to be done on this with meetings being held with GIRFT to discuss this further. CMAST has been completing work on pathways – transformation side, CMAST has chosen its specialities for those with longer waiting lists of fragile services. Background analysis has been completed prior to planning guidance being released with a report to come back in March.

NHSE recommendations outline advice and guidance, alternatives, different settings and patient reported outcomes, important to ensure the correct people and patients were being treated.

First 1,000 high risk patients have been taken through pre-habilitation and those patients come from the most deprived backgrounds, digital first approach has been taken with the uptake being the same across the groups – can demonstrate that the system were working well within that space.

Within the new planning guidance there is to be a requirement for transformation plans around five named care pathways, the Chief Executive is requesting a sixth named care pathway which is to be gynaecology. There is a new target that has been set within the new planning guidance for this coming year.

From a general practice perspective GPs are to be funded £20 per each advice and guidance from the upcoming financial year, however, concerns have been raised as to whether GPs will manage complex patients that would usually be treated within secondary care.

The Board **accepted** the report.

ICB/01/25/22 Cheshire and Merseyside Cyber Security Update

Following two high profile cyber-attacks which impacted several Trusts in C&M during December 2024, the report highlighted the nature of the incidents, the initial assessment of impact and emerging lessons learned.

There were five national strategy themes, and they were highlighted as follows.

- Focus on the greatest risks and harms
- Defend as one
- People and culture
- Build secure
- Response and recovery

Progress has been made in year on incident management protocols and how to respond to an incident in an organised manner.

Cyber plan will continue to be progressed with limited resources available.

Learning from recent incidents and subsequent detailed advice from the national Cyber Security Lead gives the ICB a clear set of ‘good housekeeping’ areas of focus, if applied rigorously will protect against the efforts of most malicious threat actors.

In late 2024, there were two significant cyber incidents, one at Wirral University Hospitals and the other at Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital (LHCH) via a shared digital infrastructure.

The Wirral incident caused the organisation to take their core Electronic Patient Record (EPR) system offline while forensic investigation and remediation took place. The process along with preparations to get the EPR back online took around eight days. The activity was picked up early and allowed early pre-emptive decisions to be taken by the Trust and this triggered business continuity processes which resulted in some patient activity being cancelled and rescheduled.

The Alder Hey and LHCH incident had significantly less disruption to clinical services with alternative solutions being provided to clinicians in a matter of hours. However, data was stolen belonging to patients from LHCH and Liverpool University Hospitals, a small sample of which was published online.

The incidents occurred during a period of extreme pressures in the unplanned and emergency care system and so consequently it was classified as a single level 3 critical incident managed through regional EPRR team.

Although the two cyber attacks happened in quick succession and root cause analysis and recovery efforts were managed in parallel, national colleagues involved could see no evidence to connect the two incidents and were felt to be unconnected.

There were a number of key learnings that came out of both incidents, and they were highlighted as follows.

- Incident plan was effective, responsibilities to be clarified and to be refined with stakeholders.
- Core team at ICS level, need to work with national team to see where this stops.
- Communication – national team brought a national cyber security operational centre; the support was comprehensive with multi agency response. System suppliers turned off key systems to maintain safety and security.
- Interlinked organisations across C&M particularly Trusts with shared infrastructure.
- Moving into a world providing larger shared systems – PACS and laboratory systems, impact with an attack is significantly higher.

The overall risk was resources and funding.

CIO from Clatterbridge Cancer Centre (CCC) was leading on a piece of work and reporting back to CCC's Board on the progress.

In depth-discussions were held and it was agreed that further discussions be held in Private.

The Board **accepted** the report.

The Board **approved** the management plan.

ICB/01/25/23 Cheshire and Merseyside Data into Action Programme Update

Andrea Astbury, Data into Action Programme Manager, C&M and Jim Hughes, Strategic Advisor Digital Data Programmes, Merseycare joined the meeting to present Data into Action Programme.

In April 2024 the Board agreed to formalise Data into Action Programme and requested it be reported to Board twice a year.

The Board were asked to embed this onto business as usual and for governance to be embedded within all Places and using health intelligence in the most meaningful way.

The Chair highlighted the remarkable progress that has been made over the last 12 months.

Following the presentation in-depth discussions were held.

The Board **accepted** the report.

ICB/01/25/24 Update on Cheshire and Merseyside Neurodiversity Recovery Programme

Laura Marsh, Dr Chris Pritchard and Dr Chris Wee joined the meeting to present the neurodiversity recovery programme.

This was currently a top priority to resolve and important to understand extent of resources available and how quickly this is commenced.

Clarification on next steps to be discussed with the Executive team.

The Board **accepted** the report.

Meeting Governance

ICB/01/25/25 Minutes of the Previous Meeting: 28th November 2024

The Board reviewed the minutes of the meeting held on 28th November 2024.

The minutes of the November 2024 NHS C&M ICB Board meeting were approved as an accurate record.

ICB/01/25/26 Board Action Log

The Chair noted that good progress had been made on the action log with some actions being cleaned up.

Reflection and Review

ICB/01/25/27 Closing remarks and review of the meeting

The Chair closed the meeting.

Consent Items

ICB/01/25/28 Board Decision Log

The Board Decision Log was noted.

ICB/01/25/29 Confirmed Minutes of ICB Committees

- Audit Committee – September 2024
- Children and Young Peoples Committee – August 2024
- Finance, Investment and Our Resources Committee – 2024
- Quality and Performance Committee – November 2024
- Strategy and Transformation Committee – November 2024
- System Primary Care Committee – October 2024
- Women's Hospital Services in Liverpool Committee – September 2024
- Cheshire and Merseyside Health and Care Partnership – October 2024

CLOSE OF MEETING

Date of Next Meeting:
Thursday 27th February 2025, 9am-4.30pm, Liverpool Venue TBC.

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2023 - 2025

Updated: **13.03.25**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
IBC-AC-22-69	25/01/2024	**NHS C&M Quality and Performance Report**	Board to receive information on secondary prevention measures in primary care (link to QOF)	Clare Watson	Mar-25	*Discussion ongoing with Performance team regarding access to reportable data that can be included within the integrated performance report. Data metrics will be agreed at System Primary Care Committee and then update to be provided to the Board*	ONGOING	
IBC-AC-22-71	25/01/2024	**Report of the Directors of Place**	Board to receive a high level summary report at its November 2024 meeting on the Operating Model for Place, an understanding of the maturity of each , the learning across each Place and a focus on the priorities of each Place to drive out unwarranted variation	Graham Urwin, Clare Watson	Nov-24	*Deferred to February 2025*	ONGOING	
ICB-AC-21-75	28/11/2024	**NHS Cheshire and Merseyside Integrated Performance Report**	The Director of Performance and planning to look at the data that is broken down through an equality lens to understand the experiences of people with protected characteristics, for regular reporting back to board.	Anthony Middleton	Jan-25	*Data capability and quality is being assessed. Initial data will be considered at Quality and Performance Committee with a view to incorporating into integrated Performance report to Bord or whether need to be a bespoke paper to Board on a cycle to be agreed. Update to be provided at March 2025 Board.*	ONGOING	
ICB-AC-79	30/01/2025	**Chief Executive Report**	The Director of Population Health to lead on a piece of work in relation to behavioural insights on flu vaccination uptake and for wider view of primary care providers to be incorporated. Report to come back to a future Board.	Ian Ashworth	Jul-25	*Added to Forward Plan*	ONGOING	

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

CONSENT ITEMS

All these items have been read by Board members and the minutes of the March 2025 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/03/25/19	Board Decision Log **(CLICK HERE)**	For information	-
ICB/03/25/20	NHS Cheshire and Merseyside Green Plan 2025-28	**Board decisions within:** **ICB Green Plan** - *recommendation from the System Sustainability Board for the ICB Board to* ***approve the NHS Cheshire and Merseyside Green Plan 2025-28***	Page 377
ICB/03/25/21	Emergency Preparedness Resilience and Response Core Standards 2024-25 Assurance Report	For assurance • ***note*** *the contents of the report* • ***note*** *the significant improvement on the 2023/24 self-assessment compliance rating.*	Page 395
ICB/03/25/22	ICB Committee Chairs Highlight Reports: • Audit Committee *(ICB/03/25/22a)* • Children and Young Peoples Committee *(ICB/03/25/22b)* • Finance, Investment and Our Resources Committee *(ICB/03/25/22c)* • Quality and Performance Committee *(ICB/03/25/22d)* • Remuneration Committee *(ICB/03/25/22e)* • System Primary Care Committee *(ICB/03/25/22f)*	**Board decisions within:** **Audit Committee Chairs Highlight Report** – *recommendation from the Committee for the ICB Board* ***to approve the minor amendments to and the adoption of the updated ICB Scheme of Reservation and Delegation (SORD) and ICB Operational SORD***	Page 402

All these items have been read by Board members and the minutes of the March 2025 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.			
AGENDA NO	**ITEM**	**Reason for presenting**	**Page No**
ICB/03/25/23	**Confirmed Minutes of ICB Committees** **Click on the links below to access the minutes:** • Audit Committee – Dec 2024 (**CLICK HERE**) • Children and Young Peoples Committee – Nov 2024 (**CLICK HERE**) • Finance, Investment and Our Resources Committee – Jan 2025 **(CLICK HERE)** • Finance, Investment and Our Resources Committee – Feb 2025 **(CLICK HERE)** • Quality and Performance Committee – Jan 2025 **(CLICK HERE)** • Quality and Performance Committee – Feb 2025 **(CLICK HERE)** • System Primary Care Committee – Dec 2024 **(CLICK HERE)**	For assurance	Page 376

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

NHS Cheshire and Merseyside Green Plan

Agenda Item No: ICB/03/25/20

Responsible Director: Clare Watson, Assistant Chief Executive

NHS Cheshire and Merseyside Green Plan

1. Purpose of the Report

1.1 The purpose of the Green Plan is to support the NHS' ambition to become the world's first net zero carbon health service by 2040, addressing climate change whilst improving patient care and community wellbeing. The ICB plays a critical role in co-ordinating efforts across Cheshire and Merseyside to reduce greenhouse gas emissions, promote sustainable practices, and adapt to the impacts of climate change.

The Green Plan has been brought to this Board as NHS England has mandated that all ICB and Trust Green Plans have Board sign-off.

2. Executive Summary

2.1 The Executive Summary has been appended (Appendix One).

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- **approve** the NHS Cheshire and Merseyside Green Plan.

4. Reasons for Recommendations

4.1 **Environmental impact:** It demonstrates a commitment to reducing carbon emissions and aligns with NHS England net zero carbon goals and contributes to global climate action.

4.2 **Health improvements**: The plan supports better public health outcomes and reduces the burden of climate-related illnesses.

4.3 **Cost savings**: Energy efficient practices, waste reduction and sustainable resource use can lead to significant financial savings.

4.4 **Resilience and adaptation:** Preparation for climate change impacts safeguards patient care and operational continuity.

4.5 **Leadership and reputation:** Approving the Green Plan positions the ICB as a leader in sustainability, enhancing its reputation amongst stakeholders, patients and the wider community.

4.6 **Staff engagement:** It fosters a sense of purpose and pride and encourages innovation and collaboration in achieving sustainability goals.

4.7 **Compliance and funding:** It ensures alignment with national and international climate targets, potentially unlocking access to funding and resources for green initiatives.

5. Background

5.1 The draft Green Plan (2025-2028) has been circulated widely and has been endorsed by the Sustainability Board.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective 1: **Tackling Health Inequalities in access, outcomes and experience**
Reducing carbon emissions and expanding green spaces improves air quality, particularly in underserved areas disproportionately impacted by pollution. By prioritising digital health solutions and community-based care, we ensure equitable access for vulnerable populations. Our focus on prevention and health education reduces outcome disparities, while patient-centred care promotes inclusive experiences. This approach aligns environmental sustainability with advancing health equity.

Objective 2: **Improving Population Health and Healthcare**
Green Plan deliverables enhance population health by fostering sustainable, healthier communities. Initiatives such as active travel promotion and the development of green infrastructure encourage physical activity and mental wellbeing, reducing the burden of lifestyle-related diseases. By embedding sustainability into our operations, we support long-term resilience against climate-related health risks, such as heatwaves and infectious diseases. Collaborative partnerships with local authorities and community organisations enable us to address wider determinants of health, such as housing and employment, creating conditions for healthier lives. Together, these efforts contribute to a proactive, holistic approach to improving population health and wellbeing.

Objective 3: **Enhancing Productivity and Value for Money**
Transitioning to low-carbon technologies and energy-efficient infrastructure lowers operational expenses. Digital innovation and sustainable practices streamline processes, reducing waste and improving service delivery. Preventative health measures and community-based initiatives decrease demand for costly acute interventions, ensuring optimal use of public funds. These strategies support financial sustainability while delivering high-quality, cost-effective healthcare.

