

Thursday 23 February 2023

10.30am to 13:05pm

Whiston Town Hall, Old Colliery Road, Whiston, Merseyside,
L35 3QX



Cheshire and Merseyside

Meeting of the Integrated Care Board

Agenda

Chair: Raj Jain

The ICB Board meeting are business meetings which, for transparency, are held in public. They are not 'public meetings' for consulting with the public, which means that those people who attend the meeting cannot take part in the meetings proceedings. There will be opportunity for members of the public to ask questions to the Board at the end of the meeting.

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
10:30am	Preliminary Business			
ICB/02/23/01	Welcome, Introductions and Apologies	Chair	Verbal	-
ICB/02/23/02	Declarations of Interest <i>(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the Board Member Register of Interests)</i>	Chair	Verbal	-
ICB/02/23/03	Minutes of the previous meeting: • 26 January 2023	Chair	Paper Approval	Page 4
ICB/02/23/04	Board Action Log	Chair	Paper For note	Page 18
ICB/02/23/05	Board Decision Log	Chair	Paper For note	Page 21
10:40am	Standing Items			
ICB/02/23/06	Report of the Chief Executive	GUR	Paper For note	Page 24
ICB/02/23/07 10:55am	Report of the Knowsley Place Director	ALE	Paper & Presentation For note	Page 48
ICB/02/23/08 11:05am	Resident Story	ALE	Presentation For note	Page 66
11:10am	ICB Key Update Reports			
ICB/02/23/09	Executive Director of Nursing & Care Update Report	CDO	Paper For noting	Page 68
ICB/02/23/10 11:15am	Cheshire & Merseyside System Month 10 Finance Report	CWI	Paper For noting	Page 82
ICB/02/23/11 11:30am	Cheshire & Merseyside ICB Quality and Performance Report	AMI/ CDO	Paper For noting	Page 99

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
11:45pm	ICB Business Items			
ICB/02/23/12	Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 - 2023	CWA / CSA	Paper For approval	Page 158
ICB/02/23/13 11:55am	Cheshire & Merseyside ICB Risk Management	CWA	Paper For approval	Page 209
ICB/02/23/14 12:05am	Cheshire & Merseyside ICB Prioritisation Framework	CWA	Paper For noting	Page 266
ICB/02/23/15 12:15pm	Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB Update	CWA	Paper For noting	Page 257
ICB/02/23/16 12:25pm	Cheshire & Merseyside Health and Care Partnership Chairs Report	RJA	Paper For noting	Page 284
ICB/02/23/17 12:30pm	Liverpool Women's Services Programme Update	GU	Paper For noting	Page 290
12:40pm	Sub-Committee Reports			
ICB/02/23/18	Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee	TFO	Paper For noting	Page 295
ICB/02/23/19 12:50pm	Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Our Resources Committee	EMO	Paper For Approval	Page 302
13:00pm	Other Formal Business			
ICB/02/23/20	Closing remarks, review of the meeting and communications from it	Chair	Verbal For Agreement	-
13:05pm	CLOSE OF MEETING			
Date and time of next meeting: 30 March 2023 <i>time tbc</i> Boardroom, The Department, Lewis's Building, 2 Renshaw Street, Liverpool, L1 2SA A full schedule of meetings, locations, and further details on the work of the ICB can be found here: www.cheshireandmerseyside.nhs.uk				

Speakers

ALE	Alison Lee, Place Director (Knowsley), C&M ICB
AMI	Anthony Middleton, Director of Performance and Planning, C&M ICB
CDO	Christine Douglas MBE, Director of Nursing and Care, C&M ICB
CSO	Christine Samosa, Chief People Officer, C&M ICB
CWA	Clare Watson, Assistant Chief Executive, C&M ICB
CWI	Claire Wilson, Executive Director of Finance, C&M ICB
EMO	Erica Morriss, Non-Executive Director, C&M ICB
GUR	Graham Urwin, Chief Executive, C&M ICB
NLA	Neil Large, Non-Executive Director, C&M ICB
TFO	Tony Foy, Non-Executive Director, C&M ICB

Meeting Quoracy arrangements:

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

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

Integrated Care Board Meeting

Meeting held in public at
Tower Room, Floral Pavilion Theatre & Conference Centre,
Marine Promenade, New Brighton, Wallasey

CH45 2JS

Thursday 26 January 2023

10.45am to 2.00pm

UNCONFIRMED Draft Minutes

MEMBERSHIP		
Name	Initials	Role
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	GUR	Chief Executive, Cheshire & Merseyside ICB (voting member)
Claire Wilson	CWI	Chief Finance Officer, Cheshire & Merseyside ICB (voting member)
Christine Douglas MBE	CDO	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowen Pritchard-Jones	RPJ	Medical Director, Cheshire & Merseyside ICB (voting member)
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Neil Large	NLA	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Ann Marr OBE	AMA	Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust (voting member)
Adam Irvine	AIR	Partner Member, Chief Executive Office, Community Pharmacy Cheshire and Wirral (CPCW) (voting member)
Prof. Joe Rafferty CBE	JRA	Partner Member, Chief Executive Office, Mersey Care NHS Trust, (voting member)
Prof. Steven Broomhead	SBR	Partner Member, Chief Executive, Warrington Borough Council (voting member)
Councillor Paul Cummins	PCU	Partner Member, Cabinet Member for Adult Social Care, Sefton Council (voting member)
IN ATTENDANCE		
Dr Fiona Lemmens	FLE	Regular Participant, Associate Medical Director, Cheshire & Merseyside ICB
Anthony Middleton	AMI	Regular Participant, Director of Performance and Improvement, Cheshire & Merseyside ICB
Christine Samosa	CSA	Regular Participant, Director of People, Cheshire & Merseyside ICB
Clare Watson	CWA	Regular Participant, Assistant Chief Executive, Cheshire &

MEMBERSHIP		
Name	Initials	Role
		Merseyside ICB
Simon Banks	CMA	Place Director – Wirral
Prof. Ian Ashworth	IAS	Director of Public Health representative
Matthew Cunningham	MCU	Regular Participant, Associate Director of Corporate Affairs & Governance / Company Secretary
Louise Murtagh	LMU	Corporate Governance Support Manager (minutes)
Karen Prior	LTH	Healthwatch
Jan Ledward	JLE	Place Director Liverpool
Dr Naomi Rankin	NRA	Designate Primary Care (GP) Partner Member
Warren Escadale	WES	Chief Executive, Voluntary Sector North West
Karen Livesey	KLI	Wirral Council for Voluntary Services
Sarah Thwaites	STH	Healthwatch Liverpool
Lorna Quigley	LQU	Associate Director of Quality & Safety Improvement, Wirral Place

APOLOGIES NOTED		
John Llewelyn	JLL	Regular Participant Chief Digital Officer, ICB

Item	Discussion, Outcomes and Action Points	Action by
10.45am	Preliminary Business	
ICB/01/23/01	Welcome, Introductions and Apologies	
	<p>RJA welcomed all present at the meeting and thanked attendees for the petition received. Question asked in the petition would be covered by information presented today or published to the ICB website.</p> <p>There had been over 30 additional questions received from the public and these would also be responded to following the meeting and published on the ICB website.</p> <p>RJA apologised that answers to the questions posed at the November 2022 Board meeting had not been published and confirmed that these would be made available shortly.</p> <p>Attendees were advised that this was a meeting held in public but that interruptions to proceedings could not be allowed.</p> <p>Apologies were received from John Llewelyn.</p>	
ICB/01/23/02	Declarations of Interest	
	<p>There were no declarations of interest made by Members that would materially or adversely impact on matters requiring discussion and decision today.</p> <p>Jan Ledward advised that she had been appointed to the role of Director of Strategy at Liverpool University Foundation Trust with effect from 1 April 2023. This appointment would not preclude her from any item being</p>	

	discussed at the meeting.	
ICB/01/23/03	Minutes of the last meeting – 28 November 2022	
	<p>Members reviewed the minutes of the meeting held on 28 November 2022 and agreed that they were a true reflection of the discussions and decisions made subject to the following amendment:</p> <p>CSA asked for minute ICB/11/22/09, under the Workforce heading paragraph four, to read as the new post being the Retention Lead. As such action under item ICB/01/23/04 should also reflect this.</p> <p>The Integrated Care Board approved the minutes of ICB Board meeting of 28 November 2022 subject to the agreed amendment.</p>	
ICB/01/23/04	Action Log	
	<p>The Board reviewed the action log and acknowledged the closed actions. Open actions were reviewed as listed in the document.</p> <p>As discussed under Item ICB/01/23/03 the action relating to ICB-AC-22-09 also included the work of the Workforce Retention Lead.</p> <p>The Integrated Care Board noted the Action Log.</p>	
ICB/01/23/05	Decision Log	
	<p>Members reviewed the decision log and confirmed it was an accurate record of substantive decisions made by the Board to date.</p> <p>It was further noted that there were no emergent actions arising from those decisions that were due for review at this meeting.</p> <p>The Integrated Care Board noted the Action Log.</p>	
10.55am	STANDING ITEMS	
ICB/01/23/06	Report of the Chief Executive (Graham Urwin)	
	<p>GUR presented the Chief Executive Report to the Committee and commented on the following items:</p> <p>System Pressures / NHS Urgent Care Status & Discharge funding for step down care - £200 million fund</p> <p>GUR reflected on NHS service provision over the Christmas period commenting that this was not of a level that felt comfortable. The were system pressures such as high levels of seasonal flu and Covid patients, plus the additional problem of fewer patients being discharged over the holiday period than usual.</p> <p>The consequences of these pressures had led to longer waits in admission to hospital and patients being treated in corridors. The system was looking at ways to improve this and the additional funding to help with patients who were fit to be discharged (those classed as ‘no right to reside’) was helpful, but the issues were complex. For example, the system had benefited from the funding but did not currently have the capacity in the community to discharge patients.</p> <p>In January 2023 there had been an improved situation but it was important for the system to remain focussed on flow and effective discharge.</p>	

	<p>SBR and PCU commented that whilst the additional funding was welcomed it provided temporary respite only, social care remained under funded. A short term, one-off payment would not resolve a long-term problem.</p> <p>STH commented that Healthwatch had been present in A&E departments over the Christmas period and that they had recorded the huge respect that patients had for staff providing services in very difficult circumstances.</p> <p>GUR confirmed that a full winter de-brief would be provided to the Board as would information relating to the plans for winter 2023/24 as appropriate.</p> <p>Industrial Action A summary of industrial action by date and the unions involved was provided in the papers. Members attention was drawn to 6 February 2022 with GUR highlighting that there were more organisations involved in action in Cheshire and Merseyside than in any other region in England.</p> <p>The ICB continued to respect the right to take industrial action.</p> <p>Development of ICB Organograms There was a requirement for ICBs to publish their organograms on their public website and Cheshire and Merseyside had complied with this.</p> <p>Members were advised that the document was subject to revisions due to the on-going management of change programme underway.</p> <p>Harmonising Clinical Commissioning Policies Update FLE confirmed that of the 111 Clinical Policies referred to, 56 would be published on the CIB website.</p> <p>Members were asked to approve the revised Legal statement as detailed within Appendix Two, as reviewed by Hill Dickinson.</p> <p>RPJ final comments on the report covered the preventative work of the system and how the ICB was using health intelligence/data to identify some of the most vulnerable citizens.</p> <p>The Integrated Care Board:</p> <ul style="list-style-type: none"> • noted the contents of the report. • approved the revised Legal statement as detailed within Appendix Two, as reviewed by Hill Dickinson 	
<p>ICB/01/23/07</p>	<p>Report of the Wirral Place Director (Simon Banks)</p>	
	<p>The Board considered a presentation by Simon Banks.</p> <p>The presentation covered demographics for Wirral and showed the diversity of the area. It was listed as one of the happiest places to live in the UK. There was much to celebrate and reference was made to the high numbers of providers, community organisations, charities and the local authority who all worked together for the benefit of residents.</p> <p>There were however large areas where people lived in poverty with 35% of the Wirral population living in the top 20% most deprived areas in England. 15% of children lived in poverty and the life expectancy at birth and at 65 was worse than the national average. It was noted that in the more affluent areas of the peninsula, life expectancy was 12 years longer than</p>	

	<p>the those in the most deprived.</p> <p>The vision and priorities for the Wirral were provided and these included the five themes of Sustainable Environment, Brighter Futures, Inclusive Economy, Safe and Pleasant Communities and Active and Healthy Lives.</p> <p>SBA explained how Place was working with system partners to achieve its aims and described the governance map showing the committees and groups set up to aid delivery.</p> <p>The final slide of the presentation highlighted how Wirral Place used public health intelligence to move from a state led paradigm to one owned by the community.</p> <p>The Integrated Care Board noted the presentation and thanked Simon for his warm welcome to Wirral Place.</p>	
<p>ICB/01/23/08</p>	<p>Resident (Frankie's) Story</p>	
	<p>SBA advised that Frankie was unable to attend the meeting and that LQU would be presenting on her behalf.</p> <p>LQU explained that in December 2022 there had been a case audit of six of most vulnerable children in the Wirral. This review had found that positive differences had been made in 5 of the 6 cases. Frankie was one of these 5 residents.</p> <p>The presentation followed Frankie's words about her and her life:</p> <ul style="list-style-type: none"> • she was 16 years old • lived with her mum and brother • her dad did not live with the family but sometimes visited. The family had contact but did not always get on very well • sometimes she struggled with mental health and had self-harmed and attempted suicide before. She felt more positive now. • her mum also struggled with low mood and drug and alcohol use • she had a diagnosis of autism and had been missing from home a number of times • she had just started at college which she was enjoying and had an Education Health Care Plan and was supported by a mentor. • she had a social worker for over two years as there were safety concerns and possible exploitation because as she had been sexually assaulted in a previous relationship <p>LQU advised that it had not always been like that for Frankie and the presentation highlighted the chronology of her life events and the contacts she had experienced with social care and health agencies.</p> <p>The audit carried out in December 2022 found areas of good practice and considered Frankie's case provided evidence of consistently good and outstanding practice by a range of agencies and services. The interventions had undoubtedly made Frankie safer and provided her with tools to support her in the long term.</p> <p>Frankie herself reported that she had a really good relationship with her social worker and that further guidance was being provided to the family to help them understand what shaped their relationship with each other.</p>	

	<p>RJA asked that the Board's thanks be passed to Frankie for allowing her story to be told and to LQU for presenting today.</p> <p>Reference was made to the one case that had not received such a positive outcome following the audit. LQU advised that there had been a deep dive in to the case and the individual had been part of a County Lines set up for too long for intervention to be successful unfortunately.</p> <p>SBA confirmed that best practice learning from the audit findings had been shared, including with the voluntary sector. Knowing your Places was vital and these small community-based organisations were key to success.</p> <p>The Integrated Care Board noted the presentation and extended its thanks to Frankie.</p>	
11.20am	ICB Key Update Reports	
ICB/01/23/09	Executive Director of Nursing & Care Update Report (Christine Douglas)	
	<p>CDO's report provided assurance from the Executive Director of Nursing & Care to the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) on the quality, safety and patient experience of services commissioned and provided across the geographical area of C&M.</p> <p>The report updated on:</p> <ul style="list-style-type: none"> • Industrial Action - the clinical/workforce cell had been meeting twice weekly since November 2022 to ensure patient safety. • System wide operational pressures - The nursing and care team had worked with regional colleagues to develop a suite of documents that provided support to ensure professional standards were maintained during periods of increased pressure. This included 'corridor care'. Any issues identified would be highlighted to the ICB Quality & Performance Committee • The All Age Continuing Health Care Review - Continuing Care assessment, and commissioning was the responsibility of each of the 9 places and there were broadly 4 different delivery models across Cheshire and Merseyside. • Special Educational Needs and Disabilities (SEND), ICS Maturity Matrix - new statutory guidance relating to Area SEND inspections came into force on 1 January 2023 and comprised of a framework and a handbook. This new framework would place increased focus on the impact that local area partnerships had on the experiences and outcomes of children and young people with SEND. • Management of Serious Incidents, including North-West Ambulance Service • Supporting Patient Discharge. <p>The Integrated Care Board noted the Executive Director of Nursing & Care Update Report.</p>	
ICB/01/23/10	Cheshire & Merseyside System Month 9 Finance Report (Claire Wilson)	
	<p>The report updated the Board on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of</p>	

	<p>available 'Capital' resources for the financial year.</p> <p>CWA highlighted that the year-to-date (YTD) system deficit position (as at 31/12/22, Month 9), was an aggregate deficit of £71.9m against a planned deficit of £34.9m resulting in an adverse year to date variance of £36.9m.</p> <p>The assessment to date was an unmitigated £36.9m deficit. This could improve due to depreciation funding, an increase in interest rates and additional funding. The system was undertaking work to mitigate the risk in full by the end of the year.</p> <p>Members were directed to ICB/CCG performance as detailed in the report. CCG allocations had been adjusted (in quarter 1) to breakeven to match the reported position, this resulted in the movement of the £6.7m favourable variance to plan from CCGs budgets to the ICB budget to support achievement of the annual plan.</p> <p>The ICB was reporting a YTD surplus of £4.3m compared to an original planned surplus of £14.7m resulting in an adverse variance to plan of £10.4m. A breakdown of spend areas was provided in the report.</p> <p>ACTION: GUR questioned the agency spend performance and outturn forecast. He asked how these figures compared to pre-pandemic levels and to performance against other ICS areas. CWA was asked to provide this information in future reports.</p> <p>The Integrated Care Board noted the Cheshire & Merseyside System Month 9 Finance Report.</p>	CWA
<p>ICB/01/23/11</p>	<p>Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton)</p>	
	<p>AMI provided an update on the Cheshire and Merseyside ICB Quality and Performance Report. This included an overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care.</p> <p>A number of key areas and risks were highlighted.</p> <p>Urgent and emergency care system - continued to experience significant and sometimes severe pressure across NHS Cheshire & Merseyside. Detailed information was provided in the report as was reference to the one-off additional payment that had been received to facilitate hospital discharges. The impact on ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience was also referred to.</p> <p>CDO commented on discharge funding and advised that the ICS was developing quality metrics and would be working with Healthwatch on collating patient feedback.</p> <p>AMA referred to urgent care and its effect on elective care. Hospitals treated urgent and emergency cases first. This could result in the organisation having the surgical space but not always the appropriate bed space for elective work.</p> <p>Significant backlogs for both elective and cancer care - long waits for</p>	

	<p>treatment often resulted in poor outcomes for patients. The key priority was to eliminate waits in excess of 78 weeks by the end of March 2023. The system was working well together to reach this target and AMI advised that 1000 patients (with a further 1500 to come) had transferred providers in order to receive quicker treatment.</p> <p>Members questioned how the patients who had been waiting 78 weeks plus were being managed against new referrals. AMI and RPJ referred to the successful use of mutual aid across providers.</p> <p>Cancer – PRJ advised the Board that the ICS had been keeping a close working brief on cancer patients. There were over 200 different types of cancer with 14,000 patients on suspected cancer pathways. There were 560 treatments each work and 95% of patients were treated in 3 weeks. 2-week referrals were at 130% pre covid rate with some closer to 160% and the conversion rate of 6% was holding true.</p> <p>Mental Health & Learning Disabilities (LD) – the target for completed LD health checks was 70% this year and 75% next year. The aim of the ICB should be 100%. Any support in this area would be welcomed.</p> <p>The final comments from Members related to recognising the human side of waiting for treatment or diagnostics. People were having to make life changing decisions such as whether they could remain in work and around their personal relationships when faced with 52 weeks and 78 weeks waits.</p> <p>The Integrated Care Board noted:</p> <ul style="list-style-type: none"> • the contents of the report and take assurance on the actions contained. • noted that work with partners on the Winter Pressure de-brief report would start by the end of the quarter. • noted that planning around Winter Pressures for 2023/24 would start by June 2023 	
11.50am	ICB Business Items	
ICB/01/23/12	Review of Liverpool Clinical Services (Jan Ledward)	
	<p>Board members received and considered the Carnall Farrar report on the Independent Review of Liverpool Clinical Services.</p> <p>There was considerable interest from members of the public in attendance at the meeting.</p> <p>It was evident following interaction with a number of members of the public in attendance that there has been a significant mismatch in terms of what members of the public thought was being asked of the Board today compared to what was outlined as the recommendations and next steps within the report.</p> <p>There was a really clear commitment from the Board that there would be no significant service changes without the full engagement of and consultation with the public and other stakeholders, following a transparent and robust process.</p> <p>After consideration the Integrated Care Board:</p> <ul style="list-style-type: none"> • noted the content of the report • agreed all the recommendations within the report; however 	

	<p>with regards those recommendations to be overseen by CMAST the Board removed from the recommendations the sentence ‘the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool.’ Only once tangible progress is made within this scope should it be broadened to a wider geography</p> <ul style="list-style-type: none"> • agreed the implementation plan and associated timescales. <p>The Board recognised that the report was commissioned to look at the configuration of hospital services in Liverpool, however that it must also sit within the context of Primary Care and Community Services and this is why the Liverpool elements of the implementation plan will be overseen by the One Liverpool Board.</p> <p>The Board also recognised that the Liverpool trusts provided care pathways that affected patients outside of Liverpool and that improvements should be for the benefit of all patients who used these care pathways and have due regards to ensuring patients outside of Liverpool were not disadvantaged. Any proposals to change clinical pathways must be consistent with the work being undertaken across C&M by CMAST and were subject to CMAST governance arrangements.</p> <p>GUR also confirmed to the Board that he had already commenced conversations with the Chief Executives of the neighbouring Local Authorities adjacent to Liverpool with regards involving them in the oversight of any changes to care pathways.</p> <p>Partners will now look to progress both the implementation plan and communications and engagement plan</p>	
<p>ICB/11/22/13</p>	<p>Cheshire & Merseyside Integrated Care Partnership Interim Draft Strategy 2023-24 (Clare Watson)</p>	
	<p>Members were presented with the Cheshire & Merseyside Integrated Care Partnership Interim Draft Strategy 2023-24 for noting.</p> <p>CWA explained that on 17 January 2023 the Cheshire and Merseyside Health and Care Partnership (HCP) had considered the draft interim strategy, which had been developed with input from partners during the final quarter of 2022.</p> <p>The draft interim strategy described the areas of work being undertaken collectively at a Cheshire and Merseyside level and complemented the nine Place based Health and Wellbeing Strategies.</p> <p>The key focus of the document was to reduce health inequalities, and to support this the Cheshire and Merseyside All Together Fairer recommendations and Beacon Indicators were embedded as Strategic Objectives as well as a focus in Section 6 of the strategy. This was a golden thread running through the document.</p> <p>The Integrated Care Board noted:</p> <ul style="list-style-type: none"> • the contents of the draft interim strategy • endorsed the next steps agreed by the Health and Care Partnership at the meeting of 17 January 2023; including the ICB using the priorities within the draft interim strategy to inform development of the ICB Five Year Joint Forward Plan. 	

<p>ICB/01/23/14</p>	<p>NHS 2023/24 Priorities and Operational Planning Guidance (Claire Wilson)</p>	
	<p>The report presented by CWI provided an overview of the national NHS Planning Guidance and requirements of the ICB, for 2023-24. This report provided a framework to operationalise the report listed in item ICB/11/22/13.</p> <p>The guidance required the ICB, and partners providers, to develop operational plans in relation to finance, activity, performance, and workforce as well as a narrative on service recovery. There was an additional requirement for development of a Five Year Joint Forward Plan which would combine the Cheshire and Merseyside delivery plans in relation to:</p> <ul style="list-style-type: none"> • Our Health and Care Partnership Interim Strategy • Our nine Health and Wellbeing Strategies • NHS Universal Commitments contained in the national NHS England Planning Guidance. <p>A return to a more traditional contracting approach with NHS providers, including “Payments by Results” for elective care, created an additional requirement to the process, having been suspended during the Covid pandemic.</p> <p>The Joint Forward Plan needed to be submitted in interim draft form by 23 February, submitted in draft form by the end of March and then published by the end of June 2023.</p> <p>Following consultation with Health and Wellbeing Boards a Planning Oversight Group had been formed to oversee development of the plans, including membership from corporate and place ICB teams and provider collaboratives.</p> <p>The Integrated Care Board noted:</p> <ul style="list-style-type: none"> • the content of the 2023-24 NHS planning guidance, including the need to develop both 2-year operational plans and an ICB Joint Forward Plan • the approach to developing our Cheshire and Merseyside plans including the role of providers in developing and approving plans as well as the need to engage with the HCP partners and HWB in developing the content of the plans. • that the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023. • the need for review by the ICB Executive Team and Provider Collaboratives before submission and review, and ratification at the February Board meeting which takes place on the day of submission. • that the final submissions would be presented to the Board for approval in March 2023. 	
<p>ICB/01/23/15</p>	<p>Public and Patient Engagement Strategy & Framework Update (Clare Watson)</p>	
	<p>CWA reminded attendees that at the Board meeting of 1 July 2022, the Board had received a draft public engagement framework. The framework was part of national readiness to operate requirements for ICBs and was</p>	

	<p>drafted according to a nationally prescribed content guide.</p> <p>Local Healthwatch and VCFSE (Voluntary, Community, Faith and Social Enterprise) leaders had been involved in framework development and were also commissioned to co-produce the document.</p> <p>The report outlined the progress made to develop the framework including the discussions that had taken place with stakeholders to gather further feedback. CWA referred to section three of the report, specifically to the information on governance and public voice. A system level forum would be created to provide this.</p> <p>The next steps for translating the framework into an overall communications and engagement strategy for NHS Cheshire and Merseyside, which will in turn inform individual Place plans and activity, were also provided.</p> <p>RJA commented that the importance of hearing from residents was pivotal to the work of the ICB and this had been demonstrated today by attendees. Thought would need to be given on how the impact would be measured.</p> <p>The Integrated Care Board noted the report.</p>	
<p>12.55pm</p>	<p>Sub-Committee Reports</p>	
<p>ICB/01/23/16</p>	<p>Report of the Chair of the Cheshire & Merseyside ICB Audit Committee, including amendments to the ICB SORD & SFIs (Neil Large)</p>	
	<p>NLA asked the Board to take the report as read. The key issues from the ICB Audit Committee held on 13 December 2022 included:</p> <ul style="list-style-type: none"> • External Audit procurement result • HFMA/Financial Controls Report • ICB Whistleblowing / Freedom to Speak Up Update • Paper on the proposed revisions to the ICB Operational SORD – The Board was asked to approve this document • Paper on ICB Procurement Waivers • An update on the Annual Report and Accounts 2022-23 • ICB Risk Management Update • ICB Declarations of Interest Progress Update • Internal Audit progress report • Counter fraud update report • External Audit plan (part year CCG)/ICB progress report • Bi-monthly Information Governance Update Report. <p>Subsequent to the December 2022 meeting, internal audit identified and agreed with the ICB the primary audit areas which would support the Head of Internal Audit opinion for 2022-23 and inform the annual governance statement.</p> <p>Audit areas included Healthcare Contract Management, Primary Care Contracts, Continuing Healthcare, Delegated commissioning – Dentistry / Optometry, Serious Incidents, Mandatory Training and Patient, Carer and Resident Engagement.</p> <p>The Integrated Care Board</p>	

	<ul style="list-style-type: none"> noted the items covered during the Audit Committee of 13 December 2022 report. approved the Operational Scheme of Delegation Update, December 2022 	
ICB/01/23/17	<p>Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee (Tony Foy)</p> <p>TFO presented the Board with a report on key issues discussed at the most recent meeting of the C&M ICB Remuneration Committee. Members were asked to take the report as read.</p> <p>Main items considered at the Remuneration Committee meeting of 28 November 2022 included:</p> <ul style="list-style-type: none"> Terms & Conditions for Clinical Roles (GP) at NHS Cheshire & Merseyside Integrated Care Board Terms and Conditions for the ICB Medical Director. ICB Board Partner Member Remuneration. <p>In early January 2023 members of the Committee also received via email a further updated paper on the proposed Terms & Conditions for Clinical Roles (GP) and for the ICB Medical Director.</p> <p>The Integrated Care Board noted:</p> <ul style="list-style-type: none"> the items covered by the Remuneration Committee at its meeting on the 28 November 2022 and subsequent considerations the decisions made by the Committee, namely: the decision of the Remuneration Committee for Partner Member Remuneration - Approval of a remuneration rate of £13k for those Partner members entitled to payment the decision of the Remuneration Committee in relation to Terms & Conditions for Clinical Roles (GP) at NHS Cheshire & Merseyside Integrated Care Board as follows: <ul style="list-style-type: none"> approval of the remuneration for the Associate Medical Directors to be set at £155,530pa and that in line with their legacy pay protection policies they will be entitled to 2 years pay protection effective from the date of employment to the role. post holders will be engaged under a contract of employment (contract of service) approval of the remuneration for senior Clinical Leads at a sessional rate of £330 (for a 4-hour 10-minute session) and that they be engaged under a contract for services approval of the remuneration for clinical leads at a sessional rate of £320 (for a session of 4 hours and 10 minutes) and that they be engaged under a contract for services approval of the remuneration for the named GPs for safeguarding at a sessional rate of £330 (for a session of 4 hours and 10 minutes) and that they be engaged under a contract of service. 	
ICB/01/23/18	<p>Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee (Tony Foy)</p> <p>TFO presented the Board with a report on key issues discussed at the most recent meeting of the C&M ICB Quality and Performance Committee. Members took the report as read.</p>	

	<p>The Board was asked to note the contents of the report at sections 2, 3 and 4 of the document as follows:</p> <ul style="list-style-type: none"> • Urgent Care Performance and the need for inclusion of social care dataset and insights by Spring 2023 • the undertaking of a Rapid Quality Review meeting with Cheshire & Wirral Partnership • the need for greater oversight and improved reporting by the C&M LMNS. <p>TFO added that the Urgent Care presentation that the committee had received was excellent. It highlighted how managing risk in one part of the system would not resolve issues experienced across the whole system.</p> <p>ACTION: The intention was to return to the Board meeting in March with a full Urgent Care report.</p> <p>The Integrated Care Board noted the report.</p>	AMI
ICB/01/23/19	<p>Report of the Chair of the Cheshire & Merseyside ICB System Primary Care Committee (Erica Morriss)</p>	
	<p>EMO provided Members with an update on key issues for consideration, approval and matters of escalation considered by the C&M ICB Primary Care Committee at its private and public meetings of 20 December 2022 and 11 January 2023 as outlined within the report. Members were asked to take the report as read.</p> <p>A number of key areas were highlighted in report as follows:</p> <p>Public meeting Edge Hill Incorporation Application Liverpool, APMS contracts Procurement, Security in General Practice and Staff Safety, Minutes of NHS England Pharmaceutical Services Regulations Committee (PSRC), Dental and GOS (General Ophthalmic Services) Handover Documents including update on Dental Deep Dive and next steps, Capital Monies - Primary Care Capital and Winter Capital Bids, and an update in relation to A Strep/Primary Care Pressures.</p> <p>Private meeting Community Pharmacy: Challenges/Update/Integration, Primary Care Workforce Update, Delegated Areas – General Medical and Community Pharmacy, Policy and Contracting Update including place reports from place primary care forums, Finance Update, Update on the Primary Care Operating Model, and unsecured APMS contracts in Liverpool.</p> <p>The Board was advised that a detailed dispersal plan for the Practice within Liverpool Place would be circulated to SPCC members. A review of the full Primary Care Estate had already been requested but priority had been given to those holding APMS Contracts which would expire by April 2024 or before. Both of these actions were with the teams at Liverpool Place, supported by the ICB Associate Director of Primary Care.</p> <p>EMO commented that the closure of a practice and dispersal of patients was the last option of choice and was a very hard decision for the committee to make. The focus would now be on supporting the patients affected.</p>	

	The Integrated Care Board noted the report	
ICB/01/23/20	Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee (Clare Watson)	
	<p>CWA provided the Board with an update on key issues considered by the C&M ICB Transformation Committee at its meeting of 10 November 2022. Members were asked to take the report as read.</p> <p>The committee had considered:</p> <ul style="list-style-type: none"> • The Integrated Care System Digital and Data Strategy. This had been considered by the Board in November 2022 • A programme reviewing the current transformational change activity occurring across the Cheshire and Merseyside system and the work to develop priorities, delivery, and governance approaches. ACTION: A report relating to this would be presented to the Board at its meeting in March 2023 • Development of the Integrated (Health and) Care Partnership Strategy. <p>The Integrated Care Board noted the report</p>	CWA
1.40pm	Other Formal Business	
ICB/01/23/21	Closing remarks, review of the meeting and communications from it (Raj Jain)	
	<p>RJA ended the meeting by commenting on the engagement with the public today.</p> <p>People sat around the table used the services of the NHS and wider care community as did their families. The overriding responsibility of the Board was to the people who use these services.</p> <p>The ICS would reflect on how the Board operated and how it listened to the patient voice.</p> <p>On behalf of the Board he thanked the 10s of thousands of people who worked for and helped to support the NHS.</p>	
	CLOSE OF MEETING	
Date, time and location of Next Meeting:		
23 February 2023 (time to be confirmed), Whiston Town Hall, Old Colliery Road, Whiston, Merseyside, L35 QX		

End of Meeting

**CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD**

Action Log 2023-24

Updated: 14.02.23

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-01	01/07/2022	ICB Constitution	The following changes to the ICB constitution will be made:- 1) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 2) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 3) The wording of section 7.3 will be reviewed to ensure completeness. 4) The role of the local authority will be strengthened and added to the final version document prior to publication. 5) The principles in section 6.2.1 will be revised and updated subject to the approval of the Board.	Clare Watson	27-Oct-2022	<i>Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map</i>	COMPLETED
ICB-AC-22-02	01/07/2022	ICB Functions and Decision Map	The diagram/wording on page 241 will be reviewed to make the link between the ICB and the Health and Wellbeing Boards clearer.	Claire Wilson	27-Oct-22	<i>Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map</i>	COMPLETED
ICB-AC-22-03	27/10/2022	Cheshire & Merseyside System Month 6 Finance Report	Requested CWA and CDO provide a Workforce Update at the next Board Meeting.	Claire Wilson	28-Nov-2022	<i>Workforce Update report included within the Director of Nursing and Care Report</i>	COMPLETED
ICB-AC-22-04	27/10/2022	Executive Director of Nursing and Care Report - Recommendations within the Kirkup Report	An independent investigation was commissioned in February 2022, reviewing 202 cases, evidence from family listening sessions, clinical records, interviews with clinical staff. Agreed to take the Kirkup recommendations to the Quality Committee for consideration.	Christine Douglas	28-Nov-2022		ONGOING
ICB-AC-22-05	27/10/2022	Continuous Glucose Monitoring Update	Requested that in 12 months' time the Board be provided with a progress update.	Rowen Pritchard-Jones	01-Oct-2023		ONGOING
ICB-AC-22-06	27/10/2022	Provider Collaborative Update	Agreed that a strategic business case relating to increased delegation be brought to the Board for consideration.	Joe Rafferty	28-Nov-2022	Requested to receive Business Case at a future Board meeting, date to be confirmed	ONGOING
ICB-AC-22-07	27/10/2022	Winter Planning 2022-23	Agreed that an updated position on winter resilience plans was reported to the Board at a future meeting	Anthony Middleton	28-Nov-2022	Winter Resilience Plan update report included on agenda for November 2022 meeting	COMPLETED

Action Log 2023-24

Updated: 14.02.23

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-08	28/11/2022	Minutes of the previous meeting – 27 October 2022	SBR questioned the minutes relating to item ICB/10/22/12 Provider Collaborative Update. He asked that the minute be changed to confirm that further discussions between JRA, SBR and GUR would take place but NOT that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration. RJA advised that his recollection was that the report had been requested. He confirmed that the recording of the meeting would be reviewed and confirmation of the agreed action be shared.	Raj Jain	Jan 2023	<i>Action completed</i>	COMPLETED
ICB-AC-22-09	28/11/2022	Executive Director of Nursing & Care Report	CDO confirmed that the C&M People Board was operational and that there was a need for robust plans to be developed to support this area of work. Early considerations included potential rostering issues and the introduction or continuation of flexible working arrangements Requested a report to January 2023 to describe if and how arrangements had been successful	Christine Douglas	Jan 2023		ONGOING
ICB-AC-22-10	28/11/2022	Cheshire & Merseyside System Month 7 Finance Report	There was a need for a comprehensive provider organisational integrated performance report to be presented to the Board covering all challenges being faced by organisations. This would be provided in the new financial year.	Claire Wilson	April 2023	<i>Added to Board Forward plan for April 2023</i>	ONGOING

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-01	01-Jul-2022	ICB Constitution	The following changes to the ICB constitution will be made:- 1) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the	Clare Watson	27-Oct-2022	<i>Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in</i>	COMPLETED

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2023 - 2024

Updated: 14 February 2023



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

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2023 - 2024

Updated: 14 February 2023



Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-10	04-Aug-2022	Cheshire & Merseyside ICB Financial Plan/Budget		1) The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. 2) The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	
ICB-DE-22-11	04-Aug-2022	Cheshire & Merseyside System Month 3 (Quarter One) Finance Report		The Board noted the Month 3 Financial Report.	
ICB-DE-22-12	04-Aug-2022	Cheshire & Merseyside Month 3 (Quarter One) Performance Report		The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB-DE-22-13	04-Aug-2022	Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire		The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB-DE-22-14	04-Aug-2022	Virtual Wards – update on their expansion across Cheshire and Merseyside		The Board noted the Virtual Wards update.	
ICB-DE-22-15	04-Aug-2022	Responses to questions raised by Members of the Public in relation to items on the agenda		The Board agreed to respond to all public questions raised prior to the August meeting.	
ICB-DE-22-16	29-Sep-2022	Chief Executive Report		1) The Board approved entering into the Sefton Partnership Board Collaboration Agreement 2) The Board approved the recommendation to delegate authority to the Chief Executive and the Assistant Chief Executive to sign off collaboration agreements or memorandum of understanding from other places noting that any arrangements requiring S75 or pooled budget agreements would be submitted to the ICB Board for approval.	
ICB-DE-22-17	29-Sep-2022	Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal		1) The Board approved the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation 2) The Board noted the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.	
ICB-DE-22-18	29-Sep-2022	Developing the Cheshire and Merseyside Integrated Care Partnership (ICP)		1) The Board approved the appointment of Louise Gittins as the designate Chair of the ICP 2) The Board approved the process for the appointment of a vice chair	
ICB-DE-22-19	29-Sep-2022	Report of the Audit Committee Chair		1) The Board approved the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee 2) The Board approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role 3) The Board approved ICB Information Governance Policies and statements / Privacy notices and their subsequent publication	
ICB-DE-22-20	29-Sep-2022	Report of the Chair of the ICB Quality and Performance Committee		The Board approved the proposed amendments to the revised Terms of Reference for the ICB Quality & Performance Committee	
ICB-DE-22-21	29-Sep-2022	Report of the Chair of the ICB System Primary Care Committee		The Board approved the proposed amendments to the Committees Terms of Reference subject to membership from LPS being included.	
ICB-DE-22-22	27-Oct-2022	Chief Executive Report		1) The Board noted the contents of the report. 2) The Board approved the recommendation change in the ICB's named Freedom to Speak Up Guardian.	
ICB-DE-22-23	27-Oct-2022	Welcome to Cheshire East		The Board noted the contents of the report and presentation.	
ICB-DE-22-24	27-Oct-2022	Residents Story Update - Social prescribing		The Board noted the presentation.	
ICB-DE-22-25	27-Oct-2022	Cheshire & Merseyside System Month 6 Finance Report		1) The Board noted the contents of this report in respect of the Month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. 2) The Board requested CWA and CDO provide a Workforce Update at the next Board Meeting.	
ICB-DE-22-26	27-Oct-2022	Cheshire & Merseyside ICB Quality and Performance Report		The Board noted the contents of the report and take assurance on the actions contained.	
ICB-DE-22-27	27-Oct-2022	Executive Director of Nursing and Care Report		1) Noted the content of the report. 2) Noted that CDO would be taking the Kirkup recommendations to the ICB Quality and Performance Committee for consideration. 3) Noted that a Workforce update will be provided within the next Director of Nursing and Care report to the Board Meeting.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2023 - 2024

Updated: 14 February 2023



Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-28	27-Oct-2022	Continuous Glucose Monitoring		1) The Board approved the retirement of the current Cheshire & Merseyside Continuous Glucose Monitoring (CGM) policy, and 2) The Board approved the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28. 3) Requested that in 12 months' time the Board be provided with a progress update.	
ICB-DE-22-29	27-Oct-2022	Provider Collaborative update		1) Noted the content of the report. 2) Agreed that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration.	
ICB-DE-22-30	27-Oct-2022	System Finance Assurance Report		The Board noted the contents of the report and the development of the financial accountability framework.	
ICB-DE-22-31	27-Oct-2022	Winter Planning 2022-23		1) The Board noted the contents of this report for information. 2) The Board agreed that an updated position on winter resilience plans is reported to the Board at a future meeting	
ICB-DE-22-32	27-Oct-2022	Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee		1) The Board noted the items covered by the Remuneration Committee. 2) The Board approved the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).	
ICB-DE-22-33	27-Oct-2022	Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee		The Board noted the contents of the report.	
ICB-DE-22-34	27-Oct-2022	Report of the Cheshire & Merseyside Chair of the ICB Transformation Committee		1) The Board noted the report 2) Approved the revised terms of reference attached to the paper.	

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Chief Executive's Report

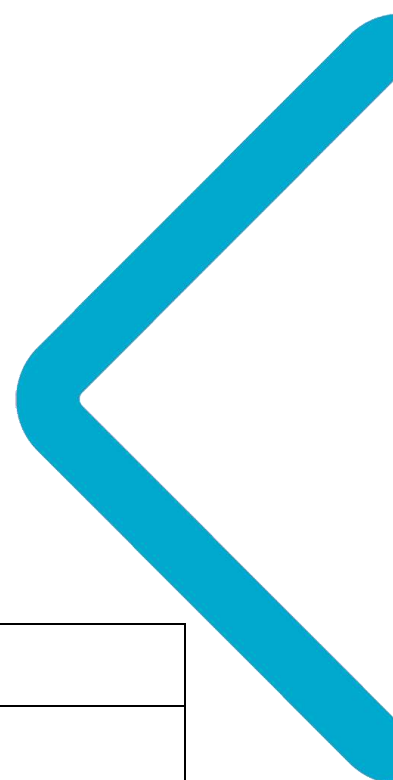
Appendix One: ICB Board Members



NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report

23 February 2023



Agenda Item No	ICB/02/23/06
Report author & contact details	Graham Urwin, Chief Executive
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Graham Urwin, Chief Executive

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executive's Report (February 2023)

Executive Summary	<p>This report provides a summary of issues not otherwise covered in detail on the Board meeting agenda. This includes updates on:</p> <ul style="list-style-type: none"> • appointments to the ICB Board • Delegation of Specialised Commissioning Services • NHS Staff Survey 2022 • Covid-19 Update • System Pressures • Elective Recovery Programme • Future ICB governance arrangements • Decision undertaken by Executives. 				
Purpose (x)	For information / note	For decision / approval	For assurance	For ratification	For endorsement
	x	x			
Recommendation	<p>The Board is asked to:</p> <ul style="list-style-type: none"> • note the contents of the report. 				
Impact (x) <small>(further detail to be provided in body of paper)</small>	Financial	IM &T	Workforce	Estate	
			x		
	Legal	Health Inequalities	EDI	Sustainability	
	x				
Management of Conflicts of Interest	No				
Next Steps	None				
Appendices	Appendix One	Board Appointments			
	Appendix Two	National map of Joint Committees for Specialised Commissioning			
	Appendix Three	List of Specialised Commissioning services that will form part of Joint arrangements from 2023-24			

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executives Report (February 2023)

1. Introduction

- 1.1 This report covers some of the work which takes place by the Integrated Care Board which is not reported elsewhere on this meeting agenda.
- 1.2 Our role and responsibilities as a statutory organisation and system leader are considerable. Through this paper we have an opportunity to recognise the enormity of work that the organisation is accountable for or is a key partner in the delivery of.

2. Appointments to the ICB Board

- 2.1 At its inaugural meeting in Jul 2022, the ICB Board received a paper outlining the appointments that had been made to the ICB Board via national or local recruitment and appointment process, observing the processes as outlined within the ICB Constitution. It was outlined within the July 2022 paper that the ICB had at that time not appointed two further roles to its Board, namely a fourth Non-Executive Director and a Partner Member (Primary Care).
- 2.2 I am pleased to announce that the ICB has successfully appointed to these vacant posts with Hilary Garratt (Non-Executive Director) and Dr Naomi Rankin (Partner Member) formally attending their first Board meeting today (23 February 2023). With the successful appointment to these two vacancies, we have now filled all identified roles on the Board, as outlined within our Constitution. The Board is asked to formally note the appointment of individuals to all of its positions on the Board, as outlined within Appendix One.

3. Delegation of Specialised Commissioning Services – next steps

- 3.1 NHS England's board has approved plans to establish joint committees between NHS England and multi-ICB collaborations¹ from 01 April 2023 - covering nine geographical footprints (Appendix Two) - that will oversee and take commissioning decisions on 59 specialised services within the portfolio. This will coincide with the introduction of population-based budgets for these services from April 2023, with the gradual and cautious application of a new needs weighted allocation formula from April 2024. Throughout 2023/24 the money and financial liability will remain fully with NHS England.

¹ <https://www.england.nhs.uk/publication/nhs-england-public-board-meeting-agenda-and-papers-2-february-2023/>

NHS Cheshire and Merseyside Integrated Care Board Meeting

- 3.2 Commissioning responsibility for all other specialised services will be retained by NHS England - for some services, this will be on a permanent basis and for others this will be temporary and until the point that they are considered ready for delegation. The arrangements in 2023/24 represent a stepping-stone to delegating full commissioning responsibility for suitable services, including budgets and financial liability, to multi-ICB collaborations from April 2024 - this will be subject to further NHS England Board consideration and decision.
- 3.3 The final service list (see Appendix Two) has indicated that there are
- 59 services (£13bn nationally) that are suitable and ready for ICB leadership in April 2023;
 - 29 services (£1.5bn nationally) that are suitable but not yet ready for greater ICB leadership (including all services in scope of Mental Health Learning Disability and Autism Provider Collaboratives); and
 - 89 services (£1.3bn nationally) that will remain nationally commissioned, including all 78 Highly Specialised Services.
- 3.4 A Joint Working Agreement has been developed to legally underpin the joint working model in 2023/24 for statutory joint committees between multi-ICBs and NHS England for the 59 services that are appropriate for more integrated commissioning.
- 3.5 These arrangements will be implemented using NHS England's powers under section 65Z5 of the NHS Act 2006. This model will support the transition to fully delegated commissioning arrangements for appropriate services in future.
- 3.6 The joint working model will be implemented to 'go live' from April 2023 and will:
- introduce joint decision-making between NHS England and ICBs for specialised services that are suitable and ready for greater ICB involvement
 - require the establishment of a joint committee of NHS England and ICBs to facilitate collaboration and decision-making in relation to the services
 - confirm that, to support a managed transition towards full delegation, for 2023/24 finances, liability and contracting will remain with NHS England, albeit overseen by the joint committee
 - confirm that commissioning teams will remain within NHS England in 2023/24 to support the transitional arrangements
 - provide decision-making safeguards for NHS England, recognising that this is a transitional year and liability remains with NHS England
 - allow the committees to be consulted on specialised services that are being retained by NHS England, although they will not have any decision-making powers relating to these services.

NHS Cheshire and Merseyside Integrated Care Board Meeting

- 3.7 The ICB has received and is currently reviewing the joint working agreement that will be held between NHS England, NHS Cumbria and South Lancashire ICB and NHS Greater Manchester ICB. A further paper will come to the Board in March 2023 seeking the approval of the joint working arrangement and establishment of the Joint Committee as a formal committee of the ICB, including the identification of representatives from the ICB to be members of the Committee.

4. NHS Staff Survey 2022

- 4.1 The 2022 survey results will be published at 9.30am on Thursday 9 March. As well as our local data, we will receive a benchmarking report against other ICBs. The ICBs Finance, Investment and Resources Committee will consider the findings of our survey results and a summary will be provided to ICB Board members at a future meeting of the ICB.

5. Covid-19 Update

- 5.1 **Performance.** The COVID booster offer (all boosters) ceased on 12 February 2023 for all cohorts. The final update for Cheshire and Merseyside was 61% uptake compared with an uptake in the North West region of 58.5%. The evergreen offer is to continue until further notice at this stage.
- 5.2 Whilst the outturn uptake for this phase five autumn 2022 booster is lower than the last autumn phase three 2021 booster (82.5%) and the spring 2022 booster (82.4%) C&M are performing best in the NW region. Nationally uptake is similarly reduced. Over the phase five programme (between the 05 September 2022 and 12 February 2023) the Cheshire and Merseyside programme delivered almost 787,000 seasonal boosters and almost 15,500 primary doses as part of the continuing evergreen offer.
- 5.3 **Capacity and Demand.** With demand low in Quarter Four and expected to be lower with withdrawal of the booster offer the network size continues to reduce with ongoing review. As well as the standard offer, targeted hyperlocal offers will continue to be used for evergreen primary courses in low uptake areas and PCNs as well as for citizen groups such as those with severe mental illness and learning disabilities. Access and inequalities funding continues to be used to support local offers and the Living Well Buses with targeted communications to ensure that citizens are aware of the ongoing evergreen offers.

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- 5.4 **Frontline HC Workers.** NHS Trust frontline Healthcare worker uptake in Cheshire and Merseyside is reported as 48.5% compared to the national and regional percentage (50.2 and 46.9% respectively). However, there remains a significant variation in the denominator used by the national team and Cheshire and Merseyside actual performance is nearer to 54%. The national team have indicated that they will correct the denominator by the end of March 2023 and establish a task and finish group with key regional individuals to resolve any other reporting and data issues. Whilst Cheshire and Merseyside are performing better than other subregions within the Northwest, uptake remains disappointing and intensive work has been ongoing at each Trust to improve the position and a continued evergreen offer remains in place.
- 5.5 **Living Well Buses.** The success of the Living Well service with the 3 buses continues (offered by Cheshire Wirral Partnership) with other regions and the national team taking a keen interest. The service has been shortlisted as a finalist in the HSJ Partnership Award. To date almost 11,000 COVID vaccinations, 3,500 MECC interventions (making every contact count) and approaching 3,000 health screenings across 300 clinics have been delivered. This offer will continue until the end of this financial year with the offer focussing on first and second doses. Comments from service users have also been very positive regarding the service and those staff who are delivering it.
- 5.6 **Homeless.** Our uptake of boosters in homeless and rough sleepers who have completed their primary courses is over 19% which exceeds the achievements of other sub regions but is behind the national figure of 27%.
- 5.7 **Strategy.** News on the future strategy for COVID vaccination including whether or not there will be a spring booster and the definition of the cohorts for any autumn booster are still awaited.

6. System Pressures

- 6.1 At our January 2023 meeting I highlighted a range of pressure felt within our main Hospitals and Ambulance services over the winter period. Whilst those pressures have subsided, a challenging operating environment remains impacting on the quality of care being received by our residents. To ensure a balanced view across a fuller range of services I am using this report to reflect upon some but not all of the challenges being faced within Mental Health and Primary Care services.
- 6.2 **Mental Health Services.** Increased demand, acuity and complexity of cases continue to cause system-wide pressure and impact on mental health acute care flow. As an example of the escalating requirement for MH services, the system has seen an increase in Adult Crisis line calls from 350 per week in the 3 months of September 2021 to December 2021 to 500 calls per week for the same period in 2022.

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- 6.3 With regards to inpatient provision, Patient's awaiting discharge from a mental health hospital bed to another setting, impact on our ability to admit new patients requiring assessment or treatment. In the most recent available data, there were a total of 35 delays within a total bed stock of 446. This in turn impacts upon our ability to provide access to local services and consequently we see patients placed outside of their local area for care. Mental Health Providers are set a target to eliminate all out of area placements for adults in acute inpatient care and have made some progress to reduce those adult out of area placements that are specifically considered to be inappropriate from over 2,000 bed days in June 2022 to 1,190 in November. Current figures show that from the North West region, 20.6 % of the inappropriate out of area placements for Mental Health are from Cheshire and Merseyside.
- 6.4 Bed occupancy for mental health is typically running at 98% against a target level of 92% and this has been rising since 2020. The most significant reasons for delays are limited access to supported accommodation and wrap around care; access to Nursing and Care Home provision; and to further non-acute NHS care. The time taken to secure a tenancy for a patient on discharge can be anything between 4 weeks to over 100 weeks dependent on the type of supported housing and available housing stock, plus the needs of the individual.
- 6.5 In order to help to address these ongoing issues an escalation framework for Adult mental health is being developed across the Northwest aligned with the System Control Centre and a 100-day Discharge Challenge is underway. There is also a plan for Strategic development of integrated housing – health, Local Authorities, and housing providers to address the availability of tenancies.
- 6.6 Delays within Mental health services inevitably have a direct impact on the length of time that these patients can wait in an acute Hospital Emergency Department. Patients accessing local Emergency Departments who require on-going care within a specialist facility has historically been problematic but with the number of patients waiting over 6 hours and over 12 hours increasing month on month since 2020. In January 2023 38% of Mental Health patients requiring a Mental Health admission waited over 6 hours for placement and 9% of patients waited over 12 hours. This current position is similar to other comparable ICSs locally. Key issues contributing to mental health 12-hour breaches in acute hospital emergency departments relate to mental health bed availability, delays in section 136 processes and access to mental health transport. An action plan is in place to address section 136 delays and a short-term contract has been agreed with Prometheus to provide observational staffing support in acute hospital places of safety.
- 6.7 Recruitment and retention of staff within mental health services remains of significant concern with the two Mental health providers showing overall vacancy rates of around 13% for qualified nursing staff and 12 % for Health Care Assistants, the vacancy rate for secured care however is significantly more with over 22% of posts vacant. This is of significant concern and reflects a regional and national shortage of Mental Health staff.

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- 6.8 Community physical health services have seen a notable increase in the number and clinical complexity of patients as care models offering alternatives to hospital admissions are developed and methods to measure this change are being investigated. Waiting lists for community appointments are also high with 40% waiting over 18 weeks for a first appointment.
- 6.9 The development of virtual wards and urgent community response (UCR) is ongoing and there are early signs of impact on hospital avoidance and supported discharge with virtual ward bed availability increasing and set to exceed 300 “beds” by April 2023
- 6.10 The Mental Health and Learning Disability provider collaborative is reviewing the variation in UCR and virtual wards to maximise their effectiveness and efficiency. The provider collaborative is also working with organisations to support small and fragile community services. Local clinical networks for specialist services are working across organisational boundaries to share pathways, peer support and mutual aid.
- 6.11 **General Practice.** GP Practices have seen unprecedented levels of demand due to usual winter respiratory illness, increased rates of Group A Strep infections and associated public anxiety, days of Industrial Action by colleagues in nursing and paramedic roles, rising Covid-19 and Influenza and ongoing pandemic recovery including long waits for elective care.
- 6.12 Practices have returned to pre-pandemic levels of appointment activity which now sits at a higher level than previously. While the exact mix of types of appointments offered has changed, latest data (Sept 22) shows that overall appointments delivered is 113.2% of pre-pandemic levels. We acknowledge there will be some variation both within and between Places, but these figures demonstrate a General Practice system that has already stepped up to meet the increases in demand being seen.
- 6.13 The General Practitioners Committee (GPC) of the British Medical Association (BMA) cite the European Union of General Practitioners recommendation of 25 contacts per day being a safe level of consulting. The majority practices report significantly higher numbers of patients being seen, with some GPs when ‘duty doctor’ essentially having to manage uncapped demand on the day. It would be unusual for GPs to be undertaking less than 30-35 contacts per day.
- 6.14 Actions taken to date to support Primary Care include:
- £1.86 million allocated to Cheshire and Merseyside from NHSE to support respiratory hubs through the end of March 2023. All Places across Cheshire and Merseyside have these hubs now operational.
 - Place escalation plans in place for practices to raise support flags/many places have supplemented this with regular PCN Clinical Director calls, practice calls and existing forums to ensure they are up to date with the pressures in the system.

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- Place can and have provided flexibility on any local enhanced service schemes and can relax any non-urgent reporting
- Place can repurpose any funding not used from local schemes, where able within their local arrangements /funding envelope.
- ICB has lobbied NHSE re relaxation of Additional Roles Reimbursement Scheme to see if this can be used for additional medical staff, we have also lobbied NHSE with regard to income protection for QoF. At the time of writing there has been no change in position from NHSE stating that there is no flexibility on either of these points. The ICB is however supportive of the ask but must act within rules set.
- ICB has secured additional capital monies circa £960k for IT equipment (so called 'future capital SDF funding 'bids). The bulk of this spend is items such as additional laptops for incoming ARRS staff.
- Slippage on Improvement Grant schemes have permitted two extra rounds of bids for Information Governance schemes that can be delivered before March end. In addition to agreed larger capital bids those schemes prioritised were to ensure space for staff/incoming ARRS staff in premises where space is a pressure.

7. Elective Recovery Programme

- 7.1 Excellent work has been underway across the CMAST Collaborative with regards the Cheshire and Merseyside Elective Recovery Programme. The system has successfully cleared all 104-week waiters with only exempt patients remaining and has reduced 78 week waits by over 25,000 in the last 19 weeks. A mutual aid hub was also established in January 2023, and which has facilitated mutual aid for over 2,000 patients across Cheshire and Merseyside. The diagnostics programme is also going from strength to strength with 79% of patient seen within 6 weeks, delivering 105,000 tests per month. The performance of this programme now ranks the ICBs as 11th best performing out of the 42 ICBs nationally.

8. Future changes to ICB Governance arrangements

- 8.1 At its meeting in March 2023, the ICB Board will be receiving formal proposals around changes to ICB Governance arrangements, which include seeking the approval of the establishment of a number of new Committees of the ICB, namely:
- ICB Children and Young Peoples Board
 - Women's Services Board
 - Specialised Commissioning Joint Committee
 - ICB Risk Committee.
- 8.2 The ICBs Finance, Investment and Our Resources Committee will also be looking to approve the establishment of Workforce Sub-Committee that will focus on the ICBs workforce. Work is underway with regards engagement around the development of Terms of Reference and identifying membership for these proposed new arrangements. Changes will need to be made to the ICBs Scheme of Reservation and Delegation to reflect these new Committee/Board

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arrangements which the Board will need to approve. This will also be true of future arrangements in relation to the delegation of ICB functions and resources to Place.

9. Decisions taken at the Executive Committee

9.1 Since the last Chief Executive report to the Board in January 2023, the following decisions have been made under the Executives' delegated authority at the Executive Committee. At each meeting of the Executive Team any conflicts of interest stated were noted and recorded within the minutes:

- **Interim Area Prescribing Group Prescribing Recommendations.** The Executive Team received a paper seeking approval for a number of prescribing recommendations on NICE Technology Appraisals (TA). The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE TAs. The Executive Team supported the prescribing recommendations.
- **Locally Commissioned Pharmacy Services.** The Executive Team received a paper regarding the proposed review of community pharmacy minor ailment schemes across Cheshire and Merseyside. The Executive Team supported the review and noted that a full business case regarding harmonisation of the schemes will go to the ICB System Primary Care Committee.
- **Consolidating transforming care programme team in Cheshire and Merseyside.** The Executive Team received a paper outlining the rationale to engage with NHS England around bringing into the ICB its people and resources from the Transforming Care Programme and consolidate with ICB staff also working on tis programme. The Executive team supported the papers recommendations to engage with NHSE on this matter.

NHS Cheshire and Merseyside ICB Board Members – confirmed as of 15.02.23

Name	Position	Term in Office end date
Raj Jain	Chair	2026
Tony Foy	Non-Executive Director	2025
Erica Morriss	Non-Executive Director	2024
Neil Large MBE	Non-Executive Director	2025
Hilary Garrett CBE	Non-Executive Director	2026
Dr Naomi Rankin	Partner Member	2026
Adam Irvine	Partner Member	2025
Professor Stephen Broomhead MBE	Partner Member	2024
Cllr Paul Cummins	Partner Member	2025
Ann Marr OBE	Partner Member	2024
Joe Rafferty CBE	Partner Member	2024
Graham Urwin	Chief Executive	-
Claire Wilson	Executive Director of Finance	-
Professor Rowan Pritchard-Jones	Medical Director	-
Christine Douglas MBE	Executive Director of Nursing and Care	-

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Appendix Two: Specialised Commissioning
Joint Committee National Map



Proposed Joint Committees

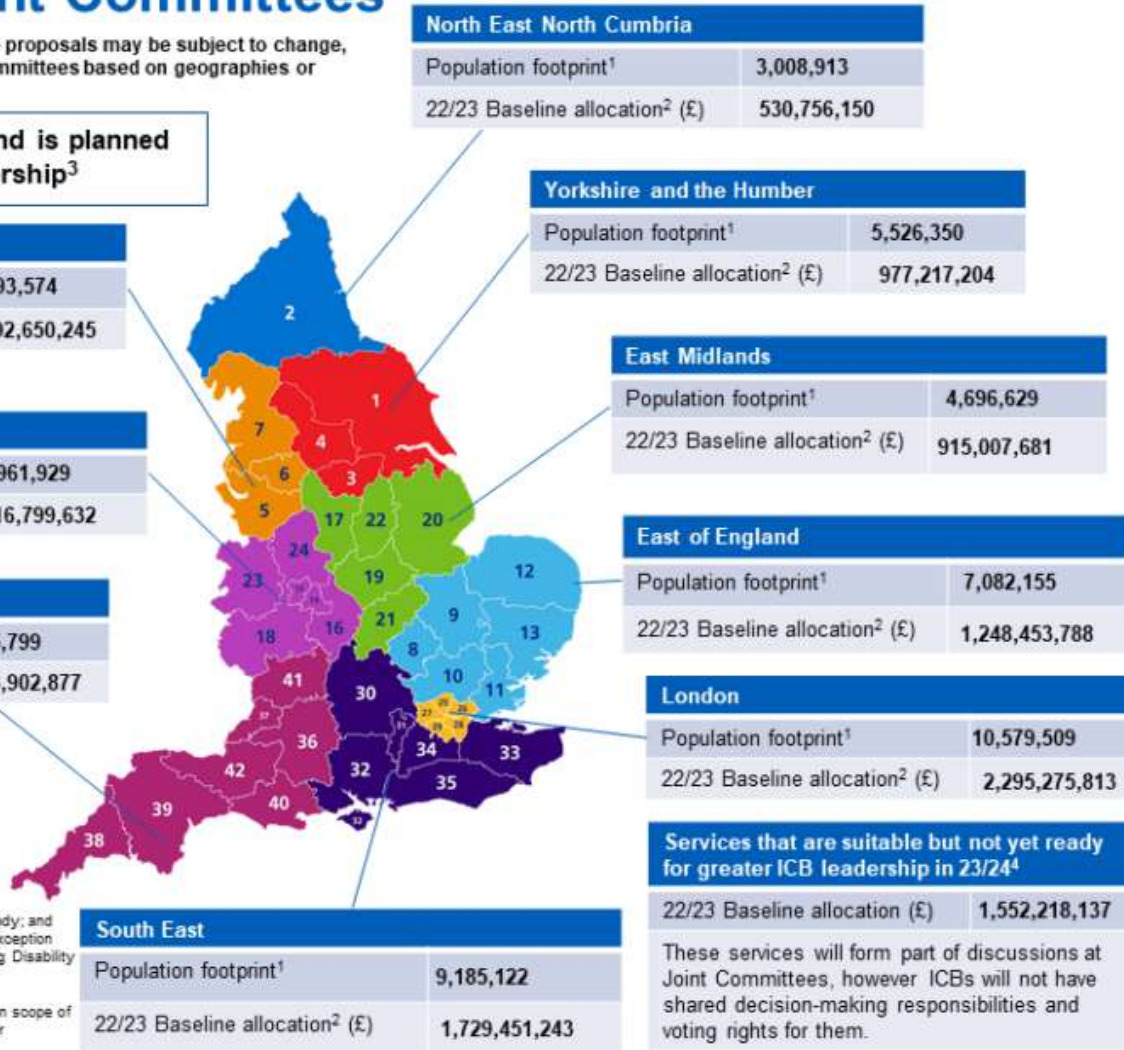
Discussions remain ongoing and these proposals may be subject to change, with some regions considering sub-committees based on geographies or services.

~ 90% of core service spend is planned for greater ICB leadership³

North West	
Population footprint ¹	7,693,574
22/23 Baseline allocation ² (£)	1,592,650,245

West Midlands	
Population footprint ¹	5,961,929
22/23 Baseline allocation ² (£)	1,216,799,632

South West	
Population footprint ¹	5,665,799
22/23 Baseline allocation ² (£)	1,093,902,877



Services that are suitable but not yet ready for greater ICB leadership in 23/24 ⁴	
22/23 Baseline allocation (£)	1,552,218,137
These services will form part of discussions at Joint Committees, however ICBs will not have shared decision-making responsibilities and voting rights for them.	

1. Population footprints used on this slide were provided by regions in their summaries or entered nationally where they were not provided. As a result, several different data sources have been used.

2. As the 23/24 allocations are not yet available, these figures are the 22/23 indicative baseline population based allocations for acute and mental health services that are suitable and ready for greater ICB leadership in 23/24.

3. This includes both services that are suitable and ready; and services that are suitable but not yet ready (with the exception of services that are in scope of Mental Health, Learning Disability and Autism Provider Collaboratives).

4. Please note this does not include services that are in scope of Mental Health, Learning Disability and Autism Provider Collaboratives.

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Appendix Three: List of Specialised Commissioning
Services



1. Services suitable and ready for greater ICS leadership

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease
		29S	Severe asthma
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Transcatheter Aortic Valve Replacement (TAVI)
13Z	Cardiac surgery (outpatient)		
9	Adult specialist endocrinology services	27E	Adrenal Cancer
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08E	Neurosurgery - Low Volume Procedures (National)
		08F	Neurosurgery - Low Volume Procedures (Regional)
		08G	Neurosurgery - Low Volume Procedures (Neuroscience Centres)
		08O	Neurology
		08P	Neurophysiology
		08R	Neuroradiology
		08S	Neurosurgery
		08T	Mechanical Thrombectomy
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery
		34R	Orthopaedic revision
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection
72	Major trauma services (adults and children)	34T	Major trauma services
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer
		01K	Malignant mesothelioma
		01M	Head and neck cancer
		01N	Kidney, bladder and prostate cancer
		01Q	Rare brain and CNS cancer
		01U	Oesophageal and gastric cancer
		01V	Biliary tract cancer
		01W	Liver cancer
		01Y	Cancer Outpatients
		01Z	Testicular cancer
		04F	Gynaecological cancer
		19V	Pancreatic cancer
24Y	Skin cancer		

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence
		33B	Complex inflammatory bowel disease
		33C	Transanal endoscopic microsurgery
		33D	Distal sacrectomy for advanced and recurrent rectal cancer
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	23X(b)	Specialist paediatric surgery services - Gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics
135	Specialist paediatric surgery services	23X(a)	Specialist paediatric surgery services - General Surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Complex termination of pregnancy
ACC	Adult Critical Care	ACC	Adult critical care

2. Services suitable but not yet ready for greater ICS leadership

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography-computed tomography services (PETCT)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids
		05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) - including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) - LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) - ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

3. Services remaining nationally commissioned

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
1	Adult ataxia telangiectasia services	23G	Adult ataxia telangiectasia services
2A	Adult oesophageal gastric services in the form of gastro-electrical stimulation for patients with intractable gastroparesis	39A	Gastro-electrical stimulation for patients with intractable gastroparesis
4	Adult specialist respiratory services	29G	Primary ciliary dyskinesia management (adult)
11	Adult specialist neurosciences services	08U	Transcranial magnetic resonance guided focused ultrasound (TcMRgFUS)
		43A	Inherited white matter disorders diagnostic and management service for adults
12	Adult specialist ophthalmology services	37D	Retinal Gene Therapy
		37E	Limbal Cell Treatment (Holoclar)
14	Adult specialist pulmonary hypertension services	13G	Adult specialist pulmonary hypertension services
15	Adult specialist renal services	36E	Cystinosis
19	Alkaptonuria service (adults)	20A	Alkaptonuria service (adults)
19A	Alpha 1 antitrypsin services (adults)	29H	Alpha 1 antitrypsin services
20	Alström syndrome service (adults and children)	H23	Alström syndrome service (adults and children)
21	Ataxia telangiectasia service for children	23J	Ataxia telangiectasia service for children
21A	Atypical haemolytic uraemic syndrome services (adults and children)	11A	Atypical haemolytic uraemic syndrome services (adults and children)
22	Autoimmune paediatric gut syndromes service	16A	Autoimmune paediatric gut syndromes service
23	Autologous intestinal reconstruction service for adults	12A	Autologous intestinal reconstruction service for adults
24	Bardet-Biedl syndrome service (adults and children)	20B	Bardet-Biedl syndrome service (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
25	Barth syndrome service (adults and children)	36A	Barth syndrome service (male adults and children)
26	Beckwith-Wiedemann syndrome with macroglossia service (children)	36B	Beckwith-Wiedemann syndrome with macroglossia service (children)
27	Behçet's syndrome service (adults and adolescents)	16B	Behçet's syndrome service (adults and adolescents)
28	Bladder exstrophy service (children)	D23	Bladder exstrophy service (children)
31	Pain-related complex cancer late effects rehabilitation service (adults)	01A	Breast radiotherapy injury rehabilitation service
33	Choriocarcinoma service (adults and adolescents)	01I	Choriocarcinoma service (adults and adolescents)
34	Chronic pulmonary aspergillosis service (adults)	29Q	Chronic pulmonary aspergillosis service (adults)
37	Complex childhood osteogenesis imperfecta service	K23	Complex childhood osteogenesis imperfecta service
38	Complex Ehlers Danlos syndrome service (adults and children)	M23	Complex Ehlers Danlos syndrome service (adults and children)
39	Complex neurofibromatosis type 1 service (adults and children)	08A	Complex neurofibromatosis type 1 service (adults and children)
41	Complex tracheal disease service (children)	B23	Complex tracheal disease service (children)
42	Congenital hyperinsulinism service (children)	N23	Congenital hyperinsulinism service (children)
43	Craniofacial service (adults and children)	15A	Craniofacial service (adults and children)
44	Cryopyrin associated periodic syndrome service (adults and children)	02A	Cryopyrin associated periodic syndrome service (adults and children)
46	Diagnostic service for amyloidosis (adults and children)	02B	Diagnostic service for amyloidosis (adults and children)
47	Diagnostic service for primary ciliary dyskinesia (adults and children)	29D	Diagnostic service for primary ciliary dyskinesia (adults and children)
48	Diagnostic service for rare neuromuscular disorders (adults and children)	08B	Diagnostic service for rare neuromuscular disorders (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
49	Encapsulating peritoneal sclerosis treatment service (adults)	11D	Encapsulating peritoneal sclerosis treatment service (adults)
50	Epidermolysis bullosa service (adults and children)	24A	Epidermolysis bullosa service (adults and children)
51	Extra corporeal membrane oxygenation service for adults with respiratory failure	29F	Extra corporeal membrane oxygenation service for adults with respiratory failure
52	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure	R23	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure
53	Ex-vivo partial nephrectomy service (adults)	01D	Ex-vivo partial nephrectomy service (adults)
56A	Hand and upper limb transplantation service (adults)	40A	Hand and upper limb transplantation service (adults)
56ZA	Ovarian and testicular tissue cryopreservation for patients receiving gonadotoxic treatment who are at high risk of infertility and cannot store mature eggs or sperm	44A	Gonadal tissue cryopreservation services for children and young people at high risk of gonadal failure due to treatment or disease
57	Heart and lung transplantation service (including mechanical circulatory support) (adults and children)	13N	Heart and lung transplantation
		13V	Ventricular Assist Devices
58	Specialist adult gynaecological surgery and urinary surgery services for females	04J	Urinary Fistula
61	Specialist dermatology services (adults and children)	43S	Stevens-Johnson syndrome and toxic epidermal necrolysis (SJS-TEN)
62	Specialist metabolic disorder services (adults and children)	36F	CLN2 Disease

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
65	Specialist services for adults with infectious diseases	18D	Human T- Cell Lymphotropic Virus Type 1 and 2
		18J	Adult high consequence infectious airborne disease service
		18L	Adult high consequence infectious contact disease service
		18U	Infectious disease isolation units
66	Hyperbaric oxygen treatment services (adults and children)	28Z	Hyperbaric oxygen treatment services (adults and children)
67	Insulin-resistant diabetes service (adults and children)	27A	Insulin-resistant diabetes service (adults and children)
68	Islet transplantation service (adults)	27B	Islet transplantation service (adults)
69	Liver transplantation service (adults and children)	19T	Liver transplantation service (adults and children)
70	Lymphangioliomyomatosis service (adults)	29C	Lymphangioliomyomatosis service (adults)
71	Lysosomal storage disorder service (adults and children)	36C	Lysosomal storage disorder service (adults and children)
73	McArdle's disease service (adults)	26A	McArdle's disease service (adults)
75	Mitochondrial donation service	20D	Mitochondrial donation service
76	NF2-schwannomatosis service (adults and children)	08C	Neurofibromatosis type 2 service (adults and children)
77	Neuromyelitis optica service (adults and adolescents)	08D	Neuromyelitis optica service (adults and adolescents)
79	Ocular oncology service (adults)	01H	Ocular oncology service (adults)
80	Ophthalmic pathology service (adults and children)	37A	Ophthalmic pathology service (adults and children)
81	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)	37B	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)
84	Paediatric intestinal pseudo-obstructive disorders service	12B	Paediatric intestinal pseudo-obstructive disorders service

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
85	Pancreas transplantation service (adults)	27C	Pancreas transplantation service (adults)
86	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)	03A	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)
88	Primary ciliary dyskinesia management service (adults and children)	29P	Primary ciliary dyskinesia management service (adults and children)
90	Proton beam therapy service (adults and children)	01B	Proton beam therapy service (adults and children)
91	Pseudomyxoma peritonei service (adults)	01F	Pseudomyxoma peritonei service (adults)
92	Pulmonary hypertension service for children	13J	Pulmonary hypertension service for children
93	Pulmonary thromboendarterectomy service (adults and adolescents)	13M	Pulmonary thromboendarterectomy service (adults and adolescents)
95	Rare mitochondrial disorders service (adults and children)	36D	Rare mitochondrial disorders service (adults and children)
97	Retinoblastoma service (children)	01G	Retinoblastoma service (children)
99	Severe acute porphyria service (adults and children)	27D	Severe acute porphyria service (adults and children)
100	Severe combined immunodeficiency and related disorders service (children)	16C	Severe combined immunodeficiency and related disorders service (children)
103	Small bowel transplantation service (adults and children)	12D	Small bowel transplantation service (adults and children)
103A	Specialist adult haematology services	03T	Thrombotic thrombocytopenic purpura (TTP)
104	Specialist burn care services (adults and children)	09A	Specialist burn care services (adults)
		09C	Specialist burn care services (children)
106A	Specialist colorectal surgery services (adults)	33E	Cytoreductive surgery and hyperthermic intraperitoneal chemotherapy for colorectal cancer
108	Specialist ear, nose and throat services for children	32E	Auditory brainstem implants for children

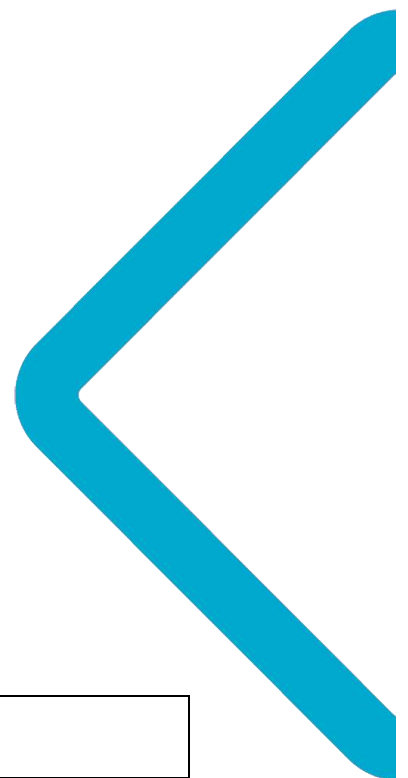
PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
114	Specialist haemoglobinopathy services (adults and children)	38S (NHP)	National haemoglobinopathy panel (NHP)
119	Specialist neuroscience services for children	08M	Spinal muscular atrophy: gene therapy
		43C	Inherited white matter disorders diagnostic and management service for children
		73M	Children's Epilepsy Surgery Service
		T23	Multiple Sclerosis Management service for children
		U23	Open Fetal surgery to treat fetuses with open spina bifida
123	Specialist paediatric liver disease service	C23	Specialist paediatric liver disease service
130	Specialist services for children with infectious diseases	14C	Specialist services for children with infectious diseases: HIV
		18K	High consequence infectious airborne disease services for children
		18M	High consequence infectious contact disease services for children
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19A	Total pancreatectomy with islet auto transplant
138	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)	P23	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)
139	Stickler syndrome service (adults and children)	20C	Stickler syndrome diagnostic service (adults and children)
139B	Uterine transplantation services (adults)	04U	Uterine transplantation services
140	Vein of Galen malformation service (adults and children)	A23	Vein of Galen malformation service (adults and children)
142	Wolfram syndrome service (adults and children)	Q23	Wolfram syndrome service (adults and children)
143	DNA Nucleotide Excision Repair Disorders Service (adults and children)	24D	DNA Nucleotide Excision Repair Disorders Service

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
6	Adult secure mental health services	22O	Offender personality disorder
		22U(a)	Secure and specialised mental health service (adult) (High) - Excluding LD
		22U(b)	Secure and specialised mental health service (adult) (High) - LD
74	Mental health service for deaf children & adolescents	22B	Mental health service for deaf children & adolescents
91A	Psychological medicine inpatient services for severe and complex presentations of medically unexplained physical symptoms (adults)	22V	Psychological medicine inpatient services for severe and complex presentations of medically unexplained physical symptoms
141	Integrated veterans' mental health and wellbeing service	22G	Veterans' mental health complex treatment service
		05V	Veterans' prosthetic service

Integrated Care Board Report

23 February 2023

Place Director Report – Knowsley



Agenda Item No	ICB/02/23/07
Report author & contact details	Alison Lee, Place Director (Knowsley)
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Alison Lee, Place Director (Knowsley)

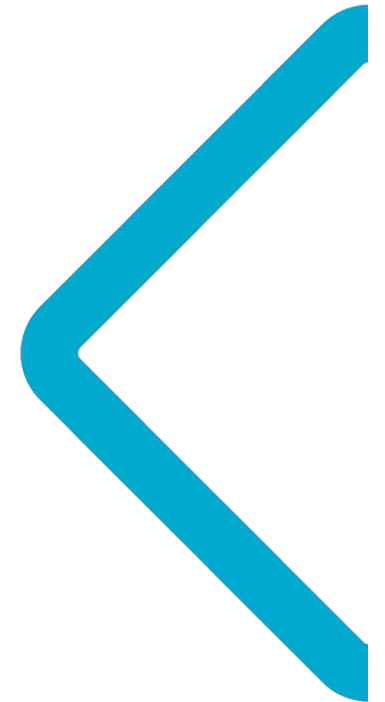
**Cheshire and Merseyside
Integrated Care Board Meeting**

Place Director Report – Knowsley

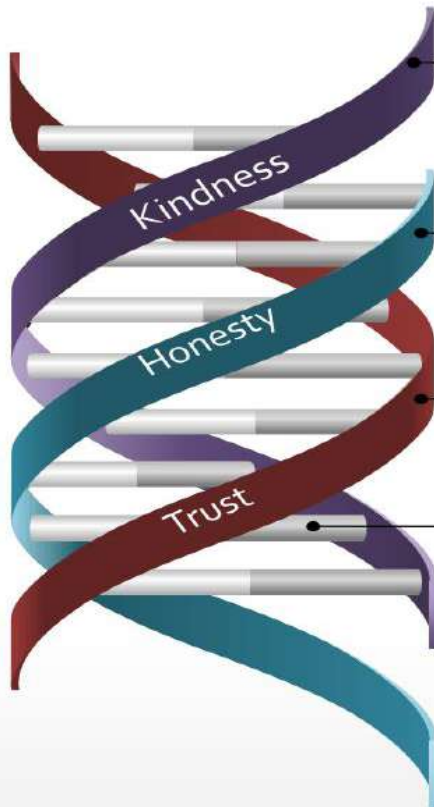
Executive Summary	<p>Each host Place is required to produce a Place Director's Report for consideration by the Cheshire and Merseyside Integrated Care Board.</p> <p>The Knowsley Place Director report aims to provide an overview of the Knowsley Place, its successes, its partnership working and its challenges.</p>				
Purpose (x)	<p>For information / note</p> <p>X</p>	<p>For decision / approval</p>	<p>For assurance</p>	<p>For ratification</p>	<p>For endorsement</p>
Recommendation	<p>The Board is asked to:</p> <ul style="list-style-type: none"> note the contents of the report and presentation. 				
Impact (x) (further detail to be provided in body of paper)	<p>Financial</p> <p>X</p>	<p>IM & T</p>	<p>Workforce</p>	<p>Estate</p>	
	<p>Legal</p>	<p>Health Inequalities</p> <p>X</p>	<p>EDI</p>	<p>Sustainability</p> <p>X</p>	
Appendices	<p>Appendix A</p>	<p>Knowsley Place Director Presentation</p>			

Welcome to Knowsley: Our Place

23rd February 2023



Our Vision & Values

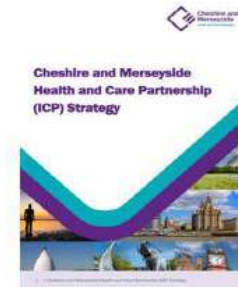


- Enabling people to live healthier and more independent lives through high quality seamless care

- Our vision is for everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer.
- We will do this by working together, as equal partners, to support seamless, person-centred care and tackle health inequalities by improving the lives of the poorest fastest.

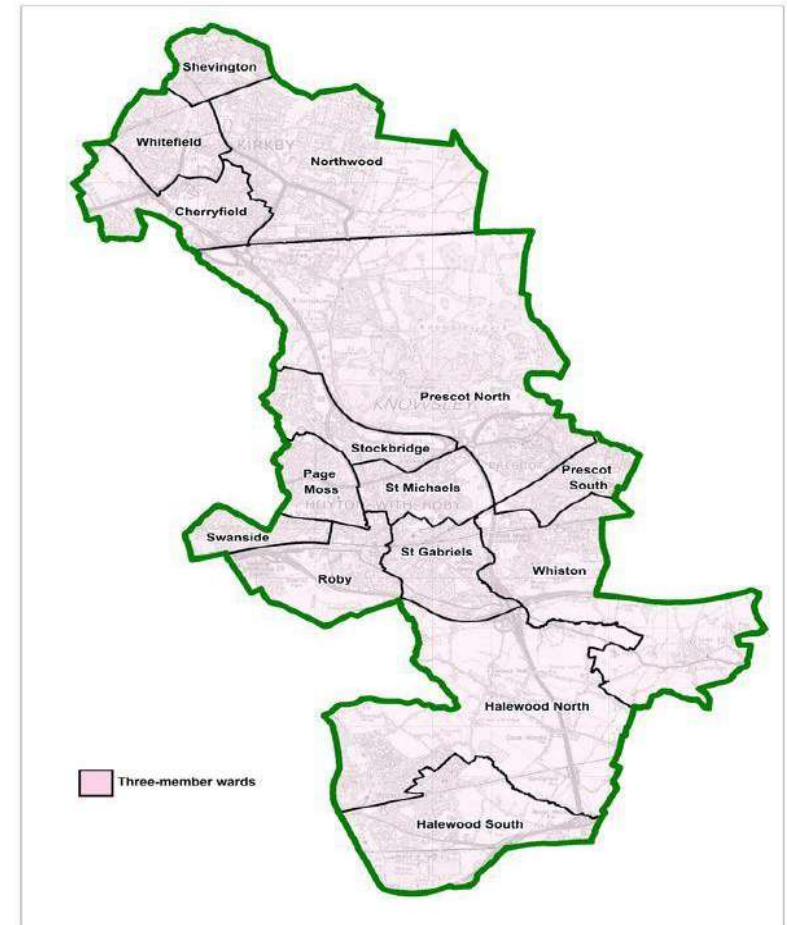
We want Knowsley to be a place:

- with a thriving, inclusive economy, with opportunities for people and business
- with welcoming, vibrant neighbourhoods and town centres;
- where people are active and healthy, and have access to the support they need;
- where people of all ages are confident and can achieve their full potential;
- where safe and strong communities can shape their future.



Our Place

Population 155,000	1 Local Authority	15 Electoral Wards
GP registered population 170,000	25 GP Practices	3 Primary Care Networks
2 Hospital Trusts	3 Trusts providing community services	1 Mental Health Trust



Our Population

Population growth

Population growth will continue in the short term. Knowsley's **resident population** has grown to **155,000** (2021) from 145,800 in 2011. It is anticipated that between 2,500 and 3,500 new homes will be developed

Ageing population

Population ageing will have an impact for health services as the largest age group in the borough (those aged 55-59 years) continues to age. Despite the impact of COVID. **Our older population is growing**

Age Grouping	Knowsley 2011	Knowsley 2021	Growth	Percentage Growth
Ages 0 to 19	36,756	36,800	44	0.1%
Ages 20 to 64	86,100	91,500	5,400	6.3%
Ages 65+	23,014	26,320	3,186	13.8%



Cheshire and Merseyside

Life expectancy

Healthy life expectancy in Knowsley stands at **58 years**. There will be an increasing demand for healthcare services (support and treatment for those developing long term conditions)

Birth rate and infants

A lower child population is evident due to lower birth rates 15-years ago, and historic migration out of the Borough. The child population is larger in the younger 0-4 group

If Knowsley was a village of just 100 people...

17



Adults suffer from depression

11



5-16 year olds have a MH disorder

42



Children are overweight or obese by year 6

31



Will die from cancer

69



Adults are overweight or obese

3



Adults under 40 have Type 2 diabetes

59



people are living with a long term condition

12



Will die from heart disease

22



Are smokers

81



Is the average age that women will live to

26



People take less than 30 mins exercise a week

77



Is the average age that men will live to

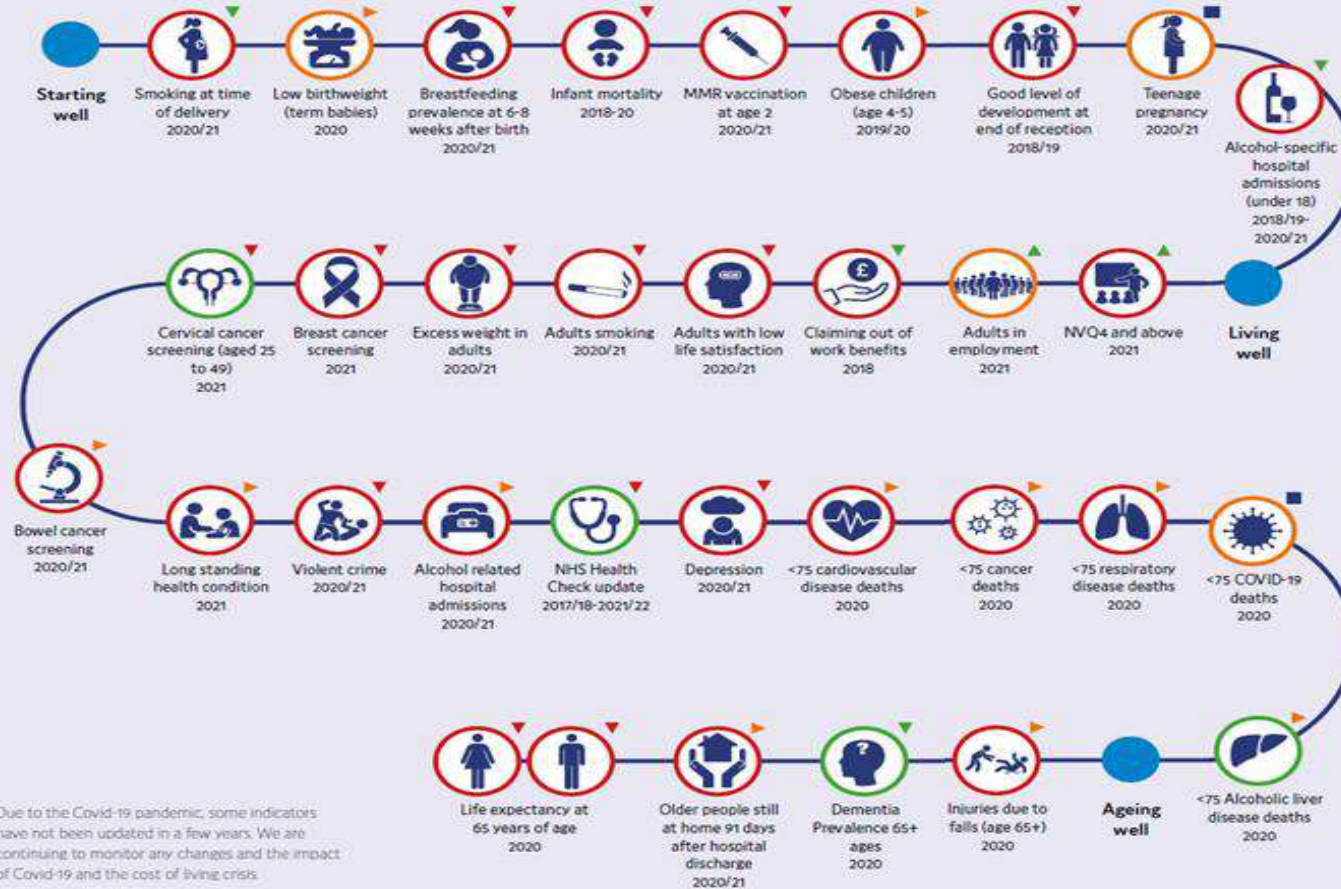
7



People are over 75

Statistics from PHE are for the Knowsley Local Authority area, pop: 147,000

KNOWSLEY HEALTH STATUS ACROSS THE LIFE-COURSE



Due to the Covid-19 pandemic, some indicators have not been updated in a few years. We are continuing to monitor any changes and the impact of Covid-19 and the cost of living crisis.

KNOWSLEY FACTS

Population
154,500
people live in Knowsley

There is:-
36,800 0-19 year olds
91,400 20-64 year olds
58,100 over 65 year olds

Deprivation
60.4% of Knowsley's population live in the top **20%** most deprived area in England.

Child poverty
25% of children aged 0-15 live in poverty in Knowsley.

KEY

Direction of travel
 ▲ Improved since last period
 ▶ Similar to last period
 ▼ Worse than last period
 ■ No comparator
 ▼ Decreasing and getting better

Statistical significance to North West
 ○ Better
 ○ No different
 ○ Worse

Top health challenges >5 Years

Life Expectancy

Life expectancy and healthy life expectancy **lower** than the North West and Cheshire & Merseyside average. An **unhealthy 50 – 60 age group** will present challenges for the health and social care system

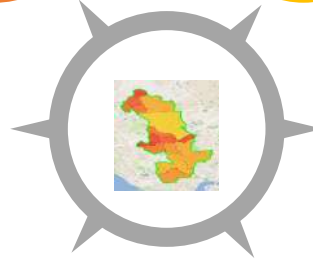


Obesity

Obesity in adults and children is relatively **high** compared to the North West and also across Cheshire and Merseyside. Activity levels are lower too.

Depression

Depression levels are **higher** than across the North West



Long term conditions

Number of people with long term conditions is **higher** than in the North West. Heart disease, type 2 diabetes and respiratory conditions are all higher

Smoking rates

Smoking rates **remain high**, compared to the North West and Cheshire and the Merseyside average



Population

There is an **ageing population** and an increase in those **living alone**. There have been lower birth rates across Knowsley, but this may change with an increase in the **20-30 year olds** in the Borough

- **We are a local based partnership** that brings together organisations responsible for planning and delivering health and care services. These include health and care providers, commissioners of their services, Knowsley Metropolitan Borough Council, primary care services (our three primary care networks), One Knowsley (the community sector) and HealthWatch.
- Knowsley is made up of towns and villages each with their own assets, opportunities and challenges. **Knowsley Healthier Together, as a placed-based partnership, will address the critical health challenges and embrace the opportunities to improve health services across the Borough.**
- We are new, but there is much expertise in the system and good work that we can build on.
- We will deliver our part of the overall strategy for the Borough, **Knowsley 2030**; our plan sets out what we want to deliver locally but also supports the delivery of the Cheshire and Merseyside Health and Care Partnership Strategy.



Partnership and Joint working

- **Partnership and joint working via our S75 agreement.**
Establishing strong relationships to enable collaborative working to deliver the outcomes of the Knowsley 2030 vision



Improving patient flow

- We focus **on home first** – both in avoiding admissions to hospital and getting people back home
- Knowsley provides more care at home and fewer people living in care homes
- We have an **integrated discharge team** with NHS and social care staff working together
- We have extended our Council in-house provided rapid and reablement team

Delivering care where it was needed

- We delivered our requirements for **virtual wards**.
- We improved the quality of services (working with Liverpool Heart and Chest Hospital) and MerseyCare) to people with **heart and respiratory** conditions.
- Our Knowsley **2 hour urgent care response** service is in operation 8-8, 7 days a week.
- Our **falls pick up service** has been fully implemented
- Improved access to low level mental health & wellbeing support with the **launch of 'Life Rooms'**

Delivering our NHS Priorities

- We **surpassed pre COVID levels for patient care and treatment**.
- We **achieved reductions in antibiotic prescribing** and met our online primary care access targets.
- There are **no out-of-area mental health placements** and we **achieved of our IAPT recovery time** targets

Our Achievements 2022-23 Performance

Urgent care

- The category 1 (life threatening) 8-minute **ambulance response** time target has been consistently met
- **A&E daily attendance** demand Apr-Nov remains below pre pandemic average (down by 3%)

Admission avoidance

- **Our 2-hour Urgent Care Response (UCR) service** is in operation 8-8, 7 days a week. The team sees an average of 80 referrals per month, mostly referred by local GPs. Around 64 admissions are avoided per month with 373 avoided this year to date
- **Virtual wards** - There is capacity for up to 95 Knowsley patients at a time to be treated on the local virtual wards across St Helens & Knowsley and Liverpool Hospitals. This capacity will increase over the next two months

Cancer

- Referrals for cancer are 27% higher than pre-pandemic levels
- Cancer treatment levels are 10% higher than pre-pandemic levels

Elective waiting times

- 104-week (2 year) waits have been eliminated in Knowsley and indeed across Cheshire and Merseyside
- The next target is to eliminate 78+ week (18 month) waits by the end of March 2023

Primary care

- GPs and their teams are seeing more patients than they did before the pandemic
- All 25 Knowsley GP practices are CQC rated 'good'
- All 25 practices meeting online access target
- Our rate of high-risk antibiotic prescribing is below national target for 23/25 practices

Mental Health

- Early Intervention in Psychosis target being met
- Improving Access to Psychological Therapies (IAPT) recovery time targets consistently met although access to IAPT remains challenging in Knowsley and across Cheshire & Merseyside)

Quality

There have been no reported cases of MRSA in current financial year (zero tolerance target.)

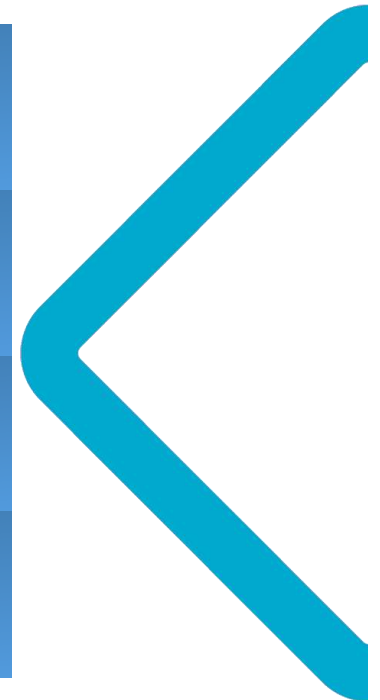
In Knowsley we are committed to carrying out meaningful engagement and communicating effectively with our communities

Making the right choices in Knowsley campaign; helping people understand the range of services available whilst promoting self-care

Starting our Northwood project – working with the people who live and work in this part of Northwood using an assets-based approach to community development

Relaunch of patient participation groups in our GP practices

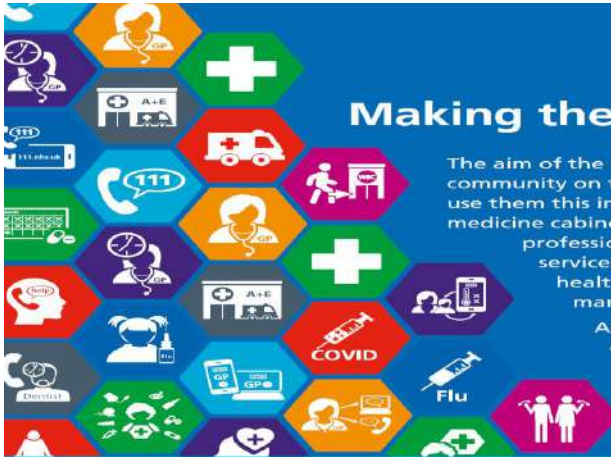
Working with the Local Authority on the Knowsley Offer - listening to our residents, setting out what the NHS offers now and being clear what will improve



Making the right choices in Knowsley

The aim of the campaign across Knowsley is to educate the community on the variety of services available locally and when to use them this included information on self-care, having a well-stocked medicine cabinet, local pharmacies, NHS 111, GP services and which professional you might see, Walk in centres, A&E and 999 services as well as other useful information such as mental health support, children's symptom checker and help with managing energy costs.

As part of the campaign a communication and engagement plan was developed to ensure the population of Knowsley received the information in a suitable format for them, this included resources, face to face engagement.



15,000 pocket guides distributed to following locations:

- Social clubs
- One stop shops
- Opticians
- Fire Service
- Community centres
- Social prescribers
- Nurseries
- Supermarkets
- Local councillors
- Living Well bus
- Warm hubs
- Cafés
- Parish council
- Dentists
- Bingo hall
- Plus many more locations



Engagements sessions include...



Support from our partners:

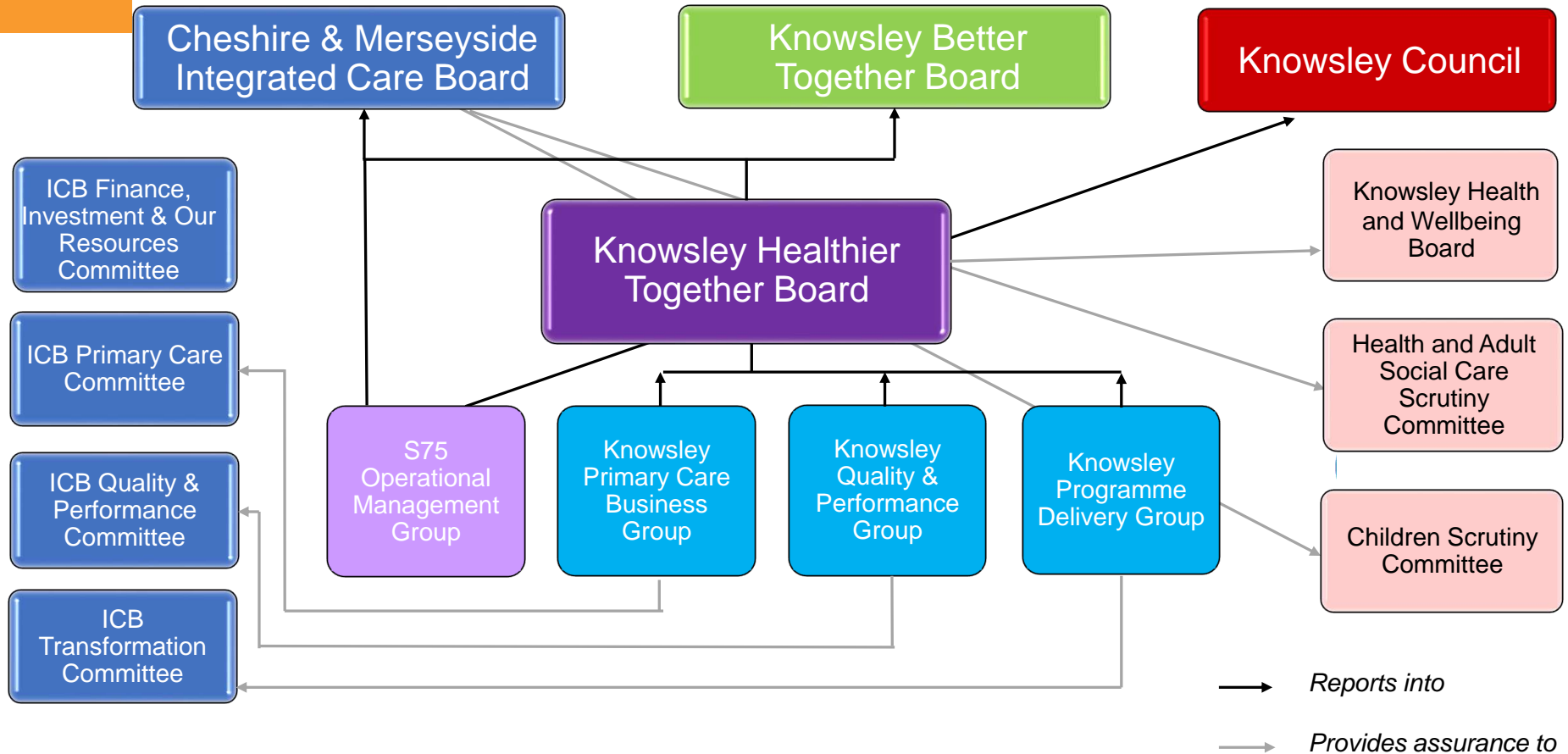


The next steps...

Following the campaign Knowsley Place communication and engagement team will continue promote this campaign and distribute resources and present the information as part of the engagement work plan to ensure the messages continue to be communication with our community.

Our Governance Arrangements

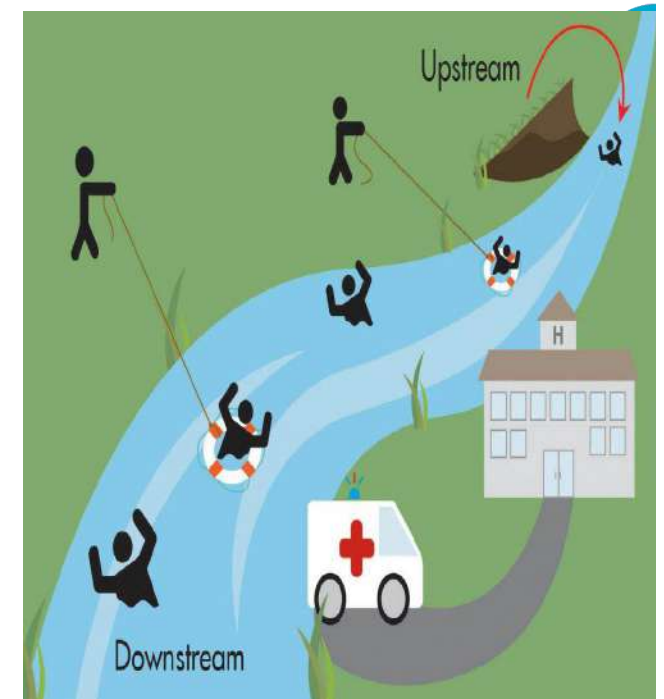
Cheshire and Merseyside



*There comes a point where we need to stop pulling people out of the river.
We need to go upstream and find out why they're falling in.'*

Bishop Desmond Tutu

- Over 65s projected to grow by c.25%
- Over 65s account for 2/3 hospital admissions
- Significant growth in long term conditions



The Revised Offer

- **Access to GPs.** Primary Care Networks have the opportunity to do this differently; digital offer, centralised call handling, same day response
- **Primary Care- more than GPs:** Pharmacists, physios etc
- **Expanding Virtual Wards and hospital at home:** ideally avoiding admission in the first place rather than supporting hospital discharge
- **Supporting care at home:** to make sure people get the daily support they need
- **Training local people to work in health and social care**
- **Connecting people with community support:** the role of the voluntary sector
- **Working with public health on prevention:** good local offer in our leisure services for example

This is where Place should focus



Our Key Objectives

Primary care

- Improving access to GPs and dentists
- Developing our 3 primary care networks
- Ensuring the additional roles reimbursement scheme is used to maximum effect.

Living well

- Ensuring we deliver direct access and/self referral for community services
- Deliver the next phase of our Health Inequalities Northwood initiative
- Work with partners to improve access to community diagnostics & cancer services

Ageing well & Urgent care

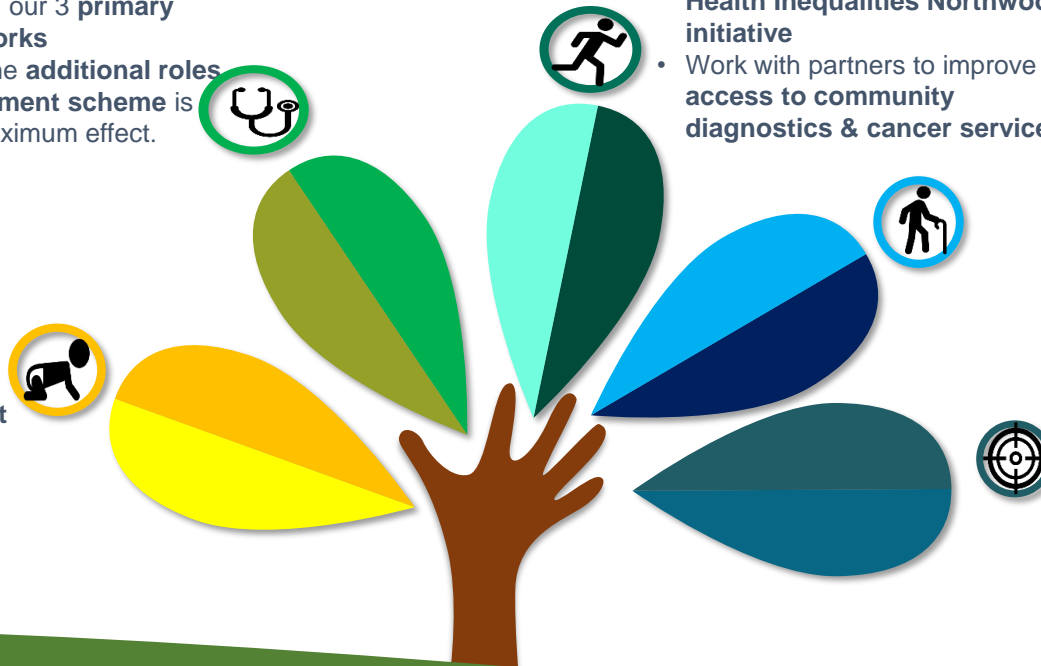
- Focused work on high-intensity users of service
- Deliver the effective transition from walk-in Centre's to the new urgent treatment Centre model
- Reducing avoidable admissions (joint work with St Helens and Halton)

Starting well

- Focus on children with special educational needs and disabilities:
- Improving the neurodevelopment pathway (joint work with St Helens & Halton)
- Developing family hubs with the Local Authority
- Development of our mental health workforce plan

Enabling

- Consistent application of prescribing formularies
- Development of our assurance and risk arrangements
- Work together to deliver the Knowsley Borough Estate Strategy
- Ensure that our service productivity and efficiency programme is delivered
- Maximise our digital assets
- Continue to engage with our community





Just before Christmas we hit crisis point with my mum and dad, particularly my mum who is 78 years old and has Alzheimer's. She caught the cough, heavy cold and flu like symptoms that is currently going around. She wasn't eating at all at her weight had dropped to 5st 8lb. We were at a loss of what to do and the only other option we had was to call 999. We didn't want her admitted to hospital because we know how overwhelmed the NHS is now but more importantly because we feared that if she went into hospital she wouldn't come out. She needed to be in familiar surroundings with familiar faces.

Urgent Community Response and Rapid Response came out to assess both of them (my dad is 80 and had a heart attack a few months ago so we were very concerned about him catching it as well). Both services were amazing! They treated my mum and dad so compassionately, with respect and dignity and a lovely touch of humour thrown in as well.



Our doctor had prescribed antibiotics for my mum to clear the infection, but she was unable to digest them and was rapidly deteriorating.

Ann-Marie from Urgent Community Response prescribed her the same antibiotics but in liquid form as well as giving them both full medical health checks.



She gave us some critical advice on the best way to care for my mum (which we followed to the letter) and she visited over several days until my mum was in a more stable position.

It was such a relief to have a medical professional give them thorough health checks and we have no doubt whatsoever that the care and advice they provided not only kept my mum out of hospital but we strongly feel that it saved us from losing her all together.

As a family we would all like to send our heartfelt thanks and gratitude to the Urgent Community Response team.



“ I have always been extremely proud to live in and work for Knowlsey and receiving a quality and critical service like this makes me even prouder.

Urgent Community Response (UCR) Service - urgent care at home in Knowsley



- ✓ Help and support to people who are experiencing a health or care crisis
- ✓ Assessments within two hours
- ✓ Works with the wider community team to reduce the risk of hospital attendances or admissions, as well as supporting early discharge

Who we are

UCR is a team of health and social care professionals who help to

maintain people at home - preventing avoidable hospital visits and stays - and to assist people returning home from hospital who need extra support.

We provide urgent two hour assessment and support to prevent hospital admission. A 48 hour response by social care can bridge the gap where ongoing care needs are identified.

UCR works closely with ambulance services, GP practices, mental health and other hospital and community services, as well as social care and voluntary sector organisations.



Who we support

People eligible for the service need to be:

- Over 18 and registered with a GP practice in Cheshire and Merseyside
- Living in Cheshire and Merseyside - whether independently, residential or care home
- Those at risk of hospital attendance or admission
- Medically safe to be treated or cared for in a community setting
- In crisis and needing assessment or intervention within two hours - must also be safe to wait for two hours.

How it works

UCR takes referrals from any health or social care professional including NHS 111 and the ambulance service. An assessment is completed and a clinical record opened ahead of the patient being assigned to a service practitioner. **To request support, call 0300 323 0240 and select option 1.**

“By wrapping a health and care response around patients in the community, we are providing an effective, integrated, responsive service that keeps Knowsley residents at home. We are seeing the benefit of this to individual patients every day”

Service manager



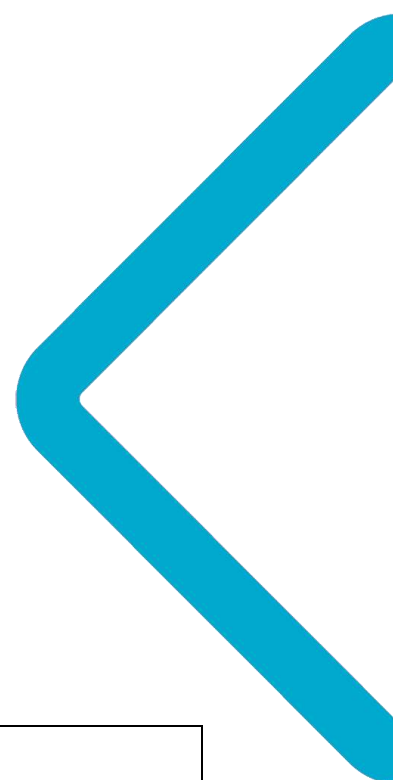
Call: 0300 323 0240 and select option 1

for two-hour Urgent Community Response (UCR) service
365 days a year, 8am to 8pm

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Director of Nursing and Care's Report



Agenda Item No	ICB/02/23/09
Report author & contact details	Kerry Lloyd – Deputy Director of Nursing & Care
Report approved by (sponsoring Director)	Chris Douglas – Executive Director of Nursing & Care
Responsible Officer to take actions forward	Kerry Lloyd – Deputy Director of Nursing & Care

Cheshire and Merseyside ICB Integrated Care Board Meeting

<p>Executive Summary</p>	<p>The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks and issues impacting on quality and safety within the Cheshire and Merseyside ICS footprint.</p> <p>The report will feature updates that include:</p> <ul style="list-style-type: none"> • Industrial Action • Health Equity Collaborative for Children & Young People • Training Support Package for Nurses in Residential Care Sector • Special Educational Needs & Disabilities (SEND) Inspection – Warrington • SEND Workforce Consultation Update. 				
<p>Purpose (x)</p>	<p>For information / note</p>	<p>For decision / approval</p>	<p>For assurance</p>	<p>For ratification</p>	<p>For endorsement</p>
<p>Recommendation</p>	<p>The Board is asked to:</p> <ul style="list-style-type: none"> • Note the content of the report and request additional information/assurance as appropriate 				
<p>Key issues</p>	<p>Preparation and planning have been ongoing since the first wave of industrial action (IA). The ICS established a governance framework that aligned to both national and regional architecture.</p> <p>The ICS is one of three ICS nationally, that has been successful in working with Barnardo's and the Institute of Health Equity, led by Sir Michael Marmot, to shape the way ICSs create health and address health inequalities among children and young people. The programme is designed to develop a Children and Young People's Health Equity Framework, with support from children and young people, and Voluntary, Community and Social Enterprise (VCSE) partners in the ICS region.</p> <p>The ICS has been successful in securing £330,000 to develop a programme of education for those nurses currently working within the residential care sector. The monies must be used to support interventions that help to avoid admission/aid discharge from acute hospital settings.</p> <p>Warrington place have just undergone a SEND inspection by the Care Quality Commission and Ofsted. The purpose of inspection is to:</p> <ul style="list-style-type: none"> • provide an independent, external evaluation of the effectiveness of the local area partnership's arrangements for children and young people with SEND • where appropriate, recommend what the local area partnership should do to improve the arrangements 				

Cheshire and Merseyside ICB Integrated Care Board Meeting

	The ICS has just gone live with its consultation on a revised workforce model for SEND. This revised model for the workforce will support the evolution into an ICS approach to delivery of the statutory functions in relation to provision and support for those with SEND and their care givers.			
Key risks	The ongoing impact of IA has the potential to impact upon the quality and safety of services.			
Impact (x) (further detail to be provided in body of paper)	Financial	IM &T	Workforce	Estate
	X	X	X	X
	Legal	Health Inequalities	EDI	Sustainability
	X	X	X	X
Route to this meeting	Not Applicable			
Management of Conflicts of Interest	No conflict of interest identified			
Patient and Public Engagement	Not Applicable			
Equality, Diversity, and Inclusion	The nature and content of the paper does not require an Equalities Health Impact assessment (EHIA) to be undertaken.			
Health inequalities	Not Applicable			
Next Steps	Reporting will continue via the established governance routes.			
Appendices	Appendix One	Health Equity Presentation		

Cheshire and Merseyside ICB Integrated Care Board Meeting

Director of Nursing and Care Report

1. Executive Summary

- 1.1 The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks and issues impacting on quality and safety within the Cheshire and Merseyside ICS footprint.
- 1.2 The report will feature updates that include:
 - Industrial Action
 - Health Equity Collaborative for Children & Young People
 - Training Support Package for Nurses in Residential Care Sector
 - Special Educational Needs & Disabilities (SEND) Inspection – Warrington
 - SEND Workforce Consultation Update.

2. Industrial Action

- 2.1 There have been ongoing periods of IA taking place throughout the month of February 2023, with most significant taking place through joint action by nurses both The Royal College of Nursing, Unite GMB members on the 6th and 7th February 2023.
- 2.2 Preparation and planning has continued via the established clinical/workforce cell. The cell comprises Nursing, Human Resource and Medical senior leaders. The cell continues to meet twice weekly and acts as a conduit for escalation and communication with ICS and regional partners.
- 2.3 The cell continues to gather insight and impact feedback from all affected organisations within C&M and has developed a tracker for oversight of any associated patient harm.

3. Health Equity Collaborative for Children & Young People

- 3.1 Through a successful bidding process, the ICS is one of only three ICSs nationally, that have been successful in securing a place to work with Barnardo's and the Institute of Health Equity, led by Sir Michael Marmot, to shape the way ICSs create health and address health inequalities among children and young people.
- 3.2 The programme is designed to develop a Children and Young People's Health Equity Framework, with support from children and young people, and Voluntary, Community and Social Enterprise (VCSE) partners in the ICS region.

Cheshire and Merseyside ICB Integrated Care Board Meeting

- 3.3 There are a range of benefits to the ICS in participating in this programme, which include:
- the opportunity to be part of a dynamic partnership that will position ICSs at the vanguard of change, working with a leading international light/thought leader on inequalities (IHE) and the UK's largest children's charity
 - to better understand local gaps and needs
 - to address childhood health inequalities and wider determinants and develop interventions against specific indicators
 - to lead best practice across all ICSs for children and young people
 - to meet NHS England's ICS health inequalities reporting requirements
 - to influence national policy in partnership with the UK's leading children's charity, Barnardo's, and the Institute of Health Equity (IHE)
 - to gain insights from other ICSs leading this work
 - to work alongside Sir Michael Marmot, who will be chairing the quarterly Steering Group for the Collaborative and supporting ICSs in the development of workstreams
 - to utilise VCSE data systematically to understand hidden need
 - to engage in a unique, collaborative, system-change project that addresses the holistic needs of children and young people.
- 3.4 The first meeting of the Children and Young People's Health Equity Collaborative Steering Group took place this month, of which the Executive Director of Nursing & Care is a member. The ICS presented at the Board, along with the other two ICSs involved (Appendix A). A series of ICS induction events are scheduled to take place during March 2023. Further updates will be brought to the ICB in due course, detailing developments, and impact.

4. Training Support Package for Nurses in Residential Care Sector

- 4.1 The ICS has been successful in securing £330,000 to develop a programme of education for those nurses currently working within the residential care sector. The monies must be used to support interventions that help to avoid admission/aid discharge from acute hospital settings.
- 4.2 The monies will support the use of a mobile training and skills hub, including access to a digital on Tour vehicle 1-2 days per week. The mobile hub is equipped with Virtual Reality equipment and includes capacity for working 1-1 with staff within the sector or through convening of training workshops.
- 4.3 This type of approach will support staff in 'taking the training to them', rather than them having to leave site, which can often be problematic in securing their participation and improving attrition rates.

Cheshire and Merseyside ICB Integrated Care Board Meeting

5. SEND

- 5.1 Warrington place has undergone a SEND inspection that took place over two weeks in February 2023. The inspection is part of a revised inspection regime, and as such Warrington is one of the first places nationally to participate.
- 5.2 The inspections are jointly led by the Care Quality Commission and Ofsted. The purpose of inspection is to:
 - Provide an independent, external evaluation of the effectiveness of the local area partnership's arrangements for children and young people with SEND
 - where appropriate, recommend what the local area partnership should do to improve the arrangements.
- 5.3 The Board will be provided with full findings of the inspection once formal notification of the inspection outcome has been received.
- 5.4 The ICS has just gone live with its consultation on a revised workforce model for SEND. This revised model for the workforce will support the evolution into an ICS approach to delivery of the statutory functions in relation to provision and support for those with SEND and their care givers.

6. System Oversight Framework (SOF) – Cheshire and Wirral Partnership NHS FT

- 6.1 Board members have previously been informed regarding Cheshire and Wirral Partnership NHS FT (CWP) and the work underway with the ICB with regards challenges at the Trust in particular to performance and quality of care.
- 6.2 Further to a recent segmentation moderation exercise, which was carried out in line with the NHS Oversight Framework 2022/23 a more focused review was undertaken. As a result of the review and in agreement with the ICB, a decision has been made to move CWP from Segment 1 to Segment 2, this is in line with requirements set out in the criteria for the framework.
- 6.3 NHSE and the ICB will continue to support CWP and work collaboratively to progress towards a Segment 1 rating.

7. Recommendations

- 7.1 The Board is asked to:
 - Note the content of the report and request additional information/assurance as appropriate.

8. Officer contact details for more information:

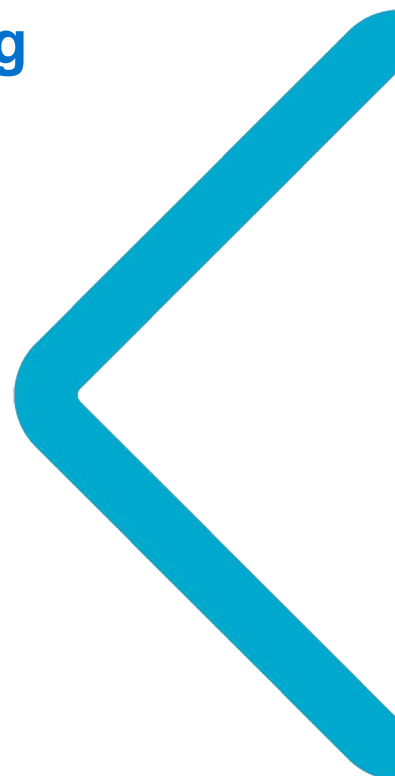
Kerry Lloyd – Deputy Director of Nursing & Care
Kerry.lloyd@cheshireandmerseyside.nhs.uk

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Director of Nursing and Care Report

Appendix One: Health Equity Presentation



Health Equity Collaborative Cheshire and Merseyside

February 2023



NHS Cheshire & Merseyside

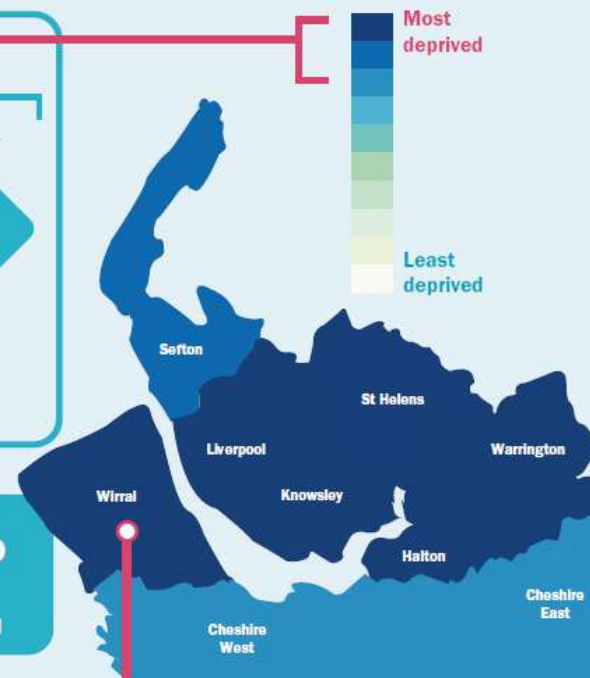
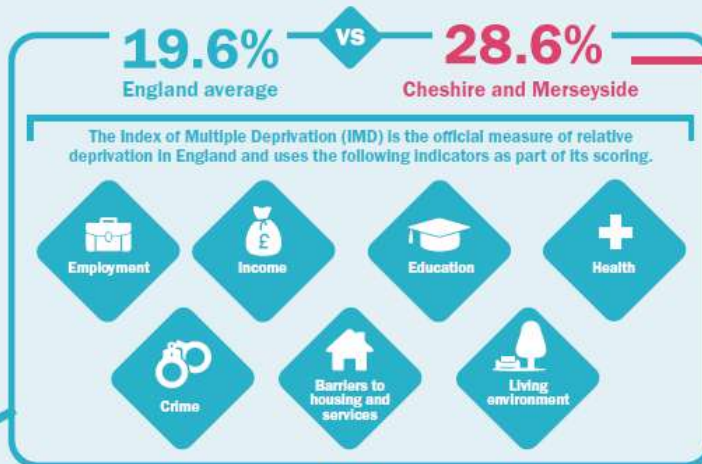


- Formally established on 1st July 2022
- Represents the bringing together of 9 former CCGs, co-terminous with local authority footprints
- 18 NHS Trusts, 355 GP Practices & 590 pharmacies
- Core Purpose of an ICB:
 - Improve population health and care
 - Tackle unequal outcomes and access
 - Enhance productivity and vfm
 - Support broader social and economic development

Understanding the challenges in Cheshire and Merseyside

Cheshire and Merseyside ICS represents a large and diverse geographical footprint.

There are 2.7 million people living across areas of both significant wealth and substantial deprivation. The mental and physical health and care challenges are faced by some of the most deprived neighbourhoods with the greatest health inequalities in England.



? What impact does this have on our people?



Reduced quality of life and disability-free years

Increased mental health problems in adults and children

Deaths due to:

are higher than the England average

Reduced life expectancy

People in the most deprived areas of Cheshire and Merseyside can live **15 years less** than those in wealthier areas. Even within Wirral there is a difference in life expectancy at birth of **11-years (women) and 13.8 years (men)** between the most and least deprived.

Children across our area do not “Start Well” (CIPHA)



Children are less likely to be breastfed at 6 – 8 weeks

In 6 of 9 Places, children have poorer communication skills at end of Reception than expected England levels

Children are performing less well in educational readiness / attainment particularly those eligible for free school meals

More school children are classified as overweight or obese at reception and Yr 6

A greater proportion of children are within Local Authority care – some Places recording double the England average

Children are more likely to have a hospital admission for asthma

3 in 5 children with Learning Disabilities are living in poverty

75% increase in ASD diagnosis over past 12 months

CYP are experiencing significant mental health difficulties

65% increase in children being referred to CAMHS

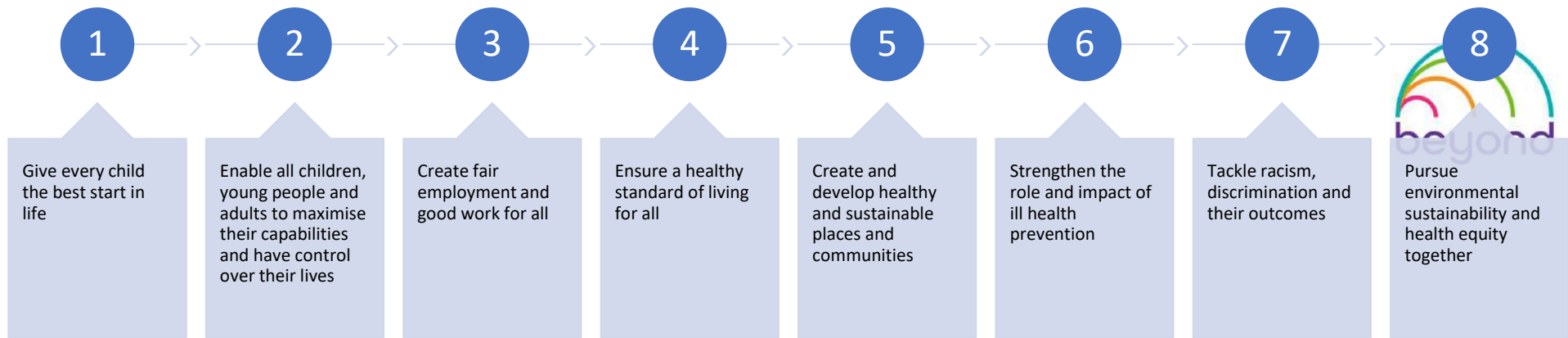
Over 35% of 5 years olds in Liverpool and Knowsley have obvious dental decay

Aims and Ambitions within the Health Equity Collaborative – Current Strengths

Thoughtful and intentional about the inclusion of all statutory & non-statutory partners to provide multi-agency approach to CYP

Data scientist already aligned to Beyond: Children's Transformation Programme to ensure data driven design, delivery and monitoring of outcomes

C&M already committed to becoming a Marmot community- "All Together Fairer"



Tackling Health Inequity



Aims and Ambitions within the Health Equity Collaborative

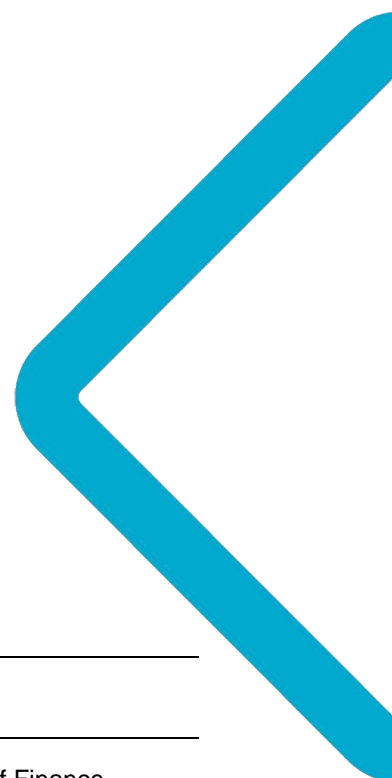
- ***To work within a partnership of ICBs, Barnardo's and the IHE with a shared vision for changing outcomes for children and young people***
- ***Data infrastructure development***– to shape data to provide validated measures where we can link the totality of CYP effort and enable a clear preventative approach linking multiple data. HI support and quality assurance to build holistic dataset/data matrix that represents wider determinants
- ***Children and young people's co-production*** – to work with other partners and Barnardo's as a trusted brand for VCSE sector involvement in systems planning.



NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Cheshire and Merseyside System Finance Report



Agenda Item No	ICB/02/23/10
Report author & contact details	Mark Bakewell – Deputy Director of Finance
Report approved by (sponsoring Director)	Claire Wilson – Executive Director of Finance
Responsible Officer to take actions forward	Claire Wilson – Executive Director of Finance



Cheshire and Merseyside System Finance Report – Month 10

Executive Summary	<p>This report updates the Board on the financial performance of Cheshire and Merseyside ICS (“the System”) for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of available ‘Capital’ resources for the financial year.</p> <p>As at 31st January 2023 (Month 10), the ICS ‘System’ is reporting an aggregate deficit of £71.9m against a planned deficit of £34.9m resulting in an adverse year to date variance of £36.9m. This is an improvement of £7.3m on the position reported a month 9.</p> <p>Detailed work has been undertaken to review forecasts at individual organisation level and updated positions are reflected in this report. The system continues to forecast a position in line with its plan by year end.</p>				
Purpose (x)	For information / note	For decision / approval	For assurance	For ratification	For endorsement
	x	x	x	x	x
Recommendation	<p>The Board is asked to:</p> <ul style="list-style-type: none"> Note the contents of this report in respect of the Month 10 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. 				
Key issues	<p>The financial plan is expected to be delivered in year; however, delivery is heavily reliant on non-recurrent measures.</p> <p>Continued focus on delivery of recurrent efficiencies will be critical in supporting the financial sustainability of our system in the future.</p>				
Key risks	<p>Outlined within the main paper.</p>				
Impact (x) <small>(further detail to be provided in body of paper)</small>	Financial	IM & T	Workforce	Estate	
	x		x	x	
	Legal	Health Inequalities	EDI	Sustainability	
				x	
Route to this meeting	<p>Papers previously discussed at ICB Finance, Investment and Resources Committee.</p> <p>Provider position will be presented to Cheshire and Merseyside Acute and Specialist Provider Collaborative in line with agreed reporting timetable</p>				
Management of Conflicts of Interest	<p>No specific issues raised</p>				
Patient and Public Engagement	<p>Financial performance at both place and provider level will be subject to local public communications and engagement arrangements.</p>				

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

Equality, Diversity, and Inclusion	Efficiency Plans and Investment decisions will need to be subject to organisation level Equality Impact Assessments (EIA). This will be subject to internal audit review in line with locally agreed audit plans.
Health inequalities	Healthcare resource and investment decisions impact on health inequalities and so future place-based allocation decisions will be subject to EIA processes. Strong budget management and control is important to minimise areas of overspend which lead to an unplanned redistribution of resources.
Next Steps	Continued monitoring of financial forecasts for revenue and capital allocations. Further development of cost improvement plans and system wide efficiency opportunities. Development of financial strategy to support future financial sustainability.
Appendices	Appendices 1-5 gives details of the narrative in the main body of the report.

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

Cheshire and Merseyside System Finance Report – Month 10

Executive Summary

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

It should be noted that full NHS provider returns for month 10 were only be submitted on 15th February 2023 and are therefore not available in time to produce this report. Summary financial performance information, or ‘key data’, is used as the basis of this report but means that the latest performance information is not readily available, for example, cash balances and better payment practice code (BPPC).

Financial performance for the period ending 31st January 2023

- The system is reporting an aggregate deficit of £63.6m in the year to date against a planned deficit of £34m, resulting in an adverse year to date variance of £29.6m.
- This represents an improvement of £7.3m from the position last reported to the board at month 9.
- Cost Improvement Plan performance has improved by £22.5m to £263.6m (full year plan is £330.9m).
- The system is no longer reporting an unmitigated financial risk and is currently reporting delivery of the planned system deficit position of £30.3m at the end of the year comprising a £43.0m deficit on the provider side, offset by a £12.7 surplus on combined CCG /ICB side

The year to date (YTD) position is set out in the table below and comprises a lower-than-plan YTD surplus position of £8.0m for CCGs/ICB (compared to a plan profile value of £16.4m) and a year-to-date deficit in the NHS providers of £71.6m (compared to plan profile of £50.4m).