Objective 4: **Helping to support broader social and economic development**

The Green Plan supports social and economic development by investing in green infrastructure and low-carbon technologies, creating jobs and stimulating local growth. Collaborations with partners address wider determinants of health, fostering inclusive development. By reducing the burden of preventable illnesses, we enable individuals to thrive, aligning healthcare sustainability with regional prosperity.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 NHS Cheshire and Merseyside's Green Plan is closely aligned with its Annual Delivery Plan, as both frameworks aim to improve health outcomes, reduce inequalities, and ensure the sustainability of healthcare services.

7.2 Integration of Sustainability Goals: The Green Plan emphasises reducing carbon emissions, improving resource efficiency, and preparing for climate change, which are integrated into the Annual Delivery Plan to ensure sustainable healthcare delivery. The Annual Delivery Plan incorporates specific actions from the Green Plan to achieve both environmental and operational efficiency.

7.3 Health Inequalities and Social Value: Both plans address health inequalities by focusing on the wider determinants of health, such as air quality and access to green spaces. The Green Plan's initiatives are reflected in the Annual Delivery Plan as measures to improve community health and wellbeing. The Green Plan also embeds social value into its strategies, which is mirrored in the Annual Delivery Plan through partnerships with local authorities and community organisations to deliver greener and more equitable healthcare services.

7.4 Operational Efficiency and Cost Savings: The Green Plan's focus on reducing waste and improving resource efficiency directly supports the Annual Delivery Plan's objectives to optimise operational costs. By aligning sustainability efforts with financial goals, the Green Plan ensures that the Annual Delivery Plan achieves both environmental and economic benefits.

7.5 Collaboration and Partnership: The Green Plan highlights the importance of collaboration with partners, including local authorities, suppliers, and community groups, to achieve sustainability targets. This collaborative approach is also a cornerstone of the Annual Delivery Plan, ensuring that sustainability initiatives are scaled and integrated across the region.

7.6 Climate Adaptation and Resilience: The Green Plan's focus on preparing for climate change, such as improving infrastructure resilience and reducing air pollution, is reflected in the Annual Delivery Plan's emphasis on adapting to extreme weather events and ensuring the continuity of healthcare services.

7.7 In summary, NHS Cheshire and Merseyside's Green Plan is a foundational element of its Annual Delivery Plan, ensuring that sustainability, health equity,

and operational efficiency are central to the region's healthcare strategy. The integration of these plans demonstrates a holistic approach to delivering high-quality, sustainable healthcare services while addressing the challenges posed by climate change.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

The CQC's quality statements focus on equity in access, experience, and outcomes, as well as safeguarding and effective staffing. The Green Plan supports these goals by:

- Reducing Health Inequalities: The Green Plan addresses the wider determinants of health which directly impact health outcomes and equity.
- Sustainable Models of Care: By promoting low-carbon healthcare practices, the Green Plan ensures that services are not only safe but also environmentally sustainable, aligning with the CQC's focus on equity in access and outcomes.

Theme Two: Integration

The CQC emphasises safe systems, pathways, and transitions, as well as how staff, teams, and services work together. The Green Plan supports integration by:

- Collaborative Partnerships: The Green Plan highlights the importance of working with local authorities, suppliers, and community groups to achieve sustainability goals. This collaborative approach mirrors the CQC's emphasis on integrated care and partnership working.
- Cross-Organisational Decision-Making: The Green Plan encourages shared responsibility for carbon reduction and sustainability across the ICS, ensuring that all partners align their efforts to deliver seamless, person-centred care.

Theme Three: Leadership

The CQC's leadership theme includes governance, sustainability, and environmental responsibility. The Green Plan directly supports this by:

- Environmental Sustainability: The Green Plan outlines commitments to reducing carbon emissions, improving resource efficiency, and preparing for climate change. These actions align with the CQC's focus on sustainable development and governance.
- Strategic Oversight: The Green Plan provides a framework for ICSs to oversee and support Trust-level sustainability initiatives, ensuring that leadership at all levels is aligned with national net-zero ambitions.

9. Risks

9.1 The climate crisis is an existential threat. There can be no greater risk to public health across Cheshire and Merseyside and to the delivery of health and care services by the ICB and its partners.

9.2 Global warming must be limited to a temperature rise of 1.5ºC to prevent catastrophic health impacts and avoid millions of climate change related deaths. However, the planet is currently on track to warm to 2.6ºC above pre-industrial levels by 2030. If the ICB and partners do not prioritise robust climate mitigation

and adaptation action the impacts will be severe and wide-ranging, with risks to infrastructure, supply chain, workforce, system capacity, IT, energy and financial sustainability.

10. Finance

10.1 Whilst the Green Plan has not been costed due to the significant financial challenges facing our system, it underscores our commitment to aligning with the NHS's net-zero ambitions and improving the health and well-being of our communities. Heat decarbonisation, alongside efforts to improve air quality and deliver social value, represent a strategic priority to future-proof our infrastructure, reduce long-term operational costs, and mitigate climate-related risks. These initiatives are not only critical for environmental sustainability but also offer opportunities to enhance resilience and efficiency in the face of rising energy prices and evolving regulatory requirements. As we navigate our financial constraints, we will explore innovative funding mechanisms, partnerships, and phased approaches to ensure progress towards our sustainability goals, whilst safeguarding the delivery of high-quality patient care.

11. Communication and Engagement

11.1 The refreshed Green Plan has been shared with Trust sustainability leads; Sustainability Board (includes CICs, VCFSE; NW Green Public Health group; Cheshire and Merseyside Greener Practice; regional sustainability colleagues; C&M LA air quality leads; LA sustainability colleagues; embedded travel and transport strategy shared with Disability and Neurodiversity staff group and NHS England's Net Zero Travel and Transport lead; Place leads; Strategic Estates Board; presentation given to Cheshire East GP practice managers.

12. Equality, Diversity and Inclusion

12.1 The Green Plan actively supports equality, diversity, and inclusion by addressing the root causes of health inequalities, engaging diverse communities, promoting social value, and ensuring that sustainability initiatives are accessible and equitable. By embedding EDI principles into its strategies, the plan ensures that the benefits of environmental sustainability are shared by all, particularly those who are most vulnerable or marginalised. This approach aligns with the NHS's broader commitment to reducing health disparities and creating a fairer, more inclusive healthcare system.

13. Climate Change / Sustainability

13.1 The refresh of the Green Plan shows a continued commitment to sustainability

14. Next Steps and Responsible Person to take forward

14.1 Following Board approval the new Green Plan will come into effect from 01 April 2025. A series of engagement sessions will be planned for staff by the Sustainability Team.

15. Officer contact details for more information

Mandi Cragg, Sustainability Programme Manager,
mandi.cragg@cheshireandmerseyside.nhs.uk

16. Appendices

Appendix One: Green Plan Executive Summary

NHS
Cheshire and Merseyside

Green Plan Executive Summary

2025-2028

Contents

Foreword

In March 2022 the first Cheshire and Merseyside system Green Plan was published, mere months before the establishment of the new integrated care system (ICS). The Plan reflected the Green Plans of NHS trusts, local authorities and partners from across Cheshire and Merseyside and commented on system-wide priorities and co-ordination. It also laid out the strategic path, directing discussions across the system and detailing specific steps to lower carbon emissions, increase environmental awareness, and eliminate unnecessary duplication.

Our Green Plan has been refreshed for 2025-2028, and we remain absolutely committed to ending our contribution to climate change by 2040 in line with the national ambitions of NHS England. As an organisation, we are committed to working individually as well as at Place and System level. Since the adoption of the first iteration of our Green Plan we have actively engaged with partner organisations to establish system priorities and have been working towards delivering them. This exemplifies the collaborative efforts of Cheshire and Merseyside ICS in mitigating our carbon footprint, reducing health inequalities, and enhancing social value.

From reducing single-use plastics to implementing energy-efficient systems, every step we take is designed to minimise our environmental impact. But our commitment goes beyond just environmental sustainability - we also create social value by partnering with local organisations and supporting initiatives that benefit the community. As an anchor institution, we have a unique opportunity to effect positive change. By leveraging our resources, expertise, and influence, we can drive economic development, promote social equity, and improve overall wellbeing.

This approach recognises climate change as the most significant health and human rights issue facing us today, and the transition to net zero as an opportunity to tackle inequalities and the wider determinants of health. It is an approach that is fundamentally important to the future survival of the NHS, the population, and the planet.

We invite all our stakeholders - from employees to patients to partners - to join us in this important journey.

Raj Jain
Chair

Graham Urwin
Chief Executive

Dave Sweeney
AD Partnerships & Sustainability

1. What is the Green Plan?

Climate change is the greatest health threat facing the world, but it also offers the greatest opportunity for us to redefine the social and environmental determinants of health in order to provide sustainable health services across Cheshire and Merseyside and to deliver the ambitions as set out in Delivering a Net Zero National Health Service, namely:

- *For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2028 to 2032.*
- *For the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction (from 1990 levels) by 2036 to 2039.*

This Plan outlines our commitment to deliver sustainable and high-quality services and highlights how we work with our partners to positively impact the wider determinants of health to address health inequalities and to embed social value. Together with our Social Value Charter and Anchor Framework, our Green Plan is aligned to the United Nations' Sustainable Development Goals, and we will continue to work with our partners to encompass these at the heart of our work.

The key elements:

- To ensure NHS Cheshire and Merseyside aligns with the wider NHS ambition to be the first healthcare system in the world to reach net zero carbon emissions.
- Prevention and wellness: Preventive care lessens the burden of chronic diseases and enhances overall public health. Implementing prevention/ early intervention strategies, reduces the need for costly treatments and hospital admissions, leading to better patient outcomes.
- Resource management: Minimising waste and enhancing efficiency reduces costs and greenhouse gas emissions. Traditional healthcare models have a significant negative impact on the environment.
- Integrated care: By breaking down organisational silos, the NHS and partners can improve care co-ordination, reduce duplication of services, and provide more holistic care to communities.
- Technology and innovation: Digital health solutions such as telemedicine, remote monitoring, and electronic health records can improve access to care, enhance communication between healthcare providers, increase efficiency, reduce costs, and empower patients to take control of their health.
- Engagement and collaboration: Involving local communities in decision-making ensures that services are tailored to meet their specific needs and preferences, and fosters a sense of ownership and accountability, leading to better health and wellbeing. Collaboration also helps in the efficient allocation of resources and development of innovative solutions to address healthcare challenges.

2. Areas of focus and Green Plan Actions

System leadership and workforce development

- Promote and engage staff in sustainable workplace activity and practices.
- Ensure sustainability is integrated into all decision-making processes.
- Work with partner organisations, stakeholders, and the local community to reach sustainability objectives.

Climate adaptation

- Establish a Climate Adaptation Committee to drive forward climate adaptation planning and actions across the NHS in Cheshire and Merseyside.
- Ensure direct and indirect climate risks are embedded into corporate risk assessments and business continuity plans.
- Assess the 'numbers behind future climate change'. Look at the impact on various metrics (excess deaths, buildings at risk, impact of heatwaves, economic losses etc.) that climate change may have if nothing were done (business as usual), versus effective adaptation.
- Embed climate adaptation into any natural environment / capital working groups.
- Prioritise measures such as improved drainage (SUDS), green infrastructure integration, cooling stations (water fountains / shaded benches).
- Initiate water saving programmes and reduce water usage.
- Assess the extent to which digital infrastructure, telecoms and ICT is considering future climate change projections.
- Identify infrastructure at risk of overheating and implement suitable measures to reduce the risk.
- Work with partners to ensure that climate risks are addressed and considered in the commissioning and provision of all health and care services and assets.
- Monitor changes in vector-borne diseases as a result of climate change to provide more accurate advice on where and when the likely hotspots in the region will be, and what to do if affected.

Air quality

- Agree a local NHS position statement on AQ and health to use our trusted voice as health professionals to influence wider action.
- Engage board level leads on air quality.
- Join up campaigns on indoor and outdoor air pollution with local authorities and VCFSEs.
- Explore how to improve indoor air pollution.
- Work with partners to explore sources of funding.

Biodiversity and nature recovery

- Complete green space mapping on larger Trust sites to identify and prioritise 15-20 areas for habitat creation.
- Establish biodiversity net gain targets and increase habitats for wildlife based on Trust mapping activity aligned and in collaboration with local nature recovery strategy (LNRS) priorities.
- Improve biodiversity through large-scale nature recovery projects in urban areas aligned with LNRS priorities.
- Prioritising the inclusion of green space and biodiversity in the design of all new buildings and refurbishments.
- Mapping nature based social prescribing opportunities on NHS sites.

Digital transformation

- Implement Electronic Patient Records (EPRs) in line with NHSE guidelines to reduce paper usage.
- Reduce use of paper for non-direct care processes within organisations across back-office functions.
- Expand the use of the Cheshire and Merseyside Shared Care Record to support reduction of paper based communications between health and care professionals.
- Complete rollout of patient empowerment portals (PEPs) into all NHS providers and further support patients to access health and care information through the NHS app.
- Continue roll-out of the remote monitoring platform for management of various long term conditions and for more Places to manage higher numbers of ‘at risk’ patients at their usual place of residence, reducing patient and care professional travel time.
- Evaluate other digital platforms ‘at scale’ for potential widespread adoption across C&M that reduce travel impact for staff and patients.

Estates and facilities

- C&M provider Trusts to finalise their heat decarbonisation plans.
- C&M Trusts to complete their waste stream supplier audit and eliminate all waste sent to landfill.
- Transition away from all fossil fuels including gas. (No new gas boilers 2025 □.)
- Develop implementation plan for transition to clean fuels.
- Providers and primary care to implement recommendations outlined within the Estates ‘Net Zero’ Carbon Delivery Plan (technical annex).
- Incorporate sustainable design into construction/ refurbishment of buildings / infrastructure using local businesses where possible.
- Planned preventative maintenance of facilities and assets should be energy focused.

Food and nutrition

- Organisations to monitor, manage and actively reduce their food waste from production waste, plate waste and unserved meals.
- Use seasonal ingredients from locally sourced suppliers and work with partners to identify opportunities for local and small to medium-sized enterprise food producers.
- Increase plant-based meal options for staff, patients and visitors.
- Educate patients on the link between food, health and obesity as well as the impact of food production on the environment.

Medicines, prescribing and anaesthetics

- Every provider Trust (using anaesthetics) to have a designated environmental anaesthetist lead.
- Support Trusts to reduce emissions from nitrous oxide and mixed nitrous oxide waste by 9-14% into 2024/25 against the 2023/24 baseline.
- Support Trusts to undertake Entonox waste audits.
- Work as a system to reduce the use of pressurised metered dose inhalers (pMDIs).
- Engage with patients to promote correct inhaler technique, self-management and adherence.
- Where clinically appropriate prioritise evidence-based therapies over pharmaceutical interventions and focus on the reduction of carbon emissions by medicines optimisation.
- Sustainability to be built into medicine purchasing decisions.
- Exploration with PCNs around ensuring the success of social prescribing is not simply measured in reduced GP visits and or/ take up of referrals.

Primary care

- Primary care practices to calculate their carbon footprints.
- Monitor and reduce energy use. Practices to move to 100% renewable energy tariffs where practicable.
- Procurement: primary care to reduce unnecessary purchasing and to choose sustainable options where appropriate.
- Primary care organisations to implement actions outlined within the 10-Point Plan for Primary Care.
- Primary Care buildings to have transitioned from fossil fuels by 2032.

Supply chain and procurement

- All NHS procurements to include a minimum of 10% net zero and social value weighting.
- From April 2024 all new procurements of high value (£5m p/a exc. VAT and above) and new frameworks operated by in-scope organisations, irrespective of the value, where relevant and proportionate to the framework, require suppliers to publish a Carbon Reduction Plan for Scope 1 and 2 emissions and a subset of Scope 3 emissions as a minimum (aligning with PPN 06/21).
- From April 2024 a Net Zero Commitment is required for procurements of lower value (below £5m p/a exc. VAT and above £10k exc. VAT).
- From April 2027 all suppliers required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions aligned to the NHS net zero target, for Scope 1, 2 and 3 emissions.
- Reconvene the ICS sustainable procurement group to drive the agenda across the system.
- Walking aid return and reuse schemes to be adopted by all C&M trusts issuing walking aids. *(If 2 out of every 5 walking aids were returned, the average hospital could save up to £46k p/a.)*

Travel and transport

- 2026: All vehicles offered in NHS vehicle salary sacrifice schemes to be electric.
- 2026: Sustainable travel strategies to be developed and incorporated into NHS organisations' Green Plans. (ICB has met the target.)
- 2027: All new vehicles owned / leased by the NHS will be zero emission (excluding ambulances).
- 2033: Staff travel emissions reduced by 50% through shifts to more sustainable forms of travel and the electrification of personal vehicles.
- 2035: All vehicles owned / leased by the NHS will be zero emission (excluding ambulances).
- 2035: All non-emergency patient transport undertaken in zero emission vehicles.
- 2040: All business travel and commuting will be zero emission.

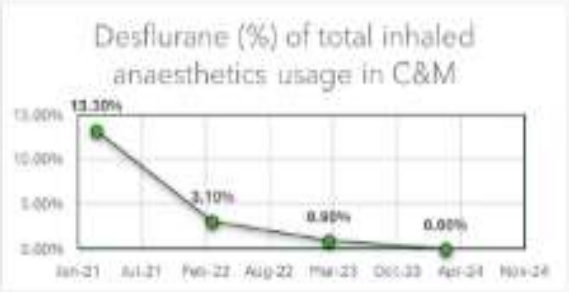
primary vt3Harry. Achievements highlights

SOCIAL VALUE DELIVERY

2022 - 2024

£94 million

ANAESTHETIC GASES



SUSTAINABILITY BOARD SUB-GROUPS

PROGRESS

Initial heat decarbonisation planning completed on Trust sites.

Green space mapping completed on larger Trust sites.

All C&M Trusts and the ICB offer cycle to work schemes.

PRIMARY CARE PROJECTS

WORKFORCE

- First ICB to introduce mandatory all-staff sustainability training.
- Sustainability clause in all job descriptions.
- Bespoke board level training offered to all C&M execs/ non-execs.

STRATEGY

4. Risks

The climate crisis is an existential threat. There can be no greater risk to public health across Cheshire and Merseyside and to the delivery of health and care services by the ICB and its partners.

Global warming must be limited to a temperature rise of 1.5°C to prevent catastrophic health impacts and avoid millions of climate change related deaths. However, the planet is currently on track to warm to 2.6°C above pre-industrial levels by 2030. If the ICB and partners do not prioritise robust climate mitigation and adaptation action the impacts will be severe and wide-ranging.

Climate change health risks

Climate hazards	Vulnerability factors	Exposure
• Extreme weather events • Heat • Sea level rise / flooding • Air pollution • Vector distribution • Water scarcity • Reduced food production	• Demographic • Geographical • Biological factors and health status • Sociopolitical • Socioeconomic • Health system capacity • Gender and equity	• People / communities • Health workforce • Infrastructure • Energy systems • Water systems • Food systems • Health systems

Health outcomes

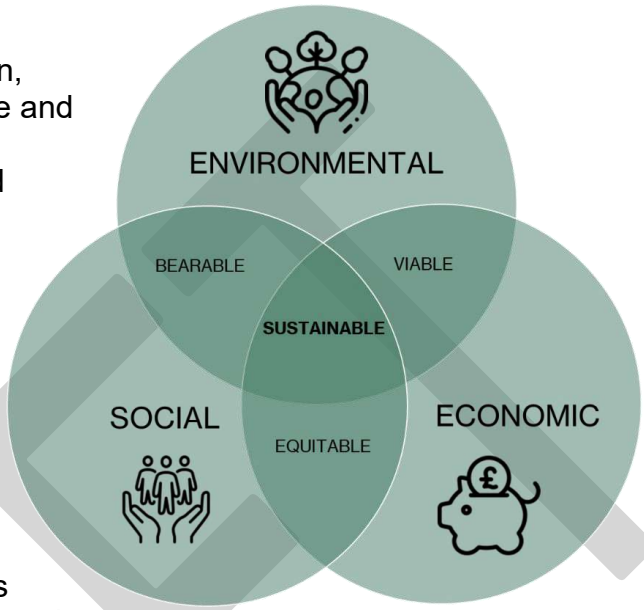
- Injury / mortality from extreme weather events
- Heat-related illness
- Water-borne disease / water-related heath impacts
- Respiratory illness
- Zoonoses
- Vector-borne diseases
- Malnutrition and food-borne diseases
- Non-communicable diseases
- Mental and psychosocial health

Health system risks

- Infrastructure
- Supply chain
- Workforce
- System capacity
- IT/ telephony
- Energy
- Financial

5. Governance

Our Green Plan is underpinned by the concept of the triple bottom line, which emphasizes the importance of sustainable practices that benefit society, protect the environment, and ensure economic viability.



Transparency and Accountability: Clare Watson, Assistant Chief Executive Officer of NHS Cheshire and Merseyside is the Board level 'net zero lead' responsible for the Green Plan. The Cheshire and Merseyside Sustainability Board has oversight of delivery, reporting regularly into the Cheshire and Merseyside Health and Care Partnership. Progress is also reported on a quarterly basis to the North West region's Net Zero Board, which in turn reports to the national Greener NHS team.

Inclusive Decision-Making: We are committed to engaging stakeholders from diverse backgrounds in the decision-making process. This will ensure that our Green Plan reflects the needs and priorities of all members of our community.

Adaptability and Continuous Improvement: Our governance structure is designed to be flexible and adaptable. We will continuously review and improve our Green Plan based on feedback, new research, and evolving best practices in sustainability, undertaking and publishing a refresh of the Plan every three years.

Version Control and Acknowledgements

Title	Cheshire and Merseyside Green Plan Executive Summary 2025 - 2028		
Version	1.0		
Date of Issue	29th Feb 2025		
Document Status	Final		
Document History:			
Date	**Version**	**Author**	**Notes**
09-01-25	1.0 (draft 1)	Mandi Cragg	Draft submitted to Dave Sweeney / Becky Jones for reviewed and agreed.

This Green Plan has been designed using resources from Flaticon.com.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Emergency Preparedness Resilience and Response Core Standards 2024-25 Assurance Report

Agenda Item No: ICB/03/25/21

Responsible Director: Anthony Middleton
Director of Performance and Planning

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

NHS
Cheshire and Merseyside

Emergency Preparedness Resilience and Response Core Standards 2024-25 Assurance Report

1. Executive Summary

1.1 The purpose of this report is to inform the NHS Cheshire and Merseyside Board of the ICB's self-assessment against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards, and subsequent actions to improve compliance over the coming year.

2. Introduction / Background

2.1 The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2022, underpin EPRR within health. Both Acts place EPRR duties on the NHS in England.

2.2 Under the CCA 2004, NHS Cheshire and Merseyside are a Category 1 responder, which are recognised as being the core of emergency response and are subject to the full set of civil protection duties including risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements, and a requirement to share information and cooperate with other agencies.

2.3 Each year, NHS England implements an annual assurance process for the NHS EPRR Core Standards. In 2022, NHS England applied a revised EPRR assurance process in the Midlands. The review included a request for supporting evidence, and a detailed analysis of organisations self-assessments against each of the EPRR core standards. The results demonstrated that there was a significant disparity between self-assessment scores and those of NHS England. The revised assurance process identified opportunities to strengthen and improve the evidential base that would stand the test of public scrutiny.

2.4 Driven by the aim of undertaking an open and transparent review, the same model was applied within the North West in 2023. The introduction of the new EPRR assurance process resulted in all Trusts and NHS Cheshire and Merseyside receiving a rating of non-compliance across the system, following scrutiny of all the core standards for each organisation.

2.5 For 2024, the assurance process responsibility and lead was shifted to ICBs for the first time. This year, the process has been moved back to the focus of a self- assessment function with evidentiary requirements. The NHS Cheshire and Merseyside Head of EPRR and Deputy Head of EPRR undertook a review of six randomly selected core standards from each Trusts self-assessment and focused on the evidence supplied for those six only. Feedback and observations were provided to allow Trusts to verify their position, and review their self-assessment based on the feedback received. The final compliance ratings

for the Cheshire and Merseyside Trusts can be found in Appendix A.

2.6 In line with contractual requirements, NHS Cheshire and Merseyside also provided an annual assurance of compliance with the EPRR Core Standards for 2024-25. This submission consisted of a Statement of Compliance, EPRR Core Standards Self-Assessment, evidence and associated action plan. The final compliance ratings for NHS Cheshire and Merseyside can be found in Appendix A.

3. Recommendatiosn and ask of the Board

3.1 **The Board is asked to:**

- note the contents of the report
- note the significant improvement on the 2023/24 self-assessment compliance rating

4. NHS Cheshire and Merseyside EPRR Core Standards Self-Assessment

4.1 There are 47 core standards applicable to NHS Cheshire and Merseyside which are self-assessed based on 4 levels of compliance.