Sector	2022/23 Annual Plan £m Surplus / (Deficit)	2022/23 YTD Plan £m Surplus / (Deficit)	2022/23 YTD Actual £m Surplus / (Deficit)	YTD Variance £m Surplus / (Deficit)	2022/23 Forecast £m Surplus / (Deficit)	Forecast Variance £m Surplus / (Deficit)
CCG/ICB	19.7	16.4	8.0	(8.4)	12.7	(7.0)
NHS Providers Trusts	(50.0)	(50.4)	(71.6)	(21.2)	(43.0)	7.0
Total System	(30.3)	(34.0)	(63.6)	(29.6)	(30.3)	0.0

The system continues to forecast achievement of the annual planned deficit of £30.3m. The £7m favorable variance to plan for providers offsets the £7m unfavorable variance

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

for the ICB and reflects achievement of a provider stretch target included during planning in the ICB position.

M10 Performance – Capital

As at 31st January 2023, provider operational capital expenditure remains below year-to-date planned values by £62.6m, forecasting £220.5m in line with the system capital allocation.

Key Performance Indicators

Full key performance indicator data is not available until providers have submitted their month 10 financial returns later in the month.

System Finance Report to 31st January 2023 (Month 10)

Background

- 1) This report updates the ICB on the financial performance of Cheshire and Merseyside ICS (“the System”) for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, and utilisation of available ‘Capital’ resources for the financial year.
- 2) The revised system plan for 2022/23 submitted on 20th June was a combined £30.3m deficit consisted of a £19.7m ‘surplus’ on the commissioning side (CCG/ ICB) which partly offset an aggregate NHS provider deficit position of £50.0m. The plan position reflected a variety of surplus / deficit positions across each C&M CCG and NHS Provider organisations as can be seen in Appendix 1.
- 3) It should be noted that ICBs as successor bodies to CCGs are required to plan for ‘at least’ a break-even position as reflected in the recent Health & Social Care Act, which has been reflected in the distribution / relative risk position within the ICS plan submission.
- 4) At the end of quarter one and in all financial performance circumstances, CCGs have been deemed to have delivered a breakeven financial performance position through an adjusting resource allocation process for the Q1 period (from the full year ICB allocation) with any residual difference in Q1 performance (both favourable / adverse) being inherited by the ICB during Q2-4. As a result, the additional surplus above plan of £6.7m originally reported by CCGs has been transferred to the ICB.

Month 10 (January) Performance

ICB/CCG performance

- 5) For quarter 1, the CCGs allocations were adjusted to breakeven to match the reported position, this has resulted in the movement of the £6.7m favourable

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

variance to plan from CCGs budgets to the ICB budget to support achievement of the annual plan.

- 6) The ICB is currently reporting a year-to-date surplus of £8m compared to an original planned surplus of £16m resulting in an adverse variance to plan of £10.4m as per the table below:

	2022/23 YTD Plan £m Surplus / (Deficit)	2022/23 YTD Actual £m Surplus / (Deficit)	2022/23 YTD Variance £m Surplus / (Deficit)	2022/23 YTD % Variance £m Surplus / (Deficit)
System Revenue Resource Limit	(3,467.9)			
ICB Net Expenditure				
Acute Services	1,827.7	1,825.2	2.6	0.1%
Mental Health Services	329.4	334.6	(5.2)	(1.6%)
Community Health Services	359.9	356.4	3.5	1.0%
Continuing Care Services	173.8	184.4	(10.7)	(6.1%)
Primary Care Services	357.7	366.6	(8.9)	(2.5%)
Other Commissioned Services	9.5	9.5	(0.0)	(0.1%)
Other Programme Services	39.2	37.5	1.7	4.4%
Reserves / Contingencies	(4.4)	(1.7)	(2.8)	62.1%
Delegated Primary Care Commissioning including:	322.0	318.3	3.7	1.2%
a) Primary Medical Services	279.6	276.7	2.9	0.0%
b) Pharmacy Services	42.4	41.6	0.8	0.0%
ICB Running Costs	30.0	30.3	(0.3)	(0.0%)
Total ICB Net Expenditure	3,444.8	3,461.1	(16.3)	(0.5%)
TOTAL ICB Surplus/(Deficit)	23.1	8.0	(15.1)	(0.4%)
* NB - CCG Q1 Adjustment	(6.7)	-	6.7	0.5%
Adjusted Surplus	16.4	8.0	(8.4)	(0.2%)

- 7) This adverse year to date performance is driven by the following issues which are being actively managed to ensure delivery of the plan by the year end.
- Mental Health - increased volume and value of packages of care, including out of area placements and non-contracted activity. This risk is being managed collaboratively with Mental Health provider partners and expected to be mitigated non-recurrently in year though risk share and slippage on other relevant allocations.
 - Primary Care Services - overspend on prescribing partially offset by underspends on GPIT and investments.
 - Community Services – overspend relating to independent sector contracts and community equipment services offset by underspends following a detailed review of place budgets.

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

- d. Continuing care - overspend relating to increases to volume and price for continuing care packages and funded nursing care. This is an area of significant focus and review by each place team.
- e. Reserves – mitigations secured to offset accepted planning risks with the exception of the provider stretch target now achieved by the provider sector.
- f. Delegated Pharmacy – additional funding has now been received to offset the pressures previously seen in the year-to-date position. In addition, the underlying position an underspend as a result of a reduction in transition fees for the remaining part of the year to cover the cost of the high uptake of the new advanced services.
- g. Efficiency savings are built into the year-to-date position and reflects a favourable position of £2.2m but a significant proportion of this is non-recurrently delivered. Development of recurrent savings was a key area of focus within the place review meetings in January 2023.

- 8) The ICB is now forecasting a surplus of £12.7m with the adverse variance to plan of £7m, offset by a favourable variance in the provider position. This is as a result of the transfer of a planning gap taken into the ICB position on behalf of providers who could not deliver their share of an improvement target, but which is now being delivered as by the provider sector overall.

NHS Provider Performance

- 9) The table below summarises the combined NHS provider position to the end of January 2023 reflecting a year-to-date cumulative deficit position of £71.6m compared to a year-to-date profile plan figure of £50.4m. Further detail is provided in Appendix 2.

	M10 YTD			M10 Forecast			
	Plan £m	Actual £m	Variance £m	Plan £m	ACTUAL £m	Variance £m	
Alder Hey Children's NHS Foundation Trust	2.6	3.2	0.6	4.6	7.1	2.5	
Bridgewater Community Healthcare NHS Foundation Trust	(0.1)	0.3	0.4	0.0	0.9	0.9	
Cheshire and Wirral Partnership NHS Foundation Trust	2.3	2.5	0.2	2.9	3.2	0.3	
Countess of Chester Hospital NHS Foundation Trust	(3.4)	(21.4)	(18.0)	(3.1)	(20.6)	(17.6)	
East Cheshire NHS Trust	(2.6)	(1.8)	0.7	(2.6)	(1.2)	1.4	
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.9	3.5	1.5	2.3	4.1	1.8	
Liverpool University Hospitals NHS Foundation Trust	(24.7)	(28.6)	(3.9)	(30.0)	(30.0)	0.0	
Liverpool Women's NHS Foundation Trust	0.6	(3.6)	(4.2)	0.6	(1.6)	(2.2)	
Mersey Care NHS Foundation Trust	4.6	6.5	2.0	5.7	16.9	11.2	
Mid Cheshire Hospitals NHS Foundation Trust	(9.3)	(11.9)	(2.6)	(10.4)	(11.7)	(1.3)	
Southport And Ormskirk Hospital NHS Trust	(14.3)	(14.0)	0.4	(14.2)	(13.8)	0.4	
St Helens And Knowsley Teaching Hospitals NHS Trust	(5.0)	(0.4)	4.5	(4.9)	7.1	12.0	
The Clatterbridge Cancer Centre NHS Foundation Trust	1.4	2.9	1.5	1.6	3.5	1.9	
The Walton Centre NHS Foundation Trust	2.2	3.1	0.9	2.9	4.6	1.7	
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(7.5)	(7.1)	0.5	(6.1)	(5.4)	0.7	
Wirral Community Health and Care NHS Foundation Trust	0.6	0.6	0.0	0.7	0.7	0.0	
Wirral University Teaching Hospital NHS Foundation Trust	0.2	(5.3)	(5.6)	0.0	(6.8)	(6.8)	
Total Providers	(50.4)	(71.6)	(21.2)	(50.0)	(43.0)	7.0	

- 10) 5 provider Trusts have reported an adverse year to date deficit position for months 1-9, resulting in an adverse position compared to plan of £34.3m.

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

- 11) Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£194.8m) and non-pay costs (£36.4m) offset set by favourable movements in Income (£198.1m) and non-operating items (£11.9m) as per the table below.

Surplus / (Deficit)	2022/23 Year-to-date				2022/23 Forecast			
	Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend	
	£m	£m	£m	%	£m	£m	£m	%
Income	(4,670.0)	(4,868.1)	198.1	-4.2%	(5,606.7)	(5,845.4)	238.7	(4.3%)
Pay	3,029.2	3,224.0	(194.8)	(6.4%)	3,632.8	3,821.9	(189.1)	(5.2%)
Non Pay	1,610.3	1,646.6	(36.4)	(2.3%)	1,926.7	1,984.3	(57.5)	(3.0%)
Non Operating Items (exc gains on disposal)	80.9	69.1	11.9	14.6%	97.2	82.3	14.9	15.3%
Total Expenditure	4,720.4	4,939.7	(219.3)	(4.6%)	5,656.7	5,888.5	(231.8)	(4.1%)
C&M NHS Providers	50.4	71.6	(21.2)	(42.0%)	50.0	43.0	7.0	13.9%

- 12) Key pressures relate to underachievement on delivery of planned cost improvement programmes, rising inflation and operational pressures associated with continued provision of escalation bed capacity.

- 13) Several upsides have crystallised in Month 10 that have improved the forecasts for a number of Trusts:

- Increase in the Bank of England base rate has increased interest receivable for a number of trusts and also decreased the provisions required for personal injury benefits.
- Capital Charges support for PDC-funded schemes in 22/23 (RAAC, Diagnostics, Mental Health and Frontline Digitisation). This funding source has not been confirmed for 23/24 and 24/25 (£6.7m)
- Profits on disposal have now been included in the System's financial performance (previously excluded up to month 10) (£1m)
- An incentive scheme offering Capital Resource Limit (CRL) support in return for an improvement in the revenue position in 22/23 (£19.6m)

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

- Countess of Chester NHS Foundation Trust**
Forecast £20.6m, £17.6m adverse variance to plan

Key drivers are a high level of substantive vacancies resulting in high levels of agency and bank spend, increased energy costs, insourcing capacity and Waiting List Initiative (WLI) costs incurred to deliver elective recovery. CIP performance is behind plan, but being delivered non-recurrently, resulting in a future pressure.

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- **Liverpool Women's NHS Foundation Trust**
Forecast £1.7m deficit, £2.2m adverse variance to plan
The variance is primarily driven by use of agency and premium rate staffing. This is due to high levels of sickness and national shortages of midwives and Obstetric consultants.
- **Mid Cheshire NHS Foundation Trust (MCHFT)**
Forecast £11.7m deficit, £1.3m adverse variance to plan
The Trust is experiencing increased unplanned demand, resulting additional escalation beds and newly opened discharge lounge. Premium costs are being incurred to staff these additional areas, driving the overspends reported against plan. CIP performance is behind plan and elective recovery is also behind pre-pandemic levels.
- **Wirral University Teaching Hospitals NHS Foundation Trust**
Forecast £6.8m deficit, £6.8m adverse variance to plan
The adverse variance to plan is as a result of 64 open escalation beds, use of corridor care in ED, increased energy costs and the Trust's underperformance in respect of recurrent CIP.

Provider Agency Costs

- 15) ICB Providers set a plan for agency spend of £113.3m, compared to actual spend in 2021/22 of £139.2m. The system is required to manage agency costs within budget and to demonstrate reduced reliance on agency staffing year on year.
- 16) Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency above £50k. In Month 10, agency spend is £130.1m (£35.9m above plan), with all Trusts except for Southport and Ormskirk and Mid-Cheshire reporting adverse positions to plan. The forecast spend being reported by Trusts is £153.6m (£40.3m above plan) which equates to 4% of total pay.

Efficiencies

ICB Efficiencies

- 17) The ICB is currently reporting a £2.2m favourable variance to plan YTD mostly because of non-recurrent savings. The ICB is currently forecasting to achieve the planned efficiencies of £68.8m.
- 18) The ICB has established a programme approach to identification, development and tracking of efficiencies and is a key area focus in respect of both this and future financial years and this has been a key area of focus in the recent place review meetings chaired by the ICB CEO.

Provider Efficiencies

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

- 19) Provider efficiency schemes are now £5.2m behind plan at month 10; efficiencies of £204.2m have been delivered to date compared to a plan of £209.4m. However, only £76.7m of this has been delivered recurrently (£127.5m non-recurrently) and this is a key risk to the underlying financial position of the system. The detail by provider is included in Appendix 4.

System Risks & Mitigations

- 20) Following identification of further mitigations to support the system financial position the ICS is no longer reporting any unmitigated risk. The system is working closely together to manage any further risks as they arise to ensure delivery of the forecast position.

Provider Capital

- 21) The 'Charge against Capital Allocation' represents the System's performance against its operational capital allocation, which is wholly managed at the System's discretion. Spend in relation to National programmes and other items chargeable to the Capital Direct Expenditure Limit (CDEL) are effectively administered on the behalf of systems, and therefore under/overspending does not score against System's Capital performance.
- 22) At month 10, progress of the system's operational capital programme expenditure remains below year-to-date planned values by £62.6m. Detail by provider is set out in Appendix 5.
- 23) All Trusts are forecasting achievement of plan, except for the following:
- a. LUHFT are forecasting an underspend of £20m, following the allocation of Additional PDC to support the New Hospital build and the release of the ICB reserve which was held by the Trust on behalf of the wider system.
 - b. Mersey Care are reporting a £1.3m underspend, which is related to spend at the Whalley Site, which is now being carried out by Lancashire Care on their behalf. An allocation transfer will take place in Month 11 to bring the position back in line with plan.
 - c. Southport and Ormskirk are reporting a £10m overspend, in accordance with the allocation of the ICB capital reserve in return for an improvement in the revenue position of the same value.
 - d. East Cheshire are reporting a small overspend as part of the capital incentive scheme described above.

Primary Care Capital

- 24) C&M ICB has a capital allocation of £4.7m for Primary Care, but also benefits this year from a legal charge redemption of £1.235m.
- 25) NHSE Primary Care commissioners have engaged with GP practices and premises grant requests totalling £1.226m in 22/23 with a further 23/24 impact of

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£0.846m have been received and reviewed against the requirements of the Premises Directions. Plans have now been approved by the ICB Primary Care Committee and NHSE.

- 26) Place digital leads identified and prioritised £4.1m for GP BAU IT. These programmes have been approved by NHSE regional team and the Primary Care Committee.
- 27) Slippage monies of £535k have been allocated to IT for Wireless LAN controllers and upgrades to Pharmacy IT infrastructure across the ICB.
- 28) In addition, the ICB has been allocated £935k related to small improvement grants and IT infrastructure for additional roles within primary care.
- 29) A £543k allocation for Falls has been distributed to Local Authorities.

Strategic Capital

- 30) There are a large number of Strategic Capital schemes, administered by NHS England, the main ones being:
 - a. Mental Health – Urgent and Emergency Care, Dorm Eradication.
 - b. Elective Targeted Investment Fund.
 - c. Community Diagnostic Centres.
 - d. Diagnostics – Levelling up, digitisation, single CT scanner sites.
 - e. Digital – EPR, frontline digitisation.
 - f. NHP – New Hospitals Programme.
- 31) Business cases to bid for these funds have been submitted and most funds allocated for Mental Health, TIF, CDC, NHP and Diagnostics. Digital diagnostics and frontline digitisation are yet to be allocated.
- 32) The revenue consequences of these investments may pose a risk to providers financial positions should anticipated efficiencies are not delivered.
- 33) Performance against these schemes does not score against the system allocation, but slippage on these schemes can adversely impact the system allocation in future years.

Recommendations

The Board is asked to:

- **Note** the contents of this report in respect of the month 10 year to date financial position for both revenue and capital allocations within the 2022/23 financial year.

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

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Appendix 1

2022/23 plan submissions by CCG / NHS provider

CCG / ICB	Full Year Plan (Deficit) / Surplus £ 000's
NHS HALTON CCG	(3,340)
NHS KNOWSLEY CCG	12,051
NHS SOUTH SEFTON CCG	(4,051)
NHS SOUTHPORT AND FORMBY CCG	(6,336)
NHS ST HELENS CCG	(1,905)
NHS WARRINGTON CCG	(2,302)
NHS WIRRAL CCG	7,499
NHS CHESHIRE CCG	(28,814)
NHS LIVERPOOL CCG	19,755
Total CCG Position	(7,788)
NHS LIVERPOOL CCG - as ICB Host	27,112
Total ICB Planned (Deficit/Surplus)	19,669

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

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

Appendix 2

System Financial Position: Combined Year-to-date Financial Position by Organisation as at Month 10 (31st January 2023)

	M10 YTD			M10 Forecast			Month 9	Forecast
	Plan £m	Actual £m	Variance £m	Plan £m	ACTUAL £m	Variance £m	Variance £m	Movement M10 - M9 £m
CCGs/ICB	16.4	8.0	(8.4)	19.7	12.7	(7.0)	0.0	(7.0)
Alder Hey Children's NHS Foundation Trust	2.6	3.2	0.6	4.6	7.1	2.5	1.5	1.0
Bridgewater Community Healthcare NHS Foundation Trust	(0.1)	0.3	0.4	0.0	0.9	0.9	0.6	0.3
Cheshire and Wirral Partnership NHS Foundation Trust	2.3	2.5	0.2	2.9	3.2	0.3	0.3	0.0
Countess of Chester Hospital NHS Foundation Trust	(3.4)	(21.4)	(18.0)	(3.1)	(20.6)	(17.6)	(3.2)	(14.4)
East Cheshire NHS Trust	(2.6)	(1.8)	0.7	(2.6)	(1.2)	1.4	0.3	1.1
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.9	3.5	1.5	2.3	4.1	1.8	0.8	1.0
Liverpool University Hospitals NHS Foundation Trust	(24.7)	(28.6)	(3.9)	(30.0)	(30.0)	0.0	(0.0)	0.0
Liverpool Women's NHS Foundation Trust	0.6	(3.6)	(4.2)	0.6	(1.6)	(2.2)	0.0	(2.2)
Mersey Care NHS Foundation Trust	4.6	6.5	2.0	5.7	16.9	11.2	2.0	9.2
Mid Cheshire Hospitals NHS Foundation Trust	(9.3)	(11.9)	(2.6)	(10.4)	(11.7)	(1.3)	0.0	(1.3)
Southport And Ormskirk Hospital NHS Trust	(14.3)	(14.0)	0.4	(14.2)	(13.8)	0.4	0.0	0.4
St Helens And Knowsley Teaching Hospitals NHS Trust	(5.0)	(0.4)	4.5	(4.9)	7.1	12.0	1.8	10.2
The Clatterbridge Cancer Centre NHS Foundation Trust	1.4	2.9	1.5	1.6	3.5	1.9	0.4	1.5
The Walton Centre NHS Foundation Trust	2.2	3.1	0.9	2.9	4.6	1.7	1.0	0.7
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(7.5)	(7.1)	0.5	(6.1)	(5.4)	0.7	(0.0)	0.7
Wirral Community Health and Care NHS Foundation Trust	0.6	0.6	0.0	0.7	0.7	0.0	0.0	0.0
Wirral University Teaching Hospital NHS Foundation Trust	0.2	(5.3)	(5.6)	0.0	(6.8)	(6.8)	(5.5)	(1.3)
Total Providers	(50.4)	(71.6)	(21.2)	(50.0)	(43.0)	7.0	(0.1)	7.0
Total System	(34.0)	(63.6)	(29.6)	(30.3)	(30.3)	0.0	(0.1)	(6.9)

Note: brackets denote deficit/overspend.

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

Appendix 3

Agency spend: Current Performance and Forecast Outturn as at Month 10 (31st January 2023)

Provider	Month 10 YTD			Month 12 Forecast		
	Plan	Actual	Variance	Plan	Forecast	Variance
Alder Hey Children's NHS Foundation Trust	0	(1,004)	(1,004)	0	(1,204)	(1,204)
Bridgewater Community Healthcare NHS Foundation Trust	(4,124)	(4,901)	(777)	(4,952)	(5,758)	(806)
Cheshire And Wirral Partnership NHS Foundation Trust	(2,582)	(6,576)	(3,994)	(3,100)	(7,715)	(4,615)
Countess Of Chester Hospital NHS Foundation Trust	(7,040)	(16,033)	(8,993)	(8,448)	(19,240)	(10,792)
East Cheshire NHS Trust	(6,403)	(9,927)	(3,524)	(7,739)	(11,434)	(3,695)
Liverpool Heart And Chest Hospital NHS Foundation Trust	(570)	(990)	(420)	(682)	(1,072)	(390)
Liverpool University Hospitals NHS Foundation Trust	(10,310)	(13,740)	(3,430)	(12,197)	(15,604)	(3,407)
Liverpool Women's NHS Foundation Trust	(695)	(2,136)	(1,441)	(834)	(2,432)	(1,598)
Mersey Care NHS Foundation Trust	(14,780)	(17,060)	(2,280)	(17,744)	(20,613)	(2,869)
Mid Cheshire Hospitals NHS Foundation Trust	(17,486)	(17,414)	72	(20,983)	(20,707)	276
Southport And Ormskirk Hospital NHS Trust	(7,840)	(5,880)	1,960	(9,413)	(7,061)	2,352
St Helens And Knowsley Teaching Hospitals NHS Trust	(8,517)	(9,912)	(1,395)	(10,228)	(11,438)	(1,210)
The Clatterbridge Cancer Centre NHS Foundation Trust	0	(1,436)	(1,436)	0	(1,617)	(1,617)
The Walton Centre NHS Foundation Trust	0	(318)	(318)	0	(444)	(444)
Warrington And Halton Teaching Hospitals NHS Foundation Trust	(8,433)	(12,283)	(3,850)	(10,241)	(14,771)	(4,530)
Wirral Community Health and Care NHS Foundation Trust	(1,429)	(2,196)	(767)	(1,715)	(2,446)	(731)
Wirral University Teaching Hospital NHS Foundation Trust	(3,934)	(8,275)	(4,341)	(5,031)	(10,057)	(5,026)
Cheshire & Merseyside Total	(94,143)	(130,080)	(35,937)	(113,307)	(153,613)	(40,306)

Forecast is 4% of Total Pay.

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

Appendix 4

System Efficiencies: Current Performance and Forecast Outturn as at Month 10 (31st January 2023)

	M10 YTD			M10 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	ACTUAL £m	VARIANCE £m
CCGs/ICB	57.3	59.5	2.2	68.8	68.8	0.0
Providers:	57.3	59.5	2.2	68.8	68.8	0.0
Alder Hey Children's NHS Foundation Trust	11.7	12.2	0.5	14.5	14.5	0.0
Bridgewater Community Healthcare NHS Foundation Trust	3.4	3.4	0.0	4.2	4.2	(0.0)
Cheshire and Wirral Partnership NHS Foundation Trust	6.8	6.8	(0.1)	8.3	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	10.4	10.1	(0.4)	13.4	13.4	0.0
East Cheshire NHS Trust	4.4	4.6	0.2	5.5	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	4.1	4.7	0.7	4.9	6.0	1.2
Liverpool University Hospitals NHS Foundation Trust	61.0	61.4	0.4	75.0	75.0	0.0
Liverpool Women's NHS Foundation Trust	4.7	4.2	(0.5)	5.6	5.8	0.2
Mersey Care NHS Foundation Trust	19.0	19.0	0.0	22.8	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	14.0	13.5	(0.5)	16.8	16.4	(0.3)
Southport And Ormskirk Hospital NHS Trust	7.5	7.5	0.0	10.8	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	20.2	20.2	0.0	28.1	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	5.6	5.6	(0.0)	6.8	6.8	(0.0)
The Walton Centre NHS Foundation Trust	4.0	4.1	0.1	4.9	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	11.8	10.5	(1.3)	15.7	14.3	(1.4)
Wirral Community Health and Care NHS Foundation Trust	3.4	3.1	(0.3)	4.1	4.1	(0.0)
Wirral University Teaching Hospital NHS Foundation Trust	17.4	13.5	(3.9)	20.8	20.1	(0.8)
Total Providers	209.4	204.2	(5.2)	262.2	261.1	(1.1)
Total System	266.7	263.6	(3.0)	330.9	329.8	(1.1)

Recurrent/Non-recurrent split of Provider CIP delivery

PROVIDERS	Recurrent				Non Recurrent				TOTAL			
	M9 YTD	M10 YTD	Forecast	Forecast	M10 YTD	M10 YTD	Forecast	Forecast	M10 YTD	M9 YTD	Forecast	Forecast
	Actual	Variance	ACTUAL	VARIANCE	Actual	Variance	ACTUAL	VARIANCE	Actual	Variance	ACTUAL	VARIANCE
£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	4.7	(3.0)	7.1	(2.6)	7.4	3.4	7.4	2.6	12.2	0.5	14.5	0.0
Bridgewater Community Healthcare NHS Foundation Trust	1.2	(0.3)	1.3	(0.5)	2.2	0.3	2.8	0.5	3.4	0.0	4.2	(0.0)
Cheshire and Wirral Partnership NHS Foundation Trust	2.4	0.3	2.9	0.2	4.3	(0.4)	5.3	(0.2)	6.8	(0.1)	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	4.4	0.2	5.6	0.1	5.6	(0.5)	7.8	(0.1)	10.1	(0.4)	13.4	0.0
East Cheshire NHS Trust	1.6	(1.2)	2.0	(1.5)	3.0	1.4	3.5	1.5	4.6	0.2	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.6	(0.6)	3.5	(0.3)	2.1	1.3	2.5	1.5	4.7	0.7	6.0	1.2
Liverpool University Hospitals NHS Foundation Trust	9.7	(13.5)	13.0	(19.0)	51.7	13.9	62.0	19.0	61.4	0.4	75.0	0.0
Liverpool Women's NHS Foundation Trust	1.5	(1.9)	1.8	(2.4)	2.7	1.5	4.0	2.6	4.2	(0.5)	5.8	0.2
Mersey Care NHS Foundation Trust	12.8	(0.2)	15.3	(0.2)	6.2	0.2	7.5	0.2	19.0	0.0	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	4.7	(1.0)	6.7	(0.4)	8.8	0.5	9.7	0.1	13.5	(0.5)	16.4	(0.3)
Southport And Ormskirk Hospital NHS Trust	5.4	(2.1)	7.8	(3.0)	2.1	2.1	3.0	3.0	7.5	0.0	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	14.2	(4.0)	22.1	0.0	6.0	4.0	6.0	0.0	20.2	0.0	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	2.2	(1.5)	2.9	(1.5)	3.4	1.4	3.8	1.5	5.6	(0.0)	6.8	0.0
The Walton Centre NHS Foundation Trust	2.5	(0.8)	3.2	(0.9)	1.6	0.9	1.8	0.9	4.1	0.1	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	0.7	(4.1)	1.6	(4.9)	9.9	2.8	12.7	3.4	10.5	(1.3)	14.3	(1.4)
Wirral Community Health and Care NHS Foundation Trust	1.6	(0.7)	2.3	(0.3)	1.5	0.3	1.8	0.3	3.1	(0.3)	4.1	(0.0)
Wirral University Teaching Hospital NHS Foundation Trust	4.5	(7.0)	5.9	(8.0)	9.0	3.1	14.2	7.2	13.5	(3.9)	20.1	(0.8)
Total Providers	76.7	(41.3)	105.2	(45.2)	127.5	36.1	155.8	44.1	204.2	(5.2)	261.1	(1.1)

Cheshire and Merseyside ICB Finance, Investment & Resource Committee

Appendix 5

Provider Capital: Current Performance and Forecast Outturn as at Month 10 (31st January 2023)

Excluding IFRS16 Impact						
PROVIDER:	M10 YTD			M10 FORECAST		
	PLAN	ACTUAL	ARIANCE	PLAN	ACTUAL	VARIANCE
	£m	£m	£m	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	5.4	5.5	(0.1)	8.9	8.9	0.0
Bridgewater Community Healthcare NHS Foundation Trust	1.9	0.4	1.5	2.1	1.7	0.4
Cheshire and Wirral Partnership NHS Foundation Trust	2.4	2.0	0.3	2.6	2.5	0.1
Countess of Chester Hospital NHS Foundation Trust	11.4	9.7	1.7	19.9	19.9	0.0
East Cheshire NHS Trust	5.1	2.4	2.7	6.1	6.7	(0.6)
Liverpool Heart and Chest Hospital NHS Foundation Trust	8.7	6.4	2.3	11.3	11.3	0.0
Liverpool University Hospitals NHS Foundation Trust	50.7	13.8	36.9	62.6	40.3	22.2
Liverpool Women's NHS Foundation Trust	8.5	6.1	2.4	8.8	8.8	0.0
Mersey Care NHS Foundation Trust	8.7	4.3	4.4	11.1	9.8	1.3
Mid Cheshire Hospitals NHS Foundation Trust	23.2	25.0	(1.7)	38.0	38.0	0.0
Southport And Ormskirk Hospital NHS Trust	9.1	6.6	2.5	11.3	21.3	(10.0)
St Helens And Knowsley Teaching Hospitals NHS Trust	3.5	2.2	1.4	4.5	4.5	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	5.7	3.3	2.3	7.0	7.2	(0.2)
The Walton Centre NHS Foundation Trust	4.8	1.9	2.9	5.7	5.7	0.0
Trust	8.1	6.8	1.2	12.5	12.5	0.0
Wirral Community Health and Care NHS Foundation Trust	8.5	6.9	1.6	9.4	9.4	0.0
Wirral University Teaching Hospital NHS Foundation Trust	9.7	9.5	0.3	11.9	11.9	0.0
Total Charge against System Operational Capital Plan	175.4	112.8	62.6	233.7	220.5	13.2
System Operational Capital Allocation				221.8	220.5	1.3

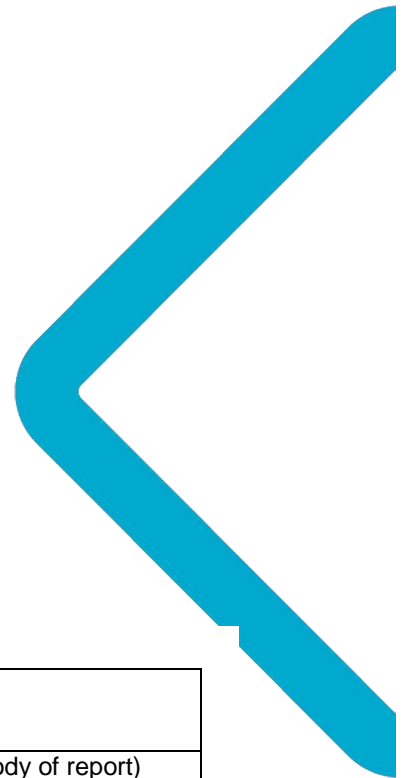
(based on formal reporting to NHSEI)

Note: brackets denote deficit/overspend

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Quality & Performance Report



Agenda Item No	ICB/02/23/11
Report author & contact details	Andy Thomas (contact details in body of report)
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Andy Thomas, Associate Director of Planning

Cheshire and Merseyside ICB Board Meeting

Performance Report Board Summary

Executive Summary	The attached presentation provides an overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact, and mitigations.				
Purpose (x)	For information / note	For decision / approval	For assurance	For ratification	For endorsement
	X		X		
Recommendation	The Board is asked to: <ul style="list-style-type: none"> note the contents of the report and take assurance on the actions contained. 				
Key issues	<ul style="list-style-type: none"> The urgent and emergency care system continues to experience significant and sometimes severe pressure across the whole of NHS Cheshire & Merseyside. Significant backlogs for both elective and cancer care. 				
Key risks	<ul style="list-style-type: none"> Impact on ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience. Long waits for cancer and elective treatment resulting in poor outcomes. 				
Impact (x) <small>(further detail to be provided in body of paper)</small>	Financial	IM &T	Workforce	Estate	
			X		
	Legal	Health Inequalities	EDI	Sustainability	
	X				
Route to this meeting	Via Quality & Performance Committee				
Management of Conflicts of Interest	n/a				
Patient and Public Engagement	n/a				
Equality, Diversity, and Inclusion	n/a				
Health inequalities	n/a				
Next Steps	n/a- regular report				
Appendices	Quality and Performance Report				

Quality and Performance Report

1. Urgent Care

- 1.1 The urgent and emergency care system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside.
- 1.2 All acute hospitals across the system report daily against a nationally defined set of Operational Pressures Escalation Levels (OPEL). The majority of Trusts across C&M have been consistently reporting at OPEL 3 for an extended period during 2022. OPEL 3 is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'.
- 1.3 As winter pressures continued to build over the course of December, a number of Trusts across C&M declared the highest level of escalation, OPEL 4.
- 1.4 This means that actions at OPEL 3 have failed to deliver sufficient capacity, that emergency care pathways are significantly compromised, with severe handover delays, ambulances unable to unload their patients, crowded emergency departments due to delays in admitting patients to hospital beds, high bed occupancy, and the system unable to manage effective flow/discharge capacity.
- 1.5 During December and early January the following Trusts have been at OPEL 4 for one or more days on one or more occasions, with 15 separate declarations over this period:
 - St Helens & Knowsley
 - Warrington & Halton
 - Southport & Ormskirk
 - Liverpool University Hospitals
 - Wirral University Teaching Hospital
 - Countess of Chester.
- 1.6 Since mid-January, all Trusts have been at OPEL 3 or better, and over the course of January the pressures described above and at last month's meeting have abated slightly but it should be noted that pressures are still consistent with a challenging winter situation as expected.
- 1.7 Ambulance handover delays over 60 minutes rose significantly in December, and this continued into the first weeks of January. Subsequently, in line with the easing of pressure described above, handover delays reduced considerably over the remainder of January, however it should be noted that C&M Trusts are not currently achieving the 15-minute handover target.

1.8 Category 2

ambulance call response times, which should be responded to within 18 minutes and includes serious presenting conditions including patients who may have had a stroke or are experiencing chest pain, deteriorated significantly in December, and into early January. The average response time for December was 1 hour 12 minutes and 11 seconds.

- 1.9 The delays in ambulance handovers at hospitals relate to overcrowding in emergency departments caused by a combination of increased Type 1 demand in December compared to plan, and also there being insufficient bed capacity available within our hospitals to admit all those patients requiring a hospital bed. This leads to patients having to wait for a bed in the emergency department or on an assessment unit, as can be seen from the increasing number of patients experiencing a delay of over 12 hours from the point of a decision to admit.
- 1.10 The impact on ED of delays from decision to admit is crowding in department and in waiting areas and corridor care, with the numbers of patients waiting more than 12 hours in A&E from a decision to admit increasing steeply over recent months. All our acute Trusts with the exception of Alder Hey and specialist trusts, have had to care for patients on corridors during times of peak demand especially in late December and early January in order to try to release ambulance crews as rapidly as possible.
- 1.11 The majority of C&M acute Trusts with an Emergency Department are reporting occupancy in a range from 97%-100%, despite the opening of additional escalation beds. The lower occupancy levels reported in the performance tables reflect the inclusion of specialist Trusts.
- 1.12 Within acute Trusts, there continues to be a significant number of patients no longer meeting the criteria to reside in hospital, who typically occupy over 20% of acute hospital beds. In conjunction with increased admissions due to influenza in December and early January and the continued underlying level of COVID-19 this in turn means that there are insufficient beds to admit patients from the Emergency Department or direct admissions requiring beds.
- 1.13 Winter plans included additional national funding to open an additional 205 beds over the course of the winter. The trajectory called for 161 of these beds to be open by the end of December. In practice 194 of these beds were open as at the end of December, and by the end of January all 205 were open.
- 1.14 The ICB opened its System Control Centre (SCC) on 01 December in line with national guidance. The SCC operates daily, gathering intelligence and where possible brokering mutual aid across the system. This has been augmented by a dedicated EPRR response to industrial action in December and January with an Incident Coordination Centre stood up alongside the SCC on these days to mitigate.

- 1.15 All winter plans included plans to discharge as many patients as possible ahead of the festive period and have held discharge focused events in January. However, pressure ahead of the Christmas weekend limited the ability of Trusts to reduce occupancy sufficiently ahead of the bank holidays, and consequently severe pressure was experienced over the week between Christmas and the New Year, and into the first weeks of January. Although there has been a slight easing in pressure, the number of patients not meeting the criteria to reside within Trusts across Cheshire and Merseyside remains in excess of 1,000 with the majority awaiting packages of support to enable their discharge home.
- 1.16 Place Directors are working closely with their respective Local Authorities to facilitate discharge. Given the extraordinary level of pressure in January, this response has included a focus on:
- increasing and then maintaining the run rate of hospital discharges every day.
 - moving patients to the first available slot, with a view to then moving them onward to the correct pathway if correct pathway capacity is not readily available.
 - collectively increasing risk-based decisions about who can go home earlier with a lower package of care than might previously have been assessed.
- 1.17 The key risk to delivery remains workforce, encompassing recruitment, retention (better wages available in other sectors), skill mix/shortages, gaps in rotas, sickness etc. These issues are apparent across medical, nursing, AHPs, ambulance service, mental health and community care, and social care including domiciliary care

2. Elective Care & Diagnostics

- 2.1. The Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) hosts the C&M Elective Recovery programme. The programme is focused on two key areas of performance namely recovery of elective activity to pre-pandemic levels and beyond, and the reduction of the longest waits for treatment.
- 2.2. Patients waiting for long periods of time may experience a deterioration in their condition and may subsequently require more interventions. We are working hard to clear the longest waiting patients to reduce this risk.
- 2.3. The current priority is on eliminating waits in excess of 78 weeks by the end of March 2023. As at the week ending 29 January 2023, 2,774 patients across Cheshire & Merseyside were waiting over 78 weeks. Trusts continue to focus on clearing the long waiting patients in order to deliver the key target of zero people waiting over 78 weeks by end of March 2023.

- 2.4. Over the last 20 weeks the system have cleared nearly 30,000 patients in this long wait cohort. The total number of patients to clear by March is now at an all-time low of 6,236 (which includes any patients that may be added between now and end of March). The providers with the highest number of patients to clear are LUHFT (2,558), St Helens & Knowsley (1,172) and Countess of Chester (620).
- 2.5. Specific support is being offered to trusts with the biggest challenge for 78 week waits, including additional validation support. A key focus is to get as many of these patients booked in as possible. The elective recovery programme team are working hard to support trusts with mutual aid, independent sector support and operational management input where needed.
- 2.6. We continue to work with trusts through the mutual aid hub and meet weekly with each trust to review their waiting list and support with accessing all possible capacity (including diagnostics, independent sector, out of area). We are on track to meet the 78 weeks target by the end of March.
- 2.7. More widely, overall numbers on elective referral to pathways are still increasing, whilst the overall 78 week wait cohort is reducing steadily as a result of the work the programme is supporting across our Trusts.
- 2.8. In November 2022 we had 24,221 patients waiting over 52 weeks, and 56 patients over 104 weeks due to patient choice and significant clinical complexity. Referral rates have increased over the last 6 months and remain high.
- 2.9. Our most recent unpublished data shows the over 52 week waits at just over 23,000, and we have reduced the numbers of 104 week waits (choice and complexity exceptions) to 35 patients and these are all dated.
- 2.10. In terms of theatre utilisation, a key measure of efficiency, Cheshire & Merseyside continues to be in the upper quartile nationally. The theatre utilisation programme continues, and each month an "opportunity pack" is produced to show where there are specialty-level opportunities to increase throughput. These conversations are then channelled through Patient Tracking List (PTL) weekly meetings to help trusts work through whether it is this due to theatre planning and operational logistics, booking and scheduling, staffing availability and planning or vacancies.
- 2.11. The Cheshire & Merseyside mutual aid hub team have facilitated mutual aid for over 2,200 patients in order to expedite their treatment and / or appointments.
- 2.12. The Clatterbridge Elective Surgical Hub continues to support trusts with mutual aid and more permanent capacity, especially in relation to orthopaedics.
- 2.13. Contractors are on site for the Cheshire Elective Surgical Hub and initial phases of demolition underway to build the new surgical hub facility on the Victoria Infirmary site. The clinical pathway planning is underway for ophthalmology, urology, ENT, and general surgery.

- 2.14. Funding has been secured to establish a paediatric dental hub to treat the low complexity patients requiring dental surgery. We currently have over 600 patients who have been waiting over 52 weeks from 11 organisations that provide paediatric dental surgery across C&M. A Paediatric Elective Recovery Group has been formed to work on the clinical pathway for these patients and agree the logistical arrangements.
- 2.15. Elective recovery is measured in terms of value-weighted elective activity for access to the Elective Recovery Fund. By this measure, the latest published data for the month ending 31 October 2022, taken from SUS puts C&M at 93.6% of 2019/20 spend value compared to 89.8% for the North West, and 96.6% for England.
- 2.16. It should be noted that in relation to the ambition to increase day case, ordinary and outpatient activity compared to 2019/20, for outpatients and ordinary elective admissions, the ICB is slightly better than the median at 19th out of 42 but ranks 25th for day cases. This is in part because of changes in coding where activity relating to some systemic anti-cancer treatments (SACT) and termination of pregnancy have been changed from delivery as a day case to an outpatient attendance.
- 2.17. For diagnostics, the national waiting target remains at <1% waiting over 6 weeks for a diagnostic test and zero 13+ week waiters. A national activity target has been set at 120% of pre-pandemic levels, specifically 2019/20 activity baseline across a range of seven common diagnostic modalities. Cheshire & Merseyside is at 147.5% as at November, compared to 109.7% for the NW region. 80% of patients have been waiting 6 weeks or less.

3. Cancer

- 3.1. A sharp and sustained rise in urgent suspected cancer referrals, capacity constraints experienced during each wave of COVID-19, alongside ongoing diagnostic backlogs and workforce constraints has resulted in the total cancer waiting list increasing considerably since 2019.
- 3.2. Urgent suspected cancer GP referrals continue on an upward trend. YTD referrals are 129% of pre-pandemic baseline. November 2022 (latest published month) was the highest on record at 137.5%.
- 3.3. More patients that ever are being seen within target time. Performance against the 14-day standard remains below target but is improving.
- 3.4. 28-day faster diagnosis performance remains challenged due to high referral volumes.
- 3.5. Lower GI cancer pathways are under significant pressure in most providers as a combined result of increased referrals and diagnostic capacity constraints. LGI referrals in 2022/23 YTD are 160% of pre-pandemic (2019) levels.

- 3.6. 62-day cancer performance remains below the operating standard. However, C&M is the fourth best performing Alliance in England (out of 21).
- 3.7. The number of patients waiting more than 62 days for a diagnosis or treatment (aka the over 62-day backlog) remains a concern despite improving by 15% during January 2023. Nearly half the backlog is made up of patients on suspected LGI cancer pathways.
- 3.8. The over 62-day cancer backlog stands at 2,352 as at 08 January 2023.
- 3.9. High referral levels have resulted in more cancer patients being diagnosed and treated than in any previous year. Data suggest that the proportion of patients diagnosed with early-stage cancers has increased, which is positive.
- 3.10. However, although a greater number of patients have been seen and treated within target times, high volumes have meant that significant numbers of patients have experienced delays. The impact will continue to be monitored through patient experience surveys and clinical harm reviews.
- 3.11. 3,000 additional cancer first appointments are being provided each month compared with 2019 to manage increased demand.
- 3.12. The Cancer Alliance is supporting improved efficiency and productivity with funding and project resources through the faster diagnosis programme.
- 3.13. Lower GI pathways continue to be the focus of targeted support, primarily through the Alliance's faecal immunochemical testing (FIT) programme and the Endoscopy Network's improvement programme.
- 3.14. In November 2022, C&M providers delivered nearly double (194%) the number of first outpatient appointments for suspected LGI cancers compared with November 2019.
- 3.15. Capital investments, training & education (in both primary and secondary care) and a pipeline of innovation are all building resilience and supporting recovery. However, significant further investment in the cancer workforce is required.
- 3.16. The key targets highlighted in the 2023/24 operational planning guidance, namely the 28-day faster diagnosis standard and the reduction of the over 62-day backlog, are both anticipated to be achieved by the end of Q4 2023/24 in line in the national expectation.
- 3.17. Cancer services are busier than ever, seeing and treating more patients each month than ever before. Conversion rates have not significantly changed, and the number of new cancers diagnosed has increased. This suggests that, in most cases, the increase in demand (i.e., GP cancer referrals) is genuine and appropriate.

4. Mental Health & Learning Disabilities

- 4.1. There has been a temporary suspension of publication of dementia diagnosis rates (DDR) due to a change in the national data collection process. Latest data indicates that only three out of nine sub-ICB areas are achieving the diagnosis rate of 66.7%. A diagnostic tool designed specifically for use in care home settings, DiADeM (Diagnosing Advanced Dementia Mandate), is being piloted in 2 areas where the DDR has remained static for long periods.
- 4.2. Published data for community MH services indicate that access rates are declining. However, this is not the case and is as a result of data not flowing for the increased levels of activity being undertaken by primary care MH practitioners employed via the Additional Roles Reimbursement Scheme (ARRS). Plans are being developed to ensure activity is being appropriately captured via national reporting routes. 81% of Primary Care Networks now have at least one MH ARRS roles in post.
- 4.3. The 60% target for early intervention in psychosis treatment within 2 weeks was not met during the reporting period. Breaches are attributed to a high number of vacancies, large caseloads, and increased number of referrals. The position is expected to improve as vacant posts have been filled and caseloads have reduced, providing more capacity to meet the 2-week target.
- 4.4. IAPT recovery rates are continuing to improve but remain just below the 50% target. Clinical leads and supervisors continue to review individual recovery rates to look at ways to help each therapist improve their own recovery rates. IAPT access rates remain significantly below target and plans to address will be developed as part of 2023/24 operational planning processes.
- 4.5. The number of out of area placement bed days has reduced for the third consecutive month despite continued high demand and delayed discharges. Lack of supported housing, nursing homes and suitable community placements are the most significant reasons for delays.
- 4.6. An escalation framework for Adult MH is being developed across the NW region and this will be aligned with the ICB System Control Centre to ensure clear routes of escalation from place level to ICB level.
- 4.7. Continued progress is being made in implementing new integrated models of community care and further developing crisis models to improve patient flow.
- 4.8. In relation to reliance on specialist inpatient care for children with a learning disability and/or autism, in December 2022 there were 5 children and young people (CYP) with LD/A in a tier 4 bed against a Q4 target of 9.

- 4.9. The development of the Dynamic Support Register work has allowed Place leads to identify children and young people at risk of admission much sooner to ensure our admissions are appropriate and hospital avoidance is achieved where its deemed appropriate. The escalation process is also used to review and reduce length of stay.
- 4.10. Low numbers of admissions and shorter length of Stay will have a positive impact on a CYP's care and treatment which is what we want to sustain.
- 4.11. In relation to adult inpatients with a learning disability and/or autism per million head of population, in December adults' inpatients was at 48 for Place commissioners, 51 for adult specialised commissioning. Target for Q4 22/23 is 70.
- 4.12. Quality and performance challenges in this area include ongoing pressure on ATU bed capacity, in part due to delayed discharges. Delays in identifying suitable housing and fitting the essential adaptations contribute to delayed discharges, as do workforce issues in terms of recruiting tams to support patients in the community. These delays in turn can affect the health and well-being of the patient and have a wider impact on families.
- 4.13. Transforming Care staff are helping with the back log of Care and Treatment reviews (CTR's) within Specialised Commissioning where a number of people have also been identified as delayed discharges.
- 4.14. Weekly Sit reps have been in place since October 2022 to update on progress of delayed discharges, along with fortnightly desktop reviews with Place commissioners and LPC case managers and individual escalation calls where required.
- 4.15. There has been some positive movement in Q3 with Cheshire and Merseyside noting 14 successful discharges over the period.

5. Primary Care

- 5.1. The number of GP Practices across Cheshire and Merseyside is 355 looking after a population of 2.7 million people with the GP Practices grouped into 55 Primary Care Networks to deliver certain functions under the relevant national contracts.
- 5.2. GP practices were asked to focus on 'recovery and restoration' of general practice services, returning to pre-pandemic levels and scope of delivery as quickly as possible during 2022-23
- 5.3. In relation to access, appointment activity remains higher than the same pre-pandemic period.
- 5.4. The mix of appointments across Cheshire & Merseyside however shows that face to face appointments, are overall slightly lower than pre pandemic but there has been a relative increase in telephone appointments.

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- 5.5. Appointment data is reported and overseen at the System Primary Care Committee (bimonthly) where assurance is given on actions to support this at place and corporate level.
- 5.6. Some Places are implementing Access improvement initiatives/improvement plans with their practices.
- 5.7. Approx 30 practices have signed up to Phase 5 of the Access Improvement Programme.

6. Summary/Recommendations

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

Performance Report

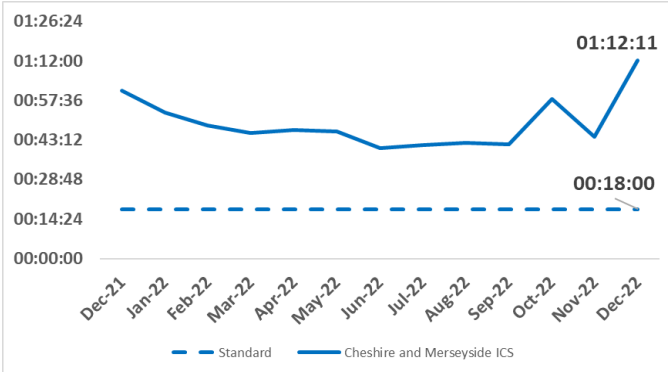
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Section I: Urgent Care Dashboard

	Latest period	Target	Value
Discharges by 11am			
30-minute ambulance handover breaches	Dec-22	n/a	4640
Proportion of patients discharged from hospital to their usual place of residence	Nov-22	Eng Ave 92.4%	C&M ave 93.47%
Cat 2 90th Centile	Dec-22	00:40:00	02:45:19

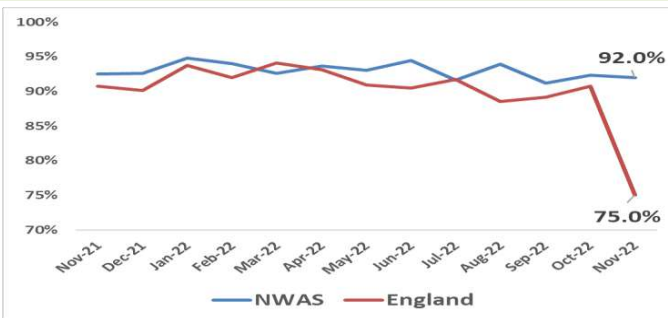
Section I: Urgent Care

Ambulance Response times – Cat 2



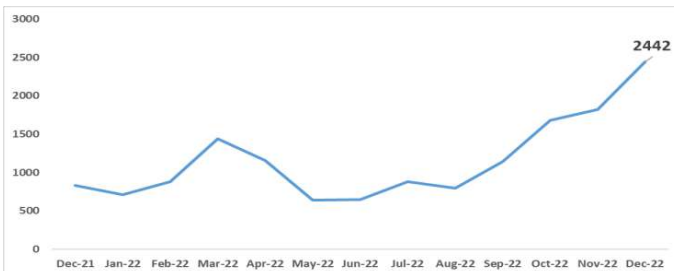
Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	00:58:03	00:44:15	01:12:11
North West	00:58:03	00:44:15	01:12:11
England	01:01:19	00:53:17	01:18:57

Friends & Family score – Ambulance Service



Organisation	Sep-22	Oct-22	Nov-22
NWAS	91.14%	92.36%	92.00%
England	89.18%	90.76%	75.00%

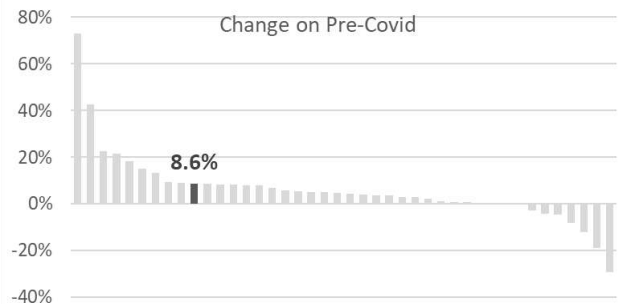
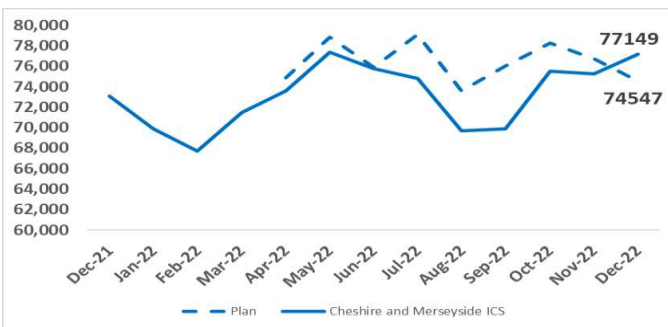
Ambulance Arrival to handover >60 mins



Organisation	Oct-22	Nov-22	Dec-22	*Jan-23
Cheshire & Merseyside	1680	1822	2442	1058
North West	5108	4710	6772	2800

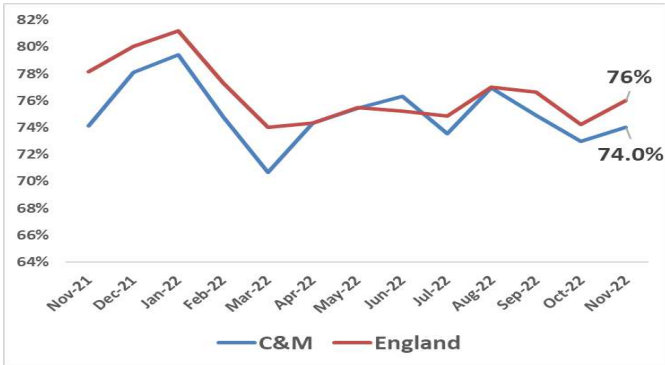
* to 16th January

A&E Attendances (Type 1)



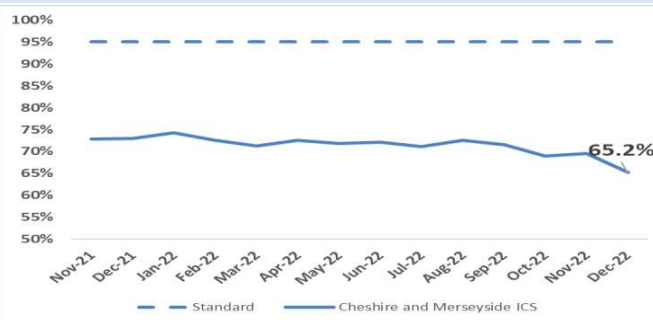
Section I: Urgent Care

Friends & Family score – A&E



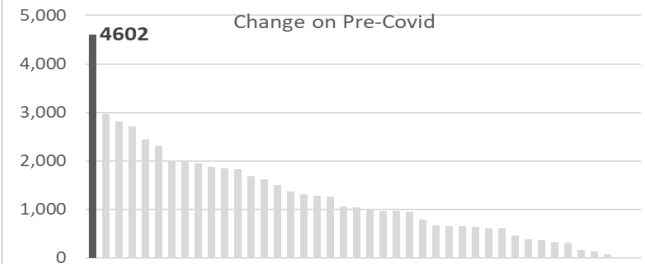
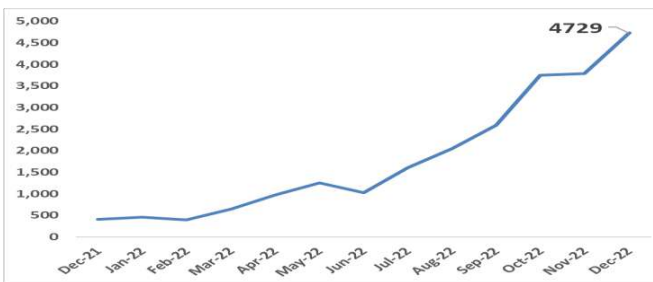
Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	75%	73%	74%
North West	75%	73%	74%
England	77%	74%	76%

A&E 4 Hour Standard

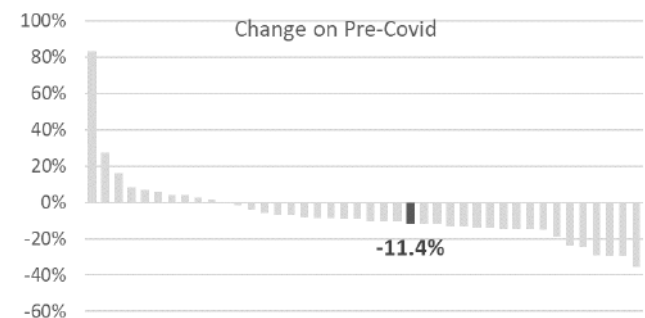
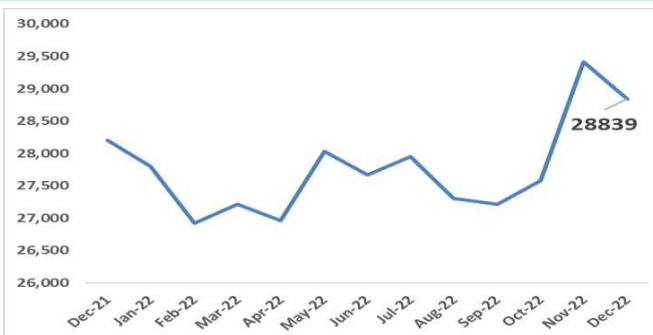


Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	68.9%	69.6%	65.2%
North West	71.5%	70.6%	65.2%
England	66.4%	65.7%	61.1%

A&E 12 hour delays from decision to admit

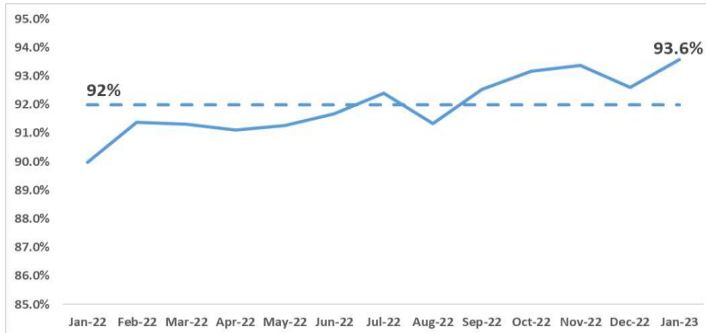


Total Emergency admissions



Section I: Urgent Care

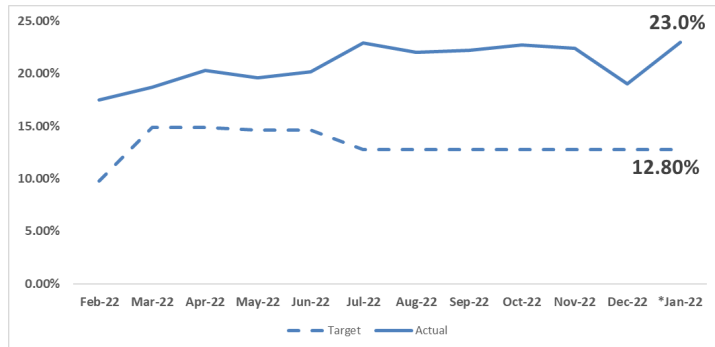
Bed Occupancy General & Acute



Organisation	Sep-22	Oct-22	Nov 22	Dec-22
Cheshire & Merseyside	92.5%	93.2%	93.4%	93.8%
North West	92.9%	93.5%	93.5%	93.3%
England	93.4%	94.3%	94.3%	94.2%

* - Daily average to 22nd December

No longer meeting criteria to reside (Percentage of G&A bed stock)



Organisation	Nov-22	Dec-22	*Jan-22
Cheshire & Merseyside	22.4%	19.0%	23.0%

* at 22nd Jan 2023

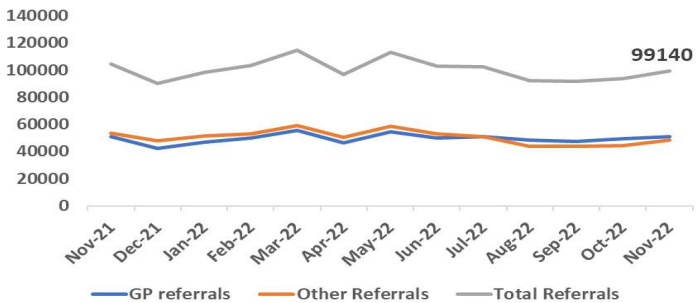
Warrington and Halton did not submit data this week

Section II: Planned Care Dashboard

	Latest period	Target	Value
52 week waiters (number)	Nov-22	0	24221
Diagnostic activity levels Total	Nov-22		105981
The number of Imaging diagnostic tests or procedures carried out in the period.	Nov-22		82738
The number of Physiological diagnostic tests or procedures carried out in the period.	Nov-22		14100
The number of Endoscopy diagnostic tests or procedures carried out in the period.	Nov-22		9143
Elective Activity : Completed pathway elective activity growth			
Total patients waiting more than 104 weeks to start consultant led treatment	Nov-22	0	56
Capped Theatre Touch time Utilisation			
Capped Theatre Touch Time Utilisation – Provider Variation			

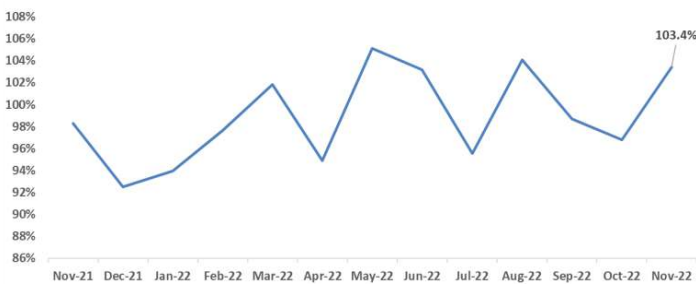
Section II: Planned Care

Referrals



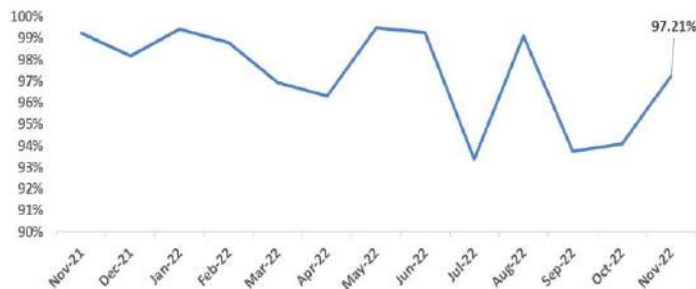
Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	91,532	93,701	99,140
North West	227,572	238,299	252,370
England	1,816,619	1,860,404	1,967,827

Outpatient First % of pre-COVID activity – Nov 22 (comparison with 2019/20)



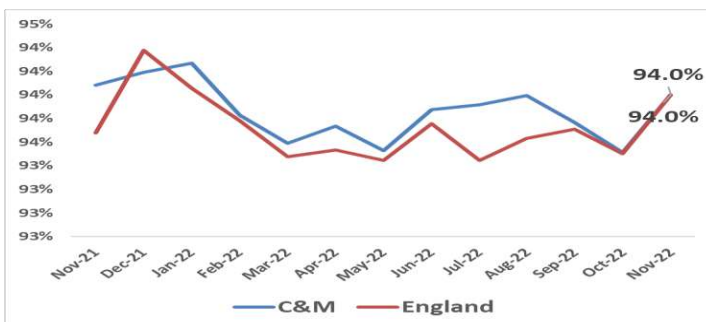
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	98.68%	96.77%	103.41%
North West	85.73%	87.54%	93.14%
England	95.09%	96.77%	99.34%

Outpatient Follow-up % of pre-COVID activity – Nov 22 (comparison with 2019/20)



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	93.73%	94.08%	97.21%
North West	88.65%	91.02%	94.88%
England	98.63%	98.47%	100.62%

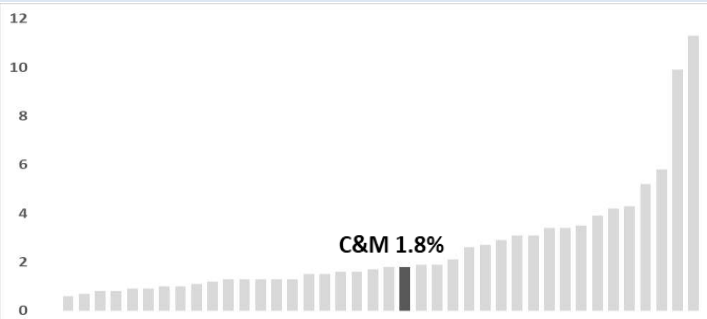
Friends & Family score – Outpatient



Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	94%	94%	94%
North West	92%	92%	94%
England	94%	94%	94%

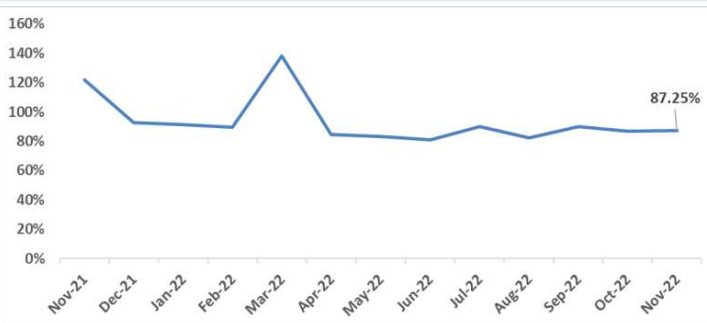
Section II: Planned Care

Patient Initiated Follow-up (PIFU) ICS Benchmark - Nov 22



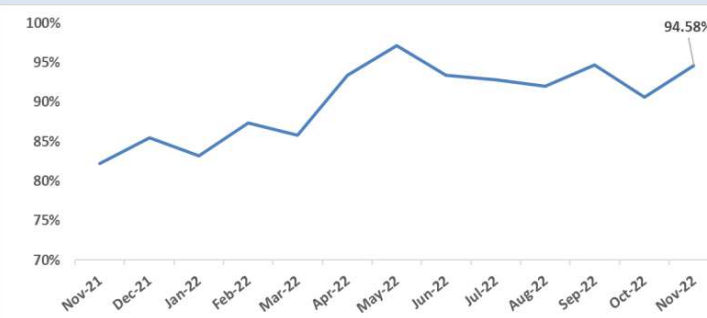
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	1.7%	2.0%	1.8%
North West	1.5%	1.6%	1.5%
England	1.7%	1.8%	1.9%