Full	Substantial	Partial	Non-Compliant
Compliant with **all** standards	The organisation is **89-99%** compliant	The organisation is **77-88%** compliant	The organisation is compliant with **76% or less**

4.2 Based on NHS Cheshire and Merseyside's self-assessment; 41 standards were declared as full compliance, and six standards were declared as partial compliance. No standards were declared as non-compliance, resulting in an overall EPRR compliance assurance rating of **partially compliant** (87%) for 2024/25. The detail of NHS Cheshire and Merseyside's compliance with the EPRR Core Standards can be found in Appendix B.

4.3 NHS Cheshire and Merseyside receiving a rating of partially compliant should not be perceived as a poor assurance rating as the EPRR Team are delivering against each NHS EPRR Core Standard. This is an increase on the rating of 40% non- compliant for 2023/24. It does indicate that there are opportunities for the organisation to further improve over the coming year, through the implementation and monitoring of effective action plans. An update on the action plan from 2023- 24 and the new action plan from 2024-25 can be found in Appendix C and D.

4.4 Actions to address the organisations partially compliant standards are in place and will be overseen by the Accountable Emergency Officer.

4.5 In addition to the 47 EPRR Core Standards, a 'deep dive' is conducted each year on a different topic to gain additional assurance. The 2024 'deep dive' was cyber security and

IT related incidents, with 11 standards for NHS Cheshire and Merseyside to self-assess against. Please note, the 'deep dive' does not contribute to the overall Integrated Care Board compliance level.

4.6 Following the 2023-24 report and the next steps identified:

a) A Local Health Resilience Partnership Task and Finish Group was established monthly for all EPRR Practitioners, which culminated in the Peer Reviews held at the beginning of September 2024, prior to the submission deadline. These were welcomely received, and good practice was shared throughout.
b) The NHS Cheshire and Merseyside EPRR Team did lead the annual assurance process and review for 2024-25.
c) Comparable data will be maintained for the following years to come following a return to the self-assessment process.
d) The Local Health Resilience Partnership Strategic Group continue to manage the overall compliance across the system.

5. Reasons for Recommendations

5.1 The report is sent for assurance.

6. Background

6.1 The EPRR Core Standards 2024-25 Assurance Report was considered at the NHS Cheshire and Merseyside Quality and Performance Committee.

6.2 The board has been asked to note the contents of this report with assurance of delivery of actions and future improved compliance through NHS Cheshire and Merseyside EPRR governance structures.

7. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

7.1 Objective One: Tackling Health Inequalities in access, outcomes and experience

Reviewing the EPRR Core Standards action plans of providers enables the ICB to set system plans that support improvement against health inequalities.

7.2 Objective Two: Improving Population Health and Healthcare

Monitoring and management of compliance with the EPRR Core Standards allows the ICB to identify where improvements have been made and address areas where further improvement is required.

7.3 **Objective Three: Enhancing Productivity and Value for Money**
The report does not directly address this objective.

7.4 **Objective Four: Helping to support broader social and economic development**
The report does not directly address this objective.

8. Link to achieving the objectives of the Annual Delivery Plan

8.1 The 2024-2025 Emergency Preparedness, Resilience and Response Core Standards Assurance Report provides the organisational position of NHS Cheshire and Merseyside, against the NHS EPRR Core Standards.

9. Link to meeting CQC ICS Themes and Quality Statements

9.1 **Theme One: Quality and Safety**
The report provides organisational visibility against all NHS EPRR Core Standards and confirmation of our compliance rating for 2024-2025.

9.2 **Theme Two: Integration**
The report addresses elements of partnership working across multi-agency partners, Acute, Specialist, Mental Health and Community Trusts across Cheshire and Merseyside, in relation to EPRR and Business Continuity.

9.3 **Theme Three: Leadership**
The report supports the ICB leadership in decision making in relation to EPRR and Business Continuity issues.

10. Risks

10.1 The report provides a breakdown of the NHS England EPRR Core Standards and the organisations compliance rating. Those core standards identified as Partial or Non-compliance, have full and robust action plans in place to work towards full compliance.

11. Finance

11.1 The report does not directly provide an overview of financial information.

12. Communication and Engagement

12.1 The report has been completed with input from all Cheshire and Merseyside trusts and is made public by presentation to the Board.

13. Equality, Diversity and Inclusion

13.1 The report does not provide an overview of equality, diversity, and inclusion.

14. Climate Change / Sustainability

14.1 This report addresses the NHS EPRR Core Standards and does not currently include the ambitions of the ICB regarding the delivery of its Green Plan / Net Zero obligations.

15. Next Steps and Responsible Person to take forward

15.1 The NHS Cheshire and Merseyside EPRR Team will continue to deliver the agreed action plan and improve the organisations compliance from partially compliant to substantially compliant by September 2025. This will be overseen by the NHS Cheshire and Merseyside Quality and Performance Committee.

15.2 To support the Integrated Care System, the Local Health Resilience Partnership Tactical Group will hold the Core Standards as a standing item on the agenda to discuss any recurring issues or obstacles being faced by Trusts in reaching fully compliance status, and to offer support.

15.3 Overall compliance will be managed by the Local Health Resilience Partnership Strategic Group.

16. Officer contact details for more information

Nicola Barnes
Interim Head of Emergency Preparedness, Resilience and Response
Nicola.Barnes@cheshireandmerseyside.nhs.uk

17. Appendices

Appendix One: 2024-2025 Emergency Preparedness, Resilience and Response Core Standards Assurance Report – ICS Scores

Appendix One: 2024-2025 Emergency Preparedness, Resilience and Response Core Standards Assurance Report – ICS Scores

Core Standard	Fully Compliant	Partially Compliant	Non-Compliant	Overall Percentage	Overall Compliance
Alder Hey Children's Hospital NHS Foundation Trust	42	20	0	68%	Non compliant
Bridgewater Community Trust	47	9	2	81%	Partially compliant
Cheshire and Wirral Partnership NHS Foundation Trust	49	9	0	84%	Partially compliant
Clatterbridge Cancer Centre	56	3	0	95%	Substantially compliant
Countess of Chester Hospital NHS Foundation Trust	50	12	0	81%	Partially compliant
East Cheshire NHS Trust	50	10	2	81%	Partially compliant
Liverpool Heart and Chest NHS Foundation Trust	51	8	0	86%	Partially compliant
Liverpool University Hospitals NHS Foundation Trust	55	7	0	89%	Substantially compliant
Liverpool Women's Hospital NHS Foundation Trust	43	16	0	73%	Non compliant
Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust	50	12	0	81%	Partially compliant
Mersey Care NHS Foundation Trust	56	2	0	97%	Substantially compliant
Mid Cheshire Hospitals NHS Foundation Trust	47	15	0	76%	Non compliant
NHS Cheshire and Merseyside	41	6	0	87%	Partially compliant
The Walton Centre NHS Foundation Trust	46	13	0	78%	Partially compliant
Warrington and Halton Teaching Hospital NHS Foundation Trust	42	20	0	68%	Non compliant
Wirral Community Health and Care NHS Foundation Trist	50	7	1	86%	Partially compliant
Wirral University Teaching Hospital NHS Foundation Trust	52	10	0	84%	Partially compliant

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 January 2025

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/03/25/22a

Report approved by: Tony Foy, Non-Executive Member, Audit Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Audit Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	04 March 2025

Key escalation and discussion points from the Committee meeting

Alert

The Audit Committee at its 04 March 2025 meeting:

- Endorsed minor changes to the ICBs Scheme of Reservation and Delegation (SORD) (Appendix One) and Operational SORD (Appendix Two). The changes to both documents reflected the following:
  - establishment of the Shaping Care Together Joint Committee (OSORD/SORD)
  - inclusion of reference to Financial Control and Oversight Group (SORD only)
  - authorised approval route for Patient Group Directions (SORD only)
  - greater clarity re authority of the Board in relation to the case for change for Women's Hospital Services in Liverpool (SORD only)
  - removal of the Care Assurance Panel and reinstatement of the sign off authority amount for Place Directors in relation to Packages of Care.(OSORD).

The Audit Committee recommends that the Board approves the minor amendments and adopts both updated documents.

- approved changes to the ICBs Appropriate Policy document for processing Special Category Data and Criminal Offence Data for Safeguarding Purposes. The main changes were updates to the principles relating to processing personal data, from the EU set to the UK set of GDPR principles.

- received an update on the progress towards the completion of the ICB's Annual Report and Accounts 2024-25 and approved the current draft of Accounting Policies selected by management

Advise

The Audit Committee at its 04 March 2025 meeting:

- received an assurance report regarding the ICBs Cyber Security controls and assurances, and which focussed on the internal provision of systems used by ICB and Primary Care staff which are supported by the ICB Digital team and its third-party IT providers. The Committee heard about the plans to deliver the ICB Cyber Security strategy and how the work undertaken reports as a programme through the ICB's Digital Transformation and Clinical Improvement group. The Committee noted the report.
- received an update report on Procurement Waivers approved in line with the ICBs SORD between 01 December 2024 and 28 February 2025, and an update on the retrospective waivers outstanding since the last report. Committee received assurance that there had been no breaches to public contract regulations and that

no financial risk s had been identified associated with the waivers. The Committee noted the report. • received the ICBs Quarter Three Freedom of Information (FOI) report outlining the number and type of requests that the ICB had received from 01 November 2024 to the end of January 2025. The Committee were informed that the ICB had received 129 FOIs during this period, and that there were 2 FOI breaches of the statutory 20 working day timescale for responses. The main themes with respect to FOIs centred around Continuing Healthcare/Packages of Care, weight management services, ADHD and ASD Services and NHS Dental contracting. The Committee noted the report. • received a report providing an update on the ICBs controls and processes around managing declarations of interest. The Committee received details on the declarations made around gifts, hospitality and sponsorship and received assurance on the process undertaken to approve those that fell technically outside of the ICBs policy. The Committee noted the report. • received a report from the ICBs Internal Auditors outlining progress against the Annual workplan for 2024-25. The Committee noted the progress report. • received a report from the ICBs Internal Auditors outlining the current draft head of Internal Audit Opinion for 2024-25, noting that the final Opinion will only be provided closer to the June 2025 final submission to NHS England. The Committee noted the report. • received a report from the ICBs Internal Auditors outlining the current draft Annual workplan for 2025-2026. The Committee noted the report. • received a report from ICBs Anti-Fraud specialist that set out the activities undertaken, and outcomes achieved, in accordance with the agreed anti-fraud work plan, compliance with counter fraud standard requirements, and in response to any referrals / investigations reported. The Committee noted the report. • received a findings report from the ICBs Anti-Fraud Specialist regarding referrals related to the alleged selling of prescription medication across Cheshire and Merseyside. The Committee noted the report. • received and noted an update paper from the ICBs External Auditors which outlined emerging national issues and developments that may impact ICBs, NHS sector updates and progress against the 2024/25 deliverables. The Committee noted the update report. • received and noted a report which summarised the results of the independent reporting accountant's assurance engagement on the ICBs 2023/24 Mental Health Investment Standard (MHIS) Compliance Statement. The Committee noted the report and the proposal of the ICBs External Auditors to issue an unmodified opinion on the ICB's 2023/24 MHIS Compliance Statement.
Assure
n/a

The next meeting of the Committee is scheduled for 08 April 2025

Appendices

Appendix One Scheme of Reservation and Delegation
Appendix Two Operational Scheme of Reservation and Delegation

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board
Scheme of Reservation and Delegation (SoRD)

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1. Regulation, control, constitution & governance						
1.1	Determine the arrangements by which the ICB approves those decisions that are reserved for the Board where they have not been delegated	Board				Assistant Chief Executive
1.2	Consider and approve applications to NHS England on changes to the Constitution	Board			ICB Executive (the executive committee meeting)	Assistant Chief Executive
1.3	Approval of the ICBs scheme of reservation and delegation (SORD), which sets out those decisions that are in statute the responsibility of the ICB and are reserved to the ICB Board, and those delegated to Committees, sub-committees, and employees	Board			ICB Executive Audit Committee Finance, Investment and Our Resources Committee	Director of Finance
1.4	Promote the governance arrangements of the ICB to employees and to people working on behalf of the ICB			ICB Executive		Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1.5	Disclosure of non-compliance with the group's constitution (incorporating its standing orders, prime financial policies and scheme of reservation and delegation)	Board			Audit Committee Finance, Investment and Our Resources Committee	Assistant Chief Executive
1.6	Review of suspension of standing orders		Audit Committee			Assistant Chief Executive
1.7	Suspension of standing orders	Board				Assistant Chief Executive
1.8	Approval of the operational scheme of delegation (incl. financial limits) that underpins the ICB's overarching scheme of reservation and delegation	Board			Audit Committee Finance, Investment and Our Resources Committee	Director of Finance
1.9	Approval of the ICBs Standing Financial Instructions	Board			ICB Executive	Director of Finance
1.10	Approve the ICB's prime financial policies and financial governance	Board			Finance, Investment and Our Resources Committee	Director of Finance
1.11	Set out who can execute a document by signature / use of the seal	Board			ICB Executive	Associate Director of Corporate Affairs and Governance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1.12	Approve the arrangements for discharging the ICB's statutory duties and functions	Board			ICB Executive	Assistant Chief Executive
1.13	Establish governance arrangements to support collective accountability between partner organisations for whole system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations	Board			Quality and Performance Committee Strategy and Transformation Committee Finance, Investment and Our Resources Committee	Assistant Chief Executive Director of Planning and Performance
1.14	Approval of Patient Group Directions on behalf of the ICB for the Cheshire and Merseyside System			Medical Director	ICB Medicines Optimisation and Pharmacy Group	Chief Pharmacy Officer Deputy Chief Pharmacist
2. Strategy & Planning						
2.1	Approve the values and planning in accordance with the strategic direction of the ICB	Board			Finance, Investment and Our Resources Committee	Director of Finance
2.2	Approve the ICB operating structure		ICB Executive	Chief Executive		Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.4	Approve the ICB arrangements for engaging the public and key stakeholders in the ICB's planning and commissioning arrangements	Board			Strategy and Transformation Committee Transformation Committee	Assistant Chief Executive
2.5	Approve the ICB budgets that meet the financial duties of the ICB	Board			Finance, Investment and Our Resources Committee	Director of Finance
2.6	Approve Cheshire and Merseyside Health and Care Partnership integrated care strategy		Cheshire and Merseyside Health and Care Partnership		Strategy and Transformation Committee	Assistant Chief Executive
2.7	Allocate resources to support the delivery of the Cheshire and Merseyside Health and Care Partnership integrated care strategy	Board			Strategy and Transformation Committee	Assistant Chief Executive
2.8	Agree a System Joint Forward Plan to meet the health and healthcare needs of the Cheshire & Merseyside population, within the context of the NHS national strategy, the C&M Health and Care Partnership integrated care strategy and place health and wellbeing	Board			Strategy and Transformation Committee	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	strategies					
2.9	Allocate resources to deliver the Joint Forward Plan across the system, determining what resources should be available to meet population need across C&M and in each place, and setting principles for how they should be allocated across services and providers (both revenue and capital)	Board			Finance, Investment and Our Resources Committee	Strategy and Transformation Transformation Committee Place Directors through Place-Based Partnership Boards
2.10	Allocate resources to deliver the System Joint Forward Plan at place, determining what resources as delegated by the Board should be available to meet population need in place and setting principles for how they should be allocated across services and providers (both revenue and capital)	Board			Finance, Investment and Our Resources Committee	Strategy and Transformation Committee Place Directors through Based Partnership Boards

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.11	Agree and publish a Joint Capital Resource Use Plan with partner NHS trusts and foundation trusts within Cheshire and Merseyside	Board			Finance, Investment and Our Resources Committee	Director of Finance
2.12	Approve decisions on the review, planning and procurement of primary medical care services (to reflect the terms of the delegation agreement between NHS England and NHS Cheshire and Merseyside ICB)		System Primary Care Committee Pharmacy Services Regulations Committee		Place Primary Care Committee / Forums ICB Associate and Heads of Primary Care Place Primary Care Staff	Assistant Chief Executive Place Directors Head of Primary Care
2.13	Approve decisions on the review, planning and procurement of Specialised Commissioning services for the Cheshire and Merseyside population (to reflect the terms of the delegation agreement between NHS England and NHS Cheshire and Merseyside ICB)		Strategy and Transformation Committee Finance, Investment and Our Resources Committee		Financial Control and Oversight Group	Assistant Chief Executive Director of Finance
2.14	Approve decisions on the review, planning and procurement of Specialised Commissioning services for		North West Specialised Commissioning Services Joint		Strategy and Transformation Committee	Assistant Chief Executive Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	the North West of England population made at the North West Specialised Commissioning Services Joint Committee		Committee		Finance, Investment and Our Resources Committee	
2.15	Have oversight of and approve the strategy and priorities for NHS Cheshire and Merseyside with regards Children and Young People		Children and Young Peoples Committee			Director of Nursing and Care Assistant Chief Executive
2.16	Have oversight of, agree and approve the prioritisation of ICB funding and allocations for Childrens and Young Peoples functions and services that NHS Cheshire and Merseyside has responsibility for and which are delegated to the Committee		Children and Young Peoples Committee			Director of Nursing and Care Assistant Chief Executive
2.17	Approve the final draft strategic case for change for Women's Hospital Services in Liverpool to recommend to the ICB Board		Women's Hospital Services in Liverpool Committee			Director of Nursing and Care
2.18	Approve the Strategic Case for Change for Women's Hospital Services in Liverpool	Board			Women's Hospital Services in Liverpool Committee	Director of Nursing and Care

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.19	Approve joint decisions in relation to the planning and commissioning of services, and any associated commissioning or statutory functions, within the scope of the Shaping Care Together programme, for the population of Southport, Formby and West Lancashire		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	Assistant Chief Executive Director of Finance
2.20	Approve any case for Change for services within scope of the Shaping Care Together programme		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	Assistant Chief Executive Director of Finance
2.21	Approve any Pre-consultation business cases and any associated capital strategic outline case for services within scope of the Shaping Care Together programme		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	Assistant Chief Executive Director of Finance
2.22	Approve any Outline Business Case or Full Business Case for services within scope of the Shaping Care Together programme		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	Assistant Chief Executive Director of Finance
2.23	Approve on behalf of both ICBs the associated		Shaping Care Together Joint		Shaping Care Together Programme	Assistant Chief Executive Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	materials involved with and the initiation of any engagement or formal consultations with the public, patients, carers and stakeholders, in respect of the services within the scope of the Shaping Care Together Programme		Committee		Board	
2.24	Approve the ICB operating structure in each place		Executive Team			Place Directors
2.25	Agree system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the center of their care		Strategy and Transformation Committee		Executive Team	Medical Director Chief Digital Officer

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.26	Agree place action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connecthealth and care services to put the citizen at the center of their care		Strategy and Transformation Committee		Digital Transformation and Clinical Improvement Assurance Group Place Based Partnership Boards	Place Directors Chief Digital Officer
2.27	Agree C&M joint work on estates, procurement, supply chain and commercial strategies to maximisevalue for money across the system and support wider goals of development and sustainability		Finance, Investment and Our Resources Committee		Strategy and Transformation Committee Place Based Partnerships Boards Financial Control and Oversight Group	Director of Finance
2.28	Agree place action on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability		Finance, Investment and Our Resources Committee		Strategy and Transformation Committee Place Based Partnerships Boards Financial Control and Oversight Group	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.29	Agree arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHSE	Board			ICB Executive	Director of Planning and Performance
3. Annual Reports and Accounts						
3.1	Approval of the ICB Annual Report and Annual Accounts	Board			Audit Committee	Director of Finance
4. Partnership, joint or collaborative working						
4.1	Agree joint working arrangements with partners that embed collaboration as the basis for delivery within the ICB plan (including arrangements under section 75 of the NHS Act 2006)	Board			Strategy and Transformation Committee Place Based Partnership Boards	Assistant Chief Executive
4.2	Develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within the ICB plan	Board			Strategy and Transformation Committee Place Based Partnership Boards	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
4.3	Approve the delegated decision-making responsibilities of individual employees of the ICB who represent the ICB in joint or collaborative arrangements with another statutory body(ies)	Board			Finance, Investment and Our Resources Committee	Chief Executive
4.4	Approve named positions within the ICB with the delegated authority to undertake any of the functions of the System Primary Care Committee were considered appropriate and / or necessary by the Committee			System Primary Care Committee		Assistant Chief Executive Associate Director of Primary Care
4.5	Approve the arrangements governing joint or collaborative arrangements between the ICB and another statutory body(ies), where those arrangements incorporate decision making responsibilities (including arrangements under section 75 of the NHS Act 2006), Section 65Z5 or Section 65Z6 of the Health and Care Act 2022)	Board			Strategy and Transformation Committee	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
4.6	Approve arrangements for coordinating the commissioning of services with other ICBs, with local authorities, or with NHS Trusts where appropriate (including under section 12ZA of the 2006 Act ('Conferral of discretion')	Board			Strategy and Transformation Committee Place Based Partnership Boards	Assistant Chief Executive
4.7	Approve arrangements for risk sharing and /or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS Act 2006, or Section 65Z6 of the Health and Care Act 2022)	Board			Finance, Investment and Our Resources Committee	Director of Finance
4.8	Receive the minutes of meetings of, or reports from, joint or collaborative arrangements between the ICB and another statutory body(ies)	Board	Children and Young Peoples Committee Strategy and Transformation Committee System Primary Care Committee			Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5. Employment, Remuneration, Workforce & OD						
5.1	Agree system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers	Board			System Peoples Board	Chief People Officer
5.2	Agree implementation in Locality of People Priorities		Place Partnership Boards		System Peoples Board	Chief People Officer
5.3	Accountability for the ICB's responsibilities as an employer including adopting a Code of Conduct for staff	Board			Audit Committee	Chief People Officer
5.4	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities		Remuneration Committee		Finance, Investment and Our Resources Committee	Chief People Officer

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.5	Approve the ICBs Pay Policy, including approving the terms and conditions of employment for non- AFC employees including pensions, remuneration, fees and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB		Remuneration Committee		ICB People Committee	Chief People Officer
5.6	Approve any other terms and conditions of services for the ICB's AFC employees		Finance, Investment and Our Resources Committee		ICB Executive	Chief People Officer
5.7	Approve disciplinary arrangements for all employees, including the Chief Executive (where he/she is an employee of the ICB) and for other persons working on behalf of the ICB		Remuneration Committee		ICB Executive	Chief People Officer
5.8	Approve disciplinary arrangements where the ICB has joint appointments with another group and the individuals are employees of that group			Shared Chief Executive discussion		Chief People Officer

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.9	Approval of the arrangements for discharging the ICB's statutory duties as an employer	Board	Finance, Investment and Our Resources Committee		Finance, Investment and Our Resources Committee ICB Executive	Chief People Officer
5.10	Approve human resources policies for ICB employees and for other persons working on behalf of the ICB		Finance, Investment and Our Resources Committee		ICB Executive	Chief People Officer
5.11	Approve arrangements for staff appointments (excluding matters detailed within the constitution)		Finance, Investment and Our Resources Committee		ICB Executive	Chief People Officer
5.11a	Appointment of the ICB Chief Executive	Board			Remuneration Committee	Chief People Officer
5.11b	Appointment of all other roles		Remuneration Committee (non AfC levels only)	ICB Executive		Chief Executive or other responsible Executive
5.12	Approve the ICB organisational development plans		Finance, Investment and Our Resources Committee		ICB Executive	Chief People Officer
6. Quality and Safety						
6.1	Establish clinical governance arrangements to support collective accountability between partner organisations	Board			Quality and Performance Committee	Director of Nursing and Care through System Quality Surveillance Group

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.2	Approve arrangements to ensure duties are discharged effectively and foster the development of policies, processes and initiatives to minimise clinical risk, maximise patient safety, and promote equality to secure the continuous improvement in quality and patient outcomes	Board			Quality and Performance Committee	Director of Nursing and Care
6.4	Approve the ICB arrangements for handling complaints and concerns		Quality and Performance Committee	ICB Executive		Assistant Chief Executive
6.5	Approve the ICB arrangements for safeguarding children and vulnerable adults		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
6.6	Approve the ICB arrangements for engaging patients and their carers in decisions concerning their healthcare		Quality and Performance Committee	ICB Executive		Director of Nursing and Care Assistant Chief Executive
6.7	Approve arrangements for supporting the NHS in discharging its responsibilities in relation to securing continuous		Quality and Performance Committee	ICB Executive		Director of Nursing and Care Deputy Medical Director

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	improvement in the quality of general medical services					
6.8	Approve the arrangements for the quality oversight, assurance and improvement systems within the ICS.		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
6.9	Approve the arrangements for delivering the NHS Patient Safety Strategy to achieve its vision to continuously improve patient safety and to develop and implement the patient safety initiatives that the strategy introduced.		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
6.10	Agree the Strategy for Quality and Patient Safety inclusive of the aligned quality priorities for the system		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
6.11	Agree the ICB arrangements for responding to and learning from patient safety events		Quality and Performance Committee	ICB Executive		Director of Nursing and Care