Elective inpatient admissions % of pre-COVID activity - Nov 22 (comparison with 2019/20)



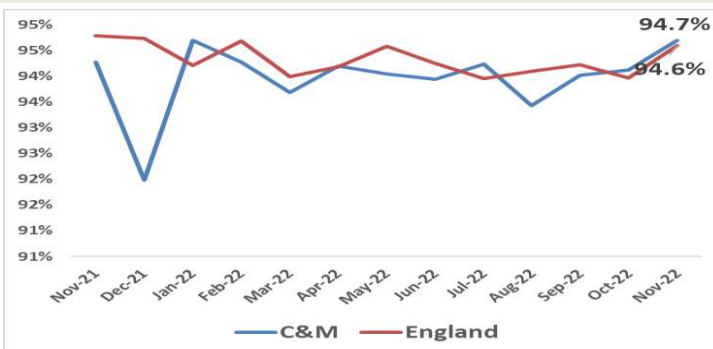
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	90.10%	86.98%	87.25%
North West	85.21%	88.25%	87.33%
England	85.15%	84.61%	82.76%

Day cases % of pre-COVID activity - Nov 22 (comparison with 2019/20)



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	94.69%	90.57%	94.58%
North West	91.62%	89.70%	90.92%
England	99.35%	100.18%	98.08%

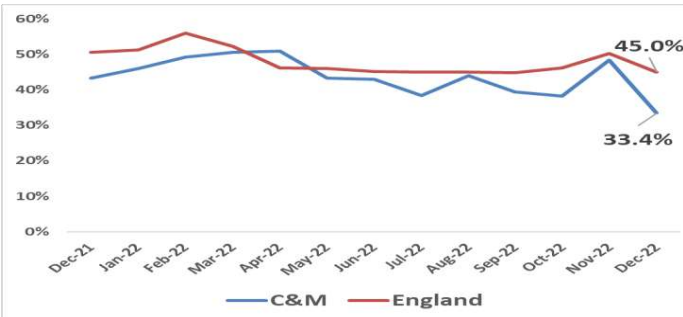
Friends & Family score – Inpatient



Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	94.0%	94.1%	94.7%
North West	94.0%	93.5%	93.6%
England	94.2%	94.0%	94.6%

Section II: Planned Care

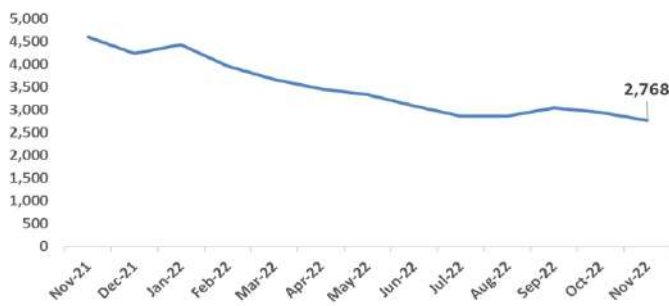
Hip fracture best practice



Organisation	Oct-22	Nov-22	Dec-22
Cheshire & Merseyside	38.2%	48.3%	33.4%
North West	38.2%	48.3%	33.4%
England	46.2%	50.1%	45.0%

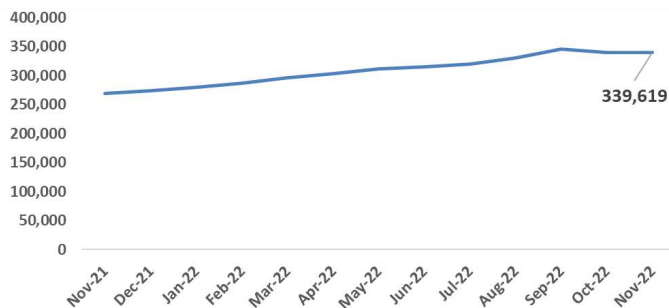
The proportion of patients that have fractured their hip whose care against a basket of indicators covering eight elements of is considered to be best practice

The number of people waiting 78 Weeks or more – Nov 22



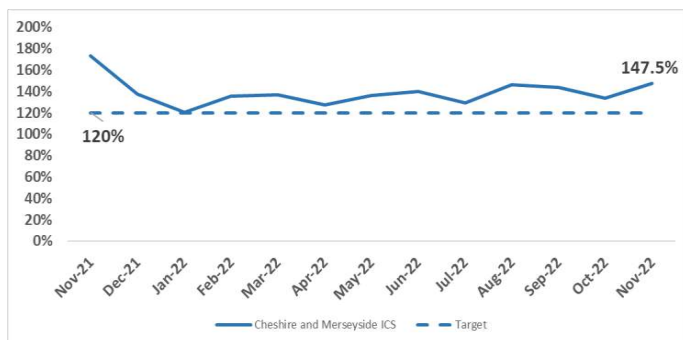
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	3047	2952	2768
North West	10111	7219	7357
England	46080	42107	40872

Waiting list (RTT total incompletes) - Nov 22



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	345,460	339,746	339,619
North West	965,635	804,964	805,231
England	6,568,470	6,469,872	6,440,864

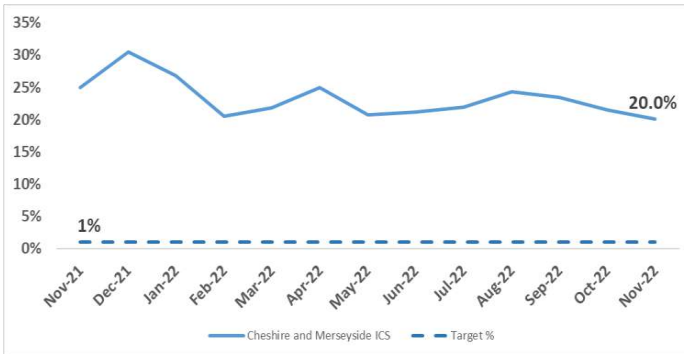
Diagnostic Activity: % of pre-COVID activity – Compared to same month in 2019



Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	145.0%	132.0%	147.5%
North West	116.4%	100.2%	109.7%
England			

Section II: Planned Care

Diagnostic 6 week wait – objective no more than 1%



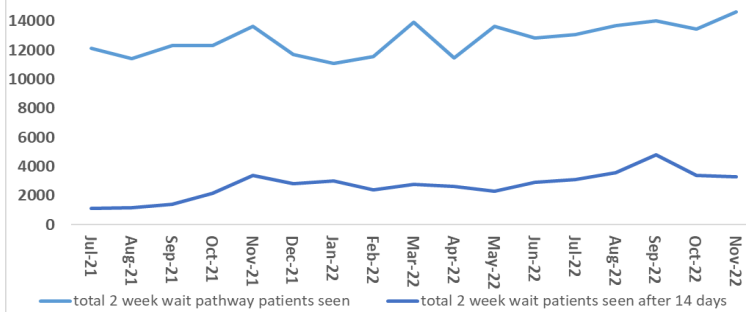
Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	23.5%	21.5%	20.0%
North West	31.8%	28.4%	20.8%
England	32.0%	30.7%	26.5%

Section III: Cancer Care Dashboard

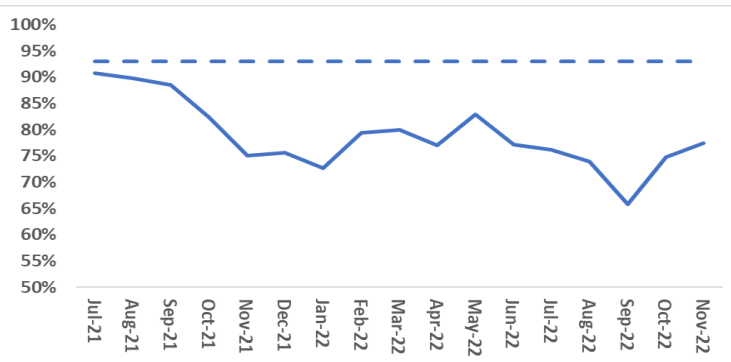
	Latest period	Target	Value
Total patients treated for cancer compared with the same point in 2019/20	22-Oct	100.00%	104.00%

Section III: Cancer Care

The number of 2 week wait pathway patients seen * proxy for referrals

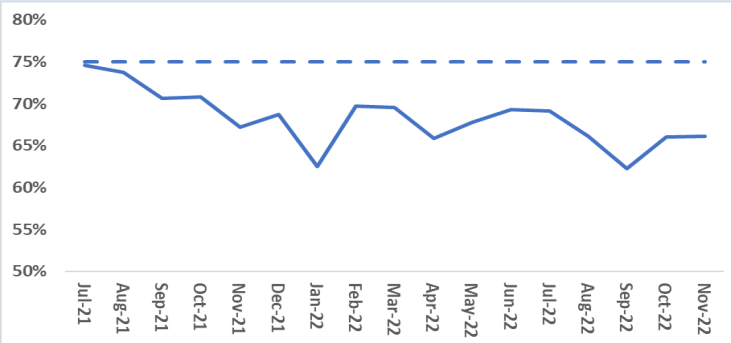


% of patients who waited for less than 14 days to be seen after referral



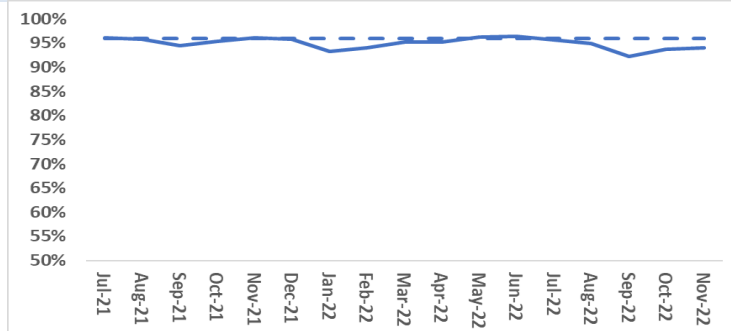
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	65.8%	74.8%	77.5%
North West	68.2%	71.6%	74.9%
England	72.6%	77.8%	78.8%

% of patients receiving a diagnosis or ruling out of cancer within 28 days of referral



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	62.3%	66.0%	66.1%
North West	64.6%	62.6%	64.4%
England	67.2%	68.5%	69.7%

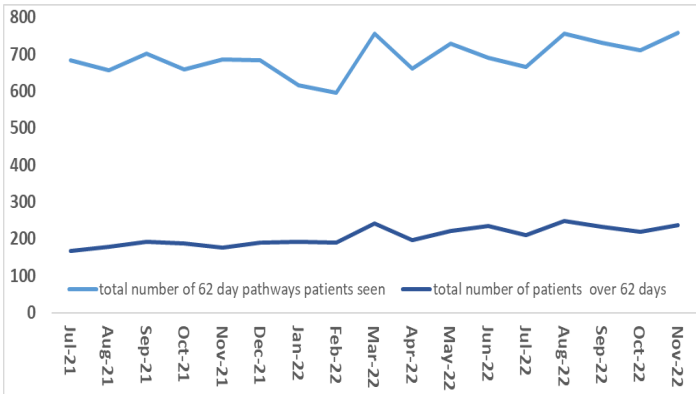
% of patients diagnosed with cancer receiving treatment within 31 days of diagnosis



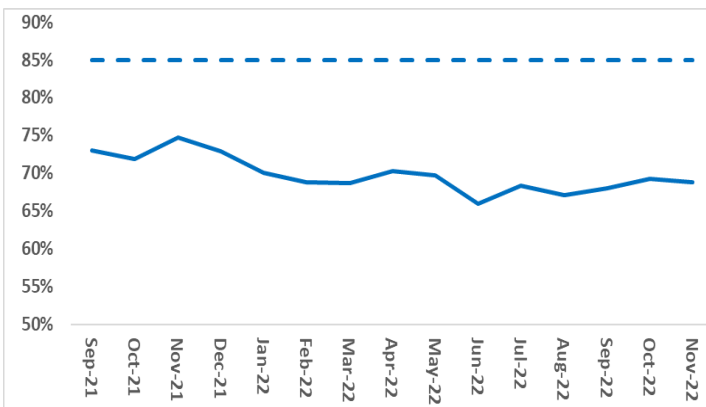
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	92.3%	93.7%	94.0%
North West	91.0%	92.6%	92.9%
England	91.1%	92.0%	91.6%

Section III: Cancer Care

Number of patients receiving treatment for cancer treatment by their GP waiting on 62 day pathway

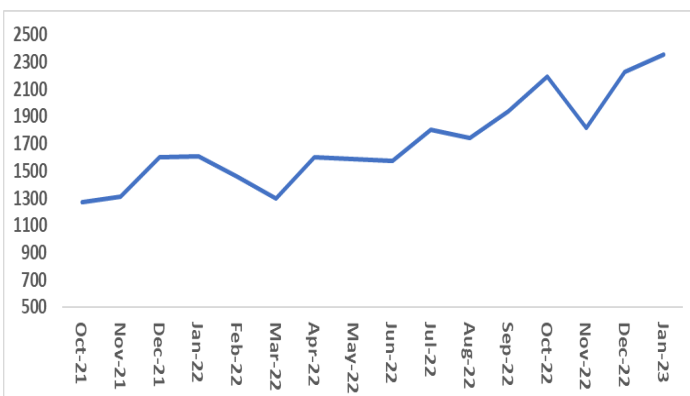


% Patients referred for cancer treatment by their GP waiting less than 62 days for treatment to start



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	68.0%	69.2%	68.8%
North West	59.7%	62.3%	63.1%
England	60.5%	60.3%	61.0%

Over 62 day cancer backlog *as at 8th Jan 2023



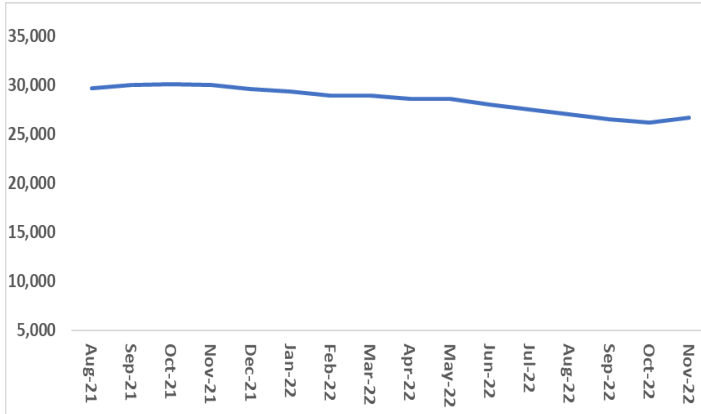
Organisation	Nov-22	Dec-22	Jan-23
Cheshire and Merseyside	1819	2226	2352
North West	5007	5392	5665
England	28409	28834	31482

Section IV: Mental Health Dashboard

	Latest period	Target	Value
% of children and young people with eating disorders seen within 4 week (Routine):	Q2 2022/23	95.00%	70.30%
Dementia diagnosis rate	22-Sep	67.00%	63.50%
Number of children and young people accessing mental health services as a % of the population	22-Oct	100.00%	74.60%
Access rates to community mental health services for adult and older adults with severe mental illness	22-Oct	16,750	11,590
Mental Health Services Dataset - Data quality maturity index score	22-Sep	90%	69.80%
Adult mental health inpatients receiving a follow up within 72 hours of discharge	22-Oct	80%	75.00%
Number of people accessing IPS services (cumulative YTD)	22-Oct	1285 * LTP plan for ICB	625.00

Section IV: Mental Health

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

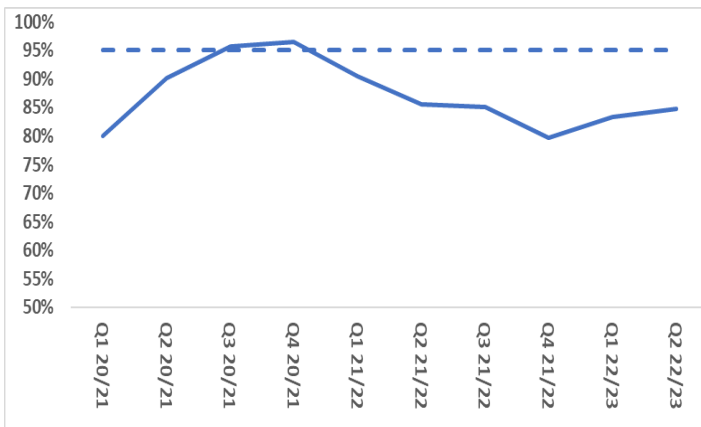


Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	-	26,190	26,650
North West	-	93,075	94,465
England	-		

source: NHS futures core data pack

* missing data due to cyber incident

% of children and young people with eating disorders seen within 1 week (Urgent): *rolling 12 months



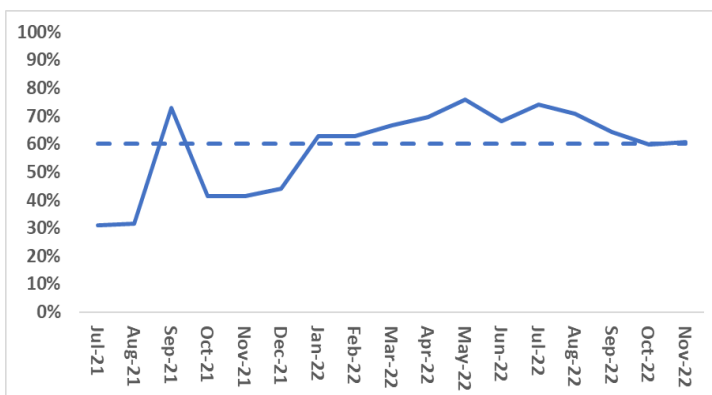
No update for this metric

Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire and Merseyside	85%	79.6%	83.3%
North West	85%	90.9%	84.6%
England	59%	61.9%	68.1%

* 12 months to end of quarter

no national/regional benchmarking available due to cyber incident affecting submissions

% of referrals on EIP pathway that waited for treatment within two weeks *rolling 3 months

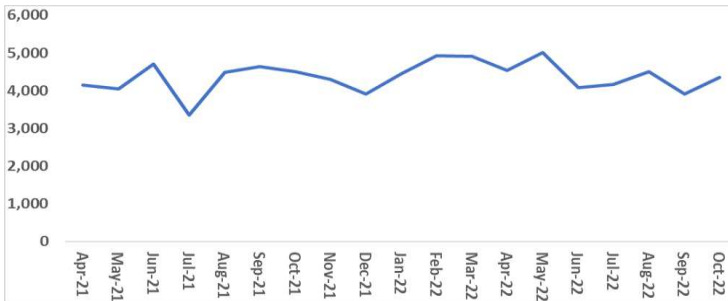


Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	70.83%	64.30%	59.40%
North West	-		62.30%
England	69.50%	72.73%	76.92%

no national/regional benchmarking available for Nov 22

Section IV: Mental Health

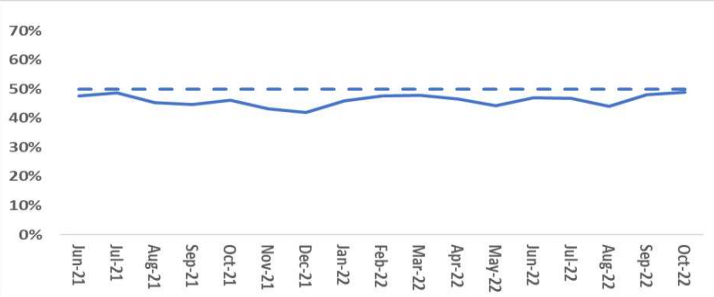
IAPT access: No of people entering NHS funded treatment



Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	4510	3915	4360
North West	14255	12605	14625
England	101382	95023	102971

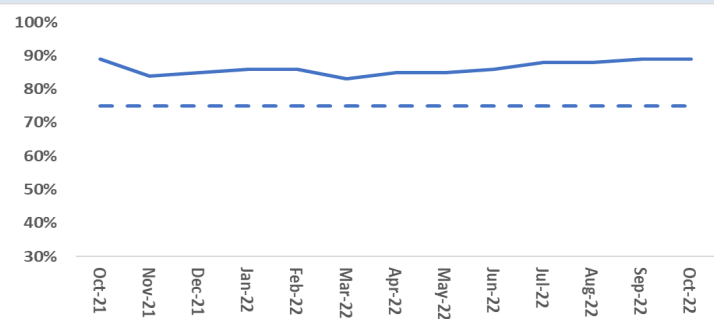
source: NHS futures core data pack

IAPT recovery: % of people that attended at least 2 treatment contacts and are moving to recovery



Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	43.30%	48.0%	49.0%
North West	47.00%	49.0%	47.0%
England	49.40%	49.8%	49.2%

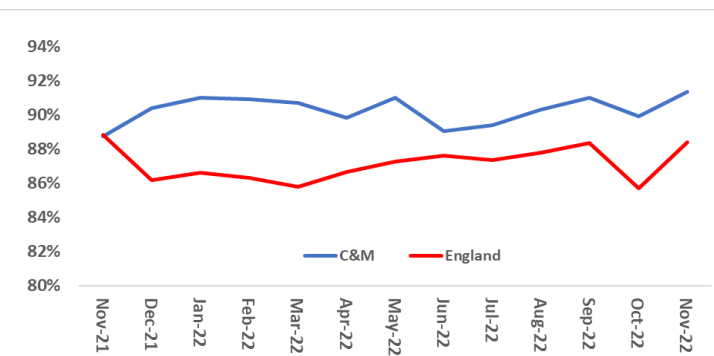
IAPT 6 week waits: * % finished treatment in the reporting period who had first treatment within 6 weeks



Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	88.0%	89.0%	89.0%
North West	83.0%	84.0%	82.0%
England	88.6%	89.3%	89.2%

*source : NHS futures MH Core Data Pack

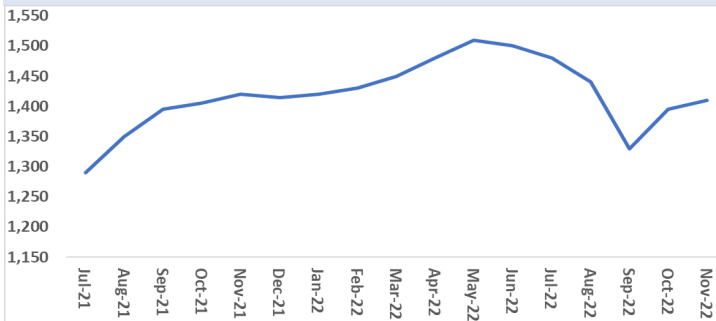
Friends & Family – Mental Health



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	91.04%	89.94%	91.37%
North West	89.14%	89.94%	89.93%
England	88.39%	85.71%	88.43%

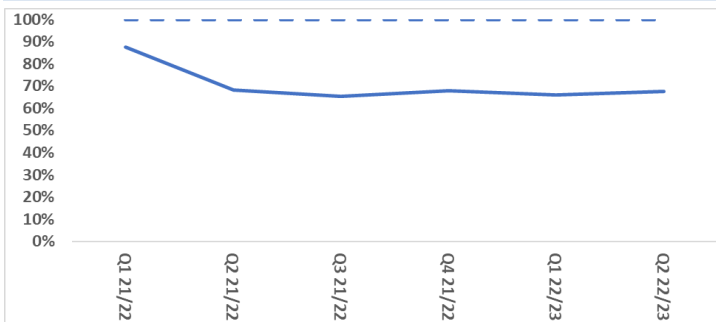
Section IV: Mental Health

No of women accessing specialist community perinatal mental health services *rolling 12 months



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	1,330	1,395	1,410
North West	5,405	5,600	5,495
England	44,650	45,240	45,440

Physical health checks for people with severe mental illness



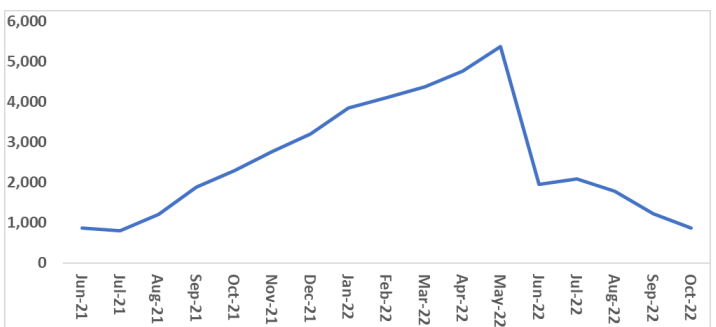
No update for this metric

Organisation	Q4 21/22	Q1 22/23	Q2 22/23
Cheshire and Merseyside	67.9%	65.9%	67.6%
North West	75.7%	73.2%	73.9%
England	75.7%	73.2%	74.5%

source: NHS SOF

* metric calculation has changed in line with SOF definition – denominator is LTP indicative trajectory (weighted share of national LTP ambition 22/23)

Total number of inappropriate adult acute mental health out of area placements bed days : rolling 3 month periods

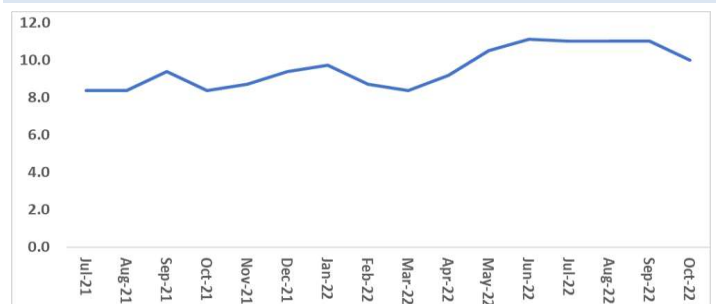


Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	1,790	1,230	865
North West	4,950	4,590	4,876
England	53,450	54,865	57,255

Source: NHS futures OAP report

* Data quality issues addressed from June (over-reported in previous periods)

Rate of people discharged per 100,000 from adult acute beds aged 18-64 with a length of stay of 60+ days *rolling 3mtr



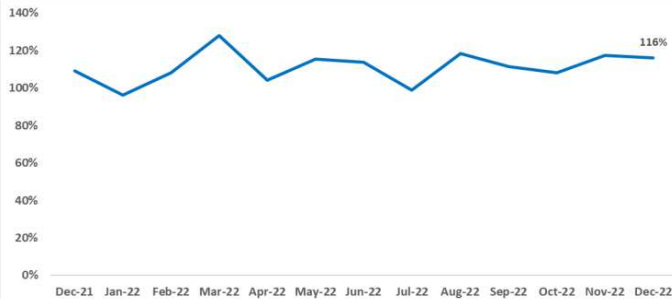
Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	-	-	10.00
North West	-	-	10.90
England	-	-	-
rolling 3mtr (MH core data pack)			
* missing data due to cyber incident			

Section V: Primary Care Dashboard

	Latest period	Target	Value
Number of general practice appointments per 10,000 weighted patients	Oct-22	5201.66 (ENG)	4743.94
Proportion of the population with access to online GP consultations			
Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Sep-22	100.00%	68.50%
Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	Oct-22	70.00%	76.20%
Rate of personalised care interventions	Q2 22-23	75.33 (ENG)	59.81%
Personal health budgets	Q1 22-23	1.45 (ENG)	1.56
COVID-19 % adults vaccinated			
Population vaccination coverage: MMR for two doses (5 year olds)	Q1 22-23	95.00%	86.10%
Proportion of people over 65 receiving a seasonal flu vaccination	Oct-22	85.00%	61.10%
Bowel screening coverage, aged 60–74, screened in last 30 months			
Breast screening coverage : % females aged 53 : 70 screened in the last 36 months	As at March 2021	80.00%	62.00%
Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	Q4 21-22	75.00%	71.60%
Proportion of diabetes patients that have received all eight diabetes care processes	Q4 21-22	46.7% (ENG)	36.80%
% of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	2021-22	90.00%	89.60%
% of hypertension patients who are treated to target as per NICE guidance	2021-22	80.00%	58.20%
% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Q1 22-23	45.00%	54.80%
Number of referrals to NHS digital weight management services per 100k population	Q2 22-23	63.8 (ENG)	89.80
Asthma			

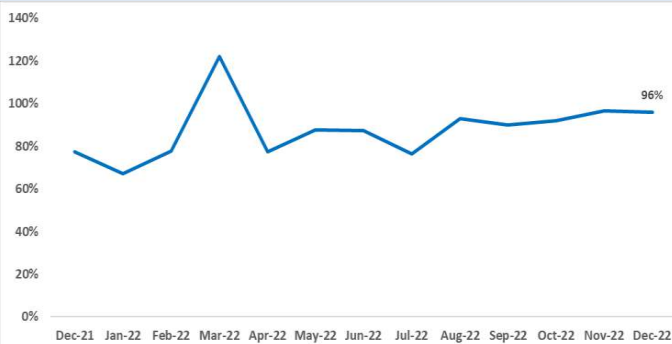
Section V: Primary Care

Total appointments delivered against pre-covid baseline



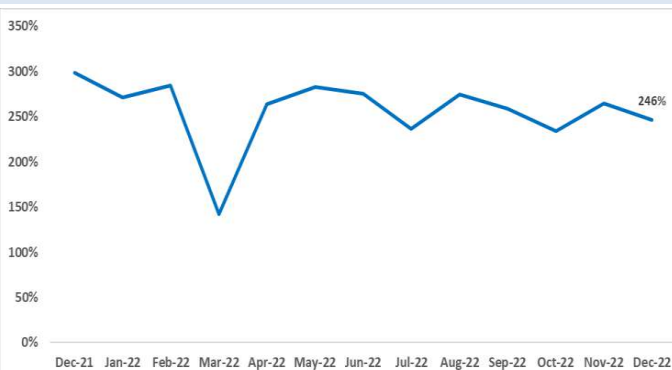
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	108.2%	117.4%	116.2%
North West	123.9%	120.0%	118.6%
England	121.0%	118.1%	114.8%

Face to Face appointments delivered against pre covid baseline



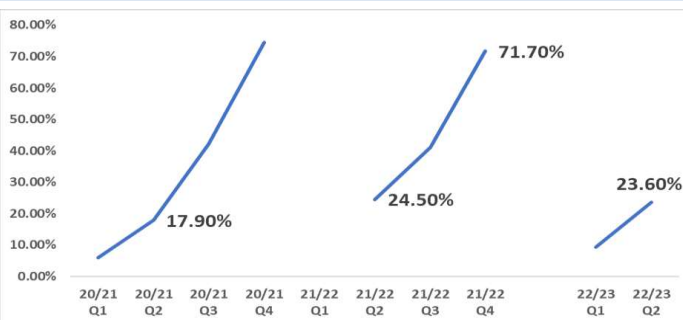
Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	91.8%	96.5%	95.7%
North West	94.8%	100.9%	99.8%
England	93.8%	100.3%	97.3%

Telephone appointments delivered against pre-covid baseline



Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	233.6%	264.9%	246.3%
North West	266.1%	294.2%	276.0%
England	215.4%	239.5%	228.5%

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



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	18.7%	23.6%	29.3%
North West	18.7%	24.1%	30.3%
England	20.2%	26.0%	32.1%

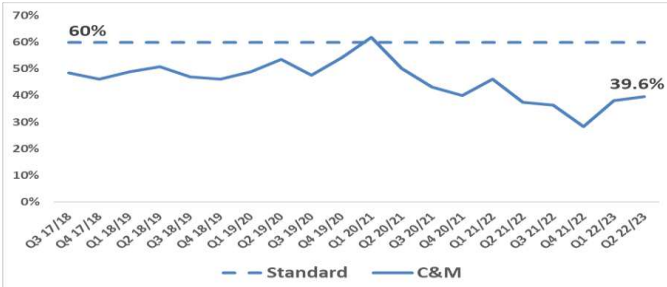
Section VI: Quality Care Dashboard

	Latest period	Target	Value
Clinical Effectiveness			
Admitted to stroke Unit < 4 hours	Q2 22/23	60.00%	39.60%
Assessed by stroke consultant within 24 hours	Q2 22/23	90.00%	82.50%
Assessed by stroke nurse within 24 hours	Q2 22/23	90.00%	91.90%
Spent >90% of stay on stroke unit	Q2 22/23	90.00%	66.00%
Stroke Audit Score	Q2 22/23	70	70
VTE risk assessment			
Antibacterial items by STAR PU	12 months to Jun 22	0.871	1.006
% Co-amoxiclav, Cephalosporins, Quinolones items	12 months to Jun 22	10.00%	8.10%
Watch Reserve DDD's / 1000 total admissions	12 months to Aug 22	2658	2707
Combined antibiotic prescribing to patients aged 70 year plus, per 1000 patient list size aged 70+	12 months to Jul 22	369	354
Percentage of Children aged 0-4 prescribed antibiotics	Aug-22		3.90%
Cancelled Operations	Q2 22/23	0.65%	1.00%
Treated Within 28 Days of Cancellation	Q2 22/23	99.00%	77.70%
Patient safety			
Summary Hospital Mortality Indicator	Jul-22	100	101.9
C.difficile (All Cases)	Oct-22	-	43.7
C.difficile (Hospital Onset)	Oct-22	13	22.9
E.coli (All Cases)	Oct-22	-	103.2
E.coli (Hospital Onset)	Oct-22	-	21
Klebsiella spp. (All Cases)	Oct-22	-	29.3
Klebsiella spp. (Hospital Onset)	Oct-22	-	8.3
MRSA (All Cases)	Oct-22	-	1.8
MRSA (Hospital Onset)	Oct-22	-	0.5
MSSA (All Cases)	Oct-22	-	36.6
MSSA (Hospital Onset)	Oct-22	-	11.4
P.aeruginosa (All Cases)	Oct-22	-	7.7
P.aeruginosa (Hospital Onset)	Oct-22	-	2.4
Serious Incidents	12 months to Sept 22		1187
Never Events	12 months to Sept 22		29
Pressure Ulcers meeting SI Criteria	12 months to Sept 22		86
NRLS - proportion incidents reported that are harmful (average of C&M Trusts)	6 months to Aug 22		23.70%
Patient Experience			
Complaints Rate	Q4 21/22	23	17.6
Mixed Sex Accommodation Breaches	Nov-22	0	21

Source: Public view & Regional Quality Group – Northwest

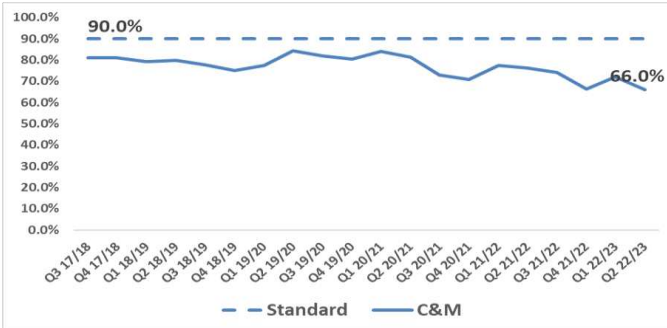
Section VI: Quality Care

Admitted to stroke unit <4 hours



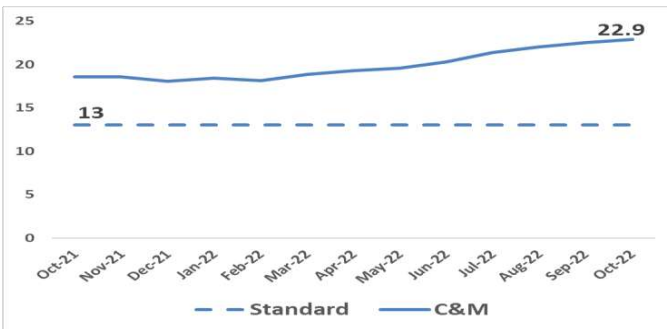
Organisation	Q4 21/22	Q1 22/23	Q2 22/23
Cheshire & Merseyside	28.2%	37.9%	39.6%
North West	36.3%	40.6%	39.9%
England	38.2%	38.6%	37.9%

Spent >90% of time on stroke unit



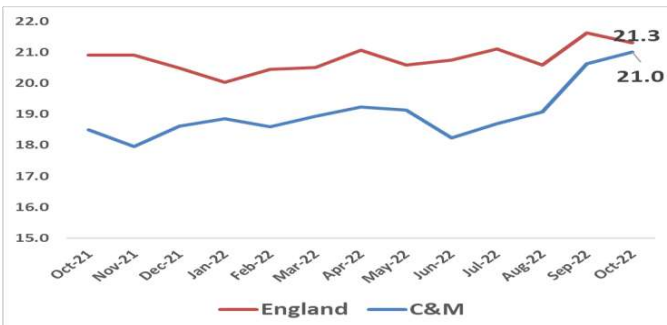
Organisation	Q4 21/22	Q1 22/23	Q2 22/23
Cheshire & Merseyside	66.3%	71.9%	66.0%
North West	68.2%	75.0%	72.5%
England	73.1%	74.2%	75.8%

C.Difficile (Hospital Onset)



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	22.0	22.5	22.9
North West	25.5	25.6	26.0
England	19.0	18.6	18.8

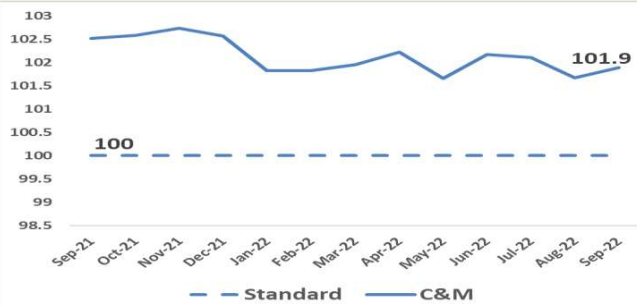
E.Coli (Hospital Onset)



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	19.1	20.6	21.0
North West	22.7	22.4	22.7
England	20.6	21.6	21.3

Section VI: Quality Care

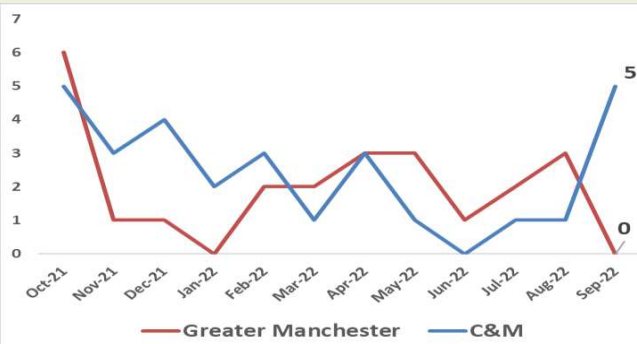
SHMI



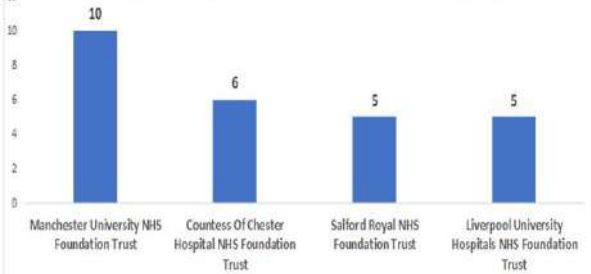
Organisation	May-22	Jun-22	Jul-22
Cheshire & Merseyside	102.1	101.7	101.9
North West	102.3	101.7	101.9
England	102.0	101.4	101.9

Data no longer appears to be available at ICS level

Never Events



Trusts with 4 or More Never Events in the Previous 12 Months



Section VII: Maternity Care Dashboard

	Latest period	Target	Value
Breast feeding initiation rate	22-Sep	71.4% (Eng)	62.50%
Stillbirths per 1,000 total births	Q2-22/23	3.26	2.02
Maternity - number of neonatal deaths per 1000 live births	Q2-22/23	0.57	0.47

Section VIII: Continuing Health Care Dashboard

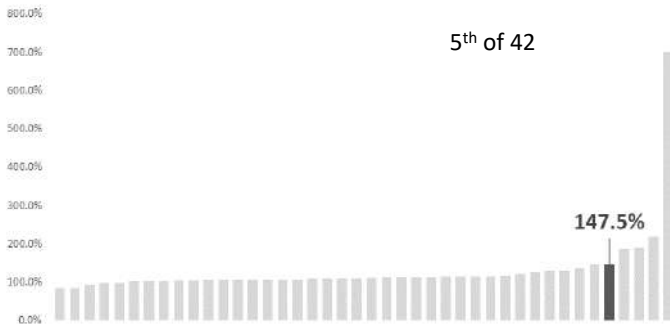
	Latest period	Target	Value
CHC referrals	Q2 22/23		2,200
% CHC assessed as eligible	Q2 22/23	75.00%	72.40%
% CHC referrals completed within 28 days	Q2 22/23	75.00%	78.20%
CHC assessed as eligible per 50k	Q2 22/23	28	35.1
CHC Std Assessment Conversion Rate	Q2 22/23	22%	25.70%
CHC Fast Track assessed s eligible per 50k	Q2 22/23	25	30.4
Location of DST (mandatory - 'Sub ICB locations must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting')	Q2 22/23	15.00%	0.00%
% Waits for assessment over 12 weeks and up to 26 weeks	End Q2 22/23	Eng ave 0.33 per 50K	0.11 (Per 50K)
CHC Numbers	End Q2 22/23		3,144
Fast Tracks	End Q2 22/23		1,182
Number of referrals exceeding 28 days	Q2 22/23		203
Percentage of Local Resolution Requests Completed Resulting in Eligibility	Q2 22/23	23.00%	35.70%
Pupocs (Previously Unassessed Period of Care) agreed eligible YTD	YTD end Q2 22/23		14
FNCs	End Q2 22/23		4,198

Section IX: Learning Disability Dashboard

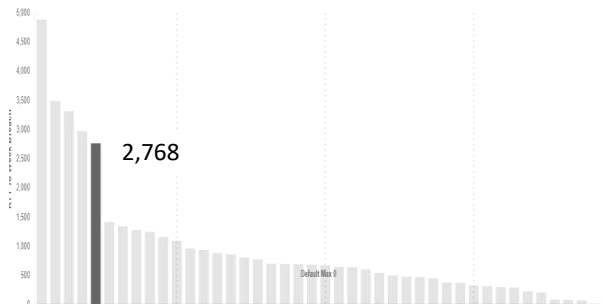
	Latest period	Target	Value
Inpatients with a learning disability and/or autism per million head of population	Q2 22/23	Nat ave 42	50.0
Reliance on specialist inpatient care for children with a learning disability and/or autism	End Dec 22		105 (45 LD, 30 Autism, 30 both)

ICB – National Performance Ambition Metrics

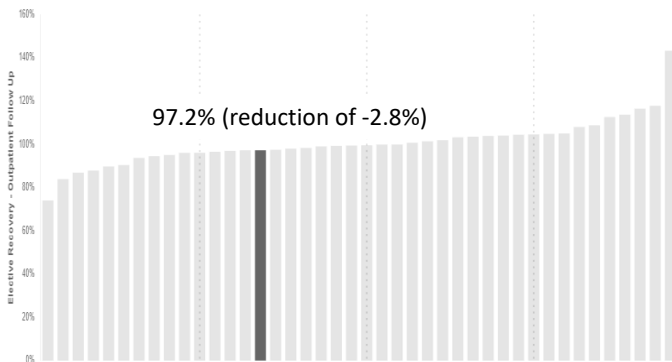
Increase diagnostic activity to 120% pre-pandemic levels



Eliminate 78 week waiters by the end of March 2023

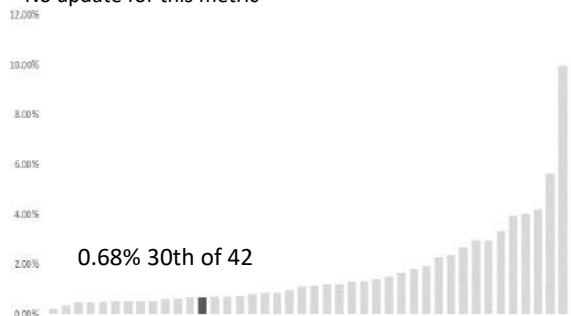


-25% reduction in outpatient follow up attendances



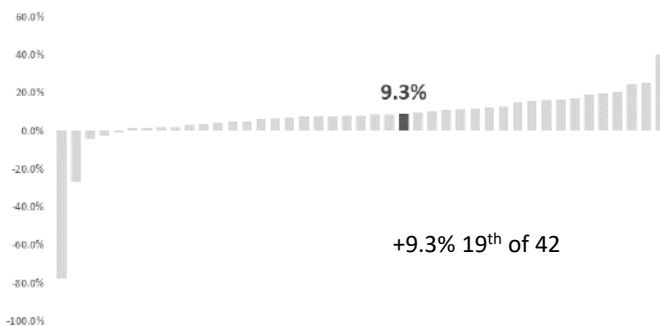
5% of outpatient attendances to convert to PIFU pathways

No update for this metric



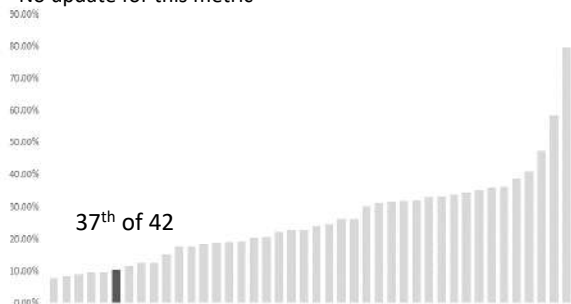
10% more patients to complete treatment through a combination of completed pathways (4% via clock stops and 6% via Advice & Guidance deflections)

Clock stops



Advice & Guidance

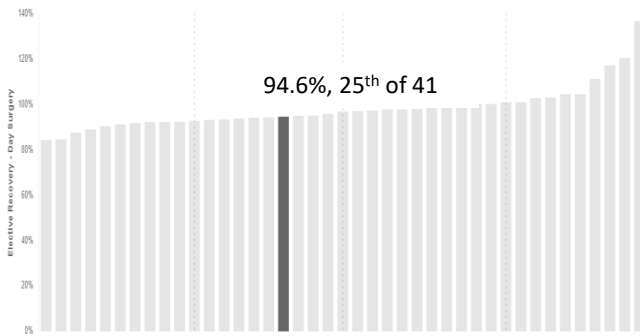
No update for this metric



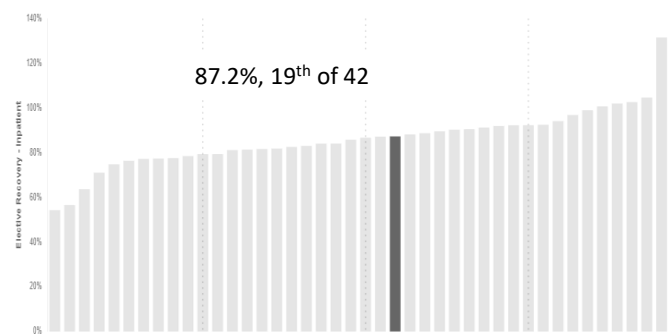
ICB – National Performance Ambition Metrics

Increase day cases, ordinary admissions, OPFA and OP with procedures (excluding OPFU) by 10% on 2019/20 levels

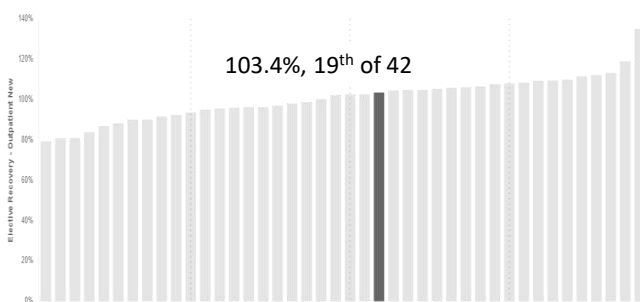
Day case



Ordinary admissions



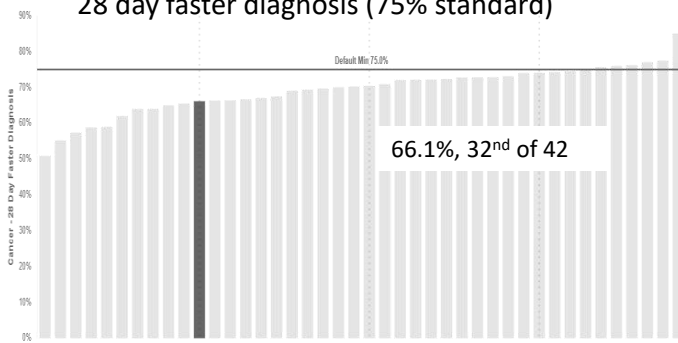
Outpatient new



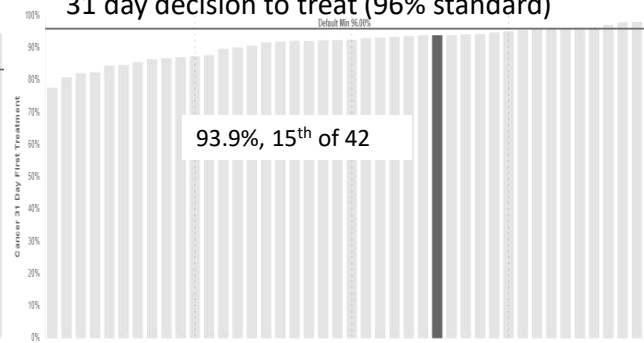
ICB – National Performance Ambition Metrics

Improvements to cancer treatments against cancer standards (62 days urgent ref to 1st treatment, 28 faster diagnosis & 31 day decision to treat to 1st treatment)

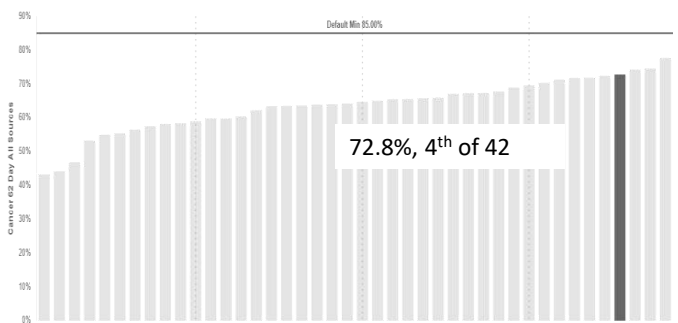
28 day faster diagnosis (75% standard)



31 day decision to treat (96% standard)



62 day referral to treat (85% standard)



Appendix 2 – Provider Summaries

Warrington & Halton Hospital Summary

Key Performance Indicator	Period	Target	Value	SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	55.1%	🔴🟡	
A&E Attendances All	Dec 22	-	11,067	🟡🟢	
Breast Feeding Initiation	Sep 22	70.0%	67.6%	🟡🟢	
C.difficile (Hospital Onset)	Oct 22	13.00	22.3	🟡🟢	
Cancelled Operations	Q2 22/23	0.65%	0.4%	🟡🟢	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	71.4%	🟡🟢	
Cancer 2 Week Wait	Nov 22	93.00%	88.4%	🟡🟢	
Cancer 2 Week Wait Breast Symptomatic	Nov 22	93.0%	100%	🟡🟢	
Cancer 31 Day First Treatment	Nov 22	96.00%	97.7%	🟡🟢	
Cancer 62 Day Classic	Nov 22	85.00%	69.6%	🟡🟢	
Day Surgery Activity	Nov 22	-	2,420	🟡🟢	
Diagnostics - 6 Week Standard	Nov 22	1.00%	24.0%	🟡🟢	
E.coli (All Cases)	Oct 22	-	117.1	🟡🟢	
Elective Inpatient Activity	Nov 22	-	260	🟡🟢	
Mixed Sex Accommodation Breaches	Nov 22	0	2	🟡🟢	
MRSA (All Cases)	Oct 22	-	3.1	🟡🟢	
MSSA (All Cases)	Oct 22	-	38.3	🟡🟢	
Outpatient Follow Up Activity	Nov 22	-	30,910	🟡🟢	
Outpatient New Activity	Nov 22	-	8,130	🟡🟢	
Outpatient Total Activity	Nov 22	-	39,040	🟡🟢	
RTT 104 Week Breach	Nov 22	0	0	🟡🟢	
RTT 52 Week Breach	Nov 22	0	1,620	🟡🟢	
RTT 78 Week Breach	Nov 22	0	199	🟡🟢	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	60.6%	🟡🟢	
RTT Total Incompletes	Nov 22	-	29,049	🟡🟢	
Sickness Absence Rate	Aug 22	4.00%	5.6%	🟡🟢	
Staff Recommend Care	Q3 21/22	80.00%	63.7%	🟡🟢	
Summary Hospital Mortality Indicator	Aug 22	100.00	96.7	🟡🟢	

Wirral University Teaching Hospital Summary

Key Performance Indicator	Period	Target	Value	SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	64.0%	⊖ ⊕	
A&E Attendances All	Dec 22	-	12,068	⊖ ⊖	
Breast Feeding Initiation	Sep 22	70.0%	59.6%	⊖ ⊕	
C.difficile (Hospital Onset)	Oct 22	13.00	45.3	⊕ ⊕	
Cancelled Operations	Q2 22/23	0.65%	0.9%	⊖ ⊖	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	73.9%	⊖ ⊕	
Cancer 2 Week Wait	Nov 22	93.00%	92.0%	⊖ ⊕	
Cancer 2 Week Wait Breast Symptomatic	Nov 22	93.0%	-	⊖ ⊖	
Cancer 31 Day First Treatment	Nov 22	96.00%	97.0%	⊖ ⊕	
Cancer 62 Day Classic	Nov 22	85.00%	74.4%	⊖ ⊕	
Day Surgery Activity	Nov 22	-	4,235	⊕ ⊖	
Diagnostics - 6 Week Standard	Nov 22	1.00%	12.0%	⊕ ⊕	
E.coli (All Cases)	Oct 22	-	94.2	⊖ ⊖	
Elective Inpatient Activity	Nov 22	-	560	⊖ ⊖	
Mixed Sex Accommodation Breaches	Nov 22	0	5	⊖ ⊕	
MRSA (All Cases)	Oct 22	-	1.6	⊕ ⊖	
MSSA (All Cases)	Oct 22	-	31.9	⊖ ⊖	
Outpatient Follow Up Activity	Nov 22	-	34,820	⊕ ⊖	
Outpatient New Activity	Nov 22	-	13,115	⊕ ⊖	
Outpatient Total Activity	Nov 22	-	47,935	⊕ ⊖	
RTT 104 Week Breach	Nov 22	0	0	⊖ ⊕	
RTT 52 Week Breach	Nov 22	0	1,219	⊕ ⊕	
RTT 78 Week Breach	Nov 22	0	44	⊖ ⊕	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	61.6%	⊖ ⊕	
RTT Total Incompletes	Nov 22	-	37,188	⊕ ⊖	
Sickness Absence Rate	Aug 22	4.00%	6.0%	⊕ ⊕	
Staff Recommend Care	Q3 21/22	80.00%	67.8%	⊖ ⊖	
Summary Hospital Mortality Indicator	Aug 22	100.00	106.3	⊕ ⊕	

St Helens & Knowsley Hospital Summary

Key Performance Indicator	Period	Target	Value	SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	52.9%	⚠️	
A&E Attendances All	Dec 22	-	15,130	⚠️	
Breast Feeding Initiation	Sep 22	70.0%	45.8%	⚠️	
C.difficile (Hospital Onset)	Oct 22	13.00	13.5	⚠️	
Cancelled Operations	Q2 22/23	0.65%	1.1%	⚠️	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	67.5%	⚠️	
Cancer 2 Week Wait	Nov 22	93.00%	85.2%	⚠️	
Cancer 2 Week Wait Breast Symptomatic	Nov 22	93.0%	94.4%	⚠️	
Cancer 31 Day First Treatment	Nov 22	96.00%	97.8%	⚠️	
Cancer 62 Day Classic	Nov 22	85.00%	83.3%	⚠️	
Day Surgery Activity	Nov 22	-	4,275	⚠️	
Diagnostics - 6 Week Standard	Nov 22	1.00%	24.4%	⚠️	
E.coli (All Cases)	Oct 22	-	91.6	⚠️	
Elective Inpatient Activity	Nov 22	-	480	⚠️	
Mixed Sex Accommodation Breaches	Nov 22	0	0	⚠️	
MRSA (All Cases)	Oct 22	-	1.5	⚠️	
MSSA (All Cases)	Oct 22	-	39.2	⚠️	
Outpatient Follow Up Activity	Nov 22	-	30,485	⚠️	
Outpatient New Activity	Nov 22	-	16,100	⚠️	
Outpatient Total Activity	Nov 22	-	46,585	⚠️	
RTT 104 Week Breach	Nov 22	0	0	⚠️	
RTT 52 Week Breach	Nov 22	0	2,411	⚠️	
RTT 78 Week Breach	Nov 22	0	373	⚠️	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	66.1%	⚠️	
RTT Total Incompletes	Nov 22	-	45,373	⚠️	
Sickness Absence Rate	Aug 22	4.00%	3.3%	⚠️	
Staff Recommend Care	Q3 21/22	80.00%	79.4%	⚠️	
Summary Hospital Mortality Indicator	Aug 22	100.00	103.8	⚠️	

Mid Cheshire Hospitals Summary

The trust have reported no patients waiting over 104 weeks for the second month. Despite more activity in most diagnostic modalities in 2022 compared to pre-pandemic, the backlog has increased slightly. Performance against the majority of Cancer targets for the trust remain above England and Cheshire & Merseyside averages.

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	51.1%	⚠️	
A&E Attendances All	Dec 22	-	9,565	⚠️	
Breast Feeding Initiation	Sep 22	70.0%	70.6%	⚠️	
C.difficile (Hospital Onset)	Oct 22	13.00	16.6	⚠️	
Cancelled Operations	Q2 22/23	0.65%	1.8%	⚠️	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	62.4%	⚠️	
Cancer 2 Week Wait	Nov 22	93.00%	91.1%	⚠️	
Cancer 2 Week Wait Breast Symptomatic	Nov 22	93.0%	82.0%	⚠️	
Cancer 31 Day First Treatment	Nov 22	96.00%	87.8%	⚠️	
Cancer 62 Day Classic	Nov 22	85.00%	63.6%	⚠️	
Day Surgery Activity	Nov 22	-	2,495	⚠️	
Diagnostics - 6 Week Standard	Nov 22	1.00%	25.7%	⚠️	
E.coli (All Cases)	Oct 22	-	102.5	⚠️	
Elective Inpatient Activity	Nov 22	-	260	⚠️	
Mixed Sex Accommodation Breaches	Nov 22	0	0	⚠️	
MRSA (All Cases)	Oct 22	-	2.0	⚠️	
MSSA (All Cases)	Oct 22	-	30.7	⚠️	
Outpatient Follow Up Activity	Nov 22	-	15,980	⚠️	
Outpatient New Activity	Nov 22	-	7,520	⚠️	
Outpatient Total Activity	Nov 22	-	23,500	⚠️	
RTT 104 Week Breach	Nov 22	0	0	⚠️	
RTT 52 Week Breach	Nov 22	0	1,658	⚠️	
RTT 78 Week Breach	Nov 22	0	101	⚠️	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	57.2%	⚠️	
RTT Total Incompletes	Nov 22	-	36,598	⚠️	
Sickness Absence Rate	Aug 22	4.00%	5.3%	⚠️	
Staff Recommend Care	Q3 21/22	80.00%	71.9%	⚠️	
Summary Hospital Mortality Indicator	Aug 22	100.00	94.4	⚠️	

Liverpool University Hospitals Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	61.9%	(L) (F)	
A&E Attendances All	Dec 22	-	26,329	(H) (C)	
C.difficile (Hospital Onset)	Oct 22	13.00	24.3	(H) (F)	
Cancelled Operations	Q2 22/23	0.65%	0.8%	(H) (C)	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	61.4%	(L) (F)	
Cancer 2 Week Wait	Nov 22	93.00%	54.3%	(L) (F)	
Cancer 2 Week Wait Breast Symptomatic	Nov 22	93.0%	51.1%	(L) (F)	
Cancer 31 Day First Treatment	Nov 22	96.00%	88.3%	(L) (F)	
Cancer 62 Day Classic	Nov 22	85.00%	46.4%	(L) (F)	
Day Surgery Activity	Nov 22	-	6,500	(H) (C)	
Diagnostics - 6 Week Standard	Nov 22	1.00%	17.2%	(H) (F)	
E.coli (All Cases)	Oct 22	-	115.4	(L) (C)	
Elective Inpatient Activity	Nov 22	-	1,225	(H) (C)	
Mixed Sex Accommodation Breaches	Nov 22	0	0	(L) (F)	
MRSA (All Cases)	Oct 22	-	2.1	(L) (C)	
MSSA (All Cases)	Oct 22	-	35.6	(L) (C)	
Outpatient Follow Up Activity	Nov 22	-	59,880	(H) (C)	
Outpatient New Activity	Nov 22	-	32,335	(H) (C)	
Outpatient Total Activity	Nov 22	-	92,215	(H) (C)	
RTT 104 Week Breach	Nov 22	0	16	(L) (F)	
RTT 52 Week Breach	Nov 22	0	10,179	(H) (F)	
RTT 78 Week Breach	Nov 22	0	1,615	(L) (F)	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	48.6%	(L) (F)	
RTT Total Incompletes	Nov 22	-	85,542	(H) (C)	
Sickness Absence Rate	Aug 22	4.00%	6.1%	(H) (F)	
Staff Recommend Care	Q3 21/22	80.00%	60.3%	(L) (C)	
Summary Hospital Mortality Indicator	Aug 22	100.00	102.1	(L) (F)	

East Cheshire Hospitals Summary

Significant progress continues with the utilisation of Independent Sector capacity, specifically within Gastroenterology, ENT, General Surgery and T&O specialties and some theatre lists are being converted to support long waiting patients. The cancer 62 day performance has seen a continuation of challenged performance. This is multi-factorial with the main impacts being the challenges of complex diagnostic pathways, delays in radiology as well as the reporting of histology.

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	47.0%	Ⓛ Ⓜ	
A&E Attendances All	Dec 22	-	4,374	Ⓜ Ⓛ	
C.difficile (Hospital Onset)	Oct 22	13.00	12.1	Ⓛ Ⓜ	
Cancelled Operations	Q2 22/23	0.65%	2.2%	Ⓛ Ⓜ	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	67.9%	Ⓛ Ⓜ	
Cancer 2 Week Wait	Nov 22	93.00%	67.9%	Ⓛ Ⓜ	
Cancer 2 Week Wait Breast Symptomatic	Nov 22	93.0%	46.2%	Ⓛ Ⓜ	
Cancer 31 Day First Treatment	Nov 22	96.00%	72.9%	Ⓛ Ⓜ	
Cancer 62 Day Classic	Nov 22	85.00%	61.5%	Ⓛ Ⓜ	
Day Surgery Activity	Nov 22	-	945	Ⓛ Ⓜ	
Diagnostics - 6 Week Standard	Nov 22	1.00%	13.5%	Ⓛ Ⓜ	
E.coli (All Cases)	Oct 22	-	101.0	Ⓛ Ⓜ	
Elective Inpatient Activity	Nov 22	-	120	Ⓛ Ⓜ	
Mixed Sex Accommodation Breaches	Nov 22	0	7	Ⓛ Ⓜ	
MRSA (All Cases)	Oct 22	-	1.7	Ⓛ Ⓜ	
MSSA (All Cases)	Oct 22	-	48.4	Ⓛ Ⓜ	
Outpatient Follow Up Activity	Nov 22	-	5,975	Ⓛ Ⓜ	
Outpatient New Activity	Nov 22	-	4,700	Ⓛ Ⓜ	
Outpatient Total Activity	Nov 22	-	10,675	Ⓛ Ⓜ	
RTT 104 Week Breach	Nov 22	0	3	Ⓛ Ⓜ	
RTT 52 Week Breach	Nov 22	0	213	Ⓛ Ⓜ	
RTT 78 Week Breach	Nov 22	0	25	Ⓛ Ⓜ	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	67.3%	Ⓛ Ⓜ	
RTT Total Incompletes	Nov 22	-	10,715	Ⓛ Ⓜ	
Sickness Absence Rate	Aug 22	4.00%	5.7%	Ⓛ Ⓜ	
Staff Recommend Care	Q3 21/22	80.00%	64.6%	Ⓛ Ⓜ	
Summary Hospital Mortality Indicator	Aug 22	100.00	116.6	Ⓛ Ⓜ	

Countess of Chester Hospital Summary

The trust upgraded from an outdated electronic patient record (EPR) system to a new EPR system in 2021. Data issues have impacted on availability of data and the trust’s ability to manage waiting lists effectively, leading to poor performance across the majority of areas.

Issue: Data, once migrated from the old system, was not visible on the new system, leading to ongoing use of manual records. Action: Detailed validation of patient records across every service and all points of delivery (POD), eg Out Patients, Inpatients etc. commenced in November 2021 and is expected to be completed by December 2022.

Mitigation: As at September 2022 validation of Diagnostic data is almost complete and good progress has been made on validating RTT, particularly Open Pathways. In addition there is notable improvements to TCI data and Outpatient Follow Ups (FUPs). The trust are also working with NHS digital to ensure data from the new system is loading accurately onto the “Spine”. For cancer the trust have implemented a process/pathway review, leadership restructure and overhaul of operational reporting governance.

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	49.5%	⬇️ ⬆️	
A&E Attendances All	Dec 22	-	7,231	⬆️ ⬇️	
Breast Feeding Initiation	Sep 22	70.0%	66.7%	⬇️ ⬆️	
C.difficile (Hospital Onset)	Oct 22	13.00	35.2	⬆️ ⬇️	
Cancelled Operations	Q2 22/23	0.65%	0.7%	⬇️ ⬆️	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	62.2%	⬇️ ⬆️	
Cancer 2 Week Wait	Nov 22	93.00%	66.4%	⬇️ ⬆️	
Cancer 2 Week Wait Breast Symptomatic	Nov 22	93.0%	-	⬇️ ⬆️	
Cancer 31 Day First Treatment	Nov 22	96.00%	99.1%	⬇️ ⬆️	
Cancer 62 Day Classic	Nov 22	85.00%	85.9%	⬇️ ⬆️	
Day Surgery Activity	Nov 22	-	2,255	⬇️ ⬆️	
Diagnostics - 6 Week Standard	Nov 22	1.00%	18.8%	⬇️ ⬆️	
E.coli (All Cases)	Oct 22	-	123.4	⬆️ ⬇️	
Elective Inpatient Activity	Nov 22	-	235	⬇️ ⬆️	
Mixed Sex Accommodation Breaches	Nov 22	0	0	⬇️ ⬆️	
MRSA (All Cases)	Oct 22	-	1.4	⬇️ ⬆️	
MSSA (All Cases)	Oct 22	-	47.4	⬆️ ⬇️	
Outpatient Follow Up Activity	Nov 22	-	21,695	⬇️ ⬆️	
Outpatient New Activity	Nov 22	-	8,975	⬇️ ⬆️	
Outpatient Total Activity	Nov 22	-	30,670	⬇️ ⬆️	
RTT 104 Week Breach	Nov 22	0	2	⬇️ ⬆️	
RTT 52 Week Breach	Nov 22	0	3,884	⬆️ ⬇️	
RTT 78 Week Breach	Nov 22	0	219	⬇️ ⬆️	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	44.0%	⬇️ ⬆️	
RTT Total Incompletes	Nov 22	-	38,554	⬆️ ⬇️	
Sickness Absence Rate	Aug 22	4.00%	5.5%	⬆️ ⬇️	
Staff Recommend Care	Q3 21/22	80.00%	57.1%	⬇️ ⬆️	
Summary Hospital Mortality Indicator	Aug 22	100.00	98.7	⬇️ ⬆️	

Southport & Ormskirk Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	70.7%		
A&E Attendances All	Dec 22	-	11,651		
Breast Feeding Initiation	Sep 22	70.0%	62.2%		
C.difficile (Hospital Onset)	Oct 22	13.00	23.2		
Cancelled Operations	Q2 22/23	0.65%	1.0%		
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	69.0%		
Cancer 2 Week Wait	Nov 22	93.00%	88.2%		
Cancer 2 Week Wait Breast Symptomatic	Nov 22	93.0%	-		
Cancer 31 Day First Treatment	Nov 22	96.00%	81.9%		
Cancer 62 Day Classic	Nov 22	85.00%	69.6%		
Day Surgery Activity	Nov 22	-	1,860		
Diagnostics - 6 Week Standard	Nov 22	1.00%	23.7%		
E.coli (All Cases)	Oct 22	-	149.4		
Elective Inpatient Activity	Nov 22	-	210		
Mixed Sex Accommodation Breaches	Nov 22	0	7		
MRSA (All Cases)	Oct 22	-	1.5		
MSSA (All Cases)	Oct 22	-	44.2		
Outpatient Follow Up Activity	Nov 22	-	16,115		
Outpatient New Activity	Nov 22	-	6,205		
Outpatient Total Activity	Nov 22	-	22,320		
RTT 104 Week Breach	Nov 22	0	0		
RTT 52 Week Breach	Nov 22	0	172		
RTT 78 Week Breach	Nov 22	0	4		
RTT Incomplete 18 Week Standard	Nov 22	92.00%	65.9%		
RTT Total Incompletes	Nov 22	-	16,308		
Sickness Absence Rate	Aug 22	4.00%	6.0%		
Staff Recommend Care	Q3 21/22	80.00%	52.8%		
Summary Hospital Mortality Indicator	Aug 22	100.00	100.1		

Liverpool Women's Hospital Summary

Key Performance Indicator	Period	Target	Value	SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	88.2%	(L) (F)	
A&E Attendances All	Dec 22	-	1,164	(H) (C)	
Breast Feeding Initiation	Sep 22	70.0%	67.5%	(H) (F)	
C.difficile (Hospital Onset)	Oct 22	13.00	0.0	(L) (P)	
Cancelled Operations	Q2 22/23	0.65%	0.2%	(C) (C)	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	55.9%	(C) (F)	
Cancer 2 Week Wait	Nov 22	93.00%	94.7%	(C) (T)	
Cancer 31 Day First Treatment	Nov 22	96.00%	82.1%	(C) (F)	
Cancer 62 Day Classic	Nov 22	85.00%	20.0%	(L) (F)	
Day Surgery Activity	Nov 22	-	465	(L) (C)	
Diagnostics - 6 Week Standard	Nov 22	1.00%	16.2%	(H) (F)	
E.coli (All Cases)	Oct 22	-	46.5	(L) (C)	
Elective Inpatient Activity	Nov 22	-	135	(C) (C)	
Mixed Sex Accommodation Breaches	Nov 22	0	0	(H) (F)	
MRSA (All Cases)	Oct 22	-	0.0	(L) (C)	
MSSA (All Cases)	Oct 22	-	3.6	(L) (C)	
Outpatient Follow Up Activity	Nov 22	-	8,205	(C) (C)	
Outpatient New Activity	Nov 22	-	5,110	(C) (C)	
Outpatient Total Activity	Nov 22	-	13,315	(C) (C)	
RTT 104 Week Breach	Nov 22	0	0	(L) (F)	
RTT 52 Week Breach	Nov 22	0	2,589	(H) (F)	
RTT 78 Week Breach	Nov 22	0	117	(H) (F)	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	44.1%	(L) (F)	
RTT Total Incompletes	Nov 22	-	17,670	(H) (C)	
Sickness Absence Rate	Aug 22	4.00%	7.6%	(H) (F)	
Staff Recommend Care	Q3 21/22	80.00%	69.1%	(L) (C)	

Liverpool Heart & Chest Hospital Summary

Key Performance Indicator	Period	Target	Value	SPC	Last 12 Months
C.difficile (Hospital Onset)	Oct 22	13.00	2.0	🟢🟢	
Cancelled Operations	Q2 22/23	0.65%	2.3%	🟡🟡	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	44.4%	🟡🟡	
Cancer 2 Week Wait	Nov 22	93.00%	100%	🟢🟢	
Cancer 31 Day First Treatment	Nov 22	96.00%	100%	🟢🟢	
Cancer 62 Day Classic	Nov 22	85.00%	73.3%	🟡🟡	
Day Surgery Activity	Nov 22	-	365	🟢🟡	
Diagnostics - 6 Week Standard	Nov 22	1.00%	0.6%	🟢🟢	
E.coli (All Cases)	Oct 22	-	13.8	🟡🟡	
Elective Inpatient Activity	Nov 22	-	340	🟢🟡	
Mixed Sex Accommodation Breaches	Nov 22	0	0	🟢🟢	
MRSA (All Cases)	Oct 22	-	0.0	🟢🟢	
MSSA (All Cases)	Oct 22	-	25.7	🟡🟡	
Outpatient Follow Up Activity	Nov 22	-	4,505	🟢🟡	
Outpatient New Activity	Nov 22	-	2,680	🟢🟡	
Outpatient Total Activity	Nov 22	-	7,185	🟢🟡	
RTT 104 Week Breach	Nov 22	0	0	🟡🟡	
RTT 52 Week Breach	Nov 22	0	46	🟡🟡	
RTT 78 Week Breach	Nov 22	0	12	🟡🟡	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	78.7%	🟡🟡	
RTT Total Incompletes	Nov 22	-	5,060	🟡🟡	
Sickness Absence Rate	Aug 22	4.00%	5.3%	🟡🟡	
Staff Recommend Care	Q3 21/22	80.00%	91.6%	🟢🟢	

Alder Hey Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	59.7%	⬇️ ⬆️	
A&E Attendances All	Dec 22	-	7,420	⬇️ ⬆️	
C.difficile (Hospital Onset)	Oct 22	13.00	0.0	⬇️ ⬆️	
Cancelled Operations	Q2 22/23	0.65%	1.3%	⬇️ ⬆️	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	100%	⬆️ ⬆️	
Cancer 2 Week Wait	Nov 22	93.00%	100%	⬆️ ⬆️	
Cancer 31 Day First Treatment	Nov 22	96.00%	100%	⬆️ ⬆️	
Cancer 62 Day Classic	Nov 22	85.00%	-	⬇️ ⬆️	
Day Surgery Activity	Nov 22	-	1,805	⬆️ ⬆️	
Diagnostics - 6 Week Standard	Nov 22	1.00%	25.7%	⬆️ ⬆️	
E.coli (All Cases)	Oct 22	-	46.8	⬆️ ⬆️	
Elective Inpatient Activity	Nov 22	-	345	⬇️ ⬆️	
Mixed Sex Accommodation Breaches	Nov 22	0	0	⬆️ ⬆️	
MRSA (All Cases)	Oct 22	-	1.5	⬇️ ⬆️	
MSSA (All Cases)	Oct 22	-	30.2	⬇️ ⬆️	
Outpatient Follow Up Activity	Nov 22	-	17,815	⬆️ ⬆️	
Outpatient New Activity	Nov 22	-	6,770	⬆️ ⬆️	
Outpatient Total Activity	Nov 22	-	24,585	⬆️ ⬆️	
RTT 104 Week Breach	Nov 22	0	0	⬇️ ⬆️	
RTT 52 Week Breach	Nov 22	0	345	⬆️ ⬆️	
RTT 78 Week Breach	Nov 22	0	8	⬇️ ⬆️	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	53.9%	⬇️ ⬆️	
RTT Total Incompletes	Nov 22	-	21,984	⬆️ ⬆️	
Sickness Absence Rate	Aug 22	4.00%	6.0%	⬆️ ⬆️	
Staff Recommend Care	Q3 21/22	80.00%	89.5%	⬆️ ⬆️	

The Walton Centre Summary

Key Performance Indicator	Period	Target	Value	SPC	Last 12 Months
C.difficile (Hospital Onset)	Oct 22	13.00	13.5	🟡🟢	
Cancelled Operations	Q2 22/23	0.65%	0.9%	🟡🟢	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	100%	🟢🟢	
Cancer 2 Week Wait	Nov 22	93.00%	100%	🟢🟢	
Cancer 31 Day First Treatment	Nov 22	96.00%	100%	🟡🟢	
Cancer 62 Day Classic	Nov 22	85.00%	-	🟡🟢	
Day Surgery Activity	Nov 22	-	845	🟢🟢	
Diagnostics - 6 Week Standard	Nov 22	1.00%	0.3%	🟡🟢	
E.coli (All Cases)	Oct 22	-	31.6	🟡🟢	
Elective Inpatient Activity	Nov 22	-	255	🟢🟢	
Mixed Sex Accommodation Breaches	Nov 22	0	0	🟡🟢	
MRSA (All Cases)	Oct 22	-	0.0	🟡🟢	
MSSA (All Cases)	Oct 22	-	15.8	🟡🟢	
Outpatient Follow Up Activity	Nov 22	-	7,745	🟢🟢	
Outpatient New Activity	Nov 22	-	3,770	🟡🟢	
Outpatient Total Activity	Nov 22	-	11,515	🟢🟢	
RTT 104 Week Breach	Nov 22	0	0	🟡🟢	
RTT 52 Week Breach	Nov 22	0	139	🟡🟢	
RTT 78 Week Breach	Nov 22	0	3	🟡🟢	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	80.1%	🟡🟢	
RTT Total Incompletes	Nov 22	-	12,563	🟡🟢	
Sickness Absence Rate	Aug 22	4.00%	5.6%	🟡🟢	
Staff Recommend Care	Q3 21/22	80.00%	88.7%	🟡🟢	

The Clatterbridge Cancer Centre Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
C.difficile (Hospital Onset)	Oct 22	13.00	39.3	⊕ ⊖	
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	84.2%	⊖ ⊕	
Cancer 2 Week Wait	Nov 22	93.00%	92.0%	⊖ ⊕	
Cancer 31 Day First Treatment	Nov 22	96.00%	100%	⊖ ⊕	
Cancer 62 Day Classic	Nov 22	85.00%	85.9%	⊖ ⊕	
Day Surgery Activity	Nov 22	-	385	⊖ ⊖	
Diagnostics - 6 Week Standard	Nov 22	1.00%	0.0%	⊕ ⊕	
E.coli (All Cases)	Oct 22	-	117.8	⊕ ⊖	
Elective Inpatient Activity	Nov 22	-	85	⊖ ⊖	
Mixed Sex Accommodation Breaches	Nov 22	0	0	⊕ ⊕	
MRSA (All Cases)	Oct 22	-	3.6	⊕ ⊖	
MSSA (All Cases)	Oct 22	-	57.1	⊕ ⊖	
Outpatient Follow Up Activity	Nov 22	-	42,085	⊕ ⊖	
Outpatient New Activity	Nov 22	-	1,495	⊕ ⊖	
Outpatient Total Activity	Nov 22	-	43,580	⊕ ⊖	
RTT 104 Week Breach	Nov 22	0	0	⊕ ⊕	
RTT 52 Week Breach	Nov 22	0	0	⊕ ⊕	
RTT 78 Week Breach	Nov 22	0	0	⊕ ⊕	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	97.7%	⊖ ⊕	
RTT Total Incompletes	Nov 22	-	969	⊕ ⊖	
Sickness Absence Rate	Aug 22	4.00%	5.3%	⊕ ⊕	
Staff Recommend Care	Q3 21/22	80.00%	85.5%	⊖ ⊖	

Cheshire & Wirral Partnership Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
Day Surgery Activity	Nov 22	-	-	🟡🟢	
EIP Open Referrals Waiting < 2 Weeks	Nov 22	75.00%	5.0%	🔴🟡	
Elective Inpatient Activity	Nov 22	-	-	🟡🟢	
IAPT Face to Face	Oct 22	-	10%	🟢🟡	
IAPT Incomplete Waiting under 18 weeks	Oct 22	95.0%	79.9%	🔴🟡	
IAPT Incomplete Waiting under 6 weeks	Oct 22	75.0%	67.1%	🔴🟡	
IAPT Recovery Rate	Oct 22	50.0%	51.9%	🟢🟡	
IAPT Referrals	Oct 22	-	985	🔴🟡	
MH AWOL Episodes	Oct 22	-	-	🟡🟢	
MH Under 18 Bed Days on Adult Ward	Oct 22	-	-	🟡🟢	
Mixed Sex Accommodation Breaches	Nov 22	0	0	🔴🟡	
Outpatient Follow Up Activity	Nov 22	-	-	🟡🟢	
Outpatient New Activity	Nov 22	-	-	🟡🟢	
Outpatient Total Activity	Nov 22	-	-	🟡🟢	
Sickness Absence Rate	Aug 22	4.00%	6.2%	🟡🟢	
Staff Recommend Care	Q3 21/22	80.00%	69.5%	🟡🟢	

Mersey Care Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	93.8%	⚠️	
A&E Attendances All	Dec 22	-	14,524	⚠️	
Day Surgery Activity	Nov 22	-	-	⚠️	
EIP Open Referrals Waiting < 2 Weeks	Nov 22	75.00%	50.0%	⚠️	
Elective Inpatient Activity	Nov 22	-	-	⚠️	
IAPT Face to Face	Oct 22	-	-	⚠️	
IAPT Incomplete Waiting under 18 weeks	Oct 22	95.0%	98.4%	✅	
IAPT Incomplete Waiting under 6 weeks	Oct 22	75.0%	95.7%	✅	
IAPT Recovery Rate	Oct 22	50.0%	47.8%	⚠️	
IAPT Referrals	Oct 22	-	2,815	⚠️	
Mixed Sex Accommodation Breaches	Nov 22	0	0	✅	
Outpatient Follow Up Activity	Nov 22	-	-	⚠️	
Outpatient New Activity	Nov 22	-	-	⚠️	
Outpatient Total Activity	Nov 22	-	-	⚠️	
RTT 104 Week Breach	Nov 22	0	0	⚠️	
RTT 52 Week Breach	Nov 22	0	0	⚠️	
RTT 78 Week Breach	Nov 22	0	0	⚠️	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	100%	⚠️	
RTT Total Incompletes	Nov 22	-	53	⚠️	
Sickness Absence Rate	Aug 22	4.00%	8.1%	⚠️	
Staff Recommend Care	Q3 21/22	80.00%	67.0%	⚠️	

Wirral Community Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	92.5%	🕒🕒	
A&E Attendances All	Dec 22	-	4,911	🕒🕒	
Cancer 31 Day First Treatment	Nov 22	96.00%	-	🕒🕒	
Cancer 62 Day Classic	Nov 22	85.00%	-	🕒🕒	
Diagnostics - 6 Week Standard	Nov 22	1.00%	59.1%	🕒🕒	
RTT 104 Week Breach	Nov 22	0	0	🕒🕒	
RTT 52 Week Breach	Nov 22	0	2	🕒🕒	
RTT 78 Week Breach	Nov 22	0	2	🕒🕒	
RTT Incomplete 18 Week Standard	Nov 22	92.00%	84.3%	🕒🕒	
RTT Total Incompletes	Nov 22	-	121	🕒🕒	
Sickness Absence Rate	Aug 22	4.00%	6.7%	🕒🕒	
Staff Recommend Care	Q3 21/22	80.00%	72.8%	🕒🕒	

Bridgewater Community Healthcare Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Dec 22	95.00%	82.3%		
A&E Attendances All	Dec 22	-	4,156		
Cancer - 28 Day Faster Diagnosis	Nov 22	75.0%	75.3%		
Cancer 2 Week Wait	Nov 22	93.00%	94.4%		
Cancer 31 Day First Treatment	Nov 22	96.00%	100%		
Cancer 62 Day Classic	Nov 22	85.00%	100%		
Day Surgery Activity	Nov 22	-	0		
Diagnostics - 6 Week Standard	Nov 22	1.00%	2.1%		
Elective Inpatient Activity	Nov 22	-	0		
IAPT Incomplete Waiting under 18 weeks	Oct 22	95.0%	-		
IAPT Incomplete Waiting under 6 weeks	Oct 22	75.0%	-		
IAPT Recovery Rate	Oct 22	50.0%	-		
IAPT Referrals	Oct 22	-	-		
Mixed Sex Accommodation Breaches	Nov 22	0	-		
Outpatient Follow Up Activity	Nov 22	-	8,015		
Outpatient New Activity	Nov 22	-	2,075		
Outpatient Total Activity	Nov 22	-	10,090		
RTT 104 Week Breach	Nov 22	0	0		
RTT 52 Week Breach	Nov 22	0	8		
RTT 78 Week Breach	Nov 22	0	0		
RTT Incomplete 18 Week Standard	Nov 22	92.00%	35.3%		
RTT Total Incompletes	Nov 22	-	2,771		
Sickness Absence Rate	Aug 22	4.00%	5.4%		
Staff Recommend Care	Q3 21/22	80.00%	77.7%		

C&M Place Summary: Jan 23 System Oversight Framework publication

NHS OF Metric Name Full	Aggregation Source	Period	SubICB								
			NHS CHESHIRE (SUB ICB LOCATION) (Z7D)	NHS HALTON (SUB ICB LOCATION) (01F)	NHS KNOWSLEY (SUB ICB LOCATION) (01J)	NHS LIVERPOOL (SUB ICB LOCATION) (99A)	NHS SOUTH SEFTON (SUB ICB LOCATION) (01T)	NHS SOUTHPORT AND FORMBY (SUB ICB LOCATION) (01V)	NHS ST HELENS (SUB ICB LOCATION) (01X)	NHS WARRINGTON (SUB ICB LOCATION) (02E)	NHS WIRRAL (SUB ICB LOCATION) (12F)
S009a: Total patients waiting more than 52 weeks to start consultant led treatment	SubICB	2022 11	6,066	899	1,864	7,059	2,907	565	1,025	1,421	1,515
S009b: Total patients waiting more than 78 weeks to start consultant led treatment	SubICB	2022 11	611	126	262	900	385	69	143	183	89
S009c: Total patients waiting more than 104 weeks to start consultant led treatment	SubICB	2022 11	27	0	2	11	6	1	2	4	3
S010a: Total patients treated for cancer compared with the same point in 2019/20	SubICB	2022 11		139%	157.9%	88.1%	85.2%	99.2%	93.2%	114.7%	115.4%
S012a: Proportion of patients meeting the faster cancer diagnosis standard	SubICB	2022 11	63.2%	72.7%	66.8%	58.8%	63.8%	67.9%	68%	71.3%	73.5%
S013a: Diagnostic activity levels: Imaging	SubICB	2022 11	112.1%	109.4%	102.3%	108.3%	104.5%	107.3%	104.4%	102.4%	102.6%
S013b: Diagnostic activity levels: Physiological measurement	SubICB	2022 11	77.8%	79%	92%	95.8%	91.9%	119.2%	90.7%	69.1%	78.8%
S013c: Diagnostic activity levels: Endoscopy	SubICB	2022 11	75.3%	119.7%	144%	118.9%	88%	163.4%	118.9%	124.6%	106%
S013d: Diagnostic activity levels: Total	SubICB	2022 11	105.5%	107.3%	103.7%	106.9%	100.5%	112.4%	103.8%	100.4%	99.5%
S031a: Rate of personalised care interventions	SubICB	22-23 Q2	57.5 per 1,000	21.03 per 1,000	52.99 per 1,000	87.44 per 1,000	40.44 per 1,000	26.15 per 1,000	43.79 per 1,000	68.05 per 1,000	63.44 per 1,000
S032a: Personal health budgets	SubICB	22-23 Q1	0.61 per 1,000	1.57 per 1,000	0.97 per 1,000	0.41 per 1,000	0.54 per 1,000	0.71 per 1,000	12.85 per 1,000	1.02 per 1,000	0.45 per 1,000
S040a: Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	SubICB	2022 11	10	2	0	11	2	0	1	3	6
S041a: Clostridium difficile infection rate	SubICB	2022 11	126.8%	132.4%	98%	102.9%	110.2%	89.6%	66.6%	159.7%	155.3%
S042a: E. coli bloodstream infection rate	SubICB	2022 11	118.6%	98.9%	137.1%	127.1%	114.5%	113.1%	100.7%	119%	129.3%
S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	SubICB	Nov 2021 - Oct 2022	89%	109.2%	107.8%	104.9%	113.7%	95%	111.2%	89.8%	107.6%
S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	Nov 2021 - Oct 2022	7.5%	6.74%	7.43%	8.28%	8.93%	9.21%	6.1%	6.53%	10.8%
S046a: Population vaccination coverage: MMR for two doses (5 year olds)	SubICB	22-23 Q1	91.5%	93.4%	78%	75.3%	83.1%	90.6%	89.2%	91.4%	89.2%
S047a: Proportion of people over 65 receiving a seasonal flu vaccination	SubICB	2022 10	72.4%	68.9%	56%	59.7%	62.4%	74.9%	64.6%	67.4%	68.8%
S050a: Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	SubICB	21-22 Q4	75.5%	71.6%	72%	64.4%	69.5%	73.3%	72.5%	74.3%	72.8%
S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	SubICB	2021-22	88.4%	90.7%	91.8%	89%	88.9%	89.5%	90.7%	90.9%	90.6%
S053b: % of hypertension patients who are treated to target as per NICE guidance	SubICB	2021-22	60.7%	57.4%	53.6%	57.3%	52.3%	52.8%	58.4%	58%	57.7%
S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	SubICB	22-23 Q1	56.9%	58.8%	59.9%	60.8%	58.9%	51.6%	58%	54.9%	59.2%
S055a: Number GP referrals to NHS Digital weight management services per 100k population	SubICB	22-23 Q2	114.2 per 100,000	86.2 per 100,000	76.3 per 100,000	124.3 per 100,000	40.9 per 100,000	133 per 100,000	89.3 per 100,000	62.9 per 100,000	24.9 per 100,000
S081a: Access rate for IAPT services	SubICB	22-23 Q2	61.6%	61.7%	56.6%	49.7%	45.9%	49%	75.6%	56.5%	71.7%
S086a: Inappropriate adult acute mental health placement out of area placement bed days	SubICB	Aug 2022 - Oct 2022	540	0	0	35	0	0	0	0	190
S105a: Proportion of patients discharged from hospital to their usual place of residence	SubICB	2022 11	89.7%	95.5%	94.5%	94%	94.6%	92%	92.8%	94.9%	92.8%
S115a: Proportion of diabetes patients that have received all eight diabetes care processes	SubICB	21-22 Q4	42.9%	26.5%	31.8%	42.9%	32.4%	47.2%	26.9%	27.3%	30.9%

Rank Banding
 Highest performing quartile
 Interquartile range
 Lowest performing quartile

ICB – Provider SOF Segments

NHS Provider Segmentation: as of 7th October 2022

Trust	Segmentation Score
Cheshire and Wirral Partnership NHS Foundation Trust	1
Liverpool Heart and Chest Hospital NHS Foundation Trust	1
The Walton Centre NHS Foundation Trust	1
Alder Hey Children’s NHS Foundation Trust	2
Bridgewater Community Healthcare NHS Foundation Trust	2
Clatterbridge Cancer Centre NHS Foundation Trust	2
Mersey Care NHS Foundation Trust	2
Mid-Cheshire Hospital NHS Foundation Trust	2
North West Ambulance Service NHS Trust	2
Southport and Ormskirk Hospital NHS Trust	2
St Helens and Knowsley Teaching Hospitals NHS Trust	2
Warrington and Halton Teaching Hospitals NHS Foundation Trust	2
Wirral Community Health and Care NHS Foundation Trust	2
Countess of Chester NHS Foundation Trust	3
East Cheshire NHS Trust	3
Liverpool Women’s Hospital NHS Foundation Trust	3
Wirral University Teaching Hospital NHS Foundation Trust	3
Liverpool University Hospitals NHS Foundation Trust	4

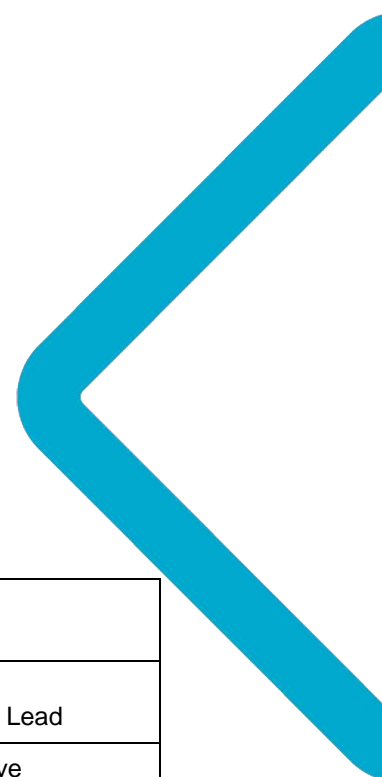
Key

Segment 1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities
Segment 2	Plans that have the support of system partners in place to address areas of challenge. Targeted support may be required to address specific identified issues
Segment 3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)
Segment 4	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Equality Diversity and Inclusion Annual Report 2022/23



Agenda Item No	ICB/02/23/12
Report author & contact details	Andrew Woods Senior Equality Inclusion and Diversity Lead
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive Christine Samosa, Chief People Officer
Responsible Officer to take actions forward	Thomasina Afful (Associate Director of EDI) Andrew Woods (Senior Governance Manager EDI)

Cheshire and Merseyside ICB Integrated Care Board Meeting

<p>Executive Summary</p>	<p>Cheshire and Merseyside Integrated Care Board (ICB) is the organisation with responsibility for paying 'due regard' to the Public Sector Equality Duty or PSED (Section 149, Equality Act 2010). The Equality Duty is supported by specific duties, set out in regulations which came into force in 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves equality objectives. The ICB is also responsible for ensuring it meets its regulatory EDI regulatory requirements, including evidence that it has implemented the mandated Equality Delivery Systems toolkit.</p> <p>This purpose of the report is to provide members of the ICB with a streamlined Annual Equality, Diversity & Inclusion report 2022/23 (Appendix One), that ensures its specific and regulatory requirements are met but also reflecting the fact that the organisation is still undertaking a major restructure process (management of change). The Annual report includes:</p> <ul style="list-style-type: none"> • Headline equality information and activity that has taken place across the ICB since July 2022, in its role as a leader, employer and a commissioner. • Available and proportionate Equality information. • ICB proposed preliminary one year Equality Objectives. • Highlight the approach taken to implementing the Equality Delivery System 2022, Domain one. • Equality Delivery Systems 2022 summary report Domain one. <p>Once the EDI Annual report (Appendix One) and EDS 2022 Summary Report, Domain one (Appendix Two) are noted and the one-year ICB Equality Objectives are approved all documentation will need to be published on the ICB's website.</p>				
<p>Purpose (x)</p>	<p>For information / note</p> <p>X</p>	<p>For decision / approval</p> <p>X</p>	<p>For assurance</p>	<p>For ratification</p>	<p>For endorsement</p>
<p>Recommendation</p>	<p>The Board is asked to:</p> <ul style="list-style-type: none"> • note the Equality Diversity & Inclusion Annual Report (Appendix One) including proportionate equality information. • note the approach taken to implement the EDS 2022, Domain one (Appendix One, section five). • note the EDS 2 Summary report for Domain One and the score of Achieving. (Appendix Two) • approve the annual ICB proposed Equality Objectives 2023 to 2024 (Appendix One, section six) 				
<p>Key issues</p>	<p>The annual report provides an overview of the work that has been undertaken to date as a new organisation, from July 2022 to February 2023 and it is important to note that:</p>				

	<ul style="list-style-type: none"> • NHS Cheshire and Merseyside is still in the process of restructuring (management of change) • Associate Director of EDI (People Directorate) will be in post from April 2023 • EDS 2022 was not launched officially to NHS leaders until September 2022 and therefore the organisation implemented the toolkit within limited timescales, as opposed to a full year cycle. • performance against domains two (workforce health and wellbeing) and three (inclusive leadership) for NHS Cheshire and Merseyside staff will be refreshed following publication of the NHS staff survey results in March 2023. The summary report for these two domains will be included in NHS Cheshire and Merseyside staff survey report to Board in April 2023 and then published on the NHS Cheshire and Merseyside website (Appendix One, section 7.3) • draft equality objectives have been set for a one-year period, as opposed to four years. The objectives will focus on the key priorities including the development of a system wide EDI strategy for April 2023 to March 2024. This approach will ensure that there is flexibility to change the objectives as NHS Cheshire and Merseyside matures and a robust framework and operating model are in place (Appendix One, section 6). 			
<p>Key risks</p>	<ul style="list-style-type: none"> • lack of diversity in workforce representation (Appendix One, section seven) • current unavailability of effective system aggregated data sets to drive strategic planning • EDS 2022 regulatory requirement -Performance against the domains two (workforce health and wellbeing) and three (inclusive leadership) for NHS Cheshire and Merseyside staff will be refreshed following publication of the NHS staff survey results in March 2023. The summary report for these two domains will be included in NHS Cheshire and Merseyside staff survey report to Board in April 2023 and then published on the NHS Cheshire and Merseyside website. • EDI strategy currently undeveloped, responsive to local, regional, and national policy (Appendix One, section six) 			
<p>Impact (x) (further detail to be provided in body of paper)</p>	<p>Financial</p>	<p>IM &T</p>	<p>Workforce</p>	<p>Estate</p>
			X	
	<p>Legal</p>	<p>Health Inequalities</p>	<p>EDI</p>	<p>Sustainability</p>
	X	X	X	
<p>Route to this meeting</p>	<p>The contents of this report have been discussed at length with key Executives, including Assistant Chief Executive and Chief People Officer. The paper received by the ICB at its Board meeting in September 2022, entitled 'Assurance for substantial change' outlined the importance and standards required of Board members 'when paying 'due regard' to the Public Sector Equality Duty prior to making any decisions.</p> <p>The ICB received a paper on the 28th of November 2022 which outlined the approach to implementation of the EDS 2022, provided an update of key EDI activity to date and highlighted key priorities, which have been incorporated into the proposed ICB Equality Objectives.</p>			

	<p>The ICB Quality and Performance Committee received a paper to consider making recommendations for future service reviews, including Core20Plus5 areas for those trusts implementing EDS 2022 from April 2023.</p>
Management of Conflicts of Interest	<p>No conflicts of interest have been identified.</p>
Patient and Public Engagement	<p>EDS2 Domain 1 Performance Report: commissioned and provided services</p> <p>To support the implementation of Equality Delivery Systems 2022 (Domain one) the ICB and NHS provider Trusts have worked with a wide range of stakeholders including Healthwatch representatives across Cheshire and Merseyside (who have provided an oversight of the process). Individual NHS Provider Trusts as part of their grading process have involved patients and the Voluntary, Community and Faith sector as part of the engagement process and gained insight from patient experience data.</p>
Equality, Diversity, and Inclusion	<p>The Annual report and EDS 2022 summary report supports the NHS Cheshire and Merseyside to meet its specific duties to publish equality information and set equality objectives (Equality Act 2020).</p>
Health inequalities	<p>The implementation of the Equality Delivery Systems 2022, Domain one (Appendix One, Section five) and the creation of interventions and improvement plans in response to the EDS findings, contribute to NHS Cheshire and Merseyside and provider organisations achieving delivery against the Core20Plus5 agenda, which is a national framework that helps define the population groups in each system experiencing health inequalities.</p>
Next Steps	<p>Review of staff survey results for EDS2 Domain 2 (health and wellbeing) and 3 (inclusive leadership) and incorporate summary reports into the NHS Cheshire and Merseyside staff survey Board report in April 2023.</p> <p>Review and development of EDI system strategy in 2023/ 2024.</p> <p>Once the EDI Annual report and EDS 2022 Summary Reports Domain one are noted and the one-year ICB Equality Objectives are approved all documentation will need to be published on the ICB's website.</p> <p>ICB will receive a paper an update paper in October 2023 on progress against its one-year Equality Objectives.</p>
Appendices	<p>Appendix One –Cheshire and Merseyside EDI Annual report 2022/2023</p> <p>Appendix Two – ICB EDS 2022 Summary Report, Domain One</p>

Equality Diversity and Inclusion Annual Report 2022/23

1. Executive Summary

- 1.1 Cheshire and Merseyside Integrated Care Board (ICB) is the organisation with responsibility for paying 'due regard' to the Public Sector Equality Duty or PSED (Section 149, Equality Act 2010). The Equality Duty is supported by specific duties, set out in regulations which came into force in 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves equality objectives. The ICB is also responsible for ensuring it meets its regulatory EDI regulatory requirements, including evidence that it has implemented the mandated Equality Delivery Systems toolkit.
- 1.2 This purpose of the report is to provide members of the ICB with a streamlined Annual Equality, Diversity & Inclusion report 2022/23 (Appendix One), that ensures its specific and regulatory requirements are met but also reflecting the fact that the organisations is still undertaking a major restructure process (management of change). The Annual report includes:
- headline equality information and activity that has taken place across the ICB since July 2022, in its role as a leader, employer and a commissioner.
 - available and proportionate Equality information.
 - ICB proposed preliminary one year Equality Objectives.
 - highlight the approach taken to implementing the Equality Delivery System 2022, Domain one.
 - Equality Delivery Systems 2022 summary report Domain one.
- 1.3 Once the EDI Annual report (Appendix One) and EDS 2022 Summary Report, Domain one (Appendix Two) are noted and the one-year ICB Equality Objectives are approved all documentation will need to be published on the ICB's website.

2. Introduction - Equality Diversity & Inclusion context

- 2.1 NHS Cheshire and Merseyside holds statutory, regulatory and compliance related responsibilities for the delivery of the equality, diversity, and inclusion agenda to include:
- delivery of its public sector equality duty under the Equality Act, 2010
 - delivery against its specific duties
 - delivery of improved organisational performance against key metrics including the Equality Delivery Systems, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), annual NHS staff survey and the Gender Pay Gap (GPG)
 - planned response to the delivery of wider performance frameworks including the Care Quality Commission (CQC) regulatory framework, Northwest NHS Antiracism Framework.
 - a clear strategy to address inequalities and close the gap on health and care inequities experienced by people with protected characteristics and other groups as defined by the CORE20Plus5 framework, EDS 2022 and wider

population health business intelligence detailed in numerous reports for example: Ockendon Report, the Elective care backlog and Ethnicity Report and Inequalities in Healthcare: a rapid evidence review, and wider evidence base.

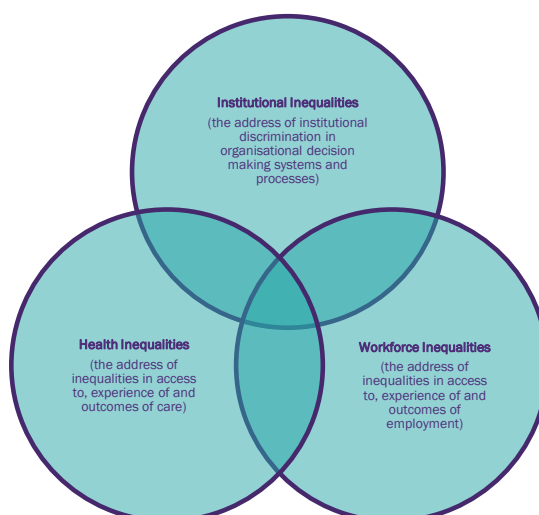
- a clear strategy to respond to National, regional, and local policy as described the NHS People Promise, The Messenger Review, The NHSE Equality Plan, the ICS Strategy and All Together Fairer.

3. Equality Delivery Systems 2022

- 3.1 NHS England have recently introduced the new EDS 2022 toolkit which will soon replace the previous version known as EDS2. NHS Cheshire and Merseyside agreed to implement the toolkit during 2022/23. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight. It comprises eleven outcomes spread across three domains, which are:
- Domain One: Commissioned and Provider services.
 - Domain Two: Workforce health and wellbeing.
 - Domain Three: Inclusive leadership.
- 3.2 The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. Grading is done in conjunction with key stakeholders to determine if the organisation is graded as:
- Underdeveloped
 - Developing
 - Achieving
 - Excelling.
- 3.3 NHS Cheshire and Merseyside ratings for domain 1 is **Achieving** across each outcome. This is the **mode** rating, as taken from the all the eleven NHS Provider trust's individual service review ratings, who agreed to early implementation of the toolkit. Further detail on how NHS Cheshire and Merseyside implemented domain one can be viewed in the EDI Annual Report (Appendix One, section five).
- 3.4 EDS is a mandated regulatory requirement and in line with NHSE instruction is required to complete an EDS summary report (Appendix Two) which needs to be published on the NHS Cheshire and Merseyside website.
- 3.5 Performance against domains two and three, cannot be currently shared due to the dependency of the assessment on the annual NHS staff survey results. The grading and summary report will be presented to the Board as part of staff survey report in April 2023.

4. Equality Objectives 2023/2024

- 4.1 Draft equality objectives are a specific duty (Equality Act 2020) and have been set for a one-year period, as opposed to four years. The objectives will focus on the key priorities including the development of a system wide EDI strategy for April 2023 to March 2024. This approach will ensure that there is flexibility to change the objectives as NHS Cheshire and Merseyside matures and a robust EDI framework and operating model are in place (Appendix One, section 6).
- 4.2 The Equality Objectives that were previously approved in both Cheshire and Merseyside CCGs have been slightly reworded. Each of these equality objectives is supported by associated priorities which will be further strengthen through a more detailed plan moving forward this year. The equality objectives are to:
- make fair, transparent, and accountable commissioning decisions.
 - improve access and outcomes for patients and communities who experience discrimination and disadvantage.
 - improve the equality performance of our providers through procurement, monitoring compliance and collaboration.
 - empower and engage our leadership and workforce.
- 4.3 To support us with our one-year equality objectives, we will develop of a system wide EDI framework and strategy, in line with our strategic objectives, that is evidence based and developed in partnership with the Cheshire and Merseyside health and care system. The framework will support us to develop the necessary governance, accountability, and assurance arrangements for a more joined up approach to addressing systemic inequalities facing underrepresented groups and advance equality of opportunity for our people, our patients, our providers, our partners, and our populations.



5. Equality Diversity and Inclusion in the workforce

- 5.1 Demographic profiling is an essential characteristic of health and care workforce planning and modelling. We are working towards a single workforce demographic profile to inform the following statutory and regulatory requirements.
- 5.2 Gender Pay Gap (GPG)- is a statutory requirement for all NHS organisations who have 250 or more staff. The GPG results are an important driver of our equality and inclusion activity in relation to improving gender equality. NHS Cheshire and Merseyside will need to prepare for gender pay gap reporting for 2023- 2024. Currently, the NHS Cheshire and Merseyside profile for gender representation across senior pay bands can be seen in the NHS Cheshire and Merseyside EDI Annual report (Appendix One, Section Seven).
- 5.3 Workforce Race Equality Standard (WRES). NHS Cheshire and Merseyside are required to participate in the WRES data return (August 2023) and publish its report and action plan in October 2023. The nine WRES indicators cover recruitment and pay; access to training; disciplinary; discrimination, bullying and harassment and ICB Board membership. Current NHS Cheshire and Merseyside ethnicity profile can be viewed in the EDI Annual Report (Appendix One, Section Seven). The main purpose of the WRES as outlined by NHS England is to:
- help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against nine indicators
 - produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
 - improve BME representation at the Board level of the organisation.
- 5.4 The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures (Metrics) to improve the experiences of disabled staff in the NHS. The WDES was mandated by the NHS Standard Contract and became applicable to all NHS Trusts and Foundation Trusts in April 2019. Mandatory reporting on WDES is restricted to NHS Trusts and Foundation Trusts however, in accordance with its commitment to best practice beyond compliance, the ICB will review its workforce disability data for the first time in 2023. Current NHS Cheshire and Merseyside disability representation profile and can be viewed in the EDI Annual Report (Appendix One, Section Seven).
- 5.5 An inclusive culture sits at the heart of NHS Cheshire and Merseyside. In July 2022, NHS Cheshire and Merseyside developed a culture code to define the behavioural operating principles for organisational identity. (Appendix One, Section Seven).

6. Next Steps

- Review of staff survey results for EDS2 Domain 2 (health and wellbeing) and 3 (inclusive leadership) and incorporate summary reports into the NHS Cheshire and Merseyside staff survey Board report in April 2023.
- Review and development of EDI system strategy in 2023/ 2024.

- Once the EDI Annual report and EDS 2022 Summary Reports Domain one are noted and the one-year ICB Equality Objectives are approved all documentation will need to be published on the ICB's website.
- ICB will receive a paper an update paper in October 2023 on progress against its performance against a range of EDI statutory and regulatory requirements and metrics.

7. Recommendations

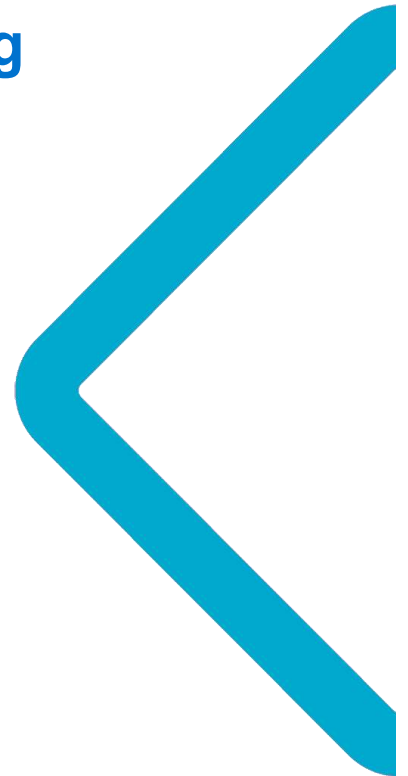
7.1 The Board is asked to note

- **Note** the Equality Diversity & Inclusion Annual Report (Appendix One) including proportionate equality information.
- **Note** the approach taken to implement the EDS 2022, Domain one (Appendix One, section five).
- **Note** the EDS 2 Summary report for Domain One and the score of Achieving. (Appendix Two)
- **Approve** the annual ICB proposed Equality Objectives 2023 to 2024 (Appendix One, section six)

NHS Cheshire and Merseyside Integrated Care Board Meeting

Equality Diversity and Inclusion Annual Report 2022/23

Appendix One: Equality Diversity & Inclusion Annual Report



NHS Cheshire and Merseyside Equality Diversity & Inclusion Annual Report

2022/2023

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1. Accessibility

We want to ensure that the information we communicate is fair and accessible to all sections of our local communities.

Patients, the public and staff can request reasonable adjustments such as information converted into other formats for easier reading.

To request information or any of our key documents in an alternative format such as braille, larger print, audio, or other format please email communications@cheshireandmerseyside.nhs.uk quoting your address, telephone number along with the title and date of the publication, plus the format you require. Alternatively, please write to us at:

Information:

NHS Cheshire and Merseyside

Regatta Place

Brunswick Business Park

Summers Lane

Liverpool

L3 4BL

In addition, you may require additional support to contact us e.g., a British Sign Language interpreter to support you or you may need language support where your first spoken language is not English.

Cheshire and Merseyside NHS will give due regard to the new Accessible Information Standard from NHS England. For more information, visit the [NHS England website](#).

1. Introduction

This document sets out how the NHS Cheshire & Merseyside (NHS C&M) has delivered actions that support the organisation to meet its requirements under the Equality Act 2010. As an Integrated Care Board (ICB) we are committed to advancing equality of opportunity and tackling the health inequalities across our sub region. The Cheshire and Merseyside Integrated Care Board was established in July 2022 as the new statutory organisations to lead integration within the NHS. The ICB will be responsible for the day-to-day running of the NHS in Cheshire and Merseyside, including planning and buying healthcare services replacing the nine clinical commissioning groups (CCGs).

This purpose of the report is to ensure that our specific legislative and regulatory requirements are met but also need to reflect on the fact that the organisations is still new and is undertaking a major restructure (Management of Change) process.

The report outlines our Equality Objectives for the next year and enables the NHS C&M to focus on key Equality diversity and inclusion priorities and embed our approaches across the organisation and develop an approach that matches our ambition to be an inclusive employer, a leader and commission services that tackles discrimination and improves outcomes for the communities we serve.

2. Legal Context

NHS Cheshire and Merseyside is committed to promoting equality and eliminating discrimination as an employer, and in ensuring the services we commission are accessible and inclusive.

This report sets out how the NHS C&M is working with the Equality Act 2010 and in particular paying 'due regard' to the Public Sector Equality Duty's (PSED) three objectives to: -

- 1) Eliminating unlawful discrimination, harassment and victimisation. This includes sexual harassment, direct and indirect discrimination on the grounds of a protected characteristic.
- 2) Advancing equality of opportunity between people who share a protected characteristic and people who do not share it. This means:
 - Removing or minimising disadvantage experienced by people due to their personal characteristics
 - Meeting the needs of people with protected characteristics
 - Encouraging people with protected characteristics to participate in public life or in other activities where their participation is disproportionately low.
- 3) Fostering good relations between people who share a protected characteristic and people who do not share it, which means:
 - Tackling prejudice, with relevant information and reducing stigma
 - Promoting understanding between people who share a protected characteristic and others who do not.

'Due regard' is a legal requirement. Having due regard means considering the above in all decision making, including:

- How the organisation acts as an employer
- Developing, reviewing and evaluating policies
- Designing, delivering and reviewing services
- Procuring and commissioning
- Providing equitable access to services.

'Due regard' means that the Board of the NHS C&M must give *advanced* consideration to issues of 'equality and discrimination' before making any commissioning or policy decisions that may affect or

impact on people who share protected characteristics. It is vitally important to consider equality implications as an integral part of the work and activities that the NHS C&M does.

‘Due regard’ can only be paid by the Board or by the NHS C&M decision makers (Committee’s). Officers can only support this process by developing and presenting information and views to the decision makers. The reports that are presented to the NHS C&M Board or committees are called Equality Analysis reports – commonly known as Equality Impact Assessments (EIAs). These reports will test the proposal/s or changes to policy and say whether it meets PSED and ultimately complies with the Equality Act 2010. The ICB is under a statutory duty to comply with the Equality Act 2010. Recommendations will be part of the reporting process, the Board in making decisions must consciously take into consideration the content of the reports as part of their deliberations and decision-making process. EIA reports cannot be undertaken after a decision is made as this is unlawful and could be grounds for Judicial Review (legal challenge).

NHS C&M continues to strengthen internal governance by developing and delivering EIA reports and linking them to the current change programmes. EIA reports need to consider the effect or impact of any change to policy, practice or procedure against all the protected characteristics this means that there must be a strong link to the consultation and engagement process in order to identify different people’s perspectives and concerns.

Support continues to be provided to staff making them aware of the process and the NHS C&M needs to ensure stronger support mechanisms are in place to help staff and the organisation to develop and deliver timely and accurate reports.

Protected Characteristics

It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation

3. Governance and Management Arrangements

NHS C&M is the organisation with responsibility for paying ‘due regard’ to the Public Sector Equality Duty (Section 149, Equality Act 2010) and for all mandated regulatory Equality Diversity and Inclusion (EDI) requirements. The board will need to provide visible leadership to advance equality of opportunity across NHS C&M and wider system and lead the ICB to become a more inclusive employer.

Strategic EDI leadership currently sits within the Central NHS C&M Director and Senior Leadership Structures. The Chief People Officer will act as the Senior Responsible Officer for EDI, Workforce and Organisational Development at Board level and the Senior Responsible Officer for EDI from a patient and commissioning perspective is the Assistant Chief Executive Officer.

4. Commissioner of Services

NHS C&M works with our partners and the people of Cheshire and Merseyside to commission services and improve the health and wellbeing of the people and communities across the sub region. The programmes are being developed and intend to be based on evidence about the population, with a focus on health needs and inequalities. These include:

- Population Health Management data
- Ward level public health profiles
- Delivery of the NHS Long Term Plan
- Delivering safe, high-quality services
- Building relationships with communities
- Taking action on health inequalities and the local strategy for health and wellbeing
- Quality intelligence
- CHAMPs intelligence and evidence findings and recommendations

Key EDI activity to date has included:

- NHS C&M equality and inclusion service reviewed the ICB committee cover template to ensure equality and health inequality impacts are included and can be considered by the Board and relevant committees.
- Equality Impact Assessments and Health Equity Assessment Tool templates are included in the programme of change toolkit guide.
- NHS C&M Board has received Equality Impact Assessments for several service change proposals in recent months, example include North Mersey and West Lancashire Stroke services reconfiguration, Liverpool University Hospitals NHS FT clinical services reconfiguration and a 'pipeline'

Actions and next steps:

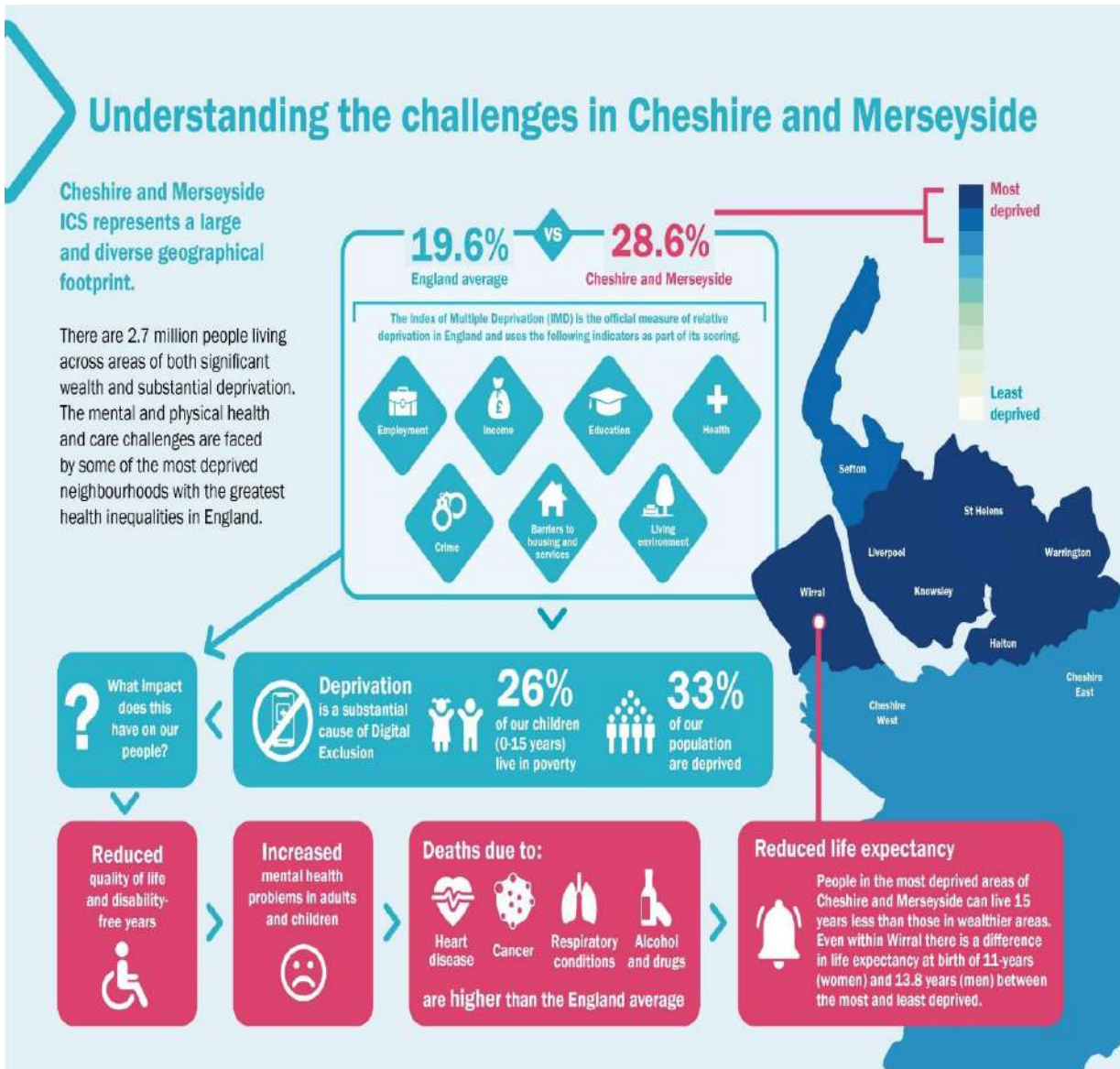
- Ensure that EDI is a key consideration as part of the NHS C&M Governance review.
- Continue to work with the Midlands and Lancashire Commissioning Support Unit, EDI team who have historically supported Cheshire, Wirral, Warrington and Halton with EIA advice and guidance.

Demographic and equality related information across the NHS C&M footprint

Discrimination against people with protected characteristics persists and contributes to negative disparate outcomes for patients in terms of access and outcomes. It is therefore vital that equality information is central to how we commission services and address health inequalities. The information can be accessed from the links below. The demographic information was commissioned by the Cheshire and Merseyside Directors of Public Health, through the Cheshire and Merseyside Public Health Intelligence Network and Champs Public Health Collaborative (Cheshire and Merseyside). Demographic profiles for the Liverpool City Region and Cheshire and Warrington March 2021 Public Health Institute, Faculty of Health, Liverpool John Moores University.

[Vulnerable groups LCR FINAL 23 3 21 \(liverpool.gov.uk\)](https://www.liverpool.gov.uk/vulnerable-groups-lcr-final-23-3-21/)

<https://www.ljmu.ac.uk/-/media/phi-reports/pdf/2021-03-vulnerable-groups-profile-cheshire-and-warrington.pdf>



5. Equality Delivery System 2022 (EDS 2022)

NHS England have recently introduced the new EDS 2022 toolkit, replacing the older EDS 2. NHS C&M has recently agreed to implement the new toolkit for implementation before March 2023. The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by

evidence and insight.

The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users. EDS 2022 comprises eleven outcomes spread across three domains, which are:

Domain 1: Commissioned or provided services

- 1A: Service users have required levels of access to the service
- 1B: Individual service user’s health needs are met
- 1C: When service users use the service, they are free from harm
- 1D: Service users report positive experiences of the service

Domain 2: Workforce health and wellbeing

- 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions (response to Covid-19)
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
- 2C: Staff have access to support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19)
- 2D: Staff recommend the organisation as a place to work and receive treatment

Domain 3: Inclusive leadership

- 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
- 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed
- 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients (response to Covid-19).

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. Scoring in conjunction with key stakeholders to determine if the organisation is graded as:

- Underdeveloped
- Developing
- Achieving
- Excelling

EDS Rating and Score Card below.

Ratings in accordance to scores are below	
Underdeveloped activity – organisations score out of 0 for each outcome	Those who score under 8 , adding all outcome scores in all domains, are rated Underdeveloped
Developing activity – organisations score out of 1 for each outcome	Those who score between 8 and 21 , adding all outcome scores in all domains, are rated Developing

Achieving activity – organisations score out of 2 for each outcome	Those who score between 22 and 32 , adding all outcome scores in all domains, are rated Achieving
Excelling activity – organisations score out of 3 for each outcome	Those who score 33 , adding all outcome scores in all domains, are rated Excelling

The completion of the EDS, and the creation of interventions and actions plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the Core20Plus5 approach and Health Inequalities priorities.

2022/23 has been used as a test period, for organisations to use this time to get used to applying the EDS 2022 in a new way, in a new system. Because of this there are some differences in the way in which we have asked organisations to apply the EDS, mainly: systems are to apply domain one to two services, rather than three as requested in the official Technical Guidance. One of the two services for domain one must fall within one of the Core20Plus5 clinical areas. These NHS England adjustments are to acknowledge that the NHS system has now changed from Clinical Commissioning Groups to ICSs and ICBs, and that NHS organisations have not had a full year to implement the EDS. Organisations are encouraged to make as much progress as possible during 2022/23, in preparation for a full cycle year starting in April 2023.

Domain One implementation

NHS C&M and the following eleven trusts opted for early implementation of EDS 2022. For domain 1, the ICB asked each trust equality / patient experience lead to liaise with executive colleagues of their respective organisation to identify two services to review, one of which had to be a clinical area part of Core20Plus5. Trusts selected the following services. Note that some trusts selected two services part of Core20Plus5.

- **Bridgewater Community Health NHS FT:** Halton Health Visiting Service and Warrington Family Nurse Partnership (Core20Plus5 Maternity)
- **East Cheshire NHS Trust:** Antenatal Screening (Core20Plus5 Maternity) and Acute Paediatrics
- **Liverpool Heart and Chest Hospital NHS FT:** Targeted Healthy Lung Check Service (Core20Plus5 Respiratory) and Hypertension Case Finding (Core20Plus5)
- **Liverpool University Hospitals NHS FT:** Cardiology, (Core20Plus5 Hypertension Case Finding) and Respiratory (Core20Plus5 Respiratory)
- **Liverpool Women’s Hospital NHS FT:** Induction of Labour (Core20Plus5 Maternity) and Early Cervical Cancer (Core20Plus5 Cancer)
- **Mersey Care NHS FT:** High Secure Services (Core20Plus5 Severe Mental Illness)
NB Mersey Care had planned to review Silver Birch Hubs Peri-natal mental health service as their second service however due to organisational pressures could not complete the review.
- **Mid Cheshire NHS Trust:** Maternity (Core20Plus5 Maternity) and Ophthalmology
- **Southport and Ormskirk Hospitals NHS Trust:** TIA (Core20Plus5 Hypertension Case Finding) and Patient Initiated Follow Ups (PIFU) in MSK
- **Warrington and Halton Hospitals NHS FT:** Team River -Warrington and Team Sunlight – Halton (Core20Plus5 Maternity) and Long COVID service
- **Wirral Community Health and Care NHS FT:** Community Cardiology CVD Rehabilitation (Core20Plus5 Hypertension Case Finding) and Bladder and Bowel
- **Wirral University Teaching Hospital NHS FT:** Maternity (Core20Plus5 Maternity), Perinatal Mental Health (Core20Plus5 Maternity)

NHS C&M equality and inclusion leads developed a service review template for organisations to adapt and complete for each service review. Organisations could then use this document to consider information available relating to patient access, meeting health needs, experience and outcomes, identify any gaps in intelligence, to help inform ratings against each outcome, and to develop service improvement plans. A list of data sources and publications were also provided to trusts for each of the Core20Plus5 clinical areas.

NHS C&M equality and inclusion leads facilitated a series of meetings for each of the Core20Plus5 clinical areas with trusts, Healthwatch and lead 'place' commissioning managers in attendance. Other stakeholders were also invited, such as Improving Me colleagues to the Maternity specific meetings. Contact was also made with CHAMPS and cancer alliance colleagues.

The approach to engagement with stakeholders was varied. Some trusts had access to well established internal patient experience groups, established links with Healthwatch and VCSE organisations and therefore were more easily able to engage with them throughout the process and collectively agree ratings. Other trusts however didn't have access to such groups; either due to them not being as well established or due to time constraints with undertaking the reviews whilst managing internal organisational pressures. These trusts therefore utilised dedicated grading meetings, facilitated by the NHS C&M equality and inclusion leads with Healthwatch, commissioning managers and trust peers in attendance to agree/ disagree with proposed ratings.

NHS C&M ratings for domain 1 is **Achieving** across each outcome. This is the **mode** rating, as taken from the trust's individual service review ratings below:

Trust	Service Review	1A: Service users have required levels of access to the service	1B: Individual service user's health needs are met	1C: When service users use the service, they are free from harm	1D: Service users report positive experiences of the service
Bridgewater Community Health NHS FT	Halton Health Visiting Service (Core20Plus5 Maternity)	Developing	Achieving	Achieving	Achieving
	Warrington Family Nurse Partnership (Core20Plus5 Maternity)	Developing	Achieving	Achieving	Achieving
East Cheshire NHS Trust	Antenatal Screening (Core20Plus5 Maternity)	Achieving	Achieving	Excelling	Achieving
	Acute Paediatrics	Achieving	Achieving	Achieving	Achieving
Liverpool Heart and Chest Hospital NHS FT	Targeted Healthy Lung Check Service (Core20Plus5 Respiratory)	Achieving	Achieving	Developing TBC	Developing TBC
	Hypertension Case Finding (Core20Plus5)	Achieving	Achieving	Achieving	Developing TBC
Liverpool University Hospital NHS FT	Cardiology (Core20Plus5 Hypertension Case Finding)	Developing	Developing	Developing	Developing
	Respiratory (Core20Plus5)	Developing	Developing	Developing	Developing

Liverpool Women's Hospital NHS FT	Induction of Labour (Core20Plus5 Maternity)	Developing	Achieving	Achieving	Developing
	Early Cervical Cancer (Core20Plus5 Cancer)	Developing	Developing	Developing	Developing
Mersey Care NHS	High Secure Services (Core20Plus5 Severe Mental Illness)	Achieving	Achieving	Excelling	Developing
Mid Cheshire NHS Trust	Maternity (Core20Plus5 Maternity)	Achieving	Excelling	Excelling	Achieving
	Ophthalmology	Developing	Achieving	Achieving	Developing
Southport and Ormskirk Hospital NHS Trust	TIA (Core20Plus5 Hypertension Case Finding)	Developing	Developing	Achieving	Undeveloped
	Patient Initiated Follow Ups (PIFU) in MSK	Achieving	Achieving	Achieving	Achieving
Warrington and Halton Hospitals NHS FT	Team River - Warrington and Team Sunlight – Halton (Core20Plus5 Maternity)	Developing	Achieving	Achieving	Achieving
	Long COVID service	Developing	Excelling	Achieving	Achieving
Wirral Community Health and Care NHS FT	Community Cardiology CVD Rehabilitation (Core20Plus5 Hypertension Case Finding)	Achieving	Achieving	Excelling	Achieving
	Bladder and Bowel	Achieving	Achieving	Achieving	Achieving
Wirral University Teaching Hospital NHS Trust	Maternity (Core20Plus5 Maternity)	Achieving	Achieving	Achieving	Achieving
	Perinatal Mental Health (Core20Plus5 Maternity)	Achieving	Developing	Developing	Achieving

EDS 2022 is only one of many tools NHS C&M uses to demonstrate how we comply with our PSED.

Workforce and Equality Delivery System (EDS2)

Performance against the domains two (workforce health and wellbeing) and three (inclusive leadership) for NHS Cheshire and Merseyside staff will be refreshed following publication of the NHS staff survey results in March 2023. The summary report for these two domains will be included in NHS C&M staff survey report to Board in April 2023 and then published on the NHS C&M website.

Patient Equality Focused Forum - PEFF

The collaborative (Patient Equality Focused Forum - PEFF) is made up of equality leads and key officers from across the healthcare system and meets on a bi-monthly basis. This group works collaboratively to share best practice, identify issues, and provide recommended actions to their respective organisations to advance equality of opportunity and support NHS C&M to address health inequalities and barriers in accessing healthcare services to improve patient journey and experience. Priority areas for this group include. Membership to be reviewed further to EDS 2022 and priorities to be agreed.

Task and Finish groups are then subsequently established to focus on priority areas agreed by the Patient Equality Focused Forum. Task and finish groups currently in progress are as follows:

- Transgender Best Practice

A virtual group, represented by equality leads and other key representatives from NHS Trusts across Cheshire and Merseyside, including Mersey Care NHS FT as the host organisation (in collaboration with CMAGIC) delivering the national Gender Identity Clinic pilot for Cheshire and Merseyside patients are working collaboratively with a view to implementing a system-wide workforce policy for supporting people who have transitioned or people who are undergoing transition in the workplace. A policy and procedure document were adapted from the previous NHS Trust known as Northwest Borough Healthcare NHS FT and have recently been reviewed and endorsed by Rainbow Badge colleagues. It is envisaged that on completion of an EIA and engagement with Trad union colleagues, system wide organisations will be able to implement these documents within their respective organisations. This group is also developing a best practice document for patient care, again for implementation by all Trusts across Cheshire and Merseyside.

- Military Veterans and Armed Forces Community Task and Finish Group:

Monthly meetings attended by equality leads and other key representatives from NHS Trusts and ICBs across Cheshire and Merseyside. The group provides a platform for healthcare partners to collaborate and share best practice in providing healthcare support to members of the Armed Forces Community and to share learning and knowledge of best practice and to help raise awareness of the wider support services that are available. The group developed a workforce policy specific to supporting Reservists and Adult Cadets. All trusts across Cheshire and Merseyside are currently working with their respective organisations to implement a standard narrative for public facing websites was developed for organisations to adapt and publish. NHS C&M Peoples function is supporting the group by exploring a system view of a Guaranteed Interview Scheme and recognising military service in annual leave entitlement for new starters.

6. Equality Objectives 2023/2024

The NHS Cheshire and Merseyside Integrated Care Board is a listed Public Authority for the purposes of the Equality Act 2010, and thereby is obliged to set out its Equality Objectives at least every 4 years alongside its progress towards meeting the Public Sector Equality Duties.