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.12	Approve the operating structure for the monitoring, oversight and reporting on Quality and Safety in each place		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
7. Business Operation and Risk Management						
7.1	Approve the ICB counter fraud and security management arrangements		Audit Committee			Director of Finance
7.2	Approval of the ICB risk management arrangements	Board			Audit Committee ICB Executive	Director of Finance
7.3	Approve ICB operational policies (i.e., excluding those defined as clinical or finance)				ICB Executive	Assistant Chief Executive
7.4	Approve ICB financial policies		Finance, Investment and Our Resources Committee		Financial Control and Oversight Group	Director of Finance
7.5	Approve requests for the waiver of any procurement rules for goods and services on an exception basis		Finance, Investment and Our Resources Committee		Financial Control and Oversight Group	Director of Finance
7.6	Approve the ICB procurement plans annually		Finance, Investment and Our Resources Committee		Financial Control and Oversight Group	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
7.5	Approve ICB Safeguarding, clinical and medical policies and clinical pathways		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
7.6	Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
7.7	Approve arrangements for managing conflicts of interest, including gifts and hospitality and for standards of business conduct.		Audit Committee			Assistant Chief Executive
7.8	Approve arrangements for complying with the NHS Provider Selection Regime	Board			Finance, Investment and Our Resources Committee	Director of Finance
7.9	Report and provide assurance to the Board on the effectiveness of ICB governance arrangements		Audit Committee			Assistant Chief Executive
7.10	Receive the annual governance letter from the External Auditor and advise the Board of proposed action		Audit Committee			Director of Finance
7.11	Appointment or removal of either the Internal or External auditor for the ICB		Audit Committee			Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
7.12	Approve the internal audit, external audit and counter-fraud plans and any changes to the provision or delivery of related services		Audit Committee			Director of Finance
8. Information Governance						
8.1	Approve the policies and arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data		Audit Committee			Advised and supported by IG & Data Security groups
8.2	Approve information sharing protocols with other organisations		ICB Executive			SIRO
8.3	Approve ICB Annual Data Security and Protection Toolkit submissions			SIRO		Associate Director of Corporate Affairs and Governance IG Officers
8.4	Approve NHS Digital Data Access Requests (DARs) – Data Sharing Agreements, Data Sharing Framework Contracts			SIRO		Associate Director of Corporate Affairs and Governance IG Officers

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
8.5	Approve arrangements for handling Freedom of Information and Subject Access Requests		ICB Executive			Assistant Chief Executive Associate Director of Corporate Affairs and Governance
9. Communications						
9.1	Approval of ICB communications and engagement plan	Board			Strategy and Transformation Committee	Assistant Chief Executive Associate Director of Communications and Empowerment
10. Arrangements for Patient & Public Involvement						
10.1	Approve arrangements for the involvement of and consultation with patients and the public in ICB decision making	Board Shaping Care Together Joint Committee			Strategy and Transformation Committee Shaping Care Together Programme Board	Assistant Chief Executive

V1.3 Approved: by the Board of NHS Cheshire and Merseyside on **27 March 2025**

NHS Cheshire and Merseyside ICB

Scheme of Operational Delegated Limits

Section	Description	Reserved By:																				
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	~~Care Assurance Panel~~	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
A	**ACCEPTANCE OF GIFTS, HOSPITALITY & SPONSORSHIP** (Governance Lead to maintain a register of declared gifts and hospitality received)																Gifts over £50	Gifts over £50		Gifts up to £50	Gifts up to £50	Gifts up to £50	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
B	**LITIGATION CLAIM PAYMENTS** Medical negligence and other litigation payments made on the advice of NHS Resolution	Over £1,000,000															Up to £1,000,000	Up to £500,000					
C	**LOSSES & SPECIAL PAYMENTS** (CFO to maintain a register of losses and special payments (including bad debts to be written off). All payments to be reported to the Audit Committee.	Over £500,000			Up to £500,000												Up to £100,000	Up to £50,000	Up to £5,000				
D	**PETTY CASH FLOAT**																						
D1	Authorisation to set up float																Over £300	Over £300	Up to £300				
D2	Replenish petty cash float																						Head of Financial Services (or equivalent role)
D3	Issue petty cash																	Up to £50	Up to £50				Associate Director of Finance (Place)
E	**CREDIT CARD**																						
E1	Account signatories (who can make changes to the account, authorise additional card holders, amend card limit)																x	x	x				
E2	Authorise single transaction (single transaction limit £2,500)																x	x	x	x	x	x	x
F	**REQUISITIONING GOODS & SERVICES: NON-HEALTHCARE**																						
F1	Utilisation of External Agency Staff (based on total expected cost as per below notes) Supporting Notes: a) Prior approval from the ICB Vacancy Panel must be sought for all consultancy requests regardless of value. b) Prior approval from NHSE must be sought for: - Any appointments over £600 per day; or any appointments for over a 6 month period, or - any appointment with significant influence (e.g. ICB roles). c) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and in line with agreed ICB IR35 policy	Over £500,000			Up to £500,000												Up to £150,000	Up to £150,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000

Section	Description	Reserved By:																				
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	~~Care Assurance Panel~~	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
F2	Utilisation of Consultancy (based on total expected cost as per below notes). Supporting Notes a) Prior approval from the ICB Vacancy Panel must be sought for all consultancy requests regardless of value. a) Prior approval from NHSE must be sought for: Any expenditure above £50,000: or Any appointments over £600 per day; or Any appointments for over a 6 month period, or Any appointment with significant influence (e.g. ICB roles) b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and in line with agreed ICB IR35 policy	Over £500,000			Up to £500,000												Up to £150,000	Up to £150,000		Up to £25,000	Up to £25,000	Up to £25,000	
F3	Services including IT, maintenance, and support services (over lifetime of contract) where not included within agreed annual budgets	Over £2,000,000			Up to £2,000,000												Up to £1,000,000	Up to £500,000		Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F4	Approval of non-healthcare payments within agreed budget *With appropriate consideration of procurement requirements																Over £2,000,000	Up to £2,000,000	Up to £500,000	Up to £500,000	Up to £500,000	Up to £500,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
G	**RELOCATION EXPENSES** In line with Policy approved by ICB Remuneration Committee																Over £8,500	Up to £8,500					
H	**DECISION TO APPROVE 'NEW' INVESTMENT BUSINESS CASES**																						
H1	Where funding is: a) available and identified within agreed financial plan or b) from additional notified resource allocations (e.g. new in-year) c) other identified income streams (e.g. other agencies / recharges)	Over £10,000,000			Up to £10,000,000	Up to £1,000,000		Up to £1,000,000 *Primary Care Related	Up to £10,000,000						Up to £10,000,000		Up to £5,000,000	Up to £3,000,000	Up to £1,000,000	Up to £1,000,000	Up to £1,000,000	Up to £1,000,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H2	Where not included in approved financial plan (but still subject to ICB Executive / Place Leadership Team Approval) N.B any material underspend / variation from plan at individual budget holder level cannot be reinvested / redirected (see Virement Policy - Section L) without Executive team approval due to overall financial management requirements of the ICB.	Over £5,000,000			Up to £5,000,000	Up to £500,000 *specialised services related		Up to £500,000 *Primary Care Related	Up to £5,000,000						Up to £5,000,000		Up to £500,000	Up to £500,000		Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H3	Primary Care Capital Expenditure Approval (within ICB allocation) NB - Capital Plan to be approved by the ICB for each financial year	Over £1,000,000						Up to £1,000,000 *Primary Care Related									Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)					
I	**CONTRACTING**																						
I1	Signing of Healthcare Contracts including S75 agreements. S75 approval via place governance processes in line with S75 agreements operational policy. (Annual Contract Value)																Over £500,000,000	Up to £500,000,000	Up to £75,000,000			Up to £100,000,000	
I2	Approval of Healthcare Contract Payments All healthcare contract payments must be supported by signed contract (see I1).																As per agreed plan / budget value	As per agreed plan / budget value)	As per agreed plan / budget value)		As per agreed plan / budget value	As per agreed plan / budget value	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
I3	Signing of Non-Healthcare Contracts (Annual Contract Value)																Over £3,000,000	Up to £3,000,000	Up to £1,000,000		Up to £1,000,000	Up to £1,000,000	Up to £100,000

Section	Description	Reserved By:																					
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	~~Care Assurance Panel~~	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
J	**APPROVAL OF OTHER HEALTHCARE PAYMENTS WITHIN BUDGET** See authorised signatory list for approval limits for other officers.																Over £1,000,000	Up to £1,000,000	Up to £100,000	Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
K	**QUOTATIONS AND TENDERS HEALTHCARE / NON-HEALTHCARE**																						
K1	Approval of ICB Procurement Plan				X																		
K2	Procurement route decision - in line with the options contained within the Healthcare Provider Selection Regime (2023) Regulations (Annual Contract Value)	X (For Novel or Contentious issues escalated by FIR Committee)			X From £5,000,000 with Novel or Contentious Procurement route decisions to be escalated to the Board	Up to £3,000,000		Up to £3,000,000							Up to £5,000,00		Up to £5,000,000	Up to £3,000,000	Up to £1,000,000	Up to £663,000	Up to £663,000	Up to £663,000	
NEW	Decision to put Non-Healthcare goods and services out to competitive procurement (Total contract value)	X (For Novel or Contentious issues escalated by FIR Committee)			X From £5,000,000 with Novel or Contentious Procurement route decisions to be escalated to the Board												From threshold up to Up to £5,000,000	From threshold up to Up to £3,000,000	From threshold up to £1,000,000				
K3	Approval of Quotations for Non-Healthcare expenditure (total value)		£20,000 to procurement thresholds specified in the Procurement Act 2023 (PA23) (currently £215k including VAT) in line with delegated limits for expenditure type. Minimum of three written quotes required																				
K4	Quotation Waiver Approval for Non-Healthcare goods and services (Total Contract Value) – see detailed financial policy on tendering when permissible)		£20,000 to procurement thresholds (currently Non Healthcare £214k) in line with delegated limits for expenditure type																				
K5	Procurement for Non-Healthcare goods and services through approved national / local framework agreement (in line with call off rules) (Total Contract Value)		From £20k to delegated budgeted limit for expenditure type (with approval from procurement team) Above delegated budgeted limits, subject to Finance, Investment & Resources Committee Approval																				
K6	Tender Waiver Approval for Non-Healtcare goods and services	In line with limits for procurement route decisions N.B. Reporting of all Tender Waiver Approval to Audit Committee																					
K7	Opening of Tender Documentation (where not received electronically) (at least 2 people from list)																x	x	x	x			
L	**VIREMENT**	Relating to a transfer of funds from an unspent or underspent budget to another; within virement rules to allow greater financial flexibility in using available resources All Transfers must be: • affordable within budget; and • agreed by both budget holders Virements may not be used to create new budgets																					
L1	Within Existing Approved Pay or Non-Pay Budgets																Over £1,000,000	Up to £1,000,000	Up to £500,000		Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
L2	With regards to transfers from reserves (including distribution of new in-year resource / capital allocations)																	Up to £70,000,000	Up to £25,000,000				As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
M	**DISPOSALS AND CONDEMNATION** All assets disposed at market value.	Over £50,000															Up to £50,000	Up to £10,000	Up to £5,000				
N	**CHARITABLE FUNDS** (Not applicable to ICB)																						
O	**HUMAN RESOURCES**																						
O1	Approve HR Decisions Not Covered By ICB HR Policies or Is Exceptional To Policies (e.g. additional compassionate leave or exceptional carry forward of leave days)																x	x	x	x	x	x	

Section	Description	Reserved By:																				
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	~~Care Assurance Panel~~	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
O2	Decisions As Set Out Within HR Policies (where there is some management discretion e.g. study leave authorisation)																x	x		x	x	x	
O3	Approval of Operational Structure (re staffing and departments), and in accordance with organisation change policy																x						
O4	Approval of Appointment to Posts Below Executive Directors (following approval at Vacancy Panel)																	x	x	x	x	x	x
O5	Approval of the below arrangements as required by the ICB: - Approval of the arrangements for discharging the ICB statutory duties as an employer - Approve human resources policies for ICB employees and for other persons working on behalf of the ICB - Approve any other terms and conditions of services for ICB AFC employees - Approve disciplinary arrangements for ICB employees - Approve arrangements for staff appointments (excluding matters detailed within the Constitution) - Approve the ICBs organisational development plans				x (following endorsement of the People Committee)																		
P	**EXTERNAL COMMUNICATIONS & REPORTING**																						
P1	Approve Complaints Responses and Letters to Politicians and Media Responses																x				x (Assistant Chief Executive)		x (Associate Director of Corporate Affairs & Governance)
P2	Approve Public Consultation Material																x				x (Assistant Chief Executive)		
P3	Approve Public & Staff Engagement Material inc Website																x				x (Assistant Chief Executive)		
P4	Approve FOI Responses and Subject Access Requests																				x (Assistant Chief Executive)		x (Associate Director of Corporate Affairs & Governance)
P5	Approve Annual Engagement & Communication Plan	x																					
Q	**FINANCE** Approval of Operational Policies as required by the organisation				x																		
R	**INDIVIDUAL PACKAGES OF CARE** Approval of Individual AACC Packages of Care (Annual Value)															~~Annual value cost of over £260,000~~						Annual value cost over to £260,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
S	**INFORMATION GOVERNANCE**																						
S1	Approve Digital and Data programmes Data Protection Impact Assessments (DPIA), Information / Data Sharing agreements and Data Processing Agreements																			x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, SIRO and Caldicott Guardian, or their deputies)
S2	Approve Confidentiality Advisory Group (CAG) Applications																			x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, Deputy SIRO and Deputy Caldicott Guardian)
S3	Approve NHS Digital Data Access Requests (DARs) – Data Sharing Agreements, Data Sharing Framework Contracts																			x (SIRO)			
S4	Data Security and Protection Toolkit submissions approval																			x (SIRO)			x (Deputy SIRO)
S5	Privacy Notices																			x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, Deputy SIRO or Deputy Caldicott Guardian)

V1.3 Approved: 27 March 2025 by the Board of NHS Cheshire and Merseyside

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Highlight report of the Chair of the ICB Children and Young Persons Committee

Agenda Item No: ICB/03/25/22b

Report approved by: Raj Jain, ICB Chair, CYP Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Children and Young Persons Committee

Committee Chair	Raj Jain
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	05 March 2025

Key escalation and discussion points from the Committee meeting

Alert

n/a

Advise

At its March 2025 meeting the CYP Committee:

- received a presentation on Appropriate Places of Care for Young People experience crisis during Christmas 2024. This presentation outlined the plans that were in place during the Christmas period for accommodation and support for young people experiencing crisis and where tier 4 inpatient services or suitable places where not available. The presentation highlighted the success of and support to the Gateway model and the Committee was supportive of the plans that had been put in place and for replication for the 2025 Christmas period. Committee members agreed to watch and share widely the **Cheshire and Merseyside - Gateway Animation - YouTube**, and agreed to be approached to be interviewed about the Gateway.
- received an update on the 2024-25 Q3 position against the Cheshire and Merseyside Children and Young People's Mental Health Plan. Progress highlights against the Plans 8 priority areas were outlined and that a key challenge for next year was the roll out of the 'As One' digital platform in light of financial challenges the system is in. The Committee commended the good work that had taken place and noted the challenges and risk to the plans delivery, and that financial planning processes for the 2025/26 period were underway
- received a presentation on 2025-26 Planning Priorities with a focus on children and young people. The Committee heard about the priorities outlined with the Health and Care Partnership Strategy alongside 2025/26 national priorities. The 2025-26 Neighbourhood Health priorities were outlined, highlighting where there was specific mention and action regarding children and young people, including development of multi-disciplinary teams The Committee also heard about the waiting list challenges for children and your people and the recovery work underway to address, as well as some of the focused work being undertaken as part of actions against the Committees priority areas around Oral Health/Dental, Obesity and Neurodiversity
- received a series of presentations from representatives of the Sefton Youth Advisors, Knowsley Youth Cabinet and Youth Focus North West, and which highlighted the different ways young people are being involved in and influencing decisions across their areas. The Committee applauded the young people who attended and presented very powerful and candid presentations. The Committee gave their commitment to respond formally to a series of questions that had been raised which would set a direction of travel for the Committee to have greater involvement in children and young people on the committee, development of a shadow Board and greater say in developing commissioning priorities

Assure

n/a

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Highlight report of the Chair of the Finance, Investment & Resource Committee

Agenda Item No: ICB/03/25/22c

Report approved by: Erica Morris,
ICB Non-Executive Member

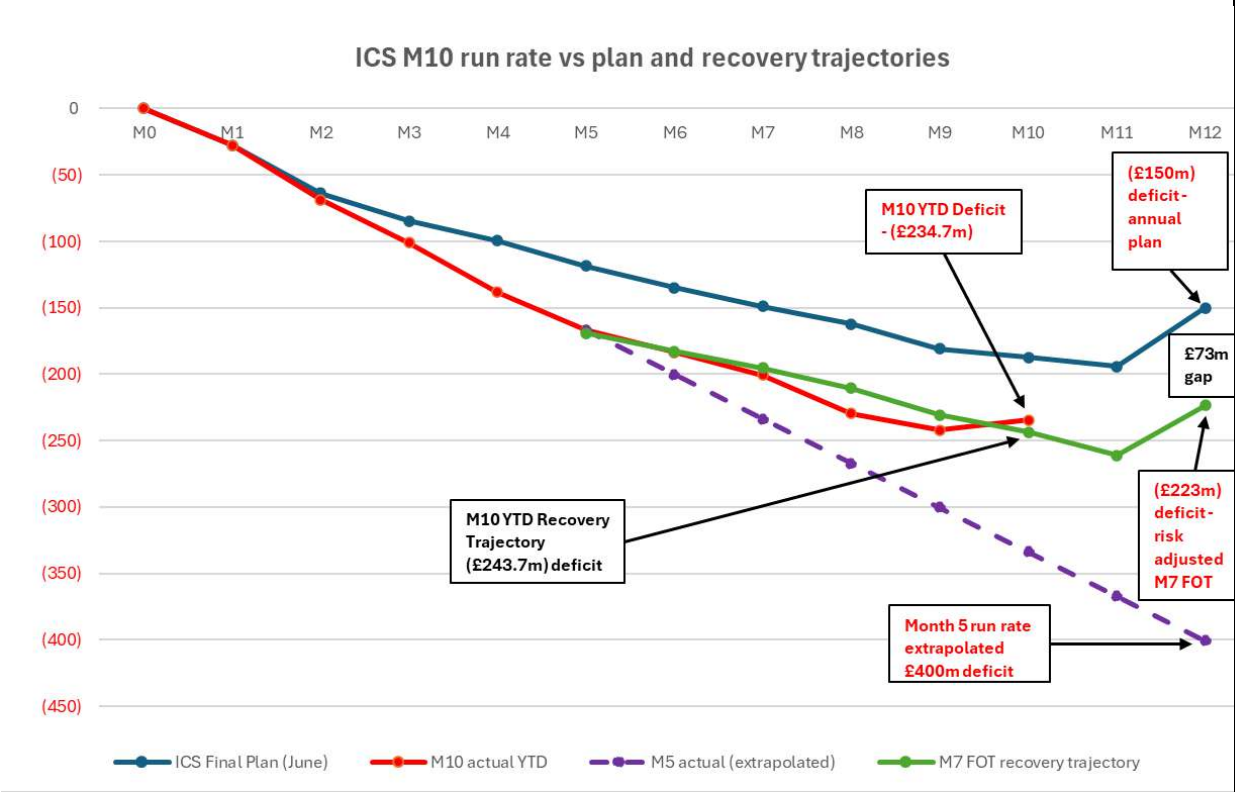
Highlight report of the Chair of the Finance Investment and Resource Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	18 March 2025

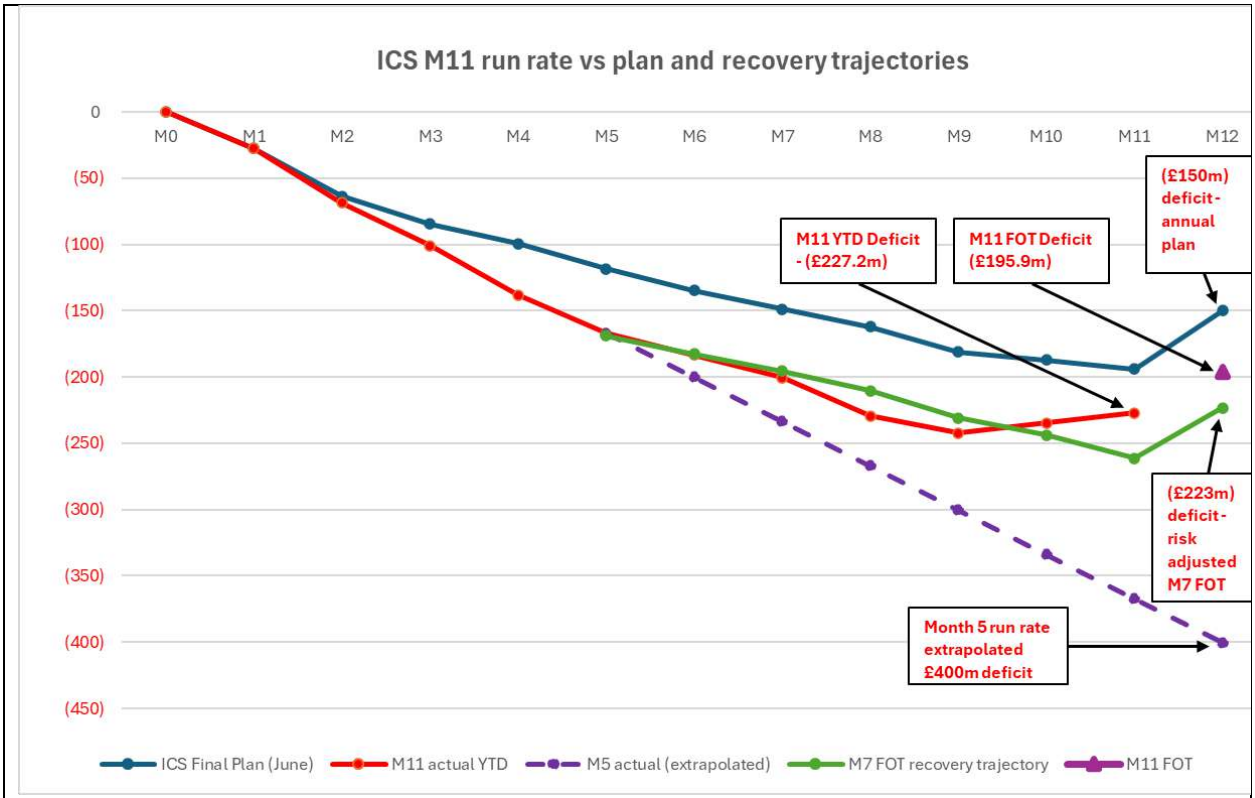
Key escalation and discussion points from the Committee meeting

Alert

M10 deep dive covering CIP, CHC, MH, Workforce, Medicine Management and Cash holdings across the system. As of 31st January 2025 (Month 10), the ICS system is reporting a YTD deficit of £109.7m against a planned YTD deficit of £62.4m resulting in an adverse **YTD variance of £47.3m** (0.7% of allocation). The adverse variance from plan has improved by £13.8m during month 10. The current in-year deficit of £109.7m would need to be recovered in the final two months of the year in order for the system to achieve the overall planned breakeven position.



At Month 11 – £**45.9m adverse to plan (ICB 33.8m/Provider 12.1m).**
This position includes: Receipt of £23m non recurrent surge funding from NHSE, any organisation with FOT adverse to original plan required to submit additional governance documentation reviewed and signed off by their Board.



- *Current Planning position with next iteration 20/3/25.*

Current position of £386m deficit across all Cheshire and Merseyside NHS organisations compared to a maximum 'allowable' control total position of a £178m deficit for the 2025/26 financial year. As such the is not accepted / affordable with a current planning gap of £208m between control total and draft submission. After deficit repayment this results in a control position of £149m.

£386m draft deficit includes £75.3m of unidentified but expected provider improvements compared to initial draft submissions which are still being progressed by the system. This expected improvement is based on follow-up conversations between the ICB and C&M NHS providers targeting areas of opportunity and the utilisation of reviews being undertaken by external individuals / organisations which have been sponsored by NHS England North West region team.

Work continues to develop plans to improve the overall system gap significantly and a final plan submission is expected by the end of March 2025 as per national timescales.

Advise

- Deferred approval for a procurement for audiology until 5 key criteria reviewed by PDRG and Place Leadership. This has subsequently been approved via quorate membership outside of FIRC to ensure efficiency and timeliness.

- Verbal update on revised approach to 24/25 Recovery programmes. 7 programmes, Digital, AACC, Medicine Optimisation, Reducing unwarranted variation, Contractors/Independent sector, Mental Health and Place Productivity

will report through a structure of PMO to Financial Control and Oversight Programme Board Chaired by Mark Bakewell and monthly review by FIRC.

Assure

- General procurement plan update for noting on Health and Non-Health covering current position 24/25 and future 25/26. Large volume of procurements detailed and exercise has been undertaken to streamline and consolidate where possible and in accordance with procurement governance.