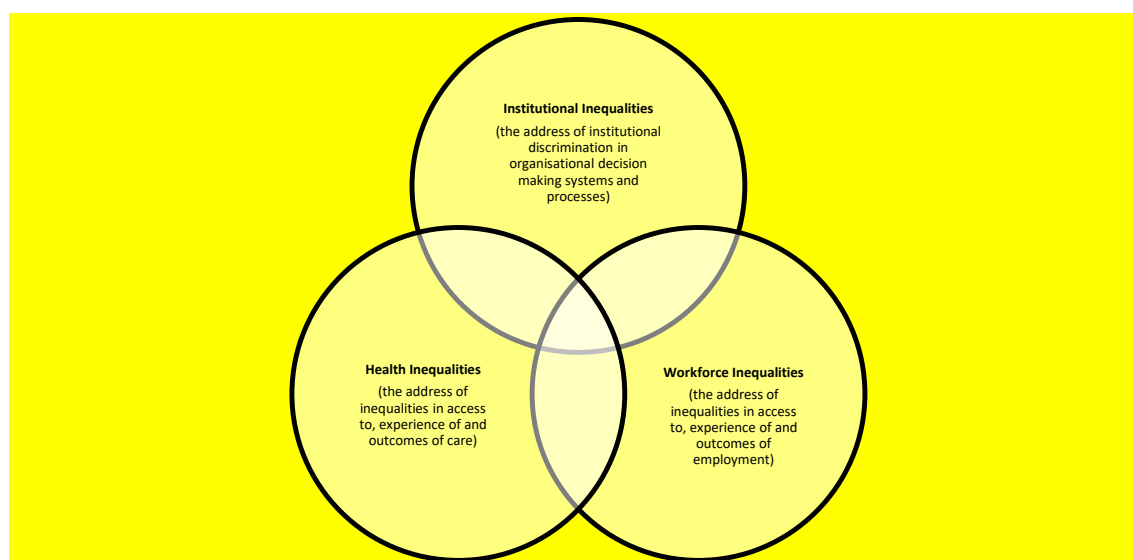
To reflect the fact that NHS C&M is still a new organisation and is still undergoing a major restructure (management of change) process, the objectives have been set for one year period only, focussed on delivering key priorities, including the development of an EDI framework and operating model that matches the full ambitions of the ICB. This will enable the organisation to involve and engage people who have lived experience of discrimination to inform our objectives from 2024/2025 and allow the us to establish more robust governance arrangements across NHS C&M and the wider system, including better integration of the EDI agenda with the ICB's work on addressing health inequalities, as outlined in the Health and Care Act 2022.

The Equality Objectives that were previously approved in both Cheshire and Merseyside CCGs have been slightly reworded. Each of these equality objectives is supported by associated priorities which will be further strengthened through a more detailed plan moving forward this year. Ultimate responsibility and accountability for advancing equality and addressing inequality rests with NHS C&M Board. The board will need to provide visible leadership on equality, diversity, and inclusion issues across the system. Its purpose is to shape the future of health and care – to help improve the access, experiences and health outcomes for all patients and communities, and to support NHS C&M to become a more inclusive employer by making full use of the talents of its diverse staff and the communities it serves.

The Equality Objectives are to:

- Make fair, transparent, and accountable commissioning decisions.
- Improve access and outcomes for patients and communities who experience discrimination and disadvantage.
- Improve the equality performance of our providers through procurement, monitoring compliance and collaboration.
- Empower and engage our leadership and workforce.

To support us with our one-year equality objectives, we will develop of a system wide EDI framework and strategy, that is evidence based and developed in partnership with the Cheshire and Merseyside health and care system. The framework will support us to develop the necessary governance, accountability and assurance arrangements for a more joined up approach to addressing systemic inequalities facing underrepresented groups and advance equality of opportunity for our people, our patients, our providers, our partners and our populations:



NHS C&M has recruited an Associate Director of EDI, who will be in post from April 2023. This key role will provide strategic and operational leadership.

We will continue to develop our plans to embed the Messenger review of NHS Leadership and this will be supported by Board, executive and senior leadership development sessions to drive our approach to decision making with a focus on the impact on equality, diversity and inclusion. It is essential that we understand the cultural competency of senior leaders and take appropriate action to improve that.

The outputs from Workforce Race Equality Standard, Workforce Disability Equality Standard, EDS 2022 and the Gender pay report will inform our approaches and strategies to increase the numbers of staff with protected characteristics.

NHS C&M looks to embed the Northwest anti racist framework and the Cheshire and Merseyside People Board have invested in the development of a programme supporting staff who have experienced racial trauma. Additional funding to support the embedding of EDI development has been secured.

We will ensure that there is a focus on workforce health inequalities including responsiveness to the growth of mental health related illness and MSK as the two highest indicators of sickness absence across the NHS

We will continue to work in close collaboration with all our NHS Provider Trust, EDI leads via Patient Equality focussed Forum and review the terms of reference and widen the membership to include representation of Healthwatch and other key stakeholders and ensure EDI and the implementation of EDS 2022 is central to the development of the ICB's public engagement strategy.

7. Equality, diversity and inclusion in the workforce

Demographic profiling is an essential characteristic of health and care workforce planning and modelling. It enables us to sense check our progress against national imperatives for the equality, diversity and inclusion relayed in the NHS People Promise 2022, NHS Long Term Plan 2019, NHS Model employer 2019 and the Messenger Review 2022 and more locally, the Northwest NHS anti racism framework 2022 and Care Quality Commission (CQC) Well Led framework.

We are working towards a single workforce demographic profile to inform our regulatory duty to report to the Workforce Race Equality Standard and in the future Workforce Disability Equality Standard and this will support our reporting on the gender pay gap. There will be ongoing development of a framework to build internal cultural competence capability.

In 2022 NHS C&M participated in the national staff survey and the results will assist us to understand any differentials in staff experience in the context of recruitment, access to development, experience of work and engagement with just culture principles within HR systems and processes.

We continue to monitor diversity in the organisation across the senior leadership tiers at Board, Executive and senior leadership body and through established networks we will continue to work with our local trusts to develop a dedicated workforce policy to support people who are transitioning gender in the workplace.

We will, in partnership with Trusts, develop a dedicated workforce policy to support Reservists and Adult Cadets and develop a standard narrative for public facing websites on our support offer for the Armed Forces community in Cheshire and Merseyside. NHS C&M has recently signed the Armed Forces covenant.

It is important that we continue to explore access to regional system-based resources of support for underrepresented groups including local staff equality networks, health and wellbeing provision and support together with opportunities to drive positive action approaches to recruitment at all levels of NHS C&M workforce to achieve diversity.

Whilst aggregated system data for workforce analytics will be developed in 2023- 2024, we recognise that the NHS C&M current workforce profile requires focused effort necessary for leadership for inclusion across health and care. Current EDI performance metrics demonstrate the following position for 2022 – 2023:

7.1 Gender Pay Gap reporting

The Gender Pay Gap is a statutory requirement for all NHS organisations who have 250 or more staff– it was mandated in March 2018. The Gender Pay Gap results are an important driver of our equality and inclusion activity in relation to improving gender equality. NHS C&M will need to prepare for gender pay gap reporting for 2023- 2024. Currently, the NHS profile for gender representation across senior pay bands can be illustrated as below:

Gender By Area/Band

Band/Grade	C&M ICB		C&M Acute Trusts		National NHS	
	Male	Female	Male	Female	Male	Female
Band 1	0%	0%	19%	81%	25%	75%
Band 2	0%	100%	19%	81%	22%	78%
Band 3	19%	81%	20%	80%	20%	80%
Band 4	22%	78%	17%	83%	18%	82%
Band 5	11%	89%	14%	86%	17%	83%
Band 6	18%	82%	16%	84%	18%	82%
Band 7	25%	75%	18%	82%	20%	80%
Band 8	34%	66%	25%	75%	29%	71%
Band 9	28%	72%	43%	57%	42%	58%
Medical Consultant	0%	100%	61%	39%	60%	40%
Medical Other	41%	59%	49%	51%	47%	53%
Other	65%	35%	29%	71%	35%	65%

7.2 Workforce Race and Disability Equality Standards

NHS C&M is required to participate in the national **Workforce Race Equality Standard (WRES)**. The nine WRES indicators cover recruitment and pay; access to training; disciplinary; discrimination, bullying and harassment and ICB Board membership. The main purpose of the WRES as outlined by NHS England is to:

- help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against nine indicators
- produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- improve BME representation at the Board level of the organisation

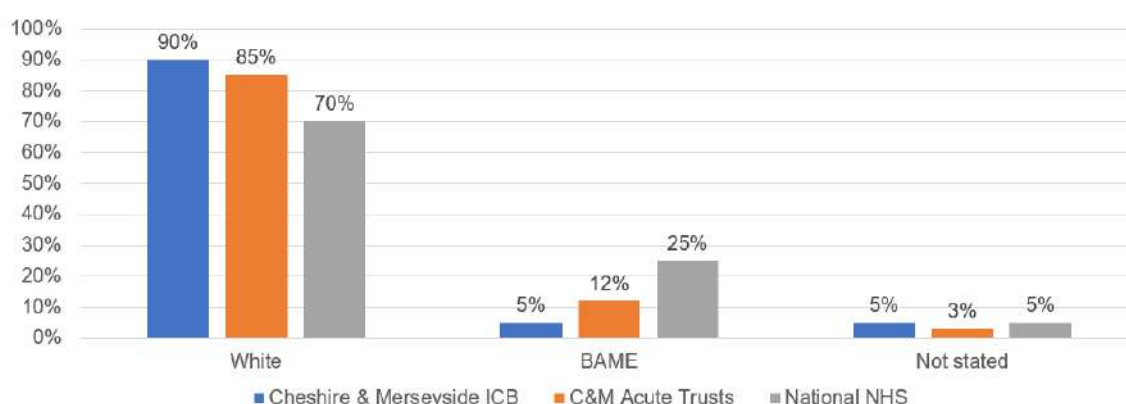
The standard supports the vision originally set out in the NHS Long Term Plan and the more recently refreshed NHS people’s plan and the need to ensure NHS workforces experience inclusive and non-discriminatory opportunities.

In practice this requires ICBs to collect data on their workforce, analyse it, and produce and publish an annual WRES report and action plan. By August 2023 NHS C&M is required to have collected and submitted its data and produced and published its report and action plan before the 1st of October 2023.

All organisations are expected to be able to demonstrate that they are starting to close the differences between the treatment and experience of White and Black and Minority Ethnic staff and also to reduce race disparity in working towards the Model Employer target to reflect representation of ethnic minority staff at equal proportions in all Agenda for Change (AfC) pay scales by 2025.

Current EDI performance metrics demonstrate the following position:

Ethnicity representation



Ethnicity By Area/Band

Band/Grade	Cheshire & Merseyside ICB			C&M Acute Trusts			National NHS		
	White	BAME	Not stated	White	BAME	Not stated	White	BAME	Not stated
Band 1	0%	0%	0%	95%	4%	1%	76%	16%	8%
Band 2	60%	20%	20%	91%	6%	3%	74%	22%	4%
Band 3	96%	2%	2%	93%	5%	2%	78%	18%	4%
Band 4	86%	7%	7%	91%	7%	2%	77%	19%	4%
Band 5	93%	4%	3%	76%	20%	4%	59%	36%	5%
Band 6	95%	3%	2%	90%	8%	2%	76%	21%	3%
Band 7	92%	6%	2%	93%	5%	2%	80%	17%	3%
Band 8	90%	5%	6%	92%	6%	2%	81%	16%	3%
Band 9	94%	3%	3%	93%	4%	3%	83%	11%	6%
Medical Consultant	0%	0%	0%	57%	36%	7%	55%	38%	7%
Medical Other	71%	15%	14%	51%	42%	7%	41%	49%	10%
Other	71%	6%	24%	88%	7%	5%	60%	16%	24%

(Source: E Connect, Feb 2023)

The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures (Metrics) to improve the experiences of disabled staff in the NHS. The WDES was

mandated by the NHS Standard Contract and became applicable to all NHS Trusts and Foundation Trusts in April 2019.

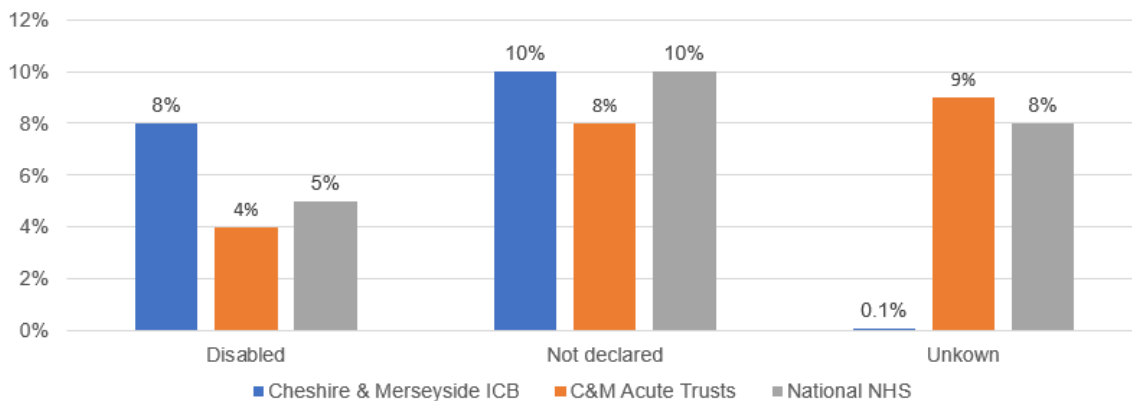
Mandatory reporting on WDES is restricted to NHS Trusts and Foundation Trusts however, in accordance with its commitment to best practice beyond compliance, the ICB will review its workforce disability data for the first time in 2023.

The WRES / WDES offers a series of workforce performance indicators from an EDI lens to include:

- Measurement of optical diversity across race and disability protected characteristics
- Senior leadership diversity across race and disability protected characteristics
- Any disparity in access to learning and development across race and disability protected characteristics in comparison to the overall workforce
- Any disparity in HR disciplinary processes across race and disability protected characteristics in comparison to the overall workforce
- Any disparity in access to promotion / progression across race and disability protected characteristics in comparison to the overall workforce and
- Any disparity in experience of discrimination across race and disability protected characteristics in comparison to the overall workforce

Current EDI performance metrics demonstrate the following position:

Disability representation



Disability By Area/Band

Band/Grade	C&M ICB			C&M Acute Trusts			National NHS		
	Disabled	Not Declared	Unknown	Disabled	Not Declared	Unknown	Disabled	Not Declared	Unknown
Band 1	0%	30%	0%	5%	18%	28%	5%	16%	24%
Band 2	6%	2%	6%	4%	8%	11%	5%	11%	8%
Band 3	0%	0%	0%	5%	7%	9%	6%	9%	6%
Band 4	4%	8%	4%	4%	7%	11%	5%	9%	7%
Band 5	5%	8%	5%	4%	7%	9%	5%	10%	7%
Band 6	4%	7%	4%	5%	7%	8%	6%	9%	6%
Band 7	3%	7%	3%	4%	8%	8%	5%	9%	7%
Band 8	4%	11%	0%	3%	9%	7%	5%	9%	6%
Band 9	6%	16%	0%	4%	5%	5%	4%	11%	7%
Medical Consultant	0%	0%	0%	1%	12%	14%	2%	16%	12%
Medical Other	0%	0%	0%	2%	8%	9%	3%	11%	14%
Other	0%	0%	0%	8%	13%	8%	4%	15%	27%

7.3 Staff training

It has been the ambition of NHS Cheshire and Merseyside to undertake a systems leadership role in its advocacy for learning, training and development. Three classifications of training offered include:

Type of training ¹	SM - Statutory / Mandatory Training	ETR - Essential to Role Training	CPD – Continued Professional Development
Mandate for development	Core Skills Training Framework (NHSE)	Professional registration / policy requirements	NHS C&M strategic objectives
Purpose	Safety in practice	Quality in practice	Improvement in practice

Data trends to understand any variations in the access to learning and development by underrepresented groups with protected characteristics for continued professional development learning that is not deemed statutory or mandatory will be a focus for 2023- 2024 WRES and WDES submissions.

7.4 Culture

An inclusive culture sits at the heart of NHS C&M. In July 2022, we developed a culture code to define the behavioural operating principles for organisational identity. The operating principle of ‘People First’ was designed into the heart of the framework:

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It was developed as a direct product of staff voice and desktop research including an analysis of the values of 9 CCGS value bases; the values of local NHS Trusts, Local Authorities and VCSE organisations. The culture code was further tested for alignment to the NHS constitution, NHS People Promise, Nolan Principles of public service, Equality Act and Public Sector Equality Duty 2010, Marmot principles and the Health and Care Act, 2022. The intention to harness an inclusive compassionate culture premised on the integrity of equality, honesty and human rights, has been successful in propelling the cementing and mainstreaming of inclusion into organisational cultural identity as reflected and reinforced accordingly in corporate communications, human systems and processes and the organisation's Equality Impact Assessment processes.

8. Monitoring NHS Provider equality and diversity compliance and performance

Due to the impact of COVID-19 on NHS organisations, quality compliance reporting paused in 2020/21 and for the first two quarters of 2021/22. NHS C&M Equality and Inclusion Service however developed a COVID-19 Equality Briefing in March 2020 to highlight Equality legal risks and challenges that Commissioners and Providers needed to be cognisant of in their response to COVID-19. The briefing highlighted that despite NHS organisations operating under emergency measures Public Sector Equality Duty remained in force. The briefing has continued to be updated to reflect the changing phases; response, recovery and reset planning, further waves, the COVID-19 vaccination programme and winter planning, "living with COVID-19" and provides a number of recommendations, information sources and resources. (Latest issue version 17 was issued in September 2022). The briefing brings together national guidance, national and regional intelligence and local reported issues for people with protected characteristics and other vulnerable groups from both a patient and workforce perspective. The briefing has been shared with ICB and Provider Incident Management Teams and other key partners across Cheshire and Merseyside footprint for information and action as appropriate for their respective organisation.

NHS C&M resumed its formal equality reporting requirements for 2023/2024 for its Merseyside NHS Provider Trusts in April 2023. The indicators are as follows:

- Evidence service change/ redesign proposals at the beginning and end of the process to ensure that the ICB is sighted and assured by the decision-making process that the Provider has paid due regard to their statutory duties.

- Action Plan to be submitted to update on progress in relation to Reasonable Adjustments, Accessible Information Standard, improving access to services for people who are Deaf or hard of hearing and also areas to address improving access to services for people whose first language is not English and an annual audit of compliance of reasonable adjustments.
- Evidence in the public domain (website) of annual equality report including objectives
- Workforce Disability Equality Standard report
- Workforce Race Equality Standard report

Currently NHS C&M have undertaken monitoring during quarters one and two. Current activity includes requesting Action Plans to be submitted to update on progress in relation to Reasonable Adjustments, Accessible Information Standard, improving access to services for people who are Deaf or hard of hearing and areas to address improving access to services for people whose first language is not English and an annual audit of compliance of reasonable adjustments.

Historically Cheshire, Wirral, Halton and Warrington CCGs EDI function, including NHS compliance has been delivered by Midlands and Lancashire Commissioning Support Unit (MLCSU) EDI team. NHS Provider Trust monitoring has taken place outside the formal quality contract process. During 2023/2024 NHS C&M intends to ensure all NHS Trust Providers across these areas are part of the formal contract process.

NHS C&M intends to publish NHS Provider Contract compliance in next year's annual report.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Equality Diversity and Inclusion Annual Report 2022/23

Appendix Two: EDS Reporting Template: Domain One

Classification: Official

Publication approval reference: PAR1262



NHS Equality Delivery System 2022

EDS Reporting Template

Domain One

Version 1, 15 August 2022

Contents

Equality Delivery System for the NHS..... 2

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation	NHS Cheshire and Merseyside	Organisation Board Sponsor/Lead
		Clare Watson (CW), Assistant Chief Executive Christina Samosa (CS), Chief People Officer
Name of Integrated Care System	Cheshire and Merseyside	

EDS Lead	Jo Roberts (JR), Accountability Manager Andy Woods (AW), Senior Governance Manager	At what level has this been completed?
		*List organisations
EDS engagement date(s)	17 th January 2023 24 th January 2023 26 th January 2023 30 th January 2023 31 st January 2023	Individual organisation
		Not applicable.
		Partnership* (two or more organisations)
		Not applicable
		Integrated Care System-wide*
		NHS Cheshire and Merseyside Bridgewater Community Health NHS FT East Cheshire NHS Trust

				Liverpool Heart and Chest Hospital NHS FT Liverpool University Hospitals NHS FT Liverpool Women's Hospital NHS FT Mersey Care NHS FT Mid Cheshire NHS Trust Southport and Ormskirk Hospitals NHS Trust Warrington and Halton Hospitals NHS FT Wirral Community Health and Care NHS FT Wirral University Teaching Hospital NHS FT
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Date completed	6 th of February 2023	Month and year published	February 2023
Date authorised	23 rd of February 2023	Revision date	February 2024

Completed actions from previous year	
Action/activity	Related equality objectives
<p>First year of completing EDS as an Integrated Care Board.</p> <p>Activity to support the organisation to meet its requirements under the Equality Act 2010 is outlined in the NHS Cheshire & Merseyside's Annual Equality Report for 2022/23.</p>	Not applicable

EDS Rating and Score Card

Ratings in accordance to scores are below

<p>Undeveloped activity – organisations score out of 0 for each outcome</p>	<p>Those who score under 8, adding all outcome scores in all domains, are rated Undeveloped</p>
<p>Developing activity – organisations score out of 1 for each outcome</p>	<p>Those who score between 8 and 21, adding all outcome scores in all domains, are rated Developing</p>
<p>Achieving activity – organisations score out of 2 for each outcome</p>	<p>Those who score between 22 and 32, adding all outcome scores in all domains, are rated Achieving</p>
<p>Excelling activity – organisations score out of 3 for each outcome</p>	<p>Those who score 33, adding all outcome scores in all domains, are rated Excelling.</p>

NHS Cheshire and Merseyside (CMICB) and the following eleven trusts opted for early implementation of EDS 2022. For domain 1, CMICB's equality and inclusion leads asked each trust equality / patient experience lead to liaise with executive colleagues of their respective organisation to identify two services to review, one of which had to be a clinical area part of Core20Plus5. Trusts selected the following services. Note that some trusts selected two services part of Core20Plus5.

Bridgewater Community Health NHS FT: Halton Health Visiting Service and Warrington Family Nurse Partnership (Core20Plus5 Maternity)

East Cheshire NHS Trust: Antenatal Screening (Core20Plus5 Maternity) and Acute Paediatrics

Liverpool Heart and Chest Hospital NHS FT: Targeted Healthy Lung Check Service (Core20Plus5 Respiratory) and Hypertension Case Finding (Core20Plus5)

Liverpool University Hospitals NHS FT: Cardiology, (Core20Plus5 Hypertension Case Finding) and Respiratory (Core20Plus5 Respiratory)

Liverpool Women's Hospital NHS FT: Induction of Labour (Core20Plus5 Maternity) and Early Cervical Cancer (Core20Plus5 Cancer)

Mersey Care NHS FT: High Secure Services (Core20Plus5 Severe Mental Illness)

NB Mersey Care had planned to review Silver Birch Hubs Peri-natal mental health service as their second service however due to organisational pressures could not complete the review.

Mid Cheshire NHS Trust: Maternity (Core20Plus5 Maternity) and Ophthalmology

Southport and Ormskirk Hospitals NHS Trust: TIA (Core20Plus5 Hypertension Case Finding) and Patient Initiated Follow Ups (PIFU) in MSK

Warrington and Halton Hospitals NHS FT: Team River -Warrington and Team Sunlight – Halton (Core20Plus5 Maternity) and Long COVID service

Wirral Community Health and Care NHS FT: Community Cardiology CVD Rehabilitation (Core20Plus5 Hypertension Case Finding) and Bladder and Bowel

Wirral University Teaching Hospital NHS FT: Maternity (Core20Plus5 Maternity), Perinatal Mental Health (Core20Plus5 Maternity)

CMICB's equality and inclusion leads developed a service review template for organisations to adapt and complete for each service review. Organisations could then use this document to consider information available relating to patient access, meeting health needs, experience and outcomes, identify any gaps in intelligence, to help inform ratings against each outcome, and to develop service improvement plans. A list of data sources and publications were also provided to trusts for each of the Core20Plus5 clinical areas.

CMICB's equality and inclusion leads facilitated a series of meetings for each of the Core20Plus5 clinical areas with trusts, Healthwatch and lead 'place' commissioning managers in attendance. Other stakeholders were also invited, such as Improving Me colleagues to the Maternity specific meetings and advocacy service to the Severe Mental Illness discussions. Contact was also made with CHAMPS and cancer alliance colleagues.

The approach to engagement with stakeholders was varied. Some trusts had access to well established internal patient experience groups, established links with Healthwatch and VCSE organisations and therefore were more easily able to engage with them throughout the process to scrutinise the available evidence, respond to any clarifying questions, discuss and collectively agree ratings prior to presenting those stakeholder approved ratings to trust peers reviewing the same clinical service. Other trusts however didn't have access to such groups; either due to them not being as well established or due to time constraints with undertaking the reviews whilst managing internal organisational pressures. These trusts therefore utilised dedicated grading meetings, facilitated by the CMICB equality and inclusion leads with Healthwatch, commissioning managers and trust peers in attendance for that forum to scrutinise the available evidence to ultimately agree/ disagree with proposed ratings. Grading meetings in both respects were delivered in a similar format; trusts delivering a presentation highlighting the available evidence, gaps in intelligence with the service review template/ supporting data available as a supporting document. Ratings were determined in accordance with the EDS 2022 score care and ratings guidance.¹

NHS C&M ratings for domain 1 is **Achieving** across each outcome. This is the **mode** rating, as taken from the trust's individual service review ratings below:

Trust	Service Review	1A: Service users have required levels of access to the service	1B: Individual service user's health needs are met	1C: When service users use the service, they are free from harm	1D: Service users report positive experiences of the service
Bridgewater Community Health NHS FT	Halton Health Visiting Service (Core20Plus5 Maternity)	Developing	Achieving	Achieving	Achieving
	Warrington Family Nurse Partnership (Core20Plus5 Maternity)	Developing	Achieving	Achieving	Achieving
East Cheshire NHS Trust	Antenatal Screening (Core20Plus5 Maternity)	Achieving	Achieving	Excelling	Achieving

¹ [EDS Ratings and Score Card Guidance \(england.nhs.uk\)](https://www.england.nhs.uk/eds-ratings-and-score-card-guidance/)

	Acute Paediatrics	Achieving	Achieving	Achieving	Achieving
Liverpool Heart and Chest Hospital NHS FT	Targeted Healthy Lung Check Service (Core20Plus5 Respiratory)	Achieving	Achieving	To be confirmed following internally committee discussion.	To be confirmed following internally committee discussion.
	Hypertension Case Finding (Core20Plus5)	Achieving	Achieving	Achieving	To be confirmed following internally committee discussion.
Liverpool University Hospital NHS FT	Cardiology (Core20Plus5 Hypertension Case Finding)	Developing	Developing	Developing	Developing
	Respiratory (Core20Plus5)	Developing	Developing	Developing	Developing
Liverpool Women's Hospital NHS FT	Induction of Labour (Core20Plus5 Maternity)	Developing	Achieving	Achieving	Developing
	Early Cervical Cancer (Core20Plus5 Cancer)	Developing	Developing	Developing	Developing
Mersey Care NHS	High Secure Services (Core20Plus5 Severe Mental Illness)	Achieving	Achieving	Excelling	Developing
Mid Cheshire NHS Trust	Maternity (Core20Plus5 Maternity)	Achieving	Excelling	Excelling	Achieving
	Ophthalmology	Developing	Achieving	Achieving	Developing

Southport and Ormskirk Hospital NHS Trust	TIA (Core20Plus5 Hypertension Case Finding)	Developing	Developing	Achieving	Undeveloped
	Patient Initiated Follow Ups (PIFU) in MSK	Achieving	Achieving	Achieving	Achieving
Warrington and Halton Hospitals NHS FT	Team River - Warrington and Team Sunlight – Halton (Core20Plus5 Maternity)	Developing	Achieving	Achieving	Achieving
	Long COVID service	Developing	Excelling	Achieving	Achieving
Wirral Community Health and Care NHS FT	Community Cardiology CVD Rehabilitation (Core20Plus5 Hypertension Case Finding)	Achieving	Achieving	Excelling	Achieving
	Bladder and Bowel	Achieving	Achieving	Achieving	Achieving
Wirral University Teaching Hospital NHS Trust	Maternity (Core20Plus5 Maternity)	Achieving	Achieving	Achieving	Achieving
	Perinatal Mental Health (Core20Plus5 Maternity)	Achieving	Developing	Developing	Achieving

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
<i>Domain 1: Commissioned or provided services</i>	1A: Patients (service users) have required levels of access to the service	<p>The service review template included information on barriers for people with protected characteristics and other health inclusion groups so that trusts could consider these as part of their review. Depending on the type of service, services were able to consider for example if conditions were more prevalent relevant to a protected characteristic.</p> <p>Each of the service reviews considered the population served, geographical location of services including domiciliary provision, hours of operation, staffing and a range of other factors.</p> <p>Services have implemented the accessible information standard.</p> <p>Services were able to identify any gaps in data relevant to protected characteristics or other health inclusion groups and identify actions for improvement.</p>	2	CW/ AW

		<p>Community based services were able to evidence how they have triangulated referral rates with patient experience and health inequalities information to adapt their services. Examples include using intelligence to inform the geographical location of community clinics.</p>		
	<p>1B: Individual patients (service users) health needs are met</p>	<p>Each of the reviews considered service activity information by protected characteristic and other health inclusion groups, considerations also included waiting times and longest wait information (where relevant to the service).</p> <p>Services considered information relating to non-attendance at appointments (where appropriate for elective services).</p> <p>Services considered patient experience information where this was available and intelligence from local Healthwatch colleagues.</p> <p>All services have access to interpretation services for patients who use British Sign Language and for patients whose first language isn't English.</p> <p>Services were able to provide examples of Reasonable Adjustments they have provided.</p>	<p>2</p>	<p>CW/AW</p>

	<p>1C: When patients (service users) use the service, they are free from harm</p>	<p>Service reviews indicated that all organisations have procedures/initiatives in place to enhance safety in services for patients. Positive incident reporting cultures reported and examples of learning from incidents.</p> <p>Services which had significant waiting lists and/or long waiters evidenced that clinical triage took place.</p> <p>Freedom to Speak up guardians available.</p> <p>Staffing resource, vacancies considered as part of the reviews.</p> <p>Trusts identified further actions in relation to considering protected characteristics in serious incident reviews and collecting equality monitoring information for complaints monitoring.</p>	2	CW / AW
	<p>1D: Patients (service users) report positive experiences of the service</p>	<p>All trusts collate data from patients with protected characteristics about their experience of the service and provide regular reporting to identify themes / actions.</p> <p>The reviews highlighted that trusts use patient experience data to influence service delivery.</p>	2	CW/ AW

Domain 1: Commissioned or provided services overall rating

8

Achieving

EDS Organisation Rating (overall rating):

Developing

Organisation name(s):

NHS Cheshire and Merseyside

Those who score **under 8**, adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21**, adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32**, adding all outcome scores in all domains, are rated **Achieving**

Those who score **33**, adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	Year(s) active
Andy Woods	23/02/2023 to 28/02/2024
EDS Sponsor	Authorisation date
Clare Watson - Assistant Chief Executive	February 2023.

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Work collaboratively with providers and other partners to identify and recommend actions to address health inequalities and barriers in accessing healthcare services across Cheshire and Merseyside to improve patient journey and experience.	Review Patient Equality Focused Forum (PEFF) membership	May 2023
			Facilitate workshop/ event for trusts to share their service review findings and learning with all trusts and wider system colleagues.	Trusts: April 2023 Wider system: May 2023
			ICB Board sub-committees to support identification of services to be reviewed in 2023/24	March 2023

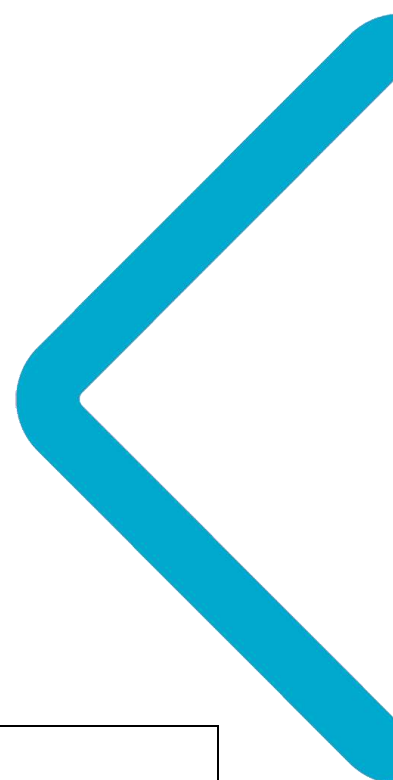
	1B: Individual patients (service users) health needs are met	Patient Equality Focused Forum works collaboratively to develop and implement best practice.	PEFF workplan to be developed.	July 2023
	1C: When patients (service users) use the service, they are free from harm	Equality considerations are embedded in SI process.	Tailored training for SI panel members/ Quality and Performance Committee members.	October 2023
	1D: Patients (service users) report positive experiences of the service	<p>Equality monitoring information incorporated into patient experience reporting.</p> <p>The ICB creates evidence-based action plans in collaboration with patients and relevant stakeholders, and monitors progress.</p>	<p>Implement any recommended actions specific to EDI following the ICB's governance review.</p> <p>Consider Citizens Panel representatives for inclusion in PEFF membership.</p>	<p>December 2023</p> <p>May 2023</p>

Patient Equality Team
NHS England and NHS Improvement
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NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Risk Management



Agenda Item No	ICB/02/23/13
Report author & contact details	Dawn Boyer , Head of Corporate Affairs & Governance
Report approved by (sponsoring Director)	Clare Watson , Assistant Chief Executive
Responsible Officer to take actions forward	Matthew Cunningham , Associate Director of Corporate Affairs & Governance / Company Secretary, Dawn Boyer , Head of Corporate Affairs & Governance

Cheshire and Merseyside ICB Integrated Care Board Meeting

Risk Management

<p>Executive Summary</p>	<p>The report presents the ICB Risk Management Strategy for review and approval by the Board. The establishment of effective risk management systems is vital to the successful management of the organisation and the local NHS system and is recognised as being fundamental in ensuring good governance. This strategy has been developed on behalf of the ICB based on best practice and subject to consultation within the ICB and with its internal auditors.</p> <p>The Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The Board Assurance Framework (BAF) is a key component of this. The proposed reporting format, together with the actions being taken to populate this, is included within this report.</p> <p>It is the role of the Board to determine the ICB's risk appetite in relation to the delivery of the organisation's strategic objectives and core functions. The risk appetite statement sets out the amount and type of risk that the ICB is willing to accept and guides managers at all levels in their decision making. A core statement of risk appetite, based on the outcome of the board development session in November, and the next steps for the Board to populate the detailed statement are proposed in the report.</p> <p>The Risk Management Strategy defines specific accountabilities, roles, and responsibilities for risk management. Its implementation is being supported by briefings, guidance, and development sessions to support those charged with the governance, leadership, and management of the ICB. A detailed report on implementation progress and plans will be provided to the Audit Committee in March reflecting its role in overseeing the ICB's risk management arrangements.</p> <p>At its meeting in April 2023 the Board will receive its populated Board Assurance Framework, reflecting the key principal risks of the ICB.</p>				
<p>Purpose (x)</p>	<p>For information / note</p> <p>X</p>	<p>For decision / approval</p> <p>X</p>	<p>For assurance</p>	<p>For ratification</p>	<p>For endorsement</p>
<p>Recommendation</p>	<p>The Board is asked to:</p> <ul style="list-style-type: none"> • APPROVE the Risk Management Strategy attached at Appendix One • APPROVE the proposed Board Assurance Framework report format attached at Appendix Three • APPROVE the core statement and risk appetite definitions included in the draft Risk Appetite Statement attached at Appendix Four • NOTE the work being undertaken to populate the Board Assurance Framework and the further input that will be requested from Board members to complete the detailed risk appetite statement. 				
<p>Key issues</p>	<p>The key components of the Risk Management Strategy are described in section 3 and illustrated in Appendix Two. The Board's attention is drawn specifically to its responsibilities in relation to the strategy.</p> <p>The Board Assurance Framework is an important tool to enable the Board to deliver these responsibilities and the proposed reporting is described in section 4 and illustrated in Appendix Three.</p>				

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	The Board is responsible for determining the amount and type of risk that the ICB is willing to accept. A draft risk appetite statement is provided at Appendix Four and section 5 sets out the further work required to complete this.			
Key risks	The approval of the risk management arrangements proposed does not present any significant risk but will provide the ICB with the necessary framework to manage risk effectively.			
Impact (x) (further detail to be provided in body of paper)	Financial	IM &T	Workforce	Estate
	Legal	Health Inequalities	EDI	Sustainability
Route to this meeting	The draft Risk Management Strategy was reviewed and endorsed by the Audit Committee in September 2022. A summary of their feedback and discussion and resulting changes to the strategy is provided at paragraph 2.5.			
Management of Conflicts of Interest	The recommendations do not present any potential conflict of interest for any members of the Board.			
Patient and Public Engagement	Engagement has been undertaken internally and with the ICB's internal auditors and this is described in section 2. No patient and public engagement has been undertaken.			
Equality, Diversity, and Inclusion	No impact assessment undertaken.			
Health inequalities	The report concerns the establishment of effective risk management systems which, while not directly impacting on health inequalities, will create a framework for the consideration, identification, and mitigation of risks to health equality, and provide assurance regarding the effectiveness of mitigation strategies.			
Next Steps	Work will continue to populate the ICB risk registers and to implement ICB Committee and place risk reporting. A more detailed report on implementation progress and plans will be presented to the Audit Committee at its meeting in March 2023.			
	The Executive Team will continue to work to develop and refine the principal risks for consideration and adoption by the Board. It is planned to complete this and present the first full BAF report to the Board meeting in April.			
	Further input will be requested from Board members individually and collectively to complete the risk appetite statements for each principal risk for final approval at the Board meeting in April.			
	Further meetings of the Board Risk Sub-group will be arranged to further support the development of the ICB Board Assurance Framework and submission to the Board in April 2023. The sub-group will also look to support the development of the Terms of Reference for the establishment of an ICB Risk Committee.			
Appendices	Appendix One	Risk Management Strategy		
	Appendix Two	Key components of the Risk Management Strategy		
	Appendix Three	Board Assurance Framework report format		
	Appendix Four	Draft Risk Appetite Statement		

Cheshire and Merseyside ICB Integrated Care Board Meeting

Risk Management

1. Executive Summary

- 1.1 The report presents the ICB Risk Management Strategy for review and approval by the Board. The establishment of effective risk management systems is vital to the successful management of the organisation and local NHS system and is recognised as being fundamental in ensuring good governance. This strategy has been developed on behalf of the ICB based on best practice and subject to consultation within the ICB and with its internal auditors.
- 1.2 The Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The Board Assurance Framework (BAF) is a key component of this. The proposed reporting format, together with the actions being taken to populate this, is included within this report., with the ask of the Board being to approve its format and use. At its meeting in April 2023 the Board will receive its populated Board Assurance Framework, reflecting the key principal risks of the ICB. The Board will also receive at the same time the top 10 ICB Operational risks.
- 1.3 It is the role of the Board to determine the ICB's risk appetite in relation to the delivery of the organisation's strategic objectives and core functions. The risk appetite statement sets out the amount and type of risk that the ICB is willing to accept and guides managers at all levels in their decision making. A core statement of risk appetite, based on the outcome of the board development session in November 2022, and the next steps for the Board to populate the detailed statement are proposed in the report for the Board to approve.
- 1.3 The Risk Management Strategy defines specific accountabilities, roles, and responsibilities for risk management. Its implementation is being supported by briefings, guidance, and development sessions to support those charged with the governance, leadership, and management of the ICB. A detailed report on implementation progress and plans will be provided to the Audit Committee at its meeting in March 2023 reflecting its role in overseeing the ICB's risk management arrangements.
- 1.4 Further meetings of the Board Risk Sub-group will be arranged to further support the development of the ICB Board Assurance Framework and submission to the Board in April 2023. The sub-group will also look to support the development of the Terms of Reference for the establishment of an ICB Risk Committee.

Cheshire and Merseyside ICB Integrated Care Board Meeting

2. Background

- 2.1 An effective risk management system is an essential component of good governance and robust internal control. The proposed Risk Management Strategy, attached at Appendix One, sets out the ICB's approach to risk management and assurance, specifically:
- the governance structure, detailing groups which have responsibility for risk.
 - roles and responsibilities of all staff with regards to risk management.
 - the process for identification, assessment, and management of risk.
 - the process for managing and reviewing the Board Assurance Framework and Corporate Risk Register.
 - the process for monitoring the Risk Management and Assurance Framework and ensuring it is effective.
- 2.2 A Risk and Assurance Task and Finish Group was established, as part of the Cheshire and Merseyside CCG / ICB Transition Programme, to develop the ICB's risk management system, including this strategy. The Group included representation from CCGs, the Health and Care Partnership and the Midlands and Lancashire Commissioning Support Unit.
- 2.3 The strategy was developed drawing on current best practice, a range of governance standards, and existing CCG strategies. The draft strategy was subject to consultation with CCG governance leads and representatives of internal audit, quality, finance, performance, and non-executive roles. The final draft has been presented to the Quality and Performance Committee, the Audit Committee and the ICB Executive Team for review and approval.
- 2.4 The Audit Committee requested changes to provide further clarity regarding escalation of risks which have been made. It highlighted the need to move forward with defining the principal risks and risk appetite through a board development session, which has subsequently taken place. There was also discussion of how wider system risks would be understood and reported and it was recognised that this is a complex area requiring further work, but beyond the scope of this ICB strategy at this point.
- 2.5 Work has continued to develop the risk management system since the establishment of the ICB on 01 July 2022. This included a board development session on risk in November which considered strategic objectives, principal risks, and risk appetite.

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- 2.6 A sub-group of the Board met in January 2023 to further consider the BAF report format and draft risk appetite statement. Outputs from this work and next steps are set out within this paper. Further meetings of this sub-group will be arranged to meet prior to the ICB Board meeting in April 2023 so as to further shape and inform the BAF and help support the development of Terms of Reference for an ICB Risk Management Committee. Subsequent to the meeting of the risk sub-group and as part of wider conversations regarding ICB governance, it was agreed that the ICB would establish of a Risk Management Committee, to be reviewed after 12 months, to oversee the implementation, embedding and further development of the risk and assurance framework. The draft strategy presented has been amended to reflect this.

3. Key Components of the Risk Management Strategy

- 3.1 The key components of the strategy are highlighted in the presentation slides attached at Appendix Two.
- 3.2 The ICB will be delivering functions at scale and in each of the 9 places within Cheshire and Merseyside. It requires a risk and assurance framework that meets the needs of the ICB as a single corporate entity, but which is also meaningful and useful at place level.
- 3.3 There will be an ICB BAF and an ICB Operational Risk Register, supported by scrutiny and assurance via the ICB committees. These will comprise risks in relation to strategic objectives and functions delivered at scale together with the aggregation of risks in relation to objectives and functions delivered in the 9 places, assessed and scored with reference to the ICB as a whole.
- 3.4 At a place level, risks will be assessed with reference to the impact and likelihood for the place. There will be a Place Delivery and Assurance Framework in respect of place strategic objectives and a Place Risk Register overseen by place committees.
- 3.5 The key risk definitions and risk impact scoring describe how risks will be assessed at corporate and place levels. Risk tolerances will drive the response and escalation at and between corporate and place levels. The strategy also sets out specific accountabilities, roles, and responsibilities for risk management.
- 3.6 The Board's attention is drawn specifically to its duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:
- identifying risks which may prevent the achievement of its strategic objectives
 - determining the organisation's level of risk appetite in relation to the strategic objectives

Cheshire and Merseyside ICB Integrated Care Board Meeting

- proactive monitoring of identified risks via the Board Assurance Framework and Corporate Risk Register
 - ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
 - receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
 - demonstrating effective leadership, active involvement, and support for risk management.
- 3.7 It is recognised that the strategy will need to adapt and evolve as the organisation and its approach to risk management matures. The Board will need to finalise the ICB's risk appetite in relation to the achievement of its strategic plan, which will be reflected in the strategy and inform strategic decisions and control efforts.
- 3.8 The scope of the strategy comprises the corporate entity of the ICB rather than the wider partnership of the ICS. Further development of a system approach to risk management and system assurance framework will be required in conjunction with partners. Guidance from NHSE/I is expected on this and will inform next steps.

4. Board Assurance Framework

- 4.1 The BAF is used to record and report the organisation's key strategic objectives, principal risks, controls, and assurances to the board. The proposed BAF report format is attached at Appendix Three. It comprises four elements which are described in more detail below.
- 4.2 **Summary** – which lists the principal risks for each strategic objective, together with key data on risk scores and priority control and assurance activity. It aims to inform the Board regarding the extent to which the principal risks are being controlled, movement and distance from target score. It suggests the priority activities and focus of scrutiny in terms of identifying additional controls to reduce the level of risk or seeking assurance that controls in place are effective.
- 4.3 **Heat Map** – which provides the current risk profile in relation to the principal risks and plots the extent to which this has shifted from the inherent (uncontrolled) risk profile.
- 4.4 **Risk Assurance Map** – which summarises the assurances available to the Board in relation to each principal risk. It provides a rating of the adequacy and effectiveness of each group of controls and briefly describes the assurances provided in relation to each of the three lines of defence,¹ being:
- 1st line - assessment and monitoring of the effectiveness of controls by the senior responsible lead and operational lead as the responsible risk owners

¹ <https://www.icas.com/professional-resources/audit-and-assurance/internal-audit/internal-audit-three-lines-of-defence-model-explained>

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- 2nd line - scrutiny and oversight of effective risk management practices by corporate teams, thematic / portfolio leadership groups, ICB committees
 - 3rd line - external review and oversight, including by auditors, external regulators and NHSE oversight.
- 4.5 **Risk Summaries** – for each principal risk and which describe the risk in more detail and provide scores, trends, controls list, ratings, gaps, and actions, planned and actual assurances, ratings, gaps, and actions. This enables the Board to dive into the detail of any area of risk which is giving cause for concern.
- 4.6 In addition, the covering report will provide a commentary, explaining the information presented, and highlighting key areas for focus, action, or decision by the Board.
- 4.7 It is proposed that Board Assurance Framework reports will be provided to the Board quarterly, commencing in April 2023.
- 4.7 Draft principal risks were discussed during the board development session in November 2023. The Chair has requested that the ICB Executive Team complete further work to develop and refine the principal risks for consideration and adoption by the Board. This is underway and it is planned to complete this and present the first full BAF report to the Board meeting in April. Between the Executive Team and the Board risk sub-group, the principal risks will be shaped prior to submission to the Board in April 2023.

5. Risk Appetite Statement

- 5.1 The Risk Management Strategy requires that the Board *‘agree and review annually the ICB’s risk appetite statement to ensure that decision makers across the organisation are clear regarding the level of risk they are permitted to expose the organisation to, and where to escalate and target action in improving controls. The statement will include:*
- *Risk appetite - the amount of risk that NHS Cheshire and Merseyside is willing to seek or accept in the pursuit of its strategic objectives, which will form part of the annual planning process and be set out in relation to each strategic objective.*
 - *Risk tolerance - the boundaries of risk taking outside of which NHS C&M is not prepared to venture in the pursuit of its strategic objectives.’*
- 5.2 Risk appetite was considered at the board development session in November 2023. The discussion and feedback provided by members present has been used to frame the draft risk appetite statement attached at Appendix Four. The statement comprises purpose, a core statement, and a more detailed statement in relation to the ICB’s strategic objectives.

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- 5.3 At this point the Board are asked to approve the proposed core statement and the risk appetite definitions. Further input will be required from the Board individually and collectively to establish the appetite in relation to each strategic objective and risk element.
- 5.4 The final approved risk appetite statement will be incorporated into the ICB's Risk Management Strategy. The detailed statement will provide a framework and guidance for managers across the ICB to shape decision making, escalation and control.

6. Recommendations

- 6.1 **The Board is asked to:**
- **APPROVE** the Risk Management Strategy attached at Appendix One
 - **APPROVE** the proposed Board Assurance Framework report format attached at Appendix Three
 - **APPROVE** the core statement and risk appetite definitions included in the draft Risk Appetite Statement attached at Appendix Four
 - **NOTE** the work being undertaken to populate the Board Assurance Framework and the further input that will be requested from Board members to complete the detailed risk appetite statement.

7. Next Steps

- 7.1 Work will continue to populate the ICB risk registers and to implement ICB Committee and place risk reporting. A more detailed report on implementation progress and plans will be presented to the Audit Committee at its meeting in March 2023.
- 7.2 The Executive Team will continue to work to develop and refine the principal risks for consideration and adoption by the Board. It is planned to complete this and present the first full BAF report to the Board meeting in April.
- 7.3 Further input will be requested from Board members individually and collectively to complete the risk appetite statements for each principal risk for final approval at the Board meeting in April.
- 7.4 Further meetings of the Board Risk Sub-group will be arranged to further support the development of the ICB Board Assurance Framework and submission to the Board in April 2023. The sub-group will also look to support the development of the Terms of Reference for the establishment of an ICB Risk Committee.
- 7.5 Subject to approval by the Board of the Risk Management Strategy and Risk Appetite statement, the Risk Management Strategy will be published on the ICB website and its publication communicated to colleagues across the ICB.

Cheshire and Merseyside ICB Integrated Care Board Meeting

8. Officer contact details for more information

Dawn Boyer

Head of Corporate Affairs & Governance

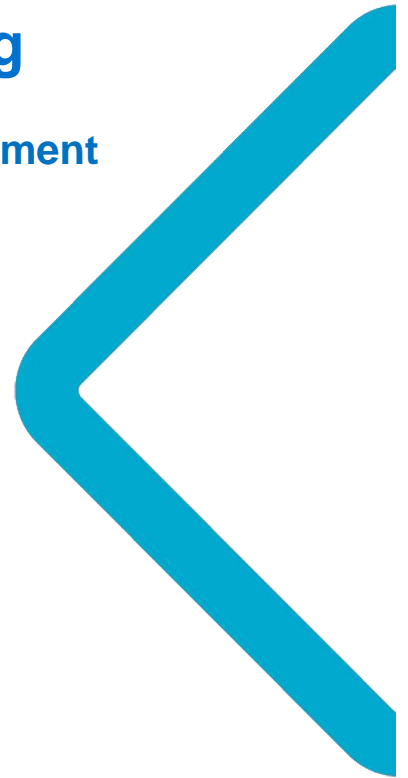
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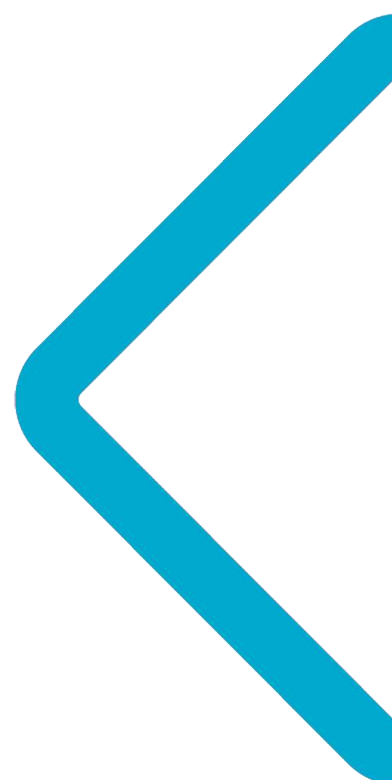
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Cheshire and Merseyside ICB Risk Management

Appendix One: Risk Management Strategy



Risk Management Strategy



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1. Organisational Context

NHS Cheshire and Merseyside Integrated Care Board (referred to in the policy as “the ICB”) was established as a statutory body on 1 July 2022. The ICB operates as NHS Cheshire and Merseyside (referred to in this policy as “NHS C&M”).

The ICB operates in the 9 geographical areas of Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral (referred to in the policy as “Places”).

The ICB has an integrated care partnership, The Cheshire and Merseyside Health and Care Partnership (referred to in the policy as “the C&M HCP”) with local authorities, NHS providers, Healthwatch, and the voluntary and community sector across Cheshire and Merseyside. In addition, it has local partnerships in each of the 9 geographical areas (referred to in the policy as “place-based partnerships”).

All staff and members operate in accordance with agreed policies and the principles relating to business conduct which can be found at <https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/>.

2. Introduction

This document outlines NHS C&M’s approach to risk management and assurance. Specifically:

- The governance structure, detailing groups which have responsibility for risk.
- Roles and responsibilities of all staff with regards to risk management.
- The process for identification, assessment and management of risk.
- The process for managing and reviewing the Board Assurance Framework and Corporate Risk Registers.
- The process for monitoring this Risk Management and Assurance Framework and ensuring it is effective.

An effective risk management framework is essential to ensuring high quality services are delivered within available resources and to providing a safe working environment for staff.

The strategy reflects current best practice, taking into account a range of governance standards including those set out in:

- UK Corporate Code of Governance (2018)
- BS31100: The British Code of Practice for Risk Management & Guidance
- NHS Controls Assurance, Risk Register Working Group 2002

3. Statement of Intent

NHS C&M is committed to the provision of high-quality commissioning, partnership and collaboration, and NHS system-wide working and oversight in the delivery of its objectives. This will be supported through the development and implementation of a robust system of internal control including processes for risk management and assurance that are understood and embedded at all levels of the organisation. The purpose of this document is to set out those processes and the monitoring arrangements to ensure effective implementation.

The establishment of effective risk management systems is vital to the successful management of the organisation and local NHS system and is recognised as being fundamental in ensuring good governance. NHS C&M’s management needs to receive robust and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate

outcomes. NHS C&M's leadership therefore has overall responsibility for ensuring they have assurance that the process of risk identification, evaluation and control are effective.

This is achieved through the management and application of the Board Assurance Framework. The reporting and monitoring of the Board Assurance Framework enables the Integrated Care Board to be assured that the controls applied in the mitigation of risk are operating effectively and/or seek assurance of further mitigation.

There are a number of principles and aims that underpin the strategy and are essential for its successful implementation.

NHS C&M Strategic Objectives 2022/23



Risk Management and Assurance Strategy – Key Principles & Aims

The following key principles are essential for the successful implementation of this strategy:

- There is executive director and senior management commitment to, and leadership of risk.
- There is widespread employee participation and consultation in risk management processes, which will operate in a fair blame culture.
- There are management systems in place that provide safe practices, premises and equipment in the working environment. Systems of work must be designed to reduce the likelihood of human error occurring.
- The risk management process must be applied to contract management especially when acquiring, expanding or outsourcing services, equipment or facilities. Contracts must be reviewed and written to ensure that only reasonable risks are accepted.
- On all NHS C&M premises, whether owned or shared, safe systems of work must be in place to protect visitors and staff.
- NHS C&M maintains an effective system of emergency preparedness, emergency response and contingency planning.
- NHS C&M provides realistic resources to implement and support effective risk management throughout the organisation.

The aims of managing risks effectively are to:

- Ensure the management of risk is consistent with and supports the achievement of NHS C&M strategic objectives.
- Provide high quality services to patients.
- Initiate action to prevent or reduce the adverse effects of risk.

- Minimise the financial and other negative consequences of losses and claims, for example, poor publicity, loss of reputation.
- Ensure the risks associated with new developments and activities remain within agreed tolerances determined by the relevant Executive Director in accordance with the ICB's risk appetite.
- Meet statutory and legal obligations and improve compliance with the ongoing requirements of best practice governance standards.
- Protect visitors and staff from risks as far as is reasonably practicable.

4. Scope

This strategy aims to identify and provide:

- Clarity on the approach and direction to be taken to manage risks
- Promote awareness of risk management
- Provide a process of identification, assessment, mitigation and elimination of risks
- Provide clarity on integrating risk management into directorates' objectives; personal objectives; project work etc.

The strategy relates directly to the strategic objectives of NHS C&M.

This strategy applies to all staff, teams and activities managed by NHS C&M.

This strategy will be supported by more detailed procedures and guidance. These documents collectively comprise the NHS C&M Risk and Assurance Framework.

It is often at the interface between organisations that the highest risks exist and clarity about responsibilities and accountabilities for those risks can sometimes be difficult. Partnership risks which are jointly owned by the ICB and its partners, as part of the C&M ICP and place-based partnerships are out of the scope of this strategy. It is anticipated that an approach to partnership risks will be developed in conjunction with partners and will be reflected in future iterations of this strategy.

NHS C&M recognises that there are risks as well as opportunities in partnership working and that failing to actively engage with partners also carries risks. NHS C&M endeavours to work closely and collaboratively with a wide range of partner organisations to ensure these risks are identified and appropriately managed and that risk management is fully integrated into all joint working arrangements.

In all partnership working agreements the Board will seek assurance that risks to strategic objectives have been identified from both NHS C&M perspective and by the partner organisation and that adequate risk controls have been put in place e.g., section 75 partnership agreements with Local Authorities, collaboration agreements etc.

Links with partners' risk management and assurance arrangements will be developed and delivered via "local" Place arrangements and "system" level via ICP arrangements. This may involve links into Health and Wellbeing Boards, local authorities and provider collaboratives.

5. Definitions

Risk	<p>The effect of uncertainty on objectives.</p> <p>Risk is the combination of the probability of an event and its consequence.</p> <p>The chance of something happening that will have an impact on objectives.</p> <p>An uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives.</p>
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Issue	<p>A relevant event that has happened or is certain to happen, was not planned, and requires specific management action.</p> <p>The distinction between an issue and a risk is that an issue is an event that has happened or will happen, and a risk is an event that may happen.</p>
Risk Assessment	A systematic process of identifying, analysing and evaluating risks.
Impact	A measure of the anticipated effect on the achievement of NHS C&M's objectives if the event or set of events occurs.
Likelihood	A measure of the chance or probability of the event or set of events occurring.
Risk Rating	The severity assigned to a risk following assessment. This is determined by multiplying the impact of the risk by the likelihood of occurrence.
Risk Matrix	A matrix setting out the criteria used to define and measure the impact and likelihood, resulting in the risk rating. This aims to ensure a consistent approach to the rating of risks across NHS C&M. Impact may be measured in the context of each of the 9 places or for the ICB as a whole.
Risk Management	The culture, framework, processes and structures that are directed towards identifying, understanding and controlling exposure to risks which may threaten the achievement of NHS C&M's objectives.
Risk Register	A log of risks of all kinds that threaten the achievement of NHS C&M's objectives. It is a dynamic document, populated through the organisation's risk management process, enabling risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how these risks should be treated. The ICB will have a Corporate Risk Register and 9 Place Risk Registers.
Controls	<p>The systems or processes we <i>currently</i> have in place to prevent a risk from occurring, or to reduce the potential consequences and likelihood. Examples of possible controls include:</p> <ul style="list-style-type: none"> • Implementation of policies and guidance • Management structure and accountabilities • Corporate and clinical governance processes • Statutory frameworks e.g., Standing Orders, Standing Financial Instructions, Scheme of Delegation • Incident reporting, complaints, and patient and public feedback procedures • Staff recruitment, retention and training.
Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved.
Assurance Framework	A structured means of identifying, mapping and assessing sources of assurance in relation to the strength and effectiveness of internal controls to mitigate the risks to the organisation's objectives. By receiving and reviewing actual assurances and using findings, the adequacy of internal control can be confirmed or modified.
Board Assurance Framework	The document used to capture and provide assurance to the ICB's board in relation to the control of the principal risks and delivery of the strategic objectives.
Principal Risks	The key risks, of such significance that should they be realised, would prevent NHS C&M from delivering its strategic objectives, continuing to operate and/or seriously affect its performance, future prospects or reputation. These include

	risks that would threaten the business model, future performance or financial sustainability of NHS C&M.
Corporate Risks	Risks that threaten the delivery of the ICB's operational plan, statutory functions and duties. These are assessed with reference to the impact and likelihood for the ICB as a whole and in some cases will be an aggregation of risks being managed in the 9 places.
Place Risks	Risks that threaten the delivery of the ICB Place objectives, operational plans, statutory functions and duties in each of the 9 places. These are assessed with reference to the impact and likelihood for the place. The same or similar risks may exist in more than one place but would be assessed independently in the context of the environment and situation in each place. Risks will be aggregated across the 9 places and assessed with reference to the impact and likelihood for the ICB as a whole for the purposes of inclusion on the Corporate Risk Register.
Risk Appetite	The amount of risk that NHS C&M is willing to seek or accept in the pursuit of its strategic objectives. This is determined by the Board in relation to each strategic objective and is reviewed annually. It is used by the leadership team to determine what potential options will / will not be considered in pursuing these objectives.
Risk Tolerance	The boundaries of risk taking outside of which NHS C&M is not prepared to venture in the pursuit of its strategic objectives. This is determined by the Board and reflected in this Risk and Assurance Strategy. It is used by leadership to determine where action is required to improve control and when risks require escalation.

6. Organisational Arrangements for Risk Management and Assurance

The ICB recognises that a robust risk management system is a key component of the organisation's system of internal control and serves to provide assurance to key stakeholders of its capability to deliver its objectives. NHS C&M's Board, Committees, Executive and Senior Teams are committed to establishing an organisational culture that embeds effective risk management into its corporate planning and management systems at all levels of the organisation. This is delivered through robust governance arrangements and clear accountabilities for ensuring effective risk management.

Roles and Responsibilities

Specific accountabilities, roles and responsibilities for risk management are set out below and provide a structure that supports the integrated approach to risk and governance. The NHS C&M governance structure is attached at Appendix 2.

The Integrated Care Board (the Board)

The Board is responsible for implementing the strategic direction for NHS C&M, ensuring delivery of the organisation's objectives, and that structures are in place to reflect the organisation's roles and responsibilities. It will consider each individual aspect of governance at an adequate level of detail but also bring them all together to give the organisation appropriate assurance.

The Board will determine the ICB's risk appetite in relation to the achievement of its strategic plan, which will inform strategic decisions and control efforts; and it will identify the principal risks to the organisation.

The Board is committed to providing the resources and support systems necessary to support the Risk Management and Assurance Strategy. It has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

- a) Identifying risks which may prevent the achievement of its strategic objectives

- b) Determining the organisation's level of risk appetite in relation to the strategic objectives
- c) Proactive monitoring of identified risks via the Board Assurance Framework and Corporate Risk Register
- d) Ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
- e) Receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
- f) Demonstrating effective leadership, active involvement and support for risk management

Audit Committee

The **Audit Committee** is part of the organisation's internal governance structures, systems and processes, and contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

In relation to Risk Management, the core responsibilities of the group include:

- reviewing the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board
- having oversight of principal risks, key controls and assurances where they relate to the achievement of the ICB's objectives.
- having oversight of corporate and place risks by exception where these are escalated or for the purposes of providing assurance to the Board on the adequacy of risk management arrangements

In carrying out this work the Committee will utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from officers and Board members as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Risk Committee

A Risk Committee will be established on an interim basis to support the Audit Committee in overseeing the successful implementation and development of this strategy and the embedding of effective risk management systems across the ICB. Its principal functions will be to:

- Oversee the implementation and further development of the risk management strategy, systems and processes
- Support the development of an effective risk culture and understanding of roles and responsibilities across the organisation and system
- Review and moderate risks ensuring completeness, consistency, and compliance with the ICB strategy and processes
- Develop and monitor key performance indicators on the operation of the risk management system
- Work with partners on the development of a system approach to BAF and risk management in relation to joint strategic objectives

Other Committees

All committees and sub-committees of NHS C&M are responsible for:

- providing assurance on key controls where this is identified as a requirement within the Board Assurance Framework
- ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed

Non-Executive Board members play a critical role in providing scrutiny, challenge, and an independent voice in support of robust and transparent decision-making and management of risk. A board appointed Chair will be assigned to each Committee and will be responsible, with the risk owner and the support of committee members, for determining the level of assurance that can be provided to the Board in relation to risks assigned to the committee and overseeing the implementation of actions as agreed by the Committee.

NHS C&M's governance lead

NHS C&M will appoint a member of staff whose responsibilities include being the designated governance lead for NHS C&M. The governance lead is responsible for the development and delivery of the Risk Management and Assurance Strategy and associated operational procedures including:

- promoting effective risk management and demonstrating leadership, involvement and support;
- preparing the Risk Management and Assurance Strategy for review by the Audit Committee and approval by the Board
- ensuring the development of risk management policy, procedures, standards and guidance to support the effective delivery of the strategy
- supporting the Audit Committee Chair in forward planning and agenda setting in respect of risk management and ensuring that committee members are aware of best practice, national guidance and other relevant documents and have access to independent advice as appropriate
- responding to requests from the Audit Committee and the Board for reports and positive assurance on risk management arrangements
- leading the preparation and regular updating of the Board Assurance Framework and Corporate Risk Registers for review by relevant Committees and the Board
- assuring the effective and consistent implementation of the risk management and assurance arrangements corporately and at place level
- identifying the training needs of the board, its committees, sub-committee and staff and ensuring these are met

Risk Leads

Each identified risk will have an Operational Lead, who as the operational owner, has responsibility for managing and reviewing the risk. This includes assessment, the identification and implementation of actions to mitigate the risks, and compliance with reporting arrangements such as updating the risk register, escalating risks and providing assurance to the relevant committee.

Each identified risk will also have a Senior Responsible Lead, who will be accountable to the Chief Executive, the relevant committee and the Board for ensuring that the risk is appropriately managed. This includes approving the risk assessment and mitigation strategy, oversight of risk management and compliance with reporting arrangements, such as the escalation of risks and providing assurance to the relevant committee and to the Board as appropriate.

Place Directors will be the Senior Responsible Leads for place risks, and a member of their team will be assigned as the Operational Lead. Where the same or similar risk exists in a number of places, this may require collaboration between places and with the relevant ICB Executive Director / Director to determine the appropriate organisational mitigation strategy. It may be appropriate for this to be led corporately or by one place on behalf of others; or for the agreed mitigation strategy to be applied in each place proportionate to the risk level in that place.

Thematic / Portfolio Leadership Teams

Executive Directors / Directors will be the Senior Responsible Leads for all corporate risks which fall within their portfolio. This includes the aggregation of place risks into a single corporate risk where the same or similar risk exists in a number of places. It is anticipated that the majority of principal risks will be led by ICB Executive Directors / Directors.

Thematic / portfolio leadership teams for quality, performance, finance, workforce, etc, led by the relevant Director and including representatives from each place will provide a holistic view of aggregated risk across the ICB. Their role in relation to risk management will include:

- Supporting the relevant committee in its oversight and assurance role in relation to thematic risks
- Considering where risks identified in one place have an impact across other places or the wider organisation and allocating operational and senior leadership roles
- Reviewing risks escalated from directorate, programme and project risk registers and making recommendations to Senior Leads regarding inclusion on Place and / or the Corporate Risk Register
- Reviewing risks where agreed actions are not progressing or having the required effect, and making recommendations to the Senior Lead to address this

- Reviewing all potentially extreme risks and making recommendations to the Senior Lead and Assistant Chief Executive for addition to the principal risks and inclusion on the Board Assurance Framework

All Managers

All managers are responsible for:

- Familiarising themselves with the Risk Management Strategy and associated procedures and guidance, and for raising awareness and understanding of risk management within their work area;
- Reviewing their areas of work to identify risks, agree appropriate actions and escalate risks as necessary;
- Fostering a supportive work environment to facilitate the reporting of risks;
- Investigating risks reported to them by staff;
- Ensuring staff have access to opportunities for training and development; and
- Ensuring that risk management is a regular agenda item at team meetings.