- MLCSU - 12 month review of savings from transfer in of MLCSU services reviewed, modest reduction in costs in Year 1 which is in line with expectations, additional saving anticipated of circa £500k in Year 2. It was noted that the transfer of services took considerable HR/management time which was not anticipated from initial due diligence and has resulted in improved performance management of services remaining with MLCSU and detailed lessons learnt for future transfers.

- Noted review of Financial policies and approved changes to Payroll and Expenses. The Financial Policies have been agreed by the Executive Director of Finance in line with areas of functional responsibility and reflect requirements in accordance with a number of supporting documents including the CCG Due Diligence Checklist, HFMA guidance, Standing Financial Instruction Requirements and previously developed internal policies.

Committee risk management

The following risks were considered by the Committee and the following actions/decisions were undertaken.

Full risk review is currently being undertaken to ensure that narrative for FIRC accountable risks and BAF are future proofed. Mark Bakewell accountable person and will be delivered to FIRC in June 25 for approval following session feedback.

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Focus Area	Key actions/discussion undertaken
24/25 Control Total Position	Improved position but highlight risks to achievement of 196m deficit control total.
Planning for 25/26	Position as at Friday 14th March with next iteration 20th and then final submission due 27/3/25.
Financial Control and Oversight	Establish with 7 programmes and will report into FIRC from April 25.Chair - MB
Mid Term Plan	Discussed urgent need for 3 year plan and will be an item for FIRC in April and ongoing - MB

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Highlight report of the Chair of the ICB Quality & Performance Committee

Agenda Item No: ICB/03/25/22d

Committee Chair: Tony Foy
ICB Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the Quality & Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date(s) of meeting	13 February 2025 and 13 March 2025

Key escalation and discussion points from the Committee meeting

Alert

Care Home Quality and Safety

Winsford Grange, (Park Homes, Cheshire) – little progress on action plan since September 2024 – CQC have issued a Notice of Proposal and therefore a risk of closure. Cheshire East and West are continuing to visit including unannounced IPC visits.

ADHD services (Cheshire)

- Cheshire and Wirral Partnership has notified the ICB that the Adult ADHD Service for Cheshire East and Cheshire West is now a vulnerable service, submitting their actions to date to remedy the challenges.
- The Trust reported a risk to service provision to existing patients plus the people on waiting lists, which is in excess of 1,200 people. The Trust has identified that there is insufficient commissioned capacity and is experiencing significant workforce shortages due to high rates of staff turnover primarily with people leaving to work in the independent sector.

Advise

Safeguarding

- A corporate risk relating to Workforce capacity has been scored as 16 with clear concerns that there is inequity in availability of designated safeguarding professional capacity within each Place. It was reported that, over the last financial quarter Place have escalated their concerns regarding the safeguarding allocation (both Doctors and more recently Designated professionals).
- Actions - Strengthening of governance between Place and corporate functions (i.e. reporting to the Executive lead to ensure: full oversight of safeguarding risks held at Place ensure reporting arrangements for Safeguarding (in line with Working Together) are transparent.

SEND

Initial request for Education Health and Care needs assessments. EHC plans show timeliness of plan completion within 20 weeks (nationally at 50.3%) shows variance in performance ranging between 40 - 96% within the ICB footprint.

- Key challenges relate to :- Therapy waiting times (Speech and Language Therapy and OT) - Timeliness of equipment purchased - Impact of ADHD medication shortages - DCO workforce in business continuity since June 2024 due to a combination of sickness absence, vacancies and maternity leave.

- Actions :- Workforce issues being addressed through vacancy control and return from long term absence (expected to be resolved within Qtr. 1 2025/26). ICB SEND Collaborative Unit staff and DCOs at Place are participating fully in the ICB Neurodevelopmental Pathway.

Assure

Paediatric Audiology

Programme Progress

All Paediatric Audiology Services across C&M have been assessed under stages1 and 2 of the national programme (desk top review and risk stratification).

- The two services have been identified as high risk Warrington and Halton Hospitals (WHH) and Wirral University Teaching Hospitals (WUFT) . One moderate risk service has been identified at Alder Hey Hospital (AHH). Areas of improvement have been identified for all providers. As WHH was previously identified in the initial national review, with recommended actions underway, it has not been prioritised for further actions. A stage 3 on-site visit for WUTH is scheduled for 21st March, AHH will also be visited.
- Fortnightly North West Region meetings allow for ICB oversight and access to Regional Chief Scientific Officer team.
- The programme as a whole has identified the lack of oversight of a relatively small service with significant quality and safety implications for a small number of children.
- The commissioning managers are being engaged through the on-site visits and will seek assurance through existing quality contract meetings. Dissemination of learning will need to be considered ICB-wide to ensure this and other small services do not lack oversight of quality.

Maternity

- Maternity Incentive Scheme – all providers report full compliance with the 10 Safety Actions save for WUTH which has a technical query with one standard.
- A review of C&M performance in relation to 3rd/4th degree tears has highlighted that LWH were the only Trust reporting variation in the latest Reporting Pack. However, following a review of the national Maternity Services Dashboard data (which includes more recent data compared with the North West Regional Maternity Dashboard), performance is improving, and the Trust is not a national outlier.
- East Cheshire Trust - at the February 25 Quality and Safety Surveillance Meeting (QSSG), with East Cheshire Trust (ECT) metrics requiring further scrutiny were identified. Variations of note relate to deliveries under 34 weeks, Post Partum Haemorrhage >=1500ml and stillbirth rate.

HCAI and AMR

- Antimicrobial prescribing position continues to demonstrate an overprescribing of antibiotics with seven of nine places above the national target, however the data also shows that there is a month on month improvement in this position and the action being taken is having a positive effect.
- Healthcare associated infections - The NHS Standard Contract has requirements for minimisation of Clostridioides difficile (CDI) and Gram-negative Bloodstream Infections rates to NHS England threshold levels. Eleven of the twelve NHS acute Trusts have already breached their tolerance in at least one recorded HCAI by

month 10. The current trajectory for the ICB would see a breach to all tolerances by the end of the year.

- The establishment of a system wide HCAI Review Group (February 2025) has provided an improved forum for oversight of current position, progress of actions. The initial focus is on the CDI challenge within WUTH and COCH the ongoing Gram-Negative BSI challenge within LUFT, the need to increase focus on community onset with increasing outlier alerts and places with 'above peer average' rates of infection.
- Progress with the hydration pilot reported to - this is now being developed into a business case for Executive consideration. The pilot findings have indicated cost and safety benefits to the system.

Committee risk management

The following risks were considered by the Committee, and the following actions/decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
QU04 and QU10 (Safeguarding) QU11 and 12 New risks – FNC delays and AACC funding pressures	Amended Retired Under development

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Understanding collective risks. Review of Countess of Chester situation and improvement opportunities
Maternity	Improving Assurance against Standards and scrutiny of outliers including East Cheshire Trust (recently included in C&M LMNS

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/03/25/22e

Committee Chair: Tony Foy,
ICB Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	26 February 2025 and 11 March 2025

Key escalation and discussion points from the Committee meeting

Alert

n/a

Advise

The Remuneration Committee at its meeting on 26 February 2025:

- considered a paper on and approved the recommendations within regarding the proposed remuneration and terms and conditions of the ICB's Interim Chief System Improvement and Delivery Officer

The Remuneration Committee at its meeting on 11 March 2025:

- considered a paper on the proposed ICB payments to Section 12 accredited Doctors, who conduct independent assessments of individuals under the Mental Health Act (MHS), alongside Advanced Mental Health Practitioners, to determine if a person should be admitted to hospital under the MHA for treatment. The paper outlined a number of payment options which had been benchmarked against other ICBs, existing rates across Cheshire and Merseyside (due to historic CCG arrangements) and also highlighted national guidance and BMA recommended rates. Following consideration of the options and risks, the Committee approved the recommended option as outlined within the paper.
- considered a paper that outlined proposed terms and conditions for Pharmacy, Optometry and Dentistry (POD) Clinical roles within the ICB. Following delegation of POD services to the ICB in 2023, the ICB inherited the responsibility around the engagement of non-employed POD clinical advisors, non-employed Chairs and Members of Local Professional Networks and Managed Clinical Networks. At the time of receiving the delegated responsibilities it was determined that the ICB would retain existing remuneration and other terms and condition arrangements until such time as a thorough review could be undertaken. Following a comprehensive review of the roles, benchmarking with other ICBs and NHS England regions a number of proposals were put forward for the Committee to consider, with the Committee approving the recommend terms and conditions option within the paper and approved that these would be reviewed again within the next 12 months so as to ensure alignment to the ICB's GP employment model.
- received a verbal update on the successful conclusion of the recruitment process for the ICBs Chief Executive
- received a verbal update on the progress to finalise the appointment of the ICB's Interim Chief System Improvement and Delivery Officer
- received a verbal update on the next steps to be taken to review the Committee's Terms of Reference
- approved the minutes of its previous meetings in October 2024, November 2024 and February 2025.

Assure

The Remuneration Committee at its meeting on 26 February 2025:

- received an update on the process being undertaken to identify and appoint an interim Non-Executive member for a 6 month period following the departure of Neil Large to become the interim Chair of The Countess of Chester NHS Foundation Trust. Assurance was provided that the individual will undergo a full Fit and Proper Persons Test check process before being formally appointed to the position. The individual appointed would undertake the responsibility of being the Chair of the ICB Audit Committee

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 March 2025

Highlight report of the Chair of the ICB System Primary Care Committee

Agenda Item No: ICB/03/25/22f

Committee Chair: Erica Morris, Non-Executive Member

Highlight report of the Chair of the ICB System Primary Care Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/media/1m0dgm5g/ics-system-pcc-tor-v12-oct23-final.pdf
Date of meeting	20 February 2025

Key escalation and discussion points from the Committee meeting

Alert

At its meeting on the 20 February 2024:

- Issues regarding Enhanced Service differentials and specifications were being raised within some Places, as a response to national Collective Action - where raised Places were managing any locally commissioned response.
- Task and Finish Risk meeting to be held prior to next SPCC to finalise the review of Primary Care Strategic Risks with the benefit of improved Place consistency and focus on the individual contractor group impact.
- The Committee received an update from the System Primary Care Quality Group – it was confirmed that this Committee should be receiving escalation for primary care quality but further clarification / coordination with Quality and Performance Committee reporting still required to avoid duplication.

Advise

At its meeting on the 20 February 2024:

- The Committee **approved** to apply the direct award process to an existing APMS contract provider, as recommended by Wirral Place who escalated the issue for decision.
- The Committee **noted** the use of the (Regulation 20) Selection Criteria Document Part 1 and Part 2 and **approved** the Provider Selection Regime documentation to undertake a competitive procurement, as recommended by Wirral Place who escalated the issue for decision
- The Committee **approved** the proposal to focus on routine care and access as part of the Dental Improvement Plan.

Assure

At its meeting on the 20 February 2024:

- The Committee received an update in relation to Primary Care Estates, noting some debt and liability issues that were flagged as part of this paper but these were being managed through the Strategic Estates Board
- The Committee received an update on Digital work programmes and pilots, noting the work being done to support further streamlining of workflows within general practice by piloting new digital tools.
- An issue relating to information forwarded by the Controlled Drugs Team regarding patient registration ID had been raised with that team, as raised by LMC Colleagues.
- Primary Medical Operational Planning Guidance asks had been released just prior to the Committee meeting and an update with more information, was to be presented at the April meeting (noting national GP Contract information had been released after the meeting so had not been considered and will also be on the agenda for April)

- Healthwatch gave a verbal update on the Access Improvement Patient Experience survey with some headlines – a report will return in April prior to a May board summary. This would need to be triangulated with the new Operational Planning Guidance asks as part of agreement for 25/26 Access Improvement priority actions, overseen by the Committee and reporting to Board. In summary Healthwatch early results still confirmed challenges for patients in accessing the front door of primary care (but care received once an appointment was secured was seen as positive).
- An update on Freedom to Speak Up in Primary Care was received with an update returning at a future meeting, actions requested in the recent national letter were progressing.
- Community Pharmacy planning and approvals were presented and access to community pharmacy would become a regular agenda item moving forward

Committee risk management

The following risks were considered by the Committee and the following actions / decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
The following updated risks were presented as part of an overall report • 6PC: Identified dental provider contract management risk potentially leading to loss of provider and impact on general dental provision, was agreed to be closed. • 13DR: a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing, was noted. • Estates risks in relation to general practice meeting the criteria for committee escalation as identified by four Places and therefore deemed a risk in common. This was noted.	

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Service Programme / Focus Area	Key actions/discussion undertaken
Finance Update	SPCC reviewed Delegated Budget as part of Finance Update
Recovering Access to Primary Care	Summary Update
Dental Improvement Plan	Full update