All Staff

All staff are responsible for:

- Attending mandatory and statutory training;
- Co-operating with arrangements for minimising risk;
- Working to NHS C&M procedures;
- Taking reasonable care for their own safety and that of others;
- Taking care of NHS C&M buildings, equipment and other assets; and
- Reporting risks, incidents and near misses using the correct processes and documentation.

Other Specialist Expertise

Expertise in specific areas of risk may be obtained from a number of sources, both internal and external, such as:

- Governance and Quality Leads at NHS England and Commissioning Support Services
- Health and Safety Lead from Commissioning Support Services
- Occupational Health Manager from locally commissioned service
- Local Anti-Fraud Specialist (AFS)
- NHS Resolution
- Health & Safety Executive (HSE)

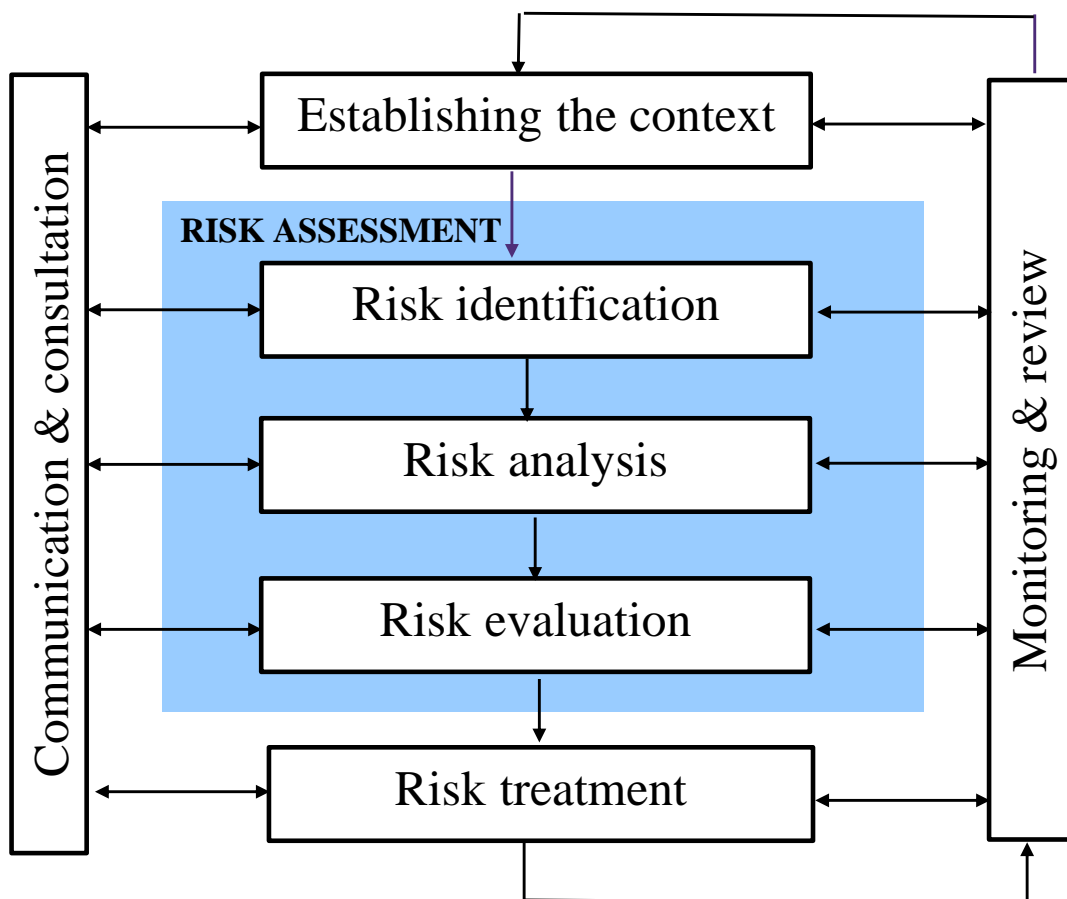
EPRR Risks

The Emergency Preparedness, Resilience and Response (EPRR) agenda is an integral component of the ICB's business. The ICB will meet its 'duty to assess risk' by drawing from various sources such as community risk registers, events planning and participation in multi-agency exercises. Any high/extreme risks to ICB objectives arising from EPRR related threats / activities will be added to the appropriate risk register (at ICB level and / or relevant Place).

7. Risk Management: Systems & Processes for the Management of Risk

Risk Management Process

It is accepted that it is neither realistic nor possible to totally eliminate all risk. It is however, feasible to develop a systematic approach to the management of risk so that adverse consequences are minimised, or in some cases, eliminated. The risk management process is illustrated below with each stage described in the following sections.



Establishing the Context: Strategy, Objective Setting and Risk Appetite

The UK Corporate Code of Governance sets out that ‘The board should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the company is willing to take in order to achieve its long-term strategic objectives.’

NHS C&M is a new organisation within a changing and developing NHS and public sector landscape. The scale of financial challenge across the system and pace of change makes effective risk management essential. This includes the need to maximise opportunities which in themselves may require a degree of risk taking.

The Board will be responsible for implementing the ICB’s strategic plan, reflecting the organisation’s purpose and the C&M HCP Strategy. The annual planning process will translate this into strategic objectives for the ICB operating corporately and in the 9 places. The annual strategic objectives will set out clear measurable delivery over the coming year towards achievement of the medium and long term goals.

As part of the annual planning process the board will carry out a robust assessment of the organisation’s emerging and principal risks. This aims to identify the significant external and internal threats to the achievement of the ICB’s strategic goals and continued functioning.

The Board will agree and review annually the ICB’s risk appetite statement to ensure that decision makers across the organisation are clear regarding the level of risk they are permitted to expose the organisation to, and where to escalate and target action in improving controls. The statement will include:

- Risk appetite - the amount of risk that NHS C&M is willing to seek or accept in the pursuit of its strategic objectives, which will form part of the annual planning process and be set out in relation to each strategic objective.

- Risk tolerance - the boundaries of risk taking outside of which NHS C&M is not prepared to venture in the pursuit of its strategic objectives. The general approach is set out below and the board may add further boundaries e.g. in respect of patient safety or specific activities.

NHS C&M's risk tolerance is as outlined below:

- **Risks rated 1 - 6** are regarded as '*tolerable (low and moderate)*' and are managed locally or within relevant directorate areas. Risks should be monitored by Operational Leads and at relevant directorate and team meetings and reviewed quarterly by Senior Responsible Leads or in the event of an increase in the risk rating.
- **Risks rated 8 - 12** are regarded as '*high*' and relevant departmental managers / heads of service must be assigned as the Operational Lead. These risks require active management with the aim of mitigating to a tolerable level and should be reviewed monthly by Senior Responsible Leads. These risks will be added to the appropriate Corporate and/or Place Risk Register and reviewed on a regular basis by the relevant Committee.
- **Risks rated 15 - 25** are regarded as '*extreme*' and outside of tolerable limits. These require immediate escalation to the relevant Senior Responsible Lead and consideration should be given to curtailing or ceasing the activity giving rise to the risk where this does not present greater risk. These risks will be added to the appropriate Corporate and/or Place Risk Register and reviewed on a regular basis by the relevant Committee and the ICB Board.

Risk Assessment

Risk assessment is the systematic process of identifying, analysing and evaluating risks, to inform decision making regarding the appropriate risk treatment.

Risk Identification

NHS C&M is exposed to a wide range of potential risks which may threaten the achievement of the strategic objectives or delivery of statutory functions.

Principal Risks

Principal Risks will be identified annually as part of the corporate planning process, aligned to the review and establishment of strategic objectives and strategic challenges.

NHS C&M's identification of strategic challenges informs the development of Principal Risks. A Principal Risk is a risk that can seriously affect the performance, future prospects or reputation of NHS C&M and is captured on the Board Assurance Framework.

The Principal Risks are defined and agreed by the ICB Board (top down) and reflect the major risks that could prevent the board from fulfilling the objectives in the ICB Strategy.

In addition to Principal Risks being informed (top down) as part of the strategic objectives, risks identified through the planning and delivery of the strategic objectives and statutory functions (bottom up) can pose a high level of risk to the performance, future prospects or reputation of NHS C&M. Such risks would be escalated to the Corporate Risk Register.

Risks may arise from external factors such as:

- Patient/ Public:** those associated with the failure to meet the current and changing needs and expectations of our population – patients & public
- Political:** those associated with the failure to deliver government or local membership policy
- Economic:** those affecting the ability of NHS C&M to meet its system financial targets – also acknowledge the ability of organisations within the C&M Integrated Care System to meet their own financial targets
- Social:** those relating to the effects of changes in demographic, residential or socio-economic trends
- Technological:** those associated with the capacity of NHS C&M to deal with the pace or scale of technological change or effectively harness technology to deliver its objectives
- Environmental:** those relating to the environmental consequences of progressing NHS C&M's strategic objectives
- Legislative:** those associated with current or potential changes in law

Risks may arise from internal factors such as:

- a) **Clinical:** those related to the delivery of effective care and treatment
- b) **Contractual:** those related to the failure of providers to deliver services
- c) **Business:** those affecting the delivery of the CCG's operational business plans
- d) **Health and Safety:** those related to accident prevention and securing the safety and welfare of patients, staff and visitors
- e) **Financial:** those associated with financial management
- f) **Workforce and recruitment:** those related to the ability to attract, develop and retain required capacity and skills
- g) **Legal liability:** those related to possible breaches of legislation
- h) **Estate and technological:** those related to reliance on buildings and operational equipment

The identification of risks is the responsibility of all ICB staff and will be done proactively, via regular planning and management activities and reactively, in response to inspections, alerts, incidents and complaints. The following are examples of some of the ways in which NHS C&M will identify risks, although this is not intended to be exhaustive:

Incidents and Complaints - All incidents and complaints must be reported and managed in line with NHS C&M's procedures. Any risks identified as part of these processes must be assessed and managed in line with these procedures. The reporting of incidents and near misses is an efficient and effective system for identifying risk. This allows rapid alert to ascertain why and how incidents occurred and facilitates a fast response in the case of adverse events, which may lead to a complaint or litigation. It enables lessons to be learnt and therefore prevent recurrence. This is best achieved in a supportive management environment where a 'fair blame' culture is advocated and makes explicit the circumstances in which disciplinary action may be considered. All incidents and near misses will be reported and managed using the NHS C&M incident reporting system in line with the Serious Incident Management Policy.

Procedures and Guidance - NHS C&M staff operate within the boundaries and principles set out in corporate policies. There is a process for ensuring that all necessary procedures and guidance that sit beneath these policies are in place, up to date and easily accessible. All risks identified through the development and implementation of procedures and guidance must be assessed and managed in line with this framework. These policies / procedures / frameworks are located on the intranet.

Group Reports - All NHS C&M committees / sub-committees should consider a regular agenda item on the review of risks. All risks identified and reported in this way must be assessed and managed in line with this framework.

External Assessments - NHS C&M will be subject to external assessments and audits. Any risks identified in relation to the requirements of an external assessment must be assessed and managed in line with this framework.

Internal Audit - NHS C&M will be subject to its own internal audit programme. All risks identified through the internal audit process must be assessed and managed in line with this framework.

Risk Analysis

The corporate risk summary will be used to analyse and record each identified risk to include:

- Risk description which should include the cause, effect and impact on the organisation
- Ownership of the risk including operational and executive leadership and overseeing committee
- Strategic objective or function that will be impacted by the risk
- Controls that are currently in place to mitigate the risk and an assessment of their effectiveness
- An evaluation of the impact and likelihood of the risk using the ICB's risk matrix at appendix 1 to arrive at a risk rating
- Risk proximity

Supporting procedures and the current NHS C&M risk management proformas will be available on the corporate intranet. Training and guidance will be available from the Governance Team.

Risk Evaluation

The purpose of risk evaluation is to assess the severity, in the context of the ICB's risk appetite and determine the appropriate risk treatment. The evaluation takes into account the appetite to accept the risk following mitigation.

It should be acknowledged that it is not always possible to show continuous improvement in all risk ratings or eliminate risk completely. For those risks that cannot be removed / reduced entirely, the risks must be mitigated to a level, which the organisation is willing to tolerate.

When assessing individual risks, the following questions should be considered to assist in determining whether a risk is acceptable:

- What is the level of risk currently being faced?
- What is the likely impact?
- Can we tolerate the possibility of that risk actually happening?
- If not, do we want or need to do more?
- Will the cost of managing this risk outweigh the benefit?

Completed risk assessments will be reviewed by the ICB's Risk Management Group for moderation purposes to ensure that it has been described and evaluated in accordance with this strategy and to promote consistent application across the ICB.

Risk Treatment

When the risk assessment has been moderated and the risk has been accepted onto the risk register, the Operational Lead needs to consider how it will be treated. It is not always possible to identify and then fully implement actions to eliminate or minimise a risk. Where this is the case it is essential that the significance of the risk that remains is understood and the organisation, with reference to the risk appetite and in accordance with the risk management governance, confirms that it is prepared to accept that level of risk (residual risk).

The level and type of treatment of risks will vary depending on the level of residual risk that has been determined and the tolerance for bearing any negative outcomes that result from a risk actually happening.

There are four different types of treatment for any risks. Each risk can be:

- **Terminated** – by simply not carrying out the activity that may cause the risk. In reality it is very difficult to terminate a risk in this way.
- **Transferred or shared** – by outsourcing an activity to pass the responsibility of the risk on to another organisation or individual. Again, in reality, it is rare that this option is available.
- **Managed through taking action** – this is the most common treatment. This can include doing something to help ensure that possible negative impact of a risk does not increase. It can also include doing something to minimise any impact should the risk occur (such as identifying contingent actions).
- **Tolerated** – a Risk Owner may feel that the level of residual risk exposure is acceptable and no further actions are necessary, or even possible. For example:
 - The risk is sufficiently low that treatment is not considered cost effective.
 - A treatment is not available e.g. a project terminated.
 - A sufficient opportunity exists that outweighs the perceived level of threat.

However, if a risk is being tolerated it still needs to be regularly monitored, as circumstances may change which could result in a different treatment in the future.

The completed risk assessment, including the proposed mitigation treatment, will be submitted to the appropriate Senior Responsible Lead for review and approval prior to inclusion on the relevant risk register.

Risk Monitoring and Review

Risk registers will be maintained for the purposes of monitoring and reporting on risks including:

Corporate Risk Register: to record all the risks which are rated as high (12+) in the context of the ICB as a whole. This will include risks to corporately delivered objectives and functions and aggregated risks across place-based objectives and functions. Risks will be categorised by strategic objective or, where they don't relate to the

delivery of a strategic objective, by functional themes of quality, finance, performance, workforce. All risks on the Corporate Risk Register will be allocated to an ICB Committee for oversight and assurance to the Board.

Committee Risk Registers: will reflect those risks attributed to each committee which are rated as high (8+) in the context of the ICB as a whole, together with any relevant place risks rated as extreme (15+) in the context of the place.

Place Risk Registers: to record all the risks to the ICB which are rated as high (8+) in the context of the place. Risks will be categorised by strategic objective or, where they don't relate to the delivery of a strategic objective, by functional themes of quality, finance, performance, workforce. Risks may appear on more than one place risk register, but the risk rating may vary reflecting the circumstance of each place. Risks rated as extreme (in the context of the place) will be escalated to the relevant ICB Committee.

Directorate Risk Registers: to record all the risks owned by a corporate or place directorate. Risks will be categorised by strategic objective or, where they don't relate to the delivery of a strategic objective, by functional themes of quality, finance, performance, workforce. Risks may appear on more than one place risk register, but the risk rating may vary reflecting the circumstance of each place. Where the aggregate of a risk across a number of places results in a high rating in the context of the ICB as a whole the risk will be recorded on the appropriate corporate director risk register.

Programme and Project Risk Registers: will be maintained for all corporate and place programmes and projects. Risks that cannot be managed locally or will have a significant impact on operational objectives (i.e. risks rated as high) will be escalated to the relevant Place and / or Corporate Risk Register and reported to the relevant committee.

Risk owners should monitor their risks – reviewing & evaluating regularly in order to:

- Confirm that action plans to address risks are being undertaken and completed
- Report any change in assessment of the impact and likelihood of the risk
- Confirm that the risks are still relevant within the changing environment
- Escalate if necessary, including if the risk cannot be managed at the current level; and
- Agree mitigating action target dates and provide an explanation as to why original target dates have not been met, for strategic and principal risks, if applicable.

The review process should fulfil the following requirements. It should:

- Monitor whether controls remain aligned to risks in their area of responsibility
- Monitor whether key risks are being managed within the risk appetite in their area of responsibility
- Monitor the risk profile and key risks identified by the process and how they are changing over time
- Monitor the progress of actions to treat key risks and the operation of key controls
- Escalate issues
- Re-prioritise resources; and
- Make better informed decisions.

Operational Leads will be prompted to review their risks monthly.

Risk Escalation

Risk escalation within NHS C&M supports the established leadership and reporting processes as described and illustrated below. Risks will similarly be de-escalated where risk ratings reduce.

Corporate (ICB Wide) Risk Score	Place Based Risk Score	Escalated to	Oversight by
High / Extreme (12+)		Corporate Risk Register	ICB Board
High (8-10)	Extreme (15+)	Committee Risk Register	ICB Committee
	High (8-12)	Place Risk Register	Place Board / Sub-Group
Moderate / Low (1-6)	Moderate / Low (1-6)	Directorate Risk Register	Management Team

Low and moderate risks will be recorded on the appropriate directorate, programme or project risk register. They will be managed through monthly monitoring and the continued application of existing controls, reporting to the appropriate team, programme or project meeting. Where risk ratings increase above tolerable limits they will be reviewed by the relevant Thematic / Portfolio Leadership Team and a recommendation made to the Senior Responsible Lead regarding escalation to the relevant Place and / or Committee / Corporate Risk Register and reported to the relevant ICB Committee.

High risks will be recorded on the appropriate Place and / or the Committee / Corporate Risk Register. Risks may be rated high in the context of Place but low or moderate in the context of the ICB as a whole, in which case they will be managed at Place level. They will be managed through monthly monitoring, the actions agreed to address the gaps in control, and the continued application of existing controls, reporting to the appropriate place committee, and for corporate risks to the overseeing ICB committee. Corporate risks rated 12+ will be escalated to the Corporate Risk Register. Where actions are not progressing as agreed or having the anticipated effect on the risk rating, the risk will be reviewed by the relevant Thematic / Portfolio Leadership Team. Any changes recommended to the mitigation strategy, including to target dates, must be approved by the Senior Responsible Lead and reported to the appropriate place or ICB committee.

Extreme risks must be escalated immediately to the Senior Responsible Lead and the NHS C&M Governance Lead to determine the mitigation strategy. This will include consideration to curtailing or ceasing the activity giving rise to the risk where this does not present a greater risk. The risk will be reviewed at the next available meeting of the relevant Thematic / Portfolio Leadership Team and ICB Committee. Place risks rated 15+ will be escalated to the relevant Committee Risk Register and corporate risks to the Corporate Risk Register.

Escalation will be based on the current assessed score reflecting current controls in place. In the case of newly identified risks potentially requiring escalation, there will be a rapid initial assessment and moderation by the operational lead supported by the governance team to confirm the initial assessment and impact of any existing controls.

Escalation of risks as part of the delegated NHS C&M Data Protection Officer

In response to the compliance requirements with the GDPR, NHS C&M will appoint a Data Protection Officer (DPO) who will escalate items of high risk to the relevant NHS C&M decision making point when NHS C&M is processing personal data.

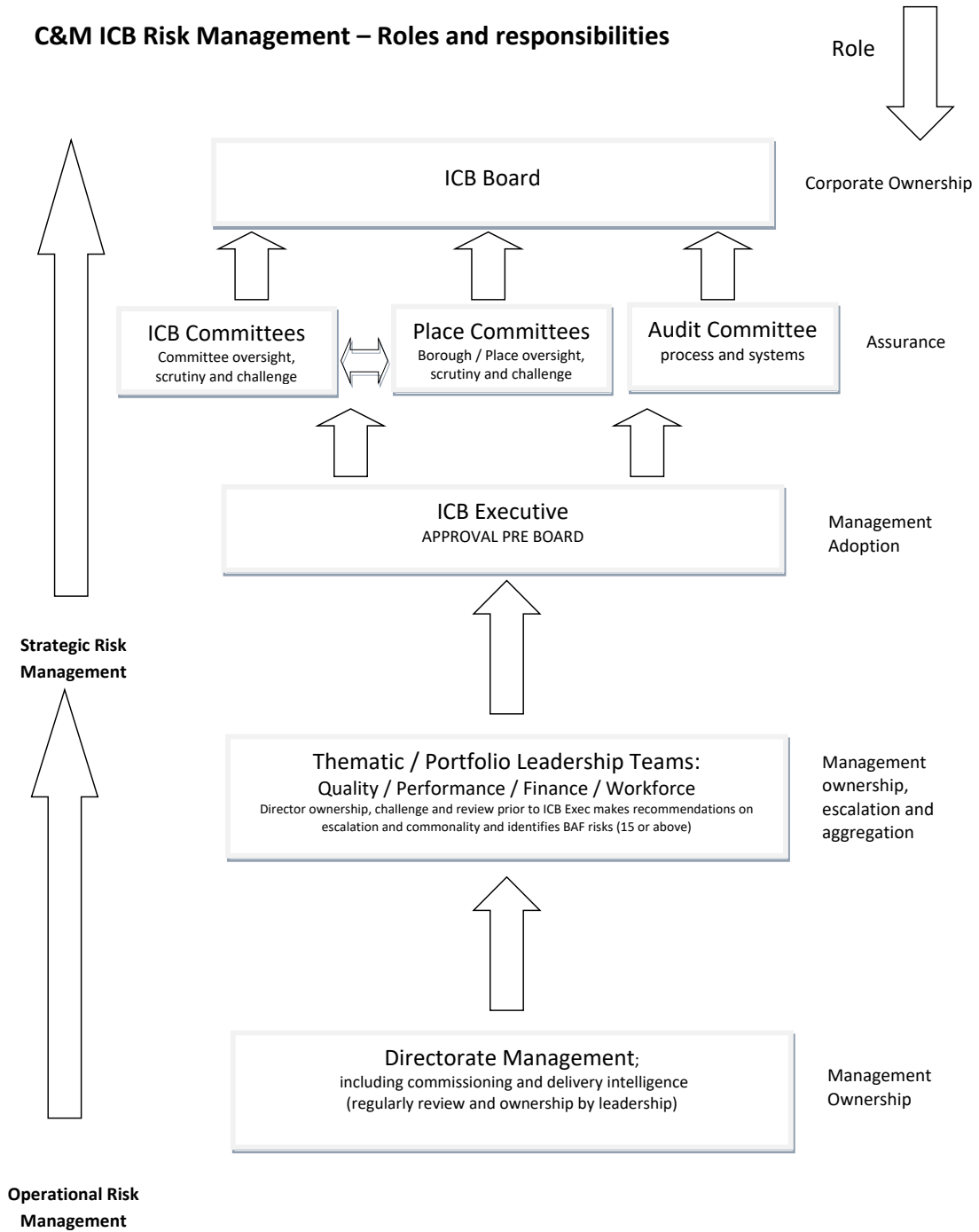
The DPO function supports the existing Information Governance Framework that NHS C&M has in place which supports the operation of IRO and Caldicott responsibilities.

All risks in relation to the processing of confidential, personal or sensitive data scored as Amber/Red or higher that cannot be mitigated any further must be reported/escalated with NHS C&M's governance framework. Once a risk with an anticipated residual risk level of Amber/Red has been identified it must be reported/escalated within 48 hours. The DPO must be emailed directly and the Corporate IG Teams generic email inbox copied into the email (xxxxxx.ig-corporate@nhs.net).

The diagram below illustrates the risk escalation process which supports the leadership and reporting process within the governance structure.

ICB Risk Escalation Process*

C&M ICB Risk Management – Roles and responsibilities

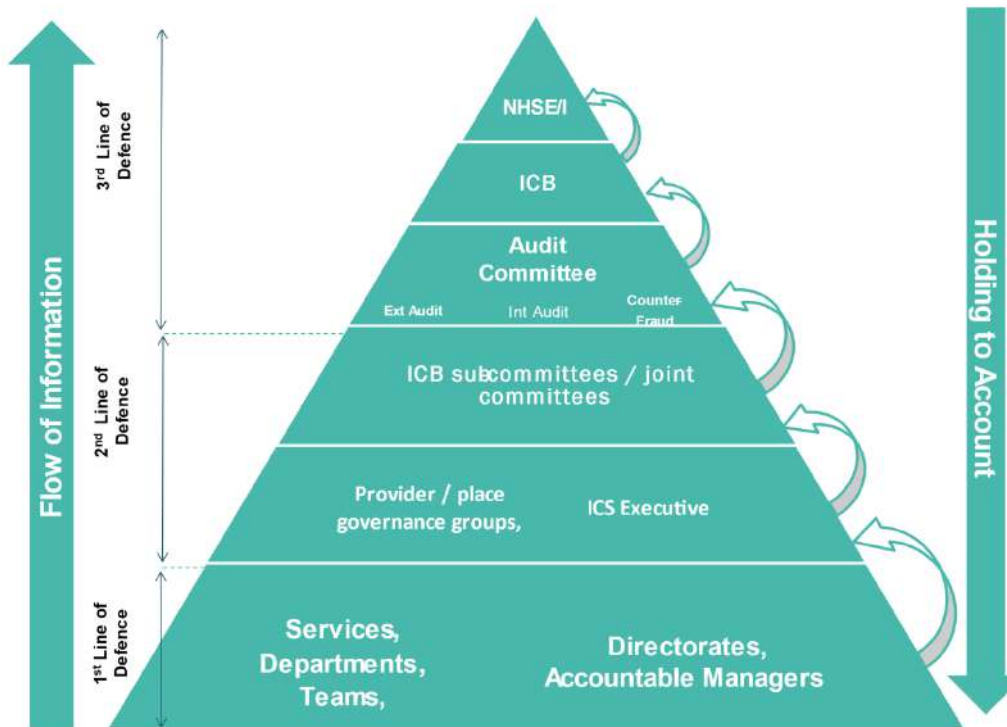


* This focusses on the ICB's risks – i.e. it is NHS-specific. Non-NHS partners may also need to escalate risks in accordance with their risk management / assurance processes.

8. Assurance Framework: Systems & Processes for the Governance of Risk

Governance of Risk – Three Lines of Defence

The assurance framework serves to assure the Board and external stakeholders, regarding effective delivery of the ICB's strategic objectives and statutory functions by providing evidence of effective management of risks. The 'Three Lines of Defence' (LOD) model has been incorporated into NHS C&M's Assurance Plan. To ensure the effectiveness of an organisation's risk management framework, NHS C&M's Exec and senior management need to be able to rely on adequate line functions, including monitoring and assurance functions within the organisation.



This is summarised as:

1. First LOD

Under the 1st LOD, Senior Responsible and Operational Leads have ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.

2. Second LOD

The 2nd LOD comprises strategic leadership and oversight through Board and Place Committees and the Thematic / Portfolio Leadership Groups, which monitors and facilitates the implementation of effective risk management practices by operational management and assists the risk owners in reporting adequate risk related information. In addition this is supported by monitoring and reporting activity undertaken by corporate functions.

3. Third LOD

The 3rd LOD is formed of external review and oversight, including reporting, by auditors to the Audit Committee and the Board as appropriate. This approach might also be supplemented through NHSE oversight and/or regulatory returns and reporting.

Annual Governance Statement

As a statutory body NHS C&M is required to produce an Annual Governance Statement which acts as a statement of assurance that appropriate strategies, policies and internal control systems are in place and functioning effectively, so that key risks which may threaten the achievement of identified strategic objectives are identified, recorded and minimised. Any significant risks identified in the Annual Governance Statement will be recorded on the NHS C&M Board Assurance Framework (BAF) and relevant Committee, Corporate or Place Risk Register.

Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) identifies and quantifies principal risks within the organisation, recording the links between the organisation's strategic objectives, key risks and key controls. The BAF is the means by which the Integrated Care Board (ICB) receives assurance that risks to the delivery of organisational objectives have been identified and are being managed. It provides a list of key pieces of evidence that the Board can use to gain this assurance.

Each principal risk is scored based on the likelihood and consequence of the risk resulting in failure to achieve the strategic objectives (see Appendix 1 for a copy of the Risk Scoring Matrix). The ICB will review the BAF regularly, during its public meeting. A target score will be set for the current financial year. BAF risks meeting their target score may be closed or de-escalated to the Corporate Risk Register for continued monitoring by the relevant committee.

A BAF risk owner, who will be a member of the Executive Team will be assigned to each principal risk, with overall responsibility for the risk and for ensuring actions are implemented; a board appointed Chair will be assigned to each Committee and will be responsible for the relevant group of risks and with the risk owner to ensure the appropriate level of assurance and that actions are implemented as agreed by the Committee.

Supporting procedures and the current NHS C&M assurance framework proformas will be available on the corporate intranet. Training and guidance will be available from the Governance Team.

The Board will regularly review the principal risks and may amend scores and assurance ratings as a result of completed actions or identified concerns.

Corporate and Place Risk Registers

The Corporate Risk Register and Place Risk Registers will be reported quarterly to the Board, together with assurances and any items escalated for action or decision from the relevant ICB committees.

ICB Committee Assurance Role

All risks on the Corporate Risk Register will be assigned to an ICB Committee for oversight and assurance to the Board. It is the role of the committees to scrutinise the assessment and mitigation of risks, holding to account the relevant Senior Responsible Lead for effective management of risks. Committee members should provide appropriate challenge and collectively form a view regarding the level of assurance that can be provided to the Board.

Reporting to the Board will be via committee minutes and key issues reports and the Corporate Risk Register. The committees will escalate any items requiring action or decision by the Board.

Place Delivery Assurance Framework (PDAF)

The Place Delivery Assurance Framework (PDAF) mirrors the format and process of the BAF above but is held at the nine Places across Cheshire & Merseyside. The PDAF will be overseen by the Place Board, and through regular reporting to relevant Committees of the ICB, risks that are identified as being relevant/ affecting multiple places and/ or potentially impacting the achievement of the ICB Strategic Objectives may be recommended to the ICB for review and inclusion on the ICB BAF. Risks may be identified for escalation by the Place Lead, ICB Committee or ICB Risk Management Team.

The PDAF may also contain risks to the delivery of place plans that are owned by partners other than the NHS. The PDAF would therefore need to be clear on the "Ownership" of PDAF entries to ensure appropriate escalation within partners' assurance frameworks.

Place Board and Sub Groups Assurance Role

The Place Board and its Sub Groups will be responsible for oversight and assurance to the Board in relation to all risks on their Place Risk Register. It is the role of the committees to scrutinise the assessment and mitigation of risks, holding to account the relevant Senior Responsible Lead for effective management of risks. Committee members should provide appropriate challenge and collectively form a view regarding the level of assurance that can be provided to the Board.

Reporting to the Board will be via committee minutes and key issues reports and the Place Risk Register. The committees will escalate any items requiring action or decision by the Board.

Audit Committee Assurance Role

The Audit Committee will review the establishment and maintenance of the risk management system and systems of internal control. It will achieve this by:

- Scrutinising the Risk Management and Assurance Strategy prior to approval by the Board
- Reviewing the Board Assurance Framework, Corporate and Place Risk Registers
- Seeking additional information, reports and assurances from Senior Responsible Leads by exception as required
- Receiving regular reports from the Risk Management Group regarding the performance and operation of the ICB's risk management framework
- Considering the outcome and findings of the Internal Audit review of the ICB Board Assurance Framework

9. Monitoring and Reporting

It is essential that organisations are properly informed about risk, and are able provide evidence that they have identified their objectives systematically, managed the principal risks to achieving them through systems of internal control and obtained assurances that risk management arrangements are effective. The Board Assurance Framework and Corporate Risk Registers are designed to fulfil this purpose.

Through a process of audit and monitoring NHS C&M will undertake a review of the risk control measures regularly; using the following risk control and monitoring measures:

- Regular review of the BAF
- Ongoing review of the Corporate Risk Register
- Annual review of the Risk Management Strategy
- Audits undertaken by internal and external auditors
- Aggregated statistical and trend reporting of incidents, complaints and claims to the Board and relevant committees
- Ongoing audit of implementation of the range of risk management policies, procedures and guidelines throughout the organisation

Communication

Consideration should be given as to who needs to be informed of the risk. Consideration should also be given as to whether any external stakeholders should also be informed as the impact may affect the achievement of their objectives e.g. partners and key stakeholders.

10. Training and Awareness

Mandatory training will be given to all new starters during corporate induction. This will include a briefing on NHS C&M Risk Management Framework, and risk reporting processes. Those roles that manage risk e.g. inputting risks into the NHS C&M Risk Management System will also receive appropriate job-specification training as appropriate.

The Risk and Assurance Manager will attend committee or team meetings as required to discuss risk management and help develop awareness.

11. Dissemination and Implementation

This strategy & policy will be disseminated throughout NHS C&M via the regular communication channels and will be available on the intranet and website.

Generic responsibilities in relation to the management of risks are included in individuals' job / role descriptions. Specific responsibilities in relation to managing risks will be outlined in job / role descriptions of relevant members of staff; in addition to the responsibilities stated at section 6.

12. Review

This framework will be reviewed in 3 years, or earlier if there are changes to national guidance or significant changes to the management of risk across the organisation.

13. Appendices

Appendix 3 – Risk Register Reporting Process

Appendix 1 – Risk Matrix

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL	DESCRIPTION – PLACE LEVEL
5	Catastrophic (>75%)	<p>Safety - multiple deaths which is responsibility of ICB. Multiple permanent injuries or irreversible health effects. An event affecting >50 people.</p> <p>Finance - significant financial loss - >1% of ICB budget</p> <p>Reputation - failure to be authorised, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence</p>	<p>Safety - multiple deaths which is responsibility of ICB. Multiple permanent injuries or irreversible health effects. An event affecting >50 people.</p> <p>Finance - significant financial loss - >1% of delegated Place budget</p> <p>Reputation - ICB delegation withheld / withdrawn, sustained adverse local media (3 days+), significant adverse public reaction / loss of public confidence</p>
4	Major (50% > 75%)	<p>Safety - individual death / permanent injury/ disability which is responsibility of ICB. 14 days off work - affects 16 – 50</p> <p>Finance - major financial loss of 0.5-1% of ICB budget</p> <p>Reputation - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public</p>	<p>Safety - individual death / permanent injury/ disability which is responsibility of ICB. 14 days off work - affects 16</p> <p>Finance - major financial loss of 0.5-1% of delegated Place budget</p> <p>Reputation - criticism or intervention by ICB, litigation, adverse local media, adverse public reaction</p>
3	Moderate (25% > - 50%)	<p>Safety - moderate injury or illness, requiring medical treatment e.g. fracture which is responsibility of ICB. RIDDOR/Agency reportable incident (4-14 days lost).</p> <p>Finance - moderate financial loss - less than 0.5% of ICB budget</p> <p>Reputation - conditions imposed on authorisation by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction</p>	<p>Safety - moderate injury or illness, requiring medical treatment e.g. fracture which is responsibility of ICB. RIDDOR/Agency reportable incident (4-14 days lost).</p> <p>Finance - moderate financial loss - less than 0.5% of delegated Place budget</p> <p>Reputation - conditions imposed on delegation by ICB, litigation, local media coverage, patient and partner complaints & dissatisfaction</p>
2	Minor (<25%)	<p>Safety - minor injury or illness requiring first aid treatment</p> <p>Finance - minor financial loss less than 0.2% of ICB budget</p> <p>Reputation - some criticism slight possibility of complaint or litigation but minimum impact on ICB</p>	<p>Safety - minor injury or illness requiring first aid treatment</p> <p>Finance - minor financial loss less than 0.2% of delegated Place budget</p> <p>Reputation - some criticism slight possibility of complaint or litigation but minimum impact on Place</p>
1	Negligible (<5%)	<p>Safety - none or insignificant injury due to fault of ICB</p> <p>Finance - no financial or very minor loss</p> <p>Reputation - no impact or loss of external reputation</p>	<p>Safety - none or insignificant injury due to fault of ICB</p> <p>Finance - no financial or very minor loss</p> <p>Reputation - no impact or loss of external reputation</p>

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	Unlikely The event could occur at some time (<25%)	Possible The event may well occur at some time (25% > 50%)	Likely The event will occur in most circumstances (50% > 75%)	Almost certain The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	IMPACT (severity) of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25
	1-3 Low Risk	4-6 Moderate Risk	8-12 High Risk	15-25 Extreme Risk	

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

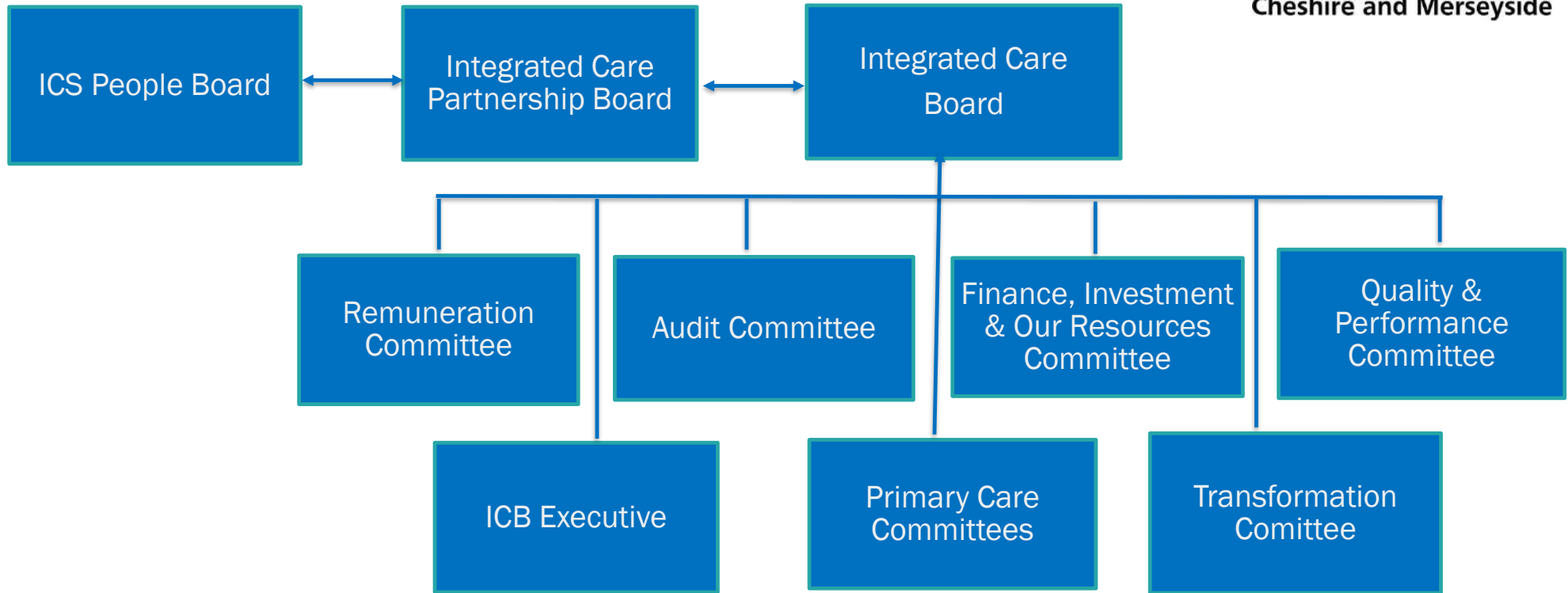
A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	A	B	C

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

ICS Governance Schematic

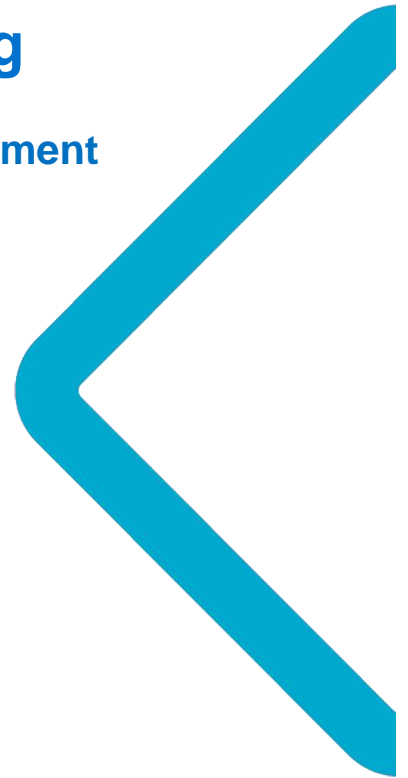


* Our resources reflects the importance of the ICB's people, its workforce, to the ICB

NHS Cheshire and Merseyside Integrated Care Board Meeting

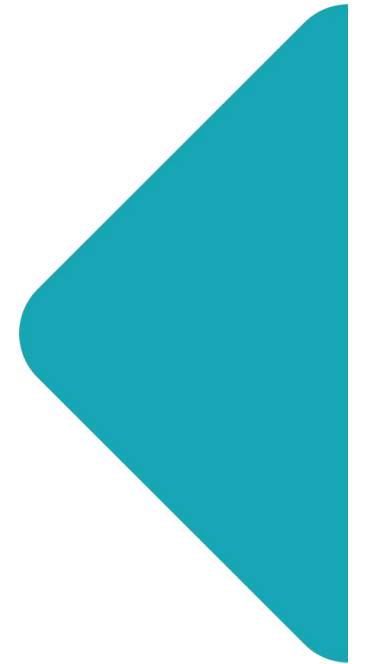
Cheshire and Merseyside ICB Risk Management

Appendix Two: Key Components



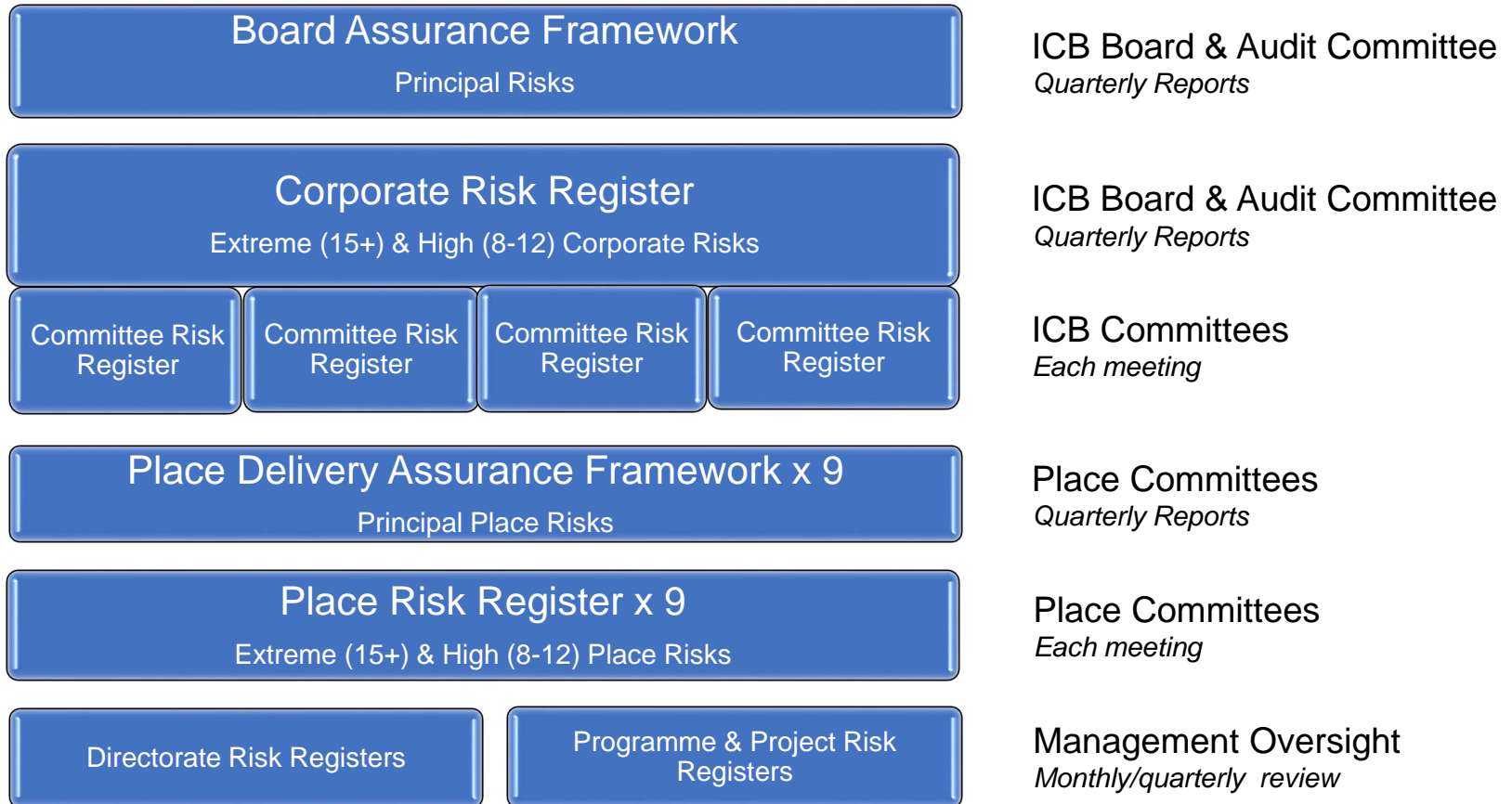
Appendix B

Key Components of the Risk Management Strategy



OFFICIAL-SENSITIVE

Key Components



OFFICIAL-SENSITIVE

Key Risk Definitions

Item	Definition
Principal Risks	The key risks, of such significance that should they be realised, would prevent NHS C&M from being able to operate and/or seriously affect its performance, future prospects or reputation. These include risks that would threaten the business model, future performance or financial sustainability of NHS C&M.
Corporate Risks	Risks that threaten the delivery of the ICB's strategic objectives or statutory functions and duties. These are assessed with reference to the impact and likelihood for the ICB as a whole and in some cases will be an aggregation of risks being managed in the 9 places.
Place Risks	Risks that threaten the delivery of the ICB Place strategic objectives or statutory functions and duties in each of the 9 places. These are assessed with reference to the impact and likelihood for the place . The same or similar risks may exist in more than one place but would be assessed independently in the context of the environment and situation in each place. Risks will be aggregated across the 9 places and assessed with reference to the impact and likelihood for the ICB as a whole for the purposes of inclusion on the Corporate Risk Register.

Risk Impact Scoring

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL	DESCRIPTION – PLACE LEVEL
5	Catastrophic (>75%)	Safety - multiple deaths which are responsibility of ICB. Multiple permanent injuries or irreversible health effects. An event affecting >50 people.	Safety - multiple deaths which are responsibility of ICB. Multiple permanent injuries or irreversible health effects. An event affecting >50 people.
		Finance - significant financial loss - >1% of ICB budget	Finance - significant financial loss - >1% of delegated Place budget
		Reputation - failure to be authorised, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence	Reputation – ICB delegation withheld / withdrawn, sustained adverse local media (3 days+), significant adverse public reaction / loss of public confidence
4	Major (50% > 75%)	Safety - individual death / permanent injury/ disability which are responsibility of ICB. 14 days off work - affects 16 – 50 people.	Safety - individual death / permanent injury/ disability which are responsibility of ICB. 14 days off work - affects 16 – 50 people.
		Finance - major financial loss of 0.5-1% of ICB budget	Finance - major financial loss of 0.5-1% of delegated Place budget
		Reputation - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public	Reputation - criticism or intervention by ICB, litigation, adverse local media, adverse public reaction
3	Moderate (25% > 50%)	Safety - moderate injury or illness, requiring medical treatment e.g. fracture which are responsibility of ICB. RIDDOR/Agency reportable incident (4-14 days lost).	Safety - moderate injury or illness, requiring medical treatment e.g. fracture which are responsibility of ICB. RIDDOR/Agency reportable incident (4-14 days lost).
		Finance - moderate financial loss - less than 0.5% of ICB budget	Finance - moderate financial loss - less than 0.5% of delegated Place budget
		Reputation - conditions imposed on authorisation by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction	Reputation - conditions imposed on delegation by ICB, litigation, local media coverage, patient and partner complaints & dissatisfaction
2	Minor (<25%)	Safety - minor injury or illness requiring first aid treatment	Safety - minor injury or illness requiring first aid treatment
		Finance - minor financial loss less than 0.2% of ICB budget	Finance - minor financial loss less than 0.2% of delegated Place budget
		Reputation - some criticism slight possibility of complaint or litigation but minimum impact on ICB	Reputation - some criticism slight possibility of complaint or litigation but minimum impact on Place
1	Negligible (<5%)	Safety - none or insignificant injury due to fault of ICB	Safety - none or insignificant injury due to fault of ICB
		Finance - no financial or very minor loss	Finance - no financial or very minor loss
		Reputation - no impact or loss of external reputation	Reputation - no impact or loss of external reputation

OFFICIAL-SENSITIVE

Risk Tolerances

Range	Management
Tolerable - rated 1 - 6	Managed locally / within relevant directorate areas. Risks to be monitored by Operational Leads and at relevant directorate and team meetings and reviewed quarterly by Senior Responsible Leads or in the event of an increase in the risk rating.
High – rated 8 – 12	Relevant departmental managers / heads of service to be assigned as the Operational Lead. Active management with the aim of mitigating to a tolerable level and reviewed monthly by Senior Responsible Leads. Added to the appropriate Corporate and/or Place Risk Register and reviewed on a regular basis by the relevant Committee.
Outside of tolerable limits – rated 15 - 25	Immediate escalation to the relevant Senior Responsible Lead and consideration given to curtailing or ceasing the activity giving rise to the risk where this does not present greater risk. Added to the appropriate Corporate and/or Place Risk Register and reviewed on a regular basis by the relevant Committee and ICB Board.

OFFICIAL-SENSITIVE



Key Roles & Responsibilities

- Identifying risks which may prevent the achievement of its strategic objectives
- Determining the organisation's level of risk appetite in relation to the strategic objectives
- Proactive monitoring of identified risks via the Board Assurance Framework and Corporate Risk Register
- Ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
- Receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
- Demonstrating effective leadership, active involvement and support for risk management



Integrated
Care
Board



Key Roles & Responsibilities

- Reviewing the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board
- Having oversight of principal risks, key controls and assurances where they relate to the achievement of the ICB's objectives.
- Having oversight of corporate and place risks by exception where these are escalated or for the purposes of providing assurance to the Board on the adequacy of risk management arrangements
- Utilising the work of internal audit, external audit and other assurance functions
- Seeking reports and assurances from officers and Board members as appropriate



Audit
Committee



Key Roles & Responsibilities

- Providing assurance on key controls where this is identified as a requirement within the Board Assurance Framework
- Ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed
- (Non Executive Board Members) Playing a critical role in providing scrutiny, challenge, and an independent voice in support of robust and transparent decision-making and management of risk
- (Committee Chair) Being responsible, with the risk owner and the support of committee members, for determining the level of assurance that can be provided to the Board in relation to risks assigned to the committee and overseeing the implementation of actions as agreed by the Committee




ICB & Place
Committees



Key Roles & Responsibilities

- Leadership and promotion of effective risk management
- Risk Management Strategy development and supporting procedures, standards and guidance
- Supporting the Audit Committee Chair in forward planning and agenda setting in respect of risk management
- Ensuring that committee members are aware of best practice, national guidance and other relevant documents and have access to independent advice as appropriate
- Leading preparation of the Board Assurance Framework and Corporate Risk Registers
- Assuring and reporting on effective implementation of risk management corporately and at place level
- Identifying the training needs of the board, its committees, sub-committee and staff and ensuring these are met



NHS C&M
Governance
Lead



Key Roles & Responsibilities

- **Senior Responsible Lead** - accountable to the Chief Executive, the relevant committee and the Board for ensuring that the risk is appropriately managed
- **Operational Lead** – accountable to the Senior Responsible Lead for managing and reviewing the risk, including identification, assessment, mitigation and compliance with reporting requirements arrangements
- Risks may be attributed to:
 - Place – assigned to Place Director
 - Multiple Places – assigned to relevant ICB Director or single Place Director on behalf of all
 - ICB wide – assigned to relevant ICB Director



Risk
Leads

NHS Cheshire and Merseyside Integrated Care Board Meeting

Cheshire and Merseyside ICB Risk Management

Appendix Two: Outline of the Board Assurance Framework

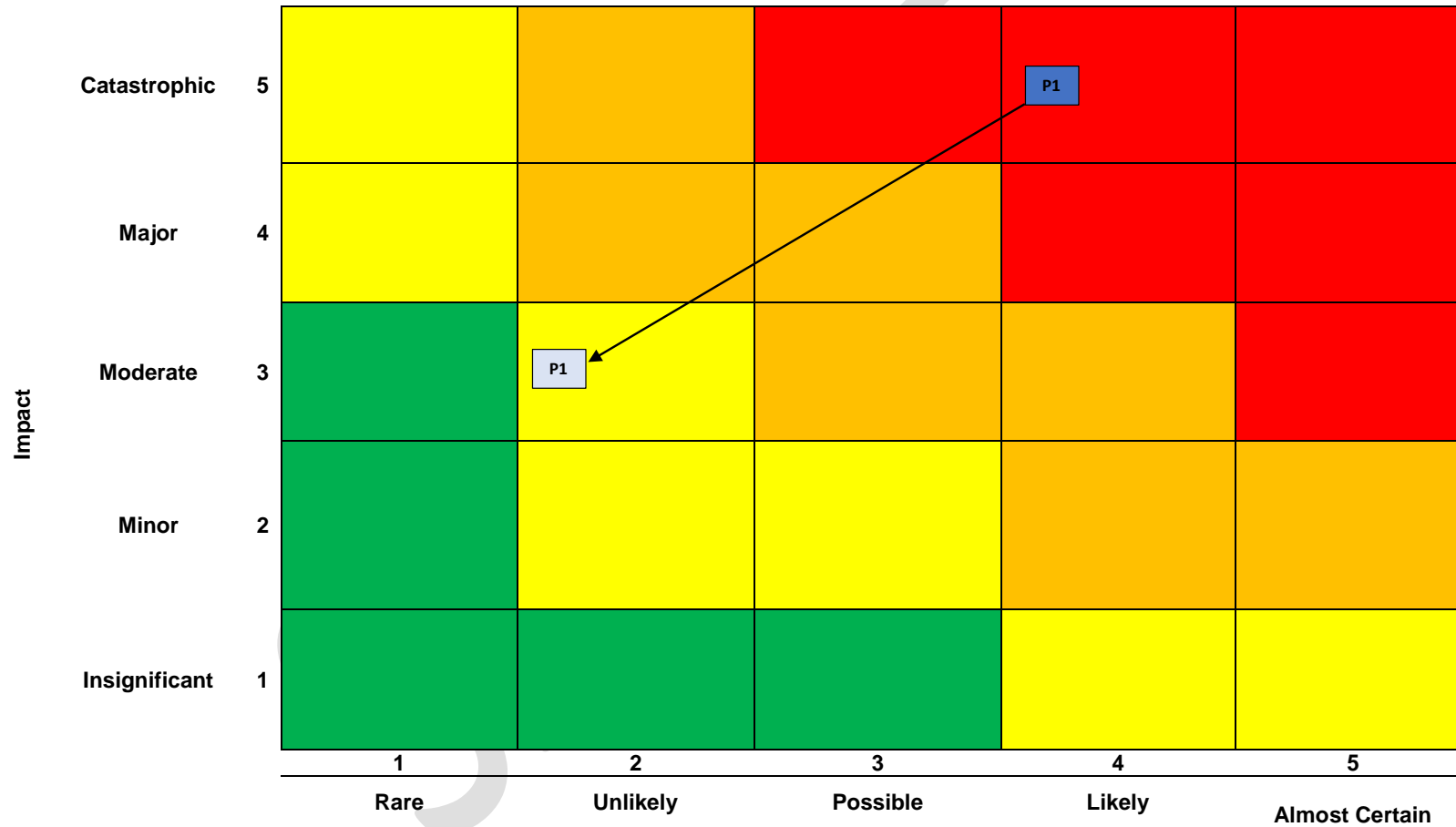


Board Assurance Framework 2022/23

Summary

Principal Risks	Inherent Risk Score (LxI)	Current Risk Score Q3	Change from previous quarter	Risk Appetite	Target Risk Score	Priority Actions / Assurance Activities
Strategic Objective 1: Tackling Health Inequality, Improving Outcomes and Access to Services						
P1: <i>Title of principal risk</i>	4x5=20	4x5=20	↔	Averse	6	Focus on improving existing controls and introducing additional controls within next 3 months
Strategic Objective 2: Improving Population Health and Healthcare						
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money						
Strategic Objective 4: Helping the NHS to support broader social and economic development						

Heat map



Risk Assurance Map

Principal Risks	Residual Risk Score Q3	Controls					1 st line of defence	2 nd line of defence	3 rd line of defence	Assurance Rating
		Policies	Processes	Plans	Contracts	Reporting				
Strategic Objective 1: Tackling Health Inequality, Improving Outcomes and Access to Services										
P1: Title of principal risk	4x5=20									Limited
Strategic Objective 2: Improving Population Health and Healthcare										
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money										
Strategic Objective 4: Helping the NHS to support broader social and economic development										

ID No:	Risk Title:
---------------	--------------------

	Likelihood	Impact	Risk Score	Trend																										
Initial Risk Score <i>[assess on 5x5 scale, this is the score before any controls are applied]</i>				<table border="1"> <caption>Risk Score Trend Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>12</td></tr> <tr><td>May</td><td>12</td></tr> <tr><td>Jun</td><td>10</td></tr> <tr><td>Jul</td><td>12</td></tr> <tr><td>Aug</td><td>16</td></tr> <tr><td>Sep</td><td>16</td></tr> <tr><td>Oct</td><td>16</td></tr> <tr><td>Nov</td><td>12</td></tr> <tr><td>Dec</td><td>12</td></tr> <tr><td>Jan</td><td></td></tr> <tr><td>Feb</td><td></td></tr> <tr><td>Mar</td><td></td></tr> </tbody> </table>	Month	Risk Score	Apr	12	May	12	Jun	10	Jul	12	Aug	16	Sep	16	Oct	16	Nov	12	Dec	12	Jan		Feb		Mar	
Month	Risk Score																													
Apr	12																													
May	12																													
Jun	10																													
Jul	12																													
Aug	16																													
Sep	16																													
Oct	16																													
Nov	12																													
Dec	12																													
Jan																														
Feb																														
Mar																														
Current Risk Score																														
Target Risk Score																														
Risk Appetite																														

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response

Date Raised	Last Updated	Next Update Due

Risk Description

Linked operational risks

Current Controls				Rating
Policies				
Processes				
Plans				
Contracts				
Reporting				
Gaps in control				
<i>[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]</i>				
Actions planned		Owner	Timescale	Progress Update

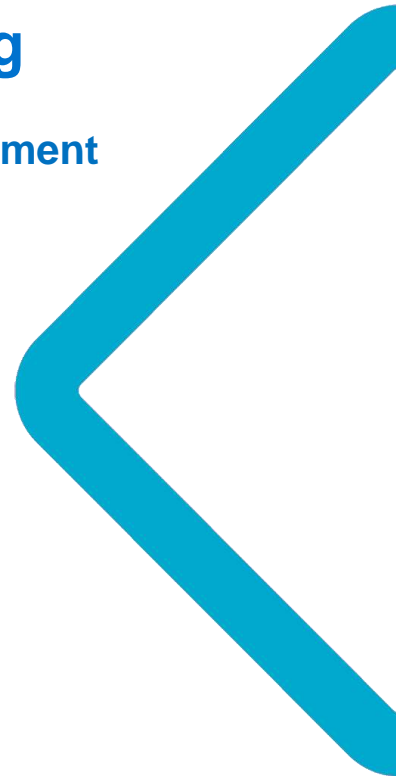
Assurances				
Planned		Actual	Rating	
Gaps in assurance				
<i>[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]</i>				
Actions planned		Owner	Timescale	Progress Update

SAMPLE

NHS Cheshire and Merseyside Integrated Care Board Meeting

Cheshire and Merseyside ICB Risk Management

Appendix Two: Risk Appetite Statement



Cheshire and Merseyside Integrated Care Board

Risk Appetite Statement

Purpose

The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. The ICB aims to create an environment in which risk is considered as a matter of course, appropriately identified and controlled by elimination, or reduction to an acceptable level and at acceptable cost.

The ICB Board is responsible for determining the nature and extent of the risks it is willing to accept. This statement sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds.

Core Statement

'The ICB's overall risk appetite is OPEN – we are willing to consider all delivery options and may accept higher levels of risk to achieve improved outcomes and benefits for patients.'

The ICB has no tolerance for safety risks that could result in avoidable harm to patients.

Our ambitions to improve the health and wellbeing of our population and reduce inequalities can only be realised through an enduring collaborative effort across our system. We will not accept risks that could materially damage trust and relationships with our partners.

We will pursue innovation to achieve our transformational objectives and are willing to accept higher levels of risk which may lead to significant demonstrable benefits to our patients and stakeholders, while maintaining financial sustainability and efficient use of resources. We will support local system / providers to take risks in pursuit of these objectives within an appropriate accountability framework.'

Strategic Objectives

The Board has determined the risk appetite for each of the ICB's strategic objectives based on the following risk appetite definitions:

- **Averse** – Prepared to accept only the very lowest levels of risk, with the preference being the ultra-safe delivery options, while recognising that these will have little or no potential for reward or return – low risk 1-3 (green)
- **Cautious** – Willing to accept some low risks, while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward or return – low / moderate 4 (yellow)
- **Moderate** – Tending always towards exposure to only moderate levels of risk in order to achieve acceptable but possibly unambitious outcomes – moderate 5-6 (yellow)

- **Open** – Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks – high 8-10 (amber)
- **Hungry** – Eager to seek original, creative, pioneering delivery options and accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward or return – high 12+ (amber / red)

Strategic Objective	Appetite	Statement
Tackling Health Inequality, improving outcomes and access to services		
Improve Population Health and Healthcare		
Enhancing quality, productivity and value for money		
Helping the NHS to support broader social and economic development		

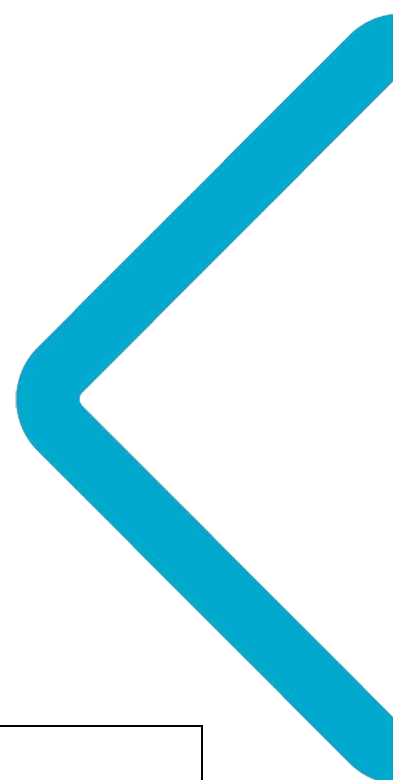
Similarly the Board has defined the risk appetite against the following risk elements:

- **Financial / Value For Money (VFM) – Level X ‘Xxxx’**
Narrative
- **Compliance / Regulatory – Level X ‘Xxxx’**
Narrative
- **Quality and Outcomes – Level X ‘Xxxx’**
Narrative
- **Innovation – Level X ‘Xxxx’**
Narrative
- **Reputation – Level X ‘Xxxx’**
Narrative
- **Workforce – Level X ‘Xxxx’**
Narrative

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Development of a Prioritisation Framework for Cheshire and Merseyside



Agenda Item No	ICB/02/23/14
Report author & contact details	Neil Evans, Associate Director of Strategy and Collaboration 07767 670497 neilevans@nhs.net
Report approved by (sponsoring Director)	Clare Watson Assistant Chief Executive
Responsible Officer to take actions forward	Neil Evans

Cheshire and Merseyside ICB Integrated Care Board Meeting

Development of a Prioritisation Framework for Cheshire and Merseyside

Executive Summary	<ul style="list-style-type: none"> In Cheshire and Merseyside, it has been recognised that it would be beneficial to have a prioritisation framework to facilitate future decision making and prioritise our allocation of resources to priority programme plans. The report describes the approach being taken to developing this framework and the progress made so far in supporting the prioritisation of plans for 2023-24, through an analysis of business intelligence to assess those areas where Cheshire and Merseyside has the greatest opportunity for improvement in outcomes when compared to peers. The output of this analysis is to be considered through a number of stakeholder and public engagement sessions, in order to deliver a set of priorities from within the Cheshire and Merseyside Health and Care Partnership Strategy which will be included in the ICB Joint Forward Plan and the key focus within our Annual Plan for 2023-24. These sessions include the Health and Care Partnership on the 7th of March 2023. In addition to this process a prioritisation framework is being developed which will enable us to assess the transformation proposals against these agreed priorities in order that investment of resources is effective and used to improve outcomes in the most effective way. This process will support the Transformation Committee of the ICB in developing our Transformation Plan. The draft Joint Forward Plan, containing the annual plan, priorities will be presented to the Integrated Care Board meeting on 30th March. 				
Purpose (x)	For information / note	For decision / approval	For assurance	For ratification	For endorsement
	x				
Recommendation	The Board is asked to note the contents of the report including next steps.				
Key issues	The paper outlines work that is taking place to develop a prioritisation framework for Cheshire and Merseyside Integrated Care System.				
Key risks	The risk of not developing a prioritisation framework is that as an Integrated Care System we fail to effectively target our resources at those areas which will have the greatest impact on improving health outcomes for our residents.				
Impact (x) <small>(further detail to be provided in body of paper)</small>	Financial	IM & T	Workforce	Estate	
	x				
	Legal	Health Inequalities	EDI	Sustainability	
		x	x	x	

Cheshire and Merseyside ICB Integrated Care Board Meeting

Route to this meeting	This paper has not been considered at any other committees, but the final prioritisation framework will be approved by the Transformation Committee in May 2023.
Management of Conflicts of Interest	There are no known conflicts of interest
Patient and Public Engagement	<p>A representative from Healthwatch is contributing to the work on the prioritisation framework and the approach to representation on future prioritisation panels will reflect the importance of representing the views of our public. The process being developed in support of the framework includes the principle of coproduction and wide stakeholder engagement as being essential when developing plans.</p> <p>The priorities identified from the work described in this paper will form part of an engagement plan which will request feedback on the priorities described in our Joint Forward, including annual plans. This will take place between April and June 2023.</p>
Equality, Diversity, and Inclusion	<p>An Equality Impact Assessment (EIA) is in production and will be further refined in advance of the Health and Care Partnership Meeting on 7th March.</p> <p>As the final priorities are identified, this EIA will be updated to reflect the final proposed areas of immediate focus within our Joint Forward and Annual Plan.</p> <p>Within the prioritisation framework we are developing, all proposals will be required to have an EIA completed and these will be assessed as part of the prioritisation panel assessment process.</p>
Health inequalities	The prioritisation process has been built around those areas identified as strategic objectives within the interim Health and Care Partnership Strategy and as such reducing Health Inequalities is the key driver behind both the phases of work described in section 4 of the paper.
Next Steps	<ul style="list-style-type: none"> • finalise the recommendations of the working group using the business intelligence analysis to make recommendations to the engagement sessions planned for March, including Health and Care Partnership on 7th March to determine the areas of CMHCP Interim Strategy which should be prioritised. • use these priorities to inform the ICB Joint Forward Plan and annual plan, with a draft to be presented to the ICB Board and Provider Collaborative Boards at the end of March 2023 with a final JFP presented for approval during June. • use these agreed priority areas to complete the design of the Cheshire and Merseyside prioritisation framework scoring matrix. During March and to then start to assess a sample of Transformation Plans to test and refine the framework. • the Transformation Committee will be asked to approve the Cheshire and Merseyside ICS Framework in May 2023.

Cheshire and Merseyside ICB Integrated Care Board Meeting

Development of a Prioritisation Framework for Cheshire and Merseyside

1. Executive Summary

- 1.1. In Cheshire and Merseyside, it has been recognised that it would be beneficial to have a prioritisation framework to facilitate future decision making and prioritise our allocation of resources to priority programme plans.
- 1.2. This report describes the approach being taken to developing this framework and the progress made so far in supporting the prioritisation of plans for 2023-24, through an analysis of business intelligence to assess those areas where Cheshire and Merseyside has the greatest opportunity for improvement in outcomes when compared to peers.
- 1.3. The output of this analysis is to be considered through a number of stakeholder and public engagement sessions in order to deliver a set of priorities from within the Cheshire and Merseyside Health and Care Partnership Strategy, which will be included in the ICB Joint Forward Plan and the key focus within our Annual Plan for 2023-24. These sessions include the Health and Care Partnership on the 7th of March 2023.
- 1.4. In addition to this process, a prioritisation framework is being developed which will enable us to assess the transformation proposals against these agreed priorities in order that investment of resources is effective and used to improve outcomes in the most effective way. This process will support the Transformation Committee of the ICB in developing our Transformation Plan.
- 1.5. The draft Joint Forward Plan, containing the annual plan, priorities will be presented to the Integrated Care Board meeting on 30th March 2023.

2. Introduction / Background

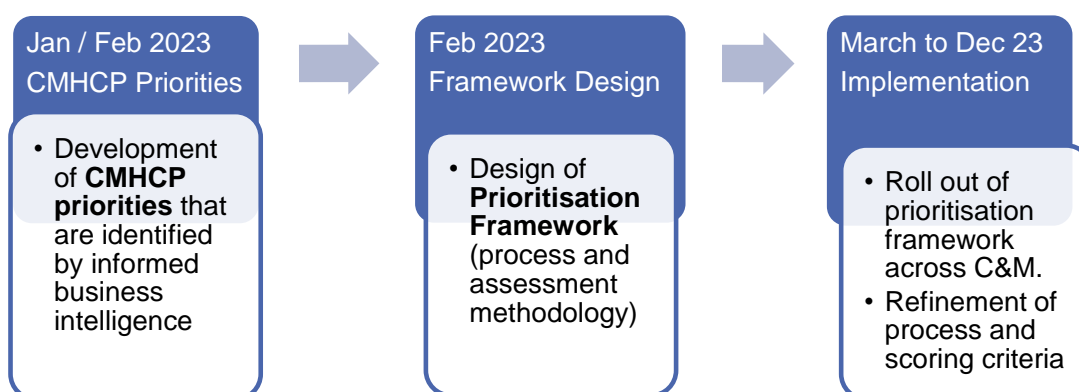
- 2.1. In developing the draft Interim Cheshire and Merseyside Health and Care Partnership (CMHCP) Strategy, it has been recognised that the vast breadth and volume of areas of focus contained within our strategic plans presents a risk, and it is more likely we will improve outcomes by focussing our greatest effort on the highest priorities.
- 2.2. There was support from CMHCP partners for further work to identify which the key priorities within our strategy are and to develop a structured approach to assessing the plans to address these priorities. This would allow us to focus our resources on a smaller number of areas and have a greater impact on the health of our population by making more significant progress in these prioritised areas.

Cheshire and Merseyside ICB Integrated Care Board Meeting

- 2.3. Initial discussions took place between the Cheshire and Merseyside Directors of Public Health and members of the Integrated Care Board, and a task and finish type approach was established to develop a standard approach and gain a consensus on our greatest priorities.
- 2.4. Two workstreams have been established:
- the first workstream is focussed on reviewing the latest available intelligence in relation to population health, health inequalities quality and access with the aim of identifying those areas which should be prioritised within the interim CMHCP Strategy.
 - the second workstream has focussed on developing a prioritisation framework which can be applied to the plans for the five-year period of the strategy but with an immediate focus on 2023-24.
- 2.5. The core team developing these plans has been designed to include a variety of perspectives and includes:
- Champs Public Health Collaborative
 - ICB Strategy and Collaboration
 - ICB Medical & Nursing Directorates
 - ICB Business Intelligence/CIPHA
 - System P
 - ICB Place representation (Liverpool Place)
 - Local Knowledge and Intelligence Service North West, Office for Health Improvements and Disparities (OHID)
 - Healthwatch
 - ICS System Improvement
 - ICB Finance Directorate.

3. Developing the Cheshire and Merseyside priorities

- 3.1. As described in 2.4 we have taken a workstream based approach (see diagram below) to the design and implementation of a prioritisation framework in Cheshire and Merseyside, recognising the challenging timescale associated with national planning processes for 2023-24.



Cheshire and Merseyside ICB Integrated Care Board Meeting

- 3.2. The two workstreams meet weekly in order to maintain momentum on the development of the priorities and Prioritisation Framework.
- 3.3. The primary objective of the **CMHCP Prioritisation Group** is to determine what the key priorities are across the HCP interim Strategy using a range of readily available datasets. Once the priorities are determined, the outputs from this group will be used by the **Framework Design Group** to ensure that the prioritisation framework (essentially a balanced scoring matrix) sets out the right questions and the right weightings that will prioritise existing or new initiatives against the prioritisation criteria.
- 3.4. This approach aims to ensure that investment decisions are backed up by clear evidence and that the work prioritised will have the greatest impact on improving health and wellbeing of the population of Cheshire and Merseyside
- 3.5. It is recognised that where there are nationally mandated activities that as an ICS we must prioritise them, the framework can however be used to assess the scale of additional investment which we would choose to invest in these areas in comparison to other priority areas.
- 3.6. These groups are conducting the key activities described below.

4. Cheshire and Merseyside HCP Prioritisation Group

4.1. Activities being undertaken:

- Analysis by OHID, Business Intelligence and Champs Public Health Consultant to assess population health metrics, health inequality data, access, quality metrics to identify areas C&M is greatest outlier in/has greatest opportunity to improve
- Consider how data fits into existing population priority segments and inequality priorities (System P identified priority cohorts, Core 20+5 disease and population priority groups)
- A summary of the conclusions from this work will be used to inform a number of workshops/meetings during March, including:
 - CMHCP.
 - Provider Collaboratives (both Acute and Specialist Trust and Mental Health, Community and Learning Disability).
 - Primary Care Clinical Forum.
 - Directors of Public Health Group.
- The output of these workshops will be used to inform the priorities in our Joint Forward Plan which will then be used to inform public engagement sessions, including within our Places, both in terms of stakeholders within Health and Wellbeing Boards but also with our communities directly

Cheshire and Merseyside ICB Integrated Care Board Meeting

Update on progress

- 4.2. **Update on Progress.** To date, several data sets and summary analysis have been produced that inform our priorities, and the core group have been working on analysing and interpreting the data to determine our recommended priorities. The different aspects that we have considered include:
- System P / Bridges to Health Population Segmentation
 - Conditions and factors that make the most significant contribution to life expectancy data (health inequalities)
 - Global Burden of Diseases
 - OHID Data – Public Health Outcomes Framework Indicators where Cheshire and Merseyside as a whole, or several places in C&M are performing poorly compared with peers
 - Right Care Data
 - Quality, Access, and Safety Data (indicators)
 - Public Feedback (based on Healthwatch intelligence).
- 4.3. By analysing the different datasets, we are not just considering prioritisation through one lens, e.g., prioritising by condition / disease. We are also bringing in thinking from a population health viewpoint, such as the recognising the approach to supporting those priority population segments identified using “Bridges to Health”, by System P, namely the segments termed as “complex lives” and “frailty and dementia” and to focus on all associated needs for people within these segments not a single condition in isolation.

5. Prioritisation Framework Design Group

- 5.1. It is important to recognise that a prioritisation framework is a supportive approach designed to support systems in making transparent, evidence-based investment decisions across programmes.
- 5.2. Prioritisation frameworks are normally used where there are multiple areas where we would wish to improve outcomes, however, resources are limited, not just in relation to investment but also people to drive improvements forward so the framework can be used to rank and prioritise plans.
- 5.3. Prioritisation frameworks have been tried and tested in health and local authorities for a number of decades and can be a useful engagement tool and way of assessing where to focus attention, especially where there are multiple and complex decisions to be made. They allow for transparency on decision making.

Cheshire and Merseyside ICB Integrated Care Board Meeting

- 5.4. The prioritisation framework, and the scoring matrix used within it, will not give a definitive answer as to our priorities, the process surrounding the tool, the discussions and conversations between stakeholders are the most important aspect, but the scoring matrix will help to drive these conversations and ensure stakeholders on the panel make data and evidence driven decisions.
- 5.5. **Activities being undertaken:**
- A review of prioritisation frameworks already in place in both Cheshire and Merseyside and nationally to identify good practice.
 - Design of a Cheshire and Merseyside prioritisation framework including a scoring matrix and supporting process
 - Work with transformation programmes to identify key interventions to address priorities/improve outcomes based on the priorities identified from the process described in section 4
 - Use the prioritisation framework to assess investment plans and prioritise where to invest the “budget” available to the ICS.
- 5.6. **Update on Progress.** Following a review of the existing frameworks and scoring mechanisms that are already/previously in place in Cheshire and Merseyside CCGs/Places and a national fact-finding exercise, there was a general commonality of approach with most including variations on the original “Portsmouth Scorecard”¹ approach.
- 5.7. Due to this commonality it was agreed by the group it was sensible to adapt an existing model and it was agreed to build a Cheshire and Merseyside Framework using the existing one established in Liverpool place, with the Cheshire and Merseyside context and programme management and governance processes embedded, to convert this to a more generic Cheshire and Merseyside Framework.
- 5.8. The Framework involves consideration of a range of questions and a scoring matrix using a weighted prioritisation criteria determined from the final CMHCP strategic priorities agreed out of the process described in section 4.
- 5.9. A key deliverable for this group is to design the process by which we prioritise, and identify the key evidence required by the “prioritisation panel”. This is using documents already developed as part of the ICB Programme Management approach; i.e. Project Initiation Document and will require key supporting information to evidence the proposal e.g. Equality Impact Assessment, evidence of co-design with key stakeholders, including communities in the plans.

¹ <https://www.nhsconfed.org/system/files/2022-05/Priority-setting-strategic-planning.pdf>

Cheshire and Merseyside ICB Integrated Care Board Meeting

5.10. The proposal is to develop a prioritisation panel to consider plans and assess plans against our agreed prioritisation framework and which reflects both varied experience and perspectives from across Cheshire and Merseyside. A proposed solution to get this breadth is shown below:

- Elected Member - from Place 1
- Finance representative - from Place 2
- Director of Public Health – from Place 3
- Clinical - from Place 4
- Quality – from Place 5
- Public (e.g. Healthwatch) – from Place 6
- Place Director – from Place 7
- Transformation - from Place 8
- Public Health Consultant – from Place 9.

5.12 Recognising that the prioritisation process is new and needs to be embedded, and refined, alongside new programme management and governance processes, in advance of having resource in place in the ICB Programme Management Office functions the suggested approach will be to initially focus on the Cheshire and Merseyside Health Inequalities and Population Health programmes for 2023-24 before expanding more widely.

6. Next Steps

- 6.1. Finalise the recommendations of the working group using the business intelligence analysis to make recommendations to the engagement sessions planned for March, including Health and Care Partnership on 7th March to determine the areas of CMHCP Interim Strategy which should be prioritised.
- 6.2. Use these priorities to inform the ICB Joint Forward Plan and annual plan, with a draft to be presented to the ICB Board and Provider Collaborative Boards at the end of March 2023 with a final JFP presented for approval during June.
- 6.3. Use these agreed priority areas to complete the design of the Cheshire and Merseyside prioritisation framework scoring matrix. During March and to then start to assess a sample of Transformation Plans to test and refine the framework.
- 6.4. The Transformation Committee will be asked to approve the Cheshire and Merseyside ICS Framework in May 2023.

7. Recommendations

- 7.1. The Board is asked to note the contents of the report including the next steps

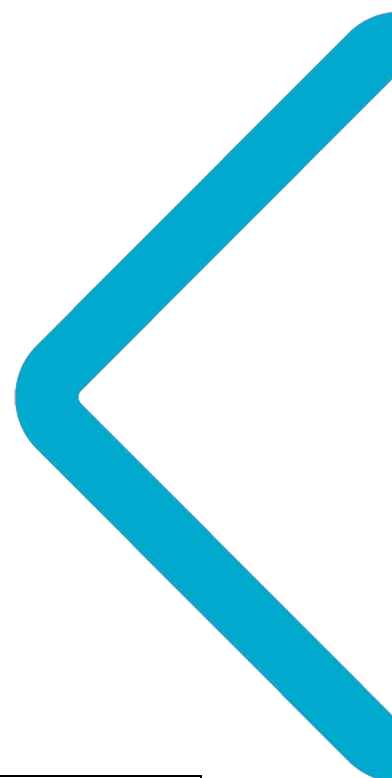
8. Officer contact details for more information

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NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Transfer of delegated commissioning responsibility for general ophthalmic services and primary, community and secondary care dental services add name of report



Agenda Item No	ICB/02/23/15
Report author & contact details	Tom Knight, Head of Primary Care, NHS England - North West, tom.knight1@nhs.net Chris Leese, Associate Director of Primary Care, c.leese@nhs.net
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Tom Knight, Head of Primary Care, NHS England - North West Chris Leese, Associate Director of Primary Care



Cheshire and Merseyside ICB Integrated Care Board Meeting

Transfer of delegated commissioning responsibility for general ophthalmic services and primary, community and secondary care dental services add name of report

<p>Executive Summary</p>	<p>ICBs will assume responsibility for Ophthalmic and Dental Services on 1 April 2023.</p> <p>The ICB assumed responsibility for Community Pharmacy services in July 2022.</p> <p>The paper sets out the position for Cheshire and Merseyside ICB with regard to the delegation of commissioning responsibility for general ophthalmic services and primary, community and secondary care dental services. services.</p> <p>Cheshire and Merseyside ICB has been working closely with the NHS England Regional Team on a process of assurance to support the safe delegation of Ophthalmic and Dental Services which has included discussions to enable effective operating and governance models for the delegated functions.</p>				
<p>Purpose (x)</p>	<p>For information / note</p> <p>X</p>	<p>For decision / approval</p> <p>X</p>	<p>For assurance</p> <p>X</p>	<p>For ratification</p>	<p>For endorsement</p>
<p>Recommendation</p>	<p>The Board is asked to:</p> <ul style="list-style-type: none"> • Note the update regarding the delegation of Ophthalmic and Dental Services to the ICB on 1 April 2023. This update includes a summary of the areas, the budget and provides associated supporting documents in the Appendices. • Note a full breakdown of the financial elements will be included in the draft financial plan that will be shared with the ICB on 10 February 2023. • Note the reported risks to delegation highlighted through the Pre-Delegation Assessment Framework (PDAF) process and assurances required a part of the process. • Approve the work undertaken to date in relation to the delegation of Ophthalmic and Dental Services on 1 April 2023. 				
<p>Key issues</p>	<p>The report provides the Board with an update on the transfer of the delegation of commissioning responsibility for general ophthalmic services and primary, community and secondary care dental services.</p> <p>The report describes the process completed to date, for the transfer of delegated responsibility and references a number of key risks and issues. The document provides additional information included in the Appendices.</p>				
<p>Key risks</p>	<p>A number of key risks have been highlighted in the report. These include:</p> <ul style="list-style-type: none"> • Reputation • Workforce • Service delivery issues 				

Cheshire and Merseyside ICB Integrated Care Board Meeting

Impact (x) (further detail to be provided in body of paper)	Financial	IM & T	Workforce	Estate
	X		X	
	Legal	Health Inequalities	EDI	Sustainability
	X	X		
Route to this meeting	The issues presented in the paper have been considered at the ICB System Primary Care Commissioning Committee and the Pharmacy Dental and Optometry Task and Finish Group.			
Management of Conflicts of Interest	Members of the Board will need to state any conflicts at the Board meeting.			
Patient and Public Engagement	The transfer of commissioning responsibility for these services has been determined by national policy. It should be noted that ICB has been engaging with local Healthwatch organisations as part of the Safer Delegation Checklist process.			
Equality, Diversity and Inclusion	The delegation of services presents opportunities and challenges in the commissioning and subsequently delivery to patients and communities. EDI groups tend to have poorer access, and inequality associated with dental access and eye care and often require specific and culturally sensitively designed services to ensure that all of our population health needs are met.			
Health inequalities	<p>COVID-19 has shone harsh light on some of the health and wider inequalities that persist in our society. It has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination, raising health inequalities as a priority area for systems.</p> <p>Underpinned by CORE20PLUS5, oral health impacts and health inequalities have been and will continue to be considered by dental commissioners. Rapid oral health needs assessments were completed in November 2022 for each of the 9 Places in the ICB. This information will be used by commissioners in response to addressing access issues and the disproportionate impact on some of our populations.</p> <p>Alongside this a key link for commissioning of dental services in the future will be with local authorities who commission or provide oral health improvement programmes to improve population oral health. Local authorities will commission or provide oral health surveys and for 2021-2022 local authorities commissioned a joint children's survey focused on 5 year olds.</p> <p>A variety of additional needs assessments to inform dental commissioning have also been completed including:</p> <ul style="list-style-type: none"> • Specialist Oral Health Services • Inclusion groups – Homelessness • Special Needs Adults 2020 • Paediatric Needs 2020 • Primary Care - Locality Contract performance modelling and oral health inequalities all completed 2022. <p>The work has included engagement with wider stakeholders and patient groups.</p> <p>Eye health impacts are also considered in the context of CORE20PLUS5 by commissioners and this includes a range of services for vulnerable groups and those that are hard to reach.</p>			

Cheshire and Merseyside ICB Integrated Care Board Meeting

	<p>For example we know that Children with learning disabilities are 28 times more likely to have a serious sight problem. Only 1 in 10 have accessed a sight test in a community optician – around half have to go to a hospital eye department to be tested and 44% have never had a sight test – most commonly, children with autism.</p> <p>Homeless people are one of the core groups identified by the NHS as a priority for improving access to healthcare. This is both because of the serious barriers they face in accessing healthcare and because they have more acute health needs than the general population. Improving access to eye care is as important as any other health service and the Local Professional Network for Eye Health published a report relating to homelessness in 2022 and additional service provision was identified to meet the needs of this often hard to reach and vulnerable group.</p> <p>Commissioners will continue to consider health inequalities related impacts to ensure the ICB has given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.</p>
Next Steps	<p>The POD Task and Finish Group will complete the PDAF and Safer Delegation Checklist process and provide assurance to the Board that it will be able to receive the safe transfer of delegated commissioning responsibility for general ophthalmic services and primary, community and secondary care dental services on April 1 2023.</p>
Appendices	

Cheshire and Merseyside ICB Integrated Care Board Meeting

Transfer of delegated commissioning responsibility for general ophthalmic services and primary, community and secondary care dental services.

1. Executive Summary

- 1.1 The ICB is due to take delegated responsibility for General Ophthalmic Services and Primary, Community and Secondary Care Dental services from 1 April 2023. As part of the due diligence process the ICB has been working with NHS England regional colleagues on the completion of the Pre-Delegation Assessment Framework (PDAF) and underpinned by a Safe Delegation Check List.
- 1.2 If the Board is satisfied the ICB will be requested to sign a refreshed delegation agreement with NHS England.

2. Introduction / Background

- 2.1 The Health and Care Act 2022 established Integrated Care Boards, tasked with the commissioning and oversight of NHS services. The future delegated responsibility of commissioning and oversight of all primary care services formed part of the Health and Care Act. The aim of delegating these services to ICBs is to make it easier for organisations to deliver joined up and responsive care, delivering high quality primary care services for our population. Local systems having responsibilities over a broad range of services is a key enabler in designing services and pathways of care that better meet local priorities and opportunities for integration.
- 2.2 In line with the requirements of the Act, Cheshire and Merseyside ICB assumed responsibility for the commissioning of Community Pharmacy Services on 1 July 2022. The process for delegation of community pharmacy services followed the same process as is being followed for General Ophthalmic Services and Primary, Community and Secondary Care dental services as described in this report.
- 2.3 NHS England governs the transfer of responsibility through a delegation agreement with ICBs. This delegation agreement sets out the functions and defines the responsibilities that will be delegated to ICBs. The delegation agreement does not prescribe operating or governance models. ICBs have the flexibility to determine the model of commissioning of functions across all primary care services.

Cheshire and Merseyside ICB Integrated Care Board Meeting

- 2.4 NHS England, in addition to the PDAF, have issued a Safe Delegation Checklist to support ICBs review their readiness for delegation. NHS England does not require this checklist to be submitted but encouraged its use to enable the safe and effective transfer of the commissioning functions for these services.
- 2.5 In Cheshire and Merseyside a POD Task and Finish Group was established last year and has been working through the PDAF and Safer Delegation Checklist to ensure the transfer of services to the ICB.
- 2.6 The PDAF includes the domains listed below and will provide assurance to the ICB that the transfer of commissioning responsibility can be completed by 01 April 2023:
- Safer Delegation Preparatory Steps
 - Quality and Transformation
 - Governance and Leadership
 - Workforce and Capability
 - Finance.
- 2.7 The PDAF process has also been underpinned by the Safer Delegation Checklist that is split into two distinct parts:
- PDAF supporting prompts - A summary of PDAF prompts and operationally critical elements to prepare for safe delegation. This outlines the areas that need to be in place as confirmation of NHSE's readiness to delegate.
 - Broader delegation preparation prompts - These do not necessarily all need to be completed. These are designed to practically support safe delegation of functions from NHSE to ICBs.

3. Transfer of services to the ICB

- 3.1 The completion of the PDAF has enabled helpful discussions regarding readiness for delegation and the associated risks or issues. The POD Task and Finish Group has identified the following key issues:
- assurance of full transfer of workforce capacity from NHS England to support the delivery of the functions outlined in the Delegation Agreement.
 - assurance that there is sufficient funding to commission the services to a satisfactory standard. Including completion and assurance of financial due diligence between NHS England and ICB finance.
 - a full understanding of the service issues, and a commitment from future NHS England Regional Teams to work together on future contractual flexibilities which will support addressing these issues, particularly with dental services.
 - recognition that the ICB is not responsible for the challenges in dental services as a result of national contract inflexibilities and historic underperformance.
- 3.2 The NHS England regional team have been working with ICB colleagues to support completion of the PDAF process and to confirm assurance on the issues highlighted above.

Cheshire and Merseyside ICB Integrated Care Board Meeting

Services that will transfer to the ICB on 1 April 2023

3.3 General Ophthalmic Services

- General Ophthalmic Services (GOS) in respect of the testing of sight and dispensing of spectacles are provided to patients by ophthalmic contractors either in a fixed premises setting or if applicable at the patient's residence.
- Currently there are 228 providers who hold a mandatory services contract and 58 who hold an additional services contract in Cheshire and Merseyside

3.4 Primary, Community and Secondary Care Dental Services.

- There are 305 General Dental Practices providing primary care services. A national contracting model is in place underpinned by a regulatory framework. These primary care services also include orthodontic and minor oral surgery provision
- An Urgent Dental Care Call Handling Service operates across the ICB. Commissioned against NHSE commissioning standards and specification.
- Referral Management Service
- General dental contractors are commissioned to provide urgent dental care sessions both In Hours and Out of Hours. Urgent dental care provision has been maintained post COVID and expanded by NHSE dental commissioners to ensure access to urgent care is appropriate to the needs of the Cheshire and Merseyside population and to mitigate the challenges faced by members of the public when trying to access dental care.
- Community Dental Services - Special Care Dental Services for Children and Adults.
- Secondary Care services – Oral Surgery, Maxilla Facial Surgery, Special Care, Paediatric Care, Restorative and Orthodontics.

Service Issues and Priorities

3.5 The delegation of services to the ICB presents both challenges and opportunities to the wider ICB strategic priorities. These will be woven into both the development of a primary care strategy the development of the Joint Forward Plan.

3.6 The ICB will be aware of the national and local issues reported in relation to access to NHS dental services. This continues to generate significant political interest.

3.7 Some of the contributory factors for those issues in relation to primary care dental services delivery are no different to those faced by many other sectors, for example;

- Workforce pressures due to retention in NHS dental services and increasing demand
- Access challenges into both routine primary care and urgent care dental services brought about through historic and recent underperformance on dental contracts as a result of the inflexibilities of the national dental contract. This has recently been exacerbated by management of covid recovery and tackling backlogs.

Cheshire and Merseyside ICB Integrated Care Board Meeting

- 3.8 Additional challenges relating to dental services and identified as part of the PDAF process include:
- Fragility of secondary care services relating to Orthodontic provision and general pressures felt as Trusts continue to deliver recovery plans now and into 2023/24.
- 3.9 Work continues with the NHS England regional team to ensure that the ICB is presented with a clear and accurate picture of known specific service delivery issues. This information has been captured in the Dental Handover Document included in the Appendices.
- 3.10 An initial Dental Deep Dive was completed by the ICB and NHE Regional team in November 2022 and a further Deep Dive is scheduled for 24 February 2023 with wider stakeholders. NHSE commissioners have also completed an initial Secondary Care Dental Deep Dive into Orthodontics and a second one is planned for early March 2023.
- 3.11 There no such similar challenges being reported in General Ophthalmic Services as part of the PDAF process. In relation Community Pharmacy additional work undertaken since delegation in July 2022 by the POD Task and Finish Group is currently resolving an issue relating to Registration Authority provision and other digital provision.
- 3.12 The commissioning and contracting of all services are bound by national contracts or contractual frameworks. This presents some challenges and barriers to flexible commissioning and achieving ICB ambitions. This is especially the case for primary care dental contracts. Commissioners are keen to understand the parameters for commissioning more flexibly and how these fit with future dental contract reform.

Financial overview and transfer of budgets

- 3.13 Full year allocations for services delegated during 2022/23 (Pharmacy) and those being delegated with effect from April 2023 (Dental, Ophthalmic, Other) are shown in the table below.

Other Primary Care Service	Allocation 23/24 £'m
Dental	178.78
Ophthalmic	27.02
Pharmacy	70.10
Other	2.15
Total Other Primary Care	278.05

Cheshire and Merseyside ICB Integrated Care Board Meeting

- 3.14 NHS planning guidance for 2023/24 requires dental allocations to be ringfenced with any in-year underperformance being used to increase access to dental services. It is anticipated that the remaining services will deliver financial balance in 2023/24.
- 3.15 A full breakdown of the financial elements will be included in the draft financial plan that will be shared with the ICB on 10 February 2023.
- 3.16 Further guidance on 2023/24 pharmacy costs is expected next week. Any impact from this will be incorporated in the next iteration of the plan but is anticipated to be favourable.

4. Recommendations

- 4.1 The Board is asked to:
- **Note** the update regarding the delegation of Ophthalmic and Dental Services to the ICB on 1 April 2023. This update includes a summary of the areas, the budget and provides associated supporting documents in the Appendices.
 - **Note** a full breakdown of the financial elements will be included in the draft financial plan that will be shared with the ICB on 10 February 2023.
 - **Note** the reported risks to delegation highlighted through the Pre-Delegation Assessment Framework (PDAF) process, underpinned by the Safe Delegation Checklist and assurances required by the ICB as part of the process.
 - **Approve** the work undertaken to date in relation to the delegation of General Ophthalmic and Dental Services to the ICB on 1 April 2023.

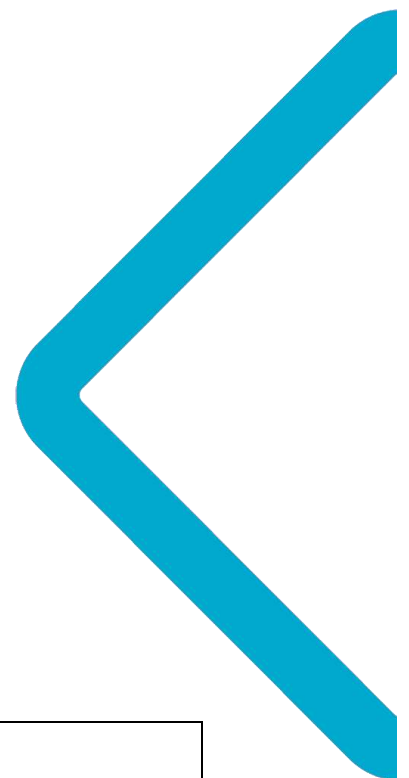
5. Next Steps

- 5.1 The POD Task and Finish Group will complete the PDAF and Safer Delegation Checklist process and provide assurance to the Board that it will be able to receive the safe transfer of delegated commissioning responsibility for general ophthalmic services and primary, community and secondary care dental services on April 1 2023.

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Cheshire and Merseyside Integrated Care Partnership – feedback from the January 2023 meeting



Agenda Item No	ICB/02/23/16
Report author & contact details	Matthew Cunningham , Associate Director of Corporate Affairs and Governance, matthew.cunningham@nhs.net
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Clare Watson, Assistant Chief Executive

Cheshire and Merseyside ICB Integrated Care Board Meeting

Cheshire and Merseyside Integrated Care Partnership – feedback from the January 2023 meeting

Executive Summary	<p>The purpose of this report is to inform members of the discussions undertaken at the January 2023 meeting of the Cheshire and Merseyside Health and Care Partnership (HCP).</p> <p>A summary report (Appendix One) of the meeting has been circulated to members and attendees of the Partnership for their use to inform colleague internally within their own respective organisations.</p>				
Purpose (x)	For information / note	For decision / approval	For assurance	For ratification	For endorsement
	x				
Recommendations	<p>The Board is asked to:</p> <ul style="list-style-type: none"> note the summary report of the discussions undertaken by the Health and Care Partnership Committee at its January 2023 meeting. 				
Key issues	n/a				
Key risks	n/a				
Impact (x) (further detail to be provided in body of paper)	Financial	IM &T	Workforce	Estate	
	Legal	Health Inequalities	EDI	Sustainability	
	x	x			
Route to this meeting	Board members received an update on the first meeting of the HCP at its Board meeting in November 2022.				
Management of Conflicts of Interest	n/a				
Patient and Public Engagement	n/a				
Equality, Diversity and Inclusion	n/a				
Health inequalities	n/a				
Next Steps					
Appendices	Appendix One	Summary Report for partners of the January 2023 meeting of the Cheshire and Merseyside Health and Care Partnership Board			

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

**Cheshire and Merseyside
Integrated Care Partnership**

**Appendix A: Chairs Summary Report of the
January 2023 meeting**

SUMMARY REPORT

CHESHIRE AND MERSEYSIDE HEALTH
AND CARE PARTNERSHIP BOARD

JANUARY 17 2023



Cheshire and
Merseyside
Health and Care Partnership

The second Cheshire and Merseyside Health and Care Partnership Board meeting was held on Tuesday, January 17th 2023.

Initially due to take place at Ellesmere Port Library, a decision was taken to switch to a virtual meeting – held on Microsoft Teams – due to adverse weather conditions and the related impact on both Board members and members of the public.

The meeting papers are available [here](#).

Opening the meeting, Chair Louise Gittins – the Leader of Cheshire West and Chester Council – welcomed those in attendance, including representatives from the NHS, local authorities, voluntary sector, housing, police and fire and rescue.

Together, Cllr Gittins and Vice Chair Raj Jain provided an update about the selection of a further Vice Chair. They explained that the appointment is likely to come from the voluntary sector and that related interviews are set to be arranged shortly.

Neil Evans, NHS Cheshire and Merseyside’s Associate Director for Strategy and Collaboration, provided an update on the development of our Health and Care Partnership strategy.

He explained that the Department of Health and Social Care had initially directed all Health and Care Partnerships to publish strategies by the end of 2022, however this deadline was subsequently softened, enabling Cheshire and Merseyside Health and Care Partnership to use the extra time to further enhance the report in collaboration with a wide range of contributors.

Members welcomed the draft report and provided feedback, with Neil committing to bring a further iteration of the report back to the next meeting on March 7th 2023. Once ready, the draft interim report will be published on the websites of all Health and Care Partnership member organisations.

Neil explained that – to achieve this – the intention is to work collaboratively with members of the Health and Care Partnership and engage with communities. Board Members highlighted the importance of maintaining focus on local needs, priorities and ambitions.

The need for NHS Cheshire and Merseyside (the local Integrated Care Board) funding to be delegated to Place was also agreed by members, with those on the call highlighting the importance of this being done at pace in order to progress the Partnership’s ambitions. Graham Urwin, Chief Executive of NHS Cheshire and Merseyside, committed to working with colleagues to detail how the delegated finances will work at a future meeting.

Neil Evans then highlighted the recently-released NHS planning guidance - informing members that NHS Cheshire and Merseyside is currently developing its response. The guidance encourages systems to prioritise recovery of core services and

productivity, returning to delivering the NHS Long Term Plan key ambitions and continuing to transform the NHS for the future.

Lindsey Dawson from Skills for Care - the strategic workforce development and planning body for adult social care in England - then presented on the challenges, and opportunities, around recruiting and retaining the adult social care workforce in Cheshire and Merseyside.

She explained how Skills for Care works with employers to ensure the social care workforce has the right people with the right skills and support to deliver high-quality care.

Lindsey emphasised the importance of incorporating in-depth workforce research into local planning to ensure residents' needs are being met both now and in the future. Members committed to working together to address health and social care workforce challenges, with the item being brought back to the next meeting for further discussion.

Closing the meeting, Cllr Gittins re-emphasised the group's commitment to making the meetings as accessible as possible, encouraging all in attendance to share ideas for making it easier for people to be involved.

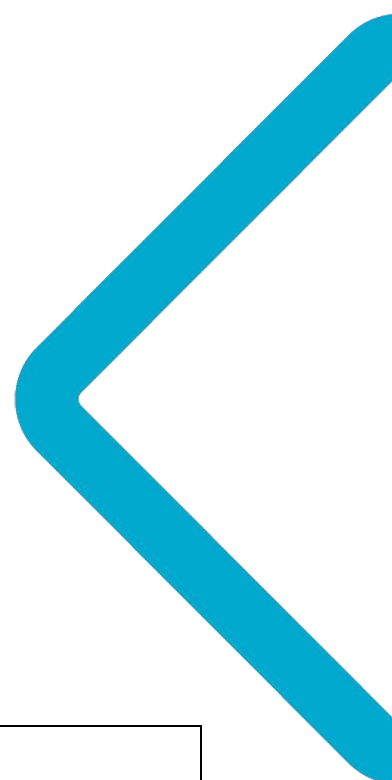
Meetings of the Cheshire and Merseyside Health and Care Partnership are held in public. The next meeting is scheduled for Tuesday, March 7th 2023 at the Lewis's Building in Liverpool.

More information about the Health and Care Partnership is available [here](#).

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Liverpool Women's Services Programme Update



Agenda Item	ICB/02/23/17
Report author & contact details	Carole Hill, Associate Director, Strategy, Integration and Partnerships, Liverpool Place
Report approved by (sponsoring Director)	Graham Urwin, Chief Executive
Responsible Officer to take actions forward	Christine Douglas, Executive Director of Nursing and Care

Cheshire and Merseyside ICB Board Meeting

Liverpool Women's Services Programme Update

Executive Summary	<p>The purpose of this paper is to provide an update to the Board about progress in establishing a programme to take forward the recommendation in the Liverpool Clinical Services to address the clinical sustainability challenges affecting women's health for people across who access the services provided by Liverpool Women's Hospital. These services are provided for people in Merseyside, Cheshire and beyond.</p> <p>The recommendations from the Liverpool Clinical Services review were considered by the Board at its January 2023 meeting. The objective of the review was to realise opportunities for greater collaboration between acute and specialised trusts to optimise clinical pathways in acute care in Liverpool. This programme, to address the clinical sustainability challenges affecting women's health, was one of three critical priorities identified through the review.</p>				
Purpose (x)	For information / note	For decision / approval	For assurance	For ratification	For endorsement
	X				
Recommendation	<p>The Board is asked to:</p> <ul style="list-style-type: none"> Note the update on progress in establishing this programme; Note that patient and public engagement will be integral to all phases of the programme and that this is an open process, with no decisions made about the future delivery model for these services. 				
Key issues	<p>The objective of the programme is to identify ways in which to improve outcomes and ensure clinical and financial sustainability of women's services. Although these services are located in Liverpool, they serve people across Merseyside and Cheshire.</p> <p>Future proposals will need to align with and complement similar services delivered across Cheshire and Merseyside.</p>				
Key risks	<ul style="list-style-type: none"> Clinical sustainability of women's services 				
Impact (x) <small>(further detail to be provided in body of paper)</small>	Financial	IM & T	Workforce	Estate	
	Legal	Health Inequalities	EDI	Sustainability	
			X		
Route to this meeting	Following the paper presented to the Board on the Liverpool Clinical Services review in January 2023				
Management of Conflicts of Interest	N/A				
Patient and Public Engagement	This paper sets out the commitment by the ICB to involve and engage with patients, public and stakeholders throughout the programme.				
Next Steps	Next steps are detailed in the body of the paper.				
Appendices	N/A				

Liverpool Women's Services Programme Update

1. Executive Summary

- 1.1 The purpose of this paper is to provide an update to the Board about progress to establish a programme to take forward the recommendation in the Liverpool Clinical Services Review to address the clinical sustainability challenges affecting women's health.
- 1.2 The recommendations from the Liverpool Clinical Services review were considered by the Board at its January 2023 meeting. The objective of the review was to realise opportunities for greater collaboration between acute and specialised trusts to optimise clinical pathways in acute care in Liverpool.

2. Introduction

- 2.1 One of three critical priorities identified in the Liverpool Clinical Services Review was to solve the clinical sustainability challenges of women's health services delivered by Liverpool Women's Hospital.
- 2.2 A previous programme to review these services led to a proposal in 2016 for a new Liverpool Women's Hospital to be co-located on an adult acute site. The proposals did not progress due to unavailability of capital funds.
- 2.3 The 2022 Liverpool Clinical Services Review highlighted that the clinical sustainability challenges in the context of these services remain, although a range of mitigating actions and investments have been made since 2016 to address some clinical risks.
- 2.4 A new programme is to be established to take forward work to identify potential options to address the clinical sustainability issues highlighted in the Liverpool Clinical Services Review. The review did not make any proposals for the future delivery of these services; it set out the clinical issues and recommended a full and open process to develop options to address these challenges.
- 2.5 The programme will incorporate patient involvement in developing options and shaping proposals. The ICB is committed to ongoing patient and public engagement. Involvement and engagement will be guided by NHS England guidance¹ setting out engagement best-practice principles and legal requirements for Integrated Care Boards and other NHS organisations, as well as the Cheshire and Merseyside ICS Public Engagement Framework.²
- 2.6 Public consultation may be required at a later stage, if proposals emerge that would lead to a change in the way services are delivered.

¹ [NHS England issued Working with People and Communities: statutory guidance, for ICBs and other NHS organisations.](#)

² <https://www.cheshireandmerseyside.nhs.uk/media/jz1ip34u/cm-public-engagement-framework-draft-101022.pdf>

3. Public Interest

- 3.1 The significant public interest in the future of the services delivered by Liverpool Women's services is understood. This stand-alone women's hospital is valued for the quality and breadth of its general and specialist services. The Save Liverpool Women's Group has campaigned to retain the delivery of women's services at the Liverpool Women's Crown Street site and has amassed a petition signed by 60,000 people since 2016. At its meeting in January 2023 the ICB Board received this petition. The wording of the petition is:

No closure. No privatisation. No cuts. No merger. Reorganise the funding structures not the hospital. Our babies and their mothers, our sick women deserve the very best.

Why is this important? All the maternity and women's health provision was pulled into this one site. It is a much-loved hospital. It provides crucial specialised care and the daily joy of new babies. The driving force of its closure is a clumsy funding structure not the needs of women and babies. The alternative of new 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 mothers, sisters, daughters, wives, and friends.

- 3.2 The objective of the women's services programme is to ensure the delivery of the very best care for women and babies. There will be no cuts or privatisation of these services. The scope of this programme does not include consideration of organisational change and in fact the ICB has no authority to propose a merger of NHS Foundation Trusts. If any of the NHS Foundation Trusts do consider a merger as a proposal then they will need to undergo a formal process, including engagement with the public and other stakeholders, and seek the approval of their respective Governors and Boards.
- 3.3 Funding structures for NHS services are set nationally through a national tariff payment system which are applied consistently for women's services. Trusts across Cheshire and Merseyside and nationally are subject to challenging financial pressures, but the driver for this review of women's services is the significant clinical risks, that have been highlighted in the Liverpool Clinical Services review and two reviews conducted by independent NHS Clinical Senates. Clinical risks are both current and those that are anticipated in future, particularly around future workforce.
- 3.4 The ICB is committed to openness and transparency in the implementation of this programme. The ICB will involve and engage with a wide range of stakeholders and interested parties, including the Save Liverpool Women's group, to address concerns that have been raised or will be raised as the work progresses. A meeting has been arranged, for example, with members of the Save Liverpool Women's Group on the 20 February. Plans are also being put in place to ensure engagement is undertaken with people who use these services.

4. Programme Governance

- 4.1 A sub-committee of the ICB Board is to be established. Its role will be to oversee the development of a future care model to ensure the best possible care for women and babies. The committee will include ICB non-executive and executive members, along with representation from NHS Trusts with dependent services across Cheshire and Merseyside, Healthwatch and patients with lived experience of these services. The first meeting of this Committee will take place at the end of February.
- 4.2 Working groups will be established to deliver the work overseen by the committee. They will include groups for engagement and involvement; finance; clinical evidence and research, estates, and workforce.
- 4.3 The committee will report to the ICB Board following each of its meetings.

5. Recommendations

- 5.1 The Board is asked to:
- **Note** the work to establish a women's services programme as outlined within the Liverpool Clinical Services review;
 - **Note** that patient and public engagement will be integral to all phases of the programme and that this is an open process, with no decisions made about the future delivery model for these services.

Officer contact details for more information

Carole Hill: carole.hill@liverpoolccg.nhs.uk

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Report of the Quality & Performance Committee Chair



Agenda Item	ICB/02/23/18
Report author & contact details	Kerry Lloyd, Deputy Director of Nursing & Care kerry.lloyd@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director/ Chair)	Tony Foy, Chair
Responsible Officer to take actions forward	Kerry Lloyd, Deputy Director of Nursing & Care

Cheshire and Merseyside ICB Board Meeting

Report of the Quality & Performance Committee Chair

Executive Summary	The purpose of this report is to provide assurance to the C&M Integrated Care Board in regard to key issues, considerations, approvals and matters of escalation considered by the C&M ICB Quality & Performance Committee in securing continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centered, well-led, sustainable, and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance.				
Purpose (x)	For information / note	For decision / approval	For assurance	For ratification	For endorsement
	X	X	X		
Recommendation	The Board is asked to: <ul style="list-style-type: none"> Section 2 note the content Section 3 note the content and the issues considered by the Committee and actions taken. Section 4 Note that no matters required escalation to the ICB Board. Section 5 Note the approval of legacy policies. 				
Key issues	-				
Key risks	-				
Impact (x) (further detail to be provided in body of paper)	Financial	IM & T	Workforce	Estate	
	X	X	X	X	
	Legal	Health Inequalities	EDI	Sustainability	
	X	X	X	X	
Management of Conflicts of Interest	No conflicts of interest declared at the Committee.				
Next Steps	Noted in the body of report.				
Appendices	None				

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Quality & Performance Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Quality & Performance Committee	<p>The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable, and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues.</p> <p>In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties:</p> <ul style="list-style-type: none"> • Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); and • Adult safeguarding and carers (the Care Act 2014). 	Tony Foy

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

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

Decision Log Ref No.	Meeting Date	Issues considered
QPC/23/01/05	17/01/23	<p>Local Maternity & Neonatal System Report (LMNS) Following the previous month’s committee recommendation, the LMNS will now report monthly to the committee as a standard agenda item.</p> <p>The committee were given a comprehensive overview of the governance of the LMNS and how this has evolved in line with the development of the Integrated Care System. The committee were given an outline of reporting requirements</p>

NHS Cheshire and Merseyside
Integrated Care Board Meeting

Decision Log Ref No.	Meeting Date	Issues considered
		<p>and content and were then given a description of the metrics captured and the LMNS approach to those organisations flagging as outliers.</p> <p>The committee asked for assurance that despite East Cheshire Trust being currently overseen via the Greater Manchester ICS, that C&M still had input and oversight of outcomes. Colleagues from the LMNS confirmed that this was the case and liaised closely with respective colleagues in Greater Manchester.</p> <p>The committee went on to hear about the recently published CQC maternity services survey completed by those experiencing care by organisation. C&M were reported to have one organisation (Mid-Cheshire Trust) within the upper quartile for maternity services nationally, as well as one organisation (St Helens & Knowsley Trust) within the lower quartile. The committee heard how the 2022 survey considered service user experience during a rise in Covid prevalence due the Omicron variant and how this may have affected outcomes.</p> <p>The committee agreed that given the very recent publication of the report and its ability to provide an overview of patient experience, then this should be a focus for future LMNS reporting via the committee.</p>
QPC/23/01/06	17/01/23	<p>Quality and Performance Dashboard</p> <p>The Committee was updated on the level of challenge faced by urgent care and the increased risk of escalation to OPEL4 faced by the ICB in January 2023. Services across Cheshire and Merseyside have also been challenged due to the number of Trusts taking part in the ongoing strike action. Extra funds have been allocated to support discharge but issues around workforce capacity continue to affect services.</p> <p>The committee appreciated the inclusion of Primary and Community Care performance and advised it can sometimes be challenging to understand the impact on these services.</p>
QPC/23/01/07	17/01/23	<p>Place Based Key Issues Report</p> <p>The committee had a focus on those places of East Cheshire, West Cheshire & Wirral with the report highlighting those areas considered 'off track'.</p> <p>The reports all described the issues facing services in relation to urgent and emergency care and those within hospital settings no longer meeting the criteria to reside. The committee discussed how system pressures may manifest in patient harm and agreed that the March 2023 Patient Safety report should include those aspects of care.</p>

NHS Cheshire and Merseyside Integrated Care Board Meeting

Decision Log Ref No.	Meeting Date	Issues considered
		The committee were also advised of a report into Serious Incidents by the Northwest Ambulance Service would be presented in March 2023 and would describe the impact of long waits for patients and the mitigation in place.
QPC/23/01/10	17/01/23	Equality Duty Service Review (EDS) The committee was presented with an overview of the approach EDS during 2022/23. The committee were informed how organisations within C&M had opted to deliver their obligations in relation to EDS and the emphasis on alignment with the Core20Plus5 workstream.
QPC/23/01/12	17/01/23	Sickle Cell – No One’s Listening Report The committee was informed by the Medical Director that C&M hematology leads across C&M have provided Liverpool University Hospitals Foundation Trust with a series of policies about a step wise approach to managing patients and escalating as required. Assurance was given that a consistent approach is now in place.
QPC/23/01/13	17/01/23	C&M Digital Transformation Programme The committee were presented with an update on the Digital Transformation agenda and were given an overview of the governance and programmes involved. The committee requested that future updates focus on the impact on quality and safety of services because of this programme.
QPC/23/01/14	17/01/23	Mental Health Transformation Update The committee were presented with an overview of Mental Health Transformation and advised on the processes in place and the challenges which need to be addressed including an increase in prevalence and ongoing investment in services.

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

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

Decision Log Ref No.	Meeting Date	Issues considered
QPC/23/01/03	17/01/23	Risk Register Update The committee was presented with an update on the quality related corporate risk register and advised work has been undertaken to look for commonality of risks across the previous 9 CCG risk registers. A workshop had taken place to score the commonly agreed risks across the 9 previous CCG’s and 4 key risks

NHS Cheshire and Merseyside Integrated Care Board Meeting

Decision Log Ref No.	Meeting Date	Issues considered
		<p>have been identified for inclusion within the Corporate Risk Register that included:</p> <ul style="list-style-type: none"> • Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience • Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm • Inadequate compliance with the CHC National Framework due to constrained market and workforce which leads to delays in assessment and unmet need • 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 <p>The committee will subsequently receive a draft of the risks in risk register format to be aligned with the corporate risk register and going forward a monthly review will take place to score and identify newly identified Corporate and Place based risks, which will then feed into the corporate approach. LMNS will consider risks around maternity service provision and update the Committee with a report at the February meeting.</p> <p>Place based quality leads have agreed to ensure place specific and legacy risks will be managed within place-based governance.</p> <p>The Committee were asked to approve the Corporate Risks to be quality to be endorsed by the Board. Any additional risks identified will be identified and presented to the Committee at the February meeting including updates from SEND and Maternity.</p>

4. Issues for 4. Escalation to the ICB Board

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

Decision Log Ref No.	Meeting Date	Issue for escalation
		None

NHS Cheshire and Merseyside Integrated Care Board Meeting

5. Committee recommendations for ICB Board approval

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

Decision Log Ref No.	Meeting Date		Recommendation from the Committee
23/01/11	17/01/23	<p>Clinical Policy Harmonisation As referenced in Chief Execs report to the January 2023 Board, the committee were presented with the work which has been undertaken to map the legacy policies inherited from the previous 9 CCG's and advised that 64 of these policies have been reviewed at Place and taken through the QIA process before being harmonised and approved for publication. 56 of the policies have now been signed off and were contained within the meeting pack. The policies and associated edits contained within the report have limited or no impact in terms of changes in access to the population. The Committee endorsed the approach and approved the policies. The Committee will receive further updates and recommendations regarding the remaining policies at future meetings.</p>	Endorsement & Approval

6. Recommendations

6.1 The ICB Board is asked to:

- Section 2 note the content
- Section 3 note the content and the issues considered by the Committee and actions taken.
- Section 4 Note that no matters required escalation to the ICB Board.
- Section 5 Note the approval of legacy policies.

NHS Cheshire and Merseyside Integrated Care Board Meeting

23 February 2023

Report of the Finance, Investment & Resource
Committee Chair of the



Agenda item	ICB/02/23/19
Report author & contact details	Claire Wilson, Executive Director of Finance Claire.wilson@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director/ Chair)	Erica Morriss, Chair of the Finance, Investment and Resource Committee
Responsible Officer(s) to take actions forward	Claire Wilson, Executive Director of Finance Mark Bakewell, Deputy Director of Finance

Cheshire and Merseyside ICB Board Meeting

Report of the Finance, Investment & Resource Committee Chair

Executive Summary	<p>The Finance, Investment and Resource committee of the NHS Cheshire and Merseyside Integrated Care Board met on 25th January 2023</p> <p>The meeting was quorate and was able to undertake its business. The main items considered at the meeting included:</p> <ul style="list-style-type: none"> • Review of Committee Workplan and Terms of Reference • Month 9 ICB / ICS Finance Report • Update on Financial Governance / Operational SORD • Update on ICB Organisational Change Process • 2023/24 Planning <p>The next meeting of the Committee is scheduled to be held on 21st February 2023.</p>				
	Purpose (x)	For information / note	For decision / approval	For assurance	For ratification
	x	x	x		
Recommendation	<p>The Board is asked to:</p> <ul style="list-style-type: none"> • note the items covered by the Committee • note that the committee considered the month 9 financial position of the ICB/ ICS in respect of both revenue and capital allocations • note that updates were received in respect of a number of other areas as per above • approve the updated Committee Terms of Reference 				
Impact (x) (further detail to be provided in body of paper)	Financial	IM & T	Workforce	Estate	
	x	x	x		
	Legal	Health Inequalities	EDI	Sustainability	
	x				
Management of Conflicts of Interest	No				
Next Steps	Subject to Board approval, publish the updated Committee TOR on the ICB website.				
Appendices	Appendix One	FIRC Terms of Reference v1.1			

**NHS Cheshire and Merseyside
Integrated Care Board Meeting**

**Report of the Finance, Investment & Resource
Committee Chair**

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Finance, Investment & Resource Committee	<p>The main purpose of the Committee is to</p> <ul style="list-style-type: none"> provide the Board with a vehicle to receive the required assurances, review the management of associated risks, and understand further details as deemed appropriate for the committee to consider in relation to matters concerning, finance (both revenue and capital), resources (e.g., workforce) and investment / dis-investment issues. support the development and delivery of the ICS' financial strategy, oversee financial delivery, and provide assurance on the arrangements in place for financial control and value for money across the system. take a system view on use of resources and deployment but also provide a forum where ICB directors and ICB members can consider, govern, and assure ICB actions as an employer. 	Erica Morriss, Non-Executive Director

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

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

Decision Log Ref No.	Meeting Date	Issues considered
-	25.01.23	<p>Committee Workplan Terms of References</p> <p>The Committee:</p> <ul style="list-style-type: none"> reviewed the existing workplan and terms of reference as part of ongoing review and to reflect wider governance review being undertaken, including the potential establishment of task and finish groups to support the committee in relevant areas. noted that they will review the effectiveness at least annually agreed the need to specifically adapt the FIRC TOR to allow a sub-Committee as well as Task & Finish should this be required

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Decision Log Ref No.	Meeting Date	Issues considered
	25.01.23	<p>Financial Governance / Operational SORD Update</p> <p>The Committee:</p> <ul style="list-style-type: none"> • Noted the recommended updates to NHS Cheshire and Merseyside ICB Operational Scheme of Reservation and Delegation that were agreed at the Audit Committee on the 13th December 2022, and received approval at Board in January 2023 • Noted the further work required on authorised signatory list once staffing structures are confirmed and further cascade of operational limits to all levels of organisation • Noted the intention (once agreed structure is in place and the majority of senior staff HR processes have been implemented) to roll out further training on aspects of Operational Scheme of Delegation alongside further finance, contracting and procurement training and education to ensure effective approach for the organisation.
	25.01.23	<p>ICB Organisational Change</p> <p>The Committee</p> <ul style="list-style-type: none"> • Received an update on the ICB Organisational Change Process, noting relevant progress on organisational structures.
	25.01.23	<p>NHS Planning Guidance 2022-23</p> <p>The Committee</p> <ul style="list-style-type: none"> • Noted the content of the 2023-24 NHS planning guidance, including the need to develop both 2-year operational plans and an ICB Joint Forward Plan. • Noted the approach to developing the Cheshire and Merseyside plan including the role of our providers in developing and approving plans as well as the need to engage with the HCP partners and HWB in developing the content of the plans. • Noted that the submission date for the draft operational plan prevents it from being approved by the ICB board before submission on 23rd February 2023, but that it will be reviewed by the ICB Executive Team and Provider Collaboratives before submission and will be presented for review and ratification at the February Board meeting which takes place on the day of submission. • Noted that the final submissions will be presented to the ICB Board for approval in March 2023.

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

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

Decision Log Ref No.	Meeting Date	Issues considered

4. Issues for escalation to the ICB Board

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

Decision Log Ref No.	Meeting Date	Issue for escalation
-	25.01.23	<p>Month 9 Finance Report The Committee noted</p> <ul style="list-style-type: none"> the contents of the finance report in respect of the month 9 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. The relative level of risk in delivering the forecast outturn position

5. Committee recommendations for ICB Board approval

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

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
-	25.01.23	Approve the updated Committee Terms of Reference. New additions are highlighted in BLUE and edition in RED .

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6. Recommendations

6.1 The ICB Board is asked to:

- **note** the items covered by the Committee
- **note** that the committee considered the month 9 financial position of the ICB/ ICS in respect of both revenue and capital allocations
- **note** that updates were received in respect of a number of other areas as per above
- **approve** the updated Committee Terms of Reference

7. Next Steps

7.1 The committee will

- continue to meet monthly at the present time in order to provide assurances to the board as per its terms of reference and agreed workplan
- continue to monitor the financial position and associated risks both as the ICB but also as part of the ICS in order to deliver the required financial position.
- Subject to Board approval, publish the updated Committee TOR on the ICB website

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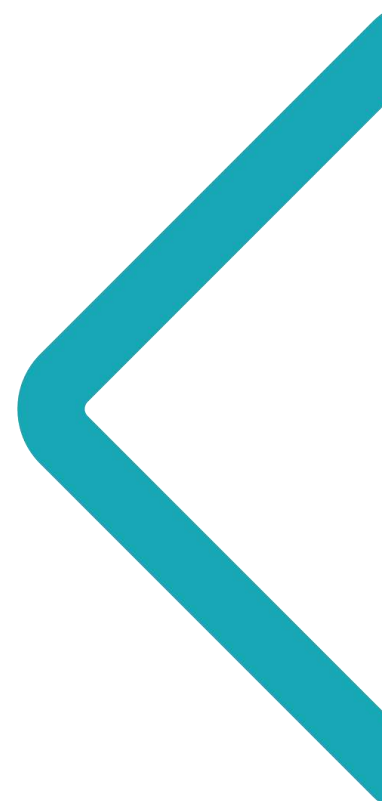
Report of the Chair of the Finance, Investment and Our Resources Committee

Appendix One: Committee Terms of Reference v1.1

C&M Integrated Care Board

Finance, Investment & Resources Committee

Terms of Reference



Document revision history



Date	Version	Revision	Comment	Author / Editor
October 2022	1.0	Initial		Mark Bakewell
Feb 2023	1.1			Matthew Cunningham

Approved by the ICB Board on

Review due

November 2023

1. Introduction

The Finance, Investment and Resources Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), will be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

High functioning Boards traditionally focus on a number of key responsibilities: setting strategy; delivery; assurance and culture and establish a number of supporting committees. This committee will provide the Board with a vehicle to receive the required assurances, review the management of associated risks, and understand further details as deemed appropriate for the committee to consider in relation to matters concerning, finance (both revenue and capital), resources (e.g workforce) and investment / dis-investment issues.

The committee will support the development and delivery of the ICS' financial strategy, oversee financial delivery and provide assurance on the arrangements in place for financial control and value for money across the system.

The committee will also take a system view on use of resources and deployment but also provide a forum where ICB directors and ICB members can consider, govern and assure ICB actions as an employer.

The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3. Responsibilities / duties

The Committee will fulfil its purpose by:

- Defining principles for financial operations and management within the ICS and making recommendations for financial priorities including:
 - Delivery of long-term system financial sustainability and year on year system balance
 - Risk and gain share
 - Capital, investment and digital investment priorities
 - Strategic estates considerations
 - Resource distribution and funds flow arrangements.
- Securing assurance, oversight and any action to ensure delivery of the financial plan



- Enabling development of a financial strategy in support of the wider system clinical strategy including:
 - Aligning financial performance to quality and activity and workforce standards
 - Reviewing the allocation of resources to organisations taking into account the strategic objective of reducing health inequalities, improving health outcomes and supporting financial sustainability.
 - Considering the road map for resource distribution across the system to support both place and provider collaboration design over the medium term
- Provide a forum to convene ICB members and directors to consider ICB employment matters (consideration if such matters will be reserved to ICB members of directors)

The Committee has, alongside the Audit Committee, a key role in disclosing non-compliance with the ICB constitution.

The Committee plays a key role for the ICB in a number of areas including:

- Regular review areas of the financial governance framework (including the operational Scheme of Reservation and Delegation standing orders, standing financial instructions/limits, and prime financial policies), making appropriate recommendations to the Board on changes as required.
- Ensure risks of exceeding expenditure limits are identified and that recommendations for immediate remedial action are agreed for consideration in order to provide assurance by the Board
- Monitor and assure the delivery of efficiency savings
- Receive regular reports on Pooled Budget Arrangements as appropriate to the ICB
- Receive regular 'thematic' updates on areas of commissioned / programme expenditure to ensure alignment with strategic objectives
- Receive regular updates with regards to procurement projects
- Assure processes for procurement and contracting in line with prevailing strategy, guidance and regulations
- Approve requests for the waiver of any procurement rules for goods and services on an exception basis.

4. Delegated Powers and Authority

The Committee has the authority to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations



- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- ~~Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.~~
- approve the terms of reference of any sub-groups or sub-committees to the Committee. The Committee shall determine the authority of any of its sub-groups or sub-committees in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) and only with regards the functions and delegations that have been reserved to the Finance, Investment and Our Resources Committee itself.
- Agree C&M joint work on and Place actions on estates, procurement, supply chain, and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability

In relation to Workforce, the Committee has the authority to:

- 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.

In relation to finance, the Committee has the authority to:

- Approve Healthcare / Non-Healthcare Expenditure as set out in the Scheme of Reservation & Delegation per the relevant sections
- Approve ICB financial operational policies.

In respect of Contracting & Procurement Activities, the committee has the authority in line with ICB Scheme of Reservation and Delegation to:

- Approve the ICB procurement plans annually and note progress against procurement plans on a quarterly basis.
- Approve the commencement of any over threshold tenders.
- Approve the award of a contract at the end of a tender process.
- Approve the extension of a contract rather than procurement, where it is permitted within the original terms of the contract.
- Approve the sign off of a tender waiver in line with the SORD and Signatory list.
- Approve the publication of a Contract Notice in line with Public Contract Regulations (2015) where a procurement will not be undertaken. (could be a contract award notice (CAN), a contract modification notice (CMN) or a Voluntary Ex-Ante Transparency Notice (VEAT).

5. Membership & Attendance

5.1 Members

ICB Non-Executive

- At least one ICB NED (Chair).

Management

- ICB Executive Director of Finance
- ICB Director of Nursing
- ICB Director of Performance and Planning
- ICB Director of HR
- A minimum of one Associate Director of 'Place' finance representative.

System Partners

- A ICS NHS 'Provider' Finance Director
- A Partner NED from at least one of each of the C&M provider collaboratives
- A Partner CEO from at least one of each of the C&M provider collaboratives
- A Primary Care Representative – nominee from the Primary Care Leadership Forum
- ICS or Partner representatives supporting any conversation.

A number of additional attendees may be invited.

Consideration has been given to the role and connection of Provider NEDs on this committee and collaboratives. Close connection with the ICS finance community and DOF level and finance conversations, dialogue and work will be critical to the success of delivery against this agenda but supporting decision making and assurance through this Committee and to the ICB.

Notified, named deputies to support attendance and participation is encouraged.

Only members of the Committee have the right to attend Committee meetings.

5.2 In attendance

The group may invite representatives from the wider system, ICB, ICS, NHSE/I region or supporting staff such as secretariat, governance, performance, direct commissioning, local authority or transformation colleagues as required to support discussions.

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.



6. Meetings

6.1 Leadership

The Committee is Chaired by an ICB NED. The Vice Chair of the Committee will be appointed from individuals who form the named membership of the Committee

6.2 Quorum

For a meeting to be quorate at least 50% of the membership must be present, with a minimum of

- two ICB executives
- one non-executive
- one partner representatives.

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote, however it is not envisaged that voting will be ether necessary or encouraged.

If a vote is required, only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6.3 Frequency

At least monthly with opportunity for use and linkages with the ICS forums established and supported by the ICB, or system partners such as the collaboratives.

The Committee shall meet at such times and place as the Chair may direct on giving reasonable written notice to members. Meetings will be scheduled to ensure that they do not conflict with known existing Board meetings and are synchronized so that members can properly engage their organisations ahead of meetings.

The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.–In these circumstances the Chair will give as much notice as possible to members.

Meetings will not, usually, be open to the public and will have the ability to schedule meetings as either face to face or electronically.

Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and no later than 4 working days.

6.4 Format

An agenda for each meeting will be agreed with the Chair. Periodic calls for items supporting discussion will also be made from the membership.

It is anticipated that the meeting may initially have both a business and developmental focus as it established and defines its role. Sufficient time will be allocated to items to enable full exploration of issues, constructive challenge and reflection.

Advice, opinion and engagement may be sought from amongst the membership outside of the regular meetings, either as a group or on an individual basis.

Private Meetings

If an agenda indicates the requirement for a 'Private and Confidential' session of the meeting (e.g. part two) usually as a result of an issue with potential conflict of interests for committee members or of a sensitive nature, then separate agendas and minutes will be produced.

The Chair of the Committee will determine who from the attendees of the 'part one' meeting may remain in attendance for the part two business. However, the default position will be to restrict the meeting to committee members only and officers invited to specifically present and discuss the part two subject matter.

Part of the justification for establishing a private and confidential agenda will be the identification of an appropriate Freedom of Information exemption together with, where required, an assessment of the public interest test on each agenda item.

It is likely that all procurement decisions are made in Part two where potentially commercially sensitive but this may also include for non-procurement related issues where the chair deems appropriate.

6.5 Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. Minutes and assurance reports of a confidential nature from the Committee will be reported to a subsequent meeting of the Board in private.

The Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year

Meeting paperwork and content can be shared within the system finance community.

6.6 Administrative Support

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those actions is monitored.

7. Assurance

The assurance required of and from the group is an area which will require development as and when it discharges its functions and responsibilities. The role of audit and the audit committee will be key in this process as will any oversight arrangements established by NHSE.

8. Behaviours and Conduct

ICB values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.


All members are required to make open and honest declarations of the interest at the commencement of each meeting or to notify the Chair of any actual, potential or perceived conflict in advance of the meeting.

All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Review



The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval