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NHS Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

(held in public)

28 March 2024

09:00am - 12:35pm

Board Room, Lewis's Building, 4th Floor, 2 Renshaw Street, Liverpool, L1 2 SA

Public Speaking Time 09:00 - 09:30am

Further detail at: https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-march-2024/

Agenda

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
09:30am	**Preliminary Business**				
ICB/03/24/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain *Chair*	For information	-
ICB/03/24/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the ICB website)*	Verbal		For assurance	-
ICB/03/24/03	Chairs opening comments	Verbal		For information	-
ICB/03/24/04	Resident Story	Film		-	
09:45am	**Leadership Reports**				
ICB/03/24/05 **09:50am**	Report of the ICB Chief Executive	Paper	Graham Urwin *Chief Executive*	For assurance	5
ICB/03/24/06 **10:05am**	Report of the ICB Director of Nursing and Care	Paper	Chris Douglas *Director of Nursing & Care*	For approval	17
ICB/03/24/07 **10:15am**	NHS Cheshire and Merseyside Finance Report Month 11	Paper	Claire Wilson *Director of Finance*	For assurance	25
ICB/03/24/08 **10:25am**	Highlight report of the Chair of the ICB Finance, Investment and Resources Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	48
ICB/03/24/09 **10:35am**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	53
ICB/03/24/10 **10:45am**	Highlight report of the Chair of the ICB Quality and Performance Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	82

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AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
ICB/03/24/11 **10:55am**	Report of the ICB Directors of Place	Paper	Deborah Butcher *Place Director (Sefton)* Mark Bakewell *Place Director (Liverpool)*	For assurance	88
11:15am	**COMFORT BREAK**				
11:25am	**Committee AAA Reports - matters of escalation and assurance**				
ICB/03/24/12	Highlight report of the Chair of the ICB Audit Committee, including: • recommendations on approving changes to the ICB Scheme of Reservation and Delegation (SORD) and Operational SORD • recommendations on approving changes to the ICB Risk Management Strategy	Paper	Neil Large *Non-Executive Member*	For approval	116
ICB/03/24/13 **11:35am**	Highlight report of the Chair of the ICB Remuneration Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	187
ICB/03/24/14 **11:40am**	Highlight report of the Chair of the ICB Children and Young Peoples Committee	Paper	Raj Jain *ICB Chair*	For assurance	189
ICB/03/24/15 **11:45am**	Highlight report of the Chair of the ICB Women's Hospital Services in Liverpool Committee	Paper	Raj Jain *ICB Chair*	For assurance	191
ICB/03/24/16 **11:50am**	Highlight report of the Chair of the ICB Transformation Committee, including: • recommendation on approving changes to the Committees Terms of Reference • recommendation on approving the ICBs Cyber Security Strategy.	Paper	Clare Watson *Assistant Chief Executive*	For approval	194
ICB/03/24/17 **12:00pm**	Highlight report of the Chair of the ICB System Primary Care Committee. Including: • recommendations on approving the ICB Dental Improvement Plan.	Paper	Erica Morriss *Non-Executive Member*	For approval	417
12:15pm	**ICB Business Items and Strategic Updates**				
ICB/03/24/18	Update on the ICB Primary Care Access Recovery Plan 2023-2024	Paper	Clare Watson *Assistant Chief Executive*	For approval	449
ICB/03/24/19 **12:30pm**	Establishment of the ICB Research and Innovation Committee	Paper	Prof. Rowan Pritchard-Jones *Medical Director*	For approval	470

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AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
ICB/03/24/20 **12:35pm**	NHS Cheshire and Merseyside NHS Staff Survey 2023: Results and Actions	Paper	Chris Samosa *Chief People Officer*	For endorsement	484
ICB/03/24/21 **12:50pm**	Building a Continuous Learning and Improvement Culture for Cheshire and Merseyside	Paper	Dr Fiona Lemmens *Deputy Medical Director*	For approval	502
ICB/03/24/22 **13:00pm**	Emergency Preparedness Resilience and Response Core Standards 2023-24 Assurance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	518
ICB/03/24/23 **13:10pm**	Establishment of the ICB Data Into Action Programme	Paper	Prof. Rowan Pritchard-Jones *Medical Director*	For assurance	530
13:25pm	**Meeting Governance**				
ICB/03/24/24	Minutes of the previous meeting: • 25 January 2024.	Paper	Chair	For approval	544
ICB/03/24/25	Board Action Log	Paper	Chair	To consider	588
13:30pm	**Any Other Business**				
ICB/03/24/26	Closing remarks and review of the meeting	Verbal	Chair / All	For information	-
CLOSE OF MEETING					

NHS
Cheshire and Merseyside

Consent items

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

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/03/24/27	Board Decision Log - **CLICK HERE TO VIEW**	For information	
ICB/03/24/28	Confirmed Minutes of ICB Committees: • *Quality and Performance Committee* • *System Primary Care Committee* • *Finance, Investment and Our Resources Committee* • *Audit Committee* • *Transformation Committee* • *Children and Young Peoples Committee* • *Women's Hospital Services in Liverpool Committee*	For information	*Add page number*

Date and time of Next Meeting

30 May 2024, 0900 - 12:30, St Helens Town Hall.
A full schedule of meetings, locations, and further details on the work of the ICB can be found here: www.cheshireandmerseyside.nhs.uk/about

Following its meeting held in Public, the Board will hold a meeting in Private from 2:00pm

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Report of the Chief Executive

Agenda Item No: ICB/03/24/05

Responsible Director: Graham Urwin, Chief Executive

Report of the Chief Executive (March 2024)

1. Introduction

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

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **consider** the updates as outlined within the report

3. Industrial Action

3.1 The British Medical Association (BMA) announced on 20 March 2024 that its junior doctor members have voted to extend their mandate for further industrial action over pay for another six month, meaning they can now strike up to 19 September 2024. At the time of writing this report the dates of any future strike action had not been announced.

3.2 As in previous periods of industrial action, the ICB will stand up its Incident Management Team (IMT) to coordinate the response in the run up, during and after each period of planned action, including the operation of its incident coordination centre (ICC) on the days of action, and clinical cells to maintain oversight of safety and quality.

4. Update on actions to address the Measles Outbreak

4.1 NHS Cheshire and Merseyside continues to lead our system response to the National Measles incident. Measles is one of the world's most infectious diseases, with one infected person passing it to approximately fifteen unvaccinated people and poses a serious risk to those who are unvaccinated. One in five children with the illness will require a hospital visit and the infection can lead to serious complications such as meningitis and sepsis. There is no specific treatment for measles, so parents and carers are being reminded that vaccination gives the best protection from serious illness.

4.2 Increasing Measles, Mumps and Rubella (MMR) vaccination uptake is critical and we were pleased to welcome the United Kingdom Health Security Agency (UKHSA) Chief Executive, Dame Jenny Harries to Liverpool on the 29 February 2024 to coincide with the launch of the new National Childhood Immunisation

campaign on 04 March 2024, which was shaped by the work we have done in Liverpool and the wider North West.

4.3 Cheshire and Merseyside has approximately 372,000 school-age children (Reception to Year 11). In January 2024, 326,000 children (87%) had received both the first and second doses of the MMR vaccine and were considered fully-vaccinated against MMR. A further 20,000 (6%) had received a first dose, while 26,000 (7%) were completely unvaccinated.

4.4 In terms of vaccinations delivered this year, in January 0.2% of children requiring at least a first MMR dose were vaccinated, an average of 53 per week, or 212 for the month. In February, the number of vaccinations increased by 308% to an average of 163 per week, and a total of 653 for the month. In March, the number of vaccinations increased by a further 14%, averaging 187 per week. In total, it is estimated that, by the end of March, a total of 1,614 will have received at least a first MMR vaccine (2% of the population, compared to 0.2% in January 2024).

4.5 Finally, in terms of absolute vaccination numbers by Place, the greatest increase has been seen in Liverpool and Cheshire, where 250 more children were vaccinated in February than in January, an increase also reflected in March. Proportionally, the greatest increases have been seen in South Sefton, Warrington and Wirral Places. South Sefton, in particular, is delivering nine times as many vaccinations now compared to January 2024.

4.6 There has been considerable work being done by all our local places working together with local communities, public health, primary care , our NHS providers and Live Well bus to help create that greater demand and easier access to MMR, that we will continue to promote with our communities.

5. Thirlwall Inquiry

5.1 As I reported to Board at its meeting in January 2024, so as to support the Thirlwall Inquiry and Rule 9 Request that the ICB had received, I submitted a witness statement covering both the ICB and our legal predecessors, along with 75 exhibits on 15 February 2024. The Chair of the Inquiry has since reviewed the witness statement, and as a result, has made the decision to decline the ICB's application to be a Core Participant.

5.2 The Chair of the Inquiry believes that "the ICB did not play any role in responding to complaints made and does not consider that there is a material risk the ICB will face significant or explicit criticism". The Chair considers that allowing the application would create unnecessary costs and prolong the Inquiry.

5.3 We will continue to assist the Inquiry without Core Participant status and respond to any future Rule 9 Requests in a timely manner. The Inquiry are still on track to start hearing evidence in September 2024.

6. ICB Constitution approval

6.1 Following the ICB Board meeting in January 2024, the ICB submitted its updated Constitution to NHS England, requesting approval for its variation. The ICB has now received approval from NHS England and the updated Constitution has now been published on the ICB website.[1]

7. Marthas Rule – Phase 1 Implementation

7.1 The first phase of the introduction of Martha's Rule will be implemented in the NHS from April 2024. Once fully implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition.

7.2 The implementation of Martha's Rule in the NHS will take a phased approach, beginning with at least 100 adult and paediatric acute provider sites who already offer a 24/7 critical care outreach capability. NHS England will be asking for expressions of interest to be part of the first phase of the programme.

7.3 This first phase will take place during 2024/25 and will focus on supporting participating provider sites to devise and agree a standardised approach to all three elements of Martha's Rule, ahead of scaling up to the remaining sites in England in the following years.

7.4 The three proposed components of Martha's Rule are:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, which they can contact should they have concerns about a patient.
2. All patients, their families, carers and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital and more widely if they are worried about the patient's condition. This is Martha's Rule.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

7.5 The Board will be updated as soon as it is confirmed which of our Trusts across Cheshire and Merseyside are part of the first phase.

[1] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/constitution/

8. Cheshire and Merseyside Super MaDE Event

8.1 NHS Cheshire and Merseyside coordinated a seven day, system wide *Super* MaDE (multi-agency discharge event) which commenced on the 22 March 2024, timed to help improve system flow ahead of the busy Easter bank holiday weekend at the end of the month.

8.2 A MaDE event brings together the local health and care system to support improved patient flow across the system, recognise and unblock delays, and challenge, improve and simplify complex discharge processes.

8.3 Although we know that many Trusts regularly hold MaDE events, this has been the first ever attempt as a *Super* MaDE event of this scale, which will be a coordinated effort across an entire system.

8.4 Our hope is that this event will create unique opportunities to work in a more focused way as system partners to address key challenges and support the achievement of key performance standards – particularly around the 4 hour Emergency Department wait target, and Category 2 ambulance response times.

8.5 The *Super* MaDE will involve clinical and operational staff from across the system, with strategic coordination support provided via our Strategic Command Centre and EPRR team. Ward and clinical teams will be supported by MaDE teams who will help to unblock delays in real time leading to improved flow for our patients.

8.6 A range of supporting resources have also been developed to assist our system partners in their readiness for this event, including:

- a series of Lunch and Learn webinar sessions will take place in the run up in relation to managing patient flow for staff involved
- a *Super* MaDE communications pack - including comms describing the purpose of the event, checklists, action cards, and other resources for use throughout the event have also been cascaded.

8.7 Board will be updated at its meeting on 28 March 2024 on how MaDE event went and any early outcomes.

9. Dental Recovery Plan

9.1 The Government and NHS England published on 07 February 2024 the Dental Recovery Plan for England. Under the plans, supported by £200m of government funding, NHS dentists will be given a 'new patient' payment of between £15-£50 (depending on treatment need) to treat around a million new patients who have not seen an NHS dentist in two years or more.

9.2 Key areas outlined within the plan include:

- a major new focus on prevention and good oral health in young children and deliver an expanded dental workforce

- the roll out a new 'Smile For Life' programme which will see parents and parents-to-be offered advice for baby gums and milk teeth, with the aim that by the time children go to school, every child will see tooth brushing as a normal part of their day.
- to attract new NHS dentists and improve access to care in areas with the highest demand, around 240 dentists will be offered one-off payments of up to £20,000 for working in under-served areas for up to three years.
- the public will also be able to see which practices in their local area are accepting new patients on the NHS website and the NHS App. To promote the increased availability of appointments, the government will also roll out a marketing campaign encouraging anyone who has not been seen by a dentist for the past two years to access treatment.
- NHS work will also be made more attractive to dental teams with the minimum value of activity increasing to £28 (from £23).
- New ways of delivering care in rural and coastal areas will also be rolled out, including launching 'dental vans' to help reach the most isolated communities.
- a water fluoridation programme will be rolled out by government, which could reduce the number of tooth extractions due to decay in the most deprived areas of the country. Subject to consultation, the programme would enable an additional 1.6 million people to benefit from water fluoridation, first expanding across the North East.
- the health service will build a pipeline of new dentists and other dental care professionals, including increasing dental training places by up to 40% by 2031/32, as part of the NHS Long Term Workforce Plan.
- new measures to attract dentists to work in the NHS, including supporting more graduate dentists to work in NHS care. The government will consult on whether dentists should be required to work in the NHS for a period upon completion of their training.

9.3 Later on in today's Board agenda, members will hear further details regarding our local Dental Improvement Plan.

10. Cancer Performance

10.1 Cheshire and Merseyside continues to make positive progress towards the national ambition of diagnosing 75% of cancers at an early stage by 2028. Cheshire and Merseyside is ahead of the national average and is improving at a much faster rate than nearly all other areas of England.

10.2 The number of patients on suspected cancer pathways for more than 62 days (aka the backlog) has reduced by over 66% since the start of last year. Cheshire and Merseyside currently significantly ahead of trajectory and on track to over-achieve the end of March 2024 target.

10.3 Whilst Cheshire and Merseyside is one of the better performing systems against the 31 and 62 day cancer waiting times standards, performance against the 28 day faster diagnosis standard (FDS) remains challenging and is below the

England average . However, it is anticipated that performance data, once published, for February and March will show improvement.

10.4 Further details about our performance can be seen within the Quality and Performance report to Board.

11. Community Diagnostics Centre – Halton

11.1 The second phase of the Warrington and Halton Diagnostics Centre (WHDC) officially opened at Halton Health Hub on 16 February 2024. The centre is part of a larger programme run by the CMAST Diagnostic Programme to make diagnostic testing more accessible for the people of Cheshire and Merseyside. Our ICS now has a total of 10 local Community Diagnostic Centres (CDC), with the Warrington and Halton centre being the first to be located within a central shopping centre.

11.2 CDCs, bring greater capacity to carry out vital NHS tests and scans in locations away from the pressures of a busy acute hospital providing emergency care, but close to where patients live. They offer a variety of tests such as, ultrasound, CT, MRI, echocardiography, ECG, phlebotomy, gastroscopy and colonoscopy to check for a wide range of conditions including cancer. The WHCDC is run by Warrington and Halton Teaching Hospitals NHS Foundation Trust.

12. Diagnostic Performance

12.1 Cheshire and Merseyside Diagnostics reported the highest rate of diagnostic testing to occur in any month ever. Over the course of January 2024, 116,479 tests were delivered which is 9% above plan YTD.

12.2 Performance improved so that 84% of patients waited 6 weeks or less for their test with plans on track to ensure that the target of 90% of patients being seen within 6 weeks by the end of March 2024 is met in Cheshire and Merseyside.

12.3 Cheshire and Merseyside ICS is now ranked 4th out of 42 ICSs for Diagnostic Performance. Much has been achieved by focussing on increasing activity, productivity and deploying mutual aid across our system but there remains much to do, and focus continues particularly in endoscopy so that all waiting times are as low as possible.

13. Endoscopy Transformation Programme Launches in April 2024

13.1 A number of the major elements and services as part the Endoscopy Transformation programme will be available to patients in Cheshire and Merseyside from April 2024. The project received £8.1 million in funding from NHS England and is a collaboration of CMAST Diagnostics and six hospital Trusts including, Alder Hey Children's NHS Foundation Trust, Countess of

Chester Hospital NHS Foundation Trust, East Cheshire NHS Trust, Liverpool University Hospitals NHS Foundation Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS Foundation Trust, Warrington and Halton Teaching Hospitals NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust.

13.2 The purpose of the transformation programme is to transform endoscopy services across Cheshire and Merseyside, ensuring they are fit for purpose, that they are using the latest and best technology and to create an "endoscopy without borders" service that allows for better access.

13.3 The programme will be delivered involving four different models of care:

- development of an additional central Hub site for endoscopy services, creating further capacity to deliver services.
- providing service users with alternatives to endoscopy at an increasing number of locations.
- delivering specialist procedures/advanced endoscopy at a limited number of sites to retain specialist skills and resources.
- testing the use of innovative digital programmes to help reduce duplication of administrative processes.

13.4 The services that will be available starting in April include:

- the additional central Hub including two additional Endoscopy rooms to be built in the Halton Endoscopy unit (bringing this to a total of four) at Warrington and Halton Teaching Hospitals NHS Foundation Trust will start to deliver the new centralised surveillance activity and bowel cancer screening programme.

- also located in Halton, teams will start providing transnasal gastroscopy (TNG), colon capsule endoscopy (CCE) and pill on a string services (all minimally invasive alternatives to traditional endoscopy procedures).

- Teams in Arrowe Park will be providing polyps removal services, Endoscopic Retrograde Cholangio-Pancreatography (ERCP) -a procedure allows the endoscopist to take detailed X-rays of the bile duct and/or pancreas- and ASL.

- East Cheshire will start providing TNG and CCE from Macclesfield District General.

- Countess of Chester will start providing TNG from their site.

- LUHFT will have their first 'bot' operational from April working towards their goal of saving administrative hours, releasing time back to patient facing activities.

14. Continuous Glucose Monitoring in Diabetes

14.1 In October 2022, the ICB approved NICE guidance for continuous glucose monitoring (CGM) and flash glucose monitoring. CGM and flash glucose monitoring are both examples of innovative diabetes technology developed to help patients manage their diabetes. The Board was particularly interested in how the new guidance would be implemented in a way that had a positive impact on health inequalities and asked to be kept updated on progress.

14.2 EPACT2 data shows that within primary care there has been a 61% increase in CGM prescribing since October 2022. Cheshire and Merseyside prescribing guidance has been developed to support a consistent approach to prescribing. Increases in CGM prescribing within primary care have occurred across all 9 places in Cheshire and Merseyside.

14.3 There is ongoing work nationally to improve the timeliness and accuracy of data relating to diabetes technology use in secondary care. This will provide future assurance relating to the implementation of the use of diabetes technology and its impact on inequalities.

14.4 The Children and Young People Transformation Programme has undertaken pilot work across two hospital teams to tackle the impact of health inequalities by providing increased access to diabetes technology for children with diabetes which has led to 184 patients moving onto diabetes related technology and of these 50% were from the most deprived decile. Learning from the work undertaken has been shared across Cheshire and Merseyside.

14.5 In December 2023, hybrid closed loop systems (HCL), the next phase of diabetes technology which builds on the use of CGM, was recommended in a NICE technology Appraisal which was approved by NHS Cheshire and Merseyside in March 2024. The ICB is now working closely with the Cheshire and Merseyside diabetes network, the national diabetes team, and clinicians in our Trusts, to finalise a delivery plan for HCL technology in line with the nationally recommended timeline of five years.

14.6 These implementation and delivery plans for access to approved diabetes technology will continue to focus on enabling fair and equitable access across Cheshire and Merseyside. Further work is planned to monitor the uptake and progress of delivery, including the impact on tackling health inequalities.

15. Clinical Policy Harmonisation Update

15.1 The Clinical Policy Harmonisation Programme to develop a single suite of commissioning policies across Cheshire and Merseyside is nearing completion. This work was necessary following the creation of NHS Cheshire and Merseyside ICB, who, as the successor body to the nine former Clinical Commissioning Groups (CCGs), inherited each CCG's commissioning policies, of which a degree of variation existed between the CCGs.

15.2 The programme has now completed the work to produce 113 recommended harmonised policies in line with the latest evidence base, with a total of 84 harmonised policies now live (with 35 of these policies launched in March 2024 following endorsement at the ICBs Finance, Investments and Resourcing and the ICB Quality and Performance Sub-Committees). More information and a link to the latest policies can be found at: https://www.cheshireandmerseyside.nhs.uk/your-health/policies/. Polices are categorised into the following areas:

Aesthetics/Cosmetics	Ophthalmology
Breast Surgery	Oral and Maxillofacial
Ear Nose & Throat (ENT)	Orthopaedic
Endocrinology	Paediatrics & Child Health
Gastroenterology	Plastic Surgery
General Surgery	Psychiatry
Multi-Speciality	Radiology
Musculoskeletal (MSK)	Rheumatology
Neurology	Urology
Non-Speciality Specific	Vascular
Obstetrics & Gynaecology	

15.3 Of the 29 policies yet to be launched, 25 proposed policies are prepared and require a level of public engagement ahead of any decision-making process, due to the proposed small changes in patient access. This engagement is planned to commence following completion of the local elections in May 2024.

15.4 For the remaining four policies, further analysis and review is required ahead of proposed harmonisation and public engagement activity. Board will continue to be updated on progress at its future meetings.

16. Altogether Fairer – Our Health and Care Partnership Plan and the 2024-2029 Cheshire and Merseyside Joint Forward Plan

16.1 In January 2023 the Cheshire and Merseyside Health and Care Partnership (HCP) published a draft Interim Strategy.[2] There was always an intention to revise this strategy as the HCP matured and reviewed its priorities. Following feedback from members of the HCP, Health and Wellbeing Boards and other stakeholders work has taken place to align a refreshed HCP strategic plan with the strategic priorities contained in the All Together Fairer Report. This approach built on feedback indicating strong system wide ownership and sense of engagement in the ATF report. The approach was supported by the ICB Board at its meeting in November 2023.

16.2 On 19th March 2024 the HCP endorsed the draft content of the revised strategic priorities described in the revised strategy; **All Together Fairer: Our Health and Care Partnership Plan**. It was agreed that within the document a set of

[2] https://www.cheshireandmerseyside.nhs.uk/media/hxqpdrot/cheshire-merseyside-draft-interim-hcp-strategy-2023.pdf

headline ambitions should be included to articulate our key priorities. Further engagement will now take place to finalise these headline ambitions and the final document content, and a supporting delivery plan will be considered at the June 2024 HCP meeting.

17. 2024-2029 Cheshire and Merseyside Joint Forward Plan

17.1 The first NHS Cheshire and Merseyside Joint Forward Plan (JFP) was approved by the Board at its meeting in June 2023. There is a requirement of ICBs and member NHS Trusts to refresh the plan each year. The plan is required to reflect the priories of our nine Health and Wellbeing Board Strategies, our HCP strategic priorities and national and local NHS priorities. In response to this the approach being taken to the refresh of our plan is to comprise of an overarching introductory document and then three separate but interrelated plans which are in the process of being produced:

- **HCP/All Together Fairer Delivery Plan**
  (as described above the strategic priorities were presented to the HCP on the 19th of March 24 as part of the All Together Fairer; Our Health and Care Partnership Plan document and a final document and associated delivery plan will be presented to the June HCP)
- **Place Partnership Delivery Plans X9**
  (A draft document has now been produced summarising each Place Partnership's priorities in delivering their local Health and Wellbeing Strategy)
- **NHS Cheshire and Merseyside Delivery Plan**
  The content remains aligned with our 2023-28 Joint Forward Plan. A draft document has been produced and will be shared with partners in early April 2024 to gain further feedback. At present national NHS Planning Guidance for 2024-25 has not been published and the final document will need to reflect this. A final version of the Plan will come to Board at its May 2024 meeting ahead of the national publication deadline of 30 June 2024.

18. International Women's Day – 08 March 2024

18.1 NHS Cheshire and Merseyside celebrated International Women's Day on 08 March 2024 by asking some of our female colleagues about their thoughts on how we can help forge a more inclusive NHS to share on social media.

18.2 Today you will see some quote cards on the screens in the Lewis' building - thank you to our board members and colleagues who took part.

19. Congratulations

19.1 Congratulations to Dr Bryony Kendall, our Named GP for Safeguarding for Liverpool Place, who received a Chief Superintendent's Commendation from Merseyside Police on 06 March 2024. This commendation is testament to Bryony's values of collaboration in sharing best practice, improving outcomes for our people and communities, and innovating new and different ways of

working to improve services. It provides a well-deserved thanks to all the hard work she has undertaken across Merseyside in her Named GP role.

19.2 Our work with C2Ai was shortlisted in the Gartner's prestigious international "Eye on Innovation in Health care awards". This is an international award with submissions form major tech companies and Health Care Systems across the world. The Cheshire & Merseyside submission "Transforming waiting List with AI " was awarded runner-up in a very competitive field. Additionally Our Digital Inclusion Programme has also been shortlisted for the 2024 HSJ Digital Awards in the Digital Equality, Diversity and Inclusion Category. The Award ceremony is due to be in June 2024.

20. Decisions taken at the Executive Committee

20.1 Since the last Chief Executive report to the Board in January 2024, the following items have been considered by the Executive Team for decision:

- **Recruitment Campaign Proposal – All Age Continuing Health Care**. The Executive Team approved proposals to run a drop in recruitment event for Nurse assessors for the ICBs CHC team. The event is being run on the 25 March 2024. Details will be published on our website[3] and advertised across different media.
- **Running Cost Proposals** – the Executive team approved the principles and proposals around agreeing fixed and flexible Place management budgets for 2024-2025.

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

21. Officer contact details for more information

Matthew Cunningham
Associate Director of Corporate Affairs and Governance
matthew.cunningham@cheshireandmerseyside.nhs.uk

[3] https://www.cheshireandmerseyside.nhs.uk/posts/band-5-and-6-nurse-assessors-sought/

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Director of Nursing and Care Report

Agenda Item No: ICB/03/24/06

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

NHS
Cheshire and Merseyside

Director of Nursing and Care Report

1. Purpose of the Report

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

1.2 A position update is provided in relation to the work of Local Maternity and Neonatal System (LMNS), alongside updates/highlights of the work in relation to the Children & Young People's Programme (Beyond) and the work underway to celebrate International Day of the Nurse and Midwife in May 2024.

2. Executive Summary

2.1 The ICB's local maternity and neonatal system (LMNS) is responsible for the delivery, oversight, and assurance of the national three-year plan for Maternity and Neonatal which has four key themes:

- Listening to Women and Families with compassion
- Growing, retaining and supporting our workforce
- Developing a culture of safety, learning and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

2.2 The report will provide an updated position of outcomes of Care Quality Commission (CQC) inspections for maternity services within Cheshire and Merseyside (C&M), as well as findings from the latest inpatient women's survey for maternity services experiences.

2.3 The report will then go on to highlight the work of the Children and Young Person Programme (Beyond) describing progress against health inequalities work stream and other identified priorities.

2.4 The report also details work underway to celebrate the International Day of the Nurse and Midwife in May 2024.

3. Ask of the Integrated Care Board & Recommendations

3.1 The Integrated Care Board is asked to consider the contents of the report for assurance purposes.

4. Reasons for Recommendations

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

5. Background

5.1 **Local Maternity & Neonatal System.** The ICB's local maternity and neonatal system (LMNS) is responsible for the delivery, oversight, and assurance of the national three-year plan for Maternity and Neonatal which has four key themes:

- **Listening to Women and Families with compassion**
  - Care that is personalised
  - Improve equity for mothers and babies.
  - Working with service users to improve care.

- **Growing, retaining and supporting our workforce**
  - Growing our workforce at all levels
  - Valuing and retaining our workforce.
  - Investing in and accrediting skills

- **Developing a culture of safety, learning and support**
  - Developing a positive safety culture
  - Learning and improving
  - Support and oversight.

- **Standards and structures that underpin safer, more personalised, and more equitable care.**
  - Standards to ensure best practice.
  - Data to inform learning.
  - Digital.

5.2 The LMNS works with all nine places within C&M to provide assurance and delivery of all elements of the delivery plan with providers of maternity and neonatal services across Cheshire and Merseyside. There are a wide range of projects and workstreams which are led and/or supported by the LMNS within the four themes which include:

5.3 All C&M Maternity providers have now undergone inspection by the CQC, outcomes received to date are illustrated in table below:

Maternity provider	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL-LED	OVERALL – Maternity inspections 2023	Progress of outstanding CQC reports following 2023 review of maternity services
Countess of Chester	Requires Improvement February 2024	Requires improvement. February 2024	Good June 2022	Good February 2024	Requires Improvement February 2024	Requires Improvement February 2024	
Liverpool Women's Hospital*	Inadequate June 2023	Good April 2020	Good April 2020	Outstanding April 2020	Requires improvement. June 2023	June 2023 Requires improvement.	
Mid-Cheshire Hospital	Requires improvement. Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Requires Improvement in **draft report** March 2024 Final rating TBC.	**Inspected Sept 2023** Draft report for factual received by Trust March 2024. Rating in draft report 'Requires Improvement' being challenged by Trust.
Ormskirk Hospital (now Mersey & W Lancs Ormskirk)	Requires improvement. March 2018	Good March 2018	Good March 2018	Good March 2018	Requires improvement. March 2018	Requires improvement. March 2018	**Inspected as Mersey and West Lancs December 2023** – Draft report received by Trust for factual accuracy
STHK (now Mersey & W Lancs Whiston)	Good March 2019	Good March 2019	Good March 2019	Good March 2019	Good March 2019	Good March 2019	**Inspected as Mersey and West Lancs December 2023** – Draft report received by Trust for factual accuracy
Warrington Hospital	Good January 2024	Good July 2019	Good July 2019	Good July 2019	Good January 2024	Good January 2024	
Wirral University Hospital*	Requires Improvement August 2023	Good May 2018	Good May 2018	Good May 2018	Requires improvement. August 2023	Good May 2018	

5.4 The top themes identified from the CQC inspection reports received to date. (COC,LWH, WHH and WUTH) share the following themes (a deeper dive into the themes across all the reports are planned once all the reports have been received by the Trusts):

- **Triage** – access to timely assessment when presenting to Triage to reduce risk, although the LMNS esitrep has shown substantial improvements in this across the system over the last year.
- **Leadership and Culture** – There is variation in culture as largely reflected by the CQC ratings. Where culture was positive the staff spoke of good engagement with the leadership team and women and families and getting good feedback from incidents and complaints. Where it was deemed that a poorer culture operated staff reported not feeling respected, supported, valued with a reluctance to raise concerns and not feedback from incidents.
- **Equipment / environment** – Out of date drugs and equipment not fit for purpose was sometimes found on inspection. There were also some gaps in equipment checks.
- **Risk assessment and recognition of deterioration**. Staff did not always use the risk assessment tools to quickly act on minimising risks and keeping

women and families safe. The NWAHSN mat/neo programme (Academic Health Science Network) is leading on a deterioration work stream including the use of maternity and neonatal early warning scores.

- **Guidelines** - these were not always in date or based on national guidance in Trust that had lower ratings.

5.5 **The CQC Women's Survey 2023.** The latest survey results were reported in February 2024. The highlight results for Cheshire and Merseyside show:

- National results relative to 2022, show signs of improvement in many areas.
- Cheshire and Merseyside comparison between 2022 and 2023:
  - C&M average response rate fell to 41% (53% in 2022) – this decrease was reflected nationally.
  - 5 of 7 Trusts showed improvement, with no decreases between 2022 and 2023.
  - All 7 Trusts had a statistically significant improvement in at least 1 question since 2022.
    - Staff Caring for you – MCHT highest section score in NW region
    - COCH in top 5 Trusts in NW region for 7 of 8 section scores- 'Better than expected' for 4 questions including '*During labour and birth, were you able to get a member of staff to help you when you needed it?'* and 'Somewhat better than expected' for 2 questions including *'Were you given information about changes you might experience to your mental health after having a baby?'*
    - LWH had highest score since 2013 for *'During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?'*
    - MCHT 'Better than expected' for 3 questions including *'Thinking about your care during labour and birth, were you involved in decisions about your care?'* and 'Somewhat better than expected' for 4 questions including *'Thinking about your care during labour and birth, were you treated with respect and dignity?'*
    - Ormskirk, MCHT and WHH had highest score since 2019 for *'Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?'*
    - Ormskirk 'Better than expected' score for '(Care at home after birth) *Did a midwife or health visitor ask about your mental health?'*
    - Whiston had significant score increase since 2022 for 10 questions including '*Did you feel that Midwives and other health professionals gave you active support and encouragement about feeding your baby?'* and '*Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?'*
    - WUTH had significant score increase since 2022 for 3 questions including '(Postnatal Care) *If you contacted a midwifery or health visiting team, were you given the help you needed?'* and '*Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?'*
    - WUTH in top 5 Trusts in NW region for 2 section scores (*Care in ward after Birth* and *Care at Home after Birth*).

5.6 **Oversight & Assurance.** The LMNS works with providers to support delivery on all aspects of the priorities and themes within the 3-year delivery plan and provides assurance of compliance with the Maternity Incentive Scheme (MIS) each year for Trusts. This includes all ten safety actions in Table below:

Safety Action 1	Use of the National Perinatal Mortality Review Tool
Safety Action 2	Submitting data to the Maternity Services Data Set
Safety Action 3	Transitional care services to minimise separation of mothers and babies.
Safety Action 4	Effective systems of clinical workforce planning
Safety Action 5	Effective system of midwifery workforce planning
Safety Action 6	Demonstrating compliance with Saving Babies Lives Care Bundle v3
Safety Action 7	Listen to women, parents and families using maternity and neonatal services with users.
Safety Action 8	Multi professional maternity Core Competency Framework Version 2 training
Safety Action 9	Board Assurance for maternity and neonatal safety and quality issues.
Safety Action 10	Reporting of all qualifying cases to HSIB/MNSI and NHS Resolution Early Notification Scheme

5.7 All providers have declared full compliance with the NHS Resolution for Year 5 of the scheme, and their submissions have received approval from their Boards and were signed off by Trust Chief Executives and ICB Chief Executive by the submission date of 01 February 2024. Routine oversight and assurance is provided via meetings, forums and events as well as opportunities for quality improvement and transformational work.

6. Children & Young People Programme (Beyond)

6.1 **Health Inequalities**. The Beyond Programme continues to support the CYP Health Equity Collaborative (HEC), a collaboration between Barnardo's, the Institute for Health Equity and 3 ICSs (C&M, South Yorkshire, and Birmingham & Solihull). The Child Health Equity Collaborative (CHEC) Framework for the Drivers of Health Inequalities has now been published. This was revised to ensure that it reflected the views of over 300 children and young people (CYP) who were consulted on what matters most to them. The information from children and young people has been collated into an Insights report and into an explainer video with the voices of children and young people involved, the link to this information is provided below:
Children and Young People Health Equity Collaborative - IHE (instituteofhealthequity.org)

6.2 Cheshire and Merseyside have recruited 4 young people to act as CHEC champions. These young people are working alongside the Beyond Programme and have recently shared their views with the Children's Committee of the ICB to

share the CYP insights with the Committee and consider how the Cheshire and Merseyside approaches to young people can reflect these themes.

6.3 Next steps include the identification of pilot interventions to address some of the drivers of health inequalities. This will be based on the data indicator set and be focused on populations most at need. A stakeholder event will be held on 28th March 2024 to discuss this in more detail.

6.4 **Beyond Programme Highlights**. The Beyond programme has been identified as the delivery partner for a 3-year supervised toothbrushing programme across the region. Recruitment has commenced for programme delivery roles to support mobilisation. Early Intervention funding from NHS England is now supporting the parent champion approach to oral health care in Liverpool: 6 parent champions and 6 staff trained (cohort 1) for the delivery of parent champions.

6.5 Work to improve pathways and provision of neurodiversity services has commenced across the ICB (chaired by Place Director for Cheshire West and Director of Childrens Services for Sefton) to develop standardised assessment, diagnosis and support systems for CYP with neuro-diversity.

6.6 To reduce rates of asthma and respiratory illness, 525 families (parent champions) have been identified and are being supported across 4 Places. The INTENT (smoking prevention programme) has launched live teaching sessions, across 49 schools, with 61 members of staff trained to deliver these programmes. Alongside this programme, there has been the launch of Asthma Friendly Schools programme, with 1 school meeting the standards for accreditation to date.

6.7 In Diabetes care, 224 CYP (Warrington & Halton, Arrowe Park) started on new technology to improve outcomes, with a particular focus on CORE20 populations. The ICB is developing its strategy for 5-year implementation plan for Hybrid Closed Loop technologies, initial focus suggested by NHSE includes:

- Children and young people
- Women, trans-men and non-binary people who are pregnant or planning a pregnancy.
- Adults already using insulin pumps who want to transition to an HCL system.

7. International Day of the Nurse & Midwife

7.1 International Nurses Day is celebrated on 12th May each year, to coincide with the birthday of Florence Nightingale, and since 1988 has been given a theme by the International Council of Nurses. The theme for 2024 is 'The economic power of care' and was chosen to highlight the need for nursing to be seen as an investment, instead of a cost, and to “reshape” perceptions of nursing’s economic and societal benefits.

7.2 Although the backbone of Health Care delivery, nursing often faces financial constraints and societal undervaluation. Organisations will be holding events within their organisation, and in addition, NHS Cheshire and Merseyside will be

holding an event for Directors of Nursing/Midwifery on 7th May 2024 which will include presentations and an opportunity to celebrate the role of nurse/midwife and to look at the future of the profession.

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

8.1 The current workplan for both maternity and children and young people programmes complements the CQC ICS Quality Statements and in particular:

- How we work as partners for the benefit of our population
- Population Health
- Children & Young People (CYP)
- Women's Health & Maternity
- Personalised Care.

9. Link to meeting CQC ICS Themes and Quality Statements

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

10. Risks

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

11. Next Steps and Responsible Person to take forward.

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

12. Officer contact details for more information

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Cheshire and Merseyside Integrated Care System Finance Report Month 11

Agenda Item No: ICB/03/24/07

Responsible Director: Claire Wilson, Director of Finance

Cheshire and Merseyside System Finance Report Month 11

1. Purpose of the Report

1.1 This report provides an update to the Board of NHS Cheshire and Merseyside on the financial performance of the Cheshire and Merseyside ICS ("the ICS") at Month 11, in terms of relative position against its financial plan to NHS England ("NHSE"), and alongside other measures of financial performance (e.g. efficiency, agency) and utilisation of available 'capital' resources for the financial year.

1.2 The report provides details of a change made to the 2023/24 forecast position at Month 11 following discussions with NHS England and in line with the risk position previously reported to the Board.

1.3 The Board is asked to **approve** the revised 2023/24 financial forecast for the Integrated Care Board and **note** the forecast for the Cheshire and Merseyside NHS Providers as per the table below. A further £7m improvement is anticipated on the Provider side, subject to confirmation.

	M11 YTD			2324 Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
ICB	54.5	33.8	(20.7)	59.4	32.6	(26.8)
Total Providers	(65.5)	(95.4)	(29.9)	(59.5)	(82.6)	(23.2)
Total System	(11.0)	(61.5)	(50.5)	(0.0)	(50.0)	(50.0)

2. Executive Summary

2.1 Regular financial performance reports are provided to the Finance, Investment and Resources Committee of the ICB who undertake detailed review and challenge on behalf of the Board. The chairs' report from this meeting is reported separately on the agenda.

2.2 In May 2023 the System plan submitted was a combined £51.2m deficit, consisting of £68.9m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £120.1m. This plan was set on the basis that there would not be significant ongoing industrial action through the year.

2.3 In November 2023 NHSE requested that ICBs and providers resubmit system 2023/24 plans to live within their re-baselined system allocation as part of the national settlement responding to the significant impact of industrial action from April to October 2023. The revised system plan submitted to NHSE was a

breakeven position, consisting of £63.9m surplus on the ICB side offsetting the aggregate NHS Provider deficit position of £63.9m.

2.4 As of 29 February 2024 (Month 11), the ICS is reporting a YTD deficit of £61.5m against a planned YTD deficit of £11m resulting in an adverse YTD variance of £50.5m.

2.5 A £50m system deficit is forecast compared to a balanced financial plan: this reflects a £32.6m surplus for the ICB, alongside a provider deficit of £82.6m. There is a further improvement of £7m expected on the Provider side, which had not been confirmed at the time of reporting to NHS England. This includes £15m of pressure associated with unfunded elements of the impact of industrial action.

2.6 The consequences of reporting off plan are still to be confirmed, but as a minimum we expect to forfeit the additional capital on offer in 24/25 £7.4m and expect that this year's deficit will be repayable in 2025/26.

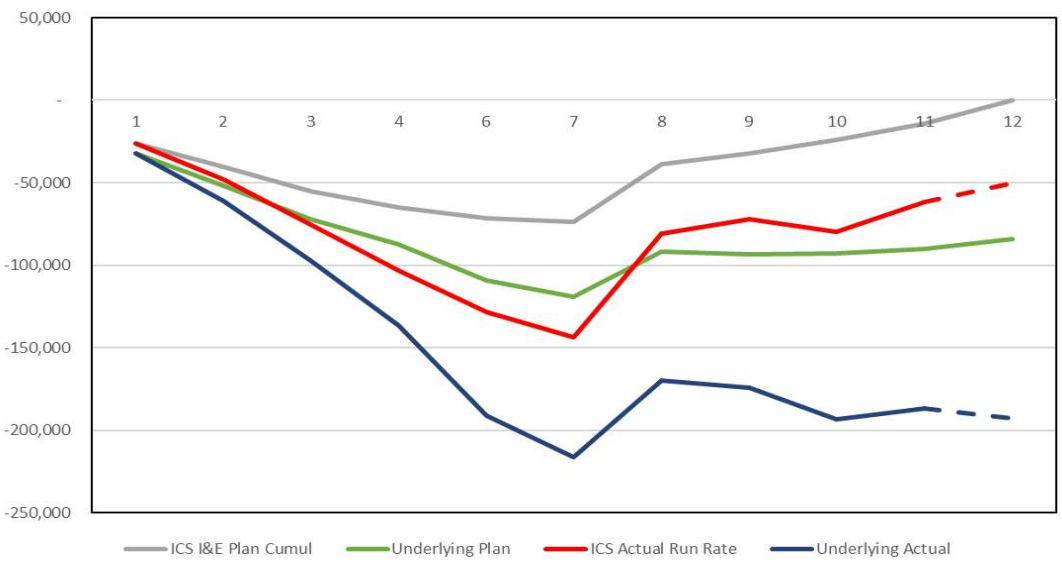
2.7 The system financial position as reported to NHS England at Month 11 is set out in Table 1:

Table 1 – Financial Performance Month 11 YTD and FOT

	M11 YTD			2324 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	54.5	33.8	(20.7)	59.4	32.6	(26.8)
Total Providers	(65.5)	(95.4)	(29.9)	(59.5)	(82.6)	(23.2)
Total System	(11.0)	(61.5)	(50.5)	(0.0)	(50.0)	(50.0)

2.8 **Chart 1** below shows profile of ICS I&E plan and actual run rate with and without impact of non-recurrent CIP to estimate the underlying position. The dotted lines indicate the required run rate to achieve the revised planned breakeven position. The reflected underlying position does not include any further non recurrent items (income and expenditure) that contained within ICB and provider forecasts. The forecast indicates the actual run rate is being supported by more non recurrent CIP than planned and therefore the underlying position is forecast to be adverse from plan.

Chart 1 – Plan Profile and Run Rate



2.9 As the system forecast has been adjusted to a £50m deficit, the level of net risk reported is significantly reduced compared to previous months. A remaining risk of £12m on the provider side has been reported.

3. Financial Performance Month 11

ICB financial performance – M11

3.1 The ICB has reported a YTD surplus of £33.8m compared to a revised planned surplus of £54.5m, resulting in an adverse variance to plan of £20.7m as per Table 3.

Table 3 – ICB Financial Performance M11 YTD

	M11 YTD Plan £m	M11 YTD Actual £m	M11 YTD Variance £m	M11 YTD Variance %
TOTAL ICS Surplus/(Deficit)	**(11.0)**	**(61.5)**	**(50.5)**	**(0.8%)**
ICB Net Expenditure:				
Acute Services	3,034.1	3,037.9	(3.8)	(0.1%)
Mental Health Services	604.0	621.6	(17.6)	(2.9%)
Community Health Services	600.2	598.5	1.7	0.3%
Continuing Care Services	317.2	358.7	(41.5)	(13.1%)
Primary Care Services	566.3	582.1	(15.8)	(2.8%)
Other Commissioned Services	12.2	12.5	(0.3)	(2.3%)
Other Programme Services	60.8	55.6	5.2	8.5%
Reserves / Contingencies	23.1	0.0	23.1	100.0%
Delegated Primary Care Commissioning	748.2	722.0	26.3	3.5%
Primary Medical Services	*481.9*	*479.4*	*2.4*	*0.0%*
Dental Services	*174.0*	*154.4*	*19.6*	*11.3%*
Ophthalmic Services	*24.8*	*23.1*	*1.6*	*6.6%*
Pharmacy Services	*67.6*	*65.0*	*2.6*	*3.8%*
ICB Running Costs	49.8	47.7	2.0	4.1%
Total ICB Net Expenditure	**6,016.0**	**6,036.7**	**(20.7)**	**(0.3%)**
Allocation adjustment for reimbursable items		0.0	0.0	
TOTAL ICB Surplus/(Deficit)	**54.5**	**33.8**	**(20.7)**	**(0.3%)**

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

a) Mental Health Services – overspend relating to packages of care linked to cost and volume of service users. The position improved by £1.2m in-month.
b) Continuing care - overspend relating to increases to volume and price for continuing care including the impact of inflation above national planning assumptions. The adverse variance increased by £3.4m in-month.
c) Prescribing – estimated overspend based on December 2023 prescribing data (latest available) and reflecting inflationary pressure above national planning assumptions.
d) Efficiency savings are built into the position and are forecasting full achievement of the £57.9m savings plan.
e) Surplus on Delegated budgets following November plan reset and slippage on centrally funded programmes.
f) Surplus on the ICBs utilisation of the running cost allowance.
g) Impact of uncommitted reserves

3.3 Details of ICB performance split by place is shown in Table 4 below, and further detail is provided in **Appendix 1.** All places have reported key pressures throughout the year in similar areas, namely prescribing, CHC and Mental Health packages of care. ICB central budgets are showing a positive variance to plan due to slippage on centrally funded programmes and the release of previously ringfenced funds as per government guidance, however this is insufficient to fully mitigate the pressures experienced in places.

Table 4 – Place M11 – Financial Performance

	M11 YTD Plan £m	M11 YTD Actual £m	M11 YTD Variance £m	Annual Plan £m	M11 Forecast Actual £m	M11 Forecast Variance £m
Cheshire - East	(33.3)	(45.9)	(12.6)	(36.4)	(50.9)	(14.5)
Cheshire - West	(25.0)	(43.1)	(18.1)	(27.3)	(45.8)	(18.5)
Halton	(7.9)	(7.6)	0.3	(8.6)	(8.5)	0.0
Knowsley	10.3	8.1	(2.2)	11.2	7.8	(3.4)
Liverpool	6.6	(7.0)	(13.5)	7.2	(8.0)	(15.2)
Sefton	(5.2)	(11.8)	(6.6)	(5.7)	(14.1)	(8.4)
St Helens	(7.9)	(12.4)	(4.5)	(8.6)	(13.8)	(5.2)
Warrington	(7.2)	(8.6)	(1.4)	(7.8)	(10.2)	(2.4)
Wirral	(6.6)	(20.3)	(13.8)	(7.2)	(23.5)	(16.4)
ICB	130.7	182.5	51.8	142.6	199.6	57.0
Total ICB	**54.5**	**33.8**	**(20.7)**	**59.4**	**32.6**	**(26.8)**

NHS Provider - Financial Performance – M11

3.4 Table 5 summarises the combined NHS Provider position to the end of February 2024, reflecting a year-to-date cumulative deficit position of £95.4m compared to a deficit plan of £65.5m, giving an adverse variance of £29.9m.

3.5 Since Month 10 NHS England has provided £18m additional funding to address the costs of industrial action. Industrial action costs for December to February have been estimated by providers to be £33m, resulting in a £15m pressure to positions. Of the £12m risk reported in month 10, £8m has materialised, leading to a forecast variance to plan of £23.2m. There is a potential upside of £7m related to capital compensation that has not yet been confirmed.

3.6 Table 5 below sets this out the M11 and forecast position by NHS Provider.

Table 5 – NHS Provider M11 – Financial Performance

	M11 YTD			2324 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Current £m	Variance £m
Alder Hey Children's NHS Foundation Trust	8.5	6.4	(2.1)	12.3	12.3	0.0
Bridgewater Community Healthcare NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	(0.1)	(0.1)	(0.0)	0.0	0.3	0.3
Countess of Chester Hospital NHS Foundation Trust	(23.1)	(23.1)	(0.1)	(25.2)	(25.2)	(0.0)
East Cheshire NHS Trust	(4.3)	(8.8)	(4.5)	(4.4)	(9.7)	(5.3)
Liverpool Heart and Chest Hospital NHS Foundation Trust	9.0	10.7	1.7	9.8	11.4	1.5
Liverpool University Hospitals NHS Foundation Trust	(5.7)	(11.3)	(5.6)	0.0	(2.3)	(2.3)
Liverpool Women's NHS Foundation Trust	(14.4)	(19.2)	(4.9)	(15.4)	(22.6)	(7.2)
Mersey Care NHS Foundation Trust	6.0	6.0	0.0	6.4	11.1	4.7
Mid Cheshire Hospitals NHS Foundation Trust	(17.8)	(21.9)	(4.1)	(18.9)	(22.9)	(4.0)
Southport And Ormskirk Hospital NHS Trust	(2.0)	(2.0)	(0.0)	(2.0)	(2.0)	(0.0)
Mersey and West Lancashire Teaching Hospitals NHS Trust	6.4	5.5	(0.9)	7.6	7.6	(0.0)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.3	2.0	1.6	0.4	2.1	1.8
The Walton Centre NHS Foundation Trust	3.8	6.7	2.8	4.1	7.3	3.2
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(15.1)	(24.3)	(9.2)	(15.7)	(27.5)	(11.8)
Wirral Community Health and Care NHS Foundation Trust	0.3	1.0	0.7	0.2	1.2	1.0
Wirral University Teaching Hospital NHS Foundation Trust	(17.5)	(22.8)	(5.3)	(18.6)	(23.8)	(5.2)
Total Providers	**(65.5)**	**(95.4)**	**(29.9)**	**(59.5)**	**(82.6)**	**(23.2)**

3.7 There are 9 Trusts reporting a year-to-date adverse variance to plan, a combination of industrial action over December and other operational issues as set out below.

3.8 Further analysis of the year-to-date position, as per the Table 6, demonstrates that the adverse position is a result of pay costs being £231.9m higher than anticipated and non-pay costs being £129.6m higher than budgeted. This is partially offset by income being £314.8m higher than expected and non-operating items being £16.8m lower than budgeted. It should be noted that the variance on pay compared to plan reflects the additional costs of the pay award agreed shortly after the planning submission, but this is funded by NHSE and reflected on the overachievement in reported income.

Table 6 – NHS Provider – Income and Expenditure vs Plan

	M11 YTD			
	Plan £m	Actual £m	Variance £m	%
Total Income	**(5,502.8)**	**(5,817.6)**	**(314.8)**	**(5.7%)**
Pay	3,643.3	3,875.2	231.9	(6.4%)
Non Pay	1,834.9	1,964.5	129.6	(7.1%)
Non Operating Items (excl gains on disposal)	90.1	73.2	(16.8)	18.7%
Total Expenditure	**5,568.3**	**5,912.9**	**344.6**	**(6.2%)**
Total Provider Surplus/(Deficit)	**(65.5)**	**(95.4)**	**(29.9)**	**(45.6%)**

NHS Provider Agency Costs

3.9 ICB NHS Providers set a plan for agency spend of £117.6m, compared to actual spend in 2022/23 of £155.9m. The System is required to manage agency costs within a ceiling and to demonstrate reduced reliance on agency staffing year on year. The ICS agency ceiling for 2023/24 is £127.3m.

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

3.11 At Month 11, year to date agency spend is £120m (£11.4m above plan), equating to 3.10% of total pay. 10 Trusts are reporting a year-to-date adverse variance to plan. Trust level information on agency spend can be found in **Appendix 2**.

3.12 Trusts are forecasting agency spend to be £129.7m, which is a £12.2m adverse variance to a plan of £117.6m and above the overall ICS agency ceiling of £127.3m. 11 Trusts are forecasting a full year adverse variance to plan for agency spend.

System Efficiencies

3.13 Table 7 shows there is currently a shortfall on planned CIP delivery, at month 11 the system is £16.8m adverse against its YTD plan and is forecasting a

£1.7m adverse variance against full year plan and is more dependent on non-recurrent efficiencies than planned. This increases the risk in the underlying financial position of the ICS and puts pressure on 2024/25 financial plans.

3.14 More detail on System efficiencies, by Trust and ICB, is included in **Appendix 3.**

Table 7 – System efficiencies performance M11 and FOT

	YTD Recurrent			YTD Non Recurrent			YTD Total		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	39.6	30.7	(8.9)	12.9	21.6	8.6	52.6	52.3	(0.3)
Total Providers	235.2	178.1	(57.1)	63.4	103.9	40.5	298.6	282.1	(16.6)
Total System	274.8	208.9	(65.9)	76.4	125.5	49.1	351.2	334.4	(16.8)
	2324 Recurrent			2324 Non Recurrent			2324 Total		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	43.8	39.5	(4.3)	14.1	18.4	4.3	57.9	57.9	0.0
Total Providers	260.8	204.9	(55.9)	70.0	124.2	54.2	330.8	329.1	(1.7)
Total System	304.6	244.4	(60.2)	84.1	142.6	58.5	388.7	387.0	(1.7)

ICB Efficiencies

3.15 The ICB is reporting broadly in line with the efficiency plan and the full £57.9m of efficiency is expected to be delivered by the end of the year.

3.16 Key schemes are focussed on Continuing Health Care and Prescribing costs in each of the 9 places.

3.17 £4.3m of planned recurrent savings are expected to be delivered through non-recurrent measures, which has an adverse impact on 2024/25 plans.

Provider Efficiencies

3.18 Provider efficiency schemes have delivered efficiencies of £282.1m year to date. £178.1m of this has been delivered recurrently. Providers are forecasting a £55.9m shortfall against the recurrent efficiency plan, which raises concerns over the underlying financial position and will need to be addressed in next years plans.

System Risks & Mitigations

3.19 At this stage in the financial year, most risks have either materialised or been mitigated and reported in the system forecast. £12m of risk remains related to the provider sector.

Provider Capital

3.20 The 'Charge against Capital Allocation' represents the Systems performance against its operational capital allocation, which is wholly managed at the Systems discretion. The Secondary Care allocation in 2023/24 is £245.0m.

3.21 Spend in relation to IFRS16 changes (movement of Operating leases from revenue to capital recognition) were previously administered by the national team, on behalf of systems, but this has been devolved in month 8. The ICS has been given an allocation of £28.3m for 2023/24 and it has been confirmed by NHSE that any leases that are internal to the NHS within the DHSC Group will be netted off and excluded against system allocations.

3.22 Table 8 represents the Month 11 YTD and FOT position against notified allocations. The current forecast is a £4.4m underspend against the combined allocation of £273.7m. Work is ongoing with providers to manage the £0.4m forecast underspend against the operational capital allocation before year end. The ICB remains in discussions with NHSE regarding the IFRS16 operating leases underspend of £4.0m which is being managed in aggregate across the North West region. The core provider operational capital and IFRS16 plan, actual and forecast by provider are set out in Appendix 4A and 4B.

Table 8 – Financial Performance against ICS capital allocations.

	Plan YTD £m	Actual YTD £m	Variance YTD £m	Plan FOT £m	Forecast FOT £m	Variance FOT £m
Provider Operational Capital						
Operational Capital Expenditure against allocation	188.3	123.8	64.6	230.0	223.0	7.0
Prior Year Adjustment		(26.0)			(22.0)	
Net Operational Capital Expenditure against allocation	188.3	149.8	38.6	230.0	245.0	(15.0)
ICS Provider Capital allocation*					**245.4**	
FOT Variance to allocation					0.4	
Allocation met					Yes	
Provider IFRS16 Leases						
IFRS16 Leases Expenditure against allocation	17.0	29.3	(12.3)	20.5	34.9	(14.5)
Expected leases internal to DHSC Group to net off					(10.6)	
Net IFRS16 Leases against allocation					24.3	
ICS Provider IFRS16 allocation					**28.3**	
FOT Variance to allocation					4.0	
Allocation met					Yes	
Combined Capital Position						
Combined Op Ex Capital and Leases against allocation	205.4	179.1	26.3	250.5	269.3	(7.5)
Combined ICS Capital Allocation					**273.7**	
FOT Variance to allocation					4.4	
Allocation met					Yes	

3.23 Spend in relation to National programmes (PDC Spend) 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. This is also for information only as it includes national schemes, such as CDCs, diagnostics, digital diagnostics, Frontline Digitisation, New Hospital Programmes and Elective Recovery.

3.24 At Month 11, providers have spent £237m against a FOT of £402m. This covers the entirety of operational capital, IFRS16 leases and nationally PDC funded schemes. Detail by provider is set out in **Appendix 4C**.

Primary Care Capital

3.25 The ICB has been allocated £4.7m in 2023/24 and £4.7m in 2024/25, for Primary Care Capital to cover GP Improvement Grants and GP BAU digital.

3.26 There has been £1.8m spend year to date in 2023/24 against Primary Care Capital allocation, and the ICB is forecasting to utilise the remaining £2.9m over Month 12 on further improvement grants and IT investments.

Cash and the Better Payment Practice Code (BPPC)

3.27 The provider cash position at Month 11 was £559.1m, with the detail set out in **Appendix 5**. This is £103.5m lower than at the end of 2022/23 and £172.7m higher than at the end of 2019/20.

3.28 4 Trusts have requested cash support from the ICS, the total value to date is £51.9m. Liverpool Women's £7.8m, Countess of Chester £17.7m, Mersey and West Lancashire £4.5m and Mid Cheshire £22m. Trusts are in the process of repaying back cash support to the ICB and have requested national cash support via NHSE.

3.29 The BPPC monitors public sector organizations on the timeliness of their financial payments both in terms of volume and value. Guidance recommends that 95% of payments are made within 30 days, the BPPC position at Month 11 for each Provider is set out in **Appendix 6**.

3.30 Providers struggling to meet the target of 95% for the combined NHS/Non-NHS year-to-date invoices are Countess of Chester, Liverpool University Hospitals, Mid Cheshire, and The Walton Centre.

4. Ask of the Board and Recommendations

4.1 The Board is asked to **approve** the revised 2023/24 financial forecast for the Integrated Care Board and **note** the forecast for the Cheshire and Merseyside NHS Providers as per the table below.

	M11 YTD			2324 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	54.5	33.8	(20.7)	59.4	32.6	(26.8)
Total Providers	(65.5)	(95.4)	(29.9)	(59.5)	(82.6)	(23.2)
Total System	(11.0)	(61.5)	(50.5)	(0.0)	(50.0)	(50.0)

4.2 The Board is asked to note the potential further improvement of £7m on the provider side, which is yet to be confirmed.

5. Officer contact details for more information

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6. Appendices

Appendix 1: **ICB Place Performance split by Programme Area M11**
Appendix 2: **Agency Spend: Current Performance and Forecast Outturn M11**
Appendix 3A: **System Efficiencies: Current Performance and Forecast Outturn M11**
Appendix 3B: **System Efficiencies: Recurrent/Non-recurrent split of YTD CIP**
Appendix 3C: **System Efficiencies Recurrent/Non-recurrent split of FOT CIP**
Appendix 4A: **Provider Capital: Current & Forecast Performance M11**
Appendix 4B: **Provider Capital: Current & Forecast Impact of IFRS16 M11**
Appendix 4C: **Provider Capital: Total CDEL M11**
Appendix 5: **Current Provider Cash Position as at M11**
Appendix 6: **Provider BPPC: Actual & YTD Total BPPC Position M11**

Appendix 1

ICB Place Performance split by Programme Area as at 29th February 2024

ICB CENTRAL	C&M ICB Default - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	576	577	(1)	619	620	(1)
Community	42	42	0	45	44	0
CHC	(0)	0	(0)	0	0	(0)
Mental Health - Packages of Care	0	0	(0)	0	0	(0)
Mental Health - Contracts	49	49	(0)	53	54	(0)
Other Commissioned Services	1	1	(0)	1	1	(0)
Other Programme	24	24	0	28	28	0
Reserves	18	0	18	86	65	21
Primary Care - Delegated GP	(0)	(1)	1	0	(1)	1
Primary Care - Delegated Other	268	243	25	289	262	27
Prescribing	0	(4)	4	0	(4)	4
Primary Care - Other	9	5	4	9	6	3
Sub Total - Programme Expenditure	**986**	**936**	**50**	**1,131**	**1,075**	**55**
Running Costs	50	48	2	53	51	2
TOTAL EXPENDITURE	**1,035**	**984**	**52**	**1,184**	**1,127**	**57**
Surplus / (Deficit) Plan	*131*	*0*	*131*	*143*	*0*	*143*
Sub Total - Net Surplus / (Deficit) Reported	***1,166***	***984***	***182***	***1,327***	***1,127***	***200***

CHESHIRE EAST	Cheshire East Place - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	328	328	(1)	357	358	(1)
Community	73	73	(0)	80	80	(0)
CHC	58	67	(8)	63	72	(8)
Mental Health - Packages of Care	20	21	(1)	22	24	(2)
Mental Health - Contracts	44	44	(0)	48	48	(1)
Other Commissioned Services	2	2	(0)	2	2	(0)
Other Programme	2	1	0	2	2	0
Reserves	2	0	2	2	0	2
Primary Care - Delegated GP	70	70	0	76	76	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	65	69	(4)	71	76	(5)
Primary Care - Other	14	15	(0)	16	16	(0)
Sub Total - Programme Expenditure	**677**	**690**	**(13)**	**739**	**753**	**(15)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**677**	**690**	**(13)**	**739**	**753**	**(15)**
Surplus / (Deficit) Plan	*(33)*	*0*	*(33)*	*(36)*	*0*	*(36)*
Sub Total - Net Surplus / (Deficit) Reported	***644***	***690***	***(46)***	***703***	***753***	***(51)***

CHESHIRE WEST	Cheshire West Place - Month 11 Position			Annual	M1 to M12	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	334	334	(0)	365	365	(0)
Community	58	58	(0)	64	63	0
CHC	45	57	(12)	49	62	(13)
Mental Health - Packages of Care	20	23	(2)	22	24	(2)
Mental Health - Contracts	47	47	(0)	51	51	(0)
Other Commissioned Services	2	2	(0)	2	2	(0)
Other Programme	2	2	0	2	2	0
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	66	67	(1)	72	73	(1)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	63	67	(4)	69	73	(4)
Primary Care - Other	14	13	1	15	14	1
Sub Total - Programme Expenditure	**652**	**670**	**(18)**	**711**	**730**	**(18)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**652**	**670**	**(18)**	**711**	**730**	**(18)**
Surplus / (Deficit) Plan	*(25)*	*0*	*(25)*	*(27)*	*0*	*(27)*
Sub Total - Net Surplus / (Deficit) Reported	***627***	***670***	***(43)***	***684***	***730***	***(46)***

HALTON	Halton Place - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	134	134	0	147	146	0
Community	33	34	(1)	36	37	(1)
CHC	15	14	1	17	16	1
Mental Health - Packages of Care	8	9	(1)	9	10	(1)
Mental Health - Contracts	22	21	1	24	23	1
Other Commissioned Services	0	0	0	1	0	0
Other Programme	1	0	1	1	0	1
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	24	25	(0)	26	27	(0)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	25	26	(1)	28	29	(1)
Primary Care - Other	3	3	0	4	3	0
Sub Total - Programme Expenditure	**268**	**267**	**0**	**292**	**292**	**0**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**268**	**267**	**0**	**292**	**292**	**0**
Surplus / (Deficit) Plan	*(8)*	*0*	*(8)*	*(9)*	*0*	*(9)*
Sub Total - Net Surplus / (Deficit) Reported	***260***	***267***	***(8)***	***283***	***292***	***(9)***

KNOWSLEY	Knowsley Place - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	167	167	(0)	182	182	(0)
Community	53	51	3	58	55	3
CHC	11	15	(4)	12	17	(5)
Mental Health - Packages of Care	7	6	0	7	7	0
Mental Health - Contracts	30	30	0	33	33	0
Other Commissioned Services	1	1	(0)	1	1	(0)
Other Programme	3	3	(0)	4	4	(0)
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	38	38	0	42	42	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	33	34	(2)	35	37	(2)
Primary Care - Other	2	2	(0)	3	3	(0)
Sub Total - Programme Expenditure	**346**	**348**	**(2)**	**378**	**381**	**(3)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**346**	**348**	**(2)**	**378**	**381**	**(3)**
Surplus / (Deficit) Plan	*10*	*0*	*10*	*11*	*0*	*11*
Sub Total - Net Surplus / (Deficit) Reported	***356***	***348***	***8***	***389***	***381***	***8***

LIVERPOOL	Liverpool Place - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	500	501	(1)	546	547	(1)
Community	112	114	(2)	122	124	(2)
CHC	52	57	(5)	57	63	(6)
Mental Health - Packages of Care	28	32	(4)	31	35	(4)
Mental Health - Contracts	107	108	(1)	117	118	(1)
Other Commissioned Services	3	3	0	4	3	0
Other Programme	8	8	0	9	9	0
Reserves	2	0	2	3	0	3
Primary Care - Delegated GP	101	99	1	110	109	1
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	89	95	(6)	97	104	(7)
Primary Care - Other	25	24	1	27	26	1
Sub Total - Programme Expenditure	**1,028**	**1,041**	**(14)**	**1,123**	**1,138**	**(15)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**1,028**	**1,041**	**(14)**	**1,123**	**1,138**	**(15)**
Surplus / (Deficit) Plan	*7*	*0*	*7*	*7*	*0*	*7*
Sub Total - Net Surplus / (Deficit) Reported	***1,034***	***1,041***	***(7)***	***1,130***	***1,138***	***(8)***

SEFTON	Sefton Place - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
	275	277	(1)	301	302	(1)
ıunity	69	68	1	75	75	1
	37	39	(2)	40	43	(2)
ɜl Health - Packages of Care	13	18	(5)	15	20	(6)
ɜl Health - Contracts	46	46	0	51	50	0
Commissioned Services	1	1	(0)	1	1	(0)
Programme	14	13	1	15	14	1
ves	2	0	2	2	0	2
ıry Care - Delegated GP	46	46	0	50	50	0
ıry Care - Delegated Other	0	0	(0)	0	0	(0)
ribing	52	56	(4)	56	61	(5)
ıry Care - Other	11	10	2	12	11	2
ɔtal - Programme Expenditure	**566**	**573**	**(7)**	**618**	**627**	**(8)**
ng Costs	0	0	(0)	0	0	(0)
L EXPENDITURE	**566**	**573**	**(7)**	**618**	**627**	**(8)**
ɹs / (Deficit) Plan	*(5)*	*0*	*(5)*	*(6)*	*0*	*(6)*
ɔtal - Net Surplus / (Deficit) Reported	***561***	***573***	***(12)***	***612***	***627***	***(14)***

ST HELENS	St. Helens Place - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	196	195	1	214	213	1
Community	49	49	(1)	53	54	(1)
CHC	22	24	(2)	24	26	(2)
Mental Health - Packages of Care	16	18	(3)	17	20	(3)
Mental Health - Contracts	30	30	0	33	33	0
Other Commissioned Services	1	1	(0)	1	1	(0)
Other Programme	3	3	0	4	4	0
Reserves	1	0	1	1	0	1
Primary Care - Delegated GP	37	37	0	40	40	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	39	40	(1)	43	44	(1)
Primary Care - Other	5	5	(0)	5	5	0
Sub Total - Programme Expenditure	**398**	**403**	**(5)**	**434**	**440**	**(5)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**398**	**403**	**(5)**	**434**	**440**	**(5)**
Surplus / (Deficit) Plan	*(8)*	*0*	*(8)*	*(9)*	*0*	*(9)*
Sub Total - Net Surplus / (Deficit) Reported	***390***	***403***	***(12)***	***426***	***440***	***(14)***

WARRINGTON	Warrington Place - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	194	194	(0)	212	212	(0)
Community	36	36	(0)	39	39	(0)
CHC	25	27	(2)	27	30	(2)
Mental Health - Packages of Care	12	11	0	13	12	0
Mental Health - Contracts	32	30	2	35	33	2
Other Commissioned Services	1	1	0	1	1	0
Other Programme	3	2	1	3	2	1
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	36	36	0	39	39	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	34	36	(3)	37	40	(3)
Primary Care - Other	5	5	(0)	5	6	(0)
Sub Total - Programme Expenditure	**376**	**378**	**(1)**	**411**	**413**	**(2)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**376**	**378**	**(1)**	**411**	**413**	**(2)**
Surplus / (Deficit) Plan	*(7)*	*0*	*(7)*	*(8)*	*0*	*(8)*
Sub Total - Net Surplus / (Deficit) Reported	***369***	***378***	***(9)***	***403***	***413***	***(10)***

WIRRAL	Wirral Place - Month 11 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	330	331	(1)	360	361	(1)
Community	75	74	1	82	80	2
CHC	51	59	(8)	56	65	(9)
Mental Health - Packages of Care	22	25	(4)	24	28	(4)
Mental Health - Contracts	52	51	1	57	57	0
Other Commissioned Services	1	1	(0)	1	1	(0)
Other Programme	0	(0)	0	0	(0)	0
Reserves	(1)	0	(1)	(1)	0	(2)
Primary Care - Delegated GP	62	62	(0)	67	68	(0)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	67	70	(3)	73	76	(3)
Primary Care - Other	11	10	1	12	11	1
Sub Total - Programme Expenditure	**669**	**683**	**(14)**	**730**	**747**	**(16)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**669**	**683**	**(14)**	**730**	**747**	**(16)**
Surplus / (Deficit) Plan	*(7)*	*0*	*(7)*	*(7)*	*0*	*(7)*
Sub Total - Net Surplus / (Deficit) Reported	***663***	***683***	***(20)***	***723***	***747***	***(24)***

Appendix 2 - Agency Spend: Current Performance and Forecast Outturn M11

	M11 YTD			2324 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Alder Hey Children's NHS Foundation Trust	(1.0)	(1.8)	(0.8)	(1.1)	(2.0)	(0.9)
Bridgewater Community Healthcare NHS Foundation Trust	(4.0)	(4.6)	(0.6)	(4.2)	(4.8)	(0.6)
Cheshire and Wirral Partnership NHS Foundation Trust	(6.1)	(8.9)	(2.8)	(6.7)	(9.8)	(3.1)
Countess of Chester Hospital NHS Foundation Trust	(6.4)	(5.6)	0.8	(6.9)	(6.1)	0.9
East Cheshire NHS Trust	(8.7)	(7.6)	1.1	(9.5)	(8.0)	1.6
Liverpool Heart and Chest Hospital NHS Foundation Trust	(1.0)	(0.8)	0.2	(1.1)	(0.9)	0.2
Liverpool University Hospitals NHS Foundation Trust	(15.2)	(16.9)	(1.7)	(15.7)	(18.2)	(2.5)
Liverpool Women's NHS Foundation Trust	(2.1)	(0.6)	1.5	(2.3)	(0.7)	1.6
Mersey Care NHS Foundation Trust	(17.7)	(18.8)	(1.1)	(19.3)	(19.9)	(0.6)
Mid Cheshire Hospitals NHS Foundation Trust	(11.4)	(12.0)	(0.6)	(12.6)	(13.3)	(0.7)
Southport And Ormskirk Hospital NHS Trust	(1.6)	(1.8)	(0.2)	(1.6)	(1.8)	(0.2)
Mersey and West Lancashire Teaching Hospitals NHS Trust	(14.2)	(18.6)	(4.4)	(15.7)	(20.7)	(5.0)
The Clatterbridge Cancer Centre NHS Foundation Trust	(1.6)	(1.7)	(0.0)	(1.8)	(1.9)	(0.1)
The Walton Centre NHS Foundation Trust	0.0	(0.6)	(0.6)	0.0	(0.6)	(0.6)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(10.8)	(8.4)	2.4	(11.6)	(9.1)	2.5
Wirral Community Health and Care NHS Foundation Trust	(1.4)	(1.2)	0.2	(1.5)	(1.4)	0.1
Wirral University Teaching Hospital NHS Foundation Trust	(5.2)	(10.0)	(4.8)	(5.7)	(10.7)	(5.0)
Total Providers	**(108.6)**	**(120.0)**	**(11.4)**	**(117.6)**	**(129.7)**	**(12.2)**
as a proportion of Total Pay	**2.98%**	**3.10%**		**2.96%**	**3.35%**	

System agency ceiling is £127.3m

Appendix 3A - System Efficiencies: Current Performance and Forecast Outturn M11

	YTD Recurrent			2324 Recurrent		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
ICB	**39.6**	**30.7**	**(8.9)**	**43.8**	**39.5**	**(4.3)**
Alder Hey Children's NHS Foundation Trust	15.9	10.0	(5.9)	17.7	10.3	(7.4)
Bridgewater Community Healthcare NHS Foundation Trust	4.7	1.7	(3.0)	5.1	1.8	(3.3)
Cheshire and Wirral Partnership NHS Foundation Trust	6.0	4.1	(1.8)	6.6	4.6	(2.0)
Countess of Chester Hospital NHS Foundation Trust	9.5	8.6	(1.0)	10.4	9.9	(0.5)
East Cheshire NHS Trust	9.1	6.0	(3.1)	10.3	6.9	(3.4)
Liverpool Heart and Chest Hospital NHS Foundation Trust	8.2	4.4	(3.8)	9.0	4.9	(4.1)
Liverpool University Hospitals NHS Foundation Trust	53.4	34.6	(18.8)	58.8	42.2	(16.6)
Liverpool Women's NHS Foundation Trust	7.3	3.1	(4.2)	8.3	4.3	(4.0)
Mersey Care NHS Foundation Trust	15.4	22.2	6.8	16.8	24.2	7.4
Mid Cheshire Hospitals NHS Foundation Trust	19.0	11.2	(7.8)	21.2	12.4	(8.8)
Mersey and West Lancashire NHS Trust	28.8	31.6	2.8	31.8	34.6	2.8
The Clatterbridge Cancer Centre NHS Foundation Trust	7.6	4.7	(2.8)	8.2	5.2	(3.1)
The Walton Centre NHS Foundation Trust	7.0	5.7	(1.3)	7.5	6.2	(1.3)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	15.5	8.2	(7.3)	17.9	9.8	(8.1)
Wirral Community Health and Care NHS Foundation Trust	4.6	1.6	(3.0)	5.0	1.8	(3.2)
Wirral University Teaching Hospital NHS Foundation Trust	23.3	20.4	(2.9)	26.2	25.9	(0.3)
Total Providers	**235.2**	**178.1**	**(57.1)**	**260.8**	**204.9**	**(55.9)**
Total System	**274.8**	**208.9**	**(65.9)**	**304.6**	**244.4**	**(60.2)**

Appendix 3B - System Efficiencies: Recurrent/Non-recurrent split of YTD CIP

	YTD Recurrent			YTD Non Recurrent			YTD Total		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
ICB	39.6	30.7	(8.9)	12.9	21.6	8.6	52.6	52.3	(0.3)
	39.6	**30.7**	**(8.9)**	**12.9**	**21.6**	**8.6**	**52.6**	**52.3**	**(0.3)**
Alder Hey Children's NHS Foundation Trust	15.9	10.0	(5.9)	0.0	6.4	6.4	15.9	16.4	0.5
Bridgewater Community Healthcare NHS Foundation Trust	4.7	1.7	(3.0)	0.0	3.1	3.1	4.7	4.8	0.1
Cheshire and Wirral Partnership NHS Foundation Trust	6.0	4.1	(1.8)	5.7	6.7	1.1	11.6	10.9	(0.8)
Countess of Chester Hospital NHS Foundation Trust	9.5	8.6	(1.0)	9.5	8.9	(0.7)	19.1	17.4	(1.6)
East Cheshire NHS Trust	9.1	6.0	(3.1)	0.0	3.4	3.4	9.1	9.3	0.2
Liverpool Heart and Chest Hospital NHS Foundation Trust	8.2	4.4	(3.8)	0.0	3.3	3.3	8.2	7.6	(0.6)
Liverpool University Hospitals NHS Foundation Trust	53.4	34.6	(18.8)	20.0	30.4	10.3	73.4	65.0	(8.5)
Liverpool Women's NHS Foundation Trust	7.3	3.1	(4.2)	0.0	3.0	3.0	7.3	6.2	(1.2)
Mersey Care NHS Foundation Trust	15.4	22.2	6.8	18.7	11.9	(6.8)	34.1	34.1	0.0
Mid Cheshire Hospitals NHS Foundation Trust	19.0	11.2	(7.8)	0.0	7.3	7.3	19.0	18.5	(0.5)
Southport And Ormskirk Hospital NHS Trust	0.0	2.8	2.8	2.8	0.0	(2.8)	2.8	2.8	0.0
Mersey and West Lancashire NHS Trust	28.8	28.8	0.0	6.4	6.4	0.0	35.2	35.2	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	7.6	4.7	(2.8)	0.0	3.0	3.0	7.6	7.7	0.2
The Walton Centre NHS Foundation Trust	7.0	5.7	(1.3)	0.0	1.3	1.3	7.0	7.0	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	15.5	8.2	(7.3)	0.0	5.5	5.5	15.5	13.7	(1.8)
Wirral Community Health and Care NHS Foundation Trust	4.6	1.6	(3.0)	0.3	3.2	3.0	4.9	4.9	0.0
Wirral University Teaching Hospital NHS Foundation Trust	23.3	20.4	(2.9)	0.0	0.2	0.2	23.3	20.6	(2.7)
Total Providers	**235.2**	**178.1**	**(57.1)**	**63.4**	**103.9**	**40.5**	**298.6**	**282.1**	**(16.6)**
Total System	**274.8**	**208.9**	**(65.9)**	**76.4**	**125.5**	**49.1**	**351.2**	**334.4**	**(16.8)**

Appendix 3C - System Efficiencies Recurrent/Non-recurrent split of FOT CIP

	2324 Recurrent			2324 Non Recurrent			2324 Total		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	43.8	39.5	(4.3)	14.1	18.4	4.3	57.9	57.9	0.0
	43.8	**39.5**	**(4.3)**	**14.1**	**18.4**	**4.3**	**57.9**	**57.9**	**0.0**
Alder Hey Children's NHS Foundation Trust	17.7	10.3	(7.4)	0.0	7.4	7.4	17.7	17.7	0.0
Bridgewater Community Healthcare NHS Foundation Trust	5.1	1.8	(3.3)	0.0	3.6	3.6	5.1	5.4	0.3
Cheshire and Wirral Partnership NHS Foundation Trust	6.6	4.6	(2.0)	6.2	8.2	2.0	12.8	12.8	0.0
Countess of Chester Hospital NHS Foundation Trust	10.4	9.9	(0.5)	10.4	10.9	0.5	20.8	20.8	0.0
East Cheshire NHS Trust	10.3	6.9	(3.4)	0.0	3.5	3.5	10.3	10.4	0.1
Liverpool Heart and Chest Hospital NHS Foundation Trust	9.0	4.9	(4.1)	0.0	3.6	3.6	9.0	8.4	(0.5)
Liverpool University Hospitals NHS Foundation Trust	58.8	42.2	(16.6)	22.9	39.5	16.6	81.7	81.7	0.0
Liverpool Women's NHS Foundation Trust	8.3	4.3	(4.0)	0.0	3.0	3.0	8.3	7.3	(1.0)
Mersey Care NHS Foundation Trust	16.8	24.2	7.4	20.4	13.0	(7.4)	37.2	37.2	0.0
Mid Cheshire Hospitals NHS Foundation Trust	21.2	12.4	(8.8)	0.0	8.0	8.0	21.2	20.4	(0.8)
Southport And Ormskirk Hospital NHS Trust	0.0	2.8	2.8	2.8	0.0	(2.8)	2.8	2.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	31.8	31.8	0.0	7.0	7.0	0.0	38.8	38.8	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	8.2	5.2	(3.1)	0.0	3.3	3.3	8.2	8.4	0.2
The Walton Centre NHS Foundation Trust	7.5	6.2	(1.3)	0.0	1.3	1.3	7.5	7.5	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	17.9	9.8	(8.1)	0.0	8.1	8.1	17.9	17.9	0.0
Wirral Community Health and Care NHS Foundation Trust	5.0	1.8	(3.2)	0.3	3.5	3.2	5.3	5.3	0.0
Wirral University Teaching Hospital NHS Foundation Trust	26.2	25.9	(0.3)	0.0	0.3	0.3	26.2	26.2	0.0
Total Providers	**260.8**	**204.9**	**(55.9)**	**70.0**	**124.2**	**54.2**	**330.8**	**329.1**	**(1.7)**
Total System	**304.6**	**244.4**	**(60.2)**	**84.1**	**142.6**	**58.5**	**388.7**	**387.0**	**(1.7)**

Appendix 4A - Provider Capital: Current & Forecast Performance M11

	YTD Charge vs Capital Allocation			FOT Charge vs Capital Allocation		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Alder Hey Children's NHS Foundation Trust	12.7	10.9	1.8	14.6	15.6	(1.0)
Bridgewater Community Healthcare NHS Foundation Trust	2.1	0.9	1.2	2.1	2.1	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	4.0	1.6	2.4	4.5	4.0	0.5
Countess of Chester Hospital NHS Foundation Trust	38.1	27.8	10.3	45.3	36.0	9.2
East Cheshire NHS Trust	3.2	2.5	0.7	3.5	3.8	(0.2)
Liverpool Heart and Chest Hospital NHS Foundation Trust	5.7	6.1	(0.4)	6.1	10.1	(4.0)
Liverpool University Hospitals NHS Foundation Trust	26.2	28.1	(2.0)	39.4	49.2	(9.8)
Liverpool Women's NHS Foundation Trust	4.9	3.5	1.4	5.0	5.0	(0.0)
Mersey Care NHS Foundation Trust	14.0	13.5	0.5	16.0	19.6	(3.6)
Mid Cheshire Hospitals NHS Foundation Trust	29.1	32.5	(3.5)	31.0	39.5	(8.5)
Southport And Ormskirk Hospital NHS Trust	0.7	(25.6)	26.3	0.7	(25.6)	26.3
Mersey and West Lancashire Teaching Hospitals NHS Trust	20.6	(0.7)	21.3	23.8	24.1	(0.3)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	3.7	(3.7)	7.3	7.5	(0.2)
The Walton Centre NHS Foundation Trust	3.7	3.0	0.7	4.8	4.8	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	8.6	8.1	0.4	8.9	9.0	(0.0)
Wirral Community Health and Care NHS Foundation Trust	3.9	2.1	1.8	4.4	2.8	1.6
Wirral University Teaching Hospital NHS Foundation Trust	11.0	5.7	5.4	12.6	15.6	(3.0)
Total Providers	**188.3**	**123.8**	**64.6**	**230.0**	**223.0**	**7.0**
Prior Year Adjustment	0.0	(26.0)	26.0	0.0	(26.0)	26.0
Total Providers (excluding Prior Year Adjustment)	**188.3**	**149.8**	**38.6**	**230.0**	**249.0**	**(19.0)**
ICS Allocation				**245.4**		
Agreement with Manchester ICB				(22.0)		
Revised ICS Allocation				**223.4**		
Variance to Allocation				**223.4**	**223.0**	**0.4**

Appendix 4B - Provider Capital: Current & Forecast Impact of IFRS16 M11

	YTD Impact of IFRS16			FOT Impact of IFRS16		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Alder Hey Children's NHS Foundation Trust	0.0	0.9	(0.9)	0.0	0.9	(0.9)
Bridgewater Community Healthcare NHS Foundation Trust	(0.7)	4.3	(5.0)	(0.7)	4.3	(5.0)
Cheshire and Wirral Partnership NHS Foundation Trust	0.4	1.1	(0.7)	0.4	1.1	(0.7)
Countess of Chester Hospital NHS Foundation Trust	2.0	0.0	2.0	2.0	1.5	0.5
East Cheshire NHS Trust	0.2	0.0	0.1	0.2	1.4	(1.2)
Liverpool Heart and Chest Hospital NHS Foundation Trust	0.0	(0.0)	0.0	0.0	(0.0)	0.0
Liverpool University Hospitals NHS Foundation Trust	0.3	7.5	(7.2)	2.0	7.5	(5.5)
Liverpool Women's NHS Foundation Trust	0.1	0.1	0.0	0.1	0.1	0.0
Mersey Care NHS Foundation Trust	6.0	4.7	1.2	6.0	4.7	1.2
Mid Cheshire Hospitals NHS Foundation Trust	3.1	1.3	1.7	3.4	2.4	0.9
Southport And Ormskirk Hospital NHS Trust	0.0	0.0	0.0	0.0	0.0	0.0
Mersey and West Lancashire Teaching Hospitals NHS Trust	0.7	5.7	(4.9)	0.7	6.0	(5.3)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	(0.1)	0.1	0.1	(0.1)	0.2
The Walton Centre NHS Foundation Trust	0.0	0.0	0.0	1.4	1.0	0.4
Warrington and Halton Teaching Hospitals NHS Foundation Trust	5.0	2.3	2.7	5.0	2.4	2.6
Wirral Community Health and Care NHS Foundation Trust	0.0	1.5	(1.5)	0.0	1.5	(1.5)
Wirral University Teaching Hospital NHS Foundation Trust	0.0	0.0	0.0	0.0	0.2	(0.2)
Total providers	**17.0**	**29.3**	**(12.3)**	**20.5**	**34.9**	**(14.5)**
Expected internal leases to DHSC Group to net off					(10.6)	
TOTAL (excluding internal leases)				**20.5**	**24.3**	**(3.9)**
ICS Allocation					**28.3**	
Variance to Allocation					**4.0**	

Appendix 4C – Provider Capital: Total CDEL M11

	YTD Charge vs Capital Allocation			FOT Charge vs Capital Allocation		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Var £m
Alder Hey Children's NHS Foundation Trust	18.2	18.6	(0.4)	21.1	25.1	(4.0)
Bridgewater Community Healthcare NHS Foundation Trust	1.6	5.2	(3.6)	1.6	6.7	(5.1)
Cheshire and Wirral Partnership NHS Foundation Trust	7.1	4.1	3.0	8.3	8.5	(0.2)
Countess of Chester Hospital NHS Foundation Trust	40.1	28.3	11.8	47.5	40.8	6.7
East Cheshire NHS Trust	12.2	11.9	0.3	12.9	19.2	(6.3)
Liverpool Heart and Chest Hospital NHS Foundation Trust	5.7	7.2	(1.6)	6.1	11.5	(5.4)
Liverpool University Hospitals NHS Foundation Trust	51.7	46.4	5.3	80.3	78.0	2.3
Liverpool Women's NHS Foundation Trust	5.1	3.7	1.4	5.2	5.4	(0.2)
Mersey Care NHS Foundation Trust	56.3	34.9	21.4	61.4	42.4	19.0
Mid Cheshire Hospitals NHS Foundation Trust	44.6	44.3	0.3	47.9	68.2	(20.3)
Southport And Ormskirk Hospital NHS Trust	0.7	(25.6)	26.3	0.7	(25.6)	26.3
Mersey and West Lancashire Teaching Hospitals NHS Trust	29.1	7.9	21.1	32.5	43.5	(11.0)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	3.8	(3.8)	7.4	7.7	(0.3)
The Walton Centre NHS Foundation Trust	3.7	3.0	0.7	6.2	6.1	0.1
Warrington and Halton Teaching Hospitals NHS Foundation Trust	23.5	19.5	4.0	24.8	29.1	(4.3)
Wirral Community Health and Care NHS Foundation Trust	3.9	3.6	0.2	4.4	4.3	0.1
Wirral University Teaching Hospital NHS Foundation Trust	25.2	19.8	5.4	26.8	31.0	(4.2)
Total providers	**328.7**	**236.7**	**92.0**	**395.1**	**401.9**	**(6.8)**

Appendix 5

Provider Cash: Current Cash Position as at Month 11

	M11 ACTUAL £m	M10 ACTUAL £m	M9 ACTUAL £m	M8 ACTUAL £m	M7 ACTUAL £m	M6 ACTUAL £m	M5 ACTUAL £m	M4 ACTUAL £m	M3 ACTUAL £m	M2 ACTUAL £m	M1 ACTUAL £m	M10 to M11 CHANGE £m	31/03/2023 BALANCE £m	31/03/2022 BALANCE £m	31/03/2021 BALANCE £m	31/03/2020 BALANCE £m
Alder Hey Children's NHS Foundation Trust	83.4	70.1	74.7	78.2	79.3	78.7	84.5	79.8	85.1	83.1	83.1	13.3	83.5	91.5	92.7	90.0
Bridgewater Community Healthcare NHS Foundation Trust	19.0	17.2	16.8	17.8	17.7	18.7	19.2	18.0	20.5	20.7	20.7	1.8	24.3	26.2	17.9	3.6
Cheshire and Wirral Partnership NHS Foundation Trust	30.0	26.6	28.3	24.5	24.7	24.8	27.6	27.6	32.8	32.7	37.6	3.4	37.5	41.1	33.9	21.2
Countess of Chester Hospital NHS Foundation Trust	12.6	22.0	16.4	15.0	16.0	16.4	9.1	2.8	8.7	10.9	10.9	(9.4)	22.9	40.9	32.7	12.2
East Cheshire NHS Trust	19.9	15.7	18.9	17.5	21.0	20.8	23.8	26.7	28.3	30.6	31.4	4.2	30.3	37.3	27.4	11.4
Liverpool Heart and Chest Hospital NHS Foundation Trust	45.3	42.4	43.5	46.1	47.2	45.8	45.9	50.1	46.2	46.2	45.0	2.8	41.3	42.7	49.0	30.2
Liverpool University Hospitals NHS Foundation Trust	37.9	45.8	42.7	49.0	54.6	46.9	61.5	76.4	89.8	100.6	100.6	(8.0)	99.3	211.4	167.5	43.6
Liverpool Women's NHS Foundation Trust	4.5	7.0	6.1	6.5	9.0	6.3	3.8	1.3	3.0	4.8	8.7	(2.5)	9.8	11.2	4.2	4.6
Mersey Care NHS Foundation Trust	84.6	77.2	81.2	87.2	91.6	88.7	92.0	94.4	95.4	93.8	94.0	7.4	83.3	84.2	90.8	59.6
Mid Cheshire Hospitals NHS Foundation Trust	34.2	16.7	5.8	10.8	10.1	8.4	11.3	11.2	17.4	14.4	12.1	17.4	8.4	26.7	33.1	14.0
Mersey and West Lancashire Teaching Hospitals NHS Trust	2.7	2.8	4.0	3.0	2.5	3.0	6.1	28.0	67.7	67.8	40.8	(0.1)	25.6	54.2	51.4	7.3
The Clatterbridge Cancer Centre NHS Foundation Trust	81.2	81.5	75.2	75.9	75.9	76.0	74.0	72.5	75.2	67.9	67.9	(0.3)	70.0	80.7	60.2	35.4
The Walton Centre NHS Foundation Trust	51.3	47.9	48.5	47.7	45.7	46.5	49.6	46.1	45.4	47.0	48.7	3.3	47.7	40.7	35.7	26.7
Warrington and Halton Teaching Hospitals NHS Foundation Trust	20.6	10.9	6.1	9.5	17.3	19.4	22.1	25.3	30.4	28.8	32.3	9.7	34.9	44.7	47.9	2.2
Wirral Community Health and Care NHS Foundation Trust	11.3	12.5	12.7	15.2	10.3	14.0	12.3	10.0	13.0	13.9	17.4	(1.1)	19.5	23.8	26.2	18.3
Wirral University Teaching Hospital NHS Foundation Trust	20.7	15.0	9.3	10.7	22.6	14.5	22.6	26.5	30.3	29.1	29.1	5.7	24.3	36.4	21.3	5.9
Total Providers	**559.1**	**511.4**	**490.2**	**514.7**	**545.6**	**529.1**	**565.5**	**596.7**	**689.2**	**692.0**	**680.0**	**47.7**	**662.6**	**893.7**	**791.9**	**386.4**
Cash Advances from ICB to Providers	**(51.9)**	**(92.7)**	**(92.7)**	**(82.6)**	**(72.6)**	**(52.9)**	**(42.8)**	**(36.6)**	**(33.6)**	**(14.0)**	**(14.0)**	**(0.0)**	**-**	**-**	**-**	**-**
Net Provider Cash Balance	**507.2**	**418.7**	**397.5**	**432.1**	**473.0**	**476.2**	**522.7**	**560.1**	**655.6**	**678.0**	**666.0**	**47.7**	**662.6**	**893.7**	**791.9**	**386.4**

Appendix 6

A. System BPPC: Actual & YTD Total BPPC Position as at Month 11

	Month 11		Month 11 YTD	
	Total by Value %	Total by Number %	Total by Value %	Total by Number %
ICB	99.1%	97.2%	99.3%	98.9%
Alder Hey Children's NHS Foundation Trust	88.2%	92.9%	93.1%	94.1%
Bridgewater Community Healthcare NHS Foundation Trust	95.9%	94.1%	96.9%	96.0%
Cheshire and Wirral Partnership NHS Foundation Trust	93.6%	98.2%	97.0%	97.7%
Countess of Chester Hospital NHS Foundation Trust	96.5%	93.8%	88.1%	86.0%
East Cheshire NHS Trust	97.0%	96.4%	95.2%	94.7%
Liverpool Heart and Chest Hospital NHS Foundation Trust	95.9%	96.6%	97.2%	96.4%
Liverpool University Hospitals NHS Foundation Trust	91.6%	80.4%	92.7%	82.3%
Liverpool Women's NHS Foundation Trust	84.6%	95.8%	93.7%	90.7%
Mersey Care NHS Foundation Trust	96.5%	95.2%	92.5%	95.2%
Mid Cheshire Hospitals NHS Foundation Trust	86.3%	92.3%	92.7%	87.9%
St Helens And Knowsley Teaching Hospitals NHS Trust	86.5%	91.1%	93.4%	90.1%
The Clatterbridge Cancer Centre NHS Foundation Trust	99.7%	96.7%	99.4%	97.6%
The Walton Centre NHS Foundation Trust	95.2%	92.5%	92.4%	90.0%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	95.6%	89.3%	91.5%	91.5%
Wirral Community Health and Care NHS Foundation Trust	98.4%	92.2%	93.0%	91.2%
Wirral University Teaching Hospital NHS Foundation Trust	96.6%	95.5%	95.0%	91.9%

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Highlight report of the Chair of the Finance, Investment & Resource Committee

Agenda Item No: ICB/03/24/08

Report approved by: Erica Morris, ICB Non-Executive Member, Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the Finance, Investment & Resource Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	12 March 2024

Key escalation and discussion points from the Committee meeting

Alert

The Committee considered the following:

- **23/24 Financial Position**
  Month 10 position received, noting the YTD deficit of £79.8m against a plan YTD deficit of £22m, resulting in an adverse variance of £57.8m. Within this are £22m of Industrial action costs related to December and January.
  Further risk of £40m had been identified.

  Month 11 update, noted that £18m of additional industrial action funding had been received, leaving a residual pressure of £15m. Furthermore, of the risks highlighted in month 10, mitigations have been materialised. Leading to a revised forecast of a £43m deficit.

- **Risk P7 – the Integrated Care System is unable to achieve its statutory financial duties – this risk has increased from a reported 16 to 25**
  Discussion on requirement for transformational change across the whole of the ICS in urgent care pathway, Continuing Health Care, utilisation of the non-clinical workforce and Mental Health Packages of care.

- **2024/25 Financial Planning**
  Flash return to region - £277m deficit, which includes system-wide schemes and mitigations which are yet to be agreed. Regional and national meetings expected prior to first formal submission on 21March 2024, immediate measures to be taken to address the deterioration.

- **Financial impact on internal workforce strategy**
  Full vacancy freeze in place, which will impact on ICB's workforce strategy

Advise

The Committee considered the following in relation to procurement:

- **Noted** the assurance on the decisions made and reviewed at the Procurement Decision Review Group.

- **Noted** the award of contracts to under Provider Selection Regime: Direct Award A NHS Acute, Mental Health and Community Trusts and awards under Provider Selection Regime: Direct Award B for Nursing, residential, CHC placements, Domiciliary, and specialist Mental Health & Learning Disability Placements.

- **Approved** – MLCSU 2024/25 contract extension of 12 months with supplementary action regarding evaluation of contract and review of inflationary uplift. Information Governance service currently out to tender.

- **Approved** – Extension of Community intermediate Care Centre in Wirral for 12 months

- **Approved** – Direct Award under Option A of Wirral Place musculoskeletal (MSK) integrated service

- **Approved** – Nice TA for hybrid closed loop systems for managing glucose levels in type 1 diabetes. Incremental financial pressure noted.

- **Approved** – Clinical Policy Harmonisation update
  Hip/Knee – already being implemented.
  Gluten-free prescribing will be reviewed further by the Pharmacy team to ensure alignment with Coeliac UK guidance.

- **Work Plan**
  Consideration being given to change the committee to quarterly**,** with finance reports circulated monthly, allowing committee to focus on specific areas of focus.

Assure

The Committee considered the following papers:

- **Risk Report**
  See detail below

- **People Committee minutes and HR Dashboard**
  including: Review of long-term sickness, appraisals performance, Staff Survey results.
  Noted that CSU staff TUPE across into ICB from 1st April 2024
  Noted vacancy freeze following financial plan flash return.

- **Month 10 Finance Report – see alert above**

- **Month 11 Finance Report – see alert above**

- **Financial Strategy** – see alert above

- **Cheshire East presentation**
  Presentation from Place Director and Place Associate Director of Finance.
  Focusing on areas of risk: CHC, Prescribing and urgent care. Discussion regarding area of influence, control and delegation.

Committee risk management

The following risks were considered by the Committee and the following actions/decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
F2 - Health inequalities continue to drive increased demand for services with financial pressures resulting in failure to achieve financial duties, currently rated as extreme (16)	Rating of 16 agreed, but not closed under further understanding of how this risk is being addressed and managed across all committees of the ICB.
F4 – Lack of clarity in respect of operating model and corresponding financial delegation to place based partnerships reduces financial control and flexibility resulting in failure to achieve financial duties	Rating of 9 agreed.
F5 – Scale of procurement requirements exceeds available capacity resulting in legal challenge and increased costs.	Rating of 9 agreed.
F7 – The ICB does not allocate the operational capital budget in a way that address capital investment risks across secondary and primary care.	Rating of 10 agreed.
W8 – Lack of workforce diversity may impair the effectiveness of the ICB response to our population's needs, exacerbating health inequalities and damaging our reputation	rating of 12 agreed
Place Financial Risks above 15	Noted that 7 places rate finance risk as extreme.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P7: The Integrated Care System is unable to achieve its statutory financial duties. (16)	Increase of risk rating score from 16 to 25 agreed to be recommended to the ICB Board at its Meeting in May 2024 when the BAF is next considered.

Board Assurance Framework Risks	
BAF P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives.	Current rating of 12 to be reviewed in light of increase to P7

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Service Programme / Focus Area	Key actions/discussion undertaken
Development and delivery of a Cheshire and Merseyside system-wide financial strategy during the first half of 2023-24	Strategy paper presented
Delivery of the Finance Efficiency & Value Programme	Performance on CIP for Providers and ICB noted in month 10 finance report. Increase in reliance on non-recurrent CIP noted.
Development and delivery of the Capital Plans.	Spend to date noted in month 10 finance report.
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	N/a to be considered at a future meeting.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Integrated Performance Report

Agenda Item No: ICB/03/24/09

Responsible Director: Anthony Middleton: Director of Performance and Planning

Integrated Performance Report

1. Purpose of the Report

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

2. Executive Summary

2.1 The integrated performance report for March 2024, see appendix one, provides an overview of key metrics drawn from the 2023/24 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

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

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

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

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

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

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

9. Risks

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

9.2 Additionally, waits for cancer and elective treatment, particularly due to industrial action and winter pressures within the urgent care system could result in reduced capacity and activity leading to poor outcomes, which maps to Board Assurance Framework Risk P3.

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

28th March 2024

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

ACUTE TRUSTS	
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT
ECT	EAST CHESHIRE NHS TRUST
MCHT	MID CHESHIRE HOSPITALS NHS FT
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST
WHH	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

SPECIALIST TRUSTS	
AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT
LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT
LWH	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT
TWC	THE WALTON CENTRE NHS FT

COMMUNITY AND MENTAL HEALTH TRUSTS	
BCHC	BRIDGEWATER COMMUNITY HEALTHCARE NHS FT
WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT
SHLA	ST HELENS LOCAL AUTHORITY
MCFT	MERSEY CARE NHS FT
CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT

KEY SYSTEM PARTNERS	
NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
OTHER	
OOA	OUT OF AREA AND OTHER PROVIDERS

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

Local Trajectory: The C&M operational plan has been formally agreed as the ICBs local performance trajectory for 2023/2024 and may differ to the national target

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

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

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

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time	Feb-24	72.0%	72.0%	73.5%	73.7%	74.5%	73.6%	73.2%	71.0%	69.7%	68.9%	69.4%	68.9%	68.1%	75.5%	76% by Year end	67.7%	70.9%	32/42
	Ambulance category 2 mean response time	Feb-24	00:28:00	00:43:54	00:24:39	00:25:30	00:32:55	00:31:56	00:35:13	00:39:13	00:39:41	00:43:45	01:04:31	00:49:45	00:43:30	00:33:00	00:30:00	00:29:00	00:36:20	-
	A&E 12 hour waits from arrival	Feb-24	15.5%	16.2%	13.9%	13.6%	13.9%	14.0%	14.6%	16.5%	17.0%	16.6%	16.1%	18.5%	16.7%	-	-	15.0%	11.3%	36/42
	Adult G&A bed occupancy	Feb-24	97.0%	97.2%	95.8%	95.3%	95.40%	94.7%	95.0%	96.0%	96.5%	96.9%	95.3%	96.6%	95.9%	94.0%	92.0%	95.3%	95.7%	24/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Feb-24	20.4%	20.2%	18.3%	18.0%	17.3%	17.7%	19.2%	20.8%	20.1%	20.6%	20.8%	21.0%	19.8%	12.8%	5.0%	16.4%	14.6%	39/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jan-24	6,515	4,807	4,867	4,762	4,528	4,332	4,888	5,078	5,393	4,842	5,227	4,732		3,074	-	18,328	98,374	-
	Total incomplete Referral to Treatment (RTT) pathways	Jan-24	340,484	344,912	360,819	361,747	362,417	367,634	375,312	372,005	376,230	369,440	372,974	369,750		327,361	-	1,084,949	7,603,675	-
	Patients waiting more than 6 weeks for a diagnostic test	Jan-24	19.1%	18.9%	22.1%	20.9%	21.2%	21.8%	23.3%	23.0%	20.0%	16.0%	17.2%	16.2%		14.9%	10.0%	23.2%	23.3%	12/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Dec-23	69.8%	70.3%	68.1%	65.9%	66.9%	70.7%	70.3%	71.3%	70.1%	70.9%	71.8%			70.0%	85.0%	68.3%	65.8%	9/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Dec-23	94.8%	94.5%	94.7%	93.3%	95.3%	93.9%	94.7%	94.1%	93.4%	94.0%	95.0%			96.0%	96.0%	93.9%	91.1%	6/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Dec-23	71.6%	67.1%	67.0%	67.7%	69.9%	70.3%	69.5%	68.6%	70.0%	68.9%	70.2%			71.7%	75.0%	73.5%	74.2%	37/42
Mental Health	Access rate to community mental health services for adults with severe mental illness	Dec-23	78.0%	81.0%	94.0%	100.0%	106.0%	95.0%	98.0%	101.0%	103.0%	105.0%	107%			100.0%	100.0%	103.0%	98.8%	10/42
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Dec-23	55.0%	59.0%	66.0%	71.0%	70.0%	67.0%	65.0%	68.0%	70.0%	72%	75%			60.0%	60.0%	76.0%	71.3%	24/42
	Access rate for Talking Therapies services	Dec-23	58.0%	70.0%	60.0%	62.0%	59.0%	61.0%	63.0%	60.0%	72.0%	67.0%	47.0%			100.0%	100.0%	48.2%	53.7%	30/42
	Dementia Diagnosis Rate	Jan-24	64.5%	65.1%	65.2%	65.2%	65.6%	65.8%	66.0%	66.2%	66.5%	66.9%	66.4%	66.3%		66.7%	66.7%	69.2%	64.4%	16/42
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Dec-23	100	105	100	105	110	110	110	105	105	100	100			≤ 60	-	285	1,830	37/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Dec 23 YTD	68.5%	80.4%	2.8%	6.6%	11.3%	16.0%	21.3%	26.9%	34.8%	40.1%	45.4%			43.3%	75% by Year end	45.3%	46.3%	17/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Dec-23	83.3%	78.7%	86.5%	83.2%	83.4%	87.0%	86.0%	84.0%	85.0%	80%	80%			70.0%	70.0%	85.0%	83.0%	28/42
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Jan-24	86.5%	97.7%	56.9%	75.4%	76.1%	81.7%	87.3%	71.2%	80.9%	94.9%	68.2%	82.8%		100.0%	100.0%	89.5%	87.9%	26/42
	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Jan-24	107.1%	102.4%	98.7%	98.4%	111.8%	105.5%	105.9%	106.9%	102.7%	98.6%	94.3%	106.8%		-	-	107.4%	110.1%	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Nov-23	7.42%	7.35%	7.34%	7.32%	7.32%	7.34%	7.31%	7.29%	7.27%	7.24%				10.0%	10.0%	7.34%	7.74%	10/42
	Total volume of antibiotic prescribing in primary care	Nov-23	1.087	1.093	1.088	1.086	1.084	1.079	1.082	1.081	1.081	1.077				0.871	0.871	1.085	0.982	33/42

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Local Trajectory	National Target	Region value	National value	Latest Rank
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)	Q3 22/23	243.5		244.8			237.0			225.3					-	-	222.6	178.3	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Dec-23	92.3%	92.3%	92.7%	92.8%	92.5%	92.8%	92.7%	92.5%	92.4%	92.5%	92.1%			-	-		92.6%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)	Sep-23	529.1		527.3			510.9			463.7					-	-	400.4	361.8	-
Health Inequalities & Improvement	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.	Oct-23	58.4%	58.8%	61.8%	61.5%	56.8%	61.3%	60.1%	56.6%	63.0%					70.0%	75% by 2028	60.5%	59.0%	3/21
	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q2-23	66.7%		66.0%			65.84%								77.0%	80.0%	67.05%	67.2%	22/42
	Children and young people accessing mental health services as % of LTP trajectory (planned number)	Dec-23	80.2%	82.0%	83.2%	84.0%	86.0%	87.0%	87.4%	89.0%	90.0%	88.0%	89.0%			100.0%	100.0%	105.7%	91.60%	18/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Dec-23										14.3%	14.2%	14.2%		12.0%	12.0%	-	12.7%^	-
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Oct-23	3.25	2.76	2.80	3.30	3.30	3.33	3.14	3.16	3.02					-	-	-	-	-
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	12 months to Dec 23	645	643	634	625	614	596	581	572	583	576	575			439	439	n/a	n/a	21/42~
	Healthcare Acquired Infections: E.Coli (Hospital onset)	12 months to Dec 23	742	727	734	736	760	779	793	779	769	768	778			518	518	n/a	n/a	39/42~
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Sep-23	1.029	1.033	1.026	1.027	1.027	1.030	1.028	1.039						0.887 to 1.127 *		-	1.000	-
	Never Events	Jan-24	2	2	2	2	2	0	0	5	3	3	3	1		0	0	-	-	-
	21+ day Length of Stay	Jan-24	1,485	1,449	1,365	1,425	1,244	1,260	1,295	1,227	1,273	1,187	1,368	1,386		1,620	-	-	-	-
Workforce / HR (ICS total)	Staff in post	Dec-23	71,504	71,766	72,150	72,089	72,205	71,950	72,298	71,902	72,324	72,903	72,784			71,837	-	198,623	-	-
	Bank	Dec-23	4,956	5,340	4,798	4,596	4,633	5,036	5,372	5,386	5,425	5,662	5,246			3,448	-	16,424	-	-
	Agency	Dec-23	1,656	1,524	1,182	1,434	1,381	1,252	1,363	1,274	1,260	1,286	1,245			1,050.6	-	4,206	-	-
	Sickness	Dec-23	6.1%	6.0%	5.8%	5.8%	5.8%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%			6.2%	-	6.0%	4.60%	35/42
	Turnover	Dec-23	14.0%	13.3%	13.1%	12.2%	12.4%	12.3%	12.1%	12.0%	11.7%	11.5%	11.4%			13.1%	-	12.3%	-	-
Note/s	* National average upper and lower control limits (UCL and LCL) for SHMI across all non-specialist trusts. This gives an indication of whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, for C&M was as expected when compared to the national baseline. This "rate" is different to the SHMI "banding" used for trusts on slide 8, therefore a comparison cannot be drawn between the two. ^ National figure is the latest ONS figure from 2022. local data is directly from GP systems. this has been reviewed against historic ONS data for LA's and the variation ranges from -0.9% to +5.9% # Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected ~Bankding based on SOF % against target not number of cases																			

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Jan-24	-47.8	-29.6	-	48.2	-75.3	-103	-123.65	-128.2	-143.9	-80.8	-72.2	-79.8	-22.1	↓	0.028	-22.7	-22.7
	Financial position £ms (ICS) VARIANCE	Jan-24	-14	0.7	-	-7.8	-20.5	-38.1	-49.9	-56.7	-70.0	-42.2	-40.8	-57.8		↓			
	Efficiencies £ms (ICS) ACTUAL	Jan-24	288.0	335.6	-	43.2	68.7	97.9	132.7	158.0	192.9	227.0	246.4	302.7	314.1	↑	388.7	388.0	-0.7
	Efficiencies £ms (ICS) VARIANCE	Jan-24	-10.8	4.7	-	-7.3	-8.2	-7.7	-4.6	-11.0	-12.2	-14.0	-30.7	56.3		↑			
	Capital £ms (ICS) ACTUAL	Jan-24	169.1	237.5	-	15.3	24	38.8	42.8	53.9	77.3	110.8	133.7	115.3	165	↑	230	244.9	14.9
	Capital £ms (ICS) VARIANCE	Jan-24	29.6	-12.7	-	2.6	6.3	6.0	16.8	41.2	17.8	2.8	7.1	49.7		↑			

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

Metric	Latest period	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Vs Target expenditure (Current)	Vs Target expenditure (Previous)	Dir. Of Travel
Mental Health Investment Standard met/not met (MHIS)	Nov-23	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Yes**	**Yes**	↔
BCF achievement (Places achieving expenditure target)	Nov-23	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	**9/9**	n/a	↔

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																			ICB *
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts					Net OOA/ Other		
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	SHLA	MCFT	CWP			
Urgent care	4-hour A&E waiting time	Feb-24	49.3%	49.2%	62.0%	63.0%	59.0%	62.9%	66.8%	78.6%	-	84.5%			93.8%	94.3%		87.6%		-	68.1%
	A&E 12 hour waits from arrival	Feb-24	22.0%	15.0%	10.0%	18.7%	23.7%	19.4%	18.1%	0.2%	-	**	-	-	-	-	-	-	-	-	16.7%
	Adult G&A bed occupancy	Feb-24	98.3%	96.4%	98.7%	96.3%	96.8%	95.4%	98.7%		81.2%	61.5%	93.0%	90.0%						-	95.9%
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Feb-24	16.9%	12.8%	21.1%	15.3%	25.8%	23.2%	17.8%											-	19.8%
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jan-24	597	77	711	398	1,233	118	831	162	26	254	0	6	0	0	-	0	-	642	4,732
	Total incomplete Referral to Treatment (RTT) pathways	Jan-24	31,101	12,882	40,206	40,930	33,241	76,948	79,394	25,597	5,176	18,724	890	15,540	3,439	53	-	28	-	36,192	369,750
	Patients waiting more than 6 weeks for a diagnostic test	Jan-24	21.0%	38.9%	11.7%	5.6%	14.2%	6.0%	20.1%	14.6%	33.2%	3.5%	0.0%	0.6%	16.2%	0.0%	-	-	-	-	16.2%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for	Dec-23	77.5%	72.5%	64.6%	74.7%	71.5%	64.0%	78.4%	-	70.0%	15.2%	90.8%	-	78.0%					-	71.8%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Dec-23	99.3%	92.6%	86.0%	91.6%	97.1%	89.1%	91.5%	100.0%	100.0%	76.3%	99.7%	100.0%	95.7%					-	95.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Dec-23	66.1%	71.6%	71.5%	73.4%	78.2%	73.6%	69.2%	65.9%	77.8%	34.9%	90.9%	100.0%	80.7%					-	70.2%
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Dec-23	Mental Health service providers only														-	75.0%	76.0%	-	75.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Dec-23	76.0%	-	82%	Community Service Providers only									78.0%	83.0%	*	77.0%	-	-	80.0%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis																				

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																		
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts					Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	SHLA	MCFT	CWP		
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Oct-23	2.08	3.89	4.50	3.84	2.88	-	2.87	-	-	2.47	-	-							3.02
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	12 months to Dec 23	(67 vs 56)	(9 vs 6)	(47 vs 31)	(111 vs 71)	(45 vs 36)	(155 vs 133)	(114 vs 85)	(4 vs 0)	(2 vs 2)	(0 vs n/a)	(12 vs 13)	(9 vs 6)							575
	Healthcare Acquired Infections: E.Coli (Hospital onset)	12 months to Dec 23	(50 vs 35)	(32 vs 27)	(59 vs 24)	(81 vs 53)	(76 vs 54)	(260 vs 165)	(163 vs 121)	(13 vs 8)	(5 vs 6)	(6 vs 5)	(24 vs 10)	(9 vs 10)							778
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Sep-23	0.9873	1.2237	0.9649	1.0741	0.9468	1.0482	1.0631												1.039
	Never Events (rolling 12 month total)	Jan-24	1	2	1	2	4	4	3	1	0	2	0	1	0	0		0	0	4***	25
	21+ day Length of Stay (ave per day)	Jan-24	109	62	115	170	139	458	254	1	22	0	19	37							1,386
Workforce / HR (Trust Figures)	Staff in post	Dec-23	3,761	2,358	4,838	5,898	4,196	13,963	9,430	4,096	1,819	1,600	1,784	1,472	1,483	1,483	-	10,174	3,761	-	72,784
	Bank	Dec-23	169	187	593	354	362	1,005	849	185	51	66	40	95	52	52	-	868	169	-	5,246
	Agency	Dec-23	100	78	118	52	64	179	264	12	11	0	10	6	8	8	-	270	100	-	1,245
	Sickness (via Ops Plan Monitoring Dashboard)	Dec-23	6.7%	5.6%	5.0%	6.0%	5.7%	6.4%	3.8%	6.0%	4.7%	6.4%	4.8%	5.7%	6.2%	6.1%	-	7.8%	6.7%	-	5.5%
	Turnover	Dec-23	11.8%	12.0%	10.9%	11.6%	11.4%	11.4%	10.7%	10.9%	12.3%	12.1%	14.6%	13.2%	19.8%	19.2%	-	11.1%	11.8%	-	11.4%
Finance	Overall Financial position Variance (£m)	Jan-24	0.59	0.91	-0.43	-4.13	2.08	-0.71	-3.72	-0.71	0.22	1.39	-0.06	-0.61	-0.65	0.13	-	-1.09	-2.51	-25.03	-34.32
	Efficiencies (Variance)	Jan-24	-2.46	0.69	0.68	-2.02	-0.95	-3.26	0.00	0.59	-0.80	-1.33	0.18	0.00	-0.00	0.00	-	0.00	-0.84	-1.93	-11.45
	Capital (Variance)																				
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. *** Independent Providers / Other providers (1 at Alternative Futures - Weaver Lodge, 1 at Fairfield Independent Hospital and 2 at Isight Clinic – Southport # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																				

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time	Feb-24	57.3%	54.4%	52.6%	49.9%	57.9%	50.1%	56.2%	62.7%	60.5%		68.1%	75.5%	76% by Year end
	Ambulance category 2 mean response time	Feb-24	00:35:48		00:45:36	00:45:51	00:45:39	00:47:33	00:47:10	00:47:23	00:47:54		00:43:30	00:33:00	00:30:00
	A&E 12 hour waits from arrival	Feb-24	12.1%	17.4%	17.5%	21.6%	13.5%	15.8%	13.6%	20.5%	17.7%		16.7%	-	-
Planned Care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jan-24	1,831		465	818	350	355	214	564	88	47	4,732	3,074	-
	Total incomplete Referral to Treatment (RTT) pathways	Jan-24	106,449		45,218	31,810	65,990	31,021	25,757	22,370	23,079	18,056	369,750	327,361	-
	Patients waiting more than 6 weeks for a diagnostic test	Jan-24	22.6%		6.9%	11.2%	9.2%	19.5%	14.4%	27.5%	6.9%	24.7%	16.2%	14.9%	10%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Nov-23	62.0%	73.3%	73.1%	70.5%	70.2%	77.7%	82.6%	74.2%	69.7%		71.8%	70.0%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Nov-23	91.4%	93.4%	92.5%	93.6%	95.5%	95.2%	95.0%	97.0%	92.6%		95.0%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Dec-23	73.1%	62.1%	72.5%	77.8%	69.3%	69.8%	71.1%	71.5%	69.0%		70.2%	71.7%	75.0%
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Dec-23	76.0%		100.0%	100.0%	61.0%	75.0%	80.0%	78.0%	82.0%	90.0%	75.0%	60.0%	60.0%
	Access rate for Talking Therapies services	Dec-23	50.0%		56.0%	42.0%	40.0%	77.0%	51.0%	33.0%	35.4%		47.0%	100.0%	100.0%
	Dementia Diagnosis Rate	Jan-24	66.2%		66.2%	72.5%	63.5%	70.3%	59.4%	66.8%	66.5%		66.3%	66.7%	66.7%
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Dec-23	30		10	10	25	10	10	5	10		100	-	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Dec 23 YTD	47.2%		45.8%	43.2%	45.1%	30.8%	52.1%	40.3%	42.0%		45.4%	43.3%	75% by Year end
Primary Care	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Jan-24	110.3%	103.5%	106.2%	109.4%	106.0%	109.3%	108.4%	98.9%	108.2%		106.8%	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Nov-23	6.92%		8.80%	6.23%	7.53%	5.82%	6.77%	6.19%	8.07%		7.24%	10.0%	10.0%
	Total volume of antibiotic prescribing in primary care	Nov-23	0.974		1.153	0.984	1.089	1.182	1.228	1.146	1.137		1.077	0.871	0.871

* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics

** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside							
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton			
			East **	West **							South Sefton	S/port & Formby				
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q3 23/24	156.3	192.7	167.0	134.6	367.9	260.7	330.1	222.9	195.5		225.3	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence ***	Q3 23/24	88.3%	89.3%	95.5%	94.5%	93.7%	94.1%	94.8%	94.6%	91.9%		92.1%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q3 23/24	451.0	459.1	366.5	269.6	739.6	493.4	539.9	421.2	433.1		463.7	-	-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q2 23/24	68.2%		64.4%	63.8%	65.5%	66.5%	61.6%	66.8%	64.6%		65.8%	77.0%	80.0%
	Improve access rate to Children and Young People's Mental Health Services (CYPMH) (12 Month Rolling) ****	Dec-23	82.0%		83.0%	94.0%	102.0%	106.0%	97.0%	63.0%	51.0%		89.0%	-	-
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Jan-24	11.5%	13.0%	14.5%	9.1%	17.0%	14.1%	17.5%	18.0%	13.7%		14.2%	12%	12%
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation	12 months to Dec 23	(208 Vs 156)		(163 Vs 131)	(58 Vs 45)	(182 Vs 172)	(64 Vs 47)	(49 Vs 47)	(39 Vs 33)	(99 vs 100)		575	439	439
	Healthcare Acquired Infections: E.Coli (Hospital onset)	12 months to Dec 23	(599 Vs 498)		(265 Vs 178)	(191 Vs 130)	(454 Vs 346)	(143 Vs 137)	(141 Vs 110)	(118 Vs 89)	(261 Vs 212)		778	518	518
Finance	Overall Financial position Variance (£m)	Jan-24	-12.6	-16.2	-14	-2.3	-11.4	-3.7	-2.6	0.5	-5.00		42.2	0.0	0.0
	Efficiencies (Variance)	Jan-24	3.4	-1.5	0	0.9	-4.0	-1.0	0.0	1.6	-0.50		-1.9	0.0	0.0
	Capital (Variance - 2023/24 data not currently available														
	Mental Health Investment Standard met/not met (MHIS)	Jan-24	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Jan-24	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9		9/9	9/9	9/9

Note/s

* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics

** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.

*** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories

**** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is different to the NHS Oversight Framework indicator used in the ICB table

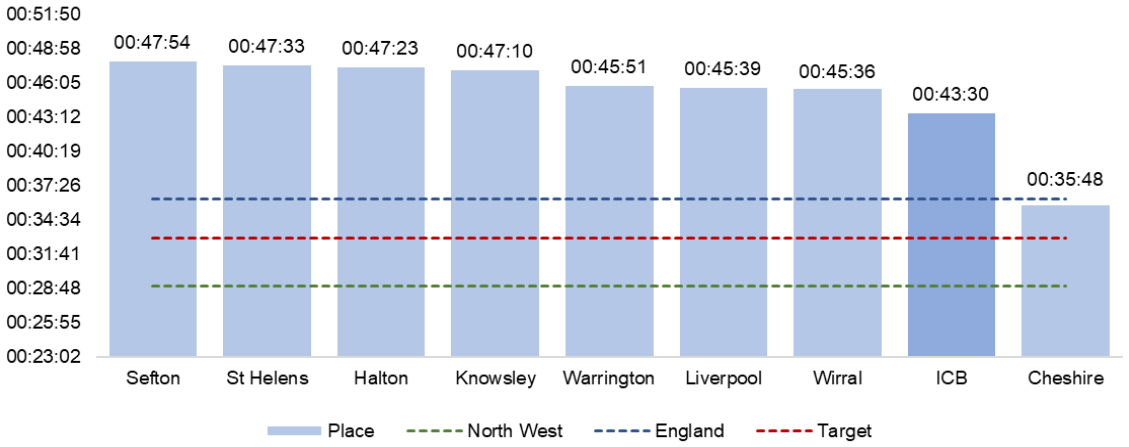
5. Exception Report – Urgent Care

Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (Feb-24)	00:43:30	National Ranking	n/a

Place Breakdown (Feb-24)



Issue

- February performance showed continued improvement from December, however worse than other North West ICBs. National category 2 mean response time target for 2023/24 is <30 minutes. Ambulance handover is a key dependency.

Action

- ICB Medical Directors have agreed shared principles for managing ambulance handover delays to release crews, where necessary accepting that this may cause increased waits in A&E and 'corridor care', to manage wider risk to patients in the community.
- COCH, M&WL (Whiston site) and WUTH in receipt of resource for ambulance handover, sustained improvement has been observed especially at WUTH and COCH.
- LUFT and WHH in receipt of ECIST (Emergency Care Improvement Support Team) support
- Clinical navigator based within ambulance control room as part of a 12-week pilot to refer category 3 & 4 calls direct to UCR (Urgency Community Response)

Delivery

- Achieve 30 minutes by March 2024

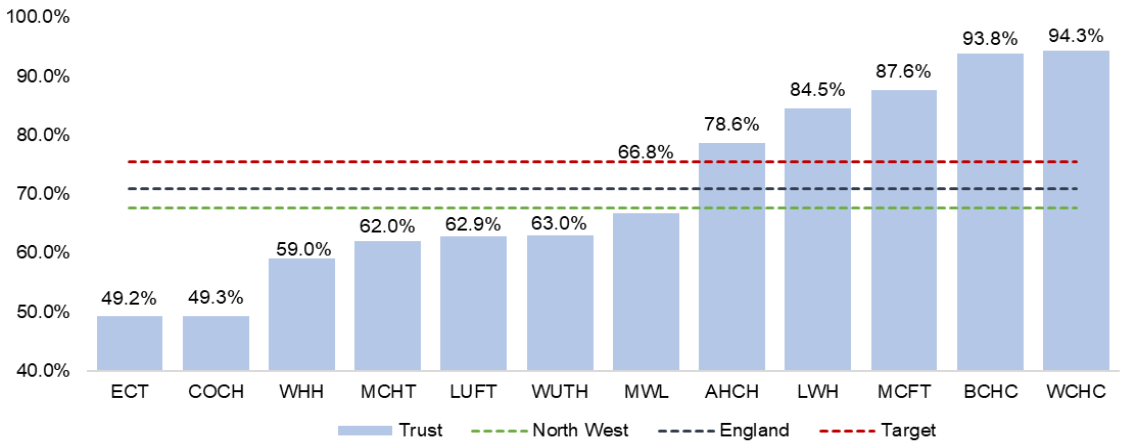
5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

A&E 4 hour waits from arrival

Latest ICB Performance (Feb-24)	68.1%	National Ranking	32/42

Provider Breakdown (Feb-24)



Issue

- Cheshire and Merseyside performance has been below trajectory since September, and currently falls 7.9% short of the 76% year-end ambition.

Action

- COCH: AQUA support in place. Trust led emergency department reset programme initiated in February. System wide UEC recovery plan in development.
- ECHT: Trust led UEC improvement programme in place focussed on ambulance handover increasing Same Day Emergency Care (SDEC) provision, direct referral pathways and improved front door navigation along with system wide work on discharge to assess
- MCHT: Well established UEC improvement programme headed up by Chief Operating Officer with workstream focus on ED practice and process.
- WUTH: Improvement plan in place overseen by the Unscheduled Care Board. Focus is on attendance and admission avoidance initiatives, UCR and 'Front Door' in reach.

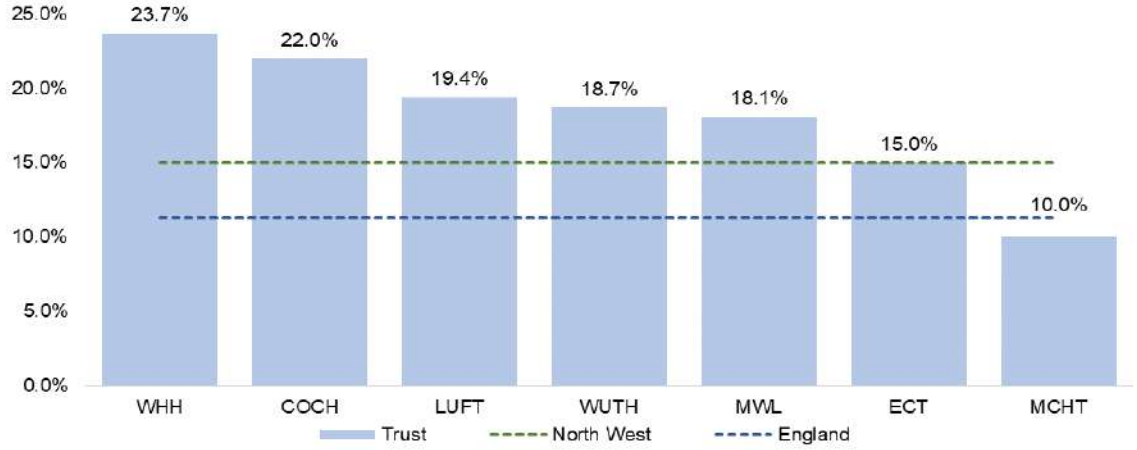
Delivery

- C&M continues to plan for achievement of 76% by March 2024, this remains a challenging trajectory within the context of ongoing urgent and emergency care pressures.

A&E 12 hour waits from arrival

Latest ICB Performance (Feb-24)	16.7%	National Ranking	36/42

Provider Breakdown (Feb-24)



Issue

- 16.7% of Cheshire & Merseyside A&E patients were delayed over 12 hours compared to the England average of 11.3%.

Action

- Acute trusts have increased their focus on ambulance handover times to avoid holding patients on vehicles outside hospital and to ensure timely handover.
- A reduction in 12-hour time in department is dependent upon overall flow from ED to specialty wards. As No Criteria to Reside (NCTR) numbers have increased, flow has become more challenged with trusts frequently enacting full capacity protocols to enable the boarding of additional patients to wards.
- WUTH and LUFT testing continuous flow models to increase flow from ED on to AMU/wards.
- Trusts actions are focused on direct access pathways to enable NWAS conveyance to SDEC and other UEC services, along with direct referral from NWAS into UCR.
- Improved flow within A&E supported by in-reach from specialties and social care teams.

Delivery

- Improvement by March 2024 in line with delivery of key UEC metrics.

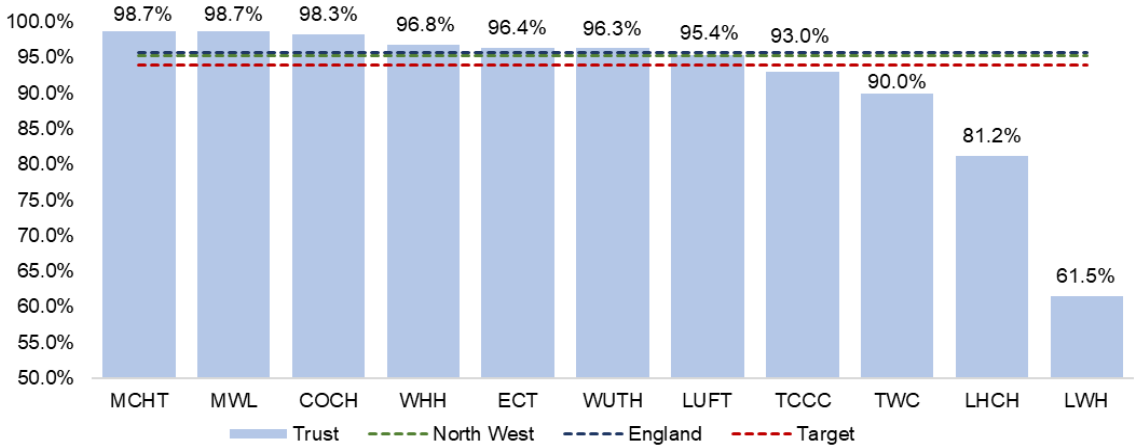
5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (Feb-24)	95.9%	National Ranking	24/42

Provider Breakdown (Feb-24)



Issue

- General and acute (G&A) bed occupancy is consistently high across acute trusts in C&M. The national ambition for winter is to reduce to 92% occupancy, Cheshire and Merseyside have set a plan to achieve 93.4% by March 2024.
- NCTR: Long length of stay and patients no longer meeting criteria to reside in hospital are a key driver of high occupancy.

Action

- Place and providers worked together to update winter demand and capacity assumptions in November 2023, these indicated that providers continued to plan to achieve 93.4%, but were predicated on planned improvement in NCTR being achieved. NCTR rates are currently higher than planned.

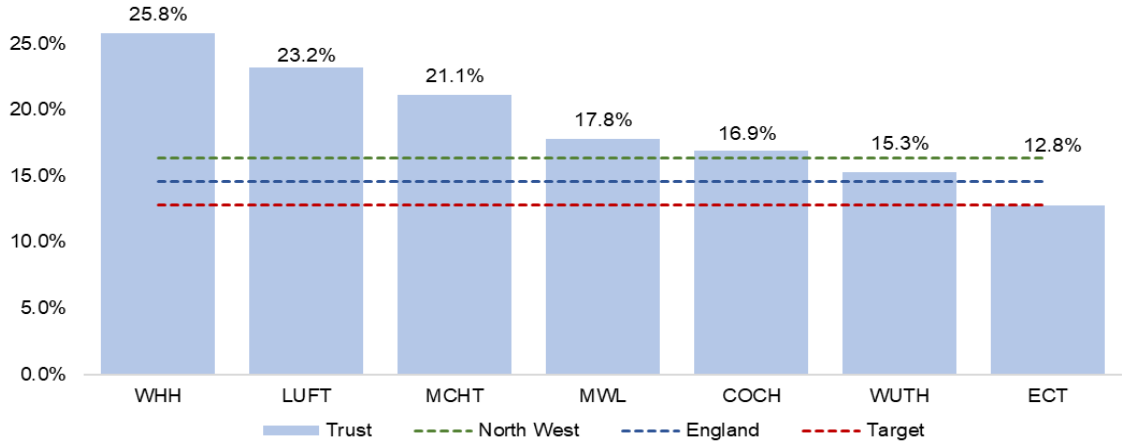
Delivery

- Achieve 93.4% bed occupancy by March 2024

No Criteria To Reside (NCTR)

Latest ICB Performance (Feb-24)	19.8%	National Ranking	39/42

Provider Breakdown (Feb-24)



Issue

- NCTR is at 19.8%, higher than England at 14.6% and NW 16.4%, and winter plans average 19%.

Action

- LUFT and WHH have a dedicated improvement work stream with national ECIST resource to focus on hospital process and discharge and operational management of the NCTR patient list.
- MCHT: Agreed target with partners to reduce number to 75 patients. Strategy agreed with place. Integrated transfer of care hub operational
- All C&M Places and Providers have reviewed their assumptions and plans regarding NCTR and winter plans are aligned to Tier 1 / 10 high impact UEC interventions.
- This includes aligning processes across the 9 C&M care transfer hubs, addressing capacity gaps in intermediate care, improving community bed productivity, and deploying this year's discharge fund to improve staffing e.g. in care transfer hubs and care arranging teams.

Delivery

- Winter plans span October 2023 to March 2024, with a plan to average 19% over this period.

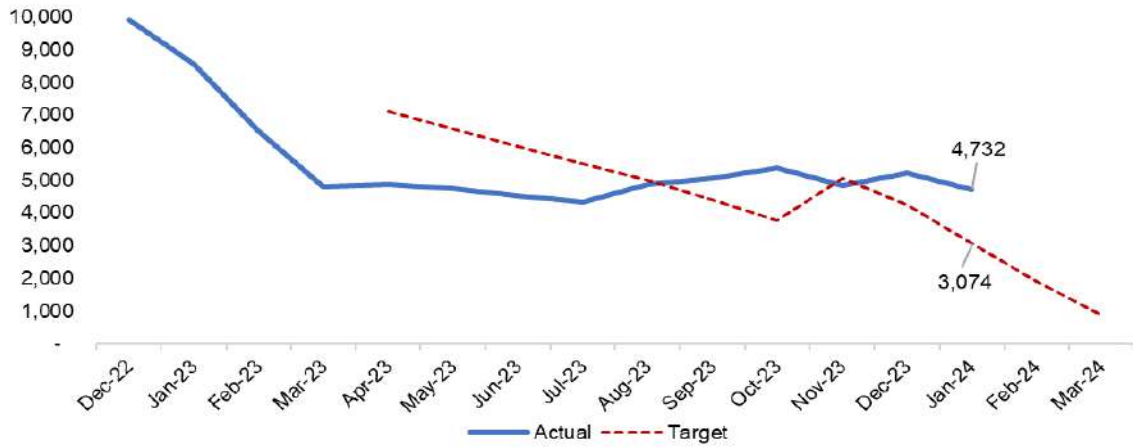
5. Exception Report – Planned Care

Cheshire and Merseyside

ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Jan-24)	4,732	National Ranking	n/a

ICB Trend (Jan-24)



Issue

- As of 10th March we have 3,497 patients waiting over 65 weeks which is a decrease from this time last month.
- There are 396 patients currently waiting over 78 weeks. This cohort is a combination of capacity, patient choice and clinically complex.
- Of note, 16,615 elective cancellations took place between December and March due to Industrial Action

Action

- Over 177,000 patients cleared from the "potential breach" category since May 2023.
- Focus on maximising local capacity within current cost base
- Regular Patient Tracking List (PTL) meetings and oversight at trust and system level.
- Mutual aid, tailored support, and elective hub utilisation programmes ongoing.
- Managing key challenges for Gynae, Ear Nose and Throat (ENT), Dermatology, Trauma & Orthopaedics and Colorectal.

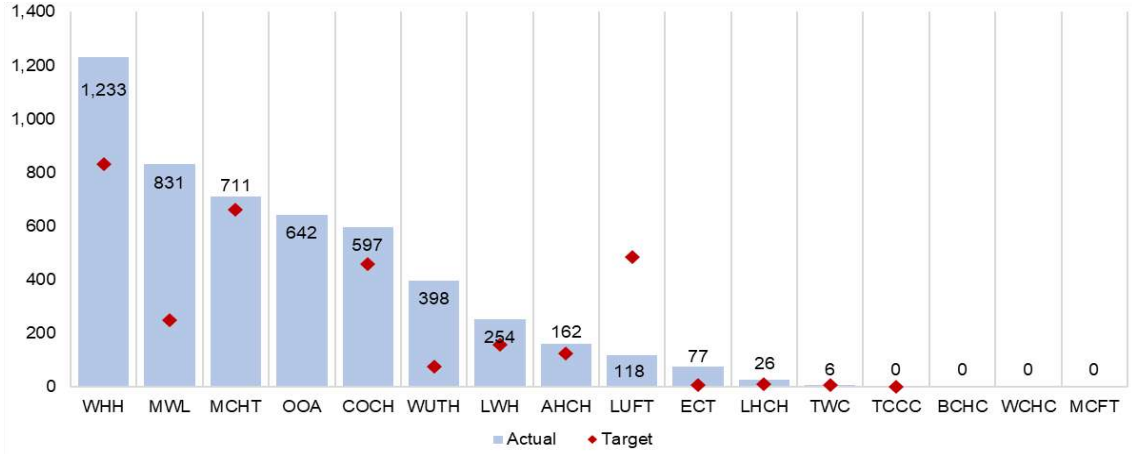
Delivery

- Due to the impact of industrial action the national timeline for the eradication of 65 week waits has moved to September 2024. C&M has set an objective to deliver this by the end of June.

Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Jan-24)	4,732	National Ranking	n/a

Provider Breakdown (Jan-24)



Issue

- Several trusts are not meeting their own internal target to clear 65 week wait patients.

Action

- WHH – Capacity problems continue to be experienced which have been escalated to surrounding trusts. The Independent Sector (IS) is also supporting with c1500 patients identified as suitable for transfer.
- MCHT – Insourcing is in place for Dermatology. Capacity issues across other specialties. Mutual aid arrangements are ongoing with the IS and NHS providers.
- Out of Area (OOA) – Monitored through partnership calls with region. Consideration being given to use of Patient Initiated Digital Mutual Aid System (PIDMAS) to enable patients to move to a different hospital to receive their treatment if they wish.

Delivery

- Due to the impact of industrial action the national timeline for the eradication of 65 week waits has moved to September 2024. C&M has set an objective to deliver this by the end of June.

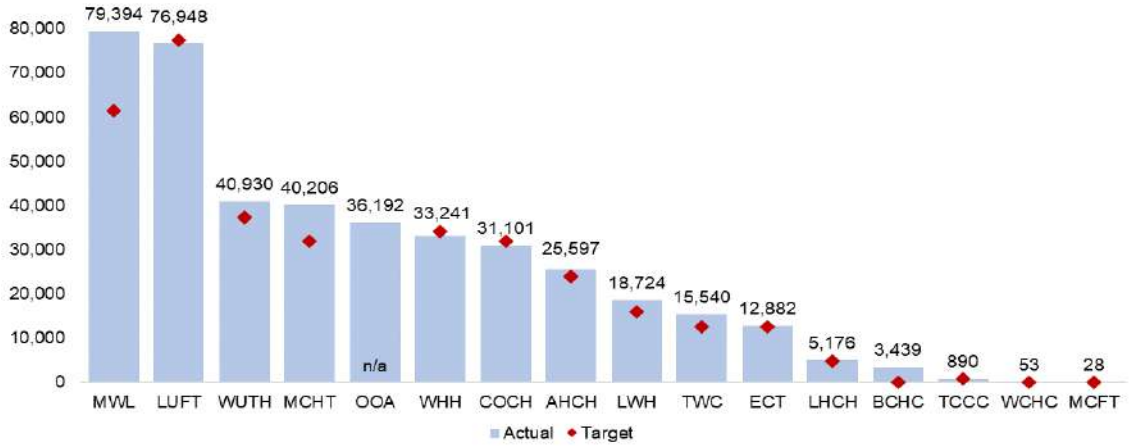
5. Exception Report – Planned Care and Diagnostics

Cheshire and Merseyside

Total incomplete Referral to Treatment (RTT) pathways

Latest ICB Performance (Jan-24)	369,750	National Ranking	n/a

Provider Breakdown (Jan-24)



Issue
- The number of incomplete pathways in C&M 2.5% higher than at the end of April 2023 compared with 2.1% nationally.
- Year on year 12-month growth in total referrals is 5.7% year to date (5.8% for England).

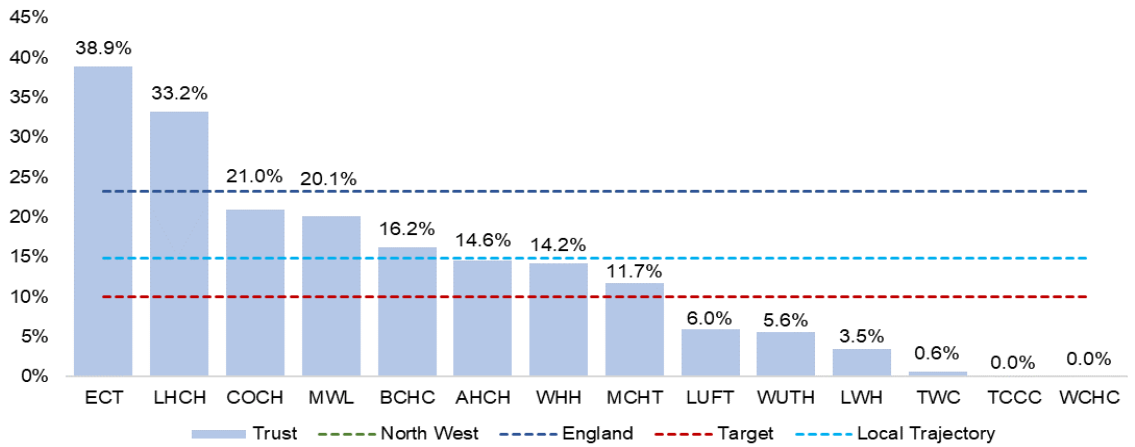
Action
- Trusts are delivering higher levels of Value Weighted Activity (VWA) compared to 19/20 baseline, despite industrial action (IA). National targets have been adjusted to reflect the impact of IA down from 105% to 103% for C&M.
- Trusts have been proactive in rebooking activity cancelled due to IA.
- The elective recovery programme has been focusing on reducing and ultimately eliminating 65 week waits. Challenges remain around complexity and patient choice.

Delivery
- The ICB target to reduce incomplete pathways to 323,190 by March 2024 is not expected to be delivered, with the primary focus on reducing long waiters.

Patients waiting more than 6 weeks for a diagnostic test

Latest ICB Performance (Jan-24)	16.2%	National Ranking	12/42

Provider Breakdown (Jan-24)



Issue
- C&M is not yet achieving the 10% 6-week standard required by end of March 2024, however is on track to deliver this.

Action
- January data shows an improvement from the December position (1.0%) with ICS ranking improving from 7th in December to 4th in January.
- Overall waiting list has decreased in January to the lowest level (69,206) since October 2021.
- Activity levels in January were the highest ever (116,479) and C&M is delivering 9% above plan YTD.
- Focus remains on colonoscopy with 6 week waiting times improving from December to January by 8.3%.
- Focus on increased activity via Community Diagnostics Centres, productivity within all providers and mutual aid across our system is delivering faster waiting times.

Delivery
- Weekly data shows that C&M is improving week on week providing confidence that the target for 90% of patients seen within 6wks by 31st March 2024 will be achieved.

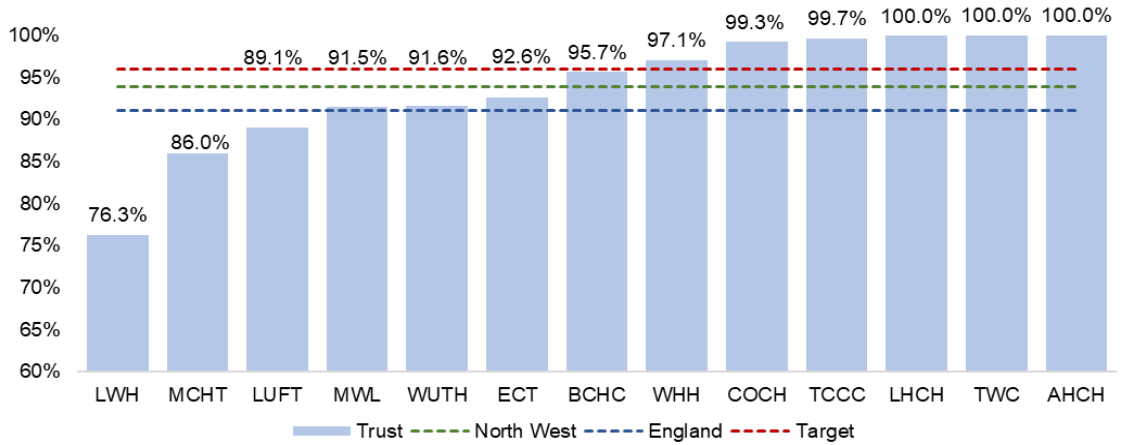
5. Exception Report – Cancer Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (Dec-23)	95.0%	National Ranking	6/42

Provider Breakdown (Dec-23)



Issue
- C&M did not meet the 96% in December, however the December position puts the Cheshire and Merseyside Cancer Alliance 3rd of 21 Cancer Alliances Nationally. The highest performing alliance achieved 95.8%.

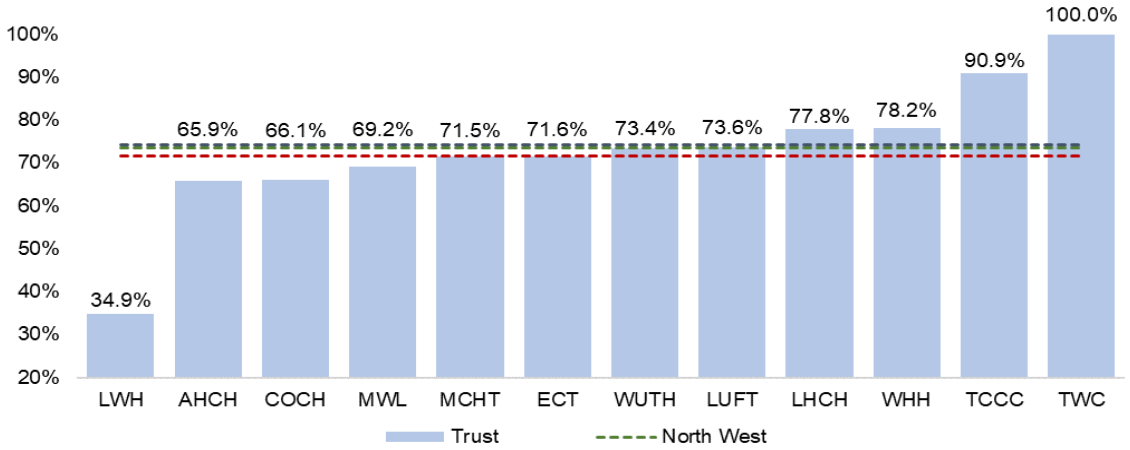
Action
- C&M have analysed the drivers for the 31-day combined position and identified that the areas of underperformance are in surgery and primarily in first treatments.
- The most challenged performance was at LWH, however the greatest number of breaches were at LUHFT.
- A performance management forum has been agreed at CMCA Steering group to commence in the 24/25 FY with 28, 62, and 31-day standards as the sole focus. Pathway analyser tools will be utilised in line with planning guidance to understand any blockers to surgical treatments in C&M.

Delivery
- C&M expects to meet the 96% performance standard by the end of Q4 23/24.

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

Latest ICB Performance (Dec-23)	70.2%	National Ranking	37/42

Provider Breakdown (Dec-23)



Issue
- C&M Faster Diagnosis Standard (FDS) is below target.

Action
- C&M continue to lead on operational performance with targeted SDF being utilised for rapid improvements in March 24 to affect the end of year position. Some positive movement is observed in LGI with one provider meeting the standard in December (CoCH).
- National modelling suggests that skin and breast should meet 90% to achieve aggregate FDS and therefore as part of 24/25 planning, trajectories have been developed at tumour group level to focus on priority pathways. These will be managed via the improvement forum.
- Improvement should be supported by the improved backlog position in C&M, which is significantly ahead of trajectory and has already met and exceeded the March 24 target (60 patients ahead). This supports a likely improvement in FDS in Jan and Feb which are each predicted to be >72%. Key drivers for this improved performance for gynaecology and skin.

Delivery
- C&M expect to achieve between 72% and 75% by March 24 in anticipation of a rise to 80% in the next 2 years. Trajectories to meet 77% have been set and agreed for 24/25.

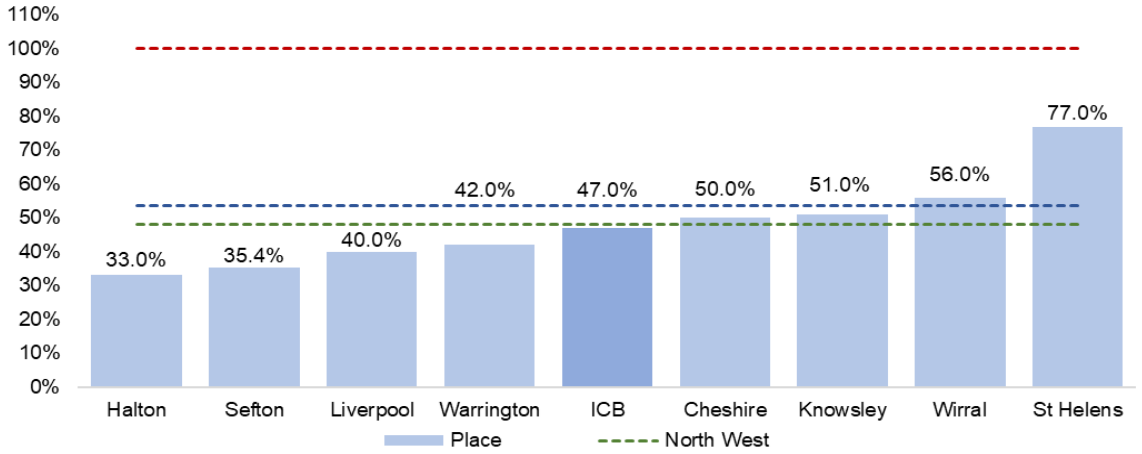
5. Exception Report – Adult Mental Health

Cheshire and Merseyside

Access rate for Talking Therapies (TT) Services (formerly IAPT)

Latest ICB Performance (Dec-23)	47.0%	National Ranking	30/42

Place Breakdown (Dec-23)



Issue
- Talking Therapies (TT) is not achieving the access ambition set out in the Long-Term Plan.

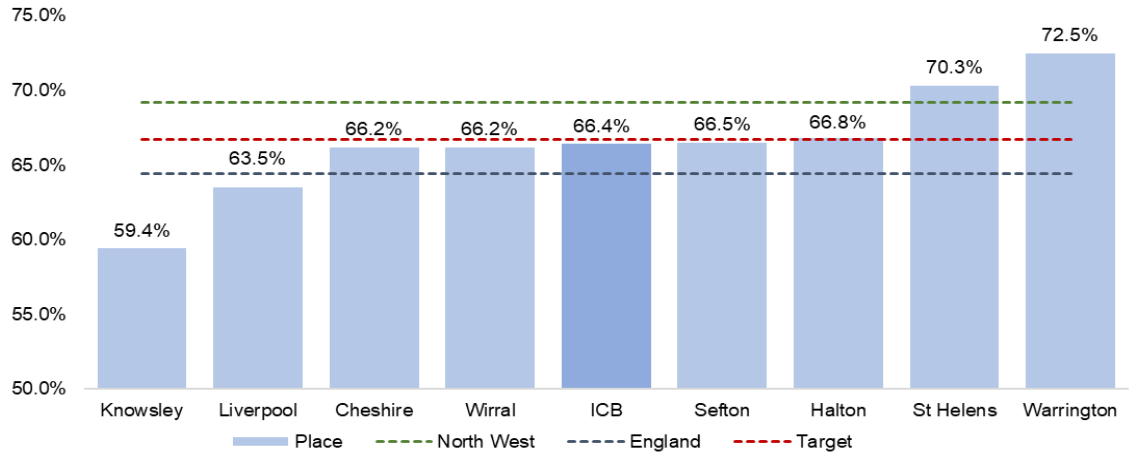
Action
- Comms: Increase awareness of TT services, supported by a Q4 National Campaign, simplify self-referral and pathways for people with long term conditions, prioritising cancer pathways.
- Service Models: Share learning between services, develop optimum service model and improve efficiency with a single service specification across C&M TT Services.
- Place: Review contracts and financial commitments. Cost analysis taking place, outcomes to be discussed between Place commissioning leads and providers (CWP, MCFT and non-NHS services, e.g. Big Life Group (C/East), MH Matters (Warrington and Sefton)).
- Exploring the use of AI technology.

Delivery
- C&M has a recovery access target of 72,724 based on a reprofiled national trajectory.
- There has been a significant decrease in performance from 67% in Nov to 47% in Dec 23, however, this appears to be a seasonal trend and activity is predicted to increase in January 2024. The decrease varies between 17% and 48% but is evident across all 9 places.

Dementia Diagnosis Rate

Latest ICB Performance (Jan-24)	66.3%	National Ranking	16/42

Place Breakdown (Jan-24)



Issue
- C&M ICB consistently met dementia diagnosis rates pre-pandemic, however performance has dipped below the national target of 66.7%
- There is unwarranted clinical variation within Sefton. Southport & Formby have consistently exceeded the national target with Jan performance at 72.5%, however, South Sefton achieved 59.3% in Jan 24.

Action
- Capacity being identified to support development of a C&M action plan which will review:
  - Place-based data and information to better understand baseline provision (including risks and issues) across the whole pathway
  - Place-based dementia strategies, key objectives and progress
  - The status of any place-based dementia groups and involvement of key partners to ensure that the recommendations of the All-Party Parliamentary Group report, Raising the Barriers, are addressed

Delivery
- St. Helens and Warrington have consistently exceeded the national target during 2023/24. Other trajectories being discussed with Quality AD's.

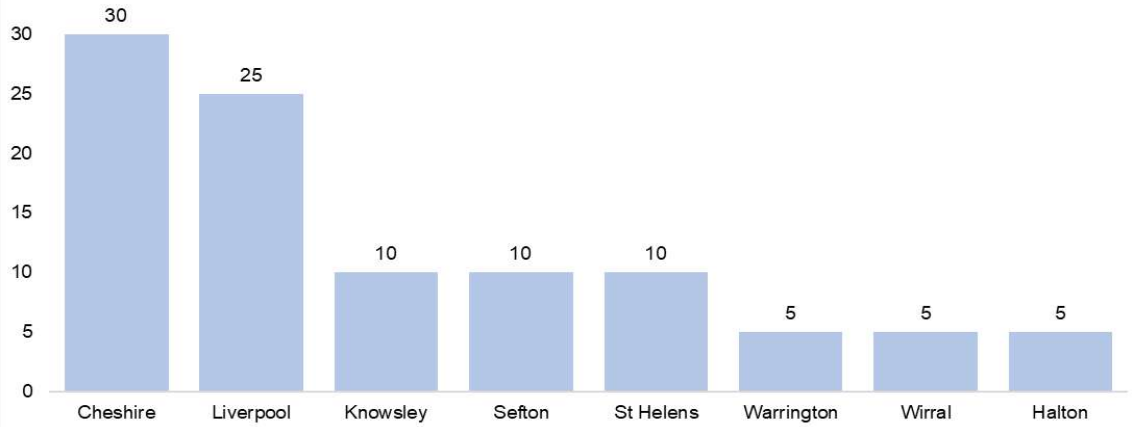
5. Exception Report – Learning Disabilities

NHS Cheshire and Merseyside

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Dec-23)	100 *	National Ranking	37/42

Place Breakdown (Dec-23) * *Data rounded up/down to nearest 5: therefore Place subtotals may not add up to the ICB total*



Issue

- There are currently 94 adult inpatients, of which 50 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 44 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 60 or fewer by the end of Q4 2024.

Action

- The Transforming Care Partnership (TCP) has scrutinised the discharge pathways of those clinically ready for discharge and there have been 7 discharges in Q4 to date, with a further 7 expected to take place before the end of Q4. This will be tightly monitored via Desktop Review over the next month to push.
- Data quality checks to be completed on Assuring Transformation to ensure accuracy.
- Weekly C&M system calls ongoing to address Delayed Discharges.
- Housing Lead continues to work with Housing Providers to find voids which can accommodate delayed discharges. Housing Lead meeting with North West Housing Lead and C&M Analytical Support to map those individuals clinically ready for discharge with housing difficulties. The follow up meeting to begin implementing plans for Housing Needs/ Development projects is due to take place on 2nd April 2024.

Delivery

- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2023/24, with further reductions in 24/25.

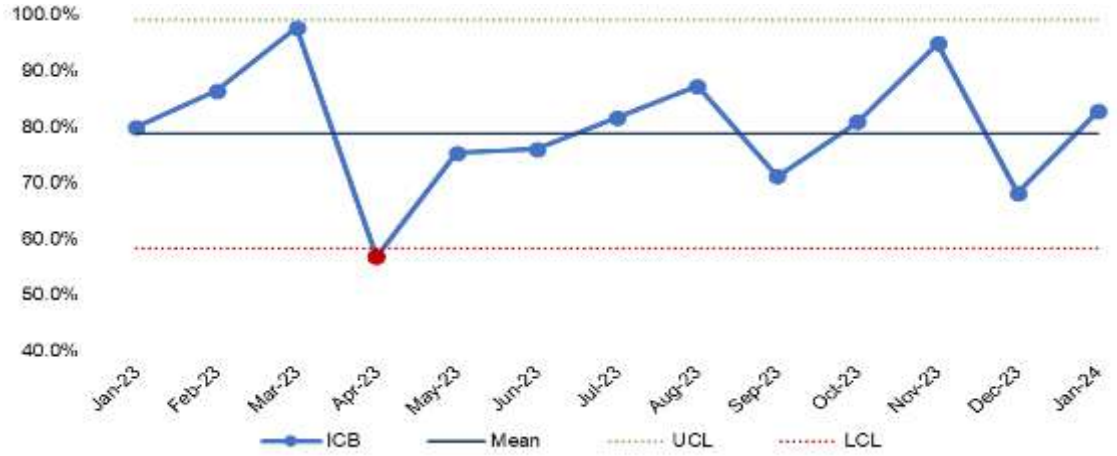
5. Exception Report – Primary Care

Cheshire and Merseyside

Units of dental activity delivered as a proportion of all units of dental activity contracted

Latest ICB Performance (Jan-24)	82.8%	National Ranking	26/42

ICB Trend (Jan-24)



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

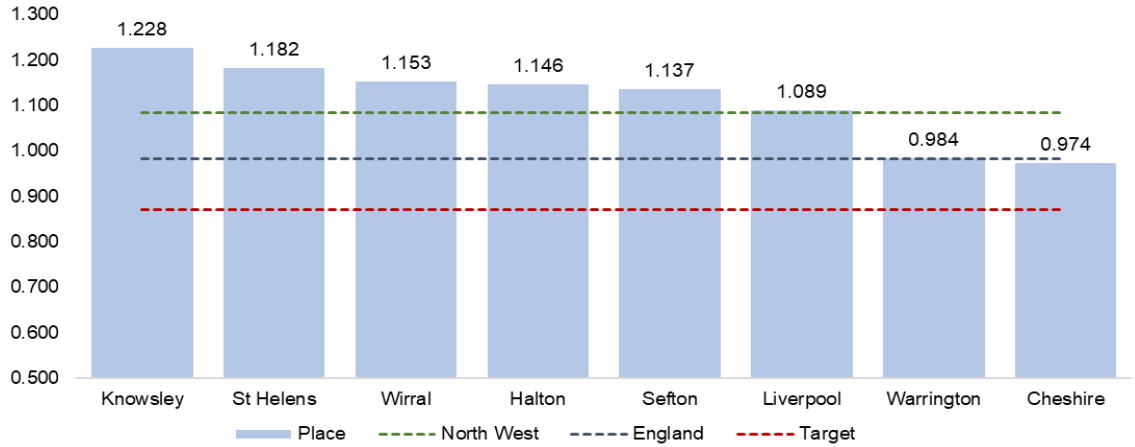
Action
- Continue to focus delivery on areas of highest need where there is poor oral health.
- Support contractors to continue to deliver and support those who can do more activity

Delivery
- 2024/26 dental improvement plan developed and supported by SPCC on 22/2/24. Recommendation from SPCC for Board approval March 2024.
- Fluctuations in delivery of target are expected throughout the year and based on previous year's performance.
- Contract management of providers follows national contract management policy and is overseen by Dental Operational Group.
- A new national dental improvement plan was launched on 7/2/24 and commissioners are working on its implementation alongside the new local plan
- In the local plan for 2024 /26 there will be a new quality access scheme for routine access appointments.

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Nov-23)	1.077	National Ranking	33/42

Place Breakdown (Nov-23)



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

Action
- All places are continuing to work with primary care on the cascading of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- A C&M antibiotic prescribing data dashboard is being utilised and shared with prescriber consistently across C&M to support targeted work and monitor outcomes.
- A C&M Antimicrobial Stewardship Working Group enables the sharing of good practice across primary and secondary care, including wider learning and agreeing actions.
- Currently the group is progressing a deferred antibiotic prescribing standard operating procedure (SOP) for use and implementation across C&M.
- Good progress made by the comms team with the agreed winter messages around childhood health in a campaign to reduce unnecessary use of antibiotics.

Delivery
- C&M expect to see an improvement in Q4 of 2023/24 for the overall volume of prescribing of antibiotics in primary care, assuming the current levels of infection remain static.

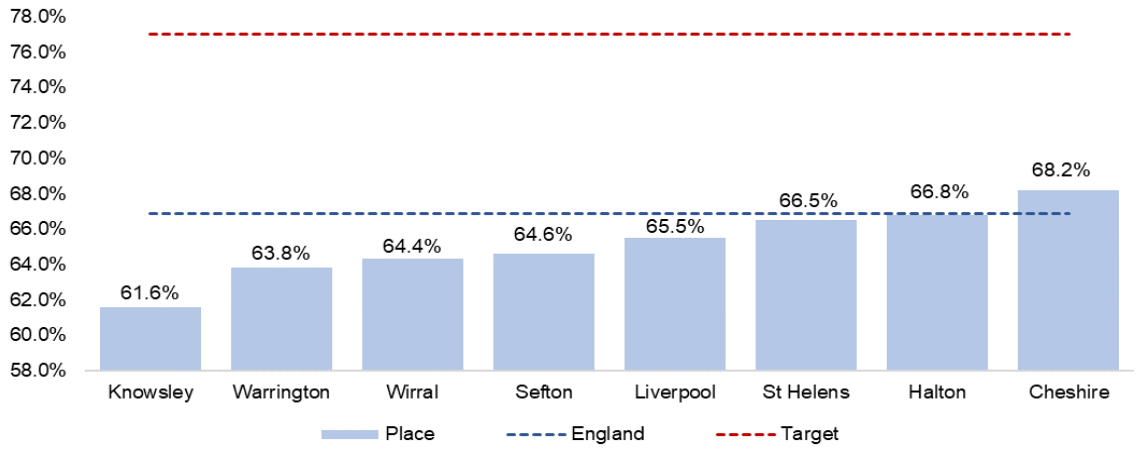
5. Exception Report – Health Inequalities & Improvement

Cheshire and Merseyside

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

Latest ICB Performance (Q2-23)	65.8%	National Ranking	n/a

Place Breakdown (Q2-23)



Issue

- There is considerable variation in C&M, with Sefton, Knowsley, Liverpool, Warrington and Wirral recording Treatment to Target rates below the C&M average.
- Reductions in capacity & funding have affected the improvement programme (e.g. reduced Cardiac Network & withdrawal of SDF funding to support Primary Care's digital programme).

Action

- National and local initiatives are underway to improve existing pathways and expand detection & case finding via new pathway partners (e.g. NWAS & Cheshire Fire & Rescue)
- As part of the NHSE Regional review of Clinical Networks, the ICB have been reviewing the available resources to ensure that CVD prevention programmes continue to be given strategic support to enable local effective prevention interventions can be further established. Mapping of governance and capacity has been commenced which includes the Cardiac Network, Innovation Agency, leadership from the Liverpool Heart and Chest Hospital and ICB clinical and population health leads.

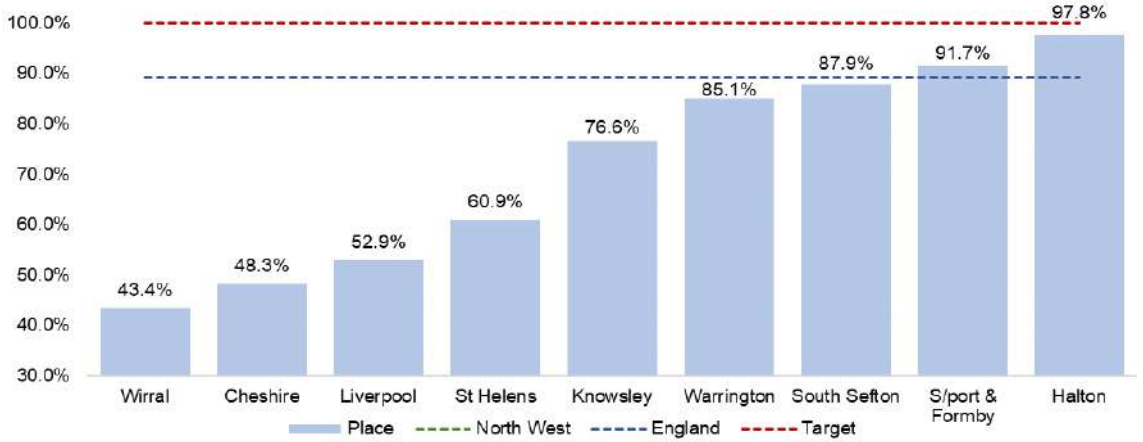
Delivery

- Under the current trajectories and available resources, the original 80% TTT by 2029 remains the more realistic outcome.

Improve access rate to CYP Mental Health Services (12 Month Rolling)

Latest ICB Performance (Dec-23)	89.0% *	National Ranking	18/42

Place Breakdown (Dec-23) **



Issue

- The CYP Access target is 37,590 to be achieved by 31st March 24 (LTP Period), the national NHS Mental Health Service Data Set (MHSDS) indicates that the C&M CYP Access target is not currently being met.

Action

- Historically CYP Access has been led at Place level. Work is underway to bring together CYP Place Leads to consider access to mental health support for CYP across Place and ICB System with collective oversight.
- A data quality plan is in place to ensure data capture of all CYP mental health providers to reflect a more accurate picture.
- C&M CYP Access Development Workstream developing plans to recover the trajectory.

Delivery

- Access levels for C&M continue to increase month on month
- Trajectories to be developed with Quality AD's

** ICB data uses number treated vs target*
*** Place data uses number treated vs no. referred*

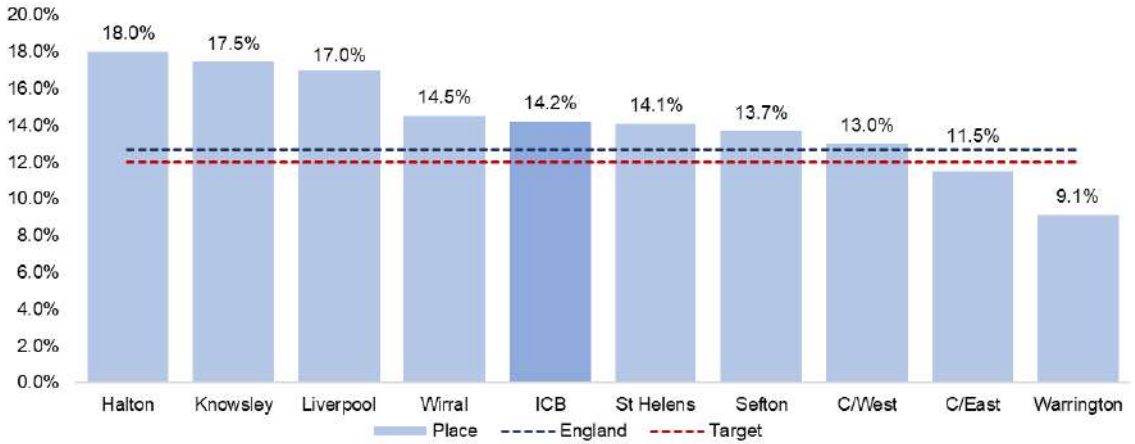
5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

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

Latest ICB Performance (Jan-24)	14.2%	National Ranking	n/a

Place Breakdown (Jan-24)



Issue

- Radically reducing smoking remains the single greatest opportunity to reduce health inequalities and improve healthy life expectancy. Smoking will kill up to 2 in 3 smokers, half in middle age. Updated estimates suggest that smoking costs the C&M system an estimated £2bn.

Action

- A Smokefree Cheshire and Merseyside Framework is being developed, ensuring integration with an effective NHS Treating Tobacco Dependency programme takes place alongside community smoking cessation services, and a new system wide owned Tobacco Control Plan. The C&M Treating Tobacco Dependency Forum was held in January which includes all ten acute trusts that have implemented a TTD service along with all seven maternity sites.
- The ICB continue to work with mental health services and a specialist TTD provider on a pilot programme for hospitalised mental health patients. Each provider is progressing contract discussions.

Delivery

- Additional strategic capacity in place to support the development of the Smokefree CM Strategic Framework through CHAMPs, the ICB and LA DsPH.
- Smokefree Framework to be co-produced building on local place plans to deliver a Smoke Free 2030. LGA Sector Led Improvement Workshop with all 9 LAs on 8th March to coproduce the new Framework ahead of national no smoking day on 13th March. An ICS Senior System Stakeholder Workshop is scheduled for 23rd April.

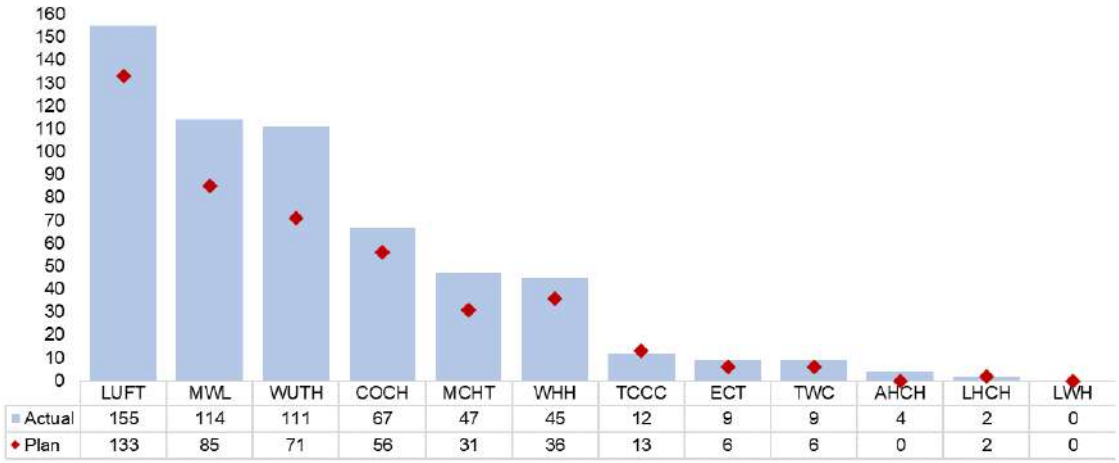
5. Exception Report – Quality

Cheshire and Merseyside

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (12 months to Dec-23)	131.0%	National Ranking	21/42

Provider Breakdown (rolling 12 months to Dec-23)

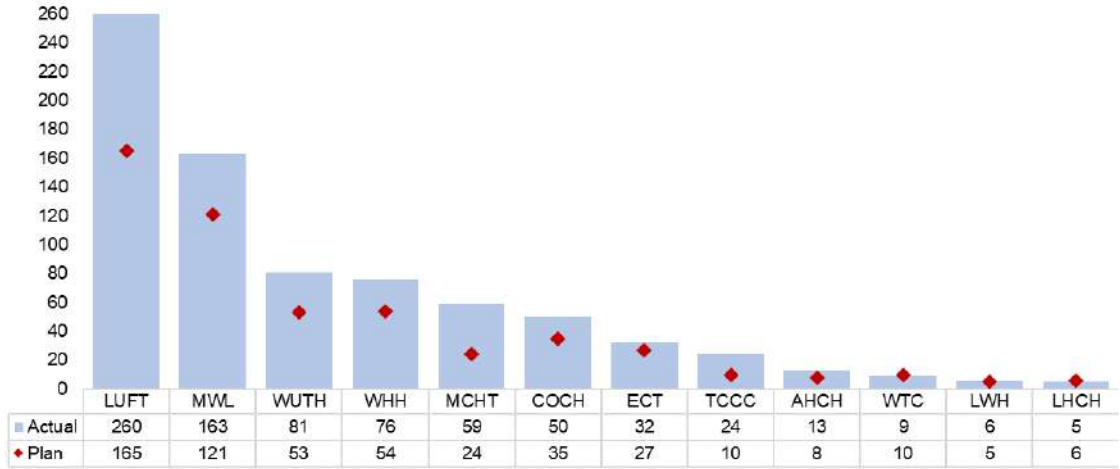


	LUFT	MWL	WUTH	COCH	MCHT	WHH	TCCC	ECT	TWC	AHCH	LHCH	LWH
Actual	155	114	111	67	47	45	12	9	9	4	2	0
Plan	133	85	71	56	31	38	13	6	6	0	2	0

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

Latest ICB Performance (12 months to Dec-23)	150.2%	National Ranking	39/42

Provider Breakdown (rolling 12 months to Dec-23)



	LUFT	MWL	WUTH	WHH	MCHT	COCH	ECT	TCCC	AHCH	WTC	LWH	LHCH
Actual	260	163	81	76	59	50	32	24	13	9	6	5
Plan	165	121	53	54	24	35	27	10	8	10	5	6

Issue

- Majority of C&M trusts are above agreed trajectories for these HCAI but it should be noted that where expected numbers are low, e.g. 1 (one) or 0 (zero), one or two infections will impact the percentages reported adversely

Action

- All place-based teams are receiving assurance from those Trusts identified as outliers on actions being taken to improve
- Performance in relation to HCAI is a feature of NOF exit criterion where appropriate
- All Trusts undertaking post infection reviews
- ICB has commissioned a review of IPC related governance, and findings will be reviewed in Q4 23/24

Delivery

- Performance will be monitored monthly via place-based reporting into Quality & Performance Committee and improvement plans assessed for efficacy and impact by place-based teams

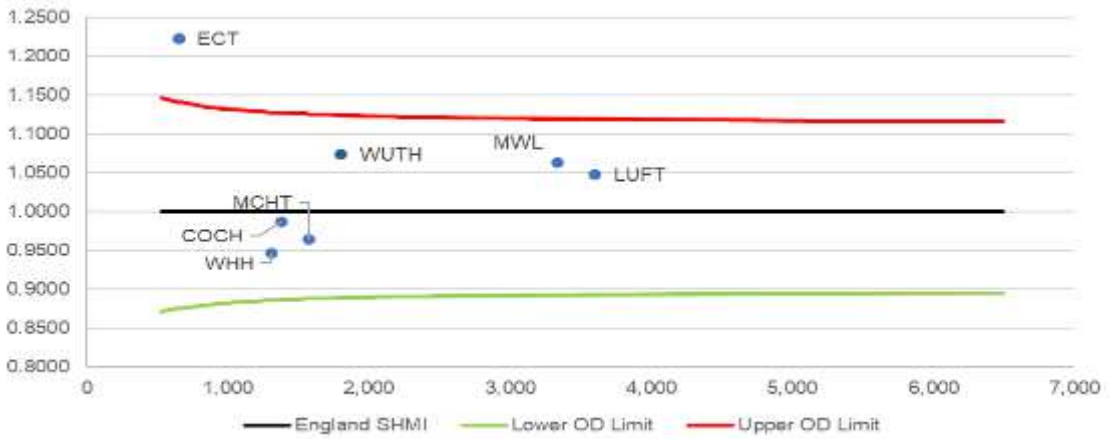
5. Exception Report – Quality

Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Sep-23)	1.039	National Ranking	n/a

Provider Breakdown (Sep-23)*



Issue
- C&M trusts are within expected tolerances except ECT, with a current value of 1.2237 against the upper control limit for ECT of 1.1445.

Action (ECT)
- The trust has moved to quality improvement phase of quality governance/escalation.
- The ICB is satisfied with the quality improvement focus to address the contributory factors.
- Further work is underway to ensure palliative care coding is improved.
- Early indication of improved rates of hospital acquired infection will not be reflected in SHMI, but monthly reporting scrutinized by trust and ICB MDs.

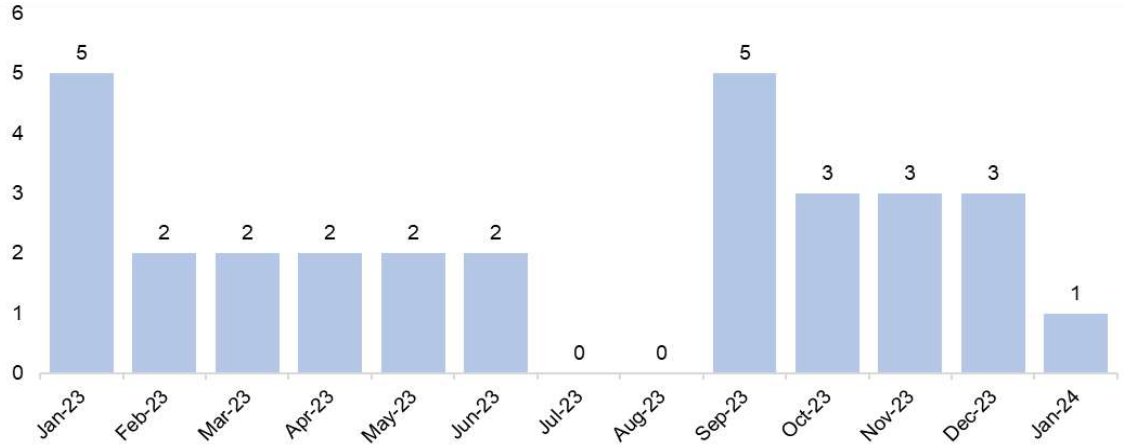
Delivery
- Measurable improvement in CRAB data by Q4 2023/24.

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

Never Events

Latest ICB Performance (Jan-24)	1	National Ranking	n/a

ICB Trend (Jan-24)



Issue
- C&M have had 29 Never Events over the last 12 month rolling period, which is consistent with the number in the previous year.

Action/s
- A quality improvement event led by the ICB Medical Director forum will take place in Q4 2023/24.

Delivery
- Measurable improvement by Q4 2023/24

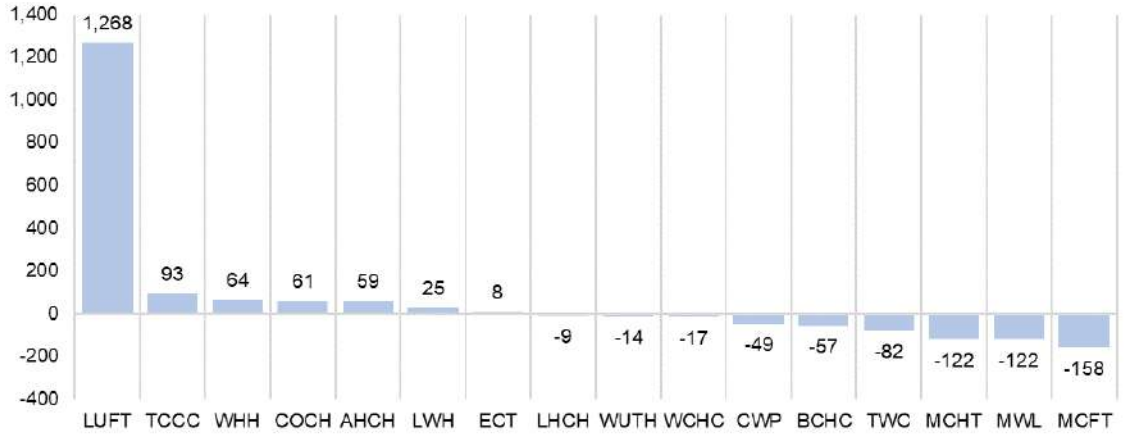
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Substantive Staff in post (WTE) via Provider Workforce Returns

Latest ICB Performance (Dec-23)	**-118.8** *(from previous month)*	National Ranking	**n/a**

Provider Breakdown (Dec-23) – variance from 23/24 Plan



Issue
- There has been a month on month increase in WTE staff in post across C&M.

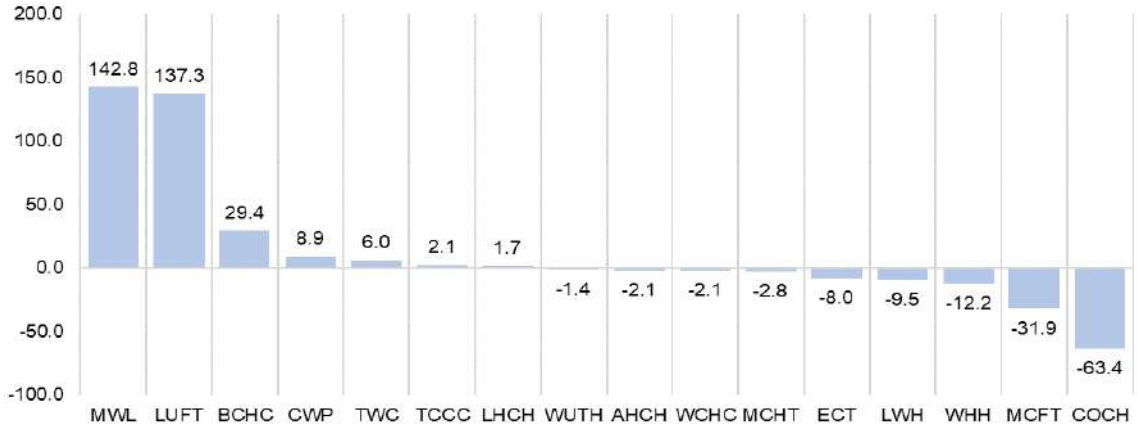
Action
- A C&M system workforce dashboard has been developed and is now shared with Trusts on a monthly basis . Greater scrutiny of workforce and productivity data at organisational and system level is now taking place via ICB an Trust Chief People Officers.

Delivery
- The workforce plans will be refreshed as part of the operational planning process due in Feb/March 24.
- Proactive monitoring of workforce data now takes place with Chief People Officers.

Agency Usage (WTE) via Provider Workforce Returns

Latest ICB Performance (Dec-23)	**-40.1** *(from previous month)*	National Ranking	**n/a**

Provider Breakdown (Dec-23) – variance from 23/24 Plan



Issue
- High levels of agency spend, however overall agency use remains within the 3.7% national target and is on a downward trajectory.

Action
- The Trusts have in place robust authorisation processes for the use of agency staff.
- Greater scrutiny of workforce and productivity data at organisational and system level is now taking place via ICB an Trust Chief People Officers.

Delivery
- The workforce plans will be refreshed as part of the operational planning process due in Feb/March 24 and this will include updated projections for agency use.
- Proactive monitoring of agency use will take place with Chief People Officers.

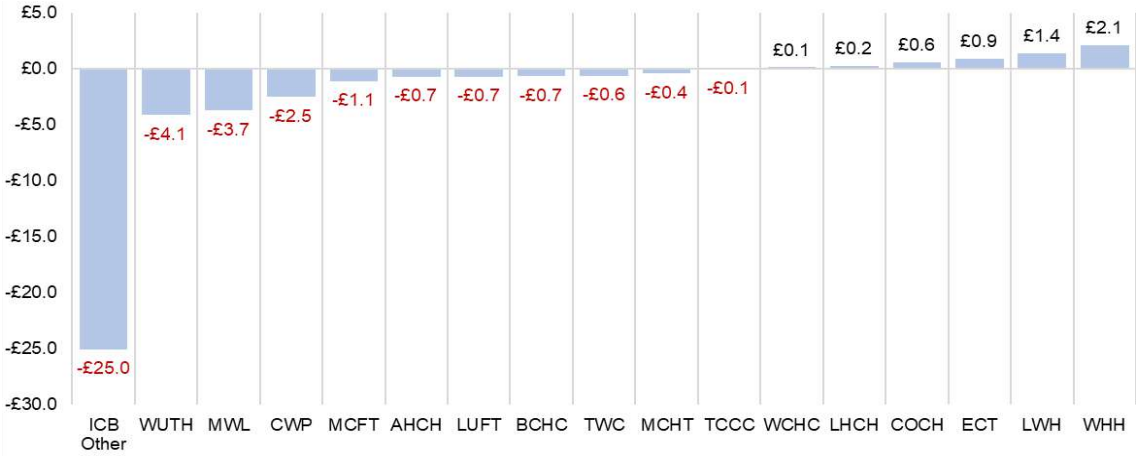
5. Exception Report – Finance

Cheshire and Merseyside

Overall Financial position Variance (£m)

Latest ICB Performance (Jan-24)	-57.8	National Ranking	n/a

Provider Breakdown (Jan-24)



Issue

- The ICS is £57.8m adverse to plan at the end of January.
- The ICB adverse variance YTD (£25.0m) is primarily driven by prescribing and CHC pressures where growth and inflation are outstripping planned levels. This is partially offset by the release of uncommitted funds including dental underspends in line with national guidance.
- The Provider adverse variance YTD (£32.7m) is due to both the impact of industrial action (£22.7m) and other operational pressures (£10m), related to undelivered CIP, emergency care pressures and excess inflation.
- Currently the system is forecasting an adverse variance to plan of £22.7m which relates entirely to Industrial Action.

Action

- The M10 system position (including Industrial Action pressures) has been reported to NHSE. The ICB requires significant mitigations to be secured in the final two months of this year to deliver the planned surplus of £59.4m.

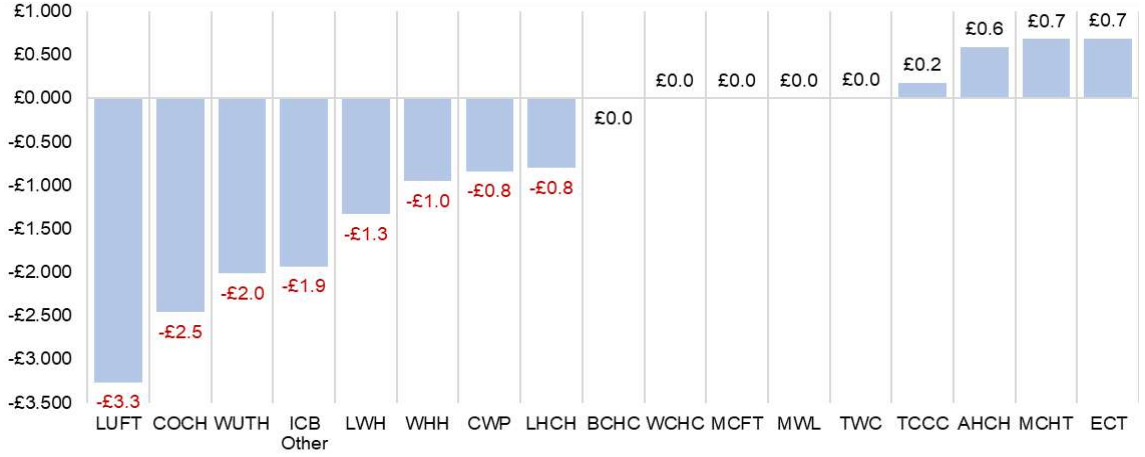
Delivery

- Financial position of the system is reported to all places and ADOFs are asked to maximise mitigations.

Efficiencies Variance (£m)

Latest ICB Performance (Jan-24	-11.4	National Ranking	n/a

Provider Breakdown (Jan-24)



Issue

- ICS efficiencies - £302m achieved YTD, £11.5m away from planned levels (£2m ICB and £9m providers).
- Forecast is now achievement of £388.0m total system efficiencies against a plan of £388.7m leaving a minor shortfall of £0.7m

Action

- Concerns over level of recurrent v non recurrent CIP – forecast £56.6m shortfall in planned recurrent efficiency which is offset through the delivery of non-recurrent measures. However, this represents an improvement compared to M9 when the recurrent shortfall was reported to be £73.7m
- Expenditure Controls Group set up to ensure providers off plan are implementing grip and control measures.

Delivery

- Review continuously as part of the monthly reporting process and will form part of 24/25 planning processes.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Highlight report of the Chair of the ICB Quality and Performance Committee

Agenda Item No: ICB/03/24/10

Report approved by: Tony Foy, Non-Executive Member, Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Quality and Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting(s)	06 February 2024 and 14 March 2024

Key escalation and discussion points from the Committee meeting

Alert

The committee received reports at its meeting on 06 February 2024 which highlighted the following areas of concern. They were noted and mitigations were discussed.

CQC Inspection

An update was provided on a CQC inspection of a St Helens Practice, Billinge Medical placed in special measures. Overall, the judgement is 'inadequate'. The practice has been supported by the Place Team for a considerable time, but changes do not appear to have been embedded. Immediate actions have been initiated by the practice which is changing its Partners.

Advise

The committee received reports at its meeting on 06 February 2024 which highlighted the following areas:

Children with Special Educational Needs and Disabilities (SEND)

The committee was advised that 2 of the 9 places within C&M have undergone inspection under the new framework, with one outcome (Warrington) resulting in a summary outcome of 'Inconsistent experiences' being experienced by children and families, and the other (Halton), resulting in a summary outcome of 'significant weaknesses'. Significant efforts are being made to address the findings of both inspections and a detailed summary of outputs will be reviewed at the System Oversight Board.

- The Committee Noted the outcome of the 2 inspections within Halton & Warrington place and the assurance that detailed progress updates, against those findings will be received at System Oversight Board.
- Requested further information in future reports to include voice of children and families, as well as inequity of information capture.

Quality Performance Dashboard/Performance Report

Key Issues reviewed

- The key three risks identified were ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience, which all correspond to Board Assurance Framework Risk P5.
- Additionally, waits for cancer and elective treatment, particularly due to industrial action and winter pressures within the urgent care system could result in reduced capacity and activity leading to poor outcomes, which maps to Board Assurance Framework Risk P3

- The Quality and Performance Committee at its March meeting will examine in detail the ED risks and the mitigations proposed to improve safety and patient experience following a model.

The Director of Performance and Planning will provide a detailed report to the Board on system performance.

The committee received reports at its meeting on 14 March 2024 which highlighted the following areas:

CQC Inspection reports - Maternity
Mid Cheshire is still awaiting its draft report - the inspection was carried out in September 2023. The Exec Director of Nursing and Care has raised the delay with the CQC link for the Trust further is informed that Mersey and West Lancs final report will go to Trust next week and will be published on 27 March 2024. Mid Cheshire and East Cheshire reports are now with the Trusts for factual accuracy with publication expected after Easter.

Countess of Chester has received its latest report 21 February 2024 following the reinspection of maternity and the Trust as a whole. Maternity services have improved but are still rated 'Requires Improvement'. The Trust remains on the Maternity Services Support Programme.

Liverpool Women's has undergone re-inspection and has had the Section 29A warning notice removed, which related to maternity triage, overall the CQC rating remains as 'Requires Improvement'

Assure

The committee received reports at its meeting on 06 February 2024 which highlighted the following areas:

Patient Safety Incident Response Framework (PSIRF) Implementation
All 17 C&M Trusts have been successfully signed-off by the ICB to implement PSIRF. The Central Patient Safety Team have worked with C&M Place colleagues and Providers to ensure the safe implementation. Work is underway to develop a robust project plan to implement a proportionate approach to the implementation of PSIRF with Independent Providers (there are circa 800 in C&M). Due to the volume of Providers this will involve a staged approach, risk stratified and proportionate to contract value.

Host Commissioner issues
St Helens Place was informed of concerns raised by Knowsley about a new mental health facility, Haydock House, geographically located within St Helens which has no placements there. Following a visit an Action Plan was initiated.
The committee requested further assurances as to the work underway to ensure host commissioner guidance is being adequately enacted and that Local Authority processes are in place to advise Place teams if new providers are registered to operate within C&M,
The committee received reports at its meeting on 14 March 2024 which highlighted the following areas:

Urgent and Emergency Care
Recognising the risk to patients waiting for an ambulance but concerned that patient experience and safety must also be supported the Committee had asked for a 'deep dive' into the performance issues and receipt of the System Quality Group's response.

The committee received an overview of the system challenges from the Director of Performance and Planning as a lead into the presentation of the toolkit to improve risks and care standards in 'corridor care'. The analysis of the urgent and emergency care flows at Trust and Place level illustrated the effect of an overheated system on AED capacity and challenges to good care. The presentation showed that the complex flow of patients in an overheated system generate a wide range of connected pressures and challenges to safe, good quality care - Category 2 ambulance attendances; turnaround times; occupancy in Majors and Resus (all Trusts well above 100%), coupled with the well-documented challenges of discharge delays and long lengths of stay.

The toolkit developed by SQG members and ICB leads is a comprehensive and effective improvement to be implemented in the next few months. It covers 4 elements – Observation and Escalation; Care and Comfort; Evidence collection; De-escalation utilising standardised checklists and strong patient-focused and system communication

Care Home Quality
There is some variation in care home quality across Cheshire and Merseyside (CQC ratings). The Northwest ADASS Monthly Care Quality Commission data shows that quality concerns tend to increase in the larger care homes as opposed to the smaller homes. There are strong partnerships between Place quality teams and Local Authority quality teams delivering robust oversight and monitoring arrangements at Place, concerns around individual care homes are escalated to QPC through the Place Quality report. Themes and issues identified include:

- Medication errors/ medicines management
- Falls
- Care home workforce concerns- particularly recruitment and retention and the high use of agency staff
- Need for more clinical training to maintain competencies.

There are a wide range of quality improvement projects and initiatives being delivered by Place teams. These include a focus on falls prevention, strengthening clinical training, dementia, end of life care and infection prevention control. The refreshed Enhancing Health in Care Homes (EHCH) is being progressed and strengthened by Place leads. Work is being progressed at Cheshire and Merseyside level around supporting clinical training and supporting care home market resilience is discussed at the Cheshire and Merseyside older people's network.

Committee risk management

The following risks were considered by the Committee and the following actions/decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
QU04, 5, 7, 8 and 9	Risks reviewed and scores agreed except for QU09 East Cheshire Trust Mortality – committee decided to keep the risk score of 20 in place but recognised local progress in implementing an improvement plan.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P5 Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience	Report on quality of care in non-ED settings and ED capacity pressures analysed in the 'deep dive' and receipt of the SQG Care Bundle Plan *(March 2024 meeting)*
P4 Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience	Report on quality of care in non-ED settings and ED capacity pressures analysed in the 'deep dive' and receipt of the SQG Care Bundle Plan. Care Homes report provided assurance on action taken to improve quality. *(March 2024 meeting)*
P3 Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures	Emergency Care pressures included in the 'deep dive' into quality of care in non-ED areas. *(March 2024 meeting)*

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Report on quality of care in non-ED settings and ED capacity pressures analysed in the 'deep dive' and receipt of the SQG Care Bundle Plan.
Working Together	The ongoing work to improve quality of health and care in care homes supports the objective of

Service Programme / Focus Area	Key actions/discussion undertaken
	partnership working to benefit our population as well as supporting urgent and emergency care/ flow. The work also includes strengthening end of life care.
Maternity Service Quality and Safety	LMNS report and receipt of CQC reports update

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Report of the ICB Directors of Place

Agenda Item No: ICB/03/24/11

Responsible Director: Mark Bakewell, Liverpool Place Director
Deb Butcher, Sefton Place Director

Report of the ICB Directors of Place

1. Purpose of the Report

1.1 The purpose of the paper is to provide the Board with an overview of key areas of focus for local place teams within the Integrated Care System.

1.2 The paper describes a number of areas of place activity, providing insight into the activities of each place, common themes and issues but also areas of good practice to highlight to the board.

1.3 This paper is the first in a series of regular updates to the board with regards to 'Place' activities, providing assurance to the Board on how local teams are working towards the delivery of the ICS objectives by working with partners locally to improve health and wellbeing of local population.

2. Executive Summary

2.1 This report provides an overview of activities being undertaken at Place level describing a number of the arrangements which support the ICB strategic priorities.

2.2 The report provides further detail on key aspects of each Place's operational activities describing a number of key features that local teams work in partnership with stakeholder in support of delivery of the organisation's objectives.

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

2.4 Within each section there are a number of common themes identified but also examples of good practice to highlight to board and for each place to reflect upon within their own local plans.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- consider the contents of the report and the work being undertaken at place to support delivery of the ICB strategic objectives.
- note the progress being made in each of the sections as described within this report and areas of good practice.

- note the relevant risks and issues as contained this report that are captured as part of the ICB risk management approach and are monitored through the Risk committee on a regular basis.

4. Place Update

4.1 **Place Partnership Development.** Each local place has developed its own place partnership arrangements including a range of supporting governance groups and workstreams as per local agreements. These arrangements are largely based on historical arrangements but have been further developed over the last 12 -18 months since the formation of the ICS. Further details of each place partnership are included in **Appendix One**, providing further details of composition, meeting frequency and membership information, with links to papers where available.

4.2 Each of the nine place partnership boards understandably have similar objectives linking back to ICS strategic goals and bring together relevant partners with an ambition to make an impact in improving the health and wellbeing for each local population. Further information is included as part of the Appendix specific to each place.

4.3 Most place partnership meetings also have regular items include partner updates, finance and performance, risk, reports from relevant subgroups including any areas of joint commissioning and from a local system delivery perspective including urgent care.

4.4 Better Care Fund / Section 75 agreements are slightly different in each place , largely due to historical CCG / Local Authority agreements being carried forward, but have iterated over time but again the majority of place partnerships to consider arrangements on a regular basis where consistent with agreed local governance.

Place Initiatives to highlight as good practice.

4.5 Key achievements from Halton Place, developed within the local partnership include,

- the establishment of two-Family Hubs to serve local populations in a more integrated manner.
- approval for the strategic principles of Integrated Neighbourhood Delivery models which are now being tested.
- opening of Warrington and Halton NHS FT Health Hub in Runcorn Shopping City which incorporates a number of hospital outpatient services alongside elements of community-based health and non-health services which supports a more integrated delivery approach.

4.6 Cheshire East has made significant progress on its first collaborative priority of Home First, supporting the development of care communities. The place team have also supported the return of maternity services to Macclesfield and are working with partners locally regarding East Cheshire Trust's work to ensure service sustainability.

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

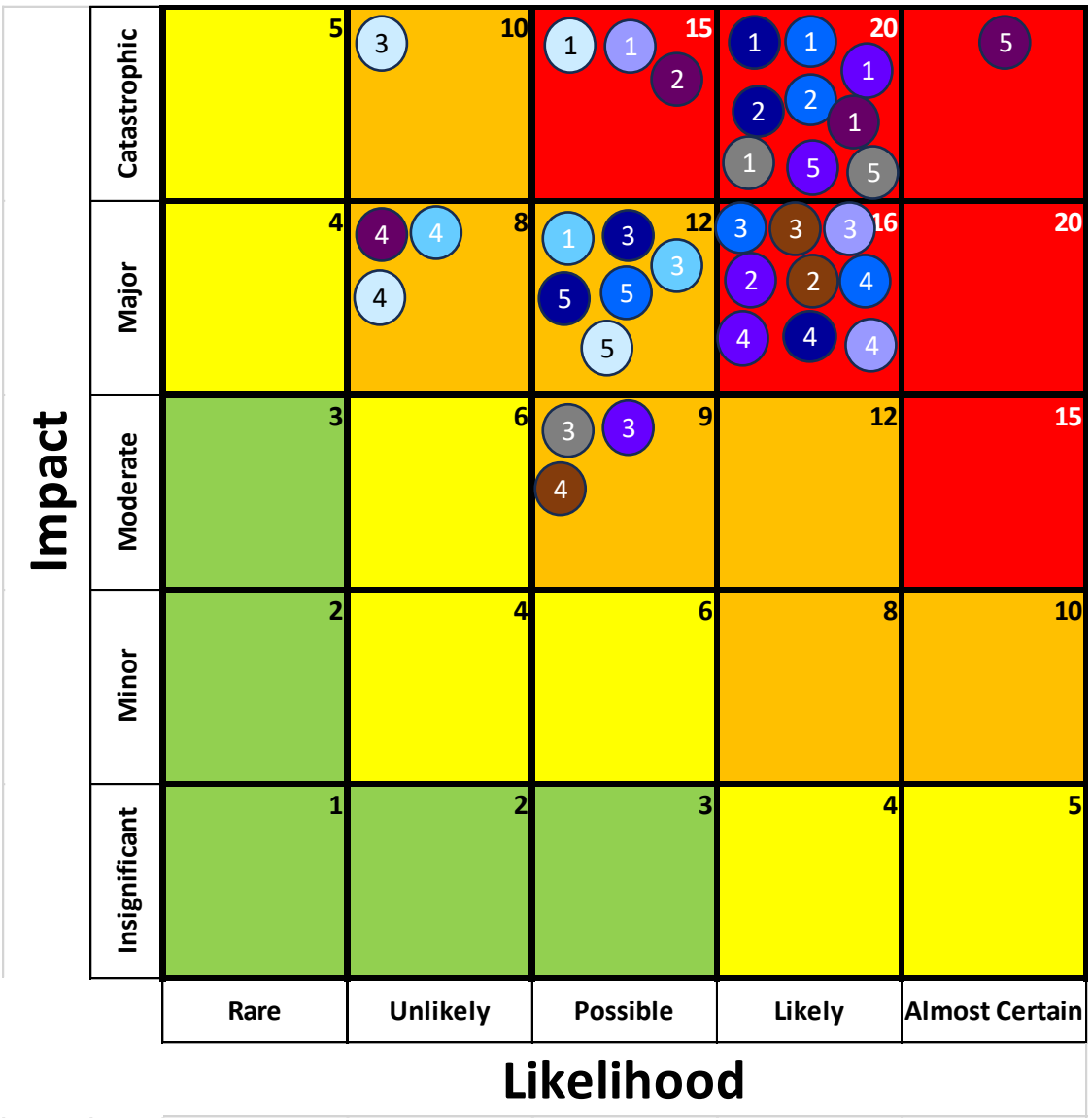
Table One

Rank	Risk	Key Actions
1	**Finance:** Cost pressures driving overspends	Current controls include delegated budgets, budgetary control and expenditure approvals process and financial monitoring and reporting. Key further action is being taken to address cost pressures in relation to CHC and prescribing.
2	**Finance:** Unable to deliver efficiency improvements	Current controls include financial recovery plans and efficiency schemes, programme and project management, monitoring and reporting. Key further actions planned include development of longer term financial plans delivering recurrent efficiencies.
3	**Quality:** Reduced standards of care	Current controls include key policies and standards, incident reporting and harm review process, standard contracts, System Quality Group and quality dashboard reporting. Key further actions planned include development of UEC patient safety principles, development of primary care quality forum and strengthening of host commissioner arrangements.
4	**Quality:** Neurodevelopmental assessment delays	Current controls include the assessment framework, performance monitoring of commissioned providers, clinical networks, SEND improvement plans, and quality and performance reporting. Key further action underway to develop joint and strategic approach to commissioning for Autism and ADHD.
5	**Performance:** Patient flow impacted by no criteria to reside	Current controls include policy, standards and guidance, daily and weekly discharge and escalation meetings, plans to increase capacity and improve pathways and monitoring and reporting systems. Key further action underway to implement plans, develop maturity and consistency of processes and implement new governance arrangements.

4.8 The scoring and distribution of these common risks across the 9 places is illustrated in the heat map (Figure One).

4.9 In addition, there are a number of significant risks unique to specific places, including some which are yet to conclude local place governance reporting and escalation to the relevant ICB Committee. The assessment of place risks will require review and update in light of the proposed changes to the Risk Management Strategy which are elsewhere on the agenda. This aspect of the report including the inclusion of significant unique place risks will be further developed in future iterations of the report.

Figure One



Key:					
	Cheshire East		Knowsley		St Helens
	Cheshire West		Liverpool		Warrington
	Halton		Sefton		Wirral

4.9 **Action on Health Inequalities at Place.** Each place has a set of actions to address health inequalities for its local area. Whilst there are clearly different issues in each of the places and variation in respect of levels of deprivation and health & wellbeing, inevitably there are set of common themes that apply to all. Underpinning this is the work with partners to ensure that the wider determinants of health are both understood and being addressed through local partnership plans.

4.10 This work at place level aligns to a number of Cheshire and Merseyside programmes around population health management and in particular in support of the 'CORE20+5' approach as is reported through the ICB governance arrangements.

4.11 The most common themes within all local place plans around inequalities improvement are focused upon

- Children & Young People
- Mental Health and Wellbeing
- Ensuring more people are living and ageing well to support independence.

4.12 Social Value remains a central feature of all local plans, supporting the ambition of ensuring economic prosperity for each place population. A number of places use local procurement frameworks and community wealth building to maximise social value for the most deprived parts of each community in order to address some of the wider determinants of poor health.

Initiatives to highlight as good practice

4.13 Knowsley Place Partnership has focused its population health efforts on one geographical area of the borough, Northwood, the ward with the biggest health inequalities. The programme aims to develop an asset-based approach to reducing identified health inequalities and improving health care. Asset mapping work has presented real opportunities to understand the Northwood community and area in detail. Currently, 54 voluntary sector or community-based activities have been identified as having a presence in the area. Early indications show a real wealth of community focused activities and offers of support for residents through key partners such as Northwood Together, Red Neighbours (LFC), One Knowsley, Welfare Rights and information providers, Faith groups and Foodbanks.

4.14 Knowsley are also one of two Places to be part of the ICB's work well partnership bid to join up the NHS and work programmes in the Borough. This programme has already developed more integrated working between the Local Authority, NHS and job centres and Knowsley Works. Each Partner a target of increasing the % of staff they employ from Knowsley.

4.15 Wirral place has established a 'CORE 20+5' system group with specific workstreams. Wirral Neighbourhood programme is improving the health outcomes of our population by working in partnership with communities via a community led bottom-up approach. Investment has been made in these

initiatives, together with actions also on fuel poverty, violence reduction, best start in life and maximising employment opportunities.

4.16 Within Sefton place, there has been a significant amount of focus on supporting local growth with a strategic investment programme in the 'Bootle Strand' with a repurposing of local infrastructure to include Health and Wellbeing hub / Health on the high street model. This supports the place ambition around Community First which is an undercutting theme in the local plan. This workstream is led by the VCF sector to progress codesign with communities and ensure a positive return on investment. Similar schemes are being developed in other places such as Warrington to increase footfall into town centres.

4.17 Liverpool City Council has secured £5M of national funding to deliver a data-led approach to tackling inequalities. This funding, facilitated by the Department of Health and Social Care through the National Institute for Health and Care Research (NIHR), aims to pioneer a data-centric approach in addressing societal inequalities. Liverpool is one of eleven areas to benefit from this initiative. The funding will enable research aimed at comprehensively understanding and implementing strategic interventions to combat health inequalities and broader deprivation issues. The focus of research will encompass neighbourhood dynamics, housing, leisure, and other social determinants.

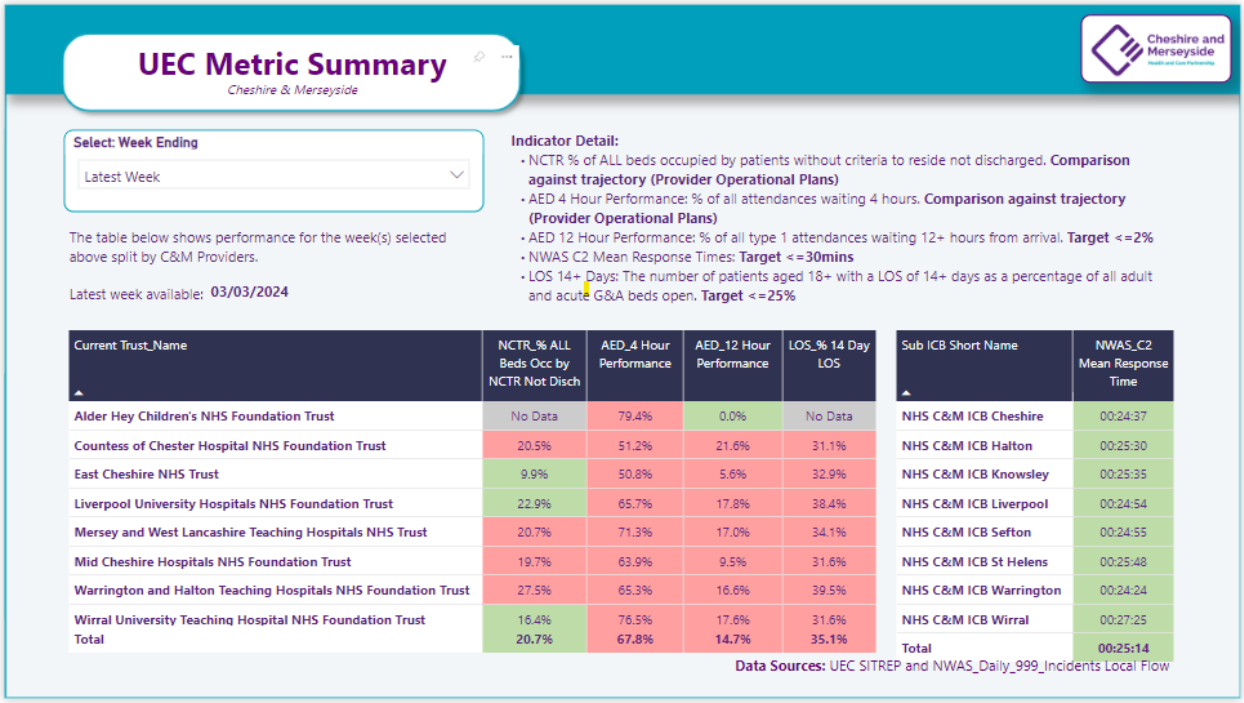
4.18 In Warrington the Transformation Team is working in partnership with C&M Paediatric Clinical Network leads, Primary Care and Warrington & Halton Hospitals Foundation Teaching Trust on a Paediatric Respiratory pilot programme that aims to improve respiratory outcomes and management for children and young people in our most deprived communities. The programme which is seeking to embed best practice and holistic assessment and interventions approaches is supported by Warrington Together and 12 months transformation funding.

4.19 **Patient Discharge and Flow.** Place teams continue to play a significant role in seeking improvements in patient discharge and flow and supporting general system issues in relation to urgent and emergency care performance.

4.20 All place teams are working with system partners around local plans in support of this and are often involved in daily meetings supporting discharge activities with system partners, including escalation approaches for patients with long lengths of stay or where there are complex discharges requiring a system response.

4.21 Current performance as measured through the 'Non-Criteria to Reside' indicator is as per Figure Two based on provider footprints, and includes a range of other urgent and emergency care performance measures. Local Governance (such as Urgent Care Boards) bring partners together to review performance and monitor improvement plans on a regular basis.

Figure Two



UEC Metric Summary

Cheshire & Merseyside

Cheshire and Merseyside

Select: Week Ending

Latest Week

The table below shows performance for the week(s) selected above split by C&M Providers.

Latest week available: **03/03/2024**

Indicator Detail:

- NCTR % of ALL beds occupied by patients without criteria to reside not discharged. **Comparison against trajectory (Provider Operational Plans)**
- AED 4 Hour Performance: % of all attendances waiting 4 hours. **Comparison against trajectory (Provider Operational Plans)**
- AED 12 Hour Performance: % of all type 1 attendances waiting 12+ hours from arrival. **Target <=2%**
- NWAS C2 Mean Response Times: **Target <=30mins**
- LOS 14+ Days: The number of patients aged 18+ with a LOS of 14+ days as a percentage of all adult and acute G&A beds open. **Target <=25%**

Current Trust_Name	NCTR_% ALL Beds Occ by NCTR Not Disch	AED_4 Hour Performance	AED_12 Hour Performance	LOS_% 14 Day LOS
Alder Hey Children's NHS Foundation Trust	No Data	79.4%	0.0%	No Data
Countess of Chester Hospital NHS Foundation Trust	20.5%	51.2%	21.6%	31.1%
East Cheshire NHS Trust	9.9%	50.8%	5.6%	32.9%
Liverpool University Hospitals NHS Foundation Trust	22.9%	65.7%	17.8%	38.4%
Mersey and West Lancashire Teaching Hospitals NHS Trust	20.7%	71.3%	17.0%	34.1%
Mid Cheshire Hospitals NHS Foundation Trust	19.7%	63.9%	9.5%	31.6%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	27.5%	65.3%	16.6%	39.5%
Wirral University Teaching Hospital NHS Foundation Trust	16.4%	76.5%	17.6%	31.6%
Total	20.7%	67.8%	14.7%	35.1%

Sub ICB Short Name	NWAS_C2 Mean Response Time
NHS C&M ICB Cheshire	00:24:37
NHS C&M ICB Halton	00:25:30
NHS C&M ICB Knowsley	00:25:35
NHS C&M ICB Liverpool	00:24:54
NHS C&M ICB Sefton	00:24:55
NHS C&M ICB St Helens	00:25:48
NHS C&M ICB Warrington	00:24:24
NHS C&M ICB Wirral	00:27:25
Total	00:25:14

Data Sources: UEC SITREP and NWAS_Daily_999_Incidents Local Flow

4.22 Two local systems have been working with external partners (Newton) to support a 'Diagnostic' to develop further understanding of local issues. The Diagnostic has been performed around provider footprints for Liverpool University Hospitals NHS Foundation Trust (Liverpool, Sefton, and Knowsley places) & Warrington & Halton Hospitals NHS Foundation Trust (Warrington and Halton places) and are progressing local plans to implement changes that will support improvements and unlock opportunities as identified within the report.

4.23 The diagnostic work conducted by Newton highlights some significant insights that will drive improvement:

- a significant percentage of people discharged to care home settings could be discharged to home or rehabilitation if we address de-conditioning in hospital and discharge promptly when they are medically fit.
- more patients could be discharged when medically fit with ongoing support from intermediate care and home-based care. This would improve flow and patient outcomes.
- up to 30% of patients would not need to be admitted into hospital if there was better utilisation of community services, such as frailty and community urgent care response services.

4.24 Place teams have been involved in these discussions and will be required to help facilitate the system changes required in order to make the necessary improvements around the three key areas of A&E attendance / hospital admissions, internal hospital opportunities (particularly on length of stay including those patients with 'Criteria to Reside'), and discharge systems and processes.

4.25 For both of these systems, refreshed governance arrangements are being put in place to oversee the delivery of these recommendations with a focus on the challenges at both a provider and catchment level.

4.26 Frailty / acuity of elderly patients remains a key issue in all places and is a feature of all local place plans in terms of understanding local issues and supporting transformation activities.

Place Initiatives to highlight as good practice

4.27 In Cheshire West, Community Response Hubs are being developed to increase discharge rates from acute hospital settings. The teams include input from therapies, nursing, social care, and care assessment. These are currently live in two neighbourhoods and are rolling out across the borough in 24/25 However there continues to be challenges with ability to recruit within some disciplines and the need for an integrated digital solution for discharge.

4.28 In Wirral, the Unscheduled Care Programme has oversight of actions on admission avoidance and flow in the acute sector and discharge. Work programmes include improvements in the Transfer of Care Hub, Care Market Sufficiency, Home First, 'AbleMe' and Virtual Ward programmes and there is recognition that further work is needed on ambulance turnaround and attendance/admission avoidance in 2024/25.

4.29 With regards to Frailty Services, in the Cheshire East System work is underway to deliver the following actions:

- Improve frailty identification from primary care records
- Develop single community and hospital assessment and care plan
- Frailty Virtual Wards
- Further develop falls specialists
- Gap assess against joint falls prevention strategy
- Roll out Steady on your feet web resource
- Deep dive Right Care Trauma packs.
- Continue to develop all age carer champions.

4.30 In Liverpool, further work is being undertaken to develop the 'Frailty at the Front Door' service at Aintree and Royal Liverpool sites, to build upon some of the opportunities identified in the 'Newton' report. More proactive care models are being developed in partnership with Community and Primary to provide support to care homes including telemedicine, and additional work around those at risk of needing adult social care.

4.31 In the community, local work with Merseycare NHS Foundation Trust has seen Dementia care co-ordinators embedded into Integrated Care Teams/community services and some service improvements in the 'Falls pick up' service is starting to see improve wrap around care targeting those who don't access community services.

4.32 Further work has been undertaken with regards to osteoporosis in the Liverpool population and improvement measures are included within the Local primary Care improvement scheme.

4.33 **Primary Care Network Development.** Primary Care Network (PCN) development remains a key part of place-based priorities as they remain a central component of local integrated care models requiring joint working between primary, community, secondary health care provision and particularly around general practice relationships.

4.34 Appendix Two sets out the current position with regards to PCNs in Cheshire and Merseyside across the 9 places. There are currently 48 PCNs operating within the ICB footprint with a variety of relative sizes and numbers of general practice.

4.35 Inevitably, there are different levels of maturity amongst the PCNs, but relationships and engagement remain largely positive, with place teams continuing to work with PCNs to aligned local programmes of work and to support national and local initiatives in relation to primary care transformation.

4.36 Local 'Place' teams continue to play a key role in managing local relationships on a day-to-day basis and also providing direct support where there are individual practice performance / sustainability issues or system level issues (for example improving access as per the National Recovery Scheme).

4.37 Each Place team oversees reviews of PCN maturity to help identify and support development plans at a PCN level, which help to improve understanding of required development and to aid longer term sustainability.

4.38 There are inevitably some challenges across the C&M footprint, including the management of practice relationships within PCNs. Issues of neighbourhood delivery still arise due to differing ward / NHS provider / PCN boundaries but resolution of issues as they arise continue to be supported by each place team.

Place Initiatives to highlight as good practice

4.39 Key achievements from Halton have been that with Service Development funding, PCNs have led a number of improvement areas including Heart Failure and Hypertension programme to improve patient outcomes.

4.40 In Sefton, the two PCNs align with community service providers and the PCNs 8 localities match the Integrated Care Teams footprint. Using the experienced clinical and managerial leadership within the PCN Collaborative, these configurations enable effective working relationships and have enabled better integrated working on areas such as Medicines Management, Social Prescribing, Mental Health, Complex Lives, Enhanced Health at Home and in Care Homes, Cancer Care, CYP Immunisations.

4.41 In Liverpool, a number Women's Health Hubs have been established across the city's 10 primary care networks, in collaboration with Liverpool City Council. The

hubs offer a range of services including long-acting reversible contraceptives, cervical screening, psychosexual services, and treatment for menopause. Liverpool's Women's Health Hubs were a first nationally and were established in response to research which shows around half of British women experience poor sexual and reproductive health, a much higher proportion than men.

4.42 Warrington Together Partnership as a part of the 'Staying Well' programme have supported the implementation of a 12-month Primary Care led pilot with local transformation funding to improve the outcomes, experiences, and management of people with 'Complex Pain' presentations. This pilot programme is taking a holistic approach to assessment, care planning and treatment/support and draws upon the skills and knowledge of a range services from across Primary, Community, Secondary and Voluntary Sector partners.

4.43 **Provider Market Development.** A key part of local place activities is the effective management of the local provider marketplace in order to ensure the delivery of high quality, accessible and cost-effective health, and care services for the population. An important aspect of the local place team's role is to monitor local market conditions with regular monitoring of local providers for quality and responsiveness of care.

4.44 Place teams are also key in understanding local market dynamics and are required to work with partners (particularly local authorities) to develop these markets to help support delivery of ICS objectives, particularly with regards to demand / capacity within local systems and ensuring flow of patients to the right care settings. This is particularly important in the 'out of hospital' setting with regards to ongoing provision of healthcare and relevant frameworks such as continuing care.

Place Initiatives to highlight as good practice

4.45 Warrington Council and the place team are jointly commissioning transitional care beds to assist people to leave hospital in a timely way. They are also working on the creation of new and much needed Nursing Dementia Capacity in one of our local Care Homes. There has also been combined investments through transformation fund and also Market Sustainability Funds to achieve growth of the Health and Social Care Academy which support the independent sector workforce.

4.46 Partners in the Mid-Mersey system (Halton, Knowsley and St Helens) have implemented a number of schemes to support discharge and flow across the urgent care pathway.

4.47 In Cheshire West a joint brokerage model has been implemented to support patient discharge flow with all packages on discharge brokered through a single team, utilising an e-brokerage system with further plans being developed to include Mental Health and Learning Disabilities packages

Strategic Initiatives

4.48 **Liverpool Clinical Service Review.** The Liverpool Clinical Services Review of acute and specialist services in the city made 12 recommendations for which Liverpool Place take a lead role in monitoring progress. The recommendations were:

1. Improving physical and mental health by strengthening ways of working with PCNs and neighbourhood teams and providing more anticipatory care.
2. Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation.
3. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at the Aintree, Broadgreen and Royal Liverpool Hospital sites.
4. Levelling-up performance on cancer and cardiovascular disease to address health inequalities.
5. Providing timely access to high-quality elective care by making efficient use of existing estates and assets.
6. Solving the clinical sustainability challenges affecting women's health in Liverpool
7. Combining expertise in clinical support services to provide consistent services across the city.
8. Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research, and clinical trials.
9. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff.
10. Achieve economies of scale in corporate services.
11. Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability.
12. Making best use of resources to secure financial sustainability for all organisations in Liverpool.

4.49 The whole Liverpool health and care system, along with the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Alliance, have a role to play in implementing these recommendations but in order to ensure progression of the relevant issues, the city's acute and specialist have formed a joint committee to oversee the integration and streamlining of services across acute sites and clinical pathways. An update on key elements of delivery of each of these recommendations is at Appendix Three and will be reported back to board on regular basis now the programme is fully underway.

4.50 **Wirral Review.** System partners in Wirral are supporting a review, commissioned by the ICB into potential further collaboration and integration opportunities across health and care in Wirral. The aim of the Review is to support partners in building an appropriate system of delivery for health and care in Wirral that meets the needs of the population of the borough.

4.51 The objectives of the Review that NHS Cheshire and Merseyside is commissioning are:

- To develop a strategy for greater collaboration and integration across acute and community services in Wirral, with an initial focus on unscheduled care but also identifying any further areas of opportunity.
- To identify priorities for collaboration and integration between Wirral Community Health and Care NHS Foundation Trust (WCHC) and Wirral University Teaching Hospital NHS Foundation Trust (WUTH) clinically, operationally, and financially.
- Develop a way forward for the collaborative and integration opportunities for WCHC and WUTH, working with system partners, to be implemented.
- Regarding the above, (i) articulate the conditions for success, (ii) set out the sup- porting arrangements that need to be put in place and (iii) produce an implementation roadmap to deliver these opportunities.

4.52 Updates will be provided back to the board on a regular basis as the review progresses.

4.53 **Children and Young People.** All Cheshire and Merseyside Places recognise the importance of the children and young people's agenda within each local system and making sure that there is a focus on 'Starting Well'. This is reflected in both short term operational performance monitoring in each place but also in respect of the longer-term health profiles and impact of future health outcomes for the population of Cheshire and Merseyside.

4.54 Each place has relevant Children and Young Peoples improvement plans relevant to its own issues and these continue to play a key part in each place partnership governance arrangements and with further details included in Appendix Four

4.55 It is worth recognising that a number of local authorities face challenges in respect of children services and have improvement plans in place with regards to areas such as SEND, Safeguarding and Inspections of Children's Services (ILACS) by Ofsted.

4.56 As recognised within place risk registers, there are a number of consistent issues facing all places within Cheshire & Merseyside relating to:

- Neurodevelopmental pathways
- Oral Health
- Children's Placement Costs.

Place Initiatives to highlight as good practice

4.57 Knowsley's recent OSFTED inspection into care leavers stated that: "The health needs of most care-experienced young people are considered and met. Most are registered with general practitioners and dentists. Typically, care-experienced young people have health passports that are shared with them. This means that they have important information about their lives, and they know where to access health advice in the future, should they need this".

4.58 St Helens ‘thrive’ offer is a very well developed with strong SEND partnership between Health and the Local Authority. Health and Public Health teams work closely to deliver integrated programmes around the SEND agenda, with a leads meeting setting local priorities and agreeing plan.

4.59 Warrington Place is committed to preventing the avoidable admission of complex children and young people to care, custody and inpatient provisions. A consortium of stakeholders including the Local Authority, ICB, Merseycare, Bridgewater and Youth Justice Services have subsequently developed a proposal and business case to establish a small 4 bedded therapeutic short stay and outreach provision we are calling the ‘Complex Needs Hub’. Capital monies of circa £750k have been secured via the Department for Education for refurb of a property provided by the Local Authority and the revenue business case for the staffing and running costs is currently under consideration. This work is in line with and in support of the Cheshire and Merseyside Appropriate Places of Care steering groups aspirations.

4.60 In Cheshire West, Cheshire and Wirral Partnership Trust are working in collaboration with Cheshire West and Chester Local Authority on the implementation of ‘The Nook’, an innovative ‘home from home’ facility in the community that would support a family to enable a child to safely transition from an inpatient setting and/or avoid inpatient admission with wraparound care and support.

4.61 **Use of Resources.** Given the current challenges facing the NHS and wider public sector, all place leadership teams continue to review financial plans for both expenditure and savings as part of the ongoing ICB financial management arrangements

4.62 Most of the places within Cheshire & Merseyside have had some form of financial recovery plan to ensure review of all existing expenditure and opportunities for further efficiencies etc.

4.63 All places are currently developing place based financial strategies for the new financial year (in support of the overall ICB /ICS approach) working with local system partners so that a single consolidated picture can be derived compared to the funding available and understanding the cost of providing health and care services.

Place Initiatives to highlight as good practice

4.64 During 2023/24, Warrington System Adaptive Reserve funding supported the Transfer of Care Hub, additional capacity in Intermediate Care at Home, the Community Equipment Store, and Voluntary Sector schemes aimed at supporting discharge.

4.65 Cheshire West has a pooled Place Transformation Fund that is utilised for jointly agreed Transformation schemes. This is utilised to drive delivery of priority programmes such as Home First, Community Partnerships, LD and Mental Health with programme capacity and where required digital innovation.

4.66 Sefton also invests its transformation fund to support key programmes of work including Shaping Care Together integration with Sefton Council, system flow across UEC services and the CYP emotional and mental health agenda. The local quality contract is used to accelerate transformation in Primary Care including key services areas such as CVD, carers support and dementia.

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6. Appendices

Appendix One: **Place Partnership Arrangements**
Appendix Two: **Primary Care Network Arrangements**
Appendix Three: **Liverpool Clinical Services Review Recommendations Update**
Appendix Four: **Children & Young People Information**

Appendix One: Place Partnership Arrangements

NHS Cheshire and Merseyside

	Cheshire East	Cheshire West	Halton	Knowsley	Sefton	St Helen	Liverpool	Warrington	Wirral
Meeting Information	Health and Care Partnership Board established with supporting g governance groups. Meets in public six times each year with the full range of place partners. Following a board development session and the lack of delegated powers, we are shifting the board to have more a development focus with, for example themed meetings.	Partnership Board meets every other month in public. Venue rotates around Cheshire West. Themed based on patient story Have a formed Place Partnership Board with public facing agendas and internal development sessions, Supported by Place Leaders meeting and Steering / Operational Groups for integration priority areas.	One Halton Partnership Board meets monthly and comprises a range of members including: NHS providers (primary, community, acute services), local authority (public health, adults, children, regeneration), VCSFE, housing, and Healthwatch.	Meeting held 9 times a year. Chaired by Council CEO. Not held in public, papers not put into the public domain. Representation from NHS Trusts, Knowsley Council, Knowsley ICB Senior Leadership Team, Primary Care Networks, One Knowsley and Healthwatch Knowsley Agenda, formal minutes and action tracker maintained Rotational agenda; Business Meeting, Performance and Transformation with a Winter meeting held in October and an Annual Review meeting in March.	The Sefton Partnership Board (SPB) was established in July 2022 and a supporting MOU was signed off in September 2022. There are a number of supporting operational groups and a workplan for the SPB. SPB meets every month, currently on MS Teams but plans are in place to move to F2F meetings. This will be discussed at a development session in April. Updates on key areas of work from the SPB are presented to the HWBB which meets in public.	PPB well established, contains membership from all health partners, LA, Councillors, Housing, YMCA, VCFSE, education, primary care, hospice, Healthwatch and CAB Meet monthly. Focus on performance and planning every other month and focus on wider partnerships on the alternate meetings	The Board meets monthly and is chaired by LCC Deputy CEO. The business programme is planned 6 months ahead and is designed to ensure all partnership member agendas are included. Standing items include partner updates, finance and performance, risk, reports from subgroups and joint commissioning.	Place Partnership Board has been established with supporting governance groups and work programmes since December 2021 Meetings take place monthly, and the Board has representatives from NHS (including providers), Council representatives (including Elected Members, Directors of Adults and Children's Services), Primary Care Network Clinical Directors, Voluntary Sector partners and Healthwatch.	Meeting at least ten times per year. NHS, Council, primary care and VCFSE partners as members. Meeting in public. Will have VCFSE Chair in 2024/25.
Paper Links	Committee details - Cheshire East Health and Care Partnership Board | Cheshire East Council	Papers available via Cheshire West Council website		n/a as not a public meeting. Updates from the Knowsley Healthier Together Board presented to the HWBB are in the public domain on the Council website.	Papers are not currently available to the public as SPB is not a decision-making forum. However, the updates from the SPB presented to the HWBB do become public and are available on the Sefton LA website.		The Board reports to the Liverpool Health and Wellbeing Board. The latest public update can be viewed here:	n/a as not a public meeting	Browse meetings - Wirral Place Based Partnership Board | Wirral Council
Ambitions	We focus on our component of the refreshed health and wellbeing strategy and implementing our recently launched	We have outlined a number of strategic intentions: - Demand Management and System Resilience -Home First	One Halton's core ambitions are set out in the One Halton Joint Health and Wellbeing Strategy which adopts a life course approach.	The vision: • A place with welcoming, vibrant, well-connected neighbourhoods and town centres. • A place with a thriving, inclusive	Place Plan Delivery of key priorities through life course approach and integrated working include Urgent Care, LTCs, Primary Care / PCNs, Integrated Care Teams, CYP, Mental	Regular focus on St Helens Cares Priorities, development of care communities, healthy weight, mental wellbeing, and health inequalities. Key	The Board's ambitions and objectives are contained in the One Liverpool Strategy: • Targeted action to reduce inequalities. • A system focus on prevention.	Delivering against the 8 priorities in the refreshed Health and Wellbeing Strategy - Health and Wellbeing Strategy 2024-	Organise services around the person to improve outcomes. Maintain personal independence by providing services

	Cheshire East	Cheshire West	Halton	Knowsley	Sefton	St Helen	Liverpool	Warrington	Wirral
	five-year delivery plan. We have delivered significant progress on our first collaborative priority of Home First. Supporting the development of our care communities has been an early priority. We have supported the return of maternity services to Macclesfield and moved closer – as place partners – to East Cheshire Trust's work to ensure service sustainability.	-Supporting Local Communities. In order to deliver these, we are focusing on: - Increasing Self-Care and Peer Support – supporting Communities to flourish and managing people in their own homes. - Building Community Care - development of Integrated Multi-Disciplinary Teams and supporting people in crisis to remain at home, enabling safe discharge. - Reducing reliance on the Acute sector / bed-based care – improving flow including health led interventions to reduce admissions.	The key thematic delivery priorities are start well, live well, age well, and wider determinants supported by enabling activities including the Integrated Neighbourhood Delivery model.	economy, with opportunities for people and business. • A place where people are active and healthy and have access to the support they need. • A place where people of all ages are confident and can achieve their full potential; and, • A place where strong and safe communities can shape their future.	Health, Health Inequalities, Community first, Estates. See attachment for more info.	achievements in each of these programmes are reported bimonthly	• Integrated services, shaped around the needs of our population. • Health creating communities. • A financially sustainable health and care system	28 Summary | warrington.gov.uk We are a well-established system with mature relationships. An effective example of this is the Warrington Together (WT) Quality and Performance committee owning the system Performance report and the WT Finance, Investment and Resource committee has shared ownership of financial sustainability across the system	the closest to home. Reduce health inequalities across the Wirral population. Provide seamless and integrated services to patients, clients, and communities, regardless of organisational boundaries. Maximise the Wirral health pound by delivery of improvements in productivity and efficiency through integration. To strengthen the focus on wellbeing, including greater focus on prevention and public health
Information about last meeting held	At our last meeting we received an update from Crewe Care Community, and discussed the Mid Cheshire clinical services strategy, system finances, a quality report, and primary care access. At our May meeting we expect to be focused thematically on SEND and the SOC for Healthier Futures (the new Leighton Hospital	Last meeting was internal development session setting out future plans / vision. Next session will be themed on progressing this with a focus on Provider Collaboratives and corporate business for Place. Usual agenda items include Place update, Finance report, Risk report, Performance report.	One Halton Partnership Board recently held a Board Time Out Session to review and refine strategic priorities and develop outline delivery plans for 2024/25. The next session of the Board will progress this work further and enable the development of an agreed delivery plan in the coming months building on existing	Last meeting was held 5/3/24 as a Development Session facilitated by the Cheshire and Mersey ICB Associate Director of Organisational Development, Taira Shaffi. The aim of the session was to strengthen ways of working and achieve consensus on the priorities for the Board for 2024-25 in context of Knowsley's Health and Wellbeing Strategy and 2 Year Plan. Next meeting is a May with a Business Focus.	February 2024 meeting discussed. • Shaping Care Together • PCN Development • Care for Care experienced CYP • The Bootle Strand Development • Assurance update • Finance, Quality Safety Improvement	Focus of last meeting: Presentation on warm homes for young lungs project, true multi sector collaboration targeted at supporting families of children with respiratory disease to get support to manage living conditions State of the Sector VCSFE report Key updates from other groups e.g. Primary Care, quality, and risks	February 24 agenda: • One Liverpool Strategy Refresh • Women's Health Hubs • Liverpool City Council Neighbourhood Model March planned agenda • Children and young people will be the key agenda item.	Standing items: Quality and Performance Report, Finance Report, Health and Care Plan Delivery Report, Unscheduled Care Programme Delivery, and updates from the Warrington Together enabling groups such as workforce and Communications & engagement.	Standing items: Place Quality and Performance Report, Place Finance Report, Health and Care Plan Delivery Report, Unscheduled Care Programme Delivery and supporting governance groups updates. February meeting: VCFSE State of the Sector, Place Governance Manual, Intermediate Care Review and

	Cheshire East	Cheshire West	Halton	Knowsley	Sefton	St Helen	Liverpool	Warrington	Wirral
			programmes of work.	Standard agenda has updates from the reporting Groups (transformation, quality & performance, primary care and finance & contracting. Public Health update, Partner updates and Provider Collaborative updates		SHC priority areas updates Public health update including measles and sexual health Skills academy update including the next workforce event due to be held to encourage local people into the health and care sector Next meeting will focus on performance against key targets		Last meeting – review of governance arrangements and future ways of working (from the workshop in Feb) and focus on Palliative Care provision. Next meeting – focus on the priority "giving every child the best start in life" from the local health and wellbeing strategy.	Workforce Programme Deep Dive. March meeting: Place Delivery Assurance Framework and Risk Management and Primary Care Access and Recovery Plan.

Appendix Two: Primary Care Network Development

	Cheshire East	Cheshire West	Halton	Knowsley	Sefton	St Helen	Liverpool	Warrington	Wirral
PCN Information	9	9	2	3	2	4	9	5	5
Number of Practices	34	14					83		
Outline of Development, what is working well and any challenges	Care communities have been in existence for six years and have evolved locally with numerous examples of good practice. Practical challenges remain though in terms of reallocating resources across the place system and spreading – where appropriate – good practice more widely. Care Communities do have early performance dashboards, which we are seeking to mature throughout the year. All Place Partners including acute Trusts are bought in to the Care Community model of care and are all seeking to priorities their development into the future.	Currently there are 9 PCNs that are geographically aligned to our Care Community Team and Community Partnership geographies. The only difference is that three Chester PCNs are working as on Community Partnerships. This helps support alignment with Local Authority Ward Profiles Good relationships are in place between GP practices, PCNs and the ICB with regular Practice Manager and PCN Clinical Director Forums which are well attended. We also hold GP Collaborative events monthly with representatives from all practices as an opportunity to focus on areas of development as well as providing an update on Place transformation work. We have also developed a primary/secondary care interface meeting	Good relationships across place / collaborative working with range of partners and with ICB Place team ensuring aligned programmes of work and funding e.g. Integrated Neighbourhood Model Same Day Primary Care PCNs reviewing the PCN Maturity Matrix to assess current position. Both PCNs fully utilised ARRS providing additional 95 wtes. Place Quality, Contracting & Transformation dashboard being finalised which identifies variation across practices and indicators. Discussions to be held with Practices where variation / low performance to understand challenges and improve position. Place PCARP plan in place and being implemented. Transition & Transformation	The 3 networks regularly review development plans that support them in operating effectively as a network of GP practices and how they will collectively work across the system to deliver health improvements for local people. We have 3 different levels of maturity. The PCNs complete the maturity matrix annually to review progress. Successes include the on-going engagement and delivery of our access plans which has seen a positive trend in patient satisfaction regarding access in Knowsley. The PCNs continue to engage and are further involved in shaping and delivering our priorities. Challenges include supporting practice relationships within PCNs whilst maintaining a focus on ongoing delivery and development of PCN role within place-based partnership, neighbourhood delivery due to differing PCN boundaries spanning more than one community however he	The two PCNs align with community service providers and our PCN 8 localities match our Integrated Care Teams footprint. Two mature PCNs with experienced clinical and managerial leadership working as system leaders within the PCN Collaborative. Configuration enables effective working relationships within Place. Examples include integrated working on Med Management, Social Prescribing, Mental Health, Complex Lives, Enhanced Health at Home and in Care Homes, Cancer Care, CYP Immunizations.	Maturing significantly over last 12 months. Examples include PCN wide winter initiatives, development of PCN wide urgent care hubs, development of PCN and borough wide PC initiatives such as CVD projects. North PCN leading the pilot care communities programme, partnership between PCN, Social Care, MH, VCFSE, 0-19, community services and wider partners. LA developing localities programme that are based over 7 footprints rather than 4 care communities but the 7 can largely be mapped to fit the geography of the 4	Liverpool has 9 PCNs of different sizes across at various stages of maturity, but all are achieving improved positions across PCN DES indicators. The emphasis of the PCNs is on reducing inequalities and increasing uptake rates for vaccinations, immunisations, and health checks, along with targeting patients who need proactive care to manage their health conditions. General practice is fully embedded in Liverpool's Integrated Care Teams. This year they have significantly increased utilisation of ARRS funding, to 91%, which is crucial to meeting the PCNs' objectives of broadening the universal offer. PCNs have demonstrated innovation in being at the forefront nationally in developing	Primary Care Network Maturity varies across place. Maturity matrix completed previously and is due a review. Challenges in developing integrated neighborhood teams include PCNs not being fully coterminous with community neighborhood teams. However strong relationships are developing in spite of this challenge. Primary Care estates for additional shared ARRS staff remains a challenge and is reflected in PCN clinical models and estates strategies. Successes: PCNs in Warrington function well in collaborative projects such as proactive care and CVD CLeAR (Clinically Led workforce and Activity Redesign) projects as well as a PCN-wide remote monitoring project, part funded by a successful bid for	Varying levels of maturity amongst PCNs. Maturity matrix completed annually to review PCN progress. Successes: System/partnership engagement continues to develop. Greater involvement of primary care leaders in developments and decision making. Integration and collaboration with CWP re ARRS MH practitioner roles. Challenges: Estates, system engagement, Neighbourhood delivery due to differing PCN boundaries spanning one community, in addition to delivery of Fuller aspirations.

	Cheshire East	Cheshire West	Halton	Knowsley	Sefton	St Helen	Liverpool	Warrington	Wirral
		with practices that face the Countess of Chester and a separate meeting for those that face Mid Cheshire Trust. Challenges include the ongoing levels of demand faced by primary care as well as the financial implications of inflationary pressures	funding provided to 7 practices. PCN CAIP being implemented and monitored. SLF offered to Practices. Integrated Neighbourhood Model Same Day Primary Care programme in place to align access to 14 Practices and 2 UTCs. SDF funding supporting: PCN led Heart Failure Improvement programme which includes collaboration with place partners and improving care in general practice. (Widnes PCN) PCN led Hypertension programme in development. (Runcorn PCN)	ICB team have supported a PCN reconfiguration process which will be effective from 1st April and provides clarity with regard to geographic areas of responsibility. This has taken considerable time and effort of team.			Women's health hubs, across the city. PCNs are delivering a range of programmes to address inequalities • SWAGGA PCN's obesity intervention programme saw 73% of participants reduce their BMI, all reduced their blood pressure and 80% improved their wellbeing score. A walking group • Aintree PCN - South Asian cardiovascular and diabetes families program saw 52% of eligible patients completing a cardiovascular health review, of which over one third had abnormal HbA1c and/or cholesterol and were offered a 12-week program of education and support. Challenges include estates capacity and quality. This is constraining the provision of a wider offer in some parts of the city. Demand continues to be a challenge, with variation in access across practices.	ICB transformation Funding. Very successful Smear and Bowel screening pilots Increasing our referrals to National Diabetes Prevention Programme Outreach educational events and training local communities to become Blood Pressure Ambassadors Identifying key work streams, as part of our successful engagement with and completion of the national CLeAR transformation programme, to support our 40–75-year-old population by increasing the number of NHS Health Checks we offer and creating a bespoke support package for those suffering from obesity	

Appendix Three: Liverpool Clinical Services Review

Recommendation	Owner	Initial Key Actions / Enablers	Current Position
1) Improving physical and mental health by strengthening ways of working with PCNs and neighbourhood teams and providing more anticipatory care;	One Liverpool Partnership Board	Liverpool Place has established five population health programmes, based on segments of the population in need a proactive, integrated model to improve outcomes. Delivery highlights include: • Complex Lives – a well-developed programme, incorporating high intensity users and homelessness support. • Healthy Children and Families - developing respiratory hubs to integrate primary, secondary care teams, community spirometry and asthma. • Long Term Conditions – implementing an enhanced offer, including IV diuretics in the community and direct access to mental health from diabetes and respiratory pathways. • Frailty & Dementia – priorities include ensuring appropriate prescribing in care homes; falls & prevention schemes; keeping care home residents safely in their homes, using technology systems which is reducing NWAS conveyances from care homes. • Disabilities – a project with Healthwatch to provide a structure for people with lived experience to be actively involved in decisions. A Neurodiversity Strategic Partnership Group and Learning Disability Strategic Partnership Group has also been established. Liverpool City Council Neighbourhood Model implementation now in progress and working closely with local Integrated Care team to align development plans	All five programmes have one year, three year and five-year plans which are incorporated into the Liverpool Integrated Business Plan. Data into action population health management platform now being utilised through an Enhanced Case Finding Tool, which identifies individual patients at risk of their health deteriorating, responding with proactive care to avoid poor outcomes and avoidable hospital admissions. This tool is currently focused on: • offering telehealth to patients with multiple long-term conditions at high risk of hospital admission • Multi-disciplinary teams supporting people with multiple, complex needs that require support from a range of specialist services Neighbourhood Managers now in place.
2) Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation;	One Liverpool Partnership Board	Initiate an integrated approach across the local system to social value / local procurement frameworks. Implementation of Liverpool City Plan	Liverpool Strategic Partnership working on number of initiatives in response to the Strategic Futures Advisory Panel including measures to improve productivity and improvements in the local economy including the Investment Zone programme.
3) Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at the Aintree, Broadgreen and Royal Liverpool Hospital sites;	Liverpool Trusts Joint Committee/ Liverpool Cardiology Partnership Board	1. Nurse led Cardiac assessment in reach to A & E at Aintree (pilot in A&E at Aintree) 2. Extend criteria for NWAS direct conveyance to LHCH for high-risk ACS nSTEMI patients (pilot based on Warrington pilot) 3. Establish a dedicated cardiology bed-base at LHCH for patients awaiting angioplasty by LHCH. Also, further development of opportunity to increase bed capacity to a whole ward at BGH. 4. Standardised use of Isoprenaline protocol across the Liverpool system 5. Implement fast tracking for head injuries and spinal patients	1. Pilot currently in operation, evaluation in progress, initial improvements include circa 50% reduction in referral time from ED attendance to ACS referral to LHCH. 2. Pilot length extended and being reviewed to understand key learning points and improvements in the proposed pathway with NWAS.

Recommendation	Owner	Initial Key Actions / Enablers	Current Position
			3. Initial pilot commenced early 2023 with 4 beds at LHCH. Ward now identified to extend model at BGH. Capacity and capital agreed to refurb. Business case for revenue (staffing etc.) being developed. 4. Draft protocol agreed between clinical leads (LHCH/LUHFT) based on best practice guidelines. Ratification by respective governance forums due end of March 2024 before sharing with wider cardiology network. 5. Existing protocols reviewed and updated, training and awareness being rolled out with existing workforce and embedded in new doctors' induction programme
4) Levelling-up performance on cancer and cardiovascular disease to address health inequalities;	One Liverpool Partnership Board	CVD is delivered through the Liverpool Cardiology Partnership, the Long-Term Conditions Population health programme and public health programmes (physical activity, obesity, and smoking). Levelling up cancer outcomes is through the Cheshire and Merseyside Cancer Alliance programme, delivered in part at Place level, along with the public health programmes.	CVD programme delivered through the Liverpool Cardiology Partnership, the Long-Term Conditions Population health programme and public health programmes (physical activity, obesity, and smoking). Levelling up cancer outcomes is through the Cheshire and Merseyside Cancer Alliance Liverpool localised programe programme. Highlights: Non-Specific Symptoms (NSS) - options appraisal underway Liver Surveillance identifying more people at high risk of liver cancer. Timely Presentation CMCA & LUHFT - Europac plus (risk stratified screening) project, offering pancreatic cancer screening stratified on family and DNA risk. CMCA piloting a cancer pre-op outpatient variation of the CURE model of smoking cessation targeted in LUHFT.

Recommendation	Owner	Initial Key Actions / Enablers	Current Position
	Cheshire & Merseyside Acute & Specialist Trust (CMAST) collaborative	• Delivering 10% Productivity gains in radiology as per planning guidance Performance Management at C&M level to deliver 90% of patients waiting 6 weeks or less • CMAST has agreed 3 hub pathology TOM model and joint LIMS procurement is in flight	applied to 19 MRI machines * Productivity baselining has commenced * Jan 2023 was Developing. Dec 2023 moved up to Maturing. * Nov 2020 27% of patients waiting 6 weeks+ Nov 2023 15% of patients waiting 6 weeks+ * reduced use of independent sector activity compared to 2019/20 down by 11% for CT, 47% for MRI and 70% for ultrasound.
8) Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research, and clinical trials;	One Liverpool Partnership Board Liverpool Cardiology Partnership Board	Establish & expand Heart Failure at Home App allowing remote monitoring of patients	Application under development to enable app to be completed circa April 2024
9) Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff;	Liverpool Trusts Joint Committee	Health and well-being offer developed jointly with Liverpool Heart & Chest NHS Foundation Trust.	
10) Achieve economies of scale in corporate services;	Cheshire & Merseyside Acute & Specialist Trust (CMAST) collaborative	Pan C&M: * Detailed analysis on corporate services data was completed in 2023 by E@S programme following the review and has been presented back to CEO/Chairs * Procurement Collaboration continues across Liverpool with BC in development to add in LUFT and LWH to the existing model which already covers Clatterbridge, Walton Centre, Alder Hey & LHCH * All Liverpool Trusts are part of the C&M medicines optimisation programme which is focusing on High Cost Drug expenditure in 24/25 * All Liverpool Trusts are part of the finance workstream looking at a single financial ledger across C&M * All Trusts are part of a procurement network	* Legal Services collaboration (LUFT, LWH & LHCH) is due to commence in April 2024, potential capabilities to extend this out to cover other Liverpool providers. * All Liverpool Trusts are part of the C&M medicines optimisation programme which is focusing on High-Cost Drug expenditure in 24/25 - first Med Value Pharmacist appointed at LUFT and C&M Homecare B/C in development * All Liverpool Trusts are part of the C&M workforce & Scaling People Services programmes - 14 priorities have been established and workplans in development. LUFT are piloting the workforce analytics and planning which has already been completed at Alder Hey * All Liverpool Trusts are part of the finance workstream looking at a single financial ledger across C&M. * Infection control workstream focusing initially in Liverpool will launch in 2024

Recommendation	Owner	Initial Key Actions / Enablers	Current Position
			* C&M procurement network to review national energy contract with the objective of system alignment where possible * HPL (health Liverpool procurement) have established a stakeholder group reviewing soft FM contracts across the 4 HPL Trusts, and Liverpool Women's Hospital. Plan in place to present full procurement options appraisal for re-procurement of services to Trust boards in spring 2024.
11) Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability;	Liverpool Trusts Joint Committee/ Liverpool Cardiology Partnership Board	Enable shared access to patient data between LHCH and LUHFT	Information Sharing Agreement is in place and signed off by the Caldicott Guardians for both Partner Trusts, Testing complete. To be rolled out to wider staffing group.
12) Making best use of resources to secure financial sustainability for all organisations in Liverpool.	All Partners	Development of Liverpool System Financial Strategy Newton 'UEC' Diagnostic re System Improvement Opportunities (as identified through UEC lens)	

Appendix Four: Children & Young People

	Cheshire East	Cheshire West	Halton	Knowsley	Sefton	St Helen	Liverpool	Warrington	Wirral
Place Updates on 'Starting Well' and Other Related Issues (Safeguarding / SEND / NDP)	We have a focus on: SEND sufficiency planning and evolving services to meet growing demand on EHCPs Redesigning CYP Neurodevelopmental pathways and support to focus on early help over diagnostics Focusing on transition pathways Developing healthy weight initiatives Developing Asthma care reviews Integrating family hubs into the care community model Maternity development New commissioned of CYP SALT	Progressing an in-depth review of Children in Care service with provider and Local Authority to consolidate efficiencies to deliver better outcomes for Children and Young People placed in care within Cheshire West Focussed piece of work around Safeguarding and Transition for CYP taking place Actively driving forward Corporate Parenting agenda in collaboration with Local Authority. Developing a joint approach with Local Authority and Voluntary Sector to invest in Early Help and support to build emotional resilience in Children and Young People Working on a neurodiversity pathway with single referral route and streamlined assessment.	Halton Safeguarding Children's Partnership has reviewed the Working Together 2023 document and completed two Partnership Diagnostic Reviews to ensure the Partnership is fit for purpose with common understanding and collective responsibility. An Independent Scrutineer has been recruited to provide challenge and support. A Participation Strategy is being co-produced with young people. A Health Operational Group chaired by the Designated Nurses has been established to share good practice and learning. Work underway to increase the number of CYP receiving MH support via: EHWB agreed to review how Thrive offer is communicated and closing gaps working with providers to improve data reporting. Recruitment underway for a CYP	Starting well initiatives include Review and redesign of the Neuro Developmental Pathway (NDP), exploration of appropriate places of care for complex children, family hub roll-out (led by the Council), development of a new antenatal offer and progression of the children's joint commissioning plan. Successes include the funding of provision to support the NDP such as a Tics and Tourette's service, and funding for a 'Collaborative Autism' project hosted by the Sensory Hive to support families in Knowsley. Safeguarding initiatives include: Improvement of the delivery of Initial Health Assessments (IHAs) for Children in Care (CIC) to meet the statutory requirement, improvement of adoption and fostering medicals completion within statutory timescales, implement the NHS Universal Family Care Leavers Covenant programme Review of current Multi Agency Safeguarding Hub (Hub) pathway which includes review of health economy input to increase the capacity within the MASH enabling contribution from wider health	Working in partnership with LA on implementing the Delivering Better Value programme – development of a graduated offer for EHWB, ND and SALT (SEND). Developing a pilot for a trauma informed wellbeing offer for leaving and care experienced children and young people. Keyworkers expanding up to 25 including introducing further oversight of DSD for this age range (specifically those without LD) Safeguarding - Children's improvement Board chaired by commissioner is in place to facilitate improvements required following Inspection of Local Authority Children's Services, resulting in an inadequate rating. There is requirement of	The thrive offer for St Helens is a very well developed. Strong SEND partnership between Health and LA. Health and Public Health teams work closely to deliver integrated programmes. Health chair a strategic SEND leads meetings which set the local priorities & workplan. Health is a key partner on Safeguarding Adults Board and Co-Chair the Safeguarding Children's partnerships as well as strategic leads meetings. In month a learning event has taken place with safeguarding and merseycare regarding mental Health cases referred due to lack of appropriate beds. As a result, future events are planned to review complex cases and MDT working.	Liverpool City Council Children's Services undergoing a reset, informed by OFSTED and LCC strategic priorities. LCC reviewing services and strategic priorities – thematic areas – transformation, improvement, modernisation and BAU. New whole-city plan for CYP to be developed. Liverpool Children's Partnership – visioning session, April 24, informed by the 'Liverpool State of Health 2040' report Liverpool vision and priorities for CYP and families published September 24. Assumed Liverpool CYP system programmes, within One Liverpool and the City Plan: • Child poverty • Looked after children • School absence • UEC • Lung health • Neurodiversity/SEND • Emotional health and wellbeing	The Starting Well Board & Plan has 5 key priority areas (Core Themes): SEND Emotional Health & Wellbeing, Care & Support Early Help Education, Training & Employment	Start well initiatives: Breaking the cycle Targeted collaborative work in North Birkenhead Established Safeguarding Team Family Hub roll out Restructure of Early Help Teams into Family Help MDTs Best Start in Life steering group oversees early years & maternity including pre-birth & infant team and roll out of maternity continuity of care model Family Nurse Partnership Healthy Child Clinics, development reviews, speech, and language

	Cheshire East	Cheshire West	Halton	Knowsley	Sefton	St Helen	Liverpool	Warrington	Wirral
			Mental Health ARRS worker in 1 PCN Successful bid to increase MHST school coverage from Sept 24/25 Family Hubs established in 23/24 with further developments in 24/25. CYP Neurodiversity offer - plans in place for 24/25 to: Review current offer (April workshop planned) Coordinator role Wait list initiative. Sensory OT offer Improve Tics/ Tourette's support.	commissioned services. Also allowing health expertise to contribute to early decision making at first point of contact, a free Prescription scheme for all Children in Care The recent OSFTED inspection into care leavers stated that: "The health needs of most care-experienced young people are considered and met. Most are registered with general practitioners and dentists. Typically, care-experienced young people have health passports that are shared with them. This means that they have important information about their lives, and they know where to access health advice in the future, should they need this"	the partnership to address key findings with the ADQSI in role as chair of three key leads partnership. Preparation for DFE 6th monitoring visit is underway.		• Prevention & early intervention		
Local action at place against agreed C&M priorities and ambitions		Working to improve the waiting times for Paediatric continence in the community through a full integrated review, to redefine the pathway, improve support for Parents/families and Primary Care via education as a system approach for all tiers of the service and possibility to align across Place Plus			Strong alignment with Beyond and DCS Programmes across pathways e.g. Place based CYP respiratory group has developed and is implementing a focussed action plan, in-line with a Core 20PLUS5 approach.	Work aligned to Beyond programme themes including Key worker scheme, autism in schools, NDP development, IST, crisis response, Thrive, family hubs, children's hub development at Lowed House (including the birthing suite), respiratory programmes such as warm homes/young lungs ante natal education development. Also working with MWL on developmental paeds		Work underway to refresh Warrington's Starting Well Priorities & Plans and establish 3–5-year plan from 2024 onwards. This will reflect the following plans: C&M ICB CYP Priorities & Plans C&M Beyond Programme Plan C&M Directors of Children Change & Integration Plan. C&M Mental Health Programme Board Plan for CYP	EHWB Transformation ND pathway transformation Speech and Language system approach

Recommendation	Owner	Initial Key Actions / Enablers	Current Position
5) Providing timely access to high-quality elective care by making efficient use of existing estates and assets;	Liverpool Trusts Joint Committee/ Liverpool Cardiology Partnership Board Cheshire & Merseyside Acute & Specialist Trust (CMAST) collaborative	1. Critical care support on Broadgreen site for more complex surgery to take place. 2. Ensure timely access to Cardiac Rehab for all suitable patients. Provide a comprehensive, outcome focused Elective Recovery and Transformation framework. Optimising delivery, maximising productivity, and outcomes. Secured and deployed TIF funding to provide additional capacity and infrastructure within the city	1. Operating procedure now agreed. 2. Review of resources and estates undertaken to enable delivery of increased cardiac rehab. • Delivery of 104ww and 78ww performance • Trajectory on 65ww • Theatre productivity performance • Pan C&M specialty optimisation, establishment of alliances and system wide facilitated mutual aid
6) Solving the clinical sustainability challenges affecting women's health in Liverpool	ICB Women's Sub-Committee and Programme Board Alder Hey /LWH Neonatal Partnership LUHFT/LWH Ops Board	A provider-led Programme Board established, tasked with developing proposals for women's hospital services to address risks and achieve all objectives. Programme plan in development including required communication and engagement plans for subsequent options appraisals.	Detailed programme plan developed. Incorporating 1,3- and 5-year deliverables Shorter term Improvements: • Medical Emergency Care Team to enable optimal care and timely transfers • Embed 24/7 obstetric consultant cover • 24/7 blood transfusion lab and imaging service • LWH deteriorating patient collaborative to improve earlier recognition of deterioration • Increased capacity and access to specialist therapy staff • Review pathway for pregnant women and patients presenting at other sites Longer term programme: • Case for change in development • Clinical event planned for May 24
7) Combining expertise in clinical support services to provide consistent services across the city; (Liverpool Clinical Laboratories) C&M Radiology Network	Liverpool Trusts Joint Committee	Pharmacy support on Broadgreen site for outpatients • Interventional Radiology review commenced at C&M level • Advanced Acceleration Technology implemented on MRI machines	* 2 Medical Physicists recruited to oversee implementation Tech being

	Cheshire East	Cheshire West	Halton	Knowsley	Sefton	St Helen	Liverpool	Warrington	Wirral
						service that has significant workforce and demand challenges		Warrington Health & Wellbeing Strategy Plan. Core 20 Plus 5 for CYP	

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/03/24/12

Report approved by: Neil Large, Non-Executive Member, Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Audit Committee

Committee Chair	Neil Large
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	05 March 2024

Key escalation and discussion points from the Committee meeting

Alert

The Audit Committee:

Received a report seeking its endorsement of the proposed changes to the ICBs **Scheme of Reservation and Delegation (SORD) and Operational Scheme of Reservation and Delegation (OSORD).** The proposed changes within the ICB SORD (Appendix One to this report) are highlighted within the document. New additions are highlighted in YELLOW and edits are in ~~RED~~. Key changes cover:

- Removal of duplications
- inclusion of new Committees of the ICB and amendments to Committee names
- inclusion of key decision making responsibilities of Committees that did not feature in the previous version of the SORD.

The proposed changes to the OSORD (Appendix Two), are set out below and highlighted in YELLOW and PEACH in Appendix Two. Key changes to the OSORD are as follows:

a) Amendments

The approval limit for the Chief Executive for F4: Approval of non-healthcare payments within agreed budget has been amended from Up to £2m to Over £2m (Executive Director of Finance can approve up to £2m).

Section K: Procurement has been updated to reflect the new Healthcare Provider Selection Regime (2023). This section now including the addition of a new item for the 'Decision to put Non-Healthcare goods and services out to competitive procurement'. This is due to the revised regulations for Non-Healthcare not yet being available.

Section H2: Decision To Approve 'New' Investment Business Cases where not in approve financial plan has been amended to include a limit of up to £500k for the Transformation Committee in relation to Delegated Specialised Commissioning Services.

Section O4: Approval of Appointment to Posts Below Executive Directors has been amended to include approval at the Vacancy Panel for band 9 and 8D posts only and for any re-bandings.

Section P1: Approve Complaints Responses and Letters to Politicians and Media Responses has been amended to include the Associate Director of Corporate Affairs & Governance.

b) Additions

The Information Governance Section 'S' has been added to confirm and formalise who, within the ICB, can approve the following documents and also Data Security and Protection Toolkit submissions:

- Digital and Data programmes Data Protection Impact Assessments (DPIA), Information / Data Sharing agreements and Data Processing Agreements;
- Confidentiality Advisory Group (CAG) Applications;
- NHS Digital Data Access Requests (DARs) – Data Sharing Agreements, Data Sharing Framework Contracts;
- Privacy Notices.

Amendments have also been included to reflect the updated position regarding the number of Committees the ICB has and their delegated authority.

The Audit Committee endorsed the changes to the ICBs SORD and OSORD and recommends to the ICB Board that it approves these changes.

Following approval, the updated documents will be published on the ICB website.

Risk Management Strategy

The Audit Committee reviewed a report outlining proposed changes to the ICB Risk Management Strategy, which the Board had approved in February 2023. Committee heard how as part of a planned review, amendments had been included following:

- a review of feedback gathered during the risk management training sessions delivered by Merseyside Internal Audit Agency (MIAA).
- a survey of Audit committee members.
- a survey of risk owners.
- Discussion with corporate and place governance leads charged with implementing the strategy.
- Review of best practice case studies and other ICB risk management strategies.

Key changes to the Risk Management Strategy were summarised to the Committee as:

- **Risk Matrix – an updated matrix with single, combined impact scores for ICB wide and place risks, and with additional impact criteria for health outcomes and inequalities, and quality**. These changes are intended to reduce complexity, simplify escalation, and improve alignment with strategic objectives. An additional critical (black) category and re-classifying some risks with minor impacts from high to moderate is also proposed to align with proposed changes to escalation criteria.
- **Escalation Criteria – increases are proposed to the thresholds for escalation to both the corporate risk register and committee risk registers**. These changes will focus Board and committee attention on the most significant risks and reflect that initial thresholds were set low and can now be increased reflecting that risk management is now more embedded and consistently applied. Together with the proposed changes to the risk matrix, this will provide unified escalation thresholds for both corporate and place risks, which is expected to speed up escalation and promote consistency.

- **Review and reporting frequency – in order to speed up the escalation of significant risks, it is proposed that initial review, and mitigation strategy for high+ risks, are completed within one month and subject to scrutiny and approval by the relevant ICB Committee**. High and extreme risks would be reviewed and reported on quarterly, or monthly by exception if mitigating actions are off track or ineffective. Critical (20+) risks would be subject to monthly review. Moderate and low risks would be subject to quarterly light touch review.

The Committee received a summary document outlining in more detail the proposed changes to the Risk Management Strategy (Appendix Three).

The Committee endorsed the proposed changes and recommends to the ICB Board that it approves the changes to the ICB Risk Management Strategy (Appendix Four).

Advise

The Audit Committee:

- received an update on the progress in pulling together the ICBs Annual Report and Accounts and the timelines required for review by the Audit Committee and ICB Board. It was noted that there will need to be an additional Committee in April and May 2024 to meet the necessary checkpoints to review the draft Annual Report and Accounts before submitting to NHS England and the ICB Board. Within this update the Committee also reviewed the updated ICB Accounting Policies to reflect national changes to the Group Accounting Manual. **The Committee approved the changes to the ICB Accounting Policies.** The Committee also considered and noted the assessment of Going Concern that has been undertaken by management.

- received a further update paper on the ongoing work to strengthen the ICBs arrangements for the management of Conflicts of Interest. Committee members were informed of the progress being made with implementing the Civica Declare system that allows staff to declare their interests, gifts, hospital and sponsorship declaration. Committee were also informed that from 01 March 2024 that the national Module 1 conflicts of interest training provided by NHS England now forms part of the ICBs statutory and mandatory training for all staff and Board members. Committee also noted the work underway with MIAA around the audit of our controls around managing declarations of interest, which will be reported at a future meeting of the ICB. The Committee noted the report.

- received a report seeking approval by the Committee of the ICBs updated Procurement Policy. The Policy has been updated to reflect the differentiation of the procurement requirements between healthcare and non-healthcare goods and services and highlights the different policy approach for each respective area, and which has come about since the health care Services (Provider Selection Regime) Regulations 2023. **The Committee approved the Policy.**

- received the quarterly Information Governance Report for the ICB. Committee were updated on the launch of and progress around the IG Training and awareness Needs Analysis, staff wide training and compliance with IG training. It was

highlighted that training compliance continues to hover around 82-83% compliance against a required achievement target of 95%. Committee discussed what measures are required to improve compliance and reinforced the ask of the Executive team to progress raising awareness and completion of the IG training for all staff. Committee were informed that during this reporting period there had been 9 data breaches, with one reported on to the DSPT but found to not be onwardly reportable to the ICO. Committee were notified about the successful submission of the DSPT baseline submission and work underway ahead of final submission at end of June 2024. Committee were also provided with the updated IG Polices and IG Handbook for the ICB. **The Committee approved these changes, and noted the update report to the Committee.**

- Received a paper seeking approval of on a new ICB Privacy Notice: C&M ICS Digital and Data Programme - Secure Data Environment (SDE) Data into Action. **The Committee approved the policy and its publication on the ICB website.**

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Assure

The Audit Committee:

- received a quarterly summary of the ICBs compliance with the ICB's Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD), in relation to the wavering of competition, to demonstrate compliance with the Public Contracts Regulations 2015. Committee were informed that since the last report to Committee in December 2023 that there had been two tender waivers and eight quotation waivers approved in line with ICB governance processes. Committee were informed that there had been no procurement breaches within this quarter period. The Committee noted the report.

- received an update report from the ICBs Internal Auditor. Committee members were provided with an update on the internal audits already completed) and progress against the remaining internal audits. Committee also received the draft Head of Internal Audit opinion for the 2023-24, noting that no overall assurance opinion had been stated as yet and that this will only be determined following completion of the internal audit planned work for 2023-24. Committee members noted the report and the current draft Head of Internal Opinion, and noted that this will come back to the April and May Committee meetings.

- received a verbal report from the ICBs External Auditors outlining the work underway towards the ICBs annual Report and Accounts and Value For Money audit. The Committee noted the report.

- received an update report from the ICBs counter fraud specialist. Committee members received information on the work undertaken with the ICB by the Counter Fraud specialist since the last report to Committee in December 2023, outlining the key campaigns and briefings circulated to the ICB. During this reporting period no fraud concerns had been flagged to the counter fraud specialist. The Committee noted the report.

- received an update report from the ICBs Risk Committee. This report outlined the work underway to progress the development of the ICB Risk Appetite statement

and planned workshop, and the work undertaken to review the ICB Risk Management strategy. The Committee noted the report.

- received and reviewed the Committees Risk Register. The report provided details on the risk aligned to the Committee and work underway to mitigate these risks. The report highlighted that Risk G1 'non-compliance with information governance policies leads to reportable data security and protection incident resulting in financial loss and / or reputational damage', as previously been reported has been mitigated from extreme (20) to moderate (6) and no longer meets the threshold for escalation to the committee. The report also provided more detail on progress around finalising the ICB Fraud risks within March, which will inform the work of the ICB's Counter Fraud Specialist in shaping the ICB's 2024/25 antifraud, bribery and corruption work plan to be approved at the April 2024 Audit Committee meeting. The Committee noted the Risk Register report.

Committee risk management

The following risks were considered by the Committee and the following actions / decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
G1 - non-compliance with information governance policies leads to reportable data security and protection incident resulting in financial loss and / or reputational damage.	Committee was informed that this risk has been mitigated from extreme (20) to moderate (6) and no longer meets the threshold for escalation to the committee. It will continue to be monitored and reviewed as part of the ACE Directorate risk register.
G2: Commissioning support or other data processors acting on the ICB's behalf breach statutory or regulatory requirements, resulting in financial loss and / or reputational damage, currently rated as high (9).	Risk mitigated from extreme (20) to high risk (9), through policies and the Data Security and Protection Toolkit Plan being in place, but the remaining controls remaining as amber, recognising that the IG assurance process for the procurement and contracting of services from suppliers that handle personal information requires review and strengthening. Key planned actions are to update the procedures during quarter 4 of 2023/24, which will be applied to all new procurements and contract renewals, and to consider requirements to review any high-risk contracts not due for renewal
G5: The inconsistent adherence to a core set of governance, financial and operational policies and procedures across the ICB leads to control failures, poor audit outcomes and reputational damage, currently rated as high (9).	Risk mitigated from extreme (20) to high risk (9), through the progress made in completing, implementing and communicating the key ICB policies via the Staff Hub. Key further action is to secure approval to the draft policy for the development and management of policies which has been drafted and is awaiting

Corporate Risk Register risks	
	approval, which will ensure that roles and responsibilities, and the process and standards for producing and maintaining documents are clear.
G10 (New): Re-procurement of information governance services de-stabilises existing arrangements resulting in adverse financial and reputational impacts, currently rated as high (9).	Risk mitigated from extreme (20) to high risk (9), through the range of controls in place, with policies rated as green, recognising that we have Standing Financial Instructions and a Procurement Policy in place. The remaining controls are rated as amber and relate to the procurement project - plan, processes, mobilisation planning, engagement, and reporting. The project plan is currently on track, with a new contract planned to be in place ready for 1st July 2024.

Appendices

Appendix One: Updated ICB Scheme of Reservation and Delegation

Appendix Two: Updated ICB Operational Scheme of Reservation and Delegation

Appendix Three: Summary Changes to the ICB Risk Management Strategy

Appendix Four: Updated ICB Risk Management Strategy

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board
Scheme of Reservation and Delegation (SoRD)

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1. Regulation, control, constitution & governance						
1.1	Determine the arrangements by which the ICB approves those decisions that are reserved for the Board where they have not been delegated	Board				Assistant Chief Executive
1.2	Consider and approve applications to NHS England on changes to the Constitution	Board			ICB Executive (the executive committee meeting)	Assistant Chief Executive
1.3	Approval of ~~prepare~~ the ICBs scheme of reservation and delegation (SORD), which sets out those decisions that are in statute the responsibility of the ICB and are reserved to the ICB Board, and those delegated to Committees, sub-committees, and employees	Board			ICB Executive Audit Committee Finance, Investment and Our Resources Committee	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
~~1.4~~	~~Approval of the ICB scheme of reservation and delegation, which sets out those decisions that are the statutory responsibility of the Board and those delegated to the~~ ~~• Board~~ ~~• committees, sub-committees, or advisory panels of the ICB or~~ ~~• employees~~	~~Board~~			~~ICB Executive~~	~~Director of Finance~~
1.4	Promote the governance arrangements of the ICB to employees and to people working on behalf of the ICB			ICB Executive		Assistant Chief Executive
1.5	Disclosure of non-compliance with the group's constitution (incorporating its standing orders, prime financial policies and scheme of reservation and delegation)	Board			Audit Committee Finance, Investment and Our Resources Committee	Assistant Chief Executive
1.6	Review of suspension of standing orders		Audit Committee			Assistant Chief Executive
1.7	Suspension of standing orders	Board				Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
~~1.9~~	~~Preparation of the operational scheme of delegation (incl. financial limits) that underpins the group's overarching scheme of reservation and delegation~~		~~Finance, Investment and Our Resources Committee~~		~~Finance, Investment and Our Resources Committee~~	~~Director of Finance~~
1.8	Approval of the operational scheme of delegation (incl. financial limits) that underpins the ICB's overarching scheme of reservation and delegation	Board			Audit Committee Finance, Investment and Our Resources Committee	Director of Finance
1.9	Approval of the ICBs Standing Financial Instructions	Board			ICB Executive	Director of Finance
1.10	Approve the ICB's prime financial policies and financial governance	Board			Finance, Investment and Our Resources Committee	Director of Finance
1.11	Set out who can execute a document by signature / use of the seal	Board			ICB Executive	Associate Director of Corporate Affairs and Governance
1.12	Approve the arrangements for discharging the ICB's statutory duties and functions	Board			ICB Executive	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1.13	Establish governance arrangements to support collective accountability between partner organisations for whole system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations	Board			Quality and Performance Committee Strategy and Transformation Committee Finance, Investment and Our Resources Committee	Assistant Chief Executive Director of Planning and Performance
2. Strategy & Planning						
2.1	Approve the values and planning in accordance with the strategic direction of the ICB~~P~~	Board			Finance, Investment and Our Resources Committee	Director of Finance
2.2	Approve the ICB operating structure		ICB Executive	Chief Executive		Chief Executive
2.4	Approve the ICB arrangements for engaging the public and key stakeholders in the ICB's planning and commissioning arrangements	Board			Strategy and Transformation Committee Transformation Committee	Assistant Chief Executive
2.5	Approve the ICB budgets that meet the financial duties of the ICB	Board			Finance, Investment and Our Resources Committee	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.6	Approve Cheshire and Merseyside Health and Care Partnership integrated care strategy		Cheshire and Merseyside Health and Care Partnership		Strategy and Transformation Committee	Assistant Chief Executive
2.7	Allocate resources to support the delivery of the Cheshire and Merseyside Health and Care Partnership integrated care strategy	Board			Strategy and Transformation Committee	Assistant Chief Executive
2.8	Agree a System Joint Forward Plan to meet the health and healthcare needs of the Cheshire & Merseyside population, within the context of the NHS national strategy, the C&M Health and Care Partnership integrated care strategy and place health and wellbeing strategies	Board			Strategy and Transformation Committee	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.9	Allocate resources to deliver the Joint Forward Plan across the system, determining what resources should be available to meet population need across C&M and in each place, and setting principles for how they should be allocated across services and providers (both revenue and capital)	Board			Finance, Investment and Our Resources Committee	Strategy and Transformation Transformation Committee Place Directors through Place-Based Partnership Boards
2.10	Allocate resources to deliver the System Joint Forward Plan at place, determining what resources as delegated by the Board should be available to meet population need in place and setting principles for how they should be allocated across services and providers (both revenue and capital)	Board			Finance, Investment and Our Resources Committee	Strategy and Transformation Committee Place Directors through Based Partnership Boards
2.11	Agree and publish a Joint Capital Resource Use Plan with partner NHS trusts and foundation trusts within Cheshire and Merseyside	Board			Finance, Investment and Our Resources Committee	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.12	Approve decisions on the review, planning and procurement of primary medical care services (to reflect the terms of the delegation agreement between NHS England and NHS Cheshire and Merseyside ICB)		System Primary Care Committee Pharmacy Services Regulations Committee		Place Primary Care Committee / Forums ICB Associate and Heads of Primary Care Place Primary Care Staff	Assistant Chief Executive Place Directors Head of Primary Care
2.13	Approve decisions on the review, planning and procurement of Specialised Commissioning services for the Cheshire and Merseyside population (to reflect the terms of the delegation agreement between NHS England and NHS Cheshire and Merseyside ICB)		Strategy and Transformation Committee Finance, Investment and Our Resources Committee			Assistant Chief Executive Director of Finance
2.14	Approve decisions on the review, planning and procurement of Specialised Commissioning services for the North West of England population made at the North West Specialised Commissioning Services Joint Committee		North West Specialised Commissioning Services Joint Committee		Strategy and Transformation Committee Finance, Investment and Our Resources Committee	Assistant Chief Executive Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.15	Have oversight of and approve the strategy and priorities for NHS Cheshire and Merseyside with regards Children and Young People		Children and Young Peoples Committee			Director of Nursing and Care Assistant Chief Executive
2.16	Have oversight of, agree and approve the prioritisation of ICB funding and allocations for Childrens and Young Peoples functions and services that NHS Cheshire and Merseyside has responsibility for		Children and Young Peoples Committee			Director of Nursing and Care Assistant Chief Executive
2.17	Approve the strategic case for change for Women's Hospital Services in Liverpool		Women's Hospital Services in Liverpool Committee			Director of Nursing and Care
2.18	Approve the ICB operating structure in each place		Executive Team			Place Directors
2.19	Agree system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the center of their care		Strategy and Transformation Committee		Executive Team	Medical Director Chief Digital Officer

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.20	Agree place action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connecthealth and care services to put the citizen at the center of their care		Strategy and Transformation Committee		Digital Transformation and Clinical Improvement Assurance Group Place Based Partnership Boards	Place Directors Chief Digital Officer
2.21	Agree C&M joint work on estates, procurement, supply chain and commercial strategies to maximisevalue for money across the system and support wider goals of development and sustainability		Finance, Investment and Our Resources Committee		Strategy and Transformation Committee Place Based Partnerships Boards	Director of Finance
2.22	Agree place action on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability		Finance, Investment and Our Resources Committee		Strategy and Transformation Committee Place Based Partnerships Boards	Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.23	Agree arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHSE	Board			ICB Executive	Director of Planning and Performance
3. Annual Reports and Accounts						
3.1	Approval of the ICB Annual Report and Annual Accounts	Board			Audit Committee	Director of Finance
4. Partnership, joint or collaborative working						
4.1	Agree joint working arrangements with partners that embed collaboration as the basis for delivery within the ICB plan (including arrangements under section 75 of the NHS Act 2006)	Board			Strategy and Transformation Committee Place Based Partnership Boards	Assistant Chief Executive
4.2	Develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within the ICB plan	Board			Strategy and Transformation Committee Place Based Partnership Boards	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
4.3	Approve the delegated decision-making responsibilities of individual employees of the ICB who represent the ICB in joint or collaborative arrangements with another statutory body(ies)	Board			Finance, Investment and Our Resources Committee	Chief Executive
4.4	Approve named positions within the ICB with the delegated authority to undertake any of the functions of the System Primary Care Committee were considered appropriate and / or necessary by the Committee			System Primary Care Committee		Assistant Chief Executive Associate Director of Primary Care
4.5	Approve the arrangements governing joint or collaborative arrangements between the ICB and another statutory body(ies), where those arrangements incorporate decision making responsibilities (including arrangements under section 75 of the NHS Act 2006), Section 65Z5 or Section 65Z6 of the Health and Care Act 2022)	Board			Strategy and Transformation Committee	Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
4.6	Approve arrangements for coordinating the commissioning of services with other ICBs, ~~or~~ with local authorities, or with NHS Trusts where appropriate (including under section 12ZA of the 2006 Act ('Conferral of discretion')	Board			Strategy and Transformation Committee Place Based Partnership Boards	Assistant Chief Executive
4.7	Approve arrangements for risk sharing and /or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS Act 2006, or Section 65Z6 of the Health and Care Act 2022)	Board			Finance, Investment and Our Resources Committee	Director of Finance
4.8	Receive the minutes of meetings of, or reports from, joint or collaborative arrangements between the ICB and another statutory body(ies)	Board	Children and Young Peoples Committee Strategy and Transformation Committee System Primary Care Committee			Assistant Chief Executive

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5. Employment, Remuneration, Workforce & OD						
5.1	Agree system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers	Board			System Peoples Board	Chief People Officer
5.2	Agree implementation in Locality of People Priorities		Place Partnership Boards		System Peoples Board	Chief People Officer
5.3	Accountability for the ICB's responsibilities as an employer including adopting a Code of Conduct for staff	Board			Audit Committee	Chief People Officer
5.4	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities		Remuneration Committee		Finance, Investment and Our Resources Committee	Chief People Officer

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.5	Approve the ICBs Pay Policy, including approving the terms and conditions of employment for non- AFC employees including pensions, remuneration, fees and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB		Remuneration Committee		~~People Board~~ ICB People Committee	Chief People Officer
5.6	Approve any other terms and conditions of services for the ICB's AFC employees		Finance, Investment and Our Resources Committee		ICB Executive	Chief People Officer
5.7	Approve disciplinary arrangements for all employees, ~~excluding~~ including the Chief Executive ~~accountable officer~~ (where he/she is an employee of the ICB) and for other persons working on behalf of the ICB		Remuneration Committee ~~Finance, Investment and Our Resources~~		ICB Executive	Chief People Officer
~~5.7ii~~	~~Approve disciplinary arrangements for employees, including the Chief Executive accountable officer (where he/she is an employee of the ICB)~~		~~Remuneration Committee~~	~~Chair~~		~~Chief People Officer~~

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.8	Approve disciplinary arrangements where the ICB has joint appointments with another group and the individuals are employees of that group			Shared Chief Executive discussion		Chief People Officer
5.9	Approval of the arrangements for discharging the ICB's statutory duties as an employer	Board	Finance, Investment and Our Resources Committee		Finance, Investment and Our Resources Committee ICB Executive	Chief People Officer
5.10	Approve human resources policies for ICB employees and for other persons working on behalf of the ICB		Finance, Investment and Our Resources Committee		ICB Executive	Chief People Officer
5.11	Approve arrangements for staff appointments (excluding matters detailed within the constitution)		Finance, Investment and Our Resources Committee		ICB Executive	Chief People Officer
5.11a	Appointment of the ICB Chief Executive	Board			Remuneration Committee	Chief People Officer
5.11b	Appointment of all other roles		Remuneration Committee (non AfC levels only)	ICB Executive		Chief Executive or other responsible Executive
5.12	Approve the ICB organisational development plans		Finance, Investment and Our Resources Committee		ICB Executive	Chief People Officer

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
7.11	Appointment or removal of either the Internal or External auditor for the ICB	~~Board~~	Audit Committee			Director of Finance
7.12	Approve the internal audit, external audit and counter-fraud plans and any changes to the provision or delivery of related services ~~(other than the appointment or removal of the external auditor where authority is reserved to the Board)~~		Audit Committee			Director of Finance
8. Information Governance						
8.1	Approve the policies and arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data		Audit Committee			Advised and supported by IG & Data Security groups
8.2	Approve information sharing protocols with other organisations		ICB Executive			SIRO
8.3	Approve ICB Annual Data Security and Protection Toolkit submissions			SIRO		Associate Director of Corporate Affairs and Governance IG Officers

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6. Quality and Safety						
6.1	Establish clinical governance arrangements to support collective accountability between partner organisations	Board			Quality and Performance Committee	Director of Nursing and Care through System Quality Surveillance Group
6.2	Approve arrangements to ensure duties are discharged effectively and foster the development of policies, processes and initiatives to minimise clinical risk, maximise patient safety, and promote equality to secure the continuous improvement in quality and patient outcomes	Board			Quality and Performance Committee	Director of Nursing and Care
6.4	Approve the ICB arrangements for handling complaints and concerns		Quality and Performance Committee	ICB Executive		~~Director of Nursing and Care~~ Assistant Chief Executive
6.5	Approve the ICB arrangements for safeguarding children and vulnerable adults		Quality and Performance Committee	ICB Executive		Director of Nursing and Care

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.6	Approve the ICB arrangements for engaging patients and their carers in decisions concerning their healthcare		Quality and Performance Committee	ICB Executive		Director of Nursing and Care Assistant Chief Executive
6.7	Approve arrangements for supporting the NHS in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services		Quality and Performance Committee	ICB Executive		Director of Nursing and Care Deputy Medical Director
6.8	Approve the arrangements for the quality oversight, assurance and improvement systems within the ICS.		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
6.9	Approve the arrangements for delivering the NHS Patient Safety Strategy to achieve its vision to continuously improve patient safety and to develop and implement the patient safety initiatives that the strategy introduced.		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
6.10	Agree the Strategy for Quality and Patient Safety inclusive of the aligned quality priorities for the		Quality and Performance Committee	ICB Executive		Director of Nursing and Care

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	system					
6.11	Agree the ICB arrangements for responding to and learning from patient safety events		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
6.12	Approve the operating structure for the monitoring, oversight and reporting on Quality and Safety in each place		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
7. Business Operation and Risk Management						
7.1	Approve the ICB counter fraud and security management arrangements		Audit Committee			Director of Finance
7.2	Approval of the ICB risk management arrangements	Board			Audit Committee ICB Executive	Director of Finance
7.3	Approve ICB operational policies (i.e., excluding those defined as clinical or finance)				ICB Executive	Assistant Chief Executive
7.4	Approve ICB financial policies		Finance, Investment and Our Resources Committee			Director of Finance
7.5	Approve requests for the waiver of any procurement rules for goods and services on an exception basis		Finance, Investment and Our Resources Committee			Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
7.6	Approve the ICB procurement plans annually		Finance, Investment and Our Resources Committee			Director of Finance
7.5	Approve ICB Safeguarding, clinical and medical policies and clinical pathways		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
7.6	Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes		Quality and Performance Committee	ICB Executive		Director of Nursing and Care
7.7	Approve arrangements for managing conflicts of interest, including gifts and hospitality and for standards of business conduct.	~~Board~~	Audit Committee			Assistant Chief Executive
7.8	Approve arrangements for complying with the NHS Provider Selection Regime	Board			Finance, Investment and Our Resources Committee	Director of Finance
7.9	Report and provide assurance to the Board on the effectiveness of ICB governance arrangements		Audit Committee			Assistant Chief Executive
7.10	Receive the annual governance letter from the External Auditor and advise the Board of proposed action		Audit Committee			Director of Finance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
8.4	Approve NHS Digital Data Access Requests (DARs) – Data Sharing Agreements, Data Sharing Framework Contracts			SIRO		Associate Director of Corporate Affairs and Governance IG Officers
8.5	Approve arrangements for handling Freedom of Information and Subject Access Requests		ICB Executive			Assistant Chief Executive Associate Director of Corporate Affairs and Governance
~~8.3~~	~~Approve arrangements for handling Freedom of Information requests~~		~~ICB Executive~~			~~Assistant Chief Executive~~
~~9. Partnership, joint or collaborative working~~						
~~9.1~~	~~Approve the arrangements governing joint or collaborative arrangements between the ICB and another statutory body(ies), where those arrangements incorporate decision making responsibilities (including arrangements under section 75 of the NHS Act 2006), Section 65Z5 or Section 65Z6 of the Health and Care Act 2022)~~	~~Board~~			~~Transformation Committee~~	~~Assistant Chief Executive~~

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
~~9.2~~	~~Approve the delegated decision-making responsibilities of individual employees of the ICB who represent the ICB in joint or collaborative arrangements with another statutory body(ies)~~	~~Board~~			~~Finance, Investment and Our Resources Committee~~	~~Chief Executive~~
~~9.3~~	~~Receive the minutes of meetings of, or reports from, joint or collaborative arrangements between the ICB and another statutory body(ies)~~	~~Board~~				~~Assistant Chief Executive~~
9.	**Communications**					
9.1	Approval of ICB communications and engagement plan	Board			Strategy and Transformation Committee	Assistant Chief Executive Associate Director of Communications and Empowerment
10.	**Arrangements for Patient & Public Involvement**					
10.1	Approve arrangements for the involvement of and consultation with patients and the public in ICB decision making	Board			Strategy and Transformation Committee	Assistant Chief Executive

Approved: XXXX by the Board of NHS Cheshire and Merseyside

NHS Cheshire & Merseyside Integrated Care Board (ICB) Scheme of Reservation & Delegation Operational Limits

Version 4

March 2024

1. Operational Delegated Limits

Section	Description	Reserved By: Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	Sefton Primary Care Committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
A	**ACCEPTANCE OF GIFTS, HOSPITALITY & SPONSORSHIP** (Governance Lead to maintain a register of declared gifts and hospitality received)														Gifts over £50	Gifts over £50		Gifts up to £50	Gifts up to £50	Gifts up to £50	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
B	**LITIGATION CLAIM PAYMENTS** Medical negligence and other litigation payments made on the advice of NHS Resolution	Over £1,000,000													Up to £1,000,000	Up to £500,000					
C	**LOSSES & SPECIAL PAYMENTS** (CFO to maintain a register of losses and special payments (including bad debts to be written off). All payments to be reported to the Audit Committee.	Over £500,000			Up to £500,000										Up to £100,000	Up to £50,000	Up to £5,000				
D	**PETTY CASH FLOAT**																				
D1	Authorisation to set up float														Over £300	Over £300	Up to £300				
D2	Replenish petty cash float																				Head of Financial Services (or equivalent role)
D3	Issue petty cash															Up to £50	Up to £50				Associate Director of Finance (Place)
E	**CREDIT CARD**																				
E1	Account signatories (who can make changes to the account, authorise additional card holders, amend card limit)														X	X	X				
E2	Authorise single transaction (single transaction limit £2,500)														X	X	X	X	X	X	X
F	**REQUISITIONING GOODS & SERVICES: NON-HEALTHCARE**																				
F1	Utilisation of External Agency Staff (based on total expected cost as per below notes) Supporting Notes: a) Prior approval from the ICB Vacancy Panel must be sought for all consultancy requests regardless of value. b) Prior approval from NHSE must be sought for: - Any appointments over £600 per day; or - any appointments for over a 6 month period, or - any appointment with significant influence (e.g. ICB roles). c) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and in line with agreed ICB IR35 policy	Over £500,000			Up to £500,000										Up to £150,000	Up to £150,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000

Section	Description	Reserved By:																			
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	Scotland Primary Care Committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioing Services Joint Committee	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
F2	Utilisation of Consultancy (based on total expected cost as per below notes). Supporting Notes a) Prior approval from the ICB Vacancy Panel must be sought for all consultancy requests regardless of value. a) Prior approval from NHSE must be sought for: -Any expenditure above £50,000: or Any appointments over £600 per day; or - Any appointments for over a 6 month period, or - Any appointment with significant influence (e.g. ICB roles) b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and in line with agreed ICB IR35 policy	Over £500,000			Up to £500,000										Up to £150,000	Up to £150,000		Up to £25,000	Up to £25,000	Up to £25,000	
F3	Services including IT, maintenance, and support services (over lifetime of contract) where not included within agreed annual budgets	Over £2,000,000			Up to £2,000,000										Up to £1,000,000	Up to £500,000		Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F4	Approval of non-healthcare payments within agreed budget *With appropriate consideration of procurement requirements														Over £2,000,000	Up to £2,000,000	Up to £500,000	Up to £500,000	Up to £500,000	Up to £500,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
G	**RELOCATION EXPENSES** In line with Policy approved by ICB Remuneration Commttee														Over £8,500	Up to £8,500					
H	**DECISION TO APPROVE 'NEW' INVESTMENT BUSINESS CASES**																				
H1	Where funding is: a) available and identified within agreed financial plan or b) from additional notified resource allocations (e.g. new in-year) c) other identified income streams (e.g. other agencies / recharges)	Over £10,000,000			Up to £10,000,000	Up to £1,000,000		Up to £1,000,000 *Primary Care Related							Up to £5,000,000	Up to £3,000,000	Up to £1,000,000	Up to £1,000,000	Up to £1,000,000	Up to £1,000,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H2	Where not included in approved financial plan (but still subject to ICB Executive / Place Leadership Team Approval) N.B any material underspend / variation from plan at individual budget holder level cannot be reinvested / redirected (see Virement Policy - Section L) without Executive team approval due to overall financial management requirements of the ICB.	Over £5,000,000			Up to £5,000,000	Up to £500,000 *Specialised services related		Up to £500,000 *Primary Care Related							Up to £500,000	Up to £500,000		Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H3	Primary Care Capital Expenditure Approval (within ICB allocation) NB - Capital Plan to be approved by the ICB for each financial year	Over £1,000,000						Up to £1,000,000 *Primary Care Related							Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)					
I	**CONTRACTING**																				
I1	Signing of Healthcare Contracts including S75 agreements. S75 approval via place governance processes in line with S75 agreements operational policy. (Annual Contract Value)														Over £500,000,000	Up to £500,000,000	Up to £75,000,000			Up to £100,000,000	
I2	Approval of Healthcare Contract Payments All healthcare contract payments must be supported by signed contract (see I1).														As per agreed plan / budget value	As per agreed plan / budget value)	As per agreed plan / budget value)		As per agreed plan / budget value	As per agreed plan / budget value	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
I3	Signing of Non-Healthcare Contracts (Annual Contract Value)														Over £3,000,000	Up to £3,000,000	Up to £1,000,000		Up to £1,000,000	Up to £1,000,000	Up to £100,000

Section	Description	Reserved By: Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	Quality Primary Care Committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
J	**APPROVAL OF OTHER HEALTHCARE PAYMENTS WITHIN BUDGET** See authorised signatory list for approval limits for other officers.														Over £1,000,000	Up to £1,000,000	Up to £100,000	Up to £250,000	Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
K	**QUOTATIONS AND TENDERS HEALTHCARE / NON-HEALTHCARE**																				
K1	Approval of ICB Procurement Plan				X																
K2	Procurement route decision ~~Whether to put Healthcare Service Out to Tender~~ In line with the options contained within the Healthcare Provider Selection Regime (2023) Regulations (Annual Contract Value)	X (For Novel or Contentious issues escalated by FIR Committee)			X From £5,000,000 with Novel or Contentious Procurement route decisions to be escalated to the Board	Up to £3,000,000		Up to £3,000,000							Up to £5,000,000	Up to £3,000,000	Up to £1,000,000	Up to £663,000	Up to £663,000	Up to £663,000	
NEW	Decision to put Non-Healthcare goods and services out to competive procurement (Total contract value)	X (For Novel or Contentious issues escalated by FIR Committee)			X From £5,000,000 with Novel or Contentious Procurement route decisions to be escalated to the Board										From threshold up to Up to £5,000,000	From threshold up to Up to £3,000,000	From threshold up to £1,000,000				
K3	Approval of Quotations for Non-Healthcare expenditure (total value)		£20,000 to procurement thresholds specificied in the Public Contract Regulations (2015) ~~currently Healthcare £663k~~, Non Healthcare £213k) in line with delegated limits for expenditure type Minimum of three written quotes required																		
K4	Quotation Waiver Approval for Non-Healthcare goods and services (Total Contract Value) – see detailed financial policy on tendering when permissible)		£20,000 to procurement thresholds (currently ~~Healthcare £663k~~ Non Healthcare £213k) in line with delegated limits for expenditure type																		
K5	Procurement for Non-Healthcare goods and services through approved national / local framework agreement (in line with call off rules) (Total Contract Value)		From £20k to delegated budgeted limit for expenditure type (with approval from procurement team) Above delegated budgeted limits, subject to Finance, Investment & Resources Committee Approval																		
K6	Tender Waiver Approval for Non-Healtcare goods and services	In line with limits for procurement route decisions N.B. Reporting of all Tender Waiver Approval to Audit Committee																			
K7	Opening of Tender Documentation (where not received electronically) (at least 2 people from list)														x	x	x	x			
L	**VIREMENT**	Relating to a transfer of funds from an unspent or underspent budget to another; within virement rules to allow greater financial flexibility in using available resources All Transfers must be: • affordable within budget; and • agreed by both budget holders Virements may not be used to create new budgets																			
L1	Within Existing Approved Pay or Non-Pay Budgets														Over £1,000,000	Up to £1,000,000	Up to £500,000		Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
L2	With regards to transfers from reserves (including distribution of new in-year resource / capital allocations)															Up to £70,000,000	Up to £25,000,000				As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
M	**DISPOSALS AND CONDEMNATION** All assets disposed at market value.	Over £50,000													Up to £50,000	Up to £10,000	Up to £5,000				
N	**CHARITABLE FUNDS** (Not applicable to ICB)																				
O	**HUMAN RESOURCES**																				
O1	Approve HR Decisions Not Covered By ICB HR Policies or Is Exceptional To Policies (e.g. additional compassionate leave or exceptional carry forward of leave days)														x	x	x	x	x	x	

Section	Description	Reserved By:																			
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	Quality Primary Care Committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioing Services Joint Committee	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
O2	Decisions As Set Out Within HR Policies (where there is some management discretion e.g. study leave authorisation)														x	x		x	x	x	
O3	Approval of Operational Structure (re staffing and departments), and in accordance with organisation change policy														x						
O4	Approval of Appointment to Posts Below Executive Directors (following approval at Vacancy Panel)															x	x	x	x	x	x
O5	Approval of the below arrangements as required by the ICB: - Approval of the arrangements for discharging the ICB statutory duties as an employer - Approve human resources policies for ICB employees and for other persons working on behalf of the ICB - Approve any other terms and conditions of services for ICB AFC employees - Approve disciplinary arrangements for ICB employees - Approve arrangements for staff appointments (excluding matters detailed within the Constitution) - Approve the ICBs organisational development plans				x (following endorsement of the People Committee)																
P	**EXTERNAL COMMUNICATIONS & REPORTING**																				
P1	Approve Complaints Responses and Letters to Politicians and Media Responses														x				x (Assistant Chief Executive)		x (Associate Director of Corporate Affairs & Governance)
P2	Approve Public Consultation Material														x				x (Assistant Chief Executive)		
P3	Approve Public & Staff Engagement Material inc Website														x				x (Assistant Chief Executive)		
P4	Approve FOI Responses and Subject Access Requests																		x (Assistant Chief Executive)		x (Associate Director of Corporate Affairs & Governance)
P5	Approve Annual Engagement & Communication Plan	x																			
Q	**FINANCE** Approval of Operational Policies as required by the organisation				x																
R	**INDIVIDUAL PACKAGES OF CARE** Approval of Individual Packages of Care (Annual Value)																			Over £260,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
S	**INFORMATION GOVERNANCE**																				
S1	Approve Digital and Data programmes Data Protection Impact Assessments (DPIA), Information / Data Sharing agreements and Data Processing Agreements																	x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, SIRO and Caldicott Guardian, or their deputies)
S2	Approve Confidentiality Advisory Group (CAG) Applications																	x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, Deputy SIRO and Deputy Caldicott Guardian)
S3	Approve NHS Digital Data Access Requests (DARs) – Data Sharing Agreements, Data Sharing Framework Contracts																	x (SIRO)			
S4	Data Security and Protection Toolkit submissions approval																	x (SIRO)			x (Deputy SIRO)
S5	Privacy Notices																	x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, Deputy SIRO or Deputy Caldicott Guardian)

Risk Management Strategy Review

Summary of Changes

Risk Management Strategy - 1st year review

Information considered:

- Feedback from risk management training sessions
- Committee member survey
- Risk owner survey
- Discussion with Governance leads
- Best practice case studies & other ICBs' strategies

Changes proposed to:

- Risk matrix
- Escalation & de-escalation thresholds
- Review & reporting frequency

Risk Matrix

Proposed change	Rationale
Adopt single, combined impact scoring for ICB wide and place risks	Reduces complexity, simplifies escalation, consistent with practice elsewhere
Additional impact criteria for health outcomes & inequalities, and quality	Alignment with strategic objectives, criteria used in other ICBs
Split extreme (red) category to create additional critical (black) category	Higher instance & longevity of extreme risk in current environment, tolerance threshold for 'unacceptable' has increased, reflects practice elsewhere
Risk scoring 8 or 10 with minor (2) impacts reduced from high to moderate	Alignment with escalation criteria, efficiency / more targeted effort, reflects practice elsewhere

Current matrix	Proposed matrix
 Microsoft Word Document	 Microsoft Word Document

Escalation & de-escalation thresholds

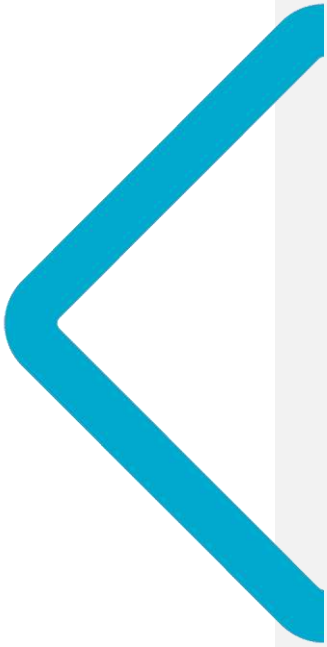
Proposed change	Rationale
Increase threshold for escalation to corporate risk register from 12+ to 15+	Board focus targeted on extreme & critical risks, initial thresholds set low & can be increased to reflect more embedded & consistent risk management, consistent with thresholds adopted by other ICBs
Increase threshold for escalation to committee risk registers from 8+ to high (removes risks scoring 8 or 10 with minor (2) impacts)	Committee oversight not required where potential impact is minor, reflects practice elsewhere
(Combined with risk impact scoring change) Unified escalation threshold for corporate and place risks – with grouping of common risks	Reduces complexity, simplifies escalation, expected to speed up escalation & promote consistency

Review & reporting frequency

Proposed change	Rationale
More intensive & rapid review on initiation to validate, including scoring, realistic target score, associated mitigation strategy & timescale	Opportunity to ensure genuinely risks & minimise duplication, quicker escalation of significant risks, robust plan & timescales negates requirement for monthly review, efficiency / more targeted effort
Critical risks reviewed monthly by Senior Responsible Owners	'Unacceptable' level of risk requiring more frequent oversight with aim to achieve rapid de-escalation
Extreme / High risks reviewed quarterly (monthly by exception if mitigating actions off track / ineffective)	Robust plan & timescales negates requirement for monthly review, efficiency / more targeted effort
Moderate / Low risks light touch review quarterly by DMTs	Sufficient to ensure nothing has changed to increase risk level, efficiency / more targeted effort
Quarterly routine reporting to ICB Committees (supplemented by new risks / exception reporting as required)	Robust plan & timescales negates requirement for monthly review, efficiency / more targeted effort, aligned to Board reporting frequency

NHS
Cheshire and Merseyside

Risk Management Strategy



Contents

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	The effect of uncertainty on objectives. Risk is the combination of the probability of an event and its consequence. The chance of something happening that will have an impact on objectives. An uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives.

Issue	A relevant event that has happened or is certain to happen, was not planned, and requires specific management action. 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.
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	The systems or processes we *currently* have in place to prevent a risk from occurring, or to reduce the potential consequences and likelihood. Examples of possible controls include: • 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~~include risks in relation to corporate and at scale functions and ~~in some cases will be an~~the aggregation of risks in common across multiple (3 or more)~~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~~include risks which are unique to a place, and risks in common across multiple (3 or more) places. ~~. The same or similar risks may exist in more than one place~~ but which 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~~development programme and understanding of roles and responsibilities across the organisation and system
- Review and ~~moderate risks~~advise risk owners regarding ~~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 or Associate 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 may include leadership of risk in common across multiple (3 or more) places where appropriate. ~~s 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~~ critical 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.

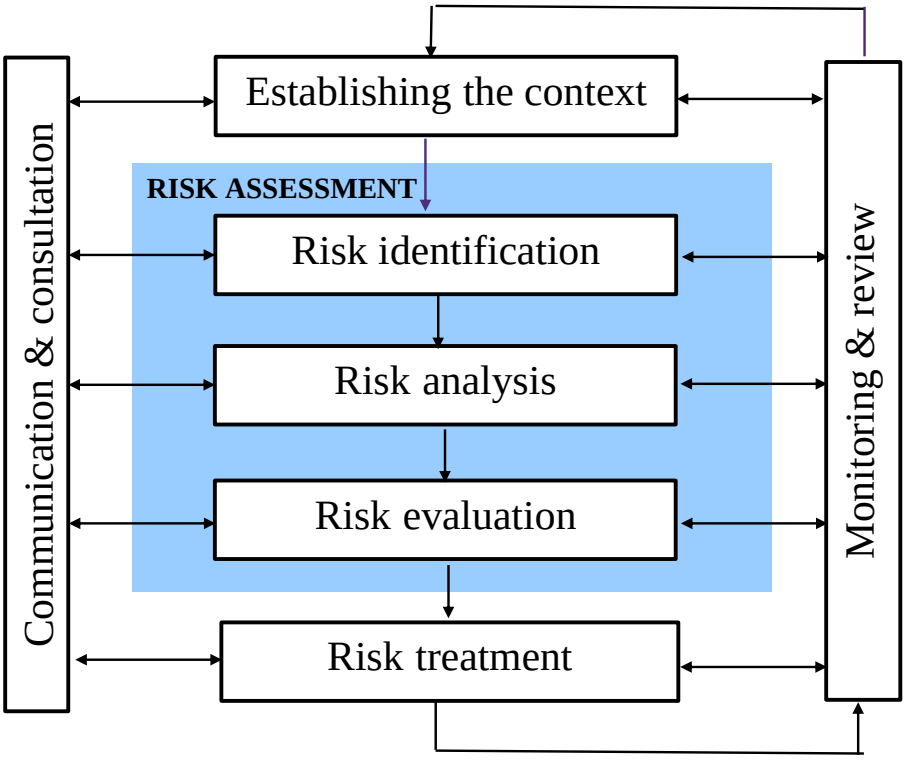
All Staff
All staff are responsible for:
- Attending mandatory and statutory training;
- Co-operating with arrangements for minimising risk;
- Working to NHS C&M procedures;
- Taking reasonable care for their own safety and that of others;
- Taking care of NHS C&M buildings, equipment and other assets; 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~~operates 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 has agreed the following risk appetite statement, which will be reviewed and updated annually:

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

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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.'

NEED TO UPDATE TO REFLECT ANNUAL REVIEW AND FURTHER DEVELOPMENT OF STATEMENT ONCE COMPLETE

This statement reflects the optimal risk position, which is the risk level with which the ICB aims to operate, and the Board expects risk owners to work towards. However, the Board recognises the necessity to balance this against what is achievable and affordable in the short term and will tolerate higher risk levels by agreement in the short term with a longer-term strategy to reach optimal levels.

~~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

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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:
a) **Patient/ Public**: those associated with the failure to meet the current and changing needs and expectations of our population – patients & public
b) **Political**: those associated with the failure to deliver government or local membership policy
c) **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
d) **Social**: those relating to the effects of changes in demographic, residential or socio-economic trends
e) **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
f) **Environmental**: those relating to the environmental consequences of progressing NHS C&M's strategic objectives
g) **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 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 – both an inherent (pre-controls) rating and a current (with existing controls) rating
- Risk proximity

Supporting procedures and the current NHS C&M risk management proformas will be available on the ~~corporate intranet~~ICB Staff Hub. Training and guidance will be available from the Corporate Affairs and 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. In the short term, a target score above the optimal risk appetite level may be approved by the relevant ICB Committee or the Board.

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, I~~the Operational Lead needs to consider and recommend how ~~it~~ risks 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.

Critical risks (20+) are outside of tolerable limits and should be immediately escalated to the relevant Senior Responsible Lead. Consideration should be given to curtailing or ceasing the activity giving rise to the risk where this does not present greater risk.

Scrutiny and Approval

~~The C~~completed risk assessments, including the proposed mitigation treatment, will be quality assured by corporate or place governance leads to ensure that they have been described and evaluated in accordance with this strategy and to promote consistent application across the ICB. Following this they will be submitted to the appropriate Senior Responsible Lead for review and approval prior to inclusion on the relevant risk register.

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The process of risk analysis, evaluation and treatment should be completed within one month of identification to ensure that risks are mitigated, escalated as required and reported promptly.

Where the current risk rating is high, extreme or critical, the risk will be escalated to the appropriate ICB Committee who will scrutinise and approve the mitigation strategy and (at or before year-end) target score. Where an extreme rated target score is proposed, Board approval is required.

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 extreme or critical~~high~~ (15~~2~~+). ~~in the context of the ICB as a whole.~~ This will include risks to corporate and at scale ~~ly delivered~~ objectives and functions and aggregated (in common) and unique risks ~~across~~to 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, including corporate and place risks. ~~(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 at place, both unique and in common with other places, 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.

Critical risks (20+) should be reviewed monthly by the Senor Risk Owner in conjunction with the Operational Lead, with the aim of reducing the risk level as soon as possible.

Following committee approval of the mitigation strategy and target score, extreme and high risks should be reviewed quarterly by Operational Leads, or monthly by exception if mitigating actions are off track or not having the anticipated impact in reducing the risk level.

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

- Confirm that action plans to address risks are being undertaken and on track or 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 or agreed tolerance 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.~~
Moderate and low risks should be subject to a quarterly light touch review by directorate / service / team management sufficient to confirm that the level of risk has not increased and controls remain effective.

Risk Escalation

Risk escalation within NHS C&M supports the established leadership and reporting processes as described and illustrated below and at appendix 3. 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~~

Risk Register	Inclusion / Escalation Criteria	De-escalation Criteria	Oversight by
Board Assurance Framework	• Principal risks to delivery of ICB strategic objectives • Identified by Board / recommended by Executive Team • Approved for inclusion by Board • Extreme / high inherent score • Reviewed annually	• Target score is met and aligned to risk appetite • Board is assured that controls are effective & approves de-escalation • CLOSE if inherent impact score reduces <3 • CLOSE if objective is achieved / no longer required	ICB Board
Corporate Risk Register	• Corporate & place risks scoring 15+ • Major programme / project failure risk meeting criteria for 15+ • Reviewed by ICB Committee & confirmed by Risk Committee	• Current risk score reduces below 15 & confirmed by Risk Committee • CLOSE if inherent impact score reduces <3 • CLOSE if objective is achieved / no longer required	ICB Board
Committee Risk Registers	• BAF risks assigned by Board for assurance oversight • Corporate and place risks rated high+ • Major programme / project failure risk meeting criteria for high+	• Current risk rating reduces below high & confirmed by Committee • CLOSE if inherent impact score reduces <3 • CLOSE if objective is achieved / no longer required	ICB Committee
Place Delivery and Assurance Framework	• Principal risks to delivery of Place strategic objectives • Identified by Place Partnership Board / recommended by Place Leadership Team • Approved for inclusion by Place Partnership Board • Extreme / high inherent score • Reviewed annually	• Target score is met and aligned to risk appetite • Place Partnership Board is assured that controls are effective & approves de-escalation • CLOSE if inherent impact score reduces <3 • CLOSE if objective is achieved / no longer required	Place Board / Leadership Team
Place Risk Registers	• Place risks (unique & in common) rated high+ • Major place programme / project failure risk meeting criteria for high+	• Current risk score reduces below 8 & confirmed by Place Leadership Team • CLOSE if inherent impact score reduces <3	Place Board / Sub-Group

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		• CLOSE if objective is achieved / no longer required	
Directorate Risk Registers	• All risks owned by a corporate or place directorate	• CLOSE if inherent impact score reduces <3 • CLOSE if objective is achieved / no longer required	Management Team

Low and moderate risks will be recorded on the appropriate directorate, programme or project risk register. They will be managed through ~~monthly~~ quarterly 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.~~ Following approval of the mitigation strategy and (in year) target score, t~~T~~hey will be managed through ~~monthly~~ quarterly 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 15~~2~~+ 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~~ Critical 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 (mlcsu.ig@nhs.net).

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

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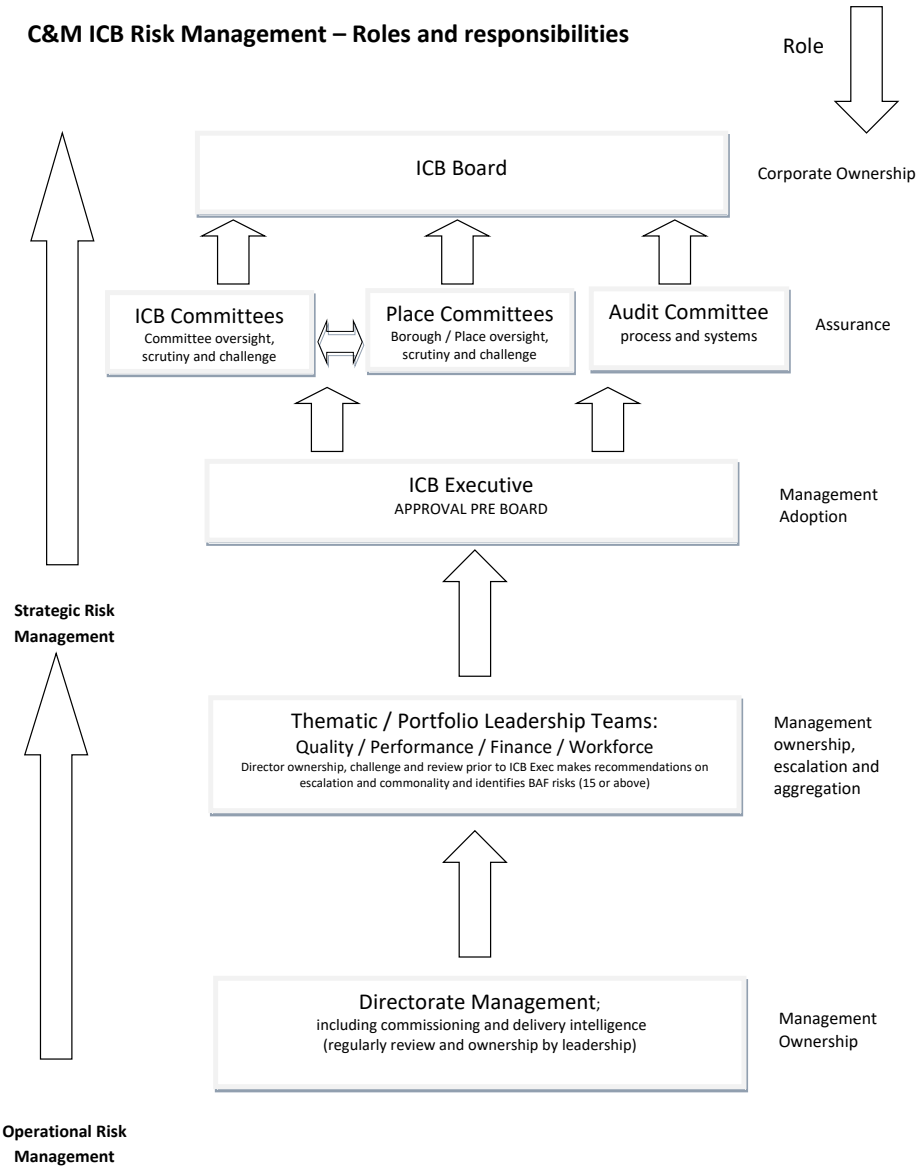
ICB Risk Escalation Process*

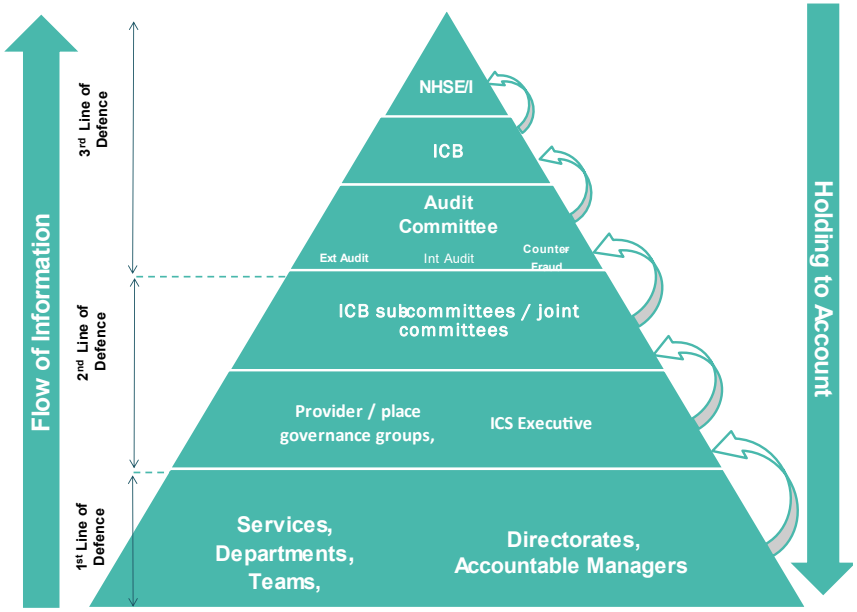


** This focusses on the ICB's risks – i.e. it is NHS-specific. Non-NHS partners may also need to escalate risks in accordance with their risk management / assurance processes.*

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~~ICB Staff Hub. Training and guidance will be available from the Corporate Affairs and 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~~Committee.

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~~ Corporate Risk Register. The committees will escalate any items requiring action or decision by the Board.

Audit Committee Assurance Role
The Audit Committee, supported by the Risk Sub 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~~Sub Committee 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~~A Corporate or Place Governance Lead 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%)	**Safety** - multiple deaths which is responsibility of ICB. Multiple permanent injuries or irreversible health effects. An event affecting >50 people. **Finance** - significant financial loss - >1% of ICB budget **Reputation** - failure to be authorised, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence	**Safety** - multiple deaths which is responsibility of ICB. Multiple permanent injuries or irreversible health effects. An event affecting >50 people. **Finance** - significant financial loss - >1% of delegated Place budget **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 is responsibility of ICB. 14 days off work - affects 16 – 50 **Finance** - major financial loss of 0.5-1% of ICB budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public	**Safety** - individual death / permanent injury/ disability which is responsibility of ICB. 14 days off work - affects 16 **Finance** - major financial loss of 0.5-1% of delegated Place budget **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 is responsibility of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Finance** - moderate financial loss - less than 0.5% of ICB budget **Reputation** - conditions imposed on authorisation by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction	**Safety** - moderate injury or illness, requiring medical treatment e.g. fracture which is responsibility of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Finance** - moderate financial loss - less than 0.5% of delegated Place budget **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 **Finance** - minor financial loss less than 0.2% of ICB budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB	**Safety** - minor injury or illness requiring first aid treatment **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 Place
1	Negligible (<5%)	**Safety** - none or insignificant injury due to fault of ICB **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation	**Safety** - none or insignificant injury due to fault of ICB **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

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.

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients. **Health Outcomes & Inequalities** – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	Moderate (25% > - 50%)	**Safety** - moderate injury or illness, requiring medical treatment e.g. fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget **Reputation** - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	Minor (<25%)	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards

		Health Outcomes & Inequalities – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	Negligible (<5%)	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

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.

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Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Low Risk	Moderate Risk	High Risk	Extreme Risk	Critical 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.

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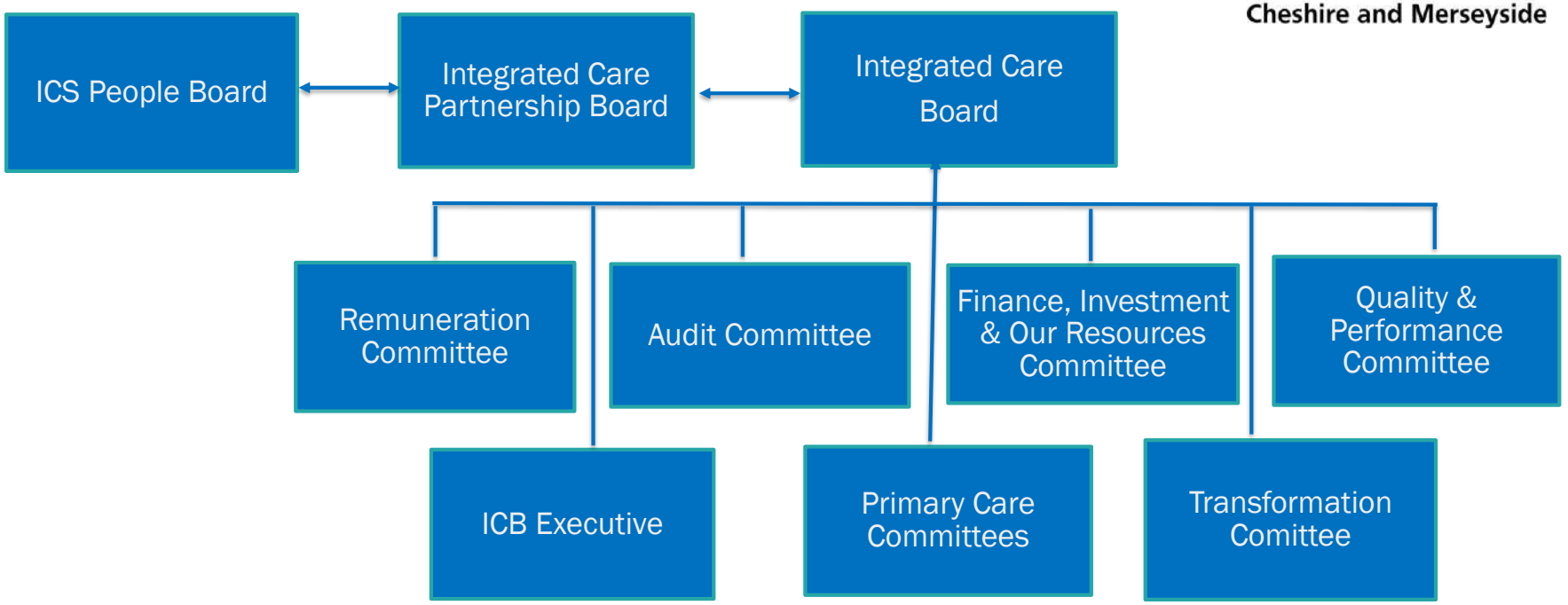
Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	A	B	C

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

~~Appendix 2 – NHS C&M Governance Structure~~

ICS Governance Schematic

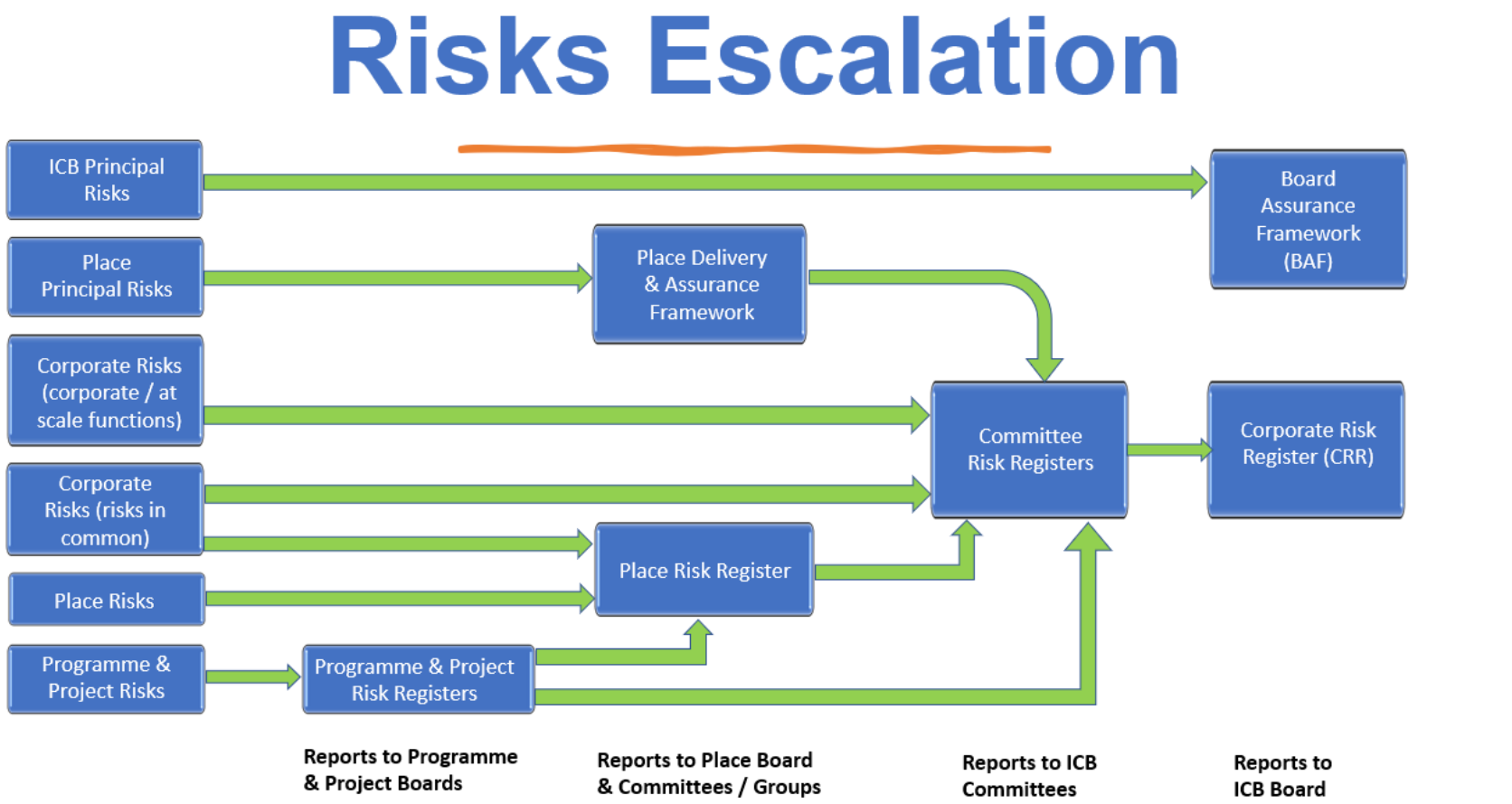
NHS
Cheshire and Merseyside



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

Appendix 2 – NHS C&M Governance Structure

~~Appendix 2 – NHS C&M Governance Structure~~



NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/03/24/13

Report approved by: Tony Foy, Non-Executive Member, Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	12 March 2024

Key escalation and discussion points from the Committee meeting
Alert
n/a
Advise
The Remuneration Committee: • learned about the results of an evaluation of the readiness and competency of the deputies for the ICBs Executive and Place Directors. The report showed that the ICBs Directors had confidence in their direct deputies to act up and provide short term cover, but acknowledged that direct permanent replacements for existing Directors who might leave the organisation would likely have to come from external candidates. It was explained that many Deputies could benefit from more experience in organisations outside of the ICB to help them develop their skills and knowledge and to help them succeed in getting a Director role within an ICB in the future. Committee members were informed about the work in progress for an ICB Leadership Development Programme, advancing appraisals and dynamic conversations and work in progress to help promote a more diverse workforce. The Committee noted the report. • deferred a report on the suggested plans to recruit to senior roles within Cheshire West place after Delyth Curtis became the CEO of Cheshire West and Chester Council in July 2023.
Assure
n/a

The next meeting of the Committee is scheduled for 11 June 2024.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Highlight report of the Chair of the ICB Children and Young Peoples Committee

Agenda Item No: ICB/03/24/14

Report approved by: Raj Jain, ICB Chair, Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Children and Young Peoples Committee

Committee Chair	Raj Jain
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	14 February 2024

Key escalation and discussion points from the Committee meeting

Alert

n/a

Advise

The Children and Young Peoples Committee:

- received a presentation from two Cheshire and Merseyside Young Persons Health Equity Champions, which outlined the role of the Health Equity Champions, the work that had been undertaken across Cheshire and Merseyside by the Champions to capture what is important to young people. Committee members agreed that the Committee meetings should have a standing item on its agenda for different children and young people's representatives to attend and address the Committee
- had an update on the thought leadership development programme that is underway that is focused on around harnessing system working to deliver improved outcomes for children and young people. Committee members heard about the key issues that have arisen from stakeholder engagement before moving on to group discussions about how to utilise budgets differently as a system to achieve better outcomes, what programmes need to be system wide vs locally driven, and how can we focus on prevention and early intervention better that we do now. At its next meeting in April, Committee members will review the first draft of the thought leadership report
- received a report that proposed the Committees 2024-2025 key priorities and the role of the Committee in planning and shaping the children and young peoples areas of the Cheshire and Merseyside Joint Forward Plan, and holding the system to account for delivery. Committee agreed its five key priority areas: Oral Health, Neurodiversity pathways, Mental Health Transformation Plan/Appropriate Places of Care, Children and Young People edging towards care, and building Children and Young Peoples capability across the system
- received a presentation on the collaborative approach underway by health and care partners across the nine places in Cheshire and Merseyside around developing Children and Young People's Neurodiversity pathways. Committee members heard about the baselining work underway to understand the variance in offer, development of a neurodiversity dashboard focusing on improving outcomes, co-development of a communications and engagement approach with neurodiverse children and young people and their families, development of a workforce plan and a training and education plan. The Committee noted and commended the work underway and confirmed that this area would be a key Committee priority for 2024-25
- received the 'single line of sight report', which is a consolidated report of the work underway my multiple partners around delivery of children and young peoples services within Cheshire and Merseyside. Committee members noted that this report will evolve over the year and will align further to the five identified priorities for the Committee. Committee agreed that it would receive this report three times per year.

Assure

n/a

The next meeting of the Committee is scheduled for 10 April 2024.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Highlight report of the Chair of the ICB Womens Hospital Services in Liverpool Committee

Agenda Item No: ICB/03/24/15

Report approved by: Hilary Garratt, Non-Executive Member, Committee Deputy Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Womens Hospital Services in Liverpool Committee

Committee Chair	Raj Jain, ICB Chair
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	17 January 2024 and 06 March 2024

Key escalation and discussion points from the Committee meeting

Alert

-

Advise

The Committee considered the following at its meeting on 17 January 2024:

- **Programme Update** presentation from Chair of the Programme Board (PB) including the approach to clinical risk management in the short, medium and long-term. The PB's focus will be on the medium-term to long-term solutions, and the PB will have oversight of the progress being made by the Trusts to manage safety and quality in the short-term. It will be important to ensure that short-term actions taken by the Trust(s) do not conflict with the medium and long-term solutions developed through the programme. There will be consistent reporting to the Committee and the Trusts involved in the work to ensure that all the boards receive the same information in a timely manner; this will avoid any misrepresentation of the work throughout the programme. **The Committee noted the progress made to date.**

The Committee considered the following at its meeting on 06 March 2024:

- **Programme Update** presentation from Chair of the Programme Board (PB) including an update on short-term actions being taken by the Trusts. A phase 1 programme plan has been developed and a clinical engagement event has been arranged for the 3 May when the case for change will be shared. This will be a significant engagement event for the programme and the case for change will be a key element of any future business case. **The Committee noted the progress made since the January meeting.**

- **Phase 1 Involvement Activity and Resourcing Plan.** The phase 1 involvement plan was discussed and the approach was agreed in principle. It was acknowledged that further discussions with ICB colleagues were required to agree the resources for the activities described and to consider how existing budgets could be used to support the work. **The Committee noted the approach and that further discussions were required with ICB colleagues to agree the resources required.** It was discussed and agreed that a briefing / communication should go out to stakeholders, and publicly via the Committee Chair's briefing, about the key milestones in the phase 1 programme plan and the intentions to recruit lay people and establish a lived experience reference group. **The Committee agreed that this communication should go out in March before the pre-election period begins**

- **Compliance with Specialised Commissioning Service Specifications.** The Committee discussed the letter from specialised commissioning to LWFT about the services currently provided that do not meet service specifications. It was agreed that meeting these service specifications should inform future plans for improvement and transformation. **The Committee noted that this is a key component of the case for change and creates a real risk for the long-term sustainability of services.**

Assure

The Committee considered the following at its meeting on 17 January 2024:

- **Programme definition and governance arrangements** – this document sets out the scope, dependencies, operational programme arrangements and governance. **The Committee formally approved the programme definition and governance arrangements.**

- **Revised Terms of Reference for the Women's Services Committee.** Following the governance refresh and the establishment of the Programme Board, the terms of reference for the Committee have been streamlined to focus on oversight and assurance. **The Committee formally endorsed the revised Terms of Reference for the Committee.**

- **Terms of Reference for the new Programme Board**. The Committee formally **approved the Terms of Reference for the Programme Board.**

- **Strategic Risks Summary** – the risks were considered and agreed. Further work on the detailed actions and mitigations to be worked up by the programme board. **The Committee agreed that a score of 12+ would be the point of escalation from PB to the Committee.**

The Committee considered the following at its meeting on 06 March 2024:

- **Phase 1 Programme Plan.** The Committee approved the Programme Plan.

- **Phase 1 Involvement Activity.** The Committee agreed that the recruitment of lay representatives should proceed as planned.

- **Phase 1 Involvement Activity.** The Committee agreed that the recruitment of lay representatives should proceed as planned.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Highlight report of the Chair of the ICB Transformation Committee

Agenda Item No: ICB/03/24/16

Report approved by: Clare Watson, Assistant Chief Executive, Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Transformation Committee

Committee Chair	Clare Watson
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting(s)	21 March 2024

Key escalation and discussion points from the Committee meeting

Alert

Committee Terms of Reference

The Committee received a paper outlining proposed changes to the Committees Terms of Reference (Appendix One) for its consideration and endorsement. Changes to the Terms of Reference reflected the following key areas:

- a broader role in relation to how the ICB plans in relation to developing our approach to integration "at scale" are progressing, with removal of the narrower reference to Better Care Fund.
- clarification on the Committees role in relation to delegation from NHS England of some specialised commissioning activity
- consistency of content, format and authority with other Committees of the ICB
- change to Chair arrangements where the Committee Chair would be drawn from one of the ICBs Non-Executive members rather than an Executive Director
- updated information on the current sub-group arrangements reporting into the Committee as well as links to our NHS Provider Collaboratives and their governance.
- a change to the name of the Committee to "Strategy and Transformation Committee"

Following discussion at Committee, the revised Terms of Reference were **endorsed** and it was agreed to review them again in September 2024**.**

The Committee is recommending to the Board that it approves the refreshed and revised Terms of Reference (Appendix One).

Cyber Security Strategy

The Committee received a paper providing an overview of the work completed to date on the cyber security agenda and was presented with the draft Cheshire and Merseyside Cyber Security Strategy for Committee endorsement before final approval by the ICB Board. Committee noted the achievements to date and NHS England's dedicated revenue cyber funding for 2024/25. Committee was informed the strategy has also gone to CMAST CEOs and Chairs, and DTCI and was suggested this also presented to the Mental Health, Community and Learning Disability Collaborative.

The Committee agreed to **endorse** the draft Cyber security strategy.

Committee is recommending that the Board approves the policy (Appendix Two)

Committee is also escalating to the ICB Board, risks relating to the medium to long term risks in respect to infrastructure and investments in Cyber Security

being understood and appropriate mitigation strategies are developed as part of the Board Assurance Framework.

Transformation Group Update
Committee received an update from the Cheshire and Merseyside Transformation Group. This included 24/25 Planning work and identified areas to take forward at a Supra Place approach such as Mental Health, Learning Disabilities and Neurodiversity, and the principles for how this would operate. The group also agreed that it would work together with the Cheshire and Merseyside Programme Directors to understand for each thematic area, what would be done once as C&M and which pieces of work required Place implementation capacity. There was also discussion around the Data into Action Board and if this should be reporting through the new Strategy and Transformation Committee rather than directly to the ICB Board to ensure that it drives the development of our strategic plans/priorities.

Committee recommends to the ICB Board that it considers the reporting route for the Data into Action Programme moving from ICB Board to Strategy & Transformation Committee.

Advise

Specialised Commissioning
The Committee received a report on the delegation of Specialised Commissioning Services from NHS England to the three North West ICBs from 01 April 2024. The report had appended key three documents as part of the delegation process:

- the Cheshire and Merseyside Specialised Services Delegation Agreement **(Appendix Three)**
- the North West Commissioning Team Agreement **(Appendix Four)**
- the Terms of Reference for the North West Specialised Commissioning Services Joint Committee **(Appendix Five)**.

These key documents were discussed in detail and were all subsequently **approved by the Committee**, as per the authority delegated to it by the ICB Board at its meeting in January 2024. The Chief Executive will be asked to now sign the agreements in advance of 01 April 2024. Committee also noted that Cheshire and Merseyside Specialised Commissioning Oversight Group will hold it's opening meeting on 27 March 2024 to agree a draft Terms of Reference and workplan and this will be reported to the next Transformation Committee for approval.

Assure

Joint Forward Plan
The Committee received a paper and a presentation that provided an update on the development and content of the NHS Delivery Plan (NHSDP) and the associated 2024/29 Joint Forward Plan (JFP). The paper also outlined the progress on the development of All Together Fairer: our Health and Care Partnership Plan as a replacement of the current HCP draft Interim Strategy, and it's the alignment with the All Together Fairer Report. Committee noted the proposed approach around the reframing and alignment of the HCP strategy with All Together Fairer and the development of a refreshed JFP which will include an associated NHS Delivery Plan alongside wider Place and HCP plans.

Risk Update
Committee was updated on the two BAF level risks for the Transformation Committee and was informed that there is no change to the current risk score of the BAF risks (January 24) with the actions and mitigations that are currently in place being considered reasonable in the overall report that went to Board. There is currently no risk register for this committee. All committee members in November and December 2023 were asked to consider if there were any new or emerging risks for the committee to consider. Only two overall risks were identified (Risk regarding the stability of the clinical networks and a risk relating to Specialised Commissioning not being currently localised to Cheshire and Merseyside but held at North West level). It was agreed to add a risk around the resource capacity to deliver the transformation programme, as well as to reflect the programme risks which emerge as part of the development of the Joint Forward Plan. The risk register for the Committee will be presented at each meeting from May 2024.

Committee Annual Report
The Committee's Annual Report was presented which summarised the work of the Committee for the previous 12 months and this was endorsed. This is included as **Appendix Six** for information to the Board.

Committee risk management

The following risks were considered by the Committee and the following actions/decisions were undertaken.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P1 - The ICB is unable to progress meeting its statutory duties to address health inequalities due to failure to secure inward investment or influence partners priorities.	The Committee noted that there is no change to the current risk score of the BAF risks (January 24) and the actions and mitigations that are currently in place were considered reasonable in the overall report that went to board.
P2 - The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities.	

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Service Programme / Focus Area	Key actions/discussion undertaken
Committee Terms of Reference refresh	As outlined earlier in the report. Committee agreed to approved the revised and refreshed Terms of Reference.
Specialised Commissioning	As outlined earlier in the report. Committee approved the key documents which were delegated from the Cheshire and Merseyside Integrated Care Board (ICB) to the Committee for approval.
Joint Forward Plan Update	The paper focused on the current Joint Forward Plan and the associated NHSDP – a revised annual delivery plan will be developed during April and May 2024 which will include enhance programme governance and reporting processes to ensure a robust delivery approach. Committee noted work being taken.
Cyber Security Strategy	The development of a Cyber strategy and associated implementation plan aims to manage and mitigate the risk of a cyber-attack on the constituent organisations across Cheshire and Merseyside and its services. Committee endorsed the strategy before being presented to ICB Board for final sign off.

Appendices

Appendix One: Updated Committee Terms of Reference

Appendix Two: NHS Cheshire and Merseyside ICB Cyber Security Strategy

Appendix Three: Cheshire and Merseyside Specialised Services Delegation Agreement

Appendix Four: North West Commissioning Team Agreement

Appendix Five: Terms of Reference for the North West Specialised Commissioning Services Joint Committee

Appendix Six: Transformation Committee Annual Report

NHS
Cheshire and Merseyside

C&M ICB Strategy and Transformation Committee

Terms of Reference
Version 4.0

Document revision history

Date	Version	Revision	Comment	Author / Editor
01 July 2022	1.0	Initial ToRs		Ben Vinter
15 September 2022	2.0	Initial proposed revisions		Natalie Robinson
19 October 2022	2.1	Revisions following agreement at the September Committee Meeting		Neil Evans
15 November 2023	3.0	Refresh of ToR		Natalie Robinson
20 February 2024	4.0	Refresh of ToR to incorporate feedback from committee members		Neil Evans

Review due: November 2024

1. Introduction

NHS C&M has been established to

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

The Strategy and Transformation Committee (the "Committee") is established by NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside') as a Committee of its Board in accordance with its constitution.

These terms of reference, which must be published on the NHS Cheshire and Merseyside 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 of NHS Cheshire and Merseyside.

The Committee is a non-executive led forum, and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS Cheshire and Merseyside.

2. Role and Purpose

The Committee has been established to support NHS Cheshire and Merseyside in the delivery of its statutory duties and provide assurance to its Board in relation to the delivery of strategy in alignment of those duties. It shall:

- Provide an NHS Cheshire and Merseyside, incorporating Place. and Provider Collaborative leadership forum to consider the development and implementation of the Joint Forward Plan (JFP) and the revised Health and Care Partnership (HCP) strategy and policy and plans of Cheshire and Merseyside securing continuous improvement of the quality of services.
- Connect with and ensure alignment of at scale programmes as may be developed by any of the constituent parts of the Cheshire and Merseyside Integrated Care System (ICS): programmes reporting to NHS Cheshire and Merseyside or Provider collaboratives as appropriate.
- Ensure that our transformational plans support our statutory financial duties to operate within our allocated budget as an ICB and NHS System.
- Support the NHS Cheshire and Merseyside financial strategy, ensuring commissioning, transformation and improvement activities and plans deliver operational and financial benefits, and value for money.
- Connect with, refer issues for clinical consideration to and develop responses to actions or issues identified by the NHS Cheshire and Merseyside Clinical Effectiveness Group or other appropriate fora as established.
- Support and champion a culture to actively innovate and disrupt, continuously improving and leading change, consistent to that as outlined within the NHS Impact Framework.
- Ensure programme activity overseen by the Committee follows the agreed ICB programme management methodology.
- Apply the intelligence led priorities included in our Joint Forward Plan and developed by the Data into Action Board, ensuring the evidence base drives population and clinical led decision making.

- Ensure there is a consistent focus on and prioritisation of reducing health inequalities and improving outcomes and ensure that the delivery of NHS Cheshire and Merseyside and HCP strategic and operational plans.
- In undertaking its decisions and recommendations, consider the impact on people's health and wellbeing, quality of services, efficiency, and sustainability.

The Committee will also provide assurance to the Board on the delivery of the following statutory duties:

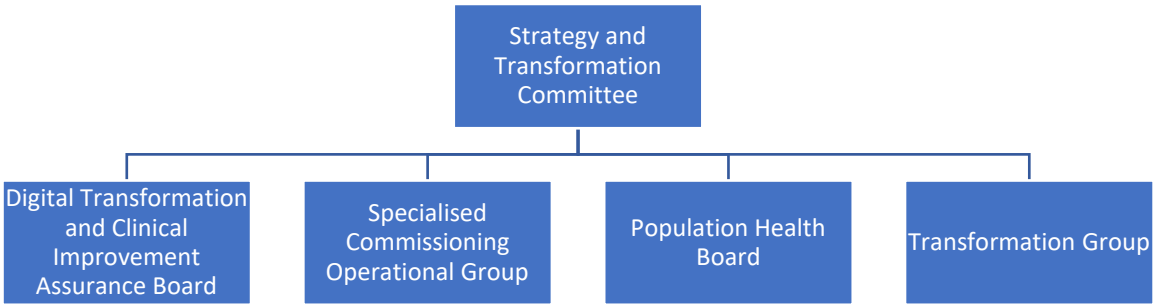
- *Duty to commission certain specified health services*
- *Duty as to reducing inequalities*
- *Duty as to patient choice*
- *Duty to exercise functions effectively, efficiently, and economically*
- *Duty to obtain appropriate advice*
- *Duty to promote innovation*
- *Duty in respect of research*
- *Duty to promote integration*
- *Duty as to public involvement and consultation (in accordance with ICB direction and potential Place implementation)*
- *Duties as to climate change*
- *Duty to have regard to the wider effect of its decisions in relation to—*
  (a) the health and well-being of the people of Cheshire and Merseyside;
  (b) the quality of services provided to individuals—
    (i) by relevant bodies, or
    (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis, or treatment of illness, as part of the health service in Cheshire and Merseyside;
  (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in Cheshire and Merseyside.

In order to deliver this, the responsibilities of the Committee will include:

a) Overseeing the development and review of NHS Cheshire and Merseyside plans in response to the HCP's developed strategy, ensuing they take account of the population need, and include the engagement and collaboration of partners and the VCFSE sector.
b) Overseeing the development of NHS Cheshire and Merseyside's operational and transformational plans (our Joint Forward and Annual Delivery Plan), supporting alignment of Place priorities at an aggregate level, and engaging with partners across the wider system (including VCSE and the social care sector).
c) Ensuring our plans and clinical commissioning policies follow the principle of proportionate universalism with the ambition to reduce health inequalities and reduce avoidable mortality.
d) Overseeing the development and delivery of work programmes that support the NHS Cheshire and Merseyside strategy and operational plans (our Joint Forward and Annual Delivery Plan), including oversight of areas developing joint commissioning with partner organisations (and making recommendations to the Board on their approval as required).
e) Receiving reports on transformation delivery, including financial management and escalating issues to the ICB as appropriate.

f) Receiving updates on the progress in delivery of Cheshire and Merseyside Provider Collaboratives agreed annual delivery programmes.
g) Oversee implementation of the duties of NHS Cheshire and Merseyside in relation to delegated Specialised Services following the delegation of commissioning arrangements from NHS England including delivery of the annual plans and joint commissioning arrangements with other ICBs,
h) Linking with the Primary Care Committees to ensure the system wide, population-based approach is implemented to other delegated NHS England functions.
i) Identifying opportunities at a Cheshire and Merseyside or Supra Place footprint for the transformation and integration of services to support the delivery of effective, high quality, accessible health and care services learning from the best practice taking place within Place Partnerships.
j) Ensuring that transformation activities promote the improvement of population health and wellbeing outcomes within our communities as well as addressing health inequalities, prioritising investment /disinvestment and ensure cost effective care is delivered, developing an evidence-based commissioning/decommissioning framework.
k) Ensuring that plans and decisions are underpinned and informed by communications and engagement with key stakeholders, including the local population as appropriate.
l) Taking account of collaborative commissioning activities, including those of clinical networks, to ascertain if they will have wider contracting / financial implications for NHS Cheshire and Merseyside (for referral to the Board if appropriate).
m) Overseeing and providing senior Board level sponsorship to programmes integral the social value contribution of NHS Cheshire and Merseyside.
n) Making decisions in line with its remit in accordance with the financial delegation of the Committee as well as that of Executive Directors and directors present, in line with the NHS Cheshire and Merseyside SORD
o) Making recommendations on investment and significant commissioning decisions to the Board that are outside of the authority of the Committee that lead to a more financially sustainable health care system.

Established Sub Groups at April 2024



Noting that where relevant the committee will consider information from other groups or sources in order to fulfil its role and purpose.

3. Authority

The Committee is authorised by NHS Cheshire and Merseyside to:

- Make decisions on commissioning decisions for services and areas within the remit of the Committee and within the limits as set out in the ICB's Schemes of Reservation and Delegation (SORD), Standing Financial Instructions and the Financial Plan of the ICB.
- Seek any information or assurance 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) as outlined in these terms of reference
- 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
- Bring matters to the attention of other Committees of NHS Cheshire and Merseyside to investigate or seek assurance where they fall within the remit of that Committee
- Make recommendations to or escalate issues to the Board of NHS Cheshire and Merseyside or the Cheshire and Merseyside HCP,
- Produce an annual work plan to discharge its responsibilities
- 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 SORD but may /not delegate any decisions to such groups without the approval of the Board of NHS Cheshire and Merseyside
- Commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

For the avoidance of doubt, in the event of any conflict, the NHS Cheshire and Merseyside Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference, other than the committee being permitted to meet in private.

4. Membership & Attendance

4.1 Members

The Committee membership shall be confirmed by the Board of NHS Cheshire and Merseyside via approval of the Committee terms of Reference and in accordance with the NHS Cheshire and Merseyside Constitution.

Membership of the Committee may be drawn from individuals employed by or appointed by NHS Cheshire and Merseyside: individuals drawn from partners within the wider health and social care system; and other individuals / representatives as deemed appropriate for the delivery of the Committees remit.

The Committee members shall be:

- At least one Non-Executive Director (Chair of the Committee)
- Assistant Chief Executive (Deputy Chair of the Committee)
- At least one of the NHS Cheshire and Merseyside ICB Board Partner Member(s) - Providers of Primary Medical Services
- ICB Executive Director of Nursing and Care or designated representative
- ICB Executive Director of Finance or designated representative
- ICB Associate Medical Director (Transformation)
- Two ICB Place Directors
- Local authority representative from DASS and DCS[1]
- ICB Director of Population Health
- A representative from each of the Cheshire and Merseyside Provider Collaboratives

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The ICB Chief Executive may attend as determined necessary.

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

4.2 Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote.

- ICB Chief Digital Information Officer
- ICB Associate Director of Digital Transformation and Clinical Improvement
- ICB Associate Director of Programme Delivery and Assurance
- ICB Associate Director of Strategy and Collaboration
- Head of Programme Delivery (CMAST Provider Collaborative)
- A representative from the ICB Place Associate Directors of Transformation and Partnerships Group
- A representative from Healthwatch
- A representative from VCFSE

[1] linked to place director nomination to ensure full coverage

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5. Meetings

5.1 Leadership

The Committee shall be chaired by a Non-Executive Member of the NHS Cheshire and Merseyside Board. They will appoint a Deputy Chair.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative NHS Cheshire and Merseyside Non-Executive Member or Executive Director to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, the Deputy Chair will be asked to Chair the meeting. On the occasion where both the Chair and Deputy Chair are unable to Chair an item due to a conflict of interest, then another member of the Committee, without any conflicts, will be asked to chair the Meeting for that item.

5.2 Quorum

A meeting of the Committee is quorate if the following are present:

- At least five Committee members in total, of which this must consist of;
    - The Chair or Deputy Chair
    - At least one clinically qualified member
    - At least one ICB Director (or their nominated deputies).

**If regular members are not able to attend, they should make arrangements for a representative to attend and act on their behalf.*

5.3 Decision-making and voting

Decisions will be taken in accordance with the Standing Orders and Operational Standing Orders of NHS Cheshire and Merseyside and within the authority as delegated to the Committee and its members. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only voting members, as identified in the “Membership” section of these terms of reference, may cast a vote. Each member is allowed one vote, and a majority will be conclusive on any matter.

A person attending a meeting as a representative of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with Section 6, no member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication. Decisions will be recorded and formally minuted and ratified at a subsequent formal meeting of the Committee.

5.4 Frequency

The Committee will meet in private.

The Committee will normally meet six times each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board of NHS Cheshire and Merseyside, ICB Chair or ICB Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.5 Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Records of members' appointments and renewal dates are retained, and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings.

5.6 Accountability and Reporting Arrangements

The Committee is accountable to the Board of NHS Cheshire and Merseyside and shall report to the Board on how it discharges its responsibilities.

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.

The Committee will also submit copies of its confirmed minutes to the Board of NHS Cheshire and Merseyside following each of its meetings.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

6. Behaviours and Conduct

Members will be expected to conduct business in line with the NHS Cheshire and Merseyside values and objectives and the principles.

Members of, and those attending, the Committee shall behave in accordance with NHS Cheshire and Merseyside constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the NHS Cheshire and Merseyside Managing Conflicts of Interest Policy at all times. In accordance with the NHS Cheshire and Merseyside policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- Comply with NHS Cheshire and Merseyside policies on standards of business conduct which include upholding the Nolan Principles of Public Life.
- Attend meetings, having read all papers beforehand.
- Arrange an appropriate deputy to attend on their behalf, if necessary.
- Act as 'champions', disseminating information and good practice as appropriate.
- Comply with the NHS Cheshire and Merseyside administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

<u>Equality diversity and inclusion</u>
Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

7. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

NHS
Cheshire and Merseyside

Cheshire and Merseyside ICS: Cyber Security Strategy

May 2023

CONTENTS

What does the ICS Cyber Security Strategy cover?

NHS Cheshire and Merseyside

01 Executive Summary

EXECUTIVE SUMMARY (1/3)

NHS Cheshire and Merseyside

In response to the 2019 NHS Long Term Plan, NHS England established 42 **Integrated Care Systems (ICSs)** across England, each led by an **Integrated Care Board (ICB)**, including our **Cheshire and Merseyside (C&M) ICS.** ICSs have facilitated NHS collaboration with local councils and other key stakeholders to take responsibility for improving the health and well-being of local residents, collectively coordinating services and managing resources.

We have an ambitions vision **to enable everyone in C&M to have a great start in life**, and get the support they need to stay healthy and live longer. To achieve it, we need to continue to develop and maintain **a secure health and care system** across C&M. We can achieve this by **levelling up our digital tools and services**, and ensuring they are **cyber secure and resilient** by working together.

Five-Year Cyber Security Strategy

Our vision is to become **cyber leaders amongst our peers** by contributing to developing and maintaining a **secure health and care system** across C&M. We will achieve this by **protecting our organisations,** as well as **information systems and critical assets** that support **our essential functions** from cyber threats, ensuring the safety of our staff and patients.

As a result, we have designed this **five-year C&M ICS Cyber Security Strategy** to enable us to strengthen our security posture and further improve organisational resilience. As such, this Strategy document details our:

- Proposed **cross-community cyber security initiatives,** which will enable us to take advantage of economies of scale that come from working as one;
- Approach to **minimising the impact of cyber incidents** and ensuring patient data security;
- Proposes an ICS-wide **cyber security governance structure** that maximises value; and
- Defines **clear metrics**, in a form of Key Performance Indicators (KPIs) to **measure success**.

Key considerations in developing this Strategy

We wanted to ensure that the Strategy **builds upon existing foundations** to **tackle the challenges we face**, and **take advantage of opportunities** open to us. External drivers, such as the **2023 Department of Health and Social Care (DHSC) Cyber Security Strategy,** our **Digital and Data Strategy**, as well as key NHS and cyber security frameworks, such as the NHS **'What Good Looks Like' framework** and **NIST Cybersecurity Framework,** guided development of the Strategy to ensure our alignment with their requirements and **industry good practice**. Additionally, we have worked with **primary stakeholders** across the C&M ICS, running workshops to identify nine fundamental strategic objectives we would like to **achieve over the next five years** and ensure that the Strategy **meets the security needs of ICS partner organisations.**

EXECUTIVE SUMMARY (2/3)

NHS Cheshire and Merseyside

Strategic objectives

At the core of this Cyber Security Strategy there are **nine strategic objectives** with corresponding **activities** to be delivered across a five-year timeline **by the ICS Regional Security Operations Centre (R-SOC) and Cyber Centre of Excellence (CCoE)**, overseen by the **Cyber Management Board.**

Working with key stakeholders across the ICS, we have identified our **current state for each objective**, defined **our target state**, and discussed a number of **detailed activities** we would need to complete to achieve each objective. In turn, each activity has been assigned **an accountable lead**, one of four **priority levels for implementation** and a **list of dependencies** that should be achieved prior to commencement. Working through these activities will enable us to level up organisational cyber security resilience throughout C&M ICS, thereby cementing our position as cyber leaders across the ICS landscape.

1. The first strategic objective, centred around Cyber Governance, outlines our aspiration for the C&M ICS to effectively and efficiently lead, drive, and oversee cyber security activities across all ICS partner organisations. To help us achieve this, the Strategy also proposes a governance approach we can implement.
2. Objective two, Cyber Risk Management, recommends that the C&M ICS and its partner organisations utilise a shared language when it comes to cyber risk, applying a unified approach to identifying and mitigating cyber risk to its shared critical systems and services wherever possible.
3. For objective three, Cyber Incident Management, we want to collaboratively and consistently identify, respond to, and recover from cyber security incidents, minimising their impact on critical services, utilising the standardised incident management approaches and ICS-wide SOC capability.
4. The fourth objective, Cyber Procurement, calls for the C&M ICS to maximise its use of nationally provisioned tools and services to eliminate procurement duplication and take advantage of economies of scale, while effectively managing third-party suppliers.
5. Objective number five, Third-Party Risk Management, proposes that the C&M ICS uses a risk-based third-party risk management framework to effectively manage cyber security risk associated with third-party tools and services, while selecting, contracting, monitoring and off-boarding external service providers.
6. The sixth, People and Culture, focuses on our objective to have a strong cyber security culture, backed by a robust training and awareness programme that communicates and embeds staff's security responsibilities, and allows the ICS to constantly upskill staff on cyber security.
7. Under objective seven, Knowledge Sharing and Good Practice, we want the C&M ICS to have a robust cyber security knowledge-sharing culture, where all personnel use tools to efficiently exchange and discuss industry good practices, information, and recent cyber activities.
8. Meeting the eighth objective, Cyber Security Policies and Processes, will help us manage cyber security across all ICS partner organisations by standardising and improving cyber security policies and processes, as well as identifying and correcting policy non-compliance.
9. Finally, the ninth strategic objective, Cyber Baselines and Minimum Standards, focuses on the C&M ICS supporting its partner organisations in upholding robust cyber security and improving cyber resilience by developing and supporting the roll out of minimum cyber security standards across the ecosystem.

EXECUTIVE SUMMARY (3/3)

NHS Cheshire and Merseyside

Cyber security governance

In order to move on as an ICS from the current 'collaboration of the willing' to a **well-functioning, ICB-led unit** and **effectively implement this ICS Cyber Security Strategy**, we require a strong **foundation of effective cyber governance and accountability** model. Consequently, we are proposing a change from how we currently operate under the Cyber Leadership Group and Cyber Group, to set up an **ICS Cyber Management Board** that will be accountable and monitor implementation of this Strategy.

Reporting to the **Digital Transformation and Clinical Improvement Board**, the Cyber Management Board will include: an **ICB Chief Technology Officer** (CTO), which will chair the Board, an **ICS Lead Chief Information Officer** (CIO) that would fulfil the role of a Senior Information Risk Officer (SIRO), a **Data Protection Officer** (DPO) – two roles mandated by the NHS 'What Good Looks Like' framework for an ICS to have, an **ICS Cyber Services Managing Director**, a **Security Operations Centre Lead,** a **Cyber Centre of Excellence Lead**, as well as other cyber leadership members.

To implement the activities outlined within this ICS Cyber Security Strategy and meet our desired strategic objectives, we are also proposing installation of an **ICS Regional Security Operations Centre (R-SOC)**, which will provide a 24/7 monitoring, detection, and response capabilities to the ICS partner organisations'; and **ICS Cyber Security Centre of Excellence (CCoE),** that will consist of a group of ICS-dedicated cyber security professionals that will drive implementation of the Strategy activities, ICS-based cyber services, and support the C&M ICS partner organisations in matters of cyber security when required.

Next steps

In order to reach our target state and implement the activities under the strategic objectives within the next five years, a certain level of **investment and buy-in** is required. Some activities would require investment into **technical solutions**, such as monitoring and alerting systems for the R-SOC to meet objective three which is focused on cyber incident management; or a knowledge management platform to meet the knowledge sharing and good practice objective.

However, majority of the identified activities would predominantly rely on **time and effort from dedicated resources** as part of the ICS R-SOC and CCoE. We are already developing a target operating model for our R-SOC and resources that would support the CCoE when it comes to cyber incident response, but to proceed with understanding the full scope of the resources we need, we need to now **agree and approve** the C&M ICS Cyber Security Strategy, the ICS cyber governance structure, as well as the services the ICS will deliver centrally to our partner organisations.

02 Context

BACKGROUND

Who are we and where are we coming from?

NHS Cheshire and Merseyside

For years, health services and care services across England were run by separate organisations with different objectives. In 2016, health services and local authorities from across **Cheshire and Merseyside (C&M)** formed what would later become the C&M Integrated Care System (ICS), to provide a forum for NHS leaders, local authorities and other key organisations to come together, as equal partners, and **take collective action**.

The NHS Long Term Plan, published in 2019, aimed towards an even greater **integration of regional healthcare services**. Subsequently, 42 ICSs, each led by an **Integrated Care Board (ICB),** have been established across England. The ICSs have become a driving force for the NHS to collaborate with local councils and other key stakeholders to take responsibility for improving the health and well-being of local residents, coordinating services, and managing resources collectively. One of which, the **C&M ICS,** was designated by NHS England in April 2021, with the following vision:

> **"We want everyone in Cheshire and Merseyside to have a great start in life, and get the support they need to stay healthy and live longer."**

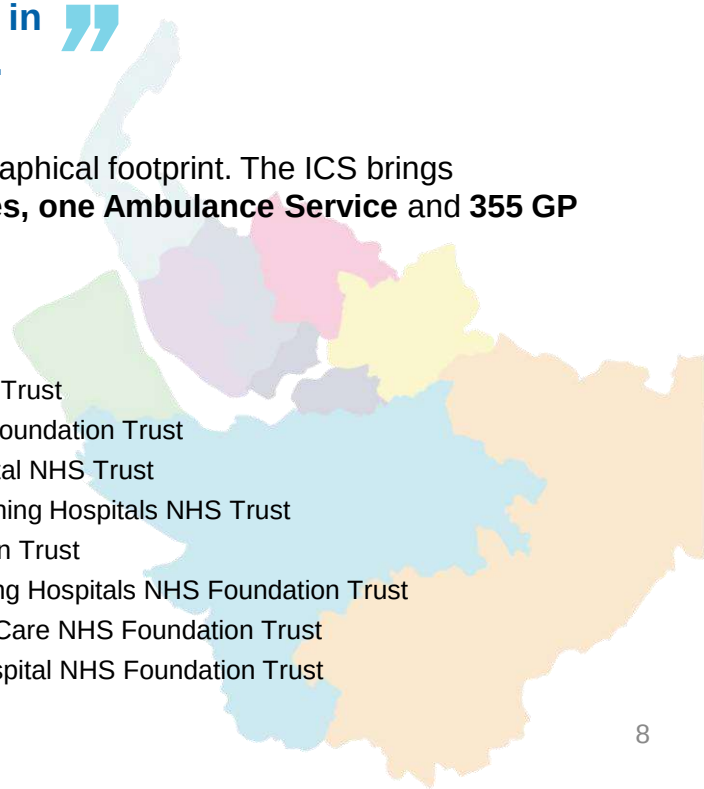
C&M is **one of the largest ICSs** in England with a population of **2.7 million people** living across a large and diverse geographical footprint. The ICS brings together **nine places**, each with an individual **local authority**, **17 NHS Provider Trusts, two NHS Provider Collaboratives, one Ambulance Service** and **355 GP practices**.

Local Authorities

Cheshire East Council
Cheshire West and Chester
Halton Borough Council
Knowsley Council
Liverpool City Council
St. Helens Council
Sefton Council
Warrington Borough Council
Wirral Council

NHS Provider Trusts

Alder Hey Children's Hospital NHS Foundation Trust
Bridgewater Community Healthcare NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Clatterbridge Cancer Centre NHS Foundation Trust
East Cheshire NHS Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust
Liverpool University Hospitals NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Mersey Care NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
Walton Centre NHS Foundation Trust
Warrington and Halton Teaching Hospitals NHS Foundation Trust
Wirral Community Health and Care NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust



BACKGROUND

What do we need to do now?

NHS Cheshire and Merseyside

To support and enable more efficient health and care delivery, C&M has ambitious plans to **better use digital tools and data** generated across the region. To do this, we need a strong **digital infrastructure** that is **accessible, secure** and **resilient**.

Currently, we have an established **Cyber Group**, spearheaded by the **Cyber Leadership Group**, which came together in the aftermath of the 2017 Wannacry cyber attack that impacted the NHS across the nation. The Group began as a **'collaboration of the willing'** to explore the potential for creating closer working arrangements to mitigate the effects of a future cyber attack and improve the collective cyber security posture across the patch.

Developing a Cyber Security Strategy

With the recent establishment of the C&M ICS, we now have the opportunity to move beyond the **'collaboration of the willing',** establish **a new governance structure**, as well as develop and deliver **cross-community cyber security initiatives to strengthen security and improve organisational resilience further**.

This document forms our **five-year C&M ICS Cyber Security Strategy,** which defines a common approach to cyber security management, and responsibilities across the ICS and partner organisations, so that we are able to deliver patient care securely and efficiently. This Strategy:

Aims to **maximise the value** of leveraging national NHS tools and services	Aligns to the **industry requirements**, **frameworks** and **standards**
Proposes an **ICS-wide cyber security governance structure,** with dedicated ICS resources to deliver on our goals	Defines **clear metrics to measure the success of the Strategy** and its impact on the cyber security state
Provides a comprehensive **risk-based approach** to minimising the impact of **cyber incidents** and **ensuring patient data security**, from standardising an approach to working with third parties to uplifting cyber security training and awareness	

While we are keen to level up our cyber security posture across the ICS in a way that **meets the needs of our ICS partner organisations**, we also wanted to ensure alignment with the overall direction of the Department of Health and Social Care (DHSC) cyber security strategy, our overarching mission and vision, as well as the goals of the ICS Digital and Data strategy.

03 Ensuring Alignment

Health & Social Care Cyber Security Strategy

Aligning with national direction (1/2)

NHS Cheshire and Merseyside

In March 2023, **DHSC** published its cyber security strategy in response to the HM Government's cyber security strategy, titled 'A cyber resilient health and adult social care system in England: cyber security strategy to 2030', setting out **an approach to cyber security** with **a vision of a health and social care sector that is resilient to cyber attack**, in turn improving the safety of patients and service users through good cyber security.

The strategy is centred **around five pillars**, underpinned by the Cyber Assessment Framework (CAF) and its four key objectives. As part of the strategy, each pillar is supported by desired outcomes:

Focus on greatest risks and harms	Defend as one	People and culture	Build secure for the future	Exemplary response and recovery
Achieving a **common understanding of risks** and increasing the **visibility of the attack surface**, whilst ensuring that any cyber security **mitigations are proportionate** to the potential threat **in line with NIS regulations**.	Organisations **work in partnership** on cyber security, **sharing threat intelligence**. There are **clearly defined accountabilities** across leadership and boards, which make **full use of available national tools** and services.	Organisations **attract and retain** a diverse cyber security workforce, where **cyber security is a valued profession**. All **understand their role** in maintaining good cyber security, and this is **underpinned by a 'just' culture**.	Organisations understand **emerging cyber risks** and how to manage them, ensure that **critical supply chain risk is managed**, any new tools and services are **secure by design** and **in line with CAF requirements**.	National, regional and local responses to cyber incidents **minimise the impact of cyber attacks** on patient and service user care.

Health & Social Care Cyber Security Strategy

Aligning with national direction (2/2)

NHS Cheshire and Merseyside

Each of the five pillars details an **approach as to how each of the desired outcomes will be achieved**. A number of those approaches **fall upon the ICSs** to drive and implement. All of these requirements and obligations are embedded within our ICS Cyber Security Strategy and its underlying activities.

Focus on greatest risks and harms

1. I**dentify and record risks** within the ICS, including supplier cyber risks, that would affect the local system's ability to function.
2. Engage with a plan at ICS level to **mitigate risks**, **invest** and **review progress**.
3. Ensure cyber risk is reviewed **as part of corporate risk management**.
4. Ensure providers maintain an **understanding of their suppliers' cyber security** controls and risks.

Defend as one

1. Create an **ICS-wide cyber security strategy** to drive security across the system.
2. Allocate **funding** to deliver the strategy, **establishing governance** to review and align plans and ensuring member and wider partner involvement.
3. Align with agreed **cyber security standards** when using existing and new cross-organisational systems.

People and culture

1. Develop an **appropriately resourced** and accountable **cyber security function**.
2. Develop strategies to recruit and **maintain an adequate cyber support** function.
3. Embed cyber security decisions into **multi-disciplinary forums** across the ICS.
4. Encourage **collaboration across organisations** to share good practice and address deficiencies.
5. Lead by example in implementing a **'just culture'** at ICS level in approaching any identified cyber vulnerabilities.

Build secure for the future

1. Build systems and services **cyber secure by design**, including engaging suppliers on their cyber security in alignment with national engagement.
2. Regularly engage organisations on **compliance with standards and frameworks.**
3. Develop a **cyber security programme** underpinning the objectives of the strategy and outline **milestones and metrics**.

Exemplary response and recovery

1. Outline **responsibilities and expectations of partner organisations** for response and recovery, as well as for a central accountable function.
2. Ensure the **ICS have a plan** for responding to, managing, and recovering from a cyber attack.
3. Lead on ICS-wide **incident response exercising**.
4. Understanding the outcomes from dry-runs and post-incident reviews, **identifying and responding to common themes.**
5. Develop **ICS resilience** with the **impact of loss or unavailability of critical ICS-wide systems** understood and mitigations agreed.

C&M ICS Strategy 2021-2025

Aligning with our regional direction (1/2)

NHS Cheshire and Merseyside

In June 2021, we agreed an overarching **five-year strategy for improving health and wellbeing in Cheshire and Merseyside** in response to the NHS Long Term Plan published in 2019. As part of the strategy, we have defined a clear **mission**, **vision** and **strategic objectives:**

C&M ICS Mission

We will tackle health inequalities and improve the lives of the poorest fastest. We believe we can do this best by working in partnership.

C&M ICS Vision

We want everyone in Cheshire and Merseyside to have a great start in life, and get the support they need to stay healthy and live longer.

Strategic Objectives

We have set four strategic objectives within the five-year strategy:

1. Improve population health and healthcare

2. Tackling health inequality, improving outcomes and access to services

3. Enhancing quality, productivity and value for money

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

We recognised that the aspirations, objectives and activities defined within our new ICS Cyber Security Strategy needed to **align with the overarching mission, vision and strategic objectives** of the ICS strategy, while interlinking key success measures outlined in the '**What Good Looks Like' framework**. This is important for us to ensure that our approach to cyber is commensurate with our approach to improving health and care outcomes across C&M more broadly. For example:

- As part of the overall mission, we want to **work collaboratively and effectively as a partnership** and so we have **defined a clear governance approach** that will enable us to do so.
- To be able **to provide the support to everyone in C&M** to stay healthy to achieve our overall vision, we want to **build strong foundations** by agreeing on **baseline security controls and minimum standards** that would ensure continued security of health services and products.
- In line with objective three, we want to **streamline our cyber procurement practices** to **increase the value for money** of working with third party providers.

C&M ICS Digital and Data Strategy 2022-2025

Aligning with our regional direction (2/2)

NHS Cheshire and Merseyside

To meet the overarching ICS mission, vision and objectives, we have also defined **a three-year Digital and Data Strategy**, as the investment into and the use of **digital solutions and data** will help us **generate insights** to support care planning, improve our services, tackle inequalities, and in turn **support better health and care delivery for all**. As such, **we want to be the most digitally advanced and data driven ICS in England by 2025**. This underpins **our vision**, where we want to see:

- A digitally empowered C&M population taking increased control of their own physical and mental health and well-being.
- A data and digital confident and competent workforce able to deliver safe, effective and efficient care.
- A secure and reliable insight and intelligence provision, underpinning joined up care planning and able to understand and help meet evolving population need.

To achieve this vision, we have identified **three key goals** we want to meet:

01 **Strong digital and data foundations**

02 **'At scale' digital and data platforms**

03 **System wide digital and data tools and services**

In turn, to meet these goals, we identified **three strategic principles** that inform and underpin the changes we want to see, and **four mechanisms for change:**

STRATEGIC PRINCIPLES

- **Outcome focused**
- **Care profession led**
- **Inspired by a rich diversity of people**

MECHANISMS FOR CHANGE

- **Transformation programmes**
- **Robust governance, leadership and management**
- **Partnerships**
- **Future proofing and innovation**

Our **C&M ICS Cyber Security Strategy** inherently builds upon this vision, goals and strategic principles – **from overarching mission and vision**, down to **strategic objectives and activities** that sit at the heart of the Strategy.

04 Our Mission and Vision

C&M ICS CYBER SECURITY STRATEGY

Where are we going from a cyber perspective?

Cheshire and Merseyside

Aligning with the mission, vision and strategic objectives outlined within the DHSC Cyber Security Strategy, C&M ICS five-year Strategy, the three-year Digital and Data Strategy, as well as considering key NHS frameworks and requirements, such as those outlined within the **'What Good Looks Like' framework**, we have developed this **five-year C&M ICS Cyber Security Strategy**.

We have designed this Cyber Security Strategy to enable us to **continue to develop and maintain a secure health and care system** across C&M. We can achieve this by **levelling up our digital tools** and **services** and **ensuring they are cyber secure** and **resilient**.

The following **mission, vision** and **strategic objectives** sit at the heart of the Strategy and form a solid foundation for levelling up our organisational cyber position:

Cyber Security Mission

To level up organisational cyber security across C&M ICS we will:

- Establish a **shared governance model** built on **smart foundations**
- Champion **safe and secure practices**
- Encourage **collaboration** within a **supportive cyber security culture.**

Cyber Security Vision

We want to become **cyber leaders amongst our peers** by contributing to developing and maintaining a **secure health and care system** across C&M. We will achieve this by **protecting our organisations,** as well as **information systems and critical assets** that support **our essential functions** from cyber threats, ensuring the safety of our staff and patients.

Cyber Security Strategic Objectives

At the core of this Cyber Security Strategy there are **nine strategic objectives** with corresponding **activities** to achieve them, to be delivered across a five-year timeline that we will use to deliver on this mission. These objectives, which are designed to guide the C&M ICS in uplifting our cyber security maturity, are detailed across pages 21-57. Each objective has been assigned one of four **priority levels for implementation** (immediate-term, short-term, medium-term or long-term. Working through these activities will enable us to level up organisational cyber security resilience throughout C&M ICS, thereby cementing our position as cyber leaders across the ICS landscape.

05 Putting the Strategy Together

CYBER SECURITY STRATEGY DEVELOPMENT

What have we considered?

Cheshire and Merseyside

There were several **considerations and key drivers** that influenced the development of the C&M ICS Cyber Security Strategy. We wanted to ensure that the Strategy **builds upon existing foundations** to **tackle the challenges similar organisations face**, and **take advantage of opportunities** open to us:

EXISTING FOUNDATIONS

Established Cyber Programme

Two Cyber Groups currently drive the cyber programme across the C&M ICS:

1. Wider 'Cyber Group' open to all cyber leads from C&M ICS organisations.
2. 'Cyber Leadership Group' comprising of a CIO and cyber leads from several ICS partner organisations.

Existing Collaboration Model

Members from several ICS partner organisations come together to collaborate on cyber security matters, as well as share knowledge and experience, as part of the 'collaboration of the willing'.

CHALLENGES

People, Process and Technology Challenges

As with other health care industry organisations, C&M ICS faces a number of challenges. Some of these challenges include cyber governance, attraction and retention of suitably qualified resources, efficient procurement and effective incident management.

Resource Constraints

The funding streams available to ICSs are still in the process of being finalised, against a backdrop of a broader funding squeeze across the NHS. This is expected to limit the financial resources available for investment in improving cyber maturity.

OPPORTUNITIES

Economies of Scale

The C&M ICS aims to build robust cyber resilience by managing cyber security investments and limited resources at the ICS level. This should enable us to properly leverage the economic benefits that come from our regional size and scale.

Working with NHS England

NHS England supports its organisations across the NHS with comprehensive cyber tools and services, including advice, assessments, and training. It's critical that we use them to avoid duplication and missed opportunities across ICS partner organisations.

CYBER SECURITY STRATEGY DEVELOPMENT

How have we put the Strategy together?

Cheshire and Merseyside

Keeping in mind the foundations we have built, our challenges and opportunities, existing ICS cyber security-related documentation and an understanding of **our current cyber security state** served as the starting point for this Cyber Security Strategy. External drivers, such as the **DHSC and other ICS security and digital strategies, key NHS and cyber security frameworks** guided development of the Strategy to ensure our alignment with their requirements and **industry good practice**. Lastly, we have worked with **primary stakeholders across the C&M** ICS to identify fundamental strategic objectives we would like to **achieve over the next five years** and ensure that the Strategy **meets the security needs of ICS partner organisations**.

Existing Documentation

C&M ICS existing documentation served as foundational understanding of the current ICS state from both an overall strategic and a cyber current state perspective.

This included previous HCP cyber strategy, existing cyber policies and plans, such as Incident Response Plan and governance committees' Terms of Reference.

Other Strategies

Key strategies, such as the DHSC Cyber Strategy, the ICS overarching Strategy, the ICS Digital and Data Strategy, and all their underlying visions and objectives, set the direction for our Cyber Security Strategy and its structure, as well as helped to identify and align our strategic objectives.

Stakeholder Workshops

We invited key stakeholders across the C&M ICS and NHS Digital to a series of workshops to discuss the ICS's cyber security current state, prioritise what we would like to achieve over the next five years in uplifting our cyber security position, and identify key ways we would be able to achieve the desired state.

These activities ranged from technical elements such as third party risk management to people-driven initiatives, including celebrating individual staff contributions towards organisational cyber security culture.

Frameworks and Good Practice

The success measures detailed within the NHS 'What Good Looks Like' framework were incorporated in our Strategy alongside the National Data Guardian's Data Security Standards, detailed in the Data Security and Protection Toolkit (DSPT).

Our knowledge of the cyber security good practice, such as the National Institute of Standards and Technology (NIST) Cyber Security Framework (CSF) and Security of Networks & Information Systems (NIS) CAF, was similarly foundational in defining key activities that would help us achieve our strategic objectives.

06 Objectives and Key Activities

STRATEGIC OBJECTIVES

How will we meet our ICS Cyber Security Strategy mission and vision?

NHS Cheshire and Merseyside

To achieve the **ICS cyber security mission and vision**, we have defined **nine cyber security objectives** to guide our efforts to uplift our cyber security state. As outlined on page 19, these objectives were identified through discussions with key stakeholders, documentation review and consideration of industry good practice, while considering the goals and guiding principles of wider relevant strategies. They are:

1	**Cyber Governance**	The C&M ICS leads, drives, and oversees cyber security activities across all ICS partner organisations, underpinned by a clear governance and efficient reporting structures.
2	**Cyber Risk Management**	The C&M ICS and its partner organisations utilise a shared language when it comes to cyber risk, applying a unified approach to managing and mitigating cyber risk to its shared critical systems and services wherever possible.
3	**Cyber Incident Management**	The C&M ICS collaboratively and consistently identifies, responds to, and recovers from cyber security incidents, minimising their impact on critical services, utilising the standardised incident management approaches and ICS-wide SOC capability.
4	**Cyber Procurement**	The C&M ICS maximises its use of nationally provisioned tools and services to eliminate procurement duplication and takes advantage of economies of scale, while effectively managing third-party suppliers.
5	**Third-Party Risk Management**	The C&M ICS uses a risk-based third-party risk management framework to effectively manage cyber security risk associated with third-party tools and services, while effectively selecting, contracting, monitoring and off-boarding external service providers.
6	**People and Culture**	The C&M ICS has a strong cyber security culture, backed by a robust training and awareness programme that communicates and embeds staff's security responsibilities, and allows the ICS to constantly upskill staff on cyber security.
7	**Knowledge Sharing and Good Practice**	The C&M ICS has a robust cyber security knowledge-sharing culture where all personnel use tools to efficiently exchange and discuss industry good practices, information, and recent cyber activities.
8	**Cyber Security Policies and Processes**	The C&M ICS manages cyber security across all ICS partner organisations by standardising and improving cyber security policies and processes, as well as identifying and correcting policy non-compliance.
9	**Cyber Baseline and Minimum Standards**	The C&M ICS supports its partner organisations in upholding robust cyber security and improving cyber resilience by developing and supporting the roll out of minimum cyber security standards across the ecosystem.

STRATEGIC OBJECTIVES

How are our strategic objectives structured?

Cheshire and Merseyside

For each of the **nine objectives** within our Strategy, we have identified our current state in each of the areas, and discussed with our key stakeholders where we want to give to. To help us get there, each of o the objectives is underpinned by a **set of actionable activities** to be delivered over the **next five years**, by **the ICS Regional Security Operations Centre (R-SOC) and Cyber Centre of Excellence (CCoE),** led **by the Cyber Management Board** (as outlined on pages 60-62).

For each of the underlying activities, we have defined an **accountable lead group** that would commission and oversee each task, delegating it as appropriate, to the R-SOC, CCoE, or individual partner organisations.

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)

We have also assigned each activity a **priority for implementation**. This would assist us with sequencing of activities over the five year timeline and help us achieve easy wins first.

We envision that any activity with **'immediate'** priority, we would look to implement within the first six months; **'short-term'** within the second half of the first year; **'medium term'** within year two and three; and **'long term'** within year four and five.

However, to bring these activities to life, we require **dedicated ICS resources** as part of the ICS Cyber Management Board, the **ICS R-SOC** and the **ICS CCoE,** and consequently, these timelines would be dependent on the level of resourcing available.

Where an activity may have a **dependency** on another, we have added the relevant references as well, to help us with sequencing of activities.

STRATEGIC OBJECTIVES

1. Cyber Governance

NHS Cheshire and Merseyside

A clear ICS cyber governance structure that defines accountabilities for cyber security and establishes well-defined lines of responsibility provides the necessary foundation and oversight for effective cyber risk management.

Where are we now?

The C&M ICS has established a strategic and an operational cyber security group in a form of 'Cyber Steering Group' and the 'Cyber Group'. Furthermore, each ICS partner organisation has developed its own approaches to regularly report to their respective boards on cyber security matters and cyber risk. However:

- Membership of ICS Cyber Group and the Cyber Steering Group currently relies on a 'collaboration of willing'. As such, there is no clear governance arrangements and underpinning processes in place to ensure coordination and collaboration between ICS partner organisations to manage cyber security effectively and minimise cyber risk exposure.
- The ICS has no formal process to oversee each ICS partner organisation's cyber investments, nor formal discussion on estimating expenses of cyber security measures and loss associated with cyber incidents to support the decision-making of budgeting at board level.

Where do we want to get to?

The ICS sets the tone from the top and cultivates **strong capabilities to lead, drive, and oversee** cyber security activities across ICS partner organisations.

Importantly, oversight of **cyber security programme** across the ICS is underpinned by a well-defined governance structure, **clear accountability and efficient reporting processes** that apply across all ICS partner organisations.

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reach the desired state:

- Agree, maintain, and implement a Cyber Security Strategy across the ICS.
- Agree a new ICS cyber governance structure and develop an ICS cyber target operating model.
- Establish a reporting mechanism to communicate effectively with executive management on cyber security.

STRATEGIC OBJECTIVES

1. Cyber Governance Activities (1/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Governance:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Governance	**1a**	Share, review and agree the ICS Cyber Security Strategy with the ICS leadership and the ICB, securing the necessary buy-in. As part of this, agree on the proposed ICS cyber governance approach, amending as required. This may include a review what services and capabilities the ICS should centrally provide to ICS partner organisations to maintain robust cyber security across the board, and what dedicated ICS resources may be required to achieve this.	ICS Cyber Management Board	Immediate	
	1b	Implement the agreed governance arrangements between the ICS, the ICB and the ICS partner organisations, communicating roles and responsibilities with relevant groups and individuals, including the ICS Data Protection Officer (DPO), Senior Information Risk Officer (SIRO) and Clinical Safety Officer (CSO).	ICS Cyber Management Board	Short-Term	1a
	1c	Review, update, or where necessary develop, the Terms of Reference for the key ICS governance groups to set clear responsibilities and accountabilities of the ICS cyber function. The responsibilities should cover the requirements of the 'What Good Looks Like' framework, including a responsibility to regularly review all ICS partner organisations' local digital strategies, cyber security plans and programmes.	ICS Cyber Management Board	Short-Term	
	1d	Develop a target operating model defining the capabilities, skills and resources required for an effective ICS cyber function per the agreed governance structure. The model shall consider the collaboration with other departments (e.g., legal, finance, HR) on cyber security matters.	ICS Cyber Management Board	Medium-Term	1a, 1b

STRATEGIC OBJECTIVES

1. Cyber Governance Activities (2/3)

Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Governance:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Governance	**1e**	Share the ICS Cyber Security Strategy for input with key clinical representatives across the ICS, making changes to strategic objectives and actions where required based on clinical representatives' feedback.	ICS Cyber Management Board	Short-Term	1a
	1f	Review and agree the implementation timelines, as well as owners of strategic objectives activities (including identification of a named individual, where appropriate) outlined within this Cyber Security Strategy.	ICS Cyber Management Board	Short-Term	1a
	1g	Implement this Cyber Security Strategy, setting direction for ICS partner organisations regarding cyber security and track progress against key objectives.	ICS Cyber Management Board	Medium-Term	1a
	1h	Establish a mechanism review the Strategy on a regular basis to ensure it is still aligned with the C&M ICS and its partner organisations' requirements, as well as with any new requirements from NHS England.	ICS Cyber Management Board	Long-Term	
	1i	Document and publish a set of cyber security requirements for the ICS partner organisations to comply with based on the objectives outlined within this Cyber Security Strategy, communicating the value of an organised approach to cyber security management. As part of this: • Identify accountable roles for meeting the cyber security requirements within the ICS partner organisations. • Define escalation paths and consequences for not complying with the set requirements. • Define a system (responsibilities, expertise, investment) for providing support to ICS partner organisations to build and enhance local cyber security arrangements, where appropriate.	ICS Cyber Management Board	Long-Term	1g

STRATEGIC OBJECTIVES

1. Cyber Governance Activities (3/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Governance:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Governance	**1j**	Develop an approach to, and perform an assessment of the cyber security capabilities at each ICS partner organisation, including but not limited to risk management, vulnerability management and data security.	ICS Cyber Management Board	Long-Term	1i
	1k	Identify and manage investments into cyber security at the ICS-level, including for cyber security resources and investments in modern infrastructure to retire old, unsupported systems, while defining responsibilities for budget management.	ICS Cyber Management Board	Long-Term	
	1l	Develop a report template (including a set of cyber security metrics, e.g., risk metrics) to be populated and shared with ICS executive management boards on the overall status of the cyber across the ICS on a regular basis, e.g., quarterly.	ICS Cyber Management Board	Long-Term	1j
	1m	Establish a mechanism to collate relevant data and populate the cyber report to be shared with ICS executive management boards on a regular basis.	ICS Cyber Management Board	Long-Term	1l

STRATEGIC OBJECTIVES

2. Cyber Risk Management

Cheshire and Merseyside

Cyber security can have a significant impact on clinical care of patients. To ensure the most critical cyber security threats and risks facing the ICS are managed in a timely manner, a centralised view of the biggest cyber security risks is crucial, so that they can be managed in the most efficient and effective way.

Where are we now?

We understand that each ICS partner organisation has an approach to identifying, recording and reporting cyber security risk. However:

- There is no one common risk assessment approach or tracking tool used by ICS partner organisations to record and track cyber security risks in a consistent manner. Organisations use several tools to record risks, such as Datix and Ulysses.
- As different ICS partner organisations have a different approach to cyber risk identification, assessment and management, there is no consistent risk language used across the ICS.
- There is currently no central view of the biggest risks facing the ICS as a whole, and no agreed ICS cyber risk appetite.
- At the moment, there is no accurate and complete view of the ICS operating environment (including IT assets) and attack surface (including external connections).

Where do we want to get to?

The ICS and its partner organisations have a **common understanding of cyber security risks** facing the ICS and are able to obtain **a single view** of the biggest cyber risk facing its **essential systems and services**.

The ICS supports its partner organisations by **investing** into the necessary tools and processes to **mitigate and manage the biggest risks**.

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reach the desired state:

- Establish a central ICS-level cyber risk coordination function and select a risk assessment methodology.
- Develop ICS-wide guidance and templates for identifying and managing cyber risk consistently.
- Create an ICS-level centralised cyber risk repository and establish a mechanism to enable accurate risk reporting.

STRATEGIC OBJECTIVES

2. Cyber Risk Management Activities (1/4)

Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Risk Management:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Risk Management	**2a**	Establish a central ICS-level cyber risk coordination function, identifying key roles required to coordinate identification of the highest cyber risks facing the ICS and where necessary, organise appropriate ICS-wide mitigating actions to manage the biggest cyber risks facing the ICS effectively and efficiently.	ICS Cyber Management Board	Short-Term	1b
	2b	Assess whether it would be necessary for the ICS to define, agree and communicate a cyber risk appetite.	ICS Cyber Management Board	Short-Term	
	2c	Select a cyber security risk identification and assessment methodology (e.g., CRAMM, IRAM2) that would meet requirements of an established framework (e.g., ISO 27001) that could be used by ICS partner organisations to identify, score and collate cyber risks in a consistent manner. The methodology should aim to be flexible enough to meet the needs of the ICS partner organisations, while allowing the ICS to use a consistent language and obtain a consolidated view of cyber risk.	ICS Cyber Management Board	Short-Term	
	2d	Share the cyber security risk identification and assessment methodology with the ICS partner organisations.	ICS Cyber Management Board	Short-Term	2c
	2e	Develop and deliver the necessary training on the chosen risk identification and assessment framework for all individuals involved in cyber risk management across the ICS to ensure consistency in implementation of the framework.	ICS Cyber Management Board	Medium-Term	2c, 2d

STRATEGIC OBJECTIVES

2. Cyber Risk Management Activities (2/4)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Risk Management:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Risk Management	**2f**	Develop and share with each ICS partner organisation the necessary templates and guidance for cyber risk identification and assessment in line with the chosen methodology and framework for the ICS partner organisations to implement as required. This could include: • Guidance for identifying cyber security risks facing each ICS partner organisation, utilising information including, but not limited to: ▪ Threat intelligence from wider NHS sources (such as NHS England); ▪ Information from the ICS Secure Operations Centre (SOC) and other tools available to each organisation for identification and management of vulnerabilities and incidents; ▪ Results of Business Impact Assessments (BIAs) and asset prioritisation activities; and ▪ Outputs from third party risk assessments. • Guidance for scoring cyber security risks (including a risk scoring matrix and accompanying definitions of ratings). • Cyber security risk response strategies. This may include defining an approach to: ▪ Identifying and implementing security controls to mitigate identified cyber security risks. Wherever possible, it should ensure that assets and services are 'secure by design'. ▪ Accepting risks (including templates to log and guidance for approving risk acceptance). ▪ Transferring risks. • Guidance for review of identified cyber security risks, their ratings and risk owners on a regular basis, including following major changes and incidents.	ICS Cyber Management Board	Medium-Term	2c, 2g

STRATEGIC OBJECTIVES

2. Cyber Risk Management Activities (3/4)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Risk Management:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Risk Management	**2g**	Develop and provide each ICS partner organisation with guidance to identify, assess and prioritise IT assets in a standardised manner. This may include: • A framework for prioritising IT assets for cyber security protection based on their data classification, criticality and business value, linking this to the BIAs. • Guidance for documenting, regularly reviewing and maintain the IT asset inventories to identify new, relocated, re-purposed and outdated IT assets. • A processes to detect and manage shadow IT. • A process to proactively identify and manage systems when they approach their end-of-life phase (e.g., unsupported or outdated software).	ICS Cyber Management Board	Short-Term	
	2h	Centrally collate and identify assets and services that are shared across the ICS, mapping out the ecosystem, identifying interdependencies. This should include the nationally provisioned NHS tools and systems, as well as services provided by individual ICS partner organisations to others. As part of this, identify the services and assets that are of highest criticality and importance to the ICS as a whole, using a standardised ICS approach.	ICS Cyber Management Board	Medium-Term	2g
	2i	Create an ICS-level centralised cyber risk repository to be able to identify and track cyber risks that come up across multiple organisations to enable the ICS to obtain a complete picture of cyber risk and align on cyber risk mitigation.	ICS Cyber Management Board	Long-Term	2c, 2d, 2e

STRATEGIC OBJECTIVES

2. Cyber Risk Management Activities (4/4)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Risk Management:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Risk Management	**2j**	Use the ICS-level centralised cyber risk register to identify any common gaps across the ICS in current security controls (preventative, detective, and corrective). Identify, where possible, mitigating controls (tools, services or processes etc.) that can be centralised and rolled out across the ICS to close the identified gaps and support mitigation of common risks.	ICS Cyber Management Board	Long-Term	
	2k	Determine and agree risk metrics and indicators to be consistently reported by the ICS partner organisations to the ICS across the ICS to track cyber risk. This may include number of cyber security risks outside the agreed risk appetite.	ICS Cyber Management Board	Long-Term	2c, 2d, 2i, 2f
	2l	Establish a mechanism to collate required information in a timely manner to enable accurate cyber risk reporting.	ICS Cyber Management Board	Long-Term	2k
	2m	To assist with meaningful cyber risk reporting to executive management boards, develop guidance and examples for reporting cyber risk posture, such as by using storytelling methods to communicate cyber risk, its likelihood and possible impact that relates to patient experience and safety.	ICS Cyber Management Board	Long-Term	2k, 2l

STRATEGIC OBJECTIVES

3. Cyber Incident Management

NHS Cheshire and Merseyside

Effective cyber incident management and response that is grounded in cyber security risk management can help organisations effectively respond to and recover from cyber attacks, minimising the adverse impact of cyber events on essential functions.

Where are we now?

The C&M ICS has drafted an incident management plan and runs incident management desktop exercises. Moreover, most ICS partner organisations have their patch and remediation activities tracked and recorded in in IT Health Assurance Dashboard after scanning for vulnerabilities and monitoring system configuration. However:

- There is currently no 24/7 coverage for incident response, particularly where ICS partner organisations consume shared services, and there are improvements to be made within the rate at which critical information about incidents is shared across the ICS partner organisations.
- There is a lack of standardisation in Disaster Recovery, Business Continuity and Incident Management Plans across the ICS.
- There is currently no centralised tool, such as a Security Information and Event Management tool (SIEM) or a SOC, to monitor the cyber security state and detect cyber incidents across the ICS.

Where do we want to get to?

The C&M ICS **identifies, responds and recovers** effectively from cyber security incidents, **minimising their impact** on the delivery of essential services, **utilising a regional SOC capability**. The ICS has a **standardised approach** to Incident Management, Disaster Recovery and Business Continuity Planning, facilitating **collaboration between ICS partner organisations** to effectively manage incidents and disaster events.

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reaching the desired state:

- Develop ICS-wide Disaster Recovery, Business Continuity, Incident Management policies, processes, plans and templates.
- Establish an ICS-wide SOC and centralised ICS monitoring systems.
- Establish a mechanism for testing cyber incident management plans engaging a variety of stakeholders.

STRATEGIC OBJECTIVES

3. Cyber Incident Management (1/4)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Incident Management:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Incident Management	**3a**	Establish an ICS-level incident management policy that would outline the ICS's approach to cyber incident management. The policy should consider how the ICS partner organisations should work together to identify and respond to incidents that may impact more than one ICS partner organisation. The policy should also: • Define and document clear accountabilities and responsibilities (including decision making) for cyber incident management within the ICS, as well as outline clear lines of command and escalation paths to ensure timely and appropriate communication and decision making. In addition, define an approach to working with other relevant departments, such as Legal and Information Governance. • Define the approach for cyber incident management, that links to wider Emergency Preparedness, Resilience and Response (EPRR) planning. This should include identification and analysis (including a standardised incident severity and impact rating scale), coordination, escalation and communication (including external, such as law enforcement, providers and suppliers), digital forensics, mitigation, and recovery.	ICS Cyber Management Board	Immediate	
	3b	Develop ICS-level response and recovery documents, plans and playbooks that provide well-defined, organised, cross-community approaches for cyber incident response activities, including criteria for activating the measures and actions to be taken during the most critical period (i.e., initial hours and days of a cyber incident).	ICS Cyber Management Board	Immediate	3a

STRATEGIC OBJECTIVES

3. Cyber Incident Management (2/4)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Incident Management:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Incident Management	**3c**	The ICS should additionally develop and share cyber incident management and response guidance and documentation templates for ICS partner organisations to use where appropriate. This should include: • Templates for local business continuity policy, disaster recovery procedure and incident response plans. • Guidance on data backup and restoration programmes to recover assets that support critical operations in accordance with recovery objective(s) (e.g., Recovery Time Objectives (RTO) and Recovery Point Objectives (RPO)) following a cyber incident.	ICS Cyber Management Board	Medium-Term	3a, 3b, 7b
	3d	Agree and select a communications mechanism to use across the C&M ICS partner organisations in an event of an incident to coordinate responses, where necessary.	ICS Cyber Management Board	Immediate	
	3e	Request and collate a list of incident management and incident response individuals, their responsibilities (per requirements of the ICS-wide cyber incident management policy) and contact information within the ICS partner organisations across C&M. This will enable swift, 24/7 communications and response across the ICS in an event of a wide-spread incident.	ICS Cyber Management Board	Immediate	3a
	3f	Assess whether the current individuals with assigned responsibilities for cyber incident response have the necessary knowledge and tools to perform their assigned tasks. As part of the exercise, identify whether there is a requirement to obtain a cyber incident response retainer with an external third party to perform incident response activities.	ICS Cyber Management Board	Medium-Term	3e

STRATEGIC OBJECTIVES

3. Cyber Incident Management (3/4)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Incident Management:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Incident Management	**3g**	Establish an ICS-wide, R-SOC with cyber-surveillance and incident response capability, or an other equivalent service, to centralise and coordinate security processes and technologies. As part of this, establish an ICS-wide process for reviewing and responding to relevant safety recommendations and alerts from NHS England, the Medicines and Healthcare products Regulatory Agency (MHRA) and the Healthcare Service Investigation Branch (HSIB).*	ICS Cyber Management Board	Long-Term	
	3h	Establish centralised ICS monitoring systems that would enable the ICS to monitor for abnormal or malicious activity within the ICS systems and networks to proactively identify potential cyber security incidents. The monitoring solutions should be backed by sufficient resources, with clearly defined roles and responsibilities.*	ICS Cyber Management Board	Long-Term	
	3i	Develop and conduct regular training on the cyber incident management and response, as well as business continuity and disaster recovery arrangements. This should include: • Tailored training to crisis and incident response teams on the steps to take in an event of an incident per the developed policies, plans and playbooks. • Cyber threat simulations and business continuity exercises for executive management board members, IT personnel, front line and other relevant departments across all ICS partner organisations to educate on common cyber threat scenarios, ways to appropriately identify and respond to cyber incidents and events, and the impact they may have on the ICS and patient care.	ICS Cyber Management Board	Medium-Term	3a, 3b

* Would require investment into technical solutions to deliver.

STRATEGIC OBJECTIVES

3. Cyber Incident Management (4/4)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Incident Management:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Incident Management	**3j**	Develop ICS-level improvement processes and mechanisms to identify opportunities to improve response and recovery capabilities, and update incident management policies, processes, plans and templates, from past cyber incidents, simulations and table-top exercises. This could include: • Lessons learned from ongoing incident handling activities, past cyber incidents, and from incident replated training, and simulation/table-top exercises. • A mechanism to regularly review the assigned roles and responsibilities for cyber incident response to ensure all key cyber incident response roles remain filled by skilled individuals.	ICS Cyber Management Board	Medium-Term	3a,3b,3c,3d, 3f, 3g, 3h, 3i

STRATEGIC OBJECTIVES

4. Cyber Procurement

Cheshire and Merseyside

Established processes for procuring tools and services that place cyber security at its core can not only help manage cyber security risk but similarly improve efficiency of services the C&M ICS can deliver while minimising costs.

Where are we now?

In some partner organisations across the C&M ICS, IT and cyber security teams have developed close relationships with procurement teams to acquire cyber security software and services. However:

- There is currently no single view of all cyber tools and services suppliers and third parties working with the ICS and ICS partner organisations.
- There are inconsistencies within the supplier screening and onboarding process across the ICS partner organisations.
- Procurement is conducted by ICS partner organisations in isolation. This often leads to duplication of tools and software purchased (e.g. Nessus, IT Health Dashboard), leading to greater costs where valuable funds could have been allocated elsewhere (e.g. towards improving patient care).

Where do we want to get to?

The ICS has a **complete view of all its cyber tools and services suppliers**, and is able to **manage them in a consistent manner** that enables the ICS to effectively **examine and manage associated risks**.

The ICS **leverages the nationally provisioned tools and services** wherever possible and is able to capitalise on the **economies of scale** and extract value from minimising duplication in procurement.

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reach the desired state:

- Develop a centralised cyber vendors and suppliers register into the ICS.
- Develop an ICS-wide framework and guidance for procurement of new cyber and tools.
- Define an approach to consistently implement and use NHS-provided national systems.

STRATEGIC OBJECTIVES

4. Cyber Procurement (1/2)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Procurement**:

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
IT Procurement	**4a**	Request ICS partner organisations identify and share a list of all current suppliers and third parties they are working with that provide cyber services and tools. This should also include NHS-provisioned tools, systems and services.	ICS Cyber Management Board	Immediate	
	4b	Develop a centralised register of all cyber suppliers into the ICS, using the information collected from individual ICS partner organisations. The register should include: who the suppliers are, what services and tools they provide, and how long the existing contracts are for. This may be achieved by leveraging NHS England's RiskLedger platform once it goes live.*	ICS Cyber Management Board	Short-Term	4a
	4c	Identify an individual within the ICS that will own and maintain the centralised register of cyber suppliers into the ICS if necessary. Grant access to key contacts within the individual ICS partner organisations to the centralised register and request ICS partner organisations to log new supplier relationships within the register.	ICS Cyber Management Board	Short-Term	4b
	4d	Investigate whether sharing information about supplier pricing across the ICS is permissible to provide cost transparency to partner organisations (subject to any contractual confidentiality prohibitions). Where possible, include the information within the central supplier register.	ICS Cyber Management Board	Short-Term	
	4e	Using the centralised supplier register, identify common cyber suppliers that are used by multiple ICS partner organisations. Where appropriate, upon existing contracts expiry, work to set up ICS-wide contractual agreements with those third parties and vendors to benefit from economies of scale. Where centralised contracts are created, identify a key contact within the ICS to act as the relationship and contract owner with each supplier, as well as to assist ICS partner organisations with joining in on the central agreement.	ICS Cyber Management Board	Medium-Term	4b

* May require investment into technical solutions to deliver.

STRATEGIC OBJECTIVES

4. Cyber Procurement (2/2)

Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Procurement**:

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
IT Procurement	**4f**	Develop an ICS-wide framework and guidance for procurement of new cyber services and tools. This framework should mandate, where appropriate, that ICS partner organisations consult the centralised supplier register when selecting suppliers to encourage consistency in tools used across the ICS and benefit from economies of scale. The framework should outline the steps to be taken and approvals required where none of the listed suppliers meet the requirements of the ICS partner organisation.	ICS Cyber Management Board	Medium-Term	
	4g	Define an approach to consistently implement and use NHS-provided national systems, tools and services across the ICS partner organisations (e.g. NHS login and NHS app, other digital communication and self-service tools, as well as systems that would enable development of an ICS-wide shared care record). As part of this approach: • Use the list of all national tools, systems and services in use across the ICS provided by the ICS partner organisations to identify gaps in usage. • Provide support to those ICS partner organisations currently not using the NHS-wide tools, systems and services to implement them.	ICS Cyber Management Board	Long-Term	

STRATEGIC OBJECTIVES

5. Third-Party Risk Management (TPRM)

NHS Cheshire and Merseyside

Working with third parties can introduce vulnerabilities and cyber security risks into the ICS ecosystem. As such, a standardised third-party risk management approach to assessing and managing third party goods and services is crucial.

Where are we now?

All ICS partner organisations must use and comply with the DSPT, which details a number of assertions for managing third-party risk. Additionally, the Information Governance teams complete Data Protection Impact Assessments (DPIAs) for new systems. However:

- Where DPIAs are completed, they are completed after the tender stage, and there is limited involvement from cyber security teams.
- There is currently no standardised set of clauses and penalties to be included within supplier contracts to address cyber security and non-compliance with agreed arrangements.
- There is limited due diligence over third-party service providers and their subcontractors' cyber security capability, security controls and infrastructure resiliency.
- There is currently no standardised approach for ongoing monitoring of third-party risk, performance, and issues experienced across the ICS.

Where do we want to get to?

The ICS utilises a **comprehensive, risk-based TPRM framework** across all ICS partner organisations that **provides transparency and visibility** into third-party relationships and associated risks.

Each ICS partner organisation is equipped with **sufficient tools and capabilities to mitigate third-party risk** while identifying, selecting, contracting with, monitoring and delivering timely off-boarding of external service providers.

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reach the desired state:

- Develop a TPRM framework to be used across all ICS partner organisations.
- Develop a template of security clauses for contractual agreements with all suppliers into the ICS.
- Develop a platform to share information about supplier performance and issues experienced across the ICS.
- Develop TPRM reporting metrics to obtain a full view of risk posed by third parties.

STRATEGIC OBJECTIVES

5. Third-Party Risk Management (TPRM) (1/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Third-Party Risk Management**:

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Third-Party Risk Management	**5a**	Develop and roll out across the ICS a TPRM framework that would mandate third parties working with the ICS to meet the requirements of an established standard (e.g., ISO 27001). The framework should detail guidance that would enable all ICS partner organisations to: • Assess the risks associated with working with each third party provider and consuming their tools and services, identifying 'high', 'medium' and 'low' risk suppliers; • Manage the risks associated with the third party tools and services dependent on the assigned risk rating. This should ensure that any standard the providers are required to meet is appropriate to the needs of the procuring ICS partner organisation(s). • Gain assurance that third parties uphold their contractual obligations and security arrangements to minimise risk to critical infrastructure and data. This may include regular assurance reviews, depending on the assigned risk rating (e.g., a self assessment regime for those classed as 'low' risk, or annual security controls review for 'high' risk third parties).	ICS Cyber Management Board	Short-Term	
	5b	Develop the standard template(s) of security clauses, including penalty clauses for non-compliance, to be included within contractual agreements with suppliers into the ICS. The standard security clauses may cover a number of cyber security arrangements, including but not limited to, staff screening and clearance requirements, vulnerability management , as well as incident response approaches, in a way that covers how a supplier should work with the relevant ICS partner organisations and other relevant bodies, such as NHS England.	ICS Cyber Management Board	Short-Term	
	5c	Share the security clauses template(s) with ICS partner organisations and mandate their inclusion within each new contract, per the third-party risk management framework.	ICS Cyber Management Board	Medium-Term	5b

STRATEGIC OBJECTIVES

5. Third-Party Risk Management (TPRM) (2/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Third-Party Risk Management**:

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Third-Party Risk Management	**5d**	Develop a platform for ICS partner organisations to share information about supplier performance and issues experienced across the ICS, so organisations can factor any issues into their approach to supplier management (as discussed in workshops as a 'TripAdvisor' solution for ICS suppliers). This may be achieved by leveraging NHS England's RiskLedger platform once it goes live, or the supplier register developed as part of activity 4b.*	ICS Cyber Management Board	Long-Term	4b, 7b
	5e	Investigate whether sharing of third-party audit reports and other forms of third-party assurance (e.g., SOC2 reports) received across the ICS is possible. Where possible, establish a mechanism to share this intelligence across the ICS (e.g., through the solution developed as part of activity 5d).	ICS partner organisations	Long-Term	5d, 7b
	5f	Develop a mechanism for feeding the supplier risk assessment results into the wider cyber risk management approach and cyber risk registers, both ICS-wide and within individual ICS partner organisations per the Risk Management actions.	ICS Cyber Management Board	Long-Term	2c, 2f, 2g

* May require investment into technical solutions to deliver.

STRATEGIC OBJECTIVES

5. Third-Party Risk Management (TPRM) (3/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Third-Party Risk Management**:

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Third-Party Risk Management	**5g**	Develop third party risk management reporting metrics to obtain a full view of risk posed by third parties. This could include number of high risk-rated suppliers into the ICS, number of legacy contracts without standard security clauses, etc. These metrics should be reported and discussed on a regular basis during the Cyber Steering Group and mitigating measures identified to uplift the third-party risk position across the ICS.	ICS Cyber Management Board	Long-Term	5a
	5h	If deemed necessary, develop and share across the ICS partner organisations guidance for executive management board reporting on third party risk management metrics.	ICS Cyber Management Board	Long-Term	5g

STRATEGIC OBJECTIVES

6. People and Culture

NHS Cheshire and Merseyside

People and culture sit at the heart of every organisation. By ensuring that staff are appropriately trained, aware and actively contributing towards cyber security culture, cyber security incidents, such as phishing attacks can be minimised.

Where are we now?

Every staff member across the ICS is required to complete annual training, as mandated by DSPT. Some ICS partner organisations take part in the Cyber Savvy awareness campaign and have Cyber Digital Champions (Bright Sparks) to uplift cyber security culture. However:

- Cyber security is not currently part of the onboarding training within all ICS partner organisations and there is no comprehensive staff cyber training programme across the ICS, and so cyber security training is performed by each individual organisation in isolation.
- IT staff who upskill by undertaking cyber security training, accreditations and certifications paid for by ICS partner organisations are not financially incentivised to stay, leading to retention challenges.
- Currently, the impact of training is not tracked, preventing the identification of improvements in user awareness and additional training needs are not monitored following initial training.

Where do we want to get to?

The ICS has a **strong cyber security culture**, supported by a comprehensive staff **training and awareness programme** that embeds the responsibilities for keeping the ICS **secure** amongst all staff, and enables the ICS to **consistently identify gaps** in cyber knowledge and **upskill staff** as required.

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reach the desired state:

- Publicise a list of free cyber training resources and opportunities across the ICS.
- Assess the existing cyber security skills across the ICS, hiring or upskilling staff to close the gaps.
- Establish an ICS-wide cyber training baseline standard and a system to continuously monitor staff training needs.

STRATEGIC OBJECTIVES

6. People and Culture (1/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **People and Culture:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
People and Culture	**6a**	Identify and collate a list of the current cyber security roles/positions across the ICS, identifying gaps that may exist. As part of this, identify what skills and knowledge are required to effectively fulfil these roles.	ICS Cyber Management Board	Medium-Term	
	6b	Conduct an assessment of skills, competencies and essential cyber qualifications currently possessed by ICS cyber security practitioners. Compare those against the roles, and their skills and knowledge requirements, identified under activity 6a, identifying gaps.	ICS Cyber Management Board	Medium-Term	6a
	6c	Identify and allocate central training funding to upskill staff with cyber security responsibilities (e.g., developers) across the C&M ICS in line with the skills and competencies required to fulfil those roles. The funding should also cover periodically renewing the required qualifications for performing the necessary cyber security responsibilities Identify where external recruitment may be necessary to close the gaps in skills, competencies and knowledge to perform key cyber security roles across the ICS.	ICS Cyber Management Board	Medium-Term	6b
	6d	Develop a comprehensive list of resources and/or cyber security staff training ideas, including making use of free and already available training resources (e.g., Microsoft ESI programme & Skills Development Network) for wider staff. Publicise this resource across the ICS (e.g., via the Cyber Bulletin, or using the knowledge sharing platform outlined in Knowledge Sharing actions).	ICS partner organisations	Short-Term	

STRATEGIC OBJECTIVES

6. People and Culture (2/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **People and Culture:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
People and Culture	6e	Develop an ICS-wide cyber training and awareness programme for all ICS partner organisations' staff. This should utilise a number of methods, from campaigns (e.g., Cyber Savvy), newsletters, phishing simulations, handouts, bite-size training opportunities throughout the year, and online training. Where possible, the training should focus on cyber impact on patient safety and use real-life examples from clinical settings to make the training meaningful. It should also cover the latest cyber trends, cyber threats and emerging issues.*	ICS Cyber Management Board	Medium-Term	
	6f	Embed cyber security training as part of the onboarding process across all ICS partner organisations, covering the most essential topics, outlining staff responsibilities	ICS partner organisations	Medium-Term	6f
	6g	Identify where specialist cyber security training may be required for certain groups, e.g., procurement teams, incident response teams, information asset owners, etc.	ICS partner organisations	Long-Term	6b, 6c
	6h	Where specialist cyber security training may be required for certain groups, develop and roll out the additional training across all ICS partner organisations.	ICS Cyber Management Board	Long-Term	6g
	6i	Define a blueprint for Digital Champions (e.g., the Bright Sparks programme in place in certain ICS partner organisations) that can be implemented across ICS partner organisations to uplift cyber culture, promote cyber knowledge and awareness	ICS Cyber Management Board	Long-Term	

* May require investment into technical solutions to deliver.

STRATEGIC OBJECTIVES

6. People and Culture (3/3)

Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **People and Culture:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
People and Culture	6j	Develop management information on the impact of training delivered. This should aim to track improvements in user awareness after training (e.g., percentage of staff failing phishing exercises) and identify who may require additional training. Consider gamification of training completion and simulation results across the ICS partner organisations	ICS Cyber Management Board	Long-Term	6e, 6f, 6h
	6k	Set up a centrally managed cyber apprenticeship programme to encourage cyber professionals to join the ICS cyber security team. To improve retention, provide those in senior positions with designated time to mentor trainees and contribute towards the success of the training programme. Where there is appetite, develop a scheme to place and rotate apprentices across ICS partner organisations to support local cyber security teams.	ICS Cyber Management Board	Long-Term	

STRATEGIC OBJECTIVES

7. Knowledge Sharing and Good Practice

NHS Cheshire and Merseyside

The ways in which cyber security knowledge is shared can facilitate, or limit adherence to good practice within organisations. Mechanisms that allow users to easily search for and share cyber security information can significantly increase efficiency and improve consistency in cyber practices.

Where are we now?

Knowledge is currently shared across the ICS through the Cyber WhatsApp Group, Cyber Bulletins, the Cyber Associates Network, the wider Cyber Group meetings and the Cyber Teams channel. Calls for assistance are frequently answered, especially when support and ideas are needed and there are ongoing discussions on cyber security good practice. However:

- There is currently no formalised ICS-wide accessible platform or guidance for sharing, storing, managing or classifying cyber security knowledge, contact lists, resources, meeting notes and external materials.
- Although the Cyber Group members are receptive to asking for and offering feedback and ideas, there are fewer instances of celebrating successes, and those that contribute the most to the overall cyber security of the ICS are often not acknowledged.
- There are limited in-person event opportunities for cyber security related learning and knowledge sharing.
- While there is a dedicated C&M workspace focused on 'Future NHS', it is not widely used.

Where do we want to get to?

The ICS has built a **strong cyber security knowledge sharing culture**, where all are given the **opportunities** and **tools** to effectively share and **discuss cyber good practice,** knowledge, innovations in the industry and latest cyber activities. The ICS recognises the **contributions of individuals** in maintaining and enhancing their cyber culture by **celebrating their accomplishments.**

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reach the desired state:

- Create an ICS-wide accessible knowledge sharing platform and corresponding guidance.
- Organise and host regular ICS-wide cyber security events to facilitate knowledge sharing and celebration of success.
- Identify and reward biggest contributors to knowledge sharing platforms.

STRATEGIC OBJECTIVES

7. Knowledge Sharing and Good Practice (1/2)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Knowledge Sharing and Good Practice:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Knowledge Sharing and Good Practice	**7a**	Continue the use of the instant messaging platforms and other existing communication channels across all ICS partner organisations (i.e., the Cyber WhatsApp Group, Cyber Associates Network, Cyber Bulletins, Cyber Teams Channel and C&M Cyber Workspace on 'Future NHS') to promote knowledge-sharing resources and their usage, share cyber security news and intelligence, ask for help from partner organisations where required and continue the ongoing discussions on cyber security good practice.	ICS partner organisations	Immediate	
	7b	Build a centralised ICS-wide knowledge sharing platform* (such as Notion, Microsoft SharePoint or Confluence) to enable all ICS partner organisations to share, organise, store, easily browse and access the cyber security-related information and documentation. The platform should aim to include: • Templates for cyber policies, processes, standard operating procedures, response plans registers, as well as guidance and handbooks available for ICS partner organisations to use. • Security configurations good practice for commonly used applications and software. • Lessons learnt from implementation of tools, systems, services and incidents. • A contact list for key cyber resources across the ICS, e.g., internal and external SMEs, that can be contacted for specialist knowledge and questions. • Cyber security staff training good practice and certification-studying materials. • Where appropriate, records of cyber security meetings (e.g., minutes of Cyber Group) and notes on knowledge gained from industry conferences and events. • Links to external cyber good practice materials, such as reports on the latest cyber trends, cyber threats and emerging issues and details of the regulatory requirements.	ICS Cyber Management Board	Medium-Term	2f, 2g, 3c, 5a, 5c, 5e, 6d, 8c

* Would require investment into technical solutions to deliver.

STRATEGIC OBJECTIVES

7. Knowledge Sharing and Good Practice (2/2)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Knowledge Sharing and Good Practice:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Knowledge Sharing and Good Practice	**7c**	Grant access to this platform to the key individuals across the ICS partner organisations and encourage the use of the platform to upload and access cyber-related documentation and best practice. As part of this, implement a protocol for an ICS assigned resource to review, classify, manage documentation and good practice and notify key contacts across the ICS partner organisations of key new additions.	ICS Cyber Management Board	Medium-Term	7b
	7d	Establish a mechanism to track the biggest contributors to the knowledge sharing platform, in terms of both value and volume (e.g., ICS partner organisations), to recognise and reward them for their efforts, to encourage all ICS partner organisations to share knowledge. This can be achieved by hosting an awards ceremony during internal cyber summits and conferences	ICS Cyber Management Board	Medium-Term	7b
	7e	Host regular cyber security learning sessions, Cyber Group meetings, cyber conferences and events, continuing with those practices that are already in place. These activities should be hosted both online and offline, and follow the principles of openness, encouraging interaction and provide positive incentives for ICS partner organisations to attend. These should include: • Sharing of knowledge and experience on current cyber security topics, trends and threats. • A mechanism to celebrate successes of cyber security professionals across the ICS partner organisations (e.g., awards ceremonies). • Presentations by external cyber security SMEs, academics and vendors to discuss the latest developments in cyber security industry.	ICS Cyber Management Board	Long-Term	

STRATEGIC OBJECTIVES

8. Cyber Security Policies and Processes

NHS Cheshire and Merseyside

Policies and processes are essential when setting a standard for cyber security activities across organisations. They should be clear, consistent, accessible and trackable to ensure that staff understand their individual roles and responsibilities within their organisation's wider collective cyber security posture.

Where are we now?

The C&M ICS has developed templates for cyber security policies and standards based on ISO 27001 and made them available to all organisations to use as required. The ICS partner organisations have a local intranet site to store and communicate cyber security policies with their staff. However:

- Each ICS partner organisation has its own cyber security policies and there is little consistency across C&M ICS, with over twenty different versions of policies and processes covering the same topics.
- Although a set of cyber security policy and standards templates was created two years ago and made available to all organisations, uptake is uncertain and there is no central resource to maintain or update these templates for best practice.
- While the ICS partner organisations have a central location to store cyber security policies, processes and standards, and while some assurance mechanisms exist, there is currently no complete view of the usage of the policies, and understanding of staff knowledge of their responsibilities for security.

Where do we want to get to?

The C&M ICS has a **uniform approach** to managing cyber security across the patch in the form of **standardisation** and **continuous improvement** of cyber security policies and processes, alongside **consistent identification** of policy **non-compliance.**

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reach the desired state:

- Review, update and share existing cyber security policy templates across the ICS.
- Develop and publicise guidance for implementation of policy templates within ICS partner organisations.
- Develop a mechanism for ICS partner organisations to track policy compliance and identify breaches

STRATEGIC OBJECTIVES

8. Cyber Security Policies and Processes (1/3)

Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Security Policies and Processes:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Security Policies and Processes	8a	Review the suite of existing cyber security policy, processes and standards templates aligned to the ISO 27001 framework to identify whether any additional templates should be developed, e.g., a template for Risk Management Policy, Cyber Incident Management Policy, Information Backup Policy etc.	ICS Cyber Management Board	Short-Term	
	8b	Update the existing example policies, processes and standards, in line with latest relevant frameworks and standards guidance, e.g., ISO 27001 and NCSC CAF. These policies, processes and standards should be tailored to the intended audience where possible. For example, an Acceptable Use Policy designed to be understood by all staff should outline their responsibilities in simple English, whereas Access Management Standard or Data Security and Protection Policy, tailored towards IT professionals, should outline the requirements in sufficient detail.	ICS Cyber Management Board	Medium-Term	8a
	8c	Share the updated templates across all the ICS partner organisations to encourage consistency in approaches, e.g., as part of the developed knowledge sharing platform.	ICS Cyber Management Board	Medium-Term	7b, 8b

STRATEGIC OBJECTIVES

8. Cyber Security Policies and Processes (2/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Security Policies and Processes:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Security Policies and Processes	**8d**	As part of sharing of the templates, develop additional guidance and share with ICS partner organisations. This guidance could include: • Directions to updating the templates to accurately reflect the ICS partner organisation's arrangements, or guidance on implementing good practice outlined within the policy and processes templates. • Directions for sharing the policies and processes with respective ICS partner organisations' executive management for review and approval. • Suggestions for frequency of review of policies and processes to ensure they remain valid. • Directions for communicating policies and processes with organisations' staff, embedding staff's responsibilities as part of local training efforts, as well as developing a clear and engaging summary of key staff responsibilities from relevant cyber security policies and procedures for staff to comply with.	ICS Cyber Management Board	Medium-Term	8c
	8e	Consider whether it would be beneficial to develop standard operating procedures for common cyber activities and tools widely used by ICS partner organisations. Where there is appetite amongst the ICS partner organisations, develop standard operating procedures, sharing those with ICS partner organisations.	ICS Cyber Management Board	Medium-Term	
	8f	Establish a cadence for regular review and update of the cyber security policy and processes templates, as well as standard operating procedure, where appropriate, assigning a responsible individual.	ICS Cyber Management Board	Long-Term	8b

STRATEGIC OBJECTIVES

8. Cyber Security Policies and Processes (3/3)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Security Policies and Processes:**

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Security Policies and Processes	8g	Where changes are made to templates, communicate the changes with ICS partner organisations, with guidance on implementation of suggested changes within local policies.	ICS Cyber Management Board	Long-Term	7b, 8f
	8h	Agree on a mechanism for ICS partner organisations to feed back to the ICS on the use of the templates and regularly share feedback on the templates.	ICS Cyber Management Board	Long-Term	8c, 8d
	8i	Where appropriate, develop a mechanism for ICS partner organisations to track policy compliance and identify breaches. As part of this, develop and share guidance for responding to identified instances of non-compliance with cyber security policies and processes. This may be achieved via performance indicators, and would depend on the specific policy and process.	ICS partner organisations	Long-Term	8b

STRATEGIC OBJECTIVES

9. Cyber Baseline and Minimum Standards

NHS Cheshire and Merseyside

Baselines and minimum standards for cyber security controls are an important component in laying strong foundations and uplifting the state of cyber security across an ecosystem of organisations to reduce the likelihood of compromise.

Where are we now?

All organisations across the C&M ICS follow the DSPT requirements as the minimum standard for the security of systems and data, which will shortly incorporate NCSC CAF requirements. Several ICS partner organisations have already achieved or are working towards Cyber Essentials Plus certification. However:

- The DSPT mandates that ICS partner organisations provide an annual, self-assessed 'snapshot' of data protection and cyber security arrangements. There is presently no reporting to acquire an overview of the state of cyber security throughout the entire ICS for the remainder of the year.
- There is no standard baseline across the ICS partner organisations for cyber security controls above that which is set by the DSPT requirements. While several organisations achieved Cyber Essentials Plus certification, this has not been possible for all.

Where do we want to get to?

The C&M ICS supports ICS partner organisations in upholding **robust cyber security and improving cyber resilience** by building smart foundations in a form of **minimum cyber security standards**, putting '**secure by design**' principle at the heart of the approach.

How do we get there?

Key activities to assist the C&M ICS with resolving the existing gaps and reach the desired state:

- Identify whether the DSPT should be supplemented by another standard to set a baseline across the ICS.
- Develop a reporting dashboard to collate the current cyber security status of all ICS partner organisations.
- Where possible, standardise the annual cyber security audit approach across the ICS partner organisations.

STRATEGIC OBJECTIVES

9. Cyber Baseline and Minimum Standards (1/2)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy of **Cyber Security Baseline and Minimum Standards**:

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Security Baseline and Minimum Standards	**9a**	Conduct an assessment to identify whether the DSPT needs to be supplemented by an additional cyber security framework or standard (e.g., Centre for Internet Security cyber security controls, Cyber Essentials Plus, or ISO 27001) to form a cyber security baseline and provide additional guidance on cyber security controls to ICS partner organisations.	ICS Cyber Management Board	Medium-Term	
	9b	If deemed necessary, identify which elements of the framework or standard should be prioritised or considered mandatory for implementation across the ICS partner organisations. This should be supplemented with guidance on what compliance with each aspect could good look like, as well as appropriate technical standards for network and information systems security (e.g., standard builds for end-points, firewall configurations, etc.).	ICS Cyber Management Board	Medium-Term	9a
	9c	If deemed unnecessary to supplement DSPT with an additional cyber framework or standard, collate and/or develop additional guidance, good practice and/or standardised technical standards for meeting the requirements of the DSPT to encourage consistency in approaches across the ICS partner organisations.	ICS Cyber Management Board	Medium-Term	9a
	9d	Communicate any requirements which are defined as part of activities 9a and 9b to the ICS partner organisations.	ICS Cyber Management Board	Medium-Term	9a, 9b
	9e	Develop a reporting tool, e.g., a dashboard, to collate the current cyber security status of all ICS partner organisations in one central place, creating the necessary data flows to collect the required information. This could be done by adding detail into the existing IT Health Assurance Dashboard, or considered as part of SOC reporting in the future.*	ICS Cyber Management Board	Long-Term	9a, 9b, 9d

* May require investment into technical solutions to deliver.

STRATEGIC OBJECTIVES

9. Cyber Baseline and Minimum Standards (2/2)

NHS Cheshire and Merseyside

Below are the activities recommended to achieve ICS Cyber Security Strategy objectives of **Cyber Security Baseline and Minimum Standards**:

Objective	ID	Activities	Accountable Lead	Priority for Implementation	Dependencies (activity reference)
Cyber Security Baseline and Minimum Standards	**9f**	Identify thresholds for the current cyber security status results (e.g., 'green', 'amber', 'red') and identify an appropriate escalation path for items breaching the thresholds.	ICS Cyber Management Board	Long-Term	9e
	9g	Using the information from the dashboard, collate a report on a monthly basis to be presented and discussed at the monthly Cyber Security Group meetings. Items rated as 'amber' and 'red' should be prioritised to identify requirements for additional support.	ICS Cyber Management Board	Long-Term	9e, 9f
	9h	Identify which metrics and results should be reported to senior leadership, and ICS partner organisations' boards, supplementing with guidance for communicating results and potential implications.	ICS Cyber Management Board	Long-Term	9g
	9i	Identify whether there is a need for additional cyber security audit beyond the DSPT assertions compliance currently mandated by NHS England. If deemed necessary and where possible, standardise the cyber security audit approach across the ICS partner organisations. This should consider standardisation of auditing authority (e.g. conducted by NHS England or MIAA), scope of the audits etc., to enable a comparable picture across the organisations.	ICS Cyber Management Board	Long-Term	

STRATEGIC OBJECTIVES

Investing into cyber security

Cheshire and Merseyside

Under this Strategy, we have identified nine strategic objectives that would enable us to continue to develop and maintain a secure health and care system across C&M, level up our cyber security maturity, ensuring that our systems are cyber secure and resilient.

In order to **implement the activities under the strategic objectives** to reach our desired target state within the next five years, a certain level of **investment is required.** Majority of the identified activities would predominantly depend on **time and effort** from **dedicated resources as part of the ICS R-SOC and CCoE** (as outlined on pages 60-62). Some, however, would require investment into **technical solutions**.

Below is a summary of the activities that may require significant investment into technical solutions**.** While in some cases, the activities can be met by building upon the existing tools, in some cases, further investment into external solutions may be required:

Objective	Activity ID	Summary of Activity	Potential Technical Solution Required	Estimated Level of Investment Required
Cyber Incident Management	3g	Establish an ICS-wide SOC with cyber-surveillance and incident response capability.	Asset Manager, SIEM, Security Orchestration, Automation and Response (SOAR) tool, Threat Intelligence Platform (TIP), Extended Detect and Response (XDR), Penetration Testing tool*	High*
	3h	Establish centralised ICS monitoring systems that would enable the ICS to monitor for abnormal or malicious activity within the ICS systems and networks.		
Cyber Procurement	4b	Develop a centralised register of all cyber suppliers into the ICS.	Third-party register and/or risk management platform (e.g., RiskLedger)	None to Low**
Third-Party Risk Management	5d	Develop a platform for ICS partner organisations to share information about supplier performance and issues experienced across the ICS.		
Knowledge Sharing and Good Practice	7b	Build a centralised ICS-wide knowledge sharing platform to enable all ICS partner organisations to share, organise, store, easily browse and access the cyber security-related information and documentation.	Knowledge sharing platform (e.g., Notion, Microsoft SharePoint or Confluence)	Low to Medium**
Cyber Baseline and Minimum Standards	9e	Develop a reporting tool to collate the current cyber security status of all ICS partner organisations in one central place.	Cyber security state dashboard (e.g., IT Health Assurance Dashboard, risk management tool, SIEM)	Low to Medium**

* Depending on the R-SOC model selected (in-house, outsourced, hybrid).
** Depending on solutions chosen (e.g., existing functionalities vs. new, bespoke tools).

07 Governance and Accountability

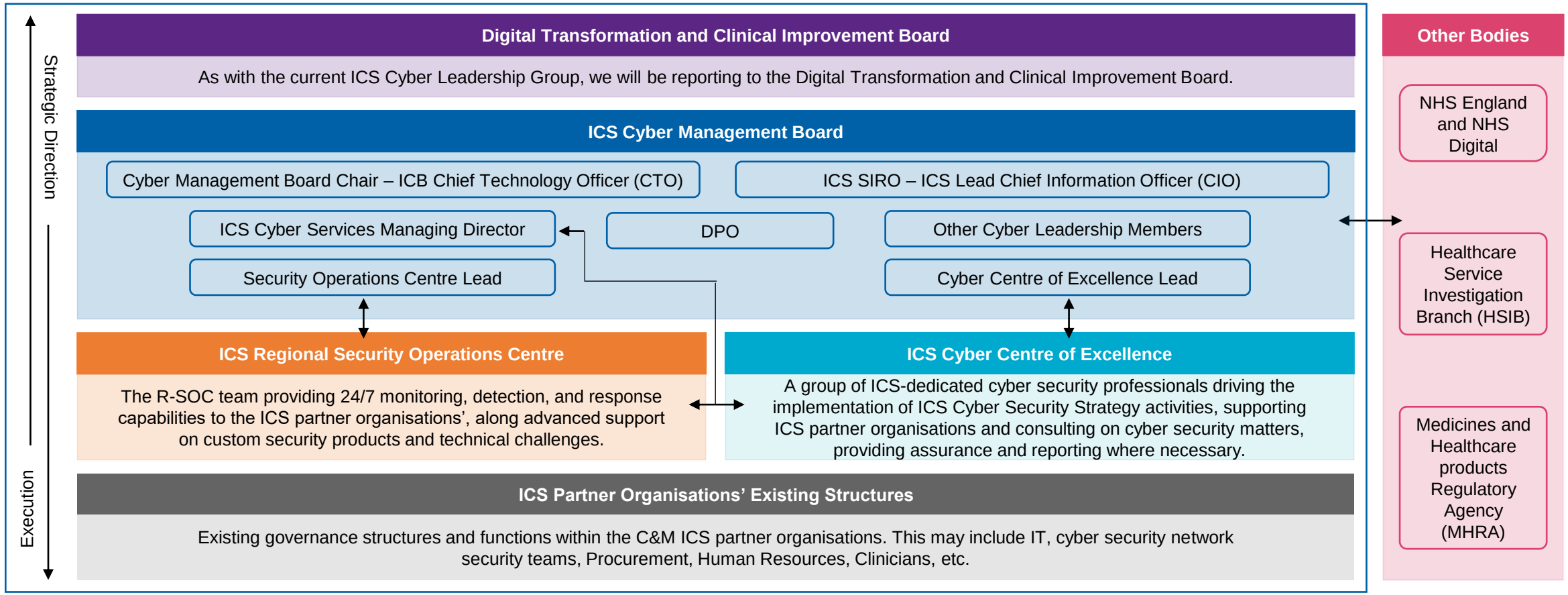
PROPOSED ICS CYBER SECURITY GOVERNANCE

How do we work together as an ICS to achieve our objectives?

NHS Cheshire and Merseyside

In order to move on as an ICS from a 'collaboration of the willing' to a **well-functioning, ICB-led unit** and **effectively implement this ICS Cyber Security Strategy**, we require a strong **foundation of effective cyber governance and accountability** model.

This model below demonstrates the **proposed governance structure** for cyber security across the ICS at high level, including the link between the local ICS partner organisations and other internal and external bodies. It is worth to note that while this proposed structure is built on the existing foundation, it is a change to our current operations, roles and responsibilities. Similarly, to effectively put this model into practice, we require **dedicated ICS resources** as part of the ICS Cyber Management Board, the **ICS R-SOC** and the **ICS CCoE to implement the strategic activities** outlined in the Strategy.



PROPOSED ICS CYBER SECURITY GOVERNANCE

NHS Cheshire and Merseyside

What will each group do?

The cyber security governance groups will hold the following proposed key accountabilities and responsibilities:

ICS Cyber Management Board

The C&M ICS Cyber Management Board will set the direction for cyber security activities for the ICS and its ICS partner organisations to drive improvements in cyber security.

In this capacity, the Board will:

- Oversee the investments into the ICS cyber security, including tools and services that would benefit ICS partner organisations.
- Oversee and monitor ICS partner organisations' implementation of this Cyber Security Strategy and related action plans.
- Define an approach to cyber risk identification and assessment across the ICS and monitor ICS risk exposure.

ICS R-SOC

The R-SOC will manage the detection, analysis, and response to cyber security threats across the ICS, including coordination of cyber incident response plans impacting more than one ICS partner organisation.

The ICS R-SOC will also:

- Support the CCoE in developing the ICS cyber incident management and response policies, procedures and playbooks.
- Maintain contact with other national bodies, such as NHS England and NCSC on threat intelligence etc.
- Report to the ICS Cyber Management Board on R-SOC findings, risks and incidents.

ICS CCoE

The ICS CCoE will be responsible for the delivery of the underlying action plans within this Cyber Security Strategy, supporting ICS partner organisations in their responsibilities as required.

As examples, the CCoE will:

- Share cyber best practice amongst the ICS partner organisations, and discuss cyber security challenges.
- Drive development of cyber security policy, processes and standards templates, working with the R-SOC where needed.
- Report to the ICS Cyber Management Board on the status of ICS Cyber Security Strategy and its key activities implementation.

ICS Partner Organisations' Structures

The existing structures and IT/cyber security teams within C&M ICS partner organisations will be responsible for existing operational cyber security activities, while ensuring alignment with the ICS Cyber Security Strategy.

Examples of activities would include:

- Developing and maintaining local Business Continuity and Disaster Recovery Plans.
- Conducting regular cyber security risk assessments and reporting top risks to the Cyber Management Board and CCoE.
- Managing IT assets and monitoring security of key services, tools and networks.

ICS partner organisations will feed back and escalate cyber security challenges and issues facing to the ICS CCoE.

PROPOSED ICS CYBER SECURITY GOVERNANCE

What would be the roles and responsibilities of ICS CSG members?

NHS Cheshire and Merseyside

We propose a number of **new ICS Cyber Management Board roles** that would enable the Board to **fulfil its accountability to effectively implement this ICS Cyber Security Strategy:**

Role	High-Level Description of Accountabilities and Responsibilities
ICB CTO – Cyber Management Board Chair	• Chairs the ICS Cyber Management Board. • Accountable for implementation of the C&M ICS Cyber Security Strategy across the ICS, as well as meeting the 'What Good Looks Like' framework requirements.
ICS SIRO – ICS Lead CIO	• Oversees the ICS-level cyber security investment and budgeting. • Monitors the ICS partner organisations' alignment with the cyber security obligations defined in the C&M ICS Cyber Security Strategy. • Oversees the highest cyber security risks across the ICS, and coordination of ICS-wide risk treatment measures as required.
ICS Cyber Services Managing Director	• Oversees the implementation of the ICS Cyber Security Strategy activities across the ICS, reporting on its progress to the Cyber Management Board. • Oversees the ICS-level cyber security services offered and delivered to the ICS partner organisations.
ICS DPO	• Monitors data protection compliance across the ICS, working with DPOs from individual partner organisations. • Provides advice on ICS-wide Data Protection Impact Assessments (DPIAs).
Cyber Centre of Excellence Lead	• Drives the implementation of the activities defined under the nine strategic objectives of the C&M ICS Cyber Security Strategy, working with the ICS Cyber Services Managing Director to identify any additional support required for the ICS partner organisations to meet their cyber security obligations under this Strategy.
Security Operations Centre Lead	• Oversees the implementation of the C&M ICS SOC, its prevention, monitoring and detection systems. • Support the CIO in identifying, collating and overseeing the highest cyber security risks across the ICS identified by the SOC. • Where necessary, coordinates cyber incident response across C&M ICS, including communications and threat intelligence to and from NHS England.
Other Cyber Leadership Members	• Support the Security Operations Centre Lead, Cyber Centre of Excellence Lead, ICS Cyber Services Managing Director, CIO and CTO in driving and overseeing the implementation of the C&M ICS Cyber Security Strategy and its strategic activities. • Collate and raise cyber security challenges and escalated issues from the ICS partner organisations to the Cyber Management Board as required.

08 Cyber Security Strategy Execution

CYBER SECURITY KPIS

How will we measure the success of the ICS Cyber Security Strategy? (1/5)

NHS Cheshire and Merseyside

We will use a set of **Key Performance Indicators (KPIs)** to track the **implementation of the C&M ICS Cyber Security Strategy** and **measure its ongoing success** in uplifting our cyber security state and strengthening our resilience. Detailed on pages 64-68 are examples and options of KPIs that we will select from to track Strategy implementation. Each of the example KPIs is defined along with a recommended reporting timeframe and implementation window, corresponding to **one or two strategic objectives defined within the Strategy**.

Strategic Objective	Metric	Metric Description	Priority for Implementation	Reporting Timeframe
Cyber Governance	Percentage of ICS Cyber Security Strategy activities in progress or completed.	Once the Strategy implementation and underlying strategic activities has begun under activity 1b, track the percentage of strategic activities in progress or completed, versus those that have not yet started.	Short-Term	Quarterly
	Percentage of ICS Cyber Security Strategy activities implemented within an agreed timeline.	As implementation of the Strategy and underlying strategic activities progresses under activity 1b, track the percentage of strategic activities being completed within the timeframe allocated during each implementation window.	Short-Term	Quarterly
	Number of non-compliances against defined partner organisation requirements identified (measured for each ICS partner organisation).	Once cyber security requirements for ICS partner organisations to comply with are agreed under activity 1i, track deviations from the set requirements per ICS partner organisation.	Long-Term	Quarterly
Cyber Risk Management	Percentage of cyber security risks on risk registers without an appropriate response strategy (e.g. without mitigating actions or controls, risk acceptance etc. (measured for each ICS partner organisation).	Once a cyber risk management methodology has been established under activity 2c and an ICS-wide centralised cyber risk repository developed under activity 2i, track the percentage of cyber security risks without an appropriate response strategy per ICS partner organisations.	Long-Term	Quarterly
	Percentage of IT assets in the asset repository without an impact assessment rating from the last year (measured for each ICS partner organisation).	Once an approach to identify and prioritise IT assets has been developed and distributed under activity 2g, track the percentage of IT assets in the asset repository without a current impact assessment rating per ICS partner organisation.	Short-Term	Quarterly
Cyber Incident Management	Number of critical and high cyber security incidents identified across the ICS in the last six months.	Once an ICS-level incident management policy has been developed and cyber incident severity ratings agreed under activity 3a, track the number of critical and high cyber security incidents identified across the ICS partner organisations.	Short-Term	Quarterly

CYBER SECURITY KPIS

How will we measure the success of the ICS Cyber Security Strategy? (2/5)

NHS Cheshire and Merseyside

Strategic Objective	Metric	Metric Description	Priority for Implementation	Reporting Timeframe
Cyber Incident Management	Number of open 'critical' and 'high' rated vulnerabilities per ICS partner organisation logged in IT Health Assurance Dashboard.	Track the number of open 'critical' and 'high' rated vulnerabilities per ICS partner organisation logged in IT Health Assurance Dashboard.	Long-Term	Quarterly
	Number of cyber security incident alerts issued by NHS 'Respond to an NHS Cyber Alert' not responded to within the agreed timeframe.	Once key incident response roles and responsibilities and incident response plans and procedures have been established under activities 3a and 3b, track the number of cyber security incident alerts issued by NHS 'Respond to an NHS Cyber Alert' not responded to within the agreed timeframe.	Medium-Term	Quarterly
	Percentage of RTO and RPO missed during recovery testing for critical assets across ICS partner organisations.	Once guidance on data backup and restoration has been created under activity 3c, track the percentage of RTO and RPO missed during recovery testing for critical assets across ICS partner organisations.	Medium-Term	Ad Hoc
IT Procurement	Percentage of IT tools and services purchased outside of the existing services catalogue (measured for each ICS partner organisation).	Once a centralised register of all suppliers into the ICS has been developed under activity 4b and a framework for procurement of new services and tools established under activity 4f, track the percentage of IT tools and services purchased outside of the existing services catalogue per ICS partner organisation.	Medium-Term	Quarterly
	Number of cyber security tools across the ICS partner organisations that cannot interface with the ICS SIEM.	Once a the ICS-wide SIEM tool is implemented under activities 3g and 3h, identify the number of tools that cannot interface with the ICS SIEM for central monitoring.	Long-Term	Annually
	Monetary savings (in GBP) identified through ICS collective purchasing efforts of IT and cybersecurity tools and services.	Once a centralised register of all suppliers into the ICS has been developed under activity 4b and a framework for procurement of new services and tools established under activity 4f, track the savings made on an annual basis from collective procurement activities.	Medium-Term	Annually

CYBER SECURITY KPIS

How will we measure the success of the ICS Cyber Security Strategy? (3/5)

NHS Cheshire and Merseyside

Strategic Objective	Metric	Metric Description	Priority for Implementation	Reporting Timeframe
Third-Party Risk Management	Percentage of third-party suppliers with Bitsight ratings classed as high risk.	Once the platform for ICS partner organisations to share information about supplier performance and issues experienced across the ICS is developed under activity 5d, track the percentage of third-party suppliers into the ICS with Bitsight ratings classed as high risk.	Long-Term	Quarterly
	Percentage of third party IT service providers into the ICS and its partner organisations that have not completed a risk assessment in the agreed time frames.	Once a TRPM framework that details guidance ensuring that third parties perform up to contractual expectations has been implemented under activity 5a, identify the percentage of third party IT service providers into the ICS and its partner organisations that have not completed a risk assessment in the agreed time frames.	Short-Term	Quarterly
	Percentage of third party IT service providers into the ICS and its partner organisations that have not engaged with mandated assurance activities in the agreed timeframe.	Once a TRPM framework that details guidance ensuring that third parties perform up to contractual expectations has been implemented under activity 5a, identify the percentage of third party IT service providers into the ICS that have not engaged with mandated assurance activities in the agreed timeframe.	Short-Term	Quarterly
	Number of third-party suppliers which have had security incidents identified through formal and agreed notification processes.	Once a TRPM framework that details guidance ensuring that third parties perform up to contractual expectations has been implemented under activity 5a, track the number of third-party suppliers which have experienced security incidents identified through formal and agreed notification processes.	Short-Term	Quarterly
	Number of third-party suppliers which have had security incidents identified through ICS assurance activities.	Once the TRPM framework that details third party assurance activities has been developed and implemented under activity 5a, track the number of third-party suppliers which have had security incidents identified through ICS assurance activities.	Short-Term	Quarterly

CYBER SECURITY KPIS

How will we measure the success of the ICS Cyber Security Strategy? (4/5)

NHS Cheshire and Merseyside

Strategic Objective	Metric	Metric Description	Priority for Implementation	Reporting Timeframe
People and Culture	Number of Digital Champions per ICS partner organisation.	Once a blueprint for Digital Champions has been developed across ICS partner organisations under activity 6i, track the number of Digital Champions per ICS partner organisation.	Long-Term	Annually
	Number of vacant cyber security roles across the ICS.	Once a list of the current cyber security roles/positions across the ICS under activity 6a has been collated, identify the number of vacancies and gaps.	Medium-Term	Quarterly
	Number of gaps in cyber skills, competencies and knowledge identified across the IT and/or cyber professionals across the ICS.	Once an assessment of skills, competencies and essential cyber qualifications currently possessed by ICS cyber security practitioners has been conducted and gaps identified under activity 6b, track the number of gaps in skills, competencies and knowledge across the ICS.	Medium-Term	Annually
	Number of cyber awareness campaigns launched across the ICS partner organisations.	Once an ICS-wide cyber training and awareness programme for all ICS partner organisation staff has been developed under activity 6c, track the number of cyber awareness campaigns launched across the ICS partner organisations.	Medium-Term	Annually
Knowledge Sharing and Good Practice	Percentage of users accessing the knowledge sharing library (measured for each ICS partner organisation).	Once a centralised ICS-wide knowledge sharing platform has been built and access has been granted to key individuals across the ICS partner organisations under activities 7b and 7c, track the percentage of users accessing the knowledge sharing library per ICS partner organisation.	Medium-Term	Quarterly
	Number of cyber security documents on the knowledge sharing library.	Once a centralised ICS-wide knowledge sharing platform has been developed under activity 7b, track the number of cyber security documents on the knowledge sharing library shared by ICS partner organisations.	Medium-Term	Quarterly

CYBER SECURITY KPIS

How will we measure the success of the ICS Cyber Security Strategy? (5/5)

NHS Cheshire and Merseyside

Strategic Objective	Metric	Metric Description	Priority for Implementation	Reporting Timeframe
Cyber Security Policies and Processes	Percentage of ICS partner organisations utilising the ICS cyber security policy and process templates.	Once the existing example policies and processes have been updated in line with the latest relevant frameworks and standards guidance (and shared across the ICS partner organisations under activity 8b, track the percentage of ICS partner organisations utilising ICS cyber security policy and process templates.	Medium-Term	Quarterly
	Percentage of cyber security policy and process templates undergoing annual review.	Once a cadence for regular review and update of the cyber security policy and process templates has been established under activity 8f, track the percentage of templates undergoing annual review and update.	Long-Term	Annually
Cyber Baseline and Minimum Standards	Percentage of unpatched or out of support devices on each ICS partner organisation's network.	Once a reporting dashboard has been established to collate the current cyber security status of all ICS partner organisations in one central place under activity 9e, track the percentage of devices remaining unpatched or out of support on each ICS partner organisation's network.	Long-Term	Quarterly
	Number of critical and high (CVSS scores) findings arising from annual penetration test (measured for each ICS partner organisation).	Once a reporting dashboard has been established to collate the current cyber security status of all ICS partner organisations in one central place under activity 9e, track the umber of critical and high findings (as rated using CVSS scores) emerging from yearly penetration testing for each ICS partner organisation.	Long-Term	Annually
	Number of cyber security audit findings identified across the ICS partner organisations.	Once the annual cyber security audit approach has been standardised across ICS partner organisations under activity 9i, track the number of cyber security audit findings discovered across the ICS partner organisations.	Long-Term	Quarterly

NEXT STEPS

Implementing the Cyber Security Strategy and achieving our goals

NHS Cheshire and Merseyside

This Strategy will help C&M ICS to **cement our position as cyber leaders** amongst our ICS peers, while **contributing towards developing and maintaining a sustainable health and care system** across C&M. To ensure our success, and achieve the strategic objectives we have set, we need to **socialise, refine and agree** this Strategy, validate that it meets the requirements of our ICS partner organisations and **gain endorsement** from management boards and leadership teams.

Below is a brief outline of the initial steps we need to take:

01

Share the first draft of the C&M ICS Cyber Security Strategy with senior leadership teams and the ICB for review and approval.

02

Following approval and any necessary amends, publicise and socialise the C&M ICS Cyber Security Strategy with relevant stakeholders and communities.

03

Establish and follow an agreed cadence for C&M ICS Cyber Security Strategy review, tracking the progress of its implementation and measuring the impact across the C&M ICS.

09 Appendices

FRAMEWORKS AND REQIREMENTS MAPPING

Covering all the bases (1/2)

NHS Cheshire and Merseyside

In developing the C&M ICS Cyber Security Strategy, identifying the strategic objectives and underlying activities, we **considered and embedded the requirements of key external frameworks and standards**, such as: the security assertions outlined within the DSPT, 'What Good Looks Like' framework, NIS CAF, NIST CSF, as well as Cyber Essentials and a suite of ISO standards (e.g., ISO 27001). We have also developed this Strategy with wider government, NHS and ICS strategies in mind, such as the DHSC cyber security strategy to 2030. Below is a mapping of our **nine strategic objectives** and how the **underlying activities** relate to **four key frameworks,** and the **DHSC cyber security strategy pillars**:

Strategic Objective	Data Security and Protection Toolkit Standards	What Good Looks Like	NIS Cyber Assessment Framework	NIST Cyber Security Framework	DHSC Cyber Security Strategy
Cyber Governance	• 'Personal confidential data'	• 'Well led' principle • 'Ensure smart foundations' principle • 'Safe practice' principle • 'Empower citizens' principle	• A1 Governance	• Business Environment (ID.BE) • Governance (ID.GV)	• 'Defend as one'
Cyber Risk Management	• 'Personal confidential data' • 'Process reviews' • 'Continuity planning' • 'Unsupported systems' • 'IT protection'	• 'Ensure smart foundations' principle • 'Safe practice' principle • 'Improve care' principle	• A2 Risk Management • A3 Asset Management • B3 Data Security • B4 System Security	• Asset Management (ID.AM) • Risk Assessment (ID.RA) • Risk Management Strategy (ID.RM) • Data Security (PR.DS) • Maintenance (PR.MA)	• 'Focus on greatest risks and harms' • 'Defend as one' • 'Build secure for the future'
Cyber Incident Management	• 'Responding to incidents' • 'Continuity planning' • 'Unsupported systems'	• 'Safe practice' principle	• B5 Resilient Networks and Systems • C1 Security Monitoring • C2 Proactive Security Event Discovery • D1 Response and Recovery Planning • D2 Lessons learned	• Information Protection Processes and Procedures (PR.IP) • Protective Technology (PR.PT) • Anomalies and Events (DE.AE) • Security Continuous Monitoring (DE.CM) • Detection Processes (DE.DP) • Response Planning (RS.RP) • Communications (RS.CO & RC.CO) • Analysis (RS.AN) • Mitigation (RS.MI) • Improvements (RS.IM) • Recovery Planning (RC.RP) • Improvements (RC.IM)	• 'Defend as one' • 'Exemplary response and recovery'

FRAMEWORKS AND REQIREMENTS MAPPING

Covering all the bases (2/2)

NHS Cheshire and Merseyside

Strategic Objective	Data Security and Protection Toolkit Standards	What Good Looks Like	NIS Cyber Assessment Framework	NIST Cyber Security Framework	DHSC Cyber Security Strategy
IT Procurement	• 'Accountable suppliers'	• 'Safe practice' principle • 'Empower citizens' principle	• A3 Asset Management • A4 Supply Chain	• Asset Management (ID.AM) • Supply Chain Risk Management (ID.SC)	• 'Build secure for the future' • 'Defend as one'
Third Party Risk Management	• 'Accountable suppliers'		• A4 Supply Chain	• Supply Chain Risk Management (ID.SC)	• 'Focus on greatest risks and harms' • 'Build secure for the future'
People and Culture	• 'Staff responsibilities' • 'Training'	• 'Support people' principle	• B6 Staff Awareness and Training	• Awareness and Training (PR.AT)	• 'People and culture'
Knowledge Sharing and Good Practice		• 'Support people' principle • 'Empower citizens' principle • 'Improve care' principle	• B6 Staff Awareness and Training		• 'Defend as one' • 'People and culture'
Cyber Security Policies and Processes	• 'Personal confidential data' • 'Managing data access' • 'IT protection'		• B1 Service Protection Policies and Processes • B2 Identity and Access Management • B3 Data Security	• Identity Management, Authentication and Access Control (PR.AC) • Data Security (PR.DS) • Information Protection Processes and Procedures (PR.IP)	• 'Defend as one'
Cyber Baseline and Minimum Standards	• 'Managing data access' • 'Unsupported systems' • 'IT protection'	• 'Safe practice' principle	• B2 Identity and Access Management • B3 Data Security • B4 System Security	• Asset Management (ID.AM) • Identity Management, Authentication and Access Control (PR.AC) • Data Security (PR.DS) • Protective Technology (PR.PT)	• 'Focus on greatest risks and harms' • 'Build secure for the future' • 'Defend as one'

GLOSSARY OF TERMS

Understanding terms and acronyms (1/3)

NHS Cheshire and Merseyside

In order to make the Strategy as accessible as possible, we have tried to make sure all **abbreviated terms**, **sector-specific language** and **jargon** are fully explained where unavoidable. We have provided a glossary of **frequently used terms and abbreviations** used on the Strategy below:

Abbreviation	Name	Definition
HCP	Health and Care Partnership	HCP is a collection of NHS, local authority, voluntary, community, faith and social enterprise organisations from across the nine local authority areas that make up Cheshire and Merseyside.
ICS	Integrated Care System	An ICS brings together the NHS organisations, councils and wider partners in a defined geographical area to deliver more joined-up approaches to improving health and care outcomes. There are 42 ICSs in England, including Cheshire and Merseyside, one of the country's largest. Each ICS has an Integrated Care Board and an Integrated Care Partnership.
ICB	Integrated Care Board	The ICB was established in July 2022 as the new statutory organisation to lead integration within the NHS. The C&M ICB have a unitary board and minimum requirements for board memberships in legislation. The ICB is responsible for the day-to-day running of the NHS in Cheshire and Merseyside, including planning and buying healthcare services.
ICP	Integrated Care Partnership	The ICP provides a forum for NHS leaders and local authorities to unite as equal partners alongside important stakeholders across C&M. Together, the ICP generates an integrated care strategy to improve health and care outcomes and experiences for the people in Cheshire and Merseyside.
	ICS partner organisations	Clinical commissioning groups, local authorities and NHS provider organisations from across the nine local authority areas of Cheshire and Merseyside, all collaborating under the umbrella of the C&M ICS.
CAN	Cyber Associates Network	The CAN, established by NHS Digital and NHS England, is a group of professionals with responsibility for, or a professional interest in, cyber security, which provides people with opportunities to shape and influence the cyber security landscape.
MIAA	Mersey Internal Audit Agency	Specialist provider of assurance and solutions services to the NHS and local authorities.
HSIB	Healthcare Safety Investigation Branch	The HSIB investigates and focuses on systems and processes in healthcare, identifying the factors that could have led, or could potentially lead, to harm patients.
MHRA	Medicines and Healthcare products Regulatory Agency	The MHRA is an executive agency of the Department of Health and Social Care in the UK, responsible for ensuring that medicines and medical devices work and are acceptably safe.
	Respond to an NHS Cyber Alert service	'Respond to an NHS Cyber Alert' service, which replaced CareCERT in 2020, provides NHS organisations a secure and effective way to respond to high severity cyber alerts.
LTP	NHS Long Term Plan	The NHS LTP was published in 2019, and sets out key ambitions for the NHS services over the next ten years.

GLOSSARY OF TERMS

Understanding terms and acronyms (2/3)

NHS Cheshire and Merseyside

Abbreviation	Name	Definition
WGLL	What Good Looks Like	The 'What Good Looks Like' framework is built on established good practices to provide ICSs clear guidance to digitise, connect and transform services safely and securely, thus improving the experience and safety of the citizens.
DSPT	Data Security and Protection Toolkit	The DSPT is an online self-assessment tool that allows ICSs to measure their performance against the National Data Guardian (NDG)'s 10 Data Security Standards.
DPIA	Data Protection Impact Assessments	The DPIA is a process to help organisations identify and minimise the data protection risks of a project, especially for processing likely to result in a high risk to individual organisations.
DPO	Data Protection Officer	The DPO is an independent, adequately resourced expert in data protection and reports to the highest management level. DPOs assist in monitoring internal compliance and inform and advise on data protection obligations. The 'What Good Looks Like' framework mandates that all ICSs have a DPO.
CSO	Clinical Safety Officer	The CSO oversees the assurance of safety-related health IT software, ensuring suppliers and ICS partner organisations meet the required safety standards. CSOs also ensure that all safety-related risks associated with a health IT system are actively managed, and that appropriate mitigations are applied. The 'What Good Looks Like' framework mandates that all ICSs have a CSO.
SIRO	Senior Information Risk Officer	A SIRO is responsible for implementing and managing information risks within an ICS partner organisation. The SIRO oversees information risks within the organisation and will inform and advise the board on how to mitigate the risk according to the organisation's risk appetite. The 'What Good Looks Like' framework mandates that all ICSs have a SIRO.
CLG	Cyber Leadership Group	The CLG consist of individuals from across the community established in the aftermath of the WannaCry incident. The Group is currently responsible for setting the cyber security agenda, defining and delivering workstreams and coordinating activities.
	Cyber Group	The Cyber Group is open to all ICS partner organisations. Under the CLG's direction, it shares best practices, provides a sounding board for cyber developments, and creates the knowledge bridge between the ICB and local organisations to drive resilience through commonality, and consolidated spending, strategies, and contracts.
TOM	Target Operating Model	A TOM is a breakdown of the capabilities required and a corresponding estimate of the full-time equivalent (FTE) resources required to discharge those capabilities. An effective TOM enables the ICSs to defend against cyber security threats and manage residual risk effectively in collaboration with other departments (e.g., HR) on cyber security matters.
	Digital Champion	A digital champion is an employee within an ICS partner organisation chosen to help lead change, promote digitalisation, and influence colleagues to support the smooth onboarding of technologies. They can also act as cyber champions to educate on, promote and maintain good cyber hygiene practices across ICS staff.

GLOSSARY OF TERMS

Understanding terms and acronyms (3/3)

NHS Cheshire and Merseyside

Abbreviation	Name	Definition
SIEM	Security Information and Event Management	SIEM is a security solution that helps ICS partner organisations recognise potential security threats and vulnerabilities before they have a chance to disrupt business operations. The underlying principle of a SIEM system is to aggregate relevant data from multiple sources, identify deviations from the norm and take appropriate action.
R-SOC	Regional Security Operations Centre	A R-SOC is a centralised function within an ICS partner organisation employing people, processes and technology to continuously monitor and improve the organisation's security posture while preventing, detecting, analysing and responding to cyber incidents.
	IT Health Dashboard	The IT Health Assurance Dashboard is a solution used by a number of ICS partner organisations that collates insights on the status and health of internal networks. Continuous, agentless network scanning (e.g., Nessus vulnerability scanner) and intuitive, tailor-made, near-real-time reports make risks easier to visualise, remediate and report on.
BIA	Business Impact Analysis	An analysis of an information system's requirements, functions, and interdependencies used to characterise system contingency requirements and priorities in the event of a significant disruption.
	Minimum Baseline	Minimum baselines are the agreed minimum cyber security controls required for safeguarding IT ecosystems based on their identified needs for confidentiality, integrity or availability protection. Minimum baselines for cyber security controls are essential in laying solid foundations and uplifting the state of cyber security across the ICS ecosystem to reduce the likelihood of compromise.
TPRM	Third-Party Risk Management	Working with third parties can introduce vulnerabilities and cyber security risks into the ICS ecosystem. As such, a standardised third-party risk management approach to assessing and managing third party goods and services is crucial.
KPI	Key Performance Indicator	A KPI is a quantifiable performance measure over time for a specific objective. KPIs provide targets for teams to shoot for, milestones to gauge progress, and insights that help people across the organisation make better decisions.
	Strategic Objectives	Strategic objectives are broad and clearly defined statements of 'end goals' that the ICS aspires to achieve within the next five years. Nine cyber security objectives have been identified to direct the C&M ICS efforts in enhancing its cyber security state through discussions with key stakeholders on the ICS's current and desired state, documentation review, and external factors, such as industry frameworks and good practices.
CE+	Cyber Essentials Plus	CE+ is a government-backed scheme that helps protect an organisation, whatever its size, against a whole range of the most common cyberattacks. Suppose you would like to bid for central government contracts that involve handling sensitive and personal information or providing certain technical products and services. In that case, you will require CE+ certification.
ISO 27001	International Organisation for Standardisation 27001	ISO 27001 helps organisations manage and protect their information assets to remain safe and secure. ICS partner organisations must document the relevant issues as part of their information security objectives and results of the risk assessment and maintain records of the competence of their staff.

Dated 2024\

(1) **NHS ENGLAND**

- and -

(2) **NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and NHS Cheshire and Merseyside ICB in relation to Specialised Commissioning Functions

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	NHS Cheshire and Merseyside ICB
Area	North West
Date of Agreement	[Date]
ICB Representative	Graham Urwin
ICB Email Address for Notices	clare.watson@cheshireandmerseyside.nhs.uk
NHS England Representative	Richard Barker
NHS England Email Address for Notices	england.regionalcommissioningdirector-northwest@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause **Error! Reference source not found.**);

1.2.2 the Terms and Conditions (Clauses 2 to 32);

1.2.3 the Schedules; and

1.2.4 the Mandated Guidance

Signed by **NHS England**

Richard Barker

Executive Regional Director (North West)

(for and on behalf of NHS England)

Signed by **Cheshire and Merseyside Integrated Care Board**

Graham Urwin

Chief Executive

Cheshire and Merseyside Integrated Care Board

TERMS AND CONDITIONS

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with SCHEDULE 1 *(Definitions and Interpretation)*.

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Developmental Arrangements;

2.2.2 the Particulars and Terms and Conditions (Clauses **Error! Reference source not found.** to 32);

2.2.3 Mandated Guidance;

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms; and

2.2.5 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.

3.2 The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.

3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.

3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.

3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

3.6 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.7 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB. It also sets out each Party's responsibilities and the measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. TERM

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with Clause 27 *(Termination)* below.

5. PRINCIPLES

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 consider how they can meet their legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.4 consider how in performing their obligations they can address health inequalities;

5.1.5 at all times exercise functions effectively, efficiently and economically;

5.1.6 act in a timely manner;

5.1.7 share information and Best Practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.8 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("Delegation").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified and included within Schedule 3 to this Agreement but excluding the Reserved Functions set out within Schedule 4.

6.3 The Delegation in respect of each Delegated Function has effect from the Effective Date of Delegation.

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.6 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.7 The terms of Clauses 6.5 and 6.6 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement;

7.2.2 Mandated Guidance;

7.2.3 any Contractual Notices;

7.2.4 the Local Terms;

7.2.5 any Developmental Arrangements;

7.2.6 all applicable Law and Guidance;

7.2.7 the ICB's constitution;

7.2.8 the requirements of any assurance arrangements made by NHS England; and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions; and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions; and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England

from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (*Variations*).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 *(Further Arrangements)*, the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England;

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards;

8.4.3 provisions for independent scrutiny of decision making;

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements;

8.4.5 the Delegated Services which are subject to the arrangements;

8.4.6 financial arrangements and any pooled fund arrangements;

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment;

8.4.8 terms of reference for decision making; and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (*Variations*) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

10. FINANCE

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England

for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions;

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance; and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise;

10.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (*Claims and Litigation)*;

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services; and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change

the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

10.12.2 any NHS payment scheme published by NHS England;

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

10.12.4 any Capital Investment Guidance;

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time; and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Pooled Funds

10.14 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.14.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

10.14.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

10.14.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

10.15 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act. Where the ICB has decided to enter into arrangements under Clause 10.14 the agreement must be in writing and must specify:

10.15.1 the agreed aims and outcomes of the arrangements;

10.15.2 the payments to be made by each partner and how those payments may be varied;

10.15.3 the specific Delegated Functions which are the subject of the arrangements;

10.15.4 the Delegated Services which are subject to the arrangements;

10.15.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements;

10.15.6 the arrangements in place for governance of the pooled fund; and

10.15.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.15.3.

10.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions; as required by NHS England from time to time; and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

11.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (*ICB Collaboration Arrangements*) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements; and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.5 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.6 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.7 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team Where appropriate, this

agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. **BREACH**

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement; and

14.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3;

14.2.2 ratify any decision in accordance with Clause 6.5;

14.2.3 substitute a decision in accordance with Clause 6.6;

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements;

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 *(Termination)* below;

14.2.6 exercise the Escalation Rights in accordance with Clause 155 *(Escalation Rights)*; and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement;

14.4.2 the ICB considers that it may not be able to comply with this Agreement;

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement; or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

14.4.5 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. **ESCALATION RIGHTS**

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance; and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with Clause 6.76, revoke the Delegation or terminate this Agreement in accordance with Clause 27 *(Termination)* below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause **Error! Reference source not found.**17.5 and subject always to compliance with this Clause 17 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and the pro-active management of Claims;

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and

17.3.5 at the request of NHS England, take such actions or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS

England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

18.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

18.6.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

18.6.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

18.6.3 subject only to Clause 17 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in

relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Delegated **Services**

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services will be delegated to the ICB on 1 April 2024:

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 (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
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	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
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 (adults)
		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 (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
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 (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
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

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
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 (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
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 (adults)
		33B	Complex inflammatory bowel disease (adults)
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	73X	Specialist paediatric surgery services - gynaecology

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
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
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 (adults and children)
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
		19B	Specialist services for complex biliary 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 (adults and children)
135	Specialist paediatric surgery services	23X	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
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

1.1.1 decisions in relation to the commissioning and management of Delegated Services;

1.1.2 planning Delegated Services for the Population, including carrying out needs assessments;

1.1.3 undertaking reviews of Delegated Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate; and

1.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England;

3.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and

3.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

5.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

6 Clinical Networks

6.1 The ICB shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The ICB shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

6.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

6.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

6.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

7.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

7.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

7.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

7.3.2.1 acknowledgements provided within three (3) Operational Days;

7.3.2.2 responses provided within forty (40) Operational Days;

7.3.2.3 response not provided within six (6) months;

7.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints; and

7.3.2.5 overall activity by volume (not as a KPI).

7.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

7.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

8.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

8.4 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Party in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

8.5 The ICB must ensure:

8.5.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;

8.5.2 effective introduction of new medicines;

8.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and

8.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

8.6 The ICB must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

8.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

9.1.3 management of Specialised Services Contracts.

9.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

10.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies;

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

10.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.

11 Finance

11.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

12 Freedom of Information and Parliamentary Requests

12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

13 Incident Response and Management

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

13.1.2 support national and regional incident management relating to Specialised Services; and

13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

13.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.

14 Individual Funding Requests

14.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

15 Innovation and New Treatments

15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

16 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

16.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

17 Provider Selection and Procurement

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population;

17.3.2 robust and defensible, with conflicts of interests appropriately managed;

17.3.3 made transparently; and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

18.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

20.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

20.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

20.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

21.1.4 support NHS England with agreed transformational programmes for Retained Services;

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

1. Reserved Functions in Relation to the Delegated Services

1.1. In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

1.2. This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

1.3. The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4. The following functions and related activities shall continue to be exercised by NHS England.

2. Retained Services

2.1. NHS England shall commission the Retained Services set out in Schedule 5.

3. Reserved Specialised Service Functions

3.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

4. Assurance and Oversight

4.1. NHS England shall:

4.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

4.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

4.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

4.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

4.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

4.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a national level, including identification, review and management of appropriate cross-ICB risks.

5. Attendance at governance meetings

5.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

5.2. NHS England shall:

5.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

5.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

5.2.3. co-ordinate, and support key national governance groups.

6. Clinical Leadership and Clinical Reference Groups

6.1. NHS England shall be responsible for the following:

6.1.1. developing local leadership and support for the ICB relating to Specialised Services;

6.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

6.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

6.2. NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

6.2.1. Clinical Commissioning Policies;

6.2.2. National Specifications, including National Standards for each of the Specialised Services.

7. Clinical Networks

7.1. Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

7.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3. NHS England shall be responsible for:

7.3.1. developing national policy for the Relevant Clinical Networks;

7.3.2. developing and approving the specifications for the Relevant Clinical Networks;

7.3.3. maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;

7.3.4. convening or supporting national networks of the Relevant Clinical Networks;

7.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

7.3.6. managing Relevant Clinical Networks jointly with the ICB; and

7.3.7. agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

8. Complaints

8.1. NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

8.2. NHS England shall manage all complaints in respect of the Reserved Services.

9. Commissioning and optimisation of High Cost Drugs

9.1. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

9.1.1. comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

9.1.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

9.1.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

9.1.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

9.1.5. provide input into national procurement, homecare and commercial processes;

9.1.6. provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups;

9.1.7. provide expert medicines advice and input into the Individual Funding Request process for Delegated Services; and

9.1.8. collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

10. Contracting

10.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

10.1.2. provide advice for ICBs on schedules to support the Delegated Services;

10.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

10.1.4. provide and distribute contracting support tools and templates to the ICB.

10.2. In respect of the Retained Services, NHS England shall:

10.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

10.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11. Data Management and Analytics

11.1. NHS England shall:

11.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

11.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

11.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

11.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

11.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

11.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups; and

11.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

12. Finance

12.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

13. Freedom of Information and Parliamentary Requests

13.1. NHS England shall:

13.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

13.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

14. Incident Response and Management

14.1. NHS England shall:

14.1.1. provide guidance and support to the ICB in the event of a complex incident;

14.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

14.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

14.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15. Individual Funding Requests

15.1. NHS England shall be responsible for:

15.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

15.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

15.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

16. Innovation and New Treatments

16.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

16.3. NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

17. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

17.1. NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

18. Provider Selection and Procurement

18.1. In relation to procurement, NHS England shall be responsible for:

18.1.1. setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;

18.1.2. monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services; and

18.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

19. Quality

19.1. In respect of quality, NHS England shall:

19.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

19.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

19.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

19.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

19.1.5. provide guidance on quality and clinical governance matters and benchmark available data;

19.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

19.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

19.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

19.1.9. identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

20. National Standards, National Specifications and Clinical Commissioning Policies

20.1. NHS England shall carry out:

20.1.1. development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);

20.1.2. production of national commissioning products and tools to support commissioning of Specialised Services;

20.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

20.1.4. determination of content for national clinical registries.

21. Transformation

21.1. NHS England shall be responsible for:

21.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

21.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

21.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

21.1.4. providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;

21.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

21.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

18.9 6 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing, information governance and the Data Sharing Agreement.

19. IT INTER-OPERABILITY

19.1 The Parties will work together to ensure that all relevant IT systems they operate in respect of the Delegated Functions and Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

19.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

20.1 The ICB must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

20.2 Without prejudice to the general obligations set out in Clause 20.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

21.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

21.2.1 to revoke the Delegation;

21.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

21.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

21.3 The ICB must put in place and maintain appropriate arrangements, including without limitation, Staff training, to address counter-fraud issues, having regard to any relevant Guidance, including from the NHS Counter Fraud Authority.

21.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, any counter-fraud arrangements put in place by the ICB.

21.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in Clause 21.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

21.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than five (5) Operational Days following the date of the request, access to:

21.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

21.7.2 all Staff who may have information to provide.

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

22. CONFIDENTIAL INFORMATION OF THE PARTIES

22.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

22.2 Subject to Clauses 22.3 to 22.5, the receiving Party agrees:

22.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;

22.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and

22.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

22.3 The receiving Party may disclose the disclosing Party's Confidential Information:

22.3.1 in connection with any dispute resolution procedure under Clause 25;

22.3.2 in connection with any litigation between the Parties;

22.3.3 to comply with the Law;

22.3.4 to any appropriate Regulatory or Supervisory Body;

22.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under Clause 22.2;

22.3.6 to NHS bodies for the purposes of carrying out their functions;

22.3.7 as permitted under or as may be required to give effect to Clause 21 (*Prohibited Acts and Counter-Fraud*); and

22.3.8 as permitted under any other express arrangement or other provision of this Agreement.

22.4 The obligations in Clauses 22.1 and 22.2 will not apply to any Confidential Information which:

22.4.1 is in, or comes into, the public domain other than by breach of this Agreement;

22.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

22.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 222 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

23.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any Intellectual Property Rights ("IPR") attaches to Best Practice) grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. DISPUTES

25.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with Legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State;

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance;

26.2.3 it is satisfied that any Developmental Arrangements are no longer required;

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (*Breach*); or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

26.4 For the avoidance of doubt, NHS England may issue or update Mandated Guidance at any point during the term of the Agreement.

26.5 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement including, but not limited to the following:

26.5.1 a request by the ICB to add, vary or remove any Developmental Arrangement; or

26.5.2 a request by NHS England to include additional Specialised Services or NHS England Functions within the Delegation; and

the Proposing Party will identify whether the proposed variation may have the impact of changing the scope of the Delegated Functions or Reserved Functions so that NHS England can establish the requisite level of approval required.

26.6 The Variation Proposal will set out the variation proposed and the date on which the Proposing Party requests the variation to take effect.

26.7 When a Variation Proposal is issued in accordance with 26.6, the Receiving Party must respond within thirty (30) Operational Days following the date that it is issued by serving notice confirming either:

26.7.1 that it accepts the Variation Proposal; or

26.7.2 that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

26.8 If the Receiving Party accepts the Variation Proposal issued in accordance with Clause 26.5, the Receiving Party agrees to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

26.9 If the Receiving Party refuses to accept a Variation Proposal submitted in accordance with 26.5 to 26.7, or to take such steps as are required to give effect to the variation, then the provisions of Clause 15 (*Escalation Rights*) shall apply.

26.10 When varying the Agreement in accordance with Clause 26, the Parties must consider the impact of the proposed variation on any ICB Collaboration Arrangements and any Further Arrangements.

27. TERMINATION

27.1 The ICB may:

27.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

27.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

27.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and its intention to terminate this Agreement; and

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss

arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2; and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority;

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

27.3.3 the ICB persistently commits non-material breaches of this Agreement;

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

27.3.6 failure to agree to a variation in accordance with Clause 26 *(Variations)*;

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 277 *(Termination)*) except that the provisions referred to in Clause 299 (*Provisions Surviving Termination*) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have

accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1; and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions; and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate;

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (*Finance*);

29.2.2 Clause 13 (*Staffing, Workforce and Commissioning Teams*);

29.2.3 Clause 16 *(Liability and Indemnity*);

29.2.4 Clause 17 (*Claims and Litigation*);

29.2.5 Clause 18 (*Data Protection, Freedom of Information and Transparency*);

29.2.6 Clause 25 (*Disputes*);

29.2.7 Clause 27 (*Termination*);

29.2.8 Schedule 6 (*Further Information Governance and Sharing Provisions*).

30. COSTS

30.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

31. SEVERABILITY

31.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

32. GENERAL

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1: Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term "including" or "includes" will be interpreted as being without limitation.

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

"Administrative and Management Services"	means administrative and management support provided in accordance with Clause 9.5 or 9.7;
"Agreement"	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
"Agreement Representatives"	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative;
"Annual Allocation"	means the funds allocated to the ICB annually under section 223G of the NHS Act;
"Area"	means the geographical area covered by the ICB;
"Assurance Processes"	has the definition given in paragraph 3.1 of Schedule 3;
"Best Practice"	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in

	the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
"Capital Investment Guidance"	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; and - the revenue consequences for commissioners or third parties making such investment;
"CEDR"	means the Centre for Effective Dispute Resolution;
"Claims"	means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
"Claim Losses"	means all Losses arising in relation to any Claim;
"Clinical Commissioning Policies"	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
"Clinical Reference Groups"	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
"Collaborative Commissioning Agreement"	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commissioning Functions"	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service;
"Commissioning Team"	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services;

Commissioning Team Arrangements	means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	means any contract or arrangement in respect of the commissioning of any of the Delegated Services;
"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services;
"Contractual Notice"	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions;
"CQC"	means the Care Quality Commission;
"Data Controller"	shall have the same meaning as set out in the UK GDPR;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Impact Assessment"	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the UK GDPR;
"Data Protection Legislation"	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and

	the Privacy and Electronic Communications (EC Directive) Regulations 2003;
"Data Sharing Agreement"	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England;
"Data Subject"	shall have the same meaning as set out in the UK GDPR;
"Delegated Commissioning Group (DCG)"	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;
"Delegated Functions"	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
"Delegated Funds"	means the funds defined in Clause 10.2;
"Delegated Services"	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England;
"Delegation"	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1;
"Developmental Arrangements"	means the arrangements set out in Schedule 9 as amended or replaced;
"Dispute"	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
"Effective Date of Delegation"	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect;
"EIR"	means the Environmental Information Regulations 2004;
"Escalation Rights"	means the escalation rights as defined in Clause 15 *(Escalation Rights)*;
"Finance Guidance"	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules; - Contracting Standard Operating Procedure; - Cashflow Standard Operating Procedure; - Finance and Accounting Standard Operating Procedure; - Service Level Framework Guidance;

"Financial Year"	shall bear the same meaning as in section 275 of the NHS Act;
"FOIA"	means the Freedom of Information Act 2000;
"Further Arrangements"	means arrangements for the exercise of Delegated Functions as defined at Clause 12;
"Good Practice"	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
"High Cost Drugs"	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"Host ICB"	means the ICB that employs the Commissioning Team as part of the Commissioning Team Arrangements;
"ICB"	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
"ICB Collaboration Arrangement"	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions;
"ICB Deliverables"	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information Governance Guidance for Serious Incidents"	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015) as may be amended or replaced;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);

"IPR"	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
"Law"	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
"Local Terms"	means the terms set out in Schedule 8 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
"Losses"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.35 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7;
"National Commissioning Group (NCG)"	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in paragraph 1.2 of Schedule 6 (*Further Information Governance and Sharing Provisions)*;
"NICE Regulations"	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced;
"NHS Act"	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time);

"NHS Counter Fraud Authority"	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
"NHS Digital Data Security and Protection Toolkit"	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ;
"NHS England"	means the body established by section 1H of the NHS Act;
"NHS England Deliverables"	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
"NHS England Functions"	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated;
"Non-Personal Data"	means data which is not Personal Data;
"Operational Days"	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"**Oversight Framework**"	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
"Party/Parties"	means a party or both parties to this Agreement;
"Patient Safety Incident Response Framework"	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ;
"Personal Data"	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
"Population"	means the individuals for whom the ICB has responsibility in respect of commissioning the Delegated Services;
"Prescribed Specialised Services Manual"	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows;
"Provider Collaborative"	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;

"Provider Collaborative Guidance"	means the guidance published by NHS England in respect of Provider Collaboratives;
"Prohibited Act"	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;

"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5;
"Secretary of State"	means the Secretary of State for Health and Social Care;
"Shared Care Arrangements"	means arrangements put in place to support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
"Single Point of Contact"	means the member of Staff appointed by each relevant Party in accordance with Paragraph 9.6 of Schedule 6;
"Special Category Personal Data"	shall have the same meaning as in UK GDPR;
"Specialised Commissioning Budget"	means the budget identified by NHS England for the purpose of exercising the Delegated Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act and Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff of roles identified as carrying out the Delegated Services Functions immediately prior to the date of this Agreement;

"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph **Error! Reference source not found.** of Schedule 6 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Staff or Staffing"	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Sub-Delegate"	shall have the meaning in Clause 12.2;
"System Quality Group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Triple Aim"	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Variation Proposal"	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2: Delegated Services

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services will be delegated to the ICB on 1 April 2024:

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 (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
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	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
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 (adults)
		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 (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
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 (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
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

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
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 (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
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 (adults)
		33B	Complex inflammatory bowel disease (adults)
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

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
112	Specialist gynaecology services for children	73X	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
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 (adults and children)
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
		19B	Specialist services for complex biliary 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 (adults and children)
135	Specialist paediatric surgery services	23X	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
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

22 Introduction

22.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

22.1.1 decisions in relation to the commissioning and management of Delegated Services;

22.1.2 planning Delegated Services for the Population, including carrying out needs assessments;

22.1.3 undertaking reviews of Delegated Services in respect of the Population;

22.1.4 supporting the management of the Specialised Commissioning Budget;

22.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate; and

22.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

22.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

23 General Obligations

23.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

23.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

23.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

24 Assurance and Oversight

24.1 The ICB must at all times operate in accordance with:

24.1.1 the Oversight Framework published by NHS England;

24.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and

24.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

24.2 The ICB must:

24.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

24.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

24.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

24.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

25 Attendance at governance meetings

25.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

25.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

25.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

26 Clinical Leadership and Clinical Reference Groups

26.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

26.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

27 Clinical Networks

27.1 The ICB shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The ICB shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

27.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

27.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

27.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

27.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

27.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

27.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

27.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

28 Complaints

28.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

28.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

28.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

28.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

28.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

28.3.2.1 acknowledgements provided within three (3) Operational Days;

28.3.2.2 responses provided within forty (40) Operational Days;

28.3.2.3 response not provided within six (6) months;

28.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints; and

28.3.2.5 overall activity by volume (not as a KPI).

28.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

28.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

28.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

29 Commissioning and optimisation of High Cost Drugs

29.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

29.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

29.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

29.4 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Party in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

29.5 The ICB must ensure:

29.5.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;

29.5.2 effective introduction of new medicines;

29.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

29.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

29.5.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and

29.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

29.6 The ICB must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

29.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

29.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

30 Contracting

30.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

30.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

30.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

30.1.3 management of Specialised Services Contracts.

30.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

31 Data Management and Analytics

31.1 The ICB shall:

31.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies;

31.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

31.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

31.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

31.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

31.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

31.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.

32 Finance

32.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

33 Freedom of Information and Parliamentary Requests

33.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

34 Incident Response and Management

34.1 The ICB shall:

34.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

34.1.2 support national and regional incident management relating to Specialised Services; and

34.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

34.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.

35 Individual Funding Requests

35.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

36 Innovation and New Treatments

36.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

37 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

37.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

38 Provider Selection and Procurement

38.1 The ICB shall:

38.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

38.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

38.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

38.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

38.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

38.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

38.3.1 made in the best interest of patients, taxpayers and the Population;

38.3.2 robust and defensible, with conflicts of interests appropriately managed;

38.3.3 made transparently; and

38.3.4 compliant with relevant Guidance and legislation.

39 Quality

39.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

39.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

39.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

39.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

39.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

39.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

39.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

39.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

39.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

39.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

39.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

39.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

39.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

40 Service Planning and Strategic Priorities

40.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

40.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

40.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

40.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

41 National Standards, National Specifications and Clinical Commissioning Policies

41.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

41.2 The ICB shall facilitate engagement with local communities on National Specification development.

41.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

41.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

41.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

41.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

42 Transformation

42.1 The ICB shall:

42.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

42.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

42.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

42.1.4 support NHS England with agreed transformational programmes for Retained Services;

42.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

42.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

42.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

22. Reserved Functions in Relation to the Delegated Services

22.1. In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

22.2. This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

22.3. The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

22.4. The following functions and related activities shall continue to be exercised by NHS England.

23. Retained Services

23.1. NHS England shall commission the Retained Services set out in Schedule 5.

24. Reserved Specialised Service Functions

24.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

25. Assurance and Oversight

25.1. NHS England shall:

25.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

25.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

25.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

25.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

25.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

25.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

national level, including identification, review and management of appropriate cross-ICB risks.

26. Attendance at governance meetings

26.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

26.2. NHS England shall:

26.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

26.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

26.2.3. co-ordinate, and support key national governance groups.

27. Clinical Leadership and Clinical Reference Groups

27.1. NHS England shall be responsible for the following:

27.1.1. developing local leadership and support for the ICB relating to Specialised Services;

27.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

27.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

27.2. NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

27.2.1. Clinical Commissioning Policies;

27.2.2. National Specifications, including National Standards for each of the Specialised Services.

28. Clinical Networks

28.1. Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

28.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

28.3. NHS England shall be responsible for:

28.3.1. developing national policy for the Relevant Clinical Networks;

28.3.2. developing and approving the specifications for the Relevant Clinical Networks;

28.3.3. maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;

28.3.4. convening or supporting national networks of the Relevant Clinical Networks;

28.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

28.3.6. managing Relevant Clinical Networks jointly with the ICB; and

28.3.7. agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

29. Complaints

29.1. NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

29.2. NHS England shall manage all complaints in respect of the Reserved Services.

30. Commissioning and optimisation of High Cost Drugs

30.1. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

30.1.1. comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

30.1.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

30.1.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

30.1.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

30.1.5. provide input into national procurement, homecare and commercial processes;

30.1.6. provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups;

30.1.7. provide expert medicines advice and input into the Individual Funding Request process for Delegated Services; and

30.1.8. collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

31. Contracting

31.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

31.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

31.1.2. provide advice for ICBs on schedules to support the Delegated Services;

31.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

31.1.4. provide and distribute contracting support tools and templates to the ICB.

31.2. In respect of the Retained Services, NHS England shall:

31.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

31.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

32. Data Management and Analytics

32.1. NHS England shall:

32.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

32.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

32.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

32.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

32.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

32.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups; and

32.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

33. Finance

33.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

34. Freedom of Information and Parliamentary Requests

34.1. NHS England shall:

34.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

34.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

35. Incident Response and Management

35.1. NHS England shall:

35.1.1. provide guidance and support to the ICB in the event of a complex incident;

35.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

35.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

35.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

36. Individual Funding Requests

36.1. NHS England shall be responsible for:

36.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

36.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

36.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

37. Innovation and New Treatments

37.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

37.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

37.3. NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

38. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

38.1. NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

39. Provider Selection and Procurement

39.1. In relation to procurement, NHS England shall be responsible for:

39.1.1. setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;

39.1.2. monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services; and

39.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

40. Quality

40.1. In respect of quality, NHS England shall:

40.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

40.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

40.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

40.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

40.1.5. provide guidance on quality and clinical governance matters and benchmark available data;

40.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

40.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

40.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

40.1.9. identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

41. National Standards, National Specifications and Clinical Commissioning Policies

41.1. NHS England shall carry out:

41.1.1. development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);

41.1.2. production of national commissioning products and tools to support commissioning of Specialised Services;

41.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

41.1.4. determination of content for national clinical registries.

42. Transformation

42.1. NHS England shall be responsible for:

42.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

42.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

42.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

42.1.4. providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;

42.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

42.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

SCHEDULE 6: Further Information Governance And Sharing Provisions

PART 1

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2. describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Parties' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.

2.2. Each Party must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose. Where necessary specific

and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Delegated Services.

4. Lawful basis for sharing

4.1. The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Parties.

5.4. Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Parties shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Party shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Parties shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Parties.

7. Governance: Staff

7.1. The Parties must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018), the employing Parties must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4. Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5. The Parties shall ensure that:

7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;

7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4. If any Party becomes aware of:

8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

8.4.2. any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body; and

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection

Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.

8.7. In particular, each Party shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

8.7.4. permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

8.8. The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.9. The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.10. The Parties' Single Points of Contact set out in paragraph **Error! Reference source not found.** will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as

the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6. The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10. Governance: Quality of Information

10.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

11.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5. The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB.

12.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

13.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 6: Further Information Governance and Sharing Provisions

PART 2

Data Sharing Agreement

The National draft version of the DPIA and Joint Controller Agreement are included below, amended future iterations of this will be agreed in future as they become available.

DPIA%20Delegation %20of%20Spec%20c

Joint%20Controller% 20Agreement%20Fina

SCHEDULE 7: Mandated Guidance

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests;
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The Prescribed Specialised Services Manual

SCHEDULE 8: Local Terms

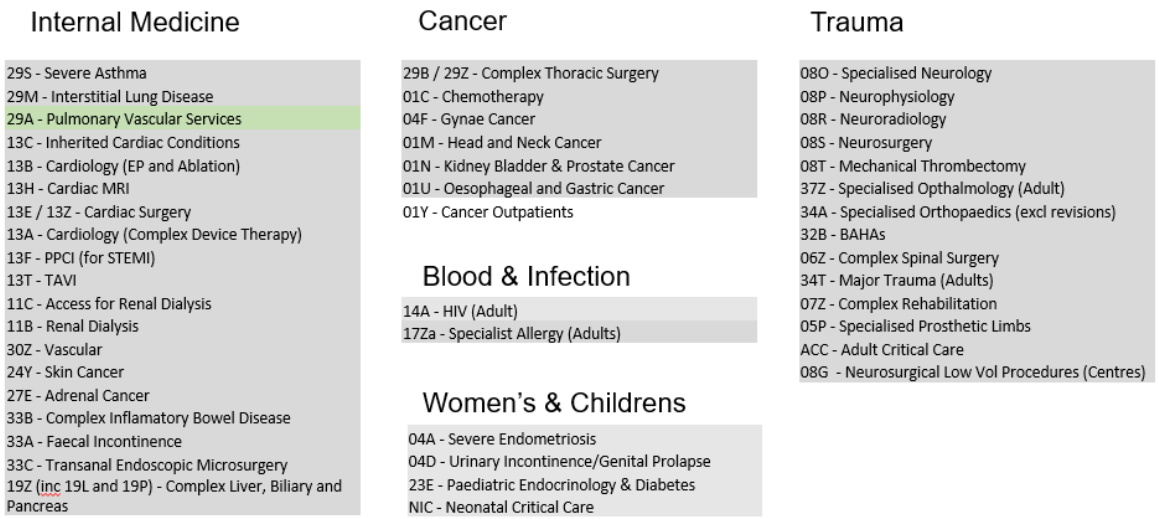
General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

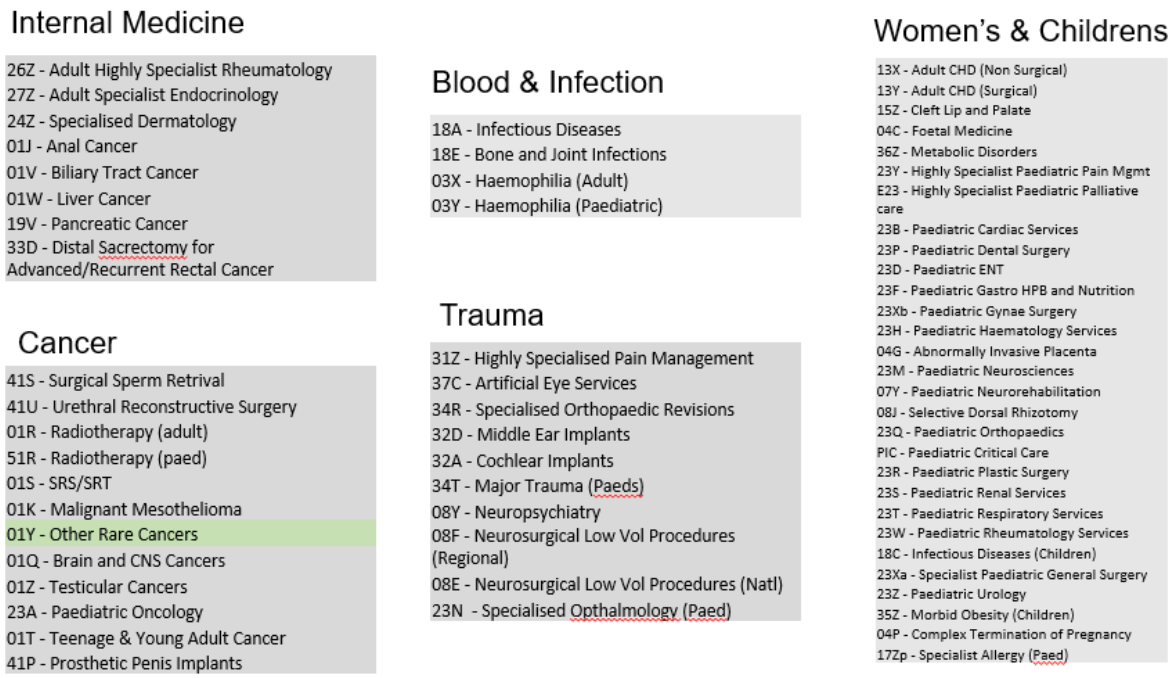
Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

Part 1 – the services to be planned or commissioned at an ICB level
Services for Individual ICBs



Part 2 – the services to be planned or commissioned by an ICB Collaboration Arrangement Services for NW planning (multi-ICB)



Part 3 – Funding arrangements

In advance of the commencement of each subsequent financial year, NHS England will notify the ICB of the amount of the Specialised Services Delegated Funds in accordance with Clause 10.2.

This section will be completed once the relevant national information about financial allocations has been provided.

Part 4 – Workforce and Commissioning Team Arrangements

The Target Operating Model is a description of the desired operating model for the Specialist Commissioning Hub ('the Hub'). This document sets out the workforce and Commissioning Team Arrangements. It is proposed the Hub will be hosted by Lancashire and South Cumbria ICB and will provide equitable support to three ICB's (Lancashire and South Cumbria, Greater Manchester, and Cheshire and Mersey) and the NHS England Regional team.

The TOM describes the operating model from the date of Specialist Commissioning Delegation from NHSE on the 1st April 2024. Based on NHSE national guidance an assumption has been made that there will be no reduction in the Specialised Commissioning (Spec Comm) team running costs prior to delegation. Directly commissioned services were not in the ICB running costs baseline at the time the target running costs reductions were set, and as a result do not need to be counted in the achievement of those running cost reductions.

Please note that the TOM is an iterative document and will be further developed as working arrangements are implemented, tested and refined over time.

Part 5 – ICB Collaboration Arrangements

North-West ICBs are working to develop the detail to complete the template Collaboration Agreement. This will be completed as part of transition year 2024/25.

Part 6 – Pooled Funds and Non-Pooled Funds

Not applicable in 2024/25.

Part 7 – Provider Collaboratives

Not applicable in 2024/25.

Part 8 – Further Governance Arrangements

Governance arrangements are set out in the North West TOM Document.

SCHEDULE 9: Developmental Arrangements

These Development Arrangements take precedence over the terms of this Agreement including other Schedules, and the Agreement shall be read as varied by these Developmental Arrangements. Save as varied by these Developmental Arrangements the Agreement remains in full force and effect.

The Developmental Arrangements

The following Developmental Arrangements apply to this Agreement:

The specialised commissioning budget and commissioning responsibilities will happen in stages. 'Suitable and ready' services will be transferred in April 2024, and specialised mental health services, highly specialised services, High Cost Drugs Budgets and funding of Specialised Clinical Networks will be retained by NHS England.

While the first tranche of specialised commissioning will be delegated to ICBs from April, the NHS England staff responsible for managing these services will not transfer until a year later. This allows for thorough staff engagement and planning. Building relationships with those affected, understanding current working relationships across ICBs and NHS England, and having the time to understand and address potential barriers to effective transfer will be crucial in building staff confidence and minimising any impact on service delivery during the next stage.

Ringfencing – ICB allocations for Delegated Specialised Services will be ringfenced, to be spent ONLY on designated specialised services. This condition includes reserves and discretionary growth funding as well as existing contractual spend (both block and variable elements). This does not determine which specialised services those allocations are spent on. Any in-year variation to this condition would need to be to approved by the Regional Director of Commissioning or Regional Director of Finance. This condition will remain in place until NHS England's NW Regional Management Team make a decision to remove it.

For the period in which this condition is in place, this condition suspends paragraphs 10.3 and 10.4 of the delegation agreement.

SCHEDULE 10: Administrative and Management Services

The North West Specialised Services Target Operating Model (TOM) is a description of the desired operating model for the Specialist Commissioning Hub ('the Hub'). This document sets out the Administrative and Management Services. It is proposed the Hub will be hosted by Lancashire and South Cumbria ICB and will provide equitable support to three ICB's (Lancashire and South Cumbria, Greater Manchester, and Cheshire and Mersey) and the NHS England Regional team.

Please note that the TOM is an iterative document and will be further developed as working arrangements are implemented, tested and refined over time.

Dated 2024

(1) **NHS ENGLAND (SPECIALISED COMMISSIONING)**

AND

(2) **NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD**

- and -

(3) **NHS GREATER MANCHESTER IINTEGRATED CARE BOARD**

- and -

(4) **NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD**

Commissioning Team Agreement for Delegated Specialised Services support via NHS England Commissioning Teams in Financial Year 2024/25

Contents

THIS AGREEMENT is made on the_____ day of _____2024

Between

NHS Cheshire and Merseyside Integrated Care Board whose principal office is at *No 1 Lakeside, Centre Park, Warrington, WA1 1QY (" NHS Cheshire and Merseyside ICB");*

NHS Greater Manchester Integrated Care Board whose principal office is at *3 Piccadilly Place, Manchester, M1 3BN ("NHS Greater Manchester ICB")*

NHS Lancashire and South Cumbria Integrated Care Board whose principal office is at *Chorley House, Lancashire Enterprise Business Park, Centurion Way, Leyland, Lancashire, PR26 6TT ("NHS Lancashire and South Cumbria ICB").*

NHS England, whose principal office is at *Regatta Place, Summers Road, Brunswick Road Business Park, Liverpool, Merseyside, L3 4BL ("NHS England North West")*

each a "Partner" and together the "Partners".

NHS Cheshire and Merseyside ICB, NHS Greater Manchester ICB and NHS Lancashire and South Cumbria ICB are together referred to in this Agreement as the "ICBs", and "ICB" shall mean any of them.

Introduction

The ICBs and NHS England wish to enter into this Commissioning Team Agreement (the "Agreement").

This is an Agreement to define the administrative and management services (the "Administrative and Management Services") to be provided by the NHS England regional teams currently commissioning Specialised Services (the "Commissioning Teams") to the ICBs during the financial year 2024/25 (1 April 2024 – 31 March 2025) for all Delegated Specialised Services.

Background

a) NHS England has statutory functions to arrange for the provision of prescribed services for the purposes of the NHS. This includes the services known as Specialised Services.

b) The ICBs have statutory functions to arrange for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.

c) NHS England will enter into a Delegation Agreement for Specialised Services with each ICB under Section 65Z5 of the NHS Act 2006 (*delegation and joint working*). The Delegation Agreement for Specialised Services will delegate to ICBs the statutory functions for commissioning those Specialised Services that have been deemed 'suitable and ready' for greater ICB involvement (Delegated Specialised Services) from April 2024. The intention of this delegation is that this will help ICBs join up the specialist elements of pathways with prevention activity and primary, community and secondary care services for which they are responsible.

d) Staff who supported the commissioning of the Delegated Specialised Services immediately prior to delegation (the "Staff"), will come together within NHS England to form commissioning teams (the "Commissioning Team").

e) In August 2023 an Executive decision was made that Commissioning Teams will remain hosted by NHS England during 2024/25 for a one-year transition period. The Commissioning Teams will be supporting the Delegated Specialised Services, as well as those specialised services retained by NHS England ("Retained Specialised Services"). This ensures stable support for the delegation of Specialised Services. The Delegation Agreement for Specialised Services provided that, as part of the delegation and joint working arrangements under Section 65Z5 of the NHS Act 2006, NHS England could provide Administration and Management Services to the ICBs in respect of the Delegated Specialised Services (Clause 9.6 of the Delegation Agreement for Specialised Services).

f) The delegation of the Delegated Specialised Services supports NHS England's long-term and continuing ambition to put decision-making at as local a level as possible to meet the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for local systems and for the wider NHS.

g) This Agreement sets out the arrangements that will apply between ICBs and NHS England to enable Commissioning Teams to provide Administrative and Management Services to the ICBs in 2024/25 to support the ICBs in exercising the statutory functions of commissioning the Delegated Specialised Services. There is no delegation of functions under this Agreement and as such the Commissioning Teams will not have the authority to take decisions in respect of the Delegated Services except as instructed by the ICBs in accordance with this Agreement.

It is agreed:

1 Commencement, duration and status of this Agreement

1.1 This Agreement shall come into force on the 1 April 2024 and continue until 31 March 2025 (the "Period") unless extended by written agreement from all Partners or terminated in accordance with Clause 7 (Termination) below.

1.2 Unless otherwise provided, the words and expressions defined in the Delegation Agreement shall have the same meaning and effect in this Agreement.

2 Principles and aims

2.1 In performing their respective obligations under this Agreement the ICBs and NHS England acknowledge that in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act, and must:

2.1.1. consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

2.1.2. consider how in performing their obligations they can address health inequalities;

2.1.3. at all times exercise functions effectively, efficiently and economically and;

2.1.4. act at all times in good faith towards each other;

2.2 The Partners agree:

2.2.1. that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.2.2. to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.2.3. to act in a timely manner;

2.2.4. to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost;

2.2.5. to act at all times to ensure the Partners comply with the requirements of the Delegation Agreements;

2.2.6. to act at all times in accordance with the scope of their statutory powers; and

2.2.7. to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any and as far as is reasonably practicable take such needs and views into account.

2.2.8. to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Services and, as far as is reasonably practicable, take such needs and views into account.

3 Scope of the arrangements

3.1 In accordance with the Delegation Agreements NHS England agrees to provide to the ICBs the Administrative and Management Services as set out in this Agreement.

3.2 The Partners agree that the costs associated with the provision of the Administrative and Management Services by the Commissioning Team shall not be included within the Delegated Funds allocated or transferred to the ICBs for the Period and that NHS England shall meet those costs.

4 Administrative and Management Services

4.1 NHS England, through the Commissioning Team, shall provide the Administrative and Management Services as set out in Schedule 1 or as otherwise agreed in writing between the Partners.

5 Staffing

5.1 The provisions of Schedule 2 shall apply in respect of the NHS England Staff providing Administrative and Management Services. – **See Staffing Schedule**

6 Governance and Decision Making

6.1 The Partners have agreed that the governance and decision-making arrangements as set out in Schedule 3 shall apply to this Agreement.

7 Variation and Termination

7.1 This Agreement may be varied by the written agreement of all Partners.

7.2 This Agreement may only be terminated prior to the end of the Period by mutual agreement in writing by all Partners.

7.3 The Escalation and Dispute provisions as set out in the Delegation Agreement shall apply to this Agreement.

8 Confidential Information

8.1 Each Partner shall at all times use its best endeavours to keep confidential and ensure that its employees and agents keep confidential any information in relation to the business and affairs of another Partner. No Partner shall disclose such information except with the consent of the other Partners. A disclosure by a Partner in accordance with an Act of Parliament or legislation made under it or in compliance with a Court Order shall not be an actionable breach of confidence.

8.2 The obligations of each Partner shall continue without limit in point of time but shall cease to apply to any information that is put into the public domain otherwise than by a Partner breaching its obligations.

8.3 If the information referred to herein is subject to a freedom of information (FOI) or other request to share the data, then NHS England will be responsible for the fulfilment of the request, but will seek views from the ICBs before undertaking this in accordance with the Freedom of Information Code of Practice issued by the Cabinet Office under section 45 of the Freedom of Information Act 2000.

8.4 Save as expressly set out in this clause or otherwise with the written consent of the other Partners, no Partner shall make any press announcements about this Agreement or publicise this Agreement or any of the terms in any way and each Partner shall ensure that any such information disclosed is solely for the purpose of performing its obligations under this Agreement.

8.5 Notwithstanding the provisions of this clause, each Partner shall be entitled to disclose any information relating to this Agreement in the following circumstances:

8.5.1 for the purpose of any examination of this Agreement by the National Audit Office pursuant to the National Audit Act 1983 or otherwise;

8.5.2 for parliamentary, governmental, statutory or judicial purposes;

8.5.3 in relation to any other legal obligation on the disclosing Partner; or

8.5.4 where such information is already in the public domain.

8.6 Each Partner shall take all reasonable steps to ensure the observance of this clause by all its servants, employees, agents and consultants.

9 Data and Business Intelligence

9.1 All Partners will comply with all applicable requirements of the Data Protection Legislation. The Partners shall ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Administrative and Management Services is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance and the Partners must assist each other as necessary to enable each other to comply with these obligations.

9.2 The Partners are satisfied that each of them have the appropriate legal basis for the processing of the data required in order for the ICBs to exercise their function in commissioning the Delegated Services and NHS England to provide the Administrative and Management Services.

9.3 NHS England shall complete a data protection impact assessment (DPIA) in respect of the provision of the Administrative and Management Services to ICBs and shall share this with the ICBs. The ICBs agree to enter into an appropriate data sharing agreement where this DPIA suggests this is required for the provision of the Administrative and Management Services.

9.4 Each ICB must carry out their own assurances (DPIA) in respect of the arrangements set out in this Agreement.

10 Assignment

10.1 No Partner shall assign, transfer, mortgage, charge, subcontract, delegate, declare a trust over or deal in any other manner with any or all of its rights and obligations under this Agreement without the prior written consent of the other Partners.

11 Costs and Liabilities

11.1 Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement.

11.2 No Partner excludes or limits liability to the other Partners for:
11.2.1 death or personal injury caused by its negligence; or
11.2.2 Fraud; or
11.2.3 fraudulent misrepresentation.

11.3 NHS England shall be liable for any losses arising out of negligent acts or omissions in respect of the provision of Administrative and Management Services except where such losses arise as a result of action taken in accordance with instruction from any ICB or a failure of an ICB to provide on request appropriate instruction.

12 Status

12.1 Unless otherwise stated, this Agreement is not intended to be legally binding, and no legal obligations or legal rights shall arise between the parties from this Agreement. The Partners enter into the Agreement intending to honour all their obligations.

IN WITNESS OF WHICH the Partners have signed this Agreement on the date shown below

NHS Cheshire and Merseyside ICB
Authorised Officer: **Date:**
Graham Urwin, Chief Executive

NHS Greater Manchester ICB
Authorised Officer: **Date:**
Mark Fisher, Chief Executive

NHS Lancashire and South Cumbria ICB
Authorised Officer: **Date:**
Kevin Lavery, Chief Executive

NHS England
Authorised Officer: **Date:**
Richard Barker, Executive Regional Director (North West)

Schedule 1 – Administrative and Management Services

NHS England shall provide the following Administrative and Management Services under this Agreement:

1 General

1.1 NHS England will provide such Services as it agrees with the ICBs as required for the ICBs to exercise the Statutory Functions as set out in Schedule 3 to the Delegation Agreement which shall include, but is not limited, to the Administrative and Management Services set out below.

2 Contract Management

See schedule 5

2.1 The Commissioning Team shall provide contract management and support in respect of the Delegated Services in order to facilitate the ICBs to meet the Delegated Functions set out in Schedule 3 of the Delegation Agreement *(delegated functions)*. Such support shall be in compliance with the agreed regional contracting strategy and Standard Operating Procedures.

3 Finance

The financial arrangements in respect of the provision of the Administrative and Management Services by NHS England to the ICBs shall be as set out in Schedule 4 [financial arrangements]. **See Schedule 4**

4 Data Management and Analytics

This Agreement is specifically about how the data arrangements will work in relation to NHSE providing the Services to the ICBs in 24/25.

Information on this section is included in the NW TOM

4.1 The Commissioning Team shall provide such data management and analytic services as NHS England considers necessary to ensure that the ICB meets its obligations under Schedule 3 of the Delegation Agreement (*Delegated Functions*).

5 Freedom of Information and Parliamentary Requests

5.1 The Commissioning Team shall provide such reasonable support as required by an ICB to ensure the appropriate handling, management and response to all freedom of information and parliamentary correspondence relating to Delegated Specialised Services.

6 Incident Response and Management

6.1 The Commissioning Team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Specialised Services (providing pre-arranged advice on business continuity and EPRR)

7 Provider Selection and Procurement

7.1 The Commissioning Team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Specialised Services.

See RASCI on NW Target Operating Model

8 Quality

8.1 The Commissioning Team shall ensure appropriate arrangements for quality oversight are in place in respect of the provision of the Administrative and Management Services.

9 Audit

9.1 During 2024/25, it is anticipated that an audit will be conducted by NHS England's auditors on the administrative and management services provided to the ICBs by the Commissioning Team. The scope of th audit is to be determined. The ICBs may be asked by NHS England to provide input to the audit.

Schedule 2 – Staffing Model

Commissioning Team Staff Model

1. NHS England will ensure such resource as it considers reasonably required and within budget is allocated to the provision of the Administrative and Management Services.

2. Under this Agreement NHS England shall be providing the Administration and Management Services to the ICB to assist the ICB in meeting its obligations in respect of the Delegated Functions under the Delegation Agreement for Specialised Services.

3. There is no delegation of statutory functions under this Agreement and therefore the responsibility for the Delegated Specialised Services, along with the decision-making responsibility, rests with the ICBs.

Availability of NHS England Staff

4. In addition to any Staff deployed in any communicated arrangement, NHS England may deploy additional Staff to the Commissioning Team to perform Management Services.

5. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

    a. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

    b. perform all duties assigned to them pursuant to this Schedule 8.

6. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

7. NHS England shall use all reasonable efforts to make its Staff available whilst the NHS England Staff are absent:

    a. by reason of industrial action;

    b. as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

    c. in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

    d. if making the NHS England Staff available would breach or contravene any Law;

    e. as a result of the cessation of employment of any individual NHS England Staff; and/or

    f. at such other times as may be agreed between NHS England and the ICB.

8. NHS England shall employ its Staff and shall be responsible for the employment of its Staff at all times on whatever terms and conditions as NHS England and its Staff may agree from time to time.

9. NHS England shall pay its Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from salaries and other payments.
10. NHS England shall not hold out its Staff as employees of the ICBs, and shall procure that its Staff do not hold themselves out as employees of the ICB.

Management of NHS England staff

11. NHS England where appropriate, shall in consultation with the ICBs, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICBs and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

12. The ICBs agree to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

13. If an ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

14. No admission of liability shall be made by or on behalf of an ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Schedule 3 - Governance and Decision-Making Arrangements

A North-West Specialised Services Target Operating Model (TOM) has been produced which sets out the governance and decision-making arrangements.

Please refer to this document for further detail.

***RECOMMENDATION**: this Schedule should be used to describe the governance and decision-making arrangements that will be in place between the Partners for 2024/25. This could include:*

- *The role of the joint committee established between the partners, with reference to the revised joint committee terms of reference;*

- *The issues that should be referred to the joint committee. For example, approval of the financial or contracting strategy; general strategy for specialised services in 2024/25; transformation proposals for specialised services;*

- *Whether there are any limitations on spending by the NHSE Commissioning Team and how ICBs should be involved in monitoring expenditure and approving any exceptional spending, or change in spending, in accordance with their standing financial instructions;*

  Where appropriate, the financial governance or arrangements can be set out in Schedule 4 (financial arrangements);

- *Whether there are any limitations on the NHSE Commissioning Team in relation to contracts on changes to contracts and how ICBs should be involved in the approval process for changes, variations or amendments to contracts;*

- *What the process for signing new contracts will be that affect the ICB or ICBs in future years;*

- *The extent to which ICBs should be involved in any procurement processes undertaken by the NHSE Commissioning Team and how the final award will be determined by the ICBs;*

- *Where there is no joint committee, this section will need to describe the relevant decision making body that includes all of the partners, its role and any limitations on decision making.*

Schedule 4 - Financial Arrangements

The term of the Commissioning Team Agreement is intended to be for one year, covering the 2024/25 financial year and the specific arrangements required (i.e. NHS England providing administration and management services to ICBs). It is envisaged that from 1 April 2025, Commissioning Teams will transfer to a host ICB and therefore the arrangements described in this financial schedule will either no longer be required or will require revision to support those arrangements.

Scope of the NHSE Commissioning Team's discretion relating to finances

1. In relation to those services delegated to ICBs, a financial condition will be applied to all NW ICBs as agreed by NHSE and outlined in schedule 9 of the delegation agreement.

2. ***Ringfencing*** *– Delegated specialised commissioning allocations 2024/25 will be ringfenced to be spent only on specialised commissioning services. This includes reserves and discretionary growth funding as well as existing contractual spend, both block and variable elements. This does not determine which specialised services those allocations are spent on. Any variation of this condition would need to be to approved by the Regional Director of Commissioning or Director of Finance.*

3. NHSE Commissioning Hub has agreed a set of financial principles with the ICBs to ensure consistency and efficiency in relation to decision making for the 2024/25 financial plan. These principles can be seen in Appendix A – Financial Planning Objective & Principles.

4. The RASCI will determine how financial decisions will be made and the SORD will determine who can approve expenditure. The finance sub group (group set up to support delegation) has developed and agreed an approach to financial governance for 2024/25. This includes how decisions will be made. For Single ICB delegated services the decisions will be made as per the RASCI and as per each existing ICBs SORD. NHSE will follow an agreed process to ensure all decisions are made in a timely and effective way. For Multi ICB delegated services the decisions will be made through the joint commissioning committee. NHSE and the ICBs will ensure that any ICB approvals are made prior to the Joint Commissioning committee to ensure decisions are made in a timely and effective way.

5. All financial decisions will be logged and reported in the monthly financial management reporting pack.

6. A copy of the RASCI and approach to financial governance (including the SORD) is detailed in Appendix B – Approach to Financial Governance and SORD

How will the ICB make payments

7. The NHSE NW Commissioning Hub will look to replicate the contracting function and processes from 2023/24 and implement NHSE-led contracts for delegated, retained and directly commissioned services for 2024/25. Responsibility for the commissioning of delegated services will be assigned to the respective ICBs through a contractual notice under the provisions of GC12 of the NHS Standard Contract in Q1 2024/25.

8. NHSE NW Commissioning Hub will provide a monthly schedule of contract payments to each ICB on working day -1 date for approval. This will include any changes/adjustments made to contracts. The schedule will have been reviewed and approved by the DOCF. It will then be sent to the ICB for final approval (CFO) and payment. This process will be replicated within NHSE for the retained and other directly commissioned services.

9. This schedule will enable ICBs to make the appropriate payments to providers, and will also enable the ICBs to manage their cash drawdown and cash position.

10. The ICBs will make the contract payments on the 15th of each month in line with NHSE specialised commissioning national team and regions. This will ensure consistency and clarity for Providers.

Financial Reporting

11. Financial transactions for the 59 delegated specialised services will be processed through the Oracle ISFE ledger system of each ICB. During 2024/25, ICBs will transition to the new Oracle ISFE2 system. NHSE NW Commissioning Hub will work with the ICBs to support this transition.

12. The NHSE NW Commissioning hub will complete the financial reporting within the ICB ledgers by working day 3.

13. A financial reporting pack will be sent to the ICBs by working day 15. Financial reporting will provided on a monthly basis and will include:

    13.1. Financial position on delegated services for each ICB, this will include a forecast from Month 3
    13.2. ERF and local variable performance as per national reporting timescales
    13.3. Reserves and investment position for delegated ICB services
    13.4. Financial decisions made/requested to delivery financial plan

14. In addition, the NHSE NW Commissioning hub will provide the completed non IFSE report templates for each ICB in relation to the delegated services. The ICB will then submit the whole non IFSE return.

15. NHSE NW Commissioning Hub will lead and complete the AOB for 2024/25 process for delegated specialised services. The hub will report AOB position to the ICBs where applicable (month 9 and month 12)

16. All financial reports will be reviewed and signed off by the DDOCF and DOCF (NHSE commissioning hub) before being shared with the ICBs

Financial Disputes

17. The financial governance arrangements will be agreed by the ICBs and NHSE NW Commissioning Hub and will cover the key financial decisions. In addition, financial planning principles, including an approach to risk management has been agreed by the ICBs through the finance sub group and the Joint Commissioning Committee. The principles can be seen in Appendix A – Financial Planning Objectives & Principles

18. A FOT Financial position will be included with the monthly reporting packs, and reported to ICB committees. Any risks that cannot be mitigated would lead to a discussion with the ICB CFO's to agree a mitigation strategy.

Ledger Access

19. In 2024/25 staff responsible for the management of specialised commissioning resources will continue to be employed by NHS England but will access ICB ledgers to process transactions for specialised services. NHSE NW Commissioning Hub has agreed access with the ICBS and the national team to ensure that the NW staff have access to the ICB ledgers for 2024/25.

20. Processes will be in place to provide appropriate governance and segregation of duties. These will also be subject to review and audits through the existing ICB audit arrangements, it will be the responsibility of the ICBs to ensure this is referenced within their 2024/25 audit plans.

Funding of Administrative & Management Services (NHSE NW Commissioning Hub)

21. The NW Commissioning Hub staff will continue to be employed by NHS England in 2024/25. The funding for these staff will remain with NHS England in 2024/25. This will cover staff costs, training and associated travel costs.

Appendix A – Financial Planning Objectives and Principles

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Appendix B – Approach to Financial Governance and SORD

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Schedule 5 - Contracting Arrangements

This section will be completed once the relevant national information about financial allocations has been provided.

North West Specialised Services Joint Committee

Terms of Reference v1.4

Date	Version	Revision	Comment	Author / Editor
29.01.24	1.1	Initial ToRs	Comments incorporated from D.Atkinson (L&SC ICB) and C.Gaffey (GM ICB)	Matthew Cunningham
04.03.24	1.2	Updated TORs	Incorporating feedback from CWIG (9.02.24) and NW ICB Governance Leads mtg (04.03.24)	Matthew Cunningham
06.03.24	1.3	Updated ToRs	Incorporating additional arrangements for members, decision making and regular participants	Debra Atkinson
07.03.24	1.4	Updated TORs	Incorporating feedback from North West Specialised Commissioning Joint Committee members at its meeting on 07.03.24	Matthew Cunningham

Review due:
Quarter 3 of 2024/25

V1.4 approved by the: Board of NHS Cheshire and Merseyside ICB *(to add)*
Board of NHS Greater Manchester ICB *(to add)*
Board of NHS Lancashire and South Cumbria ICB *(to add)*

Partner Organisations

Organisation Name	Address	Lead Contact Officer	Website
NHS Cheshire and Merseyside ICB	No1 Lakeside, Centre Park, Warrington, WA1 1QY	Clare Watson	www.cheshireandmerseyside.nhs.uk
NHS Greater Manchester ICB	4th Floor, 3 Piccadilly Place, Manchester, M1 3BN	Rob Bellingham	www.gmintegratedcare.org.uk
NHS Lancashire and South Cumbria ICB	Level 3, Christ Church Precinct, County Hall, Fishergate Hill, Preston, PR1 8XB	Professor Craig Harris	www.lancashireandsouthcumbria.icb.nhs.uk

Document control

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1. Introduction and purpose

1.1. From April 2024, Integrated Care Boards (ICBs) entering Delegation Agreements with NHS England for specialised services will become responsible for commissioning the Delegated Services set out in Schedule 2 of the NHS England Delegation Agreement, and for any associated Delegated Functions as set out in Schedule 3. These can be found in the appendices of this Terms of Reference.

1.2. Clause 8 of the Delegation Agreement requires ICBs to form an appropriate ICB Collaboration Arrangement to ensure that the Delegated Services are commissioned at the most efficient and effective level for each Specialised Service. It is acknowledged that collaborative joint working arrangements provide opportunity for ICBs to better align and transform pathways of care around the needs of local populations.

1.3. Section 65Z5 of the National Health Service Act 2006 as amended ('the NHS Act') permits NHS organisations to delegate their functions to other statutory bodies. It also permits combinations of NHS organisations to jointly exercise their functions and pool funds in a joint working arrangement. In accordance with section 65Z5 of the NHS Act, ICBs can establish and maintain joint working arrangements, overseen by a Joint Committee, to jointly exercise the commissioning functions.

1.4. NHS Cheshire and Merseyside ICB, NHS Greater Manchester ICB and NHS Lancashire and South Cumbria ICB have agreed to establish a Joint Committee, which will be known as the North West Specialised Services Joint Committee (referred to as 'Joint Committee for the purposes of this Terms of References). The Joint Committee will oversee the North West ICB Collaboration Arrangement, supporting the Partners to collaboratively make decisions on the planning and delivery of the Delegated Services.

1.5. These terms of reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the Delegation Agreements between the ICBs and NHS England, and any agreement underpinning the North West ICB Collaboration Arrangement. These Terms of Reference will be published on the website of each partner organisation

1.6. Any of the three North West ICBs may, to such extent that they consider it desirable, table an item at the Joint Committee relating to any other of their functions that is not a Joint Specialised Service or a Joint Function to facilitate engagement, promote integration and collaborative working.

2. Role of the North West Specialised Services Joint Committee

2.1 The role of the Joint Committee shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified Delegated Services as set out in Schedule 2 of the NHS England Delegation Agreement, and for any associated Delegated Functions as set out in Schedule 3 (Appendix One) and such ICB functions as agreed by the three North West ICBs.

2.2 The Joint Committee will oversee the North West ICB Collaboration Arrangement, supporting the ICBs to collaboratively make decisions on the planning and delivery

of the Delegated Services. These terms of reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the Delegation Agreements between the ICBs and NHS England, and any agreement underpinning the North West ICB Collaboration Arrangement. These Terms of Reference will be published on the website of each of the three North West ICBs.

2.3 The Joint Committee will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these Joint Specialised Services through the following key responsibilities:

- determining the appropriate structure of the Joint Committee
- oversee the development, implementation and review of the North West Specialised Services Target Operating Model (TOM) which sets out how the functions and responsibilities of commissioning specialised services will be discharged from 01 April 2024
- oversee the implementation and performance of the North West ICB Collaboration Agreement and Commissioning Team agreement between NHS England and the three North West ICBs
- making joint decisions in relation to the planning and commissioning of the relevant Delegated Services, and any associated commissioning or statutory functions, for the population, for example, through undertaking population needs assessments;
- have due regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources in all decision-making;
- monitoring and delivering the population-based specialised service financial allocation and financial plans for services commissioned by the Partners, including agreeing the annual contribution made by each North West ICB, and the commissioning intentions for any Pooled Funds or Non-Pooled Funds where these are in use;
- with reference to the oversight and assurance of the Delegated Services in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with Specialised Services Providers where there are quality or contractual issues;
- identifying and setting strategic priorities and undertaking ongoing assessment and review of Delegated Services within the remit of the Joint Committee, including tackling unequal outcomes and access;
- supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and, providing a forum that enables collaboration to integrate service pathways, improve population health and services, and reduce health inequalities. This includes establishing links and working effectively with health and care partners

including Provider Collaboratives and cancer alliances, other ICBs, joint committees and NHS England where there are cross-border patient flows to providers;

- ensuring the Joint Committee has access to appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks;

- ensuring that, prior to a decision being made by the Joint Committee in relation to the Delegated Services, appropriate consideration by relevant clinicians and other relevant disciplines has been undertaken;

- ensuring the Joint Committee has effective engagement arrangement in place with stakeholders, including patients and the public, and involving them in informing Committee decision-making;

- commencing longer-term planning of the Delegated Services, including the opportunities for transformation and integration of the services and functions;

- discussing any matter which any member of the Joint Committee considers to be of such importance that it should be brought to the attention of the Joint Committee;

- review and renew the operation of these terms of reference subject to the terms of any existing contractual commitments;

- otherwise ensuring that the roles and responsibilities set out in the agreement between the Partners are discharged.

2.4 The Joint Committee will also be used as a forum for NHS England and ICBs to discuss the development of Retained Specialised Services by NHS England. NHS England North West retains decision making responsibility for these services and will only be in attendance at the meetings of the Joint Committee.

3. Accountability and reporting

3.1 The North West ICB organisations are accountable to NHS England for the Delegated Services and Delegated Functions through the Delegation Agreement for Specialised Services.

3.2 As a Joint Committee of the three ICBs, the Joint Committee is accountable to the respective Boards of NHS Cheshire and Merseyside ICB, NHS Greater Manchester ICB and NHS Lancashire and South Cumbria ICB.

3.3 The North West ICB Collaboration Arrangement describe how the ICBs will collaborate to commission the Delegated Services and perform the Delegated Functions, and also describes how each ICB will hold each other to account for delivery of the Delegated Functions. The NHS England North West Commissioning Team Agreement with the three North West ICBs will also outline how the NHS England hosted hub will work collaboratively with and on behalf of the three ICBs throughout 2024-2025.

3.4 The Joint Committee will provide reports to the Boards of each of the three North West ICBs, and the NHS England Board via the North West Regional Management Team (RMT) and the North West Regional Commissioning Committee

3.5 The Joint Committee will report separately to each of the three ICBs via:

Cheshire and Merseyside
The Joint Committee will provide reports directly to the Board of NHS Cheshire and Merseyside. Highlight reports and confirmed minutes of meetings will be published within the papers of ICB Board meetings held in public. The Joint Committee will also provide reports and minutes to the ICBs Strategy and Transformation Committee, which is the ICB Committee that has the role and responsibility for oversight of those specialised services to be commissioned solely by NHS Cheshire and Merseyside. The Joint Committee will also provide reports and minutes to other ICB Committees where required and when needing further decisions, such as in relation to procurement.
Greater Manchester
The Joint Committee will provide reports directly to the Board of NHS Greater Manchester. Highlight reports and confirmed minutes of meetings will be published within the papers of ICB Board meetings held in public. The Joint Committee will also provide reports and minutes to the Greater Manchester Specialised Services Group and / or Commissioning Oversight Groups as appropriate, which are the Groups that have the role and responsibility for oversight of those specialised services to be commissioned solely by NHS Greater Manchester. The Joint Committee will also provide reports and minutes to other ICB Committees where required and when needing further decisions, such as in relation to procurement.
Lancashire and South Cumbria
The Joint Committee will provide reports directly to the Board of NHS Lancashire and South Cumbria. Highlight reports and confirmed minutes of meetings will be published within the papers of ICB Board meetings held in public. The highlight reports will also be received by the Specialised Commissioning Oversight Group, which is the ICB group that has the role and responsibility for oversight of those specialised services to be commissioned solely by NHS Lancashire and South Cumbria. The Joint Committee will also provide reports and minutes to other ICB Committees where required and when needing further decisions, such as in relation to procurement.

3.6 The three North West ICBs may, from time to time, establish sub-committees or sub-groups of the Joint Committee to discharge its functions, with sub-committee and sub-group terms of reference being approved by the boards of the ICBs. Any such sub-committees or sub-groups will be required to report direct to the Joint Committee.

3.8 Any such sub-committees or sub-groups will that are in place at the commencement of the relevant ICB Collaboration Arrangement may be documented in the relevant schedules to that agreement.

4. Authority

4.1 The Joint Committee is authorised to:

- investigate and approve any activity as outlined within its terms of reference and within the collaboration agreement
- seek any information it requires within its remit, from any employee or member of the three North West ICBs (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- 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 partner ICBs 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 constitution, standing orders and SORD of each partner ICB but may/not delegate any decisions to such groups that are within the delegated authority of the Joint Committee without the approval of each the three ICB Boards
- commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by any of the three ICB Boards.

5. Membership

5.1 **Members.** The committee shall comprise of six members. The three North West ICBs will each identify two individuals to sit on the Joint Committee as a member. For each ICB, one member will be drawn from its ICB Executive Officers, and one will be drawn from its ICB Non-Executive Members.

5.2 In being a named member of the Joint Committee, each member, regardless of which ICB they are drawn from, are there as a member on the Committee for all three North West ICBs and are undertaking their duties and making decisions on behalf of all three North West ICBs.

5.3 **Member Deputies**. Each of the three North West ICBs will also need to identify a named Deputy to attend meetings of the Joint Committee if its named Executive Officer or its Non- Executive Member is unavailable or unable to attend or participate in the decision-making because they are conflicted. The named deputy will undertake the duties of and have the authority of the Executive Officer or Non-Executive Member at these Committee meetings when attending on their behalf.

5.4 The Executive Director members must ensure that any such named deputy is suitably briefed and qualified to act in that capacity.

5.5 **Independent membership and independent scrutiny.** By way of ensuring independent scrutiny each of the three North West ICBs will have one of their Non-Executive Members on the Joint Committee. Their role is:

- to provide constructive impartial challenge in the decision-making process;
- to support the Joint Committee to reach a consensus position wherever possible;

- to support the Joint Committee to exercise the Functions with reference to the statutory framework, good practice and the Triple Aim;
- to encourage the joint committee to undertake effective stakeholder engagement and to have regard to the outcome of engagement exercises; and
- to role model and support a regional perspective in relation to Specialised Services.

5.6 The named deputy for Non-Executive Members must also be another Non-Executive Member.

5.7 **Chair and Deputy Chair(s).** At the first meeting of the Joint Committee in each financial year, the Membership shall select a Chair, and its Deputy Chair(s), from amongst the named members of the Committee.

5.8 The Chair and Deputy Chair may not be appointed from the same ICB.

5.9 The incumbent(s) in the role / position of Chair and Deputy Chair shall hold office until such time as an individual is formally confirmed at the first meeting of the Joint Committee in the next subsequent financial year. At the first scheduled Joint Committee meeting after the expiry of the Chair's / Deputy Chairs term of office, the Committee Membership will select a Chair, and Deputy Chair(s), who will assume office at that meeting and for the ensuing term.

5.10 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.11 **Regular Participants.** The Joint Committee may invite regular participants or observers at its meeting in order to inform its decision-making and the discharge of its functions as it sees fit.

5.12 Participants will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the Committee meetings, or part(s) of a meeting. Any such person may be invited, at the discretion of the Chair presiding over the meeting to ask questions and address the meeting but will not partake in any decision making.

5.13 The following may be invited to be regular participants to the Committee:
a) Other Officers of the three North West ICBs
b) Medical Directors or deputies
c) representatives of NHS England
d) representatives from Provider Collaboratives
e) any other person that the Chair considers can contribute to the matters under discussion.

5.14 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.15 **Membership lists.** The Joint Committee shall ensure that there is a prepared and up-to-date list of the members and regular participants of the Committee and that this list is made available to the Partners.

5.16 **Quorum.** A Joint Committee meeting is quorate if the following members are in attendance:

- the Chair, or Deputy Chair
- at least one Executive Officer (or deputy)
- at least one Non-Executive Member (or deputy).

5.17 Those in attendance should at the minimum include one member that has been drawn from each of the three North West ICBs for a meeting to be quorate.

5.18 An ICB that is unable to ensure that at least one of its members (or deputy) can attend a scheduled meeting of the Joint Committee must provide two weeks' notice in writing to the Chair to allow alternative arrangements to be considered.

5.19 Where an ICB has failed to comply with 5.18 and does not attend the meeting of the Joint Committee, the meeting shall be considered to be quorate and any joint decisions taken will be binding on that ICB.

5.20 Further to 5.19, a decision must relate to an issue already notified to all ICBs as part of the meeting agenda or papers for the meeting. Any decision on an issue not previously notified to all of the ICBs will not be binding on the absent ICB.

6. Remuneration

6.1 The three North West ICBs shall prepare a scheme for the remuneration of any external participants and for meeting the reasonable expenses incurred.

6.2 The scheme shall be reviewed on an annual basis.

7. Meeting arrangements

7.1 The Joint Committee shall meet at least four times per year.

7.2 At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule").

7.3 The Chair (or in the absence of a Chair, the Deputy Chair) shall see that the Schedule is notified to the members.

7.4 The three North West ICBs (individually or collectively) may call for a special meeting of the Joint Committee outside of the Schedule as they see fit, by giving notice of their request to the Chair and Deputy Chair. The Chair may, following consultation with all three North West ICBs, confirm the date on which the special meeting is to be held and then issue a notice giving not less than one weeks notice of the special meeting.

7.5 Use of video, telephone or other electronic communication means to conduct meetings of the Joint Committee is permissible with prior agreement of the Chair of the meeting. The Chair of the meeting will take into account the difficulties that might be posed to ensure proper access by members and attendees to the meeting should

it, on occasion, be necessary to hold remote meetings and will make adjustments where possible.

7.6 The Joint Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the Joint Committee is at the discretion of the Partners. All members in attendance at a Joint Committee are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.

7.7 Meetings of the Joint Committee will be held in public where there is the agreement of all three North West ICBs to do so and where it is deemed in the public interest to do so in relation to the decisions required to be undertaken by the Committee.

8. Decisions making arrangements

8.1 The aim of the Joint Committee will be to achieve consensus decision-making by its members wherever possible, and decisions made by the Joint Committee will be consistent with the powers provided to it within these terms of reference and the ICBs Collaboration Arrangement.

8.2 The three North West ICBs must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations between all three North West ICBs to take place, however this may not always be possible for urgent issues.

8.3 Where it has not been possible, despite the best efforts of the Committee, to come to a consensus decision on any matter before the Joint Committee, the Chair, in agreement with all members present, may defer the matter for further consideration at a future meeting of the Committee or require the decision to be put to a vote in accordance with the following provisions:

- each North West ICB has one vote, regardless of whether they have one or two of their named ICB members present at the meeting
- a vote will be passed with a simple majority
- there is no recourse for abstention.

8.4 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so

8.5 In no circumstances may a member, or nominated deputy contribute to the business of the committee meeting or decision-making by proxy.

8.6 Decisions undertaken by the Joint Committee are binding on the three North West ICBs.

9. Decisions outside of meetings of the Joint Committee (emergency decisions)

9.1 In exceptional circumstances where a decision is required outside of the schedule of meetings and where it is not possible or feasible to schedule a special meeting of the Joint Committee, a matter may be referred to the Chair of the Joint Committee for decision.

9.2 Where a decision is to be made outside of the meeting of the Joint Committee:

- each of the three North West ICBs should be notified and have the opportunity to provide input to the decision;
- the decision must be communicated in writing to all three North West ICBs as soon as practicable;
- the decision must be reported to the next meeting of the Joint Committee.

10. Dispute Resolution

10.1 Where helpful, the Joint Committee may draw on third-party support to assist them in resolving any disputes, such as peer review or support from NHS England. The Committee can invoke the escalation and dispute resolution processes as outlined within the North West ICB Collaboration Arrangement.

11. Administrative Support

11.1 The partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint Committee.

11.2 The Joint Committee shall be supported with a secretariat function which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair with the support of the relevant officer lead to the Committee
- records of conflicts of interest members' appointments and renewal dates. Provide prompts to renew membership and identify new members where necessary
- good quality minutes are taken and agreed with the chair. Keep a record of matters arising, action points and issues to be carried forward. Minutes of the meeting will be circulated to all Committee members within 10 working days of the meeting, highlighting actions by individual members
- the Chair is supported to prepare and deliver reports to the Boards of each partner ICB or other organisations, such as NHS England
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

12. Publication of notices, minutes and papers

12.1 The Chair (or in the absence of a Chair, the ICBs themselves) shall see that notices of meetings of the Joint Committee, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one week (or, in the case of a special meeting, two days) prior to the date of the meeting.

12.2 The proceedings and decisions taken by the Joint Committee shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The Joint Committee shall confirm those minutes at its next meeting.

13. Conduct and conflicts of interest

13.1 Members of the Joint Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies.

13.2 Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life).

13.3 Members should refer to and act consistently with the NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations.

13.4 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, either by participating in discussion or by voting. An ICB whose Committee Member is conflicted in this way may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that member.

13.4 Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs.

13.5 Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

14. Review

14.1 The Committee will review its effectiveness at least annually.

14.2 These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board of each North West ICB for approval.

Appendix One: Specialised Services within the responsibility and authority of the Joint Committee

Internal Medicine

26Z - Adult Highly Specialist Rheumatology
27Z - Adult Specialist Endocrinology
24Z - Specialised Dermatology
01J - Anal Cancer
01V - Biliary Tract Cancer
01W - Liver Cancer
19V - Pancreatic Cancer
33D - Distal Sacrectomy for Advanced/Recurrent Rectal Cancer

Cancer

41S - Surgical Sperm Retrival
41U - Urethral Reconstructive Surgery
01R - Radiotherapy (adult)
51R - Radiotherapy (paed)
01S - SRS/SRT
01K - Malignant Mesothelioma
01Y - Other Rare Cancers
01Q - Brain and CNS Cancers
01Z - Testicular Cancers
23A - Paediatric Oncology
01T - Teenage & Young Adult Cancer
41P - Prosthetic Penis Implants

Blood & Infection

18A - Infectious Diseases
18E - Bone and Joint Infections
03X - Haemophilia (Adult)
03Y - Haemophilia (Paediatric)

Trauma

31Z - Highly Specialised Pain Management
37C - Artificial Eye Services
34R - Specialised Orthopaedic Revisions
32D - Middle Ear Implants
32A - Cochlear Implants
34T - Major Trauma (Paeds)
08Y - Neuropsychiatry
08F - Neurosurgical Low Vol Procedures (Regional)
08E - Neurosurgical Low Vol Procedures (Natl)
23N - Specialised Opthalmology (Paed)

Women's & Childrens

13X - Adult CHD (Non Surgical)
13Y - Adult CHD (Surgical)
15Z - Cleft Lip and Palate
04C - Foetal Medicine
36Z - Metabolic Disorders
23Y - Highly Specialist Paediatric Pain Mgmt
E23 - Highly Specialist Paediatric Palliative care
23B - Paediatric Cardiac Services
23P - Paediatric Dental Surgery
23D - Paediatric ENT
23F - Paediatric Gastro HPB and Nutrition
23Xb - Paediatric Gynae Surgery
23H - Paediatric Haematology Services
04G - Abnormally Invasive Placenta
23M - Paediatric Neurosciences
07Y - Paediatric Neurorehabilitation
08J - Selective Dorsal Rhizotomy
23Q - Paediatric Orthopaedics
PIC - Paediatric Critical Care
23R - Paediatric Plastic Surgery
23S - Paediatric Renal Services
23T - Paediatric Respiratory Services
23W - Paediatric Rheumatology Services
18C - Infectious Diseases (Children)
23Xa - Specialist Paediatric General Surgery
23Z - Paediatric Urology
35Z - Morbid Obesity (Children)
04P - Complex Termination of Pregnancy
17Zp - Specialist Allergy (Paed)

NHS
Cheshire and Merseyside

Transformation Committee

Annual Report 2023

Contents

1. Introduction

The Transformation Committee (the "Committee") has been established by NHS Cheshire and Merseyside Integrated Care Board ('ICB') as a Committee of the ICB in accordance with its Constitution.

The Committee is an executive led forum, with non-executive involvement and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS C&M.

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This report sets out the work undertaken by the Transformation Committee in 2023. This demonstrates how the committee has met the responsibilities set out for it by the ICB within its constitution, its compliance with the committees Terms of Reference (TOR), its effectiveness and the impact of the Committee.

In addition to it being a formal report to the Committee, the evidence contained in this report will be shared with the Board of the ICB.

The committee's membership requirements are set out in its TOR, which was agreed by the Committee on 19th October 2022.

The Committee Terms of Reference are due to be updated at the March ICB Board meeting including a recommendation to amend the name of the committee to Strategic Commissioning and Transformation Committee and to move to a non- executive led committee as well as reflecting some revisions to the committee responsibilities.

2. Membership

The membership of the Committee is detailed below:

- Clare Watson, Assistant Chief Executive (Chair)
- Neil Large, Non-Executive Director
- Carl Marsh, Place Director for Warrington
- Mark Bakewell, Place Director for Liverpool
- Fiona Lemmens, Associate Medical Director for Transformation and Deputy Medical Director
- Christine Douglas, Executive Director of Nursing Care
- Ian Ashworth, Director of Population Health Cheshire and Merseyside ICB
- Linda Buckley, Managing Director of CMAST – (Acute Specialist Provider Collaborative)
- Tony Mayer, Provider Collaborative Director, Cheshire & Merseyside Mental Health, Learning Disabilities and Community Provider Collaborative

3. Meetings

In 2023, the Committee met on five occasions and was quorate at each meeting. The Committee met on the following dates:

- 9th March, 2023
- 11th May 2023
- 6th July, 2023
- 14th September 2023
- 23rd November 2023

4. Committee Responsibilities and Duties

The Committee was established to support NHS C&M in the delivery of its statutory duties and provide assurance to the Board in relation to the delivery of strategy in alignment of those duties to:

- Provide a Board, Place and Provider Collaborative leadership forum to consider the development and implementation of the ICP strategy and policy and plans of the ICB securing continuous improvement of the quality of services
- Connect with and ensure alignment of system programmes as may be developed by any of the system's constituent parts: progammes reporting to the ICB/ICP or provider collaboratives as appropriate),
- Connect with, refer issues for clinical consideration to and develop responses to actions or issues identified by the ICB's Clinical and Care Professional Advisory Council or other appropriate fora as established.
- Retain a focus on reducing health inequalities and improved outcomes and ensure that the delivery of the ICP / ICB's strategic and operational plans are achieved within financial allocations
- Consider the effects of decisions on people's health and wellbeing, quality of services and efficiency and sustainability
- Have delegated authority to make decisions within the limits as set out in the ICB's Schemes of Reservation and Delegation.

The responsibilities of the Committee include:

- Overseeing the development and review of the ICB plans in response to the ICP's developed strategy, ensuing they take account of the population need.
- Overseeing the development the ICB's operational and transformational plans (making recommendations to the ICB on their approval), supporting alignment of Place priorities at an aggregate level and engaging with partners across the wider system (including VCSE and the social care sector).
- Ensuring our plans and clinical commissioning policies follow the principle of proportionate universalism with the ambition to reduce health inequalities and reduce avoidable mortality.
- Overseeing the development and delivery of work programmes that support the ICB's strategy and operational plans, including oversight of areas developing joint commissioning with

partner organisations (and making recommendations to the ICB on their approval as required).

- Receiving reports on transformation delivery, including financial management and escalating issues to the ICB as appropriate.
- Receiving assurance on the ICBs' provider collaboratives' development processes.
- Linking with the ICB's Specialised Commissioning arrangements and Primary Care Committees to ensure the system wide, population-based approach is implemented to delegated NHSE functions
- Overseeing the coordination and integration of services to support the delivery of effective, high quality, accessible services, including via an aggregated view ICB Better Care Fund implementation.
- Ensuring that transformation activities promote the health and wellbeing of communities as well as addressing health inequalities, prioritising investment / disinvestment and ensure cost effective care is delivered; developing an evidence-based commissioning/decommissioning framework.
- Ensuring that plans and decisions are underpinned and informed by communications and engagement with key stakeholders, including the local population as appropriate.
- Taking account of collaborative commissioning activities, including those of clinical networks, to ascertain if they will have wider contracting / financial implications for the ICB (for referral to the Finance Committee / ICB if appropriate).
- Overseeing and providing senior Board level sponsorship to programmes integral the social value contribution of the ICB.
- Making decisions in line with its remit in accordance with the financial delegation of the Executive Directors and directors present, in line with the NHS C&M Scheme of Reservation & Delegation
- Making recommendations on investment and significant commissioning decisions to the ICB

5. Review of Committee Activities

Standing Items

The Committee received regular reports as part of standing agenda items.

Transformation Programme Assurance

The Committee received update reports on the progress of all the Cheshire and Merseyside (C&M) transformation programme delivery vehicles, highlighting any key issues or risks. Delivery vehicles responsible for the overarching transformation programme governance which report into the Transformation Committee were:

- Cheshire & Merseyside Transformation Group (Associate Directors of Transformation & Partnerships)
- Cheshire & Merseyside Acute & Specialised Trust Provider Collaborative (CMAST)
- Digital Transformation & Clinical Improvement Board (DTCI)
- Mental Health, Community & Learning Disability Provider Collaborative (MHLDC)
- Population Health Board

NHS Cheshire & Merseyside Transformation Group

Regular reports were provided from the C&M Transformation Group which comprises of the Associate Directors of Transformation and Partnerships across the nine Places along with invited

membership from NHS England regional transformation team, the Provider Collaboratives, the C&M ICS Strategy & Collaboration team, and Clinical Transformation team.

Summary of key items and decisions undertaken by the Committee

09 March 2023

Treating Tobacco Dependency
An update on Treating Tobacco Dependency was provided to the committee, detailing the roll-out of Maternity TTD sites, including funding, but confirmation of funding for 23/24 was still required to be provided from the NHSE regional team.

Reducing Smoking Prevalence
A paper was presented on behalf of CHaMPS outlining the need to complete a rapid scoping review around the future of smoking cessation across C&M with a number of key policy drivers. Funding from the Treating Tobacco Dependency Programme was available for this. The committee endorsed the proposals in the paper and the allocation of £50,000 to CHaMPs to mobilise the work.

Transformation Programme Funding & Prioritisation Framework
The Committee considered a report that gave an update on the transformation programmes and future planning, including the alignment of the planning guidance and programme mapping as well as the funding considerations for the transformation programmes in 23/24. Programmes were asked to submit details of the minimum amount of funding required for Q1 and for what purpose and this was agreed by the Committee following meeting scrutiny.

The next steps for Q1 and Q2 funding were discussed. This acknowledged the need for robust visibility on the funding and slippage, and the sequential activity that will need to be undertaken following Q1. The Committee also agreed to Q2 funding for each of the programmes, with a view that the same proportion or percentage of efficiencies are applied as for Q1. It was also agreed for a working group to be established to review the effectiveness and efficiency opportunities of the transformation programmes, looking at what is planned to be delivered, in line with planning guidance, prioritisation framework and Marmot Core20 PLUS5.

Voluntary Community Faith Social Enterprise Sector – Investment and Delivery Plan 23/24
The Committee received a presentation which outlined the plan for year one of the three year C&M VCFSE Transformation Programme. This outlined some of the outcomes delivered to date, including integrated VCFSE in system governance and workstreams on the development of Place-based VCFSE delivery models and also the key priorities being looked at for 23/24.

Teledermatology Service
A report was received relating to the implementation of the Teledermatology service and the current financial pressure to this programme. There are significant pressures to the dermatology service, including the increased rate of two-week wide cancer referrals. Programme funding of £300k was required for 2023-2024, with the risks associated to this programme not being funded discussed. The Committee's ToR/SFIs does not allow funding to be allocated which isn't within budget and therefore creates a pressure. The Committee supported the proposal on the basis of a Q1 funding allocation only, on receipt of a revised proposal that considers a financial efficiency to that originally requested.

Specialised Commissioning
The Chair updated the Committee that the ICB will not be taking on any specialised services commissioning functions until April 2024 and a shadow year to be put in place, with the need for a joint working document with the other two system in the NW and also Region to be signed off by the ICB Board. The report outlined the time plan for key activities and all updates coming back to the Committee moving forward.

11 May 2023

ICS Digital and Data Strategy
A mid-year status report on the ICS Digital and Data Strategy was presented to the Committee, detailing what has been delivered to date and also providing a forward look, with most of the commitments in the strategy falling in year two and three. There is close working with the ongoing planning exercise to ensure the strategic components are woven in. The Committee was briefed on the national exercise with providers on self-assessing on a list of digital maturity criteria and the C&M position was to be submitted to inform regional/national investment processes. The Committee recognised that C&M was identified as a leading ICB in relation to population health data analytics capability and being looked at as an exemplar.

Implementing the Prioritisation Framework for C&M
The Committee was given a summary of the background around the need to develop priorities and a prioritisation framework by the ICB and Directors of Public Health across C&M, including identifying a set of emerging priorities looking at where C&M performed worse or significantly worse than the England average. Committee endorsed the proposed approach for use by Place and Transformation Teams to support them in developing prioritised plans and to support the application of the prioritisation framework and scorecard approach to allocation of the Cheshire and Merseyside Transformation Programme Funding.

Transformation Programme Funding
The Committee was presented with a paper summarising the position around 2023/24 Q1 and Q2 Transformation Programme funding and future funding arrangements for Q3 onwards. The key Q1 & Q2 milestones and the updated financial information were also discussed around what was requested and what was agreed on funding. Committee agreed to the Q1 and Q2 programme funding detailed in the report presented to members.

Transformation Committee approved the process to allocate £2.95m of transformation funding for Q3 and Q4 of 2023/24 and £5.6m for 2024/25. The process involved inviting bid applications for new or existing transformation schemes across Cheshire and Merseyside. In order to evaluate bids, there was a detailed 4-part process for prioritisation of transformation bids. These involved bids being reviewed and scored on a set of weighted criteria by a multidisciplinary panel of NHS Cheshire and Merseyside Associate Directors in order to make recommendations to a senior executive team panel considering bids in a broader strategic context taking account of NHS Cheshire & Merseyside priorities.

Specialised Commissioning
The Committee was further updated on the ongoing work around Specialised Commissioning. C&M identified four transformational priorities for 2023-24, with the help of NHSE colleagues, and the goal to look at full pathways and to improve the overall experience of the pathway. The Committee was also informed of the additional areas where all three NW ICSs would work together on those

specialised service areas and would deliver these through new governance structures to be introduced. The priorities were identified as:

- Renal Service Transformation Programme
- Neurorehabilitation – integrated case management
- Optimisation of the Stroke Pathway from 999 to Thrombectomy
- Transition from Specialised Paediatric Services to Adult Services (local additional priority)

Committee agreed to the four key priorities detailed in the report, with the exception of 'Transition from Specialised Paediatric Services to Adult Services' with this being managed as a local priority and not being included as one of the national priorities to allow further work to be taken and without significant funding being needed.

Transformation Committee Risk Register

A report provided to Committee outlined the ICB's Risk Management Strategy, including the key components of the risk management structure and key roles and responsibilities for ICB committees. The report also provided an up-to-date position on risks assigned to the Committee and making sure they are managed and to help provide assurance to the ICB Board around the risks that are within the remit of the Committee. The Committee discussed its role in providing assurance against those risks and agreed there is a need to consider which additional areas that will be reporting into the Committee, such as Specialised Commissioning and the digital programmes.

06 July 2023

Transformation Programme Assurance

Teledermatology was reported to the Committee as an escalation, with delays to implementation in Wirral and the interdependency with the IT platform required for this programme. An escalation relating to the Diabetes Programme was raised around the resourcing impact and the ability to deliver and also an issue for all networks as a result of workforce reductions, impacting C&M's ability to work though some of the programme for these networks. Committee agreed the need to re-profile existing work programmes and the existing workforce to focus on those key priorities that are identified.

The Committee was informed about the development and implementation of a more efficient tracking system for the Delivery Plan and Operational Plan (System Outcomes Framework) to simplify performance and automate some of the work through BI. This was reported to be operational by the end of September 2023, with ongoing refinement and improvement throughout the year.

Transformation Programme Funding

Committee agreed to approve the release of the 2023/24 Q1 actual spend against funding amounts previously agreed for the ten transformation programmes. Any actual overspends were not approved. The committee was also requested to approve the release of both Q1 and Q2 allocated funding for the Teledermatology programme, totaling £125,000, in order to support the payment of the IT platform required for the service. Committee was informed that there was a total underspend within programmes of £382,799 for 2022/23 against funding agreed. Members agreed the underspend should not be used by programmes to fund new schemes/plans and should be returned to the ICB.

The total 2023/24 Q1 actual spend of £63,623 was presented to the Committee. The proposal was for this to be retained for other potential transformation programmes funding as opposed to each programme retaining their own underspend. Committee agreed that this underspend was to remain within the Transformation Programme budget, but not automatically against the programmes in the first instance. It was also agreed for due diligence to be taken with Delivery Vehicles to understand the impact this has on programme delivery to deliver schemes which may make a significant difference.

Treating Tobacco Dependency

An update on the implementation of maternity treating tobacco dependence (TTD) services across C&M which has been led and supported by the LMNS was given with funding being the significant challenge with a delay in national funding being received by the ICB. Funding for 23/24 was confirmed at the end of May 2023. There was a request to approve Trusts receiving the full allocation for 23/24 to support services rather than part year allocation based on when services 'go live' due to uncertainty around 24/25 funding and to ensure services continue. It was agreed that Finance would want to understand in more detail what has been achieved so far and evidence of delivery and would provide an answer in writing, including clarification on the future funding regime, including the baseline funding issue, from 2024/25.

Specialised Services Pre-Delegation Assessment Framework (PDAF)

A paper was presented relating to the Specialised Services PDAF submission. The PDAF is a national template that all ICBs and NHS regional teams have to submit before the transfer of specialised services in April 2024. Committee was requested to take responsibility for signing this off at its following meeting with the ICB Board being requested to confirm that it agreed to this as delegated responsibility, with the final PDAF requiring submission by mid-September 2023. Committee approved the timeline detailed in the report outlining the development of the PDAF and the recommendation for the ICB Board to delegate approval to the Transformation Committee.

14 September 2023

Transformation Programme Funding

The committee was updated on work being carried out around transformation programme funding, including understanding the close down position for 2022/23. The report detailed potential claw back of non-utilised funding of £653K to support the financial position of the organisation and offer allocation for transformation. Committee supported the proposal to set up a subgroup with finance colleagues and other colleagues to review and agree activity spend and delivery on behalf of the committee.

Transformation Programme Assurance

Committee discussed transformation programme governance and the limited scale of the portfolio size whilst continuing to ensure scrutiny on delivering is in place and on the need to develop major programme criteria which sets out the strategic priorities, biggest areas of inequalities, commissioning challenges and financial inefficiencies to determine what is within the committee work programme as ICB transformational priorities.

Specialised Services Pre-Delegation Assessment Framework (PDAF)

Committee was presented with the completed PDAF for sign off under its delegated authority (as agreed to do so by the ICB Board) and to be submitted to NHSE which was agreed. Committee was informed that further work is being carried out to develop an Implementation Plan and a Target

Operating Model (TOM) to look how this will be delivered. As part of this TOM process, there was a need to consider whether Specialised Commissiong will continue to report through this Committee or whether alternative arrangements would be recommended to the Board.

Children and Young People's Mental Health Transformation Plan

The proposal for the Children and Young People's Mental Health Transformation Plan was presented for endorsement. This was scheduled to go to the Children's Committee on 12th September 2023 but was unable to be included on the agenda as the committee is still going through formal establishment. The expectation from NHSE is to have one Children and Young People's Mental Health Transformation Plan for C&M to replace the original 9 CCG plans by September 2021. This was published in December 2021 and based on the Logic Model Framework. The committee heard that the proposal, in line with NHSE guidance, was to submit a to publish a holding statement for 2023 which will state that the next 12 months will be spent developing a refreshed and revised Children and Young People's Mental Health Transformation Plan due to the complexities and ensuring it aligns with key ICB strategies and programme priorities. This was fully supported and agreed by the committee.

Committee Survey Feedback

The effectiveness of the Transformation Committee survey feedback was presented, with some positive feedback detailed, including timeliness of committee papers being circulated. It was felt that other feedback provided can be built upon moving forward as the committee looks to shape its terms of reference.

23 November 2023

System approach to Personal Health Budgets

A paper to request supporting the ringfencing of £150k for 2024/25 to roll out projects that enable the national trajectories to increase Personal Health Budgets (PHB) across C&M was presented. Committee supported and agreed the approach taken and the prioritisation of the request for £150K to be ring-fenced against this as part of the ICB's planning process against the budget line for personalised care.

Pulmonary Rehabilitation Business Plan for 2023/24

Committee received the Pulmonary Rehabilitation Business Plan for 2023/2. The Respiratory Programme Board oversees the funding that is received annually from NHS England. Committee agreed to support the recommendations detailed in the report relating to retrospective implementation of the service specification across all nine places and that recurrent funding will be considered as part of the planning process for 2024/25. Committee also agreed for further conversations at Digital Transformation and Clinical Improvement Board on how the outcomes and the performance against the investment for Pulmonary Rehabilitation is reported on.

In relation to reports on Pulmonary Rehabilitation and Personal Health Budgets, both relating to programme funding proposals, Committee also escalated to the ICB Board:

i) The need to align the national and ICB position on funding availability with clinical networks and the challenges this presents in delivering long term plan commitments; and
ii) The need for better communications out to front line clinical teams around the financial position of the ICB and the wider ICS and the

impact this has on service development and expansion.

Roll out of PMO Software
The committee supported and agreed the proposal for the implementation of Verto as a single PMO solution software for NHS Cheshire & Merseyside. The investment of £82.5K for 2024/25 would be mainly for additional licenses, annual hosting and support.

Individual Funding Requests TOM
The committee considered a paper relating to the Individual Funding Requests as part of the wider review of the MLCSU contracts being undertaken, with a decision to "in-house" the service having been previously agreed by Finance Investments & Resource Committee. Transformation Committee agreed to support the proposed operating model. However, further work is needed to understand any further governance and implications in developing and agreeing for C&M transferring a full at scale model into C&M to deliver a North West offer across the three ICBs.

Terms of Reference Review
The Transformation Committee is currently undertaking a review and refresh of its Terms of Reference. A draft version was presented to Committee for discussion. Further work will be required around clarifying and confirming the role, purpose and responsibilities. The scope of the committee will also consider how the work of both provider collaboratives are linked in and to ensure there is no duplication and the final version to go back to the committee for final approval.

Risk Register
A report on the approach to developing the committee's Risk Register was received with the intention for members to be requested to consider any risks pertaining to the Committee to help develop a Risk Register Heat Map.

Planning for 2024 – Developing our Plans
A presentation on 'Planning for 2024 – Developing our Plans' was delivered, focusing on how to better coordinate across C&M to have a single plan, highlighting the need to delivering more efficiently and looking at opportunities to do things once at a Place Plus or C&M level. Committee was informed that work was ongoing to capture plans that are relevant and possibly replicated in other parts of the system to look at aligning them as part of the Joint Forward Plan.

6. Conduct of the Committee

In year, the Committee has commenced its review of its membership and Terms of Reference.

The Committee applied best practice in its deliberations and decision making processes. It conducted its business in accordance with national guidance and relevant codes of conduct and good governance practice.

Meetings of the Committee were conducted in accordance with the provisions of Standing Orders, Reservation and Delegation of Powers and Prime Financial Policies approved by the Board of the ICB

The proceedings of all meetings of the Committee were minuted, including recording the names of those present and in attendance. Where any declarations where made these were recorded within the minutes of the meeting. The Committee reported to the Board after each Committee meeting via a Committee Chairs report.

7. Conclusions

The Committee has met its statutory obligations, as well as performing those other functions delegated to it by the Board. The committee has met when required to discharge its functions.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Highlight report of the Chair of the ICB System Primary Care Committee

Agenda Item No: ICB/03/24/17

Report Approved by: Erica Morris, Non-Executive Member, Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB System Primary Care Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	22 February 2024

Key escalation and discussion points from the Committee meeting

Alert

The Committee

- received a draft report from Mersey Internal Audit (MIAA) which gave 'red' assurance for 'Quality' but was assured 'green' for governance and finance, with an overall 'amber' assurance. The report will be redrafted to recognise that the issues do not directly relate to all four primary care contractor groups equally – a final report and assurance on next steps will be discussed at the next Committee meeting
- linked to the above item, the Committee received further assurance in respect of actions to put in place more robust Primary Care Quality & Performance processes reporting and assurance. A proposal to set up a Primary Care Quality Group at System Level is being finalised and an update paper on agreed next steps will be discussed at the next Committee meeting.
- the Committee received verbal updates on all four contractor groups and their representatives in relation to system pressures, which is a standing agenda item. The impact of additional MMR asks, the launch of 'Pharmacy First' and a further discussion being required on ADHD patients in general practice were highlighted.
- agreed recommended spend in relation to Digital Primary Care for The Tech Innovation Framework Early Adopter Programme and ongoing ICB support of the next exploratory Phase 2 for new Clinical system providers in Primary Care. As part of this discussion it was noted that a priority remained ensuring all primary care contractor groups had aligned systems to enable primary/secondary care information to be shared but much of this was not within the gift of the ICB and was a recognised national issue.
- the Committee received an update outlining the Cheshire and Merseyside Dental Improvement Plan for 2024/26 (Appendix One). The plan is focused on 5 key pathways and seeks to focus this year on routine access whilst still supporting the delivery of urgent care/urgent care plus. Ensuring access to NHS dental care with a specific focus on vulnerable groups is very much a priority. The plan was agreed by the Committee subject to the identified funding being confirmed. Due to the financial ask of utilising an additional c£9million of anticipated under-performance on primary care dental contracts, the Board of the ICB will need to consider and approve the identified funding. A supplementary paper (Appendix Two) is to be provided to the Board at its March 2024 meetings **with a recommendation from the System Primary Care Committee to the Board to approve the additional expenditure.**

Advise

The Committee:

- agreed a request from Halton Place in relation to additional investment for Additional Roles to end of 03/24 which was within the overall ICB allocation and in line with the Guidance (which had been pre checked by Place staff)
- received but did not support revisions to one workforce related risk on the Primary Care Risk Register but agreed to recommendations in relation to 2 other risks. The challenge of consensus management of risk scores across all four contractor groups with generic risks and themes was recognised. An update on risks being managed at Place level was also noted.
- ratified the APMS (Alternative Provider of Medical Services) procurement decision made by Cheshire West Place, which was required to be agreed at the Committee in line with current scheme of delegation/standing financial instructions

Assure

The Committee:

- received assurance around actions relating to Wirral Place PCN issues, which will be agreed at Place level.
- received an update on the Task and Finish Group led through the Finance Team, which has been looking at variations in non core primary care spend at Place, overall allocations, and differences in rates paid for some key commissioned services which are a legacy from the previous CCG approaches. There will be a further meeting with Place Directors in April and a further discussion with LMCs on some of these areas.
- received an update on usual business for all four contractor groups – progress on the Access Improvement Plan including next steps was noted as part of this including noting 95 percent of local pharmacies have signed up to 'Pharmacy First; A stand alone further update/presentation on the ICB's Access Improvement Plan is included in the Board papers.
- the Mid-Year contract review process for Dental for 23/24 was discussed including workforce begin a consistent theme as a key factor in reduced delivery of UDA's. A performance snapshot using the latest access data available from NHS Digital showing a slight increase in access from previous period for both children and adults. The ICB position is also slightly better than the Northwest position overall.
- received a Finance update in relation to the combined financial summary position outlined in the financial report as at 31st January 2024 including Additional Roles spend to date and the anticipated forecast outturn and predicted central drawdown. The approach to 2024/25 planning was noted and discussed. In relation to Additional Roles, 2 Place's with lower than the ICB average spend were to be asked for further assurances to understand the reasons behind this.
- received assurances in respect of non-medical prescribing – assurance was given that each place had a legacy CCG policy and an onward proposal produced collectively, would be forwarded to Q&P committee in March.
- recognised that further progress on the Strategic Framework was limited by resources to undertake this work at system level – but engagement with the contractor groups not covered by the first plan were progressing
- the Committee received an update on the new National Dental Improvement Plan:
  - up to 2.5 million additional NHS dental appointments delivered for patients over the next 12 months, including up to 1.5 million extra treatments being delivered, nationally.

○ a major new focus on prevention and good oral health in young children and deliver an expanded dental workforce. ○ the roll out of 'Smile For Life' programme for baby gums and milk teeth ○ The public will also be able to see which practices in their local area are accepting new patients on the NHS website and the NHS App. Commissioners will be working to align the national plan with our own ambitious local plan.

Committee risk management

The following risks were considered by the Committee and the following actions / decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
Patient Safety/Quality	An update was given to offer further assurances in respect of primary care quality and actions to assure and standardise reporting.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
BAF P1//P6/P9 Annual Plan Primary Care.	Progress of the Access Improvement Plan Updates in respect of place spend/resources and overall priorities, under the work of the Finance Task and Finish Group

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Service Programme / Focus Area	Key actions/discussion undertaken
Internal Audit for Contracting and Commissioning underway	Update at next meeting
Finance Update	SPCC reviewed all the budgets and have a task & finish finance group that will look for consistency / efficiencies across the Places in C&M.
Capital Update	Digital allocations discussed and agreed
Recovering Access to Primary care & Dental Improvement Plan	As above plus progress/plans in relation to the national and local Dental Improvement Plan(s)

Appendix One: Cheshire and Merseyside Dental Improvement Plan
Appendix Two: Cheshire and Merseyside Dental Improvement Plan Summary Paper

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Cheshire and Merseyside

PRIMARY CARE DENTAL IMPROVEMENT PLAN 2024-2026

Increasing capacity, improving access and addressing oral health inequalities

OUR AMBITION

NHS
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- Will build upon the current programmes in place and aligns to the delivery of the national dental recovery plan Our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)(Published Feb 24).
- **£4.8 million** was previously approved by SPPC in June 2023
- SPCC has also already agreed funding of **£600k** for the oral health programme and this is included in the overall total.
- Utilisation of a further **£9.985m** of anticipated under-performance is now requested for the expansion of the plan giving a total investment of **£15.420m.**
- Maintain and create workforce development opportunities within existing practices and wider within health and social care. Maximise the opportunity of flexing contracts to take into account the altered contracting mechanisms outlined in the dental recovery plan and previous contract reforms.
- Increase access to primary care dental services and review any “knock on” impact to specialist primary care, community and secondary care services.
- Include preventative advice for all patients and in specific defined areas support a collaborative approach for preventative treatment.
- Focus on ensuring our most vulnerable populations are able to access NHS dental services as an integral element of the ICB ambitions regarding population health management.
- Addressing our health inequalities agenda by focussing activity on areas of highest need and linking to the oral health strategic partnership
- Underpinned by **5 key PATHWAYS that provide access to NHS Dental services**

ACCESS AS A PRIORITY

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Our plan will be focussed on:

- Three **General** Access pathways

  Pathway 1 Access to urgent dental care for those in immediate need of support, such as dental pain, or specific medical/statutory requirement*

  Pathway 2 Urgent Care Plus -- Definitive treatment following urgent care, if required/requested

  Pathway 3 Routine care for patients who require a check up and any follow up care to make sure they are orally fit

- Pathway 4 Access for **children**, with additional preventative/treatment needs “ACCDP”**
- Pathway 5 Access for “cared for” **frail** vulnerable **adults**

*looked after children, prerequisite for specific cancer treatment/cardiac

** includes principles of starting well- which is an initiative recommend within the prevention domain of the dental recovery plan

PATHWAYS 1-5 AND ALIGNMENT TO NATIONAL PLAN

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LOCAL SCHEME	DESCRIPTION	ALIGNMENT TO NATIONAL PLAN
PATHWAY 1	URGENT CARE • Requires adequately funded fully functioning helpline • Network of commissioned urgent care practices	Not in the national plan.
PATHWAY 2	URGENT CARE PLUS • Follow up DEFINITIVE care for patients without a dentist.	Providers opt in to the local one but cannot do both. Will need to be opted out of the national.
PATHWAY 3	ROUTINE CARE FOR ALL (termed quality access scheme)	Providers opt in to the local one but cannot do both. Will need to be opted out of the national.
PATHWAY 4	ACCESS for children with additional preventative/treatment needs “ACCDP”.	Providers can do both national and local scheme.
PATHWAY 5	ACCESS for “cared for” frail & vulnerable Adults – will align.	Providers can do both national and local scheme.

UNDERSTANDING THE NATIONAL PLAN

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- Recently launched with guidance now following and short timescales
- Providers need to opt in or opt out (this will avoid duplication)
- Due to the success urgent care plus many new patients will not incur the premium (due to full treatment being provided within the session)
- Not a targeted approach therefore providers could ‘cherry pick’ patients
- No impact on improving access for vulnerable patients
- Providers could cease routine care for established patient group and opt to see new patients only to take advantage of the scheme

NEW PATIENT PREMIUM

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- Not additional funding:

- Participating practices will receive a nominal credit of UDAs equivalent to:
- £15 for each eligible new patient requiring only band 1 care,
- £50 for each eligible new patient requiring a band 2 or 3 treatment

- In practice this means the new patient premium value for seeing a new patient would be translated into the equivalent UDA rate for each contractor. For example, in a case where a band 2 or 3 treatment has been completed (£50 new patient premium):

- Where a contractor has a UDA rate of £30, they will receive a 1.67 UDA credit, and
- Where their UDA rate is £40, they will receive a 1.25 UDA credit

National Plan Minimum UDA Rate

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- National Plan indicates a new minimum UDA rate increasing from £23 to £28.
- **OPTION 1 Cost is either a maximum of an extra £141.2k per annum on the contract value**
- **OPTION 2 a reduction of 5,042 contracted UDAs**
- Commissioning team will review performance of identified contracts but approval for recurrent funding is required
- Decision required by commissioners based on national timescale and agreeing preferred option

PLANNING ASSUMPTIONS AND PRIORITISATION

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ASSUMPTIONS

- The affordability of the plan depends on:

a) take-up of the schemes within the local improvement plan;

b) the ability of ICBs to permanently and unilaterally reduce the contracts of practices which persistently under-perform (action indicated in the national recovery plan);

c) The future redistribution of ICB dental allocations based on need, as identified in the national recovery plan;

d) the number of patients attracting the new patient premium (ending in March 2025).

e) relies on dentists delivering to similar levels of under-performance in 22023/24 and not recovering to pre-COVID levels.

PRIORITISATION

- Pathway 3 is the priority scheme for delivery once plan is approved today
- Pathways 1 and 2 already commenced under last year's plan and will continue to run in 2024
- Pathways 4 and 5 will be led by the Local Professional Network supported by NHSE NW Public Health

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

CONTINUATION OF FUNDING FOR ADVICE TRIAGE HELPLINE

- Feedback from stakeholders and service provider is that this service is much needed and an integral part of the primary care dental system
- Service is based on national service specification. Service covers C+M and operates 7 days per week providing access to urgent care/urgent care and advice help to patients
- Continuation of funding post April 2024 to ensure resilience and capacity to respond to need

Total investment requested for continuation of funding £0.468k

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

Pathway 1

URGENT CARE

- Continuation of network of practices formerly referred to as Urgent Care Centres was agreed in June 2023 up to 31 March 2025. These practices provide urgent care appointments, in addition to the commissioned service, which are available via the local dental helpline.
- This network also provide support to defined vulnerable patient pathways including ‘looked after children’ and priority breast cancer patients
- Work is being undertaken with Clatterbridge to extend the cancer pathway to other priority cancer patients and also to cardiac patients. This will include the pathways being added to the e referral management system
- In addition, collaboration is in place with LA leads to consider expansion of the LAC pathway to include families/children at risk.
- Evaluation has been completed from 2023 -2024 and reviewed by commissioners. See APPENDIX 1.

Total requested for this pathway is up to £3.162 million

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

Pathway 2

URGENT CARE PLUS

- Funded as additional sessions and are an extension to the urgent care pathway, allowing patients who have attended an urgent care appointment to attend a separately commissioned session where they are offered a full examination and any substantive treatment to get them dentally fit.
- Due to the success of the urgent care plus scheme we have worked with NHS England (formerly Health Education England) to include Dental Foundation Trainees (DFTs), supervised by their 'Educational Supervisor', in the delivery of this service as of 29 January 2024. 17 DFT practices are now undertaking the delivery of the project. This supports both education and access for patients.
- Following rapid evaluation we propose to continue to continue this scheme.

Total requested for this Pathway is up to £3.488 million

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

Pathway 3

ROUTINE CARE FOR ALL – QUALITY ACCESS SCHEME

Funded from 10% reduction in contract activity

This is an opt–in scheme. Those not opting in will be eligible for the new national top-up of £15 - £50

From 1st April 2024 to 31st March 2025, participating practices will have a reduction in the annual contractual target by 10% at the start of the year. Access to new patients and liaison with a local vulnerable group (will be monitored at the end of each quarter to ensure compliance with the scheme.

To qualify for the scheme practices must:

- Attend the initial webinar – a Teams invite will be sent. Dates available are listed below for your information.
- Amend practice NHS.uk status to ‘Accepting new patients’.
- Accept an increased amount of urgent patients.
- Accept an increased amount of new patients (new patient is defined as someone that has not attended the practice in the previous 24 months).
- Engage with local vulnerable group/third sector organisation/charity (e.g homeless centre/family hub)
- Complete dementia friendly toolkit, amr audit and oral cancer toolkit by 30 June 2024
- Complete and submit quarterly data return.

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

Pathway 3

ROUTINE CARE FOR ALL

- Proposal to pay for up to 10% overperformance on contracted activity for 24/25
- NB where practice can evidence seeing new patients
- Practices will see more complex patients and new patients linking in with vulnerable patient groups
- Only a proportion of practices will be eligible
- Since Covid, C&M has funded overperformance of £1.2m in 22/23 and estimates £1.0m in 23/24

Total requested for this Pathway is up to £6.082 million

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

Pathway 4
ACCESS FOR CHILDREN WITH ADDITIONAL PREVENTATIVE/TREATMENT NEEDS "ACCDP"

- Propose to expand Advanced Child Care Dental Practices across C&M
- The ACCDP practices are currently operational in Liverpool, Sefton, Knowsley and referrals are from CDS services where the child doesn't meet the criteria for specialist dental service but require more time than a routine primary care appointment.
- These areas experience the highest level of dental disease burden within the greatest number of children within C&M hence selection. Roll out will be to second group of areas with greatest need.
- ACCDP focus on stabilisation and prevention for the referred child
- Collaboration with Paediatric Managed clinical network to support training and development of this network of practices
- Evaluation has been completed and reviewed by commissioners. See APPENDIX 2.

Total requested for this Pathway is up to £215k (£200k recurrent)

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

Pathway 5
ACCESS FOR “CARED FOR” FRAIL & VULNERABLE ADULTS

- Proposal to work collaboratively (LDN, Special Care MCN, LA, GPs) initially to link dental practices with care homes to support/facilitate oral health plans, signpost to training for care home staff, facilitate appointment at the practice where required and support end of life care

- Project to be evaluated to assess need and future provision

- The amount requested is based on 50 practices each delivering 2 nurse led sessions per month plus a small set-up cost

Total requested for this Pathway is up to £435k (£420k recurrent)

INVESTMENT AND FINANCE

NHS
Cheshire and Merseyside

DENTAL ACCESS AND WORKFORCE DEVELOPMENT CENTRES

- To complement our existing plans we are seeking to develop at **least 3 Dental Access and Workforce Development Centres** across Cheshire and Merseyside in areas of highest need.
- One centre will be up and running in the first year of our plan and will act as a proof of concept and we envisage investing between **£676k to £1million**
- We want to encourage and support a collaborative approach when developing any proposals to deliver this vision.
- We will use the national contracting flexibilities announced recently and are seeking to find creative solutions.
- We envisage that the centres will be accessed for new patients with no dentist via existing referral routes and want to avoid the unacceptable vision of long queues of patients trying to access a service.
- The access centres could offer both undergraduate and post graduate workforce opportunities but we expect to see a skill mix model in operation.
- Centres could offer a mix of Pathways 1 to 5.
- The access centres will offer bookable appointments 7 days a week and this would be via NHS 111 or the local dental advice triage helpline.
- We want to support a sustainable model that has evaluation built in from the outset.

Total requested up to £1 million for the first centre

SUMMARY - INVESTMENT PLAN

NHS
Cheshire and Merseyside

	Estimated Costs 2024/25	Risk / Opportunity	Risk / Opportunity
PATHWAY 1	£3.162 million	£-1.960m million	Review scheme in Qtr1. Reduce payment value or incorporate vulnerable patients in Pathway 3.
PATHWAY 2	£3.488 million		Monitor activity and affordability
PATHWAY 3	£4.882 million (Local) £1.200 million (National)	£3.882 million (local) £1.200 million (national)	Estimated cost of paying up to 10% over-performance to half the eligible contractors. No commitment to pay for more than 100% of contracted activity until the affordability of all Pathways is confirmed. Assumed that remaining contractors are unlikely to incur full impact of National scheme.
PATHWAY 4	£0.200 million		
PATHWAY 5	£0.420 million		
DENTAL ACCESS AND WORKFORCE DEVELOPMENT CENTRES x 1 proof of concept PDS agreement	£1 million		Specification and costs to be confirmed
ADDITIONAL FUNDING FOR ADVICE TRIAGE HELPLINE	£0.468 million		
Early Years Oral Health Programe	£0.600 million		3 year project
Total reinvestment of anticipated under-performance requested	**£15.420 million**	**£3.122 million**	**Review under-performance each mid year**
Less Funding Approved June 23/24	£-4.835 million		
Less Oral Health funding approved 23/24	£-0.600 million		
Net Annual Funding Requested	**£ 9.985 million**	**£3.122 million**	

NEXT STEPS FOLLOWING APPROVAL

NHS Cheshire and Merseyside

ACTION 1 - Establish Programme Board and schedule of meetings COMPLETED

ACTION 2 - PMO support/capacity already identified and agreed COMPLETED

ACTION 3 - Agree Pathway 1-5 project leads COMPLETED

ACTION 4 - Agree support for Dental Access and Workforce Development Centres IN PROGRESS

ACTION 5 - Agree performance quality metrics. Quarterly reporting to SPCC IN PROGRESS

ACTION 6 - Develop Implementation Plan and Risk Log IN PROGRESS

Completion of the ALL actions by 26/3/24

NHS
Cheshire and Merseyside

APPENDICES

APPENDIX 1. URGENT CARE EVALUATION

Rapid evaluation of the UDC plus scheme has been taken from September 2023 – December 2023

Overall, there is a consistent number of appointments used within this service, with an increase over time.

On average over the 4 months, 986 patients have received treatment through this service, of which 95.1% were deemed by the UDC plus providers to be appropriate for the pathway.

More adults (3602, 91.4%) than children (364, 9.2%) were treated. Using this pathway, 2,116 patients have had a full course of dental treatment to restore their dentition within NHS primary dental care.

There is a reported sense that patients have been motivated, engaged and happy with the pathway.

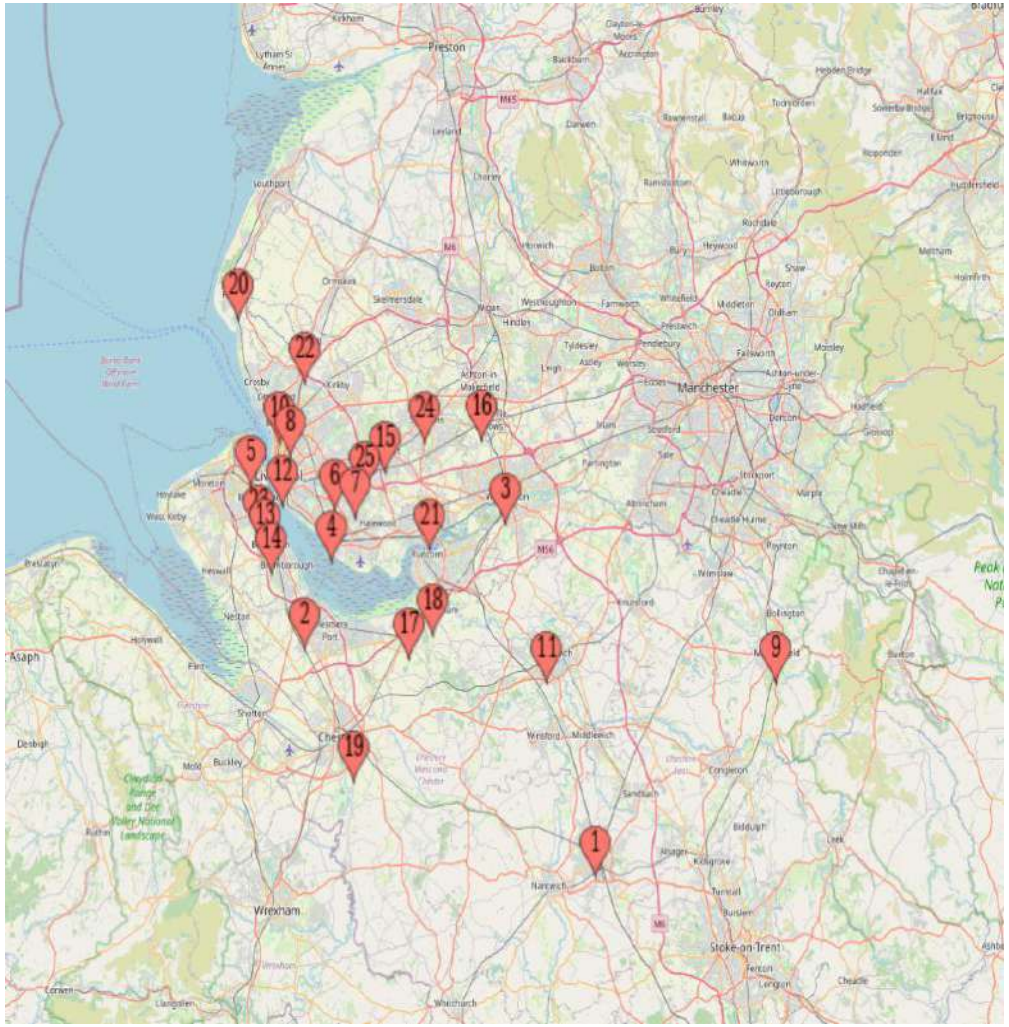
There is also documentation of access for some vulnerable groups, as well as the high dental needs of this group of patients.

Providers also reported positively about the treatment they are providing for these high need patients with very few issues raised

Map no	Dental Practice IMD*	Dental Practice Local Authority
4	1	Liverpool
8	1	Liverpool
10	1	Sefton
15	1	Knowsley
21	1	Halton
24	1	St Helens
3	2	Warrington
5	2	Wirral
7	2	Liverpool
13	2	Wirral
23	2	Wirral
1	3	Cheshire East
12	3	Liverpool
9	4	Cheshire East
25	4	Knowsley
14	5	Wirral
16	6	St Helens
6	7	Liverpool
11	7	Cheshire West and Chester
19	7	Cheshire West and Chester
22	7	Sefton
17	8	Cheshire West and Chester
2	9	Cheshire West and Chester
18	9	Cheshire West and Chester
20	9	Sefton

1	2	3	4	5	6	7	8	9	10

Key: Dental Practice Index of Multiple Deprivation Decline 1 = most deprived 10% nationally, 10 = least deprived 10% nationally

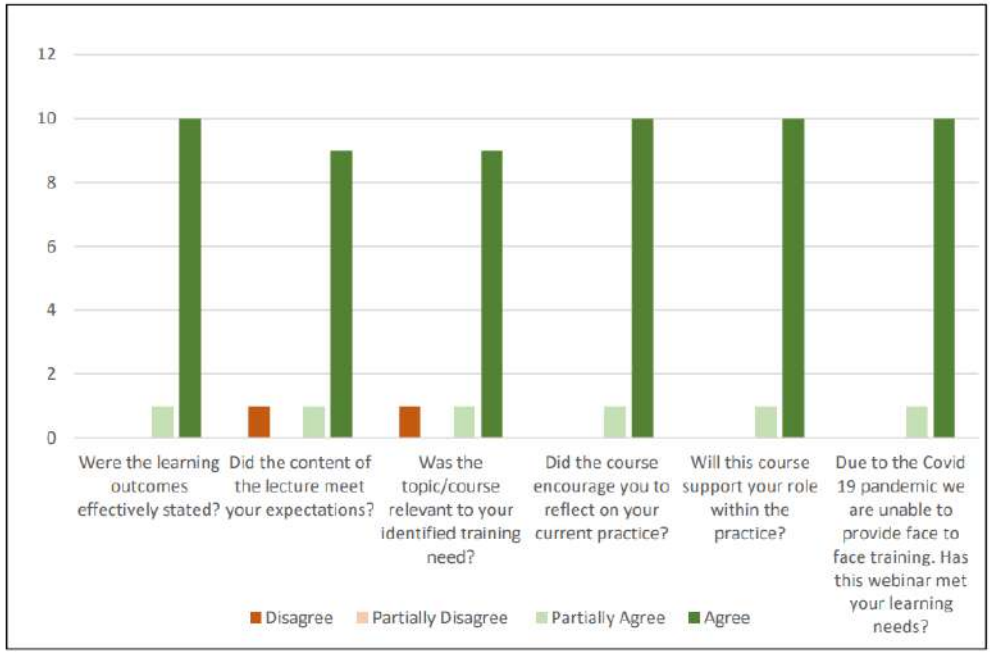


APPENDIX 2. EVALUATION ADVANCED CHILD CARE DENTAL PRACTICE PATHWAY IN CHESHIRE AND MERSEYSIDE

Dental practices completing management/treatment procedures for children (≤16 years-olds) to either stabilise and/or definitively treat. It was anticipated that this would help to ease the burden on the CDS, whilst ensuring that each child is seen within a timely manner in the appropriate healthcare setting.

Pathway is important for addressing oral health inequalities to ensure those who have the highest dental needs within C&M have access to appropriate dental care. Furthermore, this fits within the NHS national CORE20plus5 agenda as well as ensuring Children and Young People (CYP) across the pilot area receive the “right care, right time, right place”.

A set criteria specification formed the governance process of choosing suitable dental practices. Key criteria were included to ensure the appropriate selection of dental practices, which consisted of three domains: dental practice location; dental practice facilities; and dental practice activities. All general dental practices within Liverpool, Sefton and Knowsley had the opportunity to express participation interest.

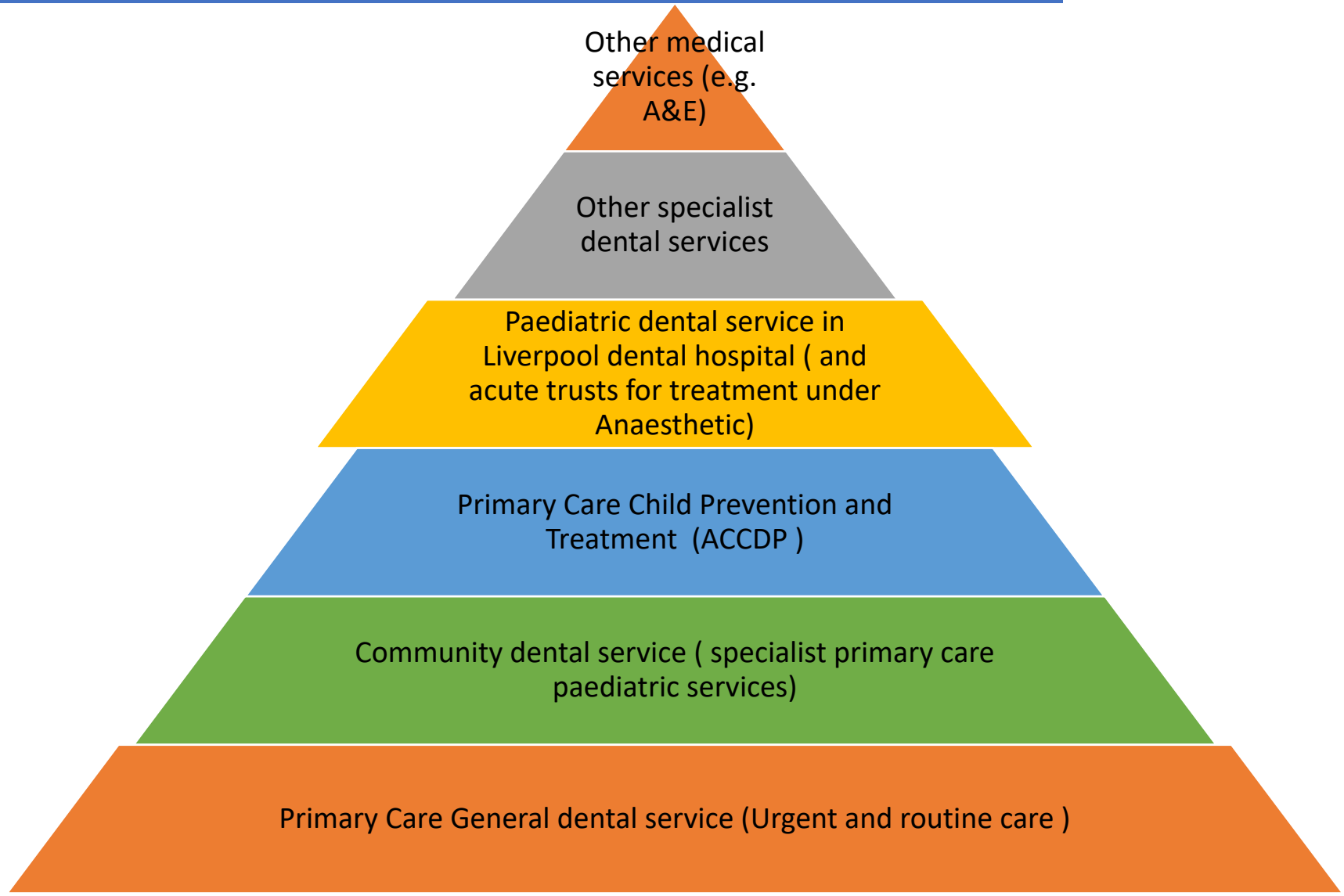


Overall, 28 patients were referred from the triage hub to ACCDP practices. Of these 28, 16 (57.1%) patients had their treatment treated through the ACCDP pathway, with 9 (32.1%) patients either uncontactable or WNB to their scheduled dental appointment. Only 3 (10.7%) patients required onward referral to Community Dental Service, after treatment part completed within ACCDP.

Next steps

- Consider the roll out of the pilot to other localities across C&M with appropriate training and evaluation required via the C&M Paediatric MCN
- Funding considerations for the sustainability of alternative dental care pathway service for paediatric patients within C&M
- Consider medium to long-term strategies to educated and upskill general dental practitioners to provide Tier 1 paediatric care, with consideration to undergraduate training

APPENDIX 3. Example – Integration of dental access pathways across C+M for children and young people



DR Y Dailey NHSE Northwest
Dental Public Health 2024

NHS
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CHESHIRE AND MERSEYSIDE DENTAL IMPROVEMENT PLAN 2024-2026

Increasing capacity, improving access and addressing oral health inequalities

On 22 February 2024 System Primary Care Commissioning Committee (SPCC) reviewed the proposed dental improvement plan for 2024-26.

The plan will build upon the current programmes in place and will align to the delivery of the national dental recovery plan Our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk) (Published Feb 24).

The new Dental Improvement Plan aims to utilise anticipated under-performance on primary care dental contracts up to the value of £15.420 million for 2024-25. £4.835 million was previously approved in June 2023 for the Dental Improvement Plan and SPCC has also agreed funding of £600k pa for three years for an oral health programme.

Utilisation of a further £9.985m of anticipated under-performance is now requested for the expansion of the plan.

Following a detailed discussion, review of the SORDs and to provide a level of assurance for the Board, the SPCC is recommending that the Board now approve the plan and additional expenditure up to the value of £15.420 million.

The plan seeks to maintain and create workforce development opportunities within existing practices and wider within health and social care. Maximise the opportunity of flexing contracts to consider the altered contracting mechanisms outlined in the dental recovery plan and previous contract reforms.

The plan will increase access to primary care dental services and will include preventative advice for all patients and in specific defined areas support a collaborative approach for preventative treatment.

The plan will focus on ensuring our most vulnerable populations are able to access NHS dental services as an integral element of the ICB ambitions regarding population health management.

We intend to address health inequalities agenda by focussing activity on areas of highest need and linking to the oral health strategic partnership recently established. Some of the key themes raised in the SPCC review of the dental improvement plan were as follows:

COMMISSIONING DENTAL SERVICES FOR OUR RESIDENTS AND COMMUNITIES

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.

Oral Health and Dental Healthcare inequalities exist in Cheshire and Merseyside. The 2019 5 year old National Dental Epidemiological Survey (NDEP) showed that 34% living in the 10% most deprived areas of the country and 14% living in the 10% least deprived areas had experienced dental caries.

Deprivation explained 38% of the variation in prevalence of dental caries and 42% of the variation in severity of dental caries. We have recently embarked on a new programme of work focused on addressing the impact of these health inequalities and improving outcomes for children in our communities.

The ICB has committed to working with its nine local authority partners to establish a 3-year supervised tooth brushing programme for 2-7 year olds in our 20% most deprived communities. We will be enhancing this offer with targeted free provision of oral health packs to help ensure that barriers are removed for those most at risk of dental decay.

This work has commenced via Beyond our Children and Young people's group, with recruitment to crucial delivery posts for the programme, system wide mapping with local areas to help enhance and introduce new oral health programmes.

Procurement processes have commenced to achieve the best value for money and model for local areas to access the oral health dental packs in their local areas. Full implementation will be achieved during 2024/25.

We are committed to tackling health inequalities in outcomes, experiences and access and improving population health and healthcare.

Promoting equality, diversity, human rights and inclusion is at the heart of everything we do as shown through our "*All Together Fairer*" commitments. This leads us to ensure that we commission, redesign and decommission services fairly and that no community or protected group in Cheshire and Merseyside is disproportionately affected.

The ICB has signed up to the Northwest BAME Assembly Anti-racism Framework and its five anti-racism pledges. Working with our provider collaboratives to build a strong and sustainable NHS provider sector that delivers services which offer consistently high levels of access and quality.

We think our plans for 2024/26 will support the move towards improving access and the continued requirement in the NHS operational plan to restore dental activity to pre-pandemic levels.

Our plan will focus on three key areas including Urgent Care, Urgent Care Plus and Access including continued focus on our most vulnerable groups.

Delivery of the plan will be supported by the Local Dental Professional Network and the NHS England Northwest Dental Public Health team.

CONFIRMATION OF THE BASIS OF THE FUNDING, RISKS AND ASSUMPTIONS

	Estimated Costs 2024/25	Risk / Opportunity	Risk / Opportunity
PATHWAY 1	£3.162 million	£-1.960m million	Review scheme in Qtr1. Reduce payment value or incorporate vulnerable patients in Pathway 3.
PATHWAY 2	£3.488 million		Monitor activity and affordability
PATHWAY 3	£4.882 million (Local) £1.200 million (National)	£3.882 million (local) £1.200 million (national)	Estimated cost of paying up to 10% over-performance to half the eligible contractors. No commitment to pay for more than 100% of contracted activity until the affordability of all Pathways is confirmed. Assumed that remaining contractors are unlikely to incur full impact of National scheme.
PATHWAY 4	£0.200 million		
PATHWAY 5	£0.420 million		
DENTAL ACCESS AND WORKFORCE DEVELOPMENT CENTRES x 1 proof of concept PDS agreement	£1 million		Specification and costs to be confirmed
ADDITIONAL FUNDING FOR ADVICE TRIAGE HELPLINE	£0.468 million		
Early Years Oral Health Programe	£0.600 million		3 year project
Total reinvestment of anticipated under-performance requested	**£15.420 million**	**£3.122 million**	**Review under-performance each mid year**
Less Funding Approved June 23/24	£-4.835 million		
Less Oral Health funding approved 23/24	£-0.600 million		
Net Annual Funding Requested	**£ 9.985 million**	**£3.122 million**	

Funding for the Dental Investment Plan comes from existing non-recurrent sources. It relies on primary care dentists continuing to provide significantly less activity than they are contracted to deliver. It is this under-performance, which is recovered each year, that will be reinvested in the new pathways.

The ability of the ICB to invest in the Dental Investment Plan depends upon the continuation of under-performance on core primary care dental contracts.

The affordability of the plan depends on:

a) The level of take-up of the schemes within the local improvement plan;

b) The ability of ICBs to permanently and unilaterally reduce the contracts of practices which persistently under-perform (action indicated in the national recovery plan); A change to legislation in order to undertake this is still awaited.

c) Any future redistribution of ICB dental allocations based on need, as identified in the national recovery plan.

d) The number of patients attracting the new national patient premium (ending in March 2025).

e) The level of under-performance against existing primary care dental contracts. Ie. relies on dentists delivering similar levels of under-performance as in 2023/24 and not recovering to pre-COVID levels.

f) Pathways being withdrawn or activity on the Pathways being scaled down should take-up exceed initial estimates or funding available.

g) The availability of accurate and timely data to monitor activity and costs on each of the Pathways.

SYSTEM ENTRY POINTS AND RESPONDING TO THE WORKFORCE CHALLENGE

We recently completed a rapid evaluation of the urgent dental care clinical activity within Cheshire and Merseyside in January 2024, and this provided a number of recommendations for action.

One of the recommendations was to ensure the Triage Advice Helpline is adequately funded and monitored to enable smooth transition of patients through the system. This service acts as the gateway to the now well-established urgent care system and is a key part of the system.

A secondary recommendation was to expand referral mechanisms to allow health and social care professionals to refer vulnerable patients with urgent dental needs into the UDC / UDC plus system accessed via the Advice Triage Helpline Service.

To complement our existing plans, we are seeking to develop at least 3 dental access and workforce development centres across Cheshire and Merseyside in areas of highest need.

The initial access and workforce centre will be up and running in the first year and will act as a proof of concept. We want to encourage and support a collaborative approach when developing any proposals to deliver this vision.

We will use the national contracting flexibilities announced recently and are seeking to find creative solutions. The centres could offer both undergraduate and post graduate workforce opportunities, but we expect to see a skill mix model in operation.

The centres could offer bookable appointments 7 days a week and this would be via NHS 111 or the Triage Advice Helpline.

A MODEL BUILT AROUND 5 PATHWAYS WITH A PRIORITY ON ACCESS TO ROUTINE NHS DENTAL CARE

The plan is built around the following pathways:

Pathway 1 Access to urgent dental care for those in immediate need of support, such as dental pain, or specific medical/statutory requirement*

Pathway 2 Urgent Care Plus -- Definitive treatment following urgent care, if required/requested

Pathway 3 Routine care for patients who require a check-up and any follow up care to make sure they are orally fit. In addition there are two further pathways with a focus on local vulnerable groups.

Pathway 4 Access for children, with additional preventative/treatment needs.

Pathway 5 Access for “cared for” frail vulnerable adults.

With Pathways 1 and 2 now well established, the priority in our new plan is **Pathway 3** as we must focus on our population being able to access routine dental care.

Access to routine dental care has been one of the main issues reported to Healthwatch and the subject of many letters of complaint to the ICB from patients, elected members and our local MPs.

Investment in **Pathway 3** and its prioritisation reflect the best use of the funding available and align to the NHS Operational Plan priority requiring that the ICB must deliver primary care dental activity to pre COVID levels of performance.

SHARING OUR AMBITIONS WITH STAKEHOLDERS, PATIENTS AND THE PUBLIC

The plan will build on existing work already being undertaken within the region and will also complement the government’s national dental recovery plan (published in February 2024) with a range of additional measures to help achieve its ambitions.

The first key priority within the plan will be to increase access to regular dental check-ups for more of the population in Cheshire and Merseyside – with additional funding and training being made available to help more dental practices to enhance existing provision.

The plan will also include a range of key measures to help address the current inequity of access to dental care across the region – including the proposed establishment of Dental Access and Workforce Development Centres in areas identified as having the highest level of need.

In addition, the plan will also look at ways to help reduce health inequalities around oral health for a number of key patients groups – including children and young

people who need specialist dental care, and 'cared for' frail vulnerable adults, working in close collaboration with local professional networks such as Local Dental Committees and NHSE NW Public Health, as well as Healthwatch and local patient groups.

COMMUNICATIONS & ENGAGEMENT ACTIVITY

Once the Dental Improvement Plan and associated budget is fully signed off, we will share a briefing about this ambitious plan with a range of key stakeholders across Cheshire and Merseyside – including dental networks, system leaders, political stakeholders, community and voluntary sector partners, the media, and the general public.

The team will also develop an overarching communications plan, with a range of key communications and engagements to support each individual phase of roll out (or pathway) identified with the dental improvement plan.

This plan will include a number of key elements such as:

- Keeping all of our key stakeholders regularly updated on progress being made against the plan

- Developing key campaign materials and messages to help promote key messages to patients/public about how to access both routine and urgent dental care services across the region

- Engaging with Healthwatch and other VCSFE partners to help us effectively reach and listen to key patient groups, and use their feedback to help us co-create solutions that will effectively meet the needs of local communities.

RECOMMENDATIONS

The new Dental Improvement Plan aims to utilise anticipated under-performance on primary care dental contracts up to the value of £15.420 million for 2024-25.

£4.835 million was previously approved in June 2023 for the Dental Improvement Plan and SPCC has also agreed funding of £600k pa for three years for an oral health programme.

Utilisation of a further £9.985m of anticipated under-performance is now requested for the expansion of the plan.

Following a detailed discussion, review of the SORDs and to provide a level of assurance for the Board, the Committee is recommending that the Board now approve the plan and additional expenditure.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Primary Care (General Practice) Access Improvement Plan - Update

Agenda Item No: ICB/03/2418

Responsible Director: Clare Watson, Assistant Chief Executive

Primary Care (General Practice) Access Improvement Plan - Update

1. Purpose of the Report

1.1 To update the Board on progress of the ICB's Access Improvement Plan, following approval by the Board in November 2023. This paper is supported by an in depth presentation (Appendix One).

1.2 To offer assurance in respect of progress, actions and next steps, including the specific actions requested by the Board following the November meeting.

2. Executive Summary

2.1 On 09 May 2024 NHS England released 'Recovering Access to Primary Care', a major policy announcement with a national commitment to 'tackle the 8am rush' and make it easier and quicker for patients to get the help they need from primary care. https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care.

2.2 The ICB's improvement plan 'response' had to be submitted to ICB Board's in either October or November 2023, returning for updates in early 2024.

2.3 The plan aims were to support recovery by focusing for 2023/24 on four areas:
- Empower patients to manage their own health
- Implement Modern General Practice Access 'model'
- Build capacity to deliver more appointments from more staff than ever
- Cut bureaucracy and reduce the workload across the interface between primary and secondary care.

2.4 To support delivery of the Access Improvement Plan, the ICB set up a programme management governance structure, detailed project plan for delivery of the improvement plan, under the Executive leadership of the Assistant Chief Executive with SRO (Senior Responsible Officer) for each of the four areas above.

2.5 In response, each Place agreed their own Access Improvement Plan, which were drawn together into a System Level plan, as per the policy ask, which was agreed at the Board in November 2023.

2.6 In response to the specific ask that Boards were updated in early 2024, this paper is supported by a presentation which gives progress/updates on:
- each of the 4 areas of the policy document
- per Place update
- Equality and Health Inequalities (EQHIA) in relation to the plan.

2.7 In addition an Access Improvement Dashboard is presented (Appendix Two) with data presented where available for the specific areas.

2.8 The specific asks following the Board in November 2023 are given below with the corresponding update:

- An updated/completed Equality and health inequality analysis (EHIA) and report noting an action plan will need to be developed as part of this with actions at both place and system level. That the dashboard contains the actions from the EHIA so they are not seen as 'separate'
  The action plan is in development and during Q1 of 24/25 this will be finalised and form part of the next Board update. Some key deliverable metrics are in the dashboard

- Completed metrics and targets as far as possible within the dashboard
  Contained within the dashboard and where gaps, a narrative is provided.

- Numbers of Pharmacy Technicians included in the dashboard in the relevant workforce/Building Capacity section
  This is now in the dashboard but the figures are still being collated

- Assurance that places are engaged with their Health and Wellbeing Boards as part of the local place led improvement plans
  Places have confirmed this

- Places to be encouraged to share best practice and approaches between them, systematically
  This is happening via place primary care leads 'ways of working' forum and facilitated centrally.

- A simple monthly reporting place plan template to be agreed to support the system level/NHS England assurance process and to give some key feel for progress before the next iterations
  As the NHS England assurance document is monthly, we have incorporated this.

- Measuring the difference for patients – in January, working with our Healthwatches and other bodies, develop/commission measures for impact of these measures and the real time experiences of patients. This may already be happening at Place level but this should form part of the update to the Board – noting that this may need to be ongoing over 24/25 dovetailing into the national General Practice survey
  The ICB have discussed this with Healthwatches and have identified a source of funding to deliver some Access Improvement Related questionnaires across all places, that do not duplicate the GP Patient Survey but concentrate on 'is it feeling different' based on specific areas of the policy document.

2.9 Information has been released in respect of Access Recovery for 2024/25 and further guidance is awaited at the time of writing this paper, details below https://www.england.nhs.uk/wp-content/uploads/2024/02/PRN01111-letter-gp-contract-arrangements-24-25.pdf

https://www.england.nhs.uk/publication/arrangements-for-the-gp-contract-in-2024-25/

2.10 Given the new Guidance and that there will some key further actions happening during Q1 into Q2 of 24/25 it is recommended that an updated plan, based on the new guidance, the 9 updated place plan return to the Board in September 2024. This will include an updated dashboard and equality and health inequality analysis action plan.

2.11 Between now and that Board meeting, each Place Primary Care Forum and System Primary Care Committee are receiving ongoing assurances in respect of progress, driven operationally through the Access Improvement Programme Board chaired by the Assistant Chief Executive.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- note the update in respect of the Access Improvement Plan for Primary Care (General Practice)
- agree that a further update on Access Recovery for 2024/25 as outlined in para 2.9 returns to the Board at its meeting in September 2024.

4. Next Steps and Responsible Person to take forward

4.1 The Programme Board and System Primary Care Committee, working with the nine Place Primary Care Fora will take forward the recommendations.

4.2 SRO for overall delivery: Christopher Leese, Associate Director of Primary Care

5. Officer contact details for more information

Christopher Leese, Associate Director of Primary Care – chris.leese@Cheshireandmerseyside.nhs.uk

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

Tackling Health Inequalities in outcomes, experience and access (all 8 Marmot Principles)

Improve population health and healthcare

7. Link to meeting CQC ICS Themes and Quality Statements

- Supporting to People to live healthier lives
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes
- Care provision, integration and continuity
- How staff, teams and services work together

8. Risks

8.1 Risks are detailed in the paper appendices.

9. Finance

9.1 Full financial information is contained within original plan and by exception in this presentation

10. Communication and Engagement

10.1 A communications plan summary was contained within the original plan and by exception in this presentation

11. Equality, Diversity and Inclusion

11.1 An Equality and health inequality analysis and report was included with the original plan and any updates are by exception within the presentation.

12. Appendices

Appendix One: Summary Presentation of Recovery Plan

Appendix Two: Access Improvement Dashboard

NHS
Cheshire and Merseyside

Update – Primary Care Access Improvement Plan

March 2024

Clare Watson, Assistant Chief Executive – Executive Lead for Access Improvement

Policy Background & Patient Experience

- Access recovery/improvement a major tranche of national policy around General Practice (with some related Community Pharmacy actions)
- Remains an ICB priority with overall circa £88 million being invested in this area for 23/24

Why is the policy important for patients – National Policy patient feedback

- To tackle the 8am rush and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.
- For patients to know on the day they contact their practice how their request will be managed**.** a. If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.
    - If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.
    - Where appropriate, patients will be signposted to self-care or other local services (eg community pharmacy or self-referral services).

What our patients told us (GP Patient Survey 22/23)

- Easier access, ability to make a timely appointment that meets patient needs within a reasonable timescale and understanding the reasons for being offered the appointment with that member of staff, were priority areas

Local Healthwatch feedback included

- Patients need to feel valued and important/understood from their first point of contact with their GP surgery
- Clear information about how to access timely appointments and services with a choice means available - avoiding people feeling isolated and dis-enfranchised particularly recognising certain groups such as unpaid carers language and accessibility requirements
- Patients able to make or manage appointments by visiting the Surgery; by an uncomplicated telephone system that is answered in a timely manner; or by online systems where appropriate and accessible to people. Each of these methods should respect people's privacy.
- Know what the next step/action is, when that is likely to take place, and how they can keep track of any referral. 'Who, when and why'

Progress to date (1)

NHS Cheshire and Merseyside

Empowering Patients

- **Pharmacy First Launch** - 98% of community pharmacies signed up to deliver the service as of 04/03/24 ***more of our patients can access Pharmacy for a range of health needs rather than their GP practice***

- **NHS App-** Exceeded targets for enablement of access to Appointments, Prescriptions & Record Access ***patients are accessing a greater range of services in C and M through the app***

Building a Modern General Practice Access Model

- **Practice Websites** ("What Good Looks Like"): 8 out of 9 Places have started to review their practice websites against national guidance (ease of access, navigation, clarity of information, sign-posting) with the remaining Places to start imminently ***to support patients in understanding services and access options through practice websites***

- **Cloud Based Telephony** – 141 of 142 new telephony contracts have been signed - Phase 1 40 practices live by 25th March Phase 2 102 practices live by end Q1 24/25 ***CBT helps practices improve patient experience, supports better signposting, triage and demand management/call monitoring in line with patient ask re access by telephone***

- **Care Navigation training** ICB enhanced the national offer with local bespoke training supporting 270 plus staff and 290 practices sending teams of staff to the various offers ***supporting practice staff to engage with patients to help understand the various care offers, timescales and assurances regarding their needs***

- **Transformation Support through General Practice Improvement Programme*:*** Participation in this national programme is voluntary 172 practices are participating in the universal offer; 36 in the intermediate offer; 10 in the intensive offer with an increased number of practices taking up the universal offer of support ***this training supports practice in improving/enhancing their services to patients based on for some offers, their particular capacity challenges, looking at outcomes of their patient survey for example***

Progress to date (2)

NHS Cheshire and Merseyside

Building Capacity

- **Additional roles** - the ICB has accessed overall 94.8 per cent of draw down funding bringing 1,264 additional direct patient care into the ICB since December 23, 305 recruited this year alone ***increasing the range of available direct patient care staff for patients within general practice***
- **Number of appointments within 2 weeks** continues to rise (88.9%/261 practices delivering this) ***in line with patient expectations for timely appointments***
- **23/24 investment in premises improvement grants** £2.45m additional 16 schemes approved ***delivering practice premises changes to increase space for staff and enhancing the patient experience***

Reducing Bureacracy

- **Primary/Secondary Care Interface** groups established and operating in all places **– *clinicians engaging to support further streamlining of work to enhance patient referral / handover processes and reduce bureacracy***
- **Primary Secondary Care Interface Comms Toolkit** – published Jan 24 to support the above
- The ICB has received **national recognition** for this and has showcased the work to national policy leaders

Equality and Health Inequalities

- **Draft 3-year, EHI action plan** has been developed and initial actions are captured in the Access Improvement Dashboard *recognising the actions needed to support our diverse population in their access requirements including language, format and deprivation considerations*
- Established a strategic ethnicity quality data group

Key Next Steps

- Places agreeing the improvements achieved via **PCN Capacity and Access Improvement Plan for 23/24** *which details the PCN specific improvement and changes that underpin the system plan, based on local populations*

- **Self Referral** – challenges remain and this work needs to be progressed as a priority workstream

- **GP Retention**– although outside of the Additional Roles scheme further work is required to embed retention initiatives *recognising the importance of continuity of care as part of the patient experience and the loss of an experienced workforce*

- **Workforce Planning and Modelling -** response to the National NHS Workforce plan needs to include Primary Care ambitions and trajectories to help us 'measure' capacity further

- **Appointments within 2 weeks / same day** – push towards 90 per cent of appointments being offered within 2 weeks and further work required to measure same day appointments *to further meet the ask of our patient experience feedback regarding timely, relevant appointments to individual needs*

- **Patient Experience – measuring the 'impact' of all the actions** - Results of GP Patient Survey due Summer 24 / Healthwatch surveys and place level feedback planned – *to understand 'what is the difference being felt Recognising that the HW work / patient experience needs to be ongoing to truly understand the impact*

- **Equalities and Health Inequalities Health Impact Assessment related actions** – *roll out of place bespoke and system level action plan recognising the diversity of our population and identifying additional actions*

- **Implementing Access Improvement Year 2** – awaiting revised national policy expectations in more detail

- **More detailed place/system updates return to Board in September 2024**

NHS
Cheshire and Merseyside

Update – Primary Care Access Improvement

Place Summaries

Place Update – Access Improvement Plan March Board
Cheshire East

NHS
Cheshire and Merseyside

Progress since November 2023

- Cheshire East Practices continue to make good progress with implementation of CBT. 19/37 sites having migrated to a new digital telephony provider. The remaining 18 sites have go live dates booked before the 31/3/24.
- Continue to maximise the financial and procurement support within the PCARP Programme.
- Access Improvement data has been updated and shared with practices for local measures by 31.3.24
- PCARP Toolkit check list updated.
- Workforce return completed.
- Continue to meet with PCN CDs and Managers on a weekly basis.

Key actions for next period March-July

- Receive and review end of year PCN CAIP Plans, taking through Place Governance for recommendation
- Work through 2024/25 contract changes aligned to Aligned to PCARP with PCNs and agree implementation.

Key challenges/exceptions/risks

- Challenge of capacity to undertake GPIP Visits
- Cheshire East Practices - lack eligibility of funding from the digital framework against the nationally agreed criteria.
- ARRS recruitment and retention.

Showcase of any best practice/good example

- Eaglebridge implementing the cloud based telephony and triage- -have been sharing best practice and operational protocols around triage so the patient journeys are very similar, supporting further joint / central working

Place Update – Access Improvement Plan March Board
Cheshire West

Progress since November 2023

- 33 (77%) practices have moved to Cloud Based Telephony as at end February 24. The remining are expected to have completed the process by end March 24.
- Transition Funding accessed

Key actions for next period March-July

- Ensure the final 10 practices complete the move to Cloud Based Telephony by the deadline.
- Ensure that the Practices/PCNs undertake their Quarter 4 Local Survey to provide the information for the matrixes to monitor improvement in Capacity and Access work.
- Maximise the number of Support Level Framework conversations undertaken with practices

Key challenges/exceptions/risks

- Estates – physical space for both core general practice roles as well as ARRS roles continues to be a significant issue.
- Financial position regarding System Development Funding
- Challenges regarding implementation of CBT/Digital asks re pace and timelines

Showcase of any best practice/good example

- 14 Practices undertaken GPIP – 2 Intensive programme, 12 Intermediate Programme

Place Update – Access Improvement Plan March Board Halton

NHS Cheshire and Merseyside

Progress since November 2023

- % of patients with NHS App increased from 50 to 52 % (July to December 2023.)
- Call back functionality now in place in all Practices.
- PCN DES ARRS funding fully invested with 95 wte additional staff working across primary care.
- Transition & Transformation funding provided to 7 Practices to support improvements in access to be implemented.
- At scale website provider identified for Practices, GP Federations and PCNs.

Key actions for next period March-July 2024

- Transition & Transformation Funding - collate outcomes of successful bids, seek further bids for 2024/25 funding.
- SDF – Follow up meetings arranged with 2 Practices, 1 initial meeting to be held, continue to offer to all practices.
- Evaluate PCN CAIP plan outcomes.
- Refine and implement project with Health Watch to gather patient experience of access and insights to inform improvements.
- Continue delivery of Integrated Neighbourhood Model Same Day Primary Care programme of work to align approach to same day access across 14 Practices and 2 UTCs. Commence development of UTC DOS into a simplified programme for care navigation.
- Implement at scale website across all Practices, GP Federations and PCNs.

Key challenges/exceptions/risks

- Capacity in General Practice and competing priorities e.g. New CQC inspection regime launched which includes a focus on Access.
- Reporting time lag for some data e.g. at start of March, December is the latest available data for NHS App uptake.
- Reporting issue with Online Consultations via Patchs and ARRS appointments not being reflected in GPAD data.

Showcase of any best practice/good example

- Place Led Care Navigation programme – 245 staff trained across all practices and GP Federations at two PLT events. Continue to build on this with plan to expand Care Navigation into two UTCs as part of Integrated Neighbourhood Model Same Day Primary Care.
- Transition & Transformation Funding - £75,512 allocated to practices.
- PC Workforce Group established to develop relationships between ICB Place, Training Hub and General Practice/PCNs. Benefits include improved collaboration on workforce challenges, developing PDL/LEF roles, commenced GP Training Needs Analysis survey and supporting PCN development & clinical leadership via nominated PCN Workforce Leads.
- Place level Practice, GP Federation & PCN Websites project to ensure consistent approach across Place.
- Strong collaboration with PCNs and Place PC Team, with regular meetings to align programmes of work and priorities across PCN and ICB Place.

Place Update – Access Improvement Plan March Board Knowsley

NHS Cheshire and Merseyside

Progress since November 2023

Empowering Patients:

- Self Referral pathways reviewed and promoted via practice websites & care navigators
- Knowsley average is 49 % of registered patients have the NHS App. (National target is 90%) Practices range from 43.6% to 66.3% - Monthly review to track progression.
- 23% of patients are registered/ enabled to book/cancel appointments online – Ongoing monitoring of activity.
- Overall NHS App utilisation included in PCN CAIP plans. BI support to be accessed to enable Practice level data to be extracted and included in monitoring data set. – System Ops Team monitoring activity

Implementing Modern General Practice:

- Online consultation – All 24 practices live with PATCHs
- Self-Monitoring – Home BP monitoring in place Via Community Pharmacy.
- Appointment booking tools – available via NHS App - included in PCN CAIP plans.
- LQIS plan submitted and under review via the Primary Care Steering Group – Sign Off Feb/March

Building Capacity:

- Continue to support PCNs to report accurate complement of staff onto NWRS portal.
- Local Place PC Workforce Group to be established with representation from the Spinney Training Hub and PCN GP Workforce Leads
- Process now in place for Section 106 requests to request infrastructure funding to support General Practice estate development.
- Strategic Estates group (SEG) established.

Cutting Bureaucracy

- Automation - EMIS Web enables integrated care, supports coordinated working across organisations.
- Analyse Rx, is a clinically integrated platform that allows primary care teams to quickly and automatically gain insight to determine clinical priorities

Key actions for next period March-July

- Review of AARs allocation and workforce effectiveness
- Review of LQIS and PCN development Plans
- Ongoing of implementation of Digital Plans inc Call back functionality and EMIS Hub roll out

Key challenges/exceptions/risks

- Re alignment work with some PCNs and their configuration ongoing

Showcase of any best practice/good example

- Borough wide collaboration to provide additional access to MMR / Childhood Imms

Place Update – Access Improvement Plan March Board Liverpool

NHS Cheshire and Merseyside

Progress since November 2023

- 7 of the 9 PCNs have maximised ARRS budgets this year, and re-distribution of underspend process currently underway
- All SDF funding has been allocated and quarterly monitoring of delivery is in progress
- c25 Practices have now accessed the Modern General Practice Transformation and Transition funding
- c200 general practice reception/admin staff have attended Care Navigation Training within more sessions planned in Feb and March (Connexus)
- Support Level Framework visits have commenced, and small numbers of increases also in practices signing up for the GPIP offer
- Prospective Record Access is enabled in the majority of practices, with a project in place at Informatics Merseyside to support a small number of practices with higher than 10% use of the exclusion code preventing patients from accessing records online; Nearly all practices have now enabled all functionality in the patient NHS App (appointment booking, records access, prescriptions).

Key actions for next period March-July

- Review and sign-off of PCN Access Improvement plans (30% CAIP funding) and the QOF Quality Improvement projects
- Cloud based telephony: c 11 practices progressing in 'phase 1' telephony migrations, and c60 practices currently working to sign up to 'phase 2' telephony migrations (plans not yet finalised); small numbers of practices are now starting to progress next steps with ICB digital team and suppliers for kit orders and training.

Key challenges/exceptions/risks

- Workforce – capacity and demand
- Estates
- Accuracy of the GPAD data and issues with online consultations and other external systems including PCN Enhanced Access data not pulling through
- National issues with patients' prospective access to records
- ANP Digital Badge requirements for working at a PCN
- Digital framework timescales and implementation

Showcase of any best practice/good example

- SDF projects have been well thought out and innovative – including a collaborative approach to new care models for ADHD between 7 PCNs.

Place Update – Access Improvement Plan March Board Sefton

NHS Cheshire and Merseyside

Progress since November 2023

- November care navigation training taken place
- Phase 1 and 2 telephony in progress
- S&F PCN moved into new premises
- See good example information below

Key actions for next period March-July

- Progress transition to Modern General Practice Model
- Review of CAIP plan outcomes 23/24
- Work to support NHS app usage and secondary care interface issues
- Support/embed changes to 24/25 GP contract

Key challenges/exceptions/risks

- Sustainability of general practice, increased demands, i.e winter pressures, Industrial Action, Measles, 24/25 GP contract, etc.
- SDF funding can only support short term schemes, challenges with 0.93p digital PCARP funds
- Further communications required (national) regarding evolving nature of primary care, new roles etc to the public
- Elections (24/25)

Showcase of any best practice/good example

- ARI hub continued/enhanced in South Sefton (4000 appts delivered Nov and Dec)
- ARI hub set up for quarter 4 in Southport and Formby (an approximate additional 3,200 appts expected)
- Additional resource for Acute Visiting Service capacity in Quarter 4

Place Update – Access Improvement Plan March Board St Helens

NHS Cheshire and Merseyside

Progress since November 2023

- All Practices are compliant with NHS App System enablement - 51% of St Helens population are Registered for the NHS App
- All Practices have enabled call queuing functionality and 16 Practices will have gone live with call back as at 14/03/24.
- 49% of patients are registered/ enabled to order repeat prescriptions online and 48% of patients are registered to book/cancel appointments online.
- Place Workforce development group established, working in partnership with the Training Hub to support Recruitment and Retention in St Helens
- The Digital Inclusion team is supporting patients on how to access services, messaging, on-line booking, repeat prescriptions, self-referral pathways etc. The Digital Inclusion Team are running onboarding campaigns at 9 practices currently. PCNs are rolling out their own local surveys to measure improvement to patient experience

Key actions for next period March-July

- Completion of Call Back roll out
- GP/Nurse Retention event/Questionnaire 'Your Voice, Your Career
- Evaluation of local PCN Patient surveys
- Review of achievement of PCN Capacity and Access Plans
- Maximising Digital Access with drop-in sessions supported by digital inclusion team

Key challenges/exceptions/risks

- Insufficient estate to enable Hubs for ARRS staff
- Financial sustainability of practices
- Ensuring communications maximisation of resources
- Increased workload on Community Pharmacy.
- Workforce - Reduced Access to Primary Care due to Insufficient clinicians (GPs, Practice Nurses and Advance Nurse Practitioners) alongside increased patient demand

Showcase of any best practice/good example

- Learning Environment Facilitators across all PCNs who are supporting practices to be Learning Environments and attract students/apprenticeships, discussions taking place with Edge Hill University.
- Establishment of first/last 5-year GP support

Place Update – Access Improvement Plan March Board Warrington

NHS Cheshire and Merseyside

Progress since November 2023

- Cloud Based Telephony in place in all GP practice in Warrington – 4 remaining analogue practices supported to switch to an advanced cloud-based telephony solution
- Maximised ARRS budgets
- All SDF funding has been allocated and monitoring of delivery is in progress
- Increased on the day access
- 100% appointment mapping

Key actions for next period March-July

- Complete all outstanding practice Support Level Framework conversations
- Continue to promote GPIP and further Warrington Place Engagement
- Continue to develop the Cloud Based Telephony Solutions on offer to ensure they are optimised and meet the requirements of the 2024/25 contract
- Review and sign-off of PCN Access Improvement plans (30% CAIP funding) and the QOF Quality Improvement projects

Key challenges/exceptions/risks

- Primary Care Estates in order to host PCN level roles
- Risk on improving Survey and F&F test scores as positive change doesn't always evoke positive feedback initially
- Accuracy of GPAD data and issues with online consultations and other external systems including PCN Enhanced Access data not pulling through
- Implementing National Digital Framework

Showcase of any best practice/good example

- Full implementation of Anima in Warrington Innovation Network PCN
- Improved patient satisfaction.
- Implementation of automated patient registration tool has been well received by patients and staff improving access but reducing workload.

Place Update – Access Improvement Plan March Board Wirral

NHS Cheshire and Merseyside

Progress since November 2023

- All CBT contracts signed and in place in line with deadlines. Majority of applications successful.
- 10 out of 44 practices have accessed the Transition and Cover Support Funding 2023-2024.
- Most practices have enabled the 3 NHS App functions – working with 5 practices to ensure full compliance
- Access Hub in place from 18 Dec – 31 March 2024 for urgent/acute on the day appointments – available to all practices. Additional 462 extra appointments for urgent on the day care.

Key actions for next period March-July

- Patient surveys undertaken by PCNs
- Progress with SLF conversations for the targeted practices first (as capacity allows).
- Website audits by Place to be completed.
- Greater understanding of CAIP 24-25 requirements and what this means once further guidance released.

Key challenges/exceptions/risks

- Capacity to undertake SLF conversations for all practices.
- Practices working to tight deadlines to change telephony provider, with some challenges regarding implementation.

Category	Metric	Latest period	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Local Trajectory	National Target	Region value	National value	Latest Rank	By	RAG	Updated / Notes	Source: BI Input
Primary Care 1. Empowering Patients	No. of additional CCS consultations delivered	Nov-23	N/A	-32	182	N/A	N/A	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.24		**Additional onsultaions are determined by using a monthly avrage of the previous 12ths as baseline (Jul- Sept 23 - 7,512 monthly average baseline)**	**NHSBSA - Via Email CPCS Severices data monthly**
	No. of additional BP consultations delivered	Nov-23	N/A	3,980	2,204	N/A	N/A	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.24		**Additional onsultaions are determined by using a monthly avrage of the previous 12ths as baseline Combining Ambulatory BP and Standard BP monitoring. (Jul- Sept 23 - 7,710 monthly average baseline)**	
	No. of additional OC consultations delivered	Nov-23	N/A	25	63	N/A	N/A	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.24		**Additional onsultaions are determined by using a monthly avrage of the previous 3ths as baseline (Jul- Sept 23 - 143 monthly average baseline)**	
	No. of pharmacies registered for CCS/PF	Jan-24	N/A	N/A	N/A	538	537	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.24		**YTD number of Pharmacies registered to deliver the service. At Feb 24 we are working with the assumption that there are 559 Pharmacies in C&M ICB**	**NHSE - Advanced Service data set Registration/Deregistraion - NHSE Teams folder - Weekly Data sets**
	No. of pharmacies registered for BP	Jan-24	496	494	500	514	519	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.24		**YTD number of Pharmacies registered to deliver the service. At Feb 24 we are working with the assumption that there are 559 Pharmacies in C&M ICB**	
	No. of pharmacies registered for OC	Jan-24	139	145	204	370	336	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.24		**YTD number of Pharmacies registered to deliver the service. At Feb 24 we are working with the assumption that there are 559 Pharmacies in C&M ICB**	
	% of 7 self-referral pathways in place across ICBs	Nov-23	TBC	49.0%	49.0%	49.0%	49.0%	TBC	50.0%	TBC	TBC	TBC	30.09.23		Have NW posto but not C&M as a %	Not provided by BI
	50% increase in self-referrals	Nov-23	3,090	3,282	3,066	N/A	N/A	TBC	**4,314**	TBC	TBC	TBC	31.03.24		Provided by BI via NHSE	Provided by BI via NHSE
	CPS Referrals	Dec-23	15,557	18,382	21,132	23,759	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Provided by BI	Provided by BI
	Practices/PCN have enabled all four NHS App functions for patients: Records	Dec-23	97.4%	98.8%	99.4%	99.4%	N/A	TBC	**90.0%**	TBC	TBC	TBC	31.07.23			Provided by BI
	Practices/PCN have enabled all four NHS App functions for patients: Appointments	Dec-23	84.6%	92.2%	94.8%	95.9%	N/A	TBC	**90.0%**	TBC	TBC	TBC	Ongoing			Provided by BI
	Practices/PCN have enabled all four NHS App functions for patients: Messages	TBC	N/A	N/A	N/A	N/A	N/A	TBC	**N/A**	TBC	TBC	TBC	TBC	TBC	Not currently available	Not Currently Available
	Practices/PCN have enabled all four NHS App functions for patients: Prescriptions	Dec-23	97.1%	98.6%	99.1%	99.1%	N/A	TBC	**90.0%**	TBC	TBC	TBC	TBC			Provided by BI
	Enable patients to have access to the four key NHS App functionalities (records, messages, apps, scripts): % practices enabled to book/cancel appointments	Dec-23	44.1%	46.7%	47.7%	48.3%	N/A	TBC	**TBC**	TBC	45.2%	TBC	31.03.24			Provided by BI
	Enable practices to have access to the four key NHS App functionalities (records, messages, apps, scripts): % patients enabled to order repeat prescriptions	Dec-23	49.6%	50.3%	50.7%	50.8%	N/A	TBC	**TBC**	TBC	50.3%	TBC	31.03.24			Provided by BI
	Enable practices to have access to the four key NHS App functionalities (records, messages, apps, scripts): % patients enabled to view care records	Dec-23	20.3%	41.4%	44.5%	44.6%	N/A	TBC	**TBC**	TBC	41.4%	TBC	31.03.24			Provided by BI
	Enable practices to have access to the four key NHS App functionalities (records, messages, apps, scripts): % patients enabled for at least one online service	Dec-23	50.1%	50.7%	51.1%	51.3%	N/A	TBC	**TBC**	TBC	50.7%	TBC	31.03.24			Provided by BI
Primary Care 2. Modern General Practice Access	No. of practices participating in INTERMEDIATE support offer:	TBC	30	N/A	N/A	N/A	36	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.25		This is the data which all Places returned recently. Need to see how this correlates to NHSE data when received. They have said they will send through. It may not be in the same format as their previous data set. This section will need review	Not provided by BI
	No. of practices participating in INTENSIVE support offer:	TBC	16	N/A	N/A	N/A	10	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.25		This is the data which all Places returned recently. Need to see how this correlates to NHSE data when received. They have said they will send through. It may not be in the same format as their previous data set. This section will need review	Not provided by BI
	Total Number of Practices participating in national support offers:	Jan-24	46	46	46	46	55	TBC	**63**	TBC	TBC	TBC	31.03.25		63 is ICB "fair share" of national available resource.	Not provided by BI
	No. of practices at Modern General Practice Access Model:	TBC						TBC	TBC	TBC	TBC	TBC	TBC	TBC	This will be collated based on the national definitions by the next board update.	Not provided by BI
	Number of Practices identified as receiving Transition cover 23/24	Sep-23	0					TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.25		this will be updated at end of 23.24 see main report for narrative	Not provided by BI
	How many practices have identified 1 x person for the national training programme?	Sep-23	146				272	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.25		Practice participation is voluntary; ICB continues to encourage uptake at regular Place Forums.	Not provided by BI
	How many practices have identified 6 x persons for the C&M local training programme ?	Nov-23	220	220	220	220	290	TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.25		Practice participation is voluntary; ICB continues to encourage uptake at regular Place Forums.	Not provided by BI
	How many PCNs have identified digital and transformation leads?	Nov-23	36	36	36			TBC	**No Nat. ICB Target**	TBC	TBC	TBC	31.03.25		PCN participation is voluntary; ICB continues to encourage uptake at regular Place Forums.	Not provided by BI
	Number of Practices transitioned to cloud-based telephony	Jan-24	0	0	1	2	3	TBC	**36**	TBC	TBC	TBC	31.03.24		All practices actively working with National Commercial & Procurement hub. Contracts must be signed by 15th December 2023. National target is local target changed = 35 analogue practices. 01-03-24 6 practices live, 3 in Feb 24. Remaining 29 to go live by 25th March 24.	Provided by Digital
	Number of evergreen practices transitioned to cloud-based telephony	Jan-24	0	0	1	1	1	TBC	**5**	TBC	TBC	TBC	31.03.24		All practices actively working with National Commercial & Procurement hub. Contracts must be signed by 15th January 2024. National target is local target = 5 evergreen practices. 01-03-24 1 practice live, remaining 4 to go live by Q1 24/25.	Provided by Digital
Primary Care 3. Building Capacity	ARRS - Number of ARRS WTE and which roles	Dec-23	1,138	N/A	N/A	1,175	N/A	TBC	**759**	TBC	TBC	TBC	31.03.24		Position vs. baseline	Provided by BI
	Additional GPs recruited in year (numbers are WTE GPs)	Jan-24	1,820	1,820	1,829	1,819	1,817	TBC	**1,888**	TBC	TBC	TBC	31.03.24		using national ambition 'extra 6000 GPs by 23/24'	Provided by BI
	DPC Staff our share of 26,000 national ambition by 31.3.204	Sep-23	1,692	N/A	N/A	1,843	N/A	TBC	**759**	TBC	TBC	TBC	31.03.24		figure is number of roles' DPC direct patient care staff	Provided by BI
	GP Mentors	Jan-24	20	20	20	20	20	TBC	**25**	TBC	TBC	TBC	31.03.24			Not provided by BI / Provided by the Training Hub
	GPN & GP Fellowships	Jan-24	140	N/A	N/A	N/A	174	TBC	**103**	TBC	TBC	TBC	31.03.24			Not provided by BI / Provided by the Training Hub
	UNDERGRAD MED SCHOOL PLACES: NW Baseline – 900 approx. NW increase 100 by 2025. 375 by 2028 and 1000+ by 2031	N/A	N/A	N/A	N/A	N/A	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC	NHSE to confirm this	Not provided by BI
	ST1 Trainees	Nov-23	254	243	240	N/A	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Provided by Training Hub	Not provided by BI
	ST2 Trainees	Nov-23	260	251	248	N/A	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Provided by Training Hub	
	ST3 Trainees	Nov-23	302	310	311	N/A	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Provided by Training Hub	
	Number of GPs on National Retention Scheme	Sep-23	30	N/A	N/A	N/A	34	TBC	TBC	TBC	TBC	TBC	TBC	TBC	https://www.england.nhs.uk/gp/the-best-place-to-work/retaining-the-current-medical-workforce/retained-doctors/ (National GP Retention Scheme)	Not provided by BI / Provided by DI Randall - Primary Care Contracting & Policy Team
	Training Practices - increase number	Sep-23	210					TBC		TBC	TBC	TBC	24/25		seeking updated figure	Not provided by BI
	Practice Nurse HC total	Jan-24	1,040	1,043	1,056	1,054	1,055	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC		Provided by BI
	Vacancies GP	N/A	N/A	N/A	N/A	N/A	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Not currently collected - 24/25 ambition	Not provided by BI
	Vacancies supported / filled by MIAA offer 23/24	Jan-24	92	N/A	N/A	N/A	419	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Jan 24 figure is 419 vacancies over the 3 year period. Sept Figure was 23/24 YTD	Not provided by BI
	No. of additional appointments	Dec-23	955,683	1,104,303	1,292,969	1,395,153	N/A	TBC	**1,800,000**	TBC	TBC	TBC	30.03.24		Performance against 2019	Provided by BI
	Face to face appointments	Dec-23	950,778	1,068,284	932,752	753,736	N/A	TBC	TBC	TBC	TBC	TBC	TBC		Pre-Pandemic 2019 was 988333	Provided by BI
	Telephone appointments	Dec-23	336,391	353,158	360,781	305,367	N/A	TBC	TBC	TBC	TBC	TBC	TBC		Pre-Pandemic 2019 was 153109	Provided by BI
	On line appointments	Dec-23	34,363	43,322	48,498	46,300	N/A	TBC	TBC	TBC	TBC	TBC	TBC		Pre-Pandemic 2019 was 1640	Provided by BI
	Deliver on same day appointments - No.of GPs	N/A	N/A	N/A	N/A	N/A	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Target/Data source TBA	Not provided by BI
	Deliver on appointment within 2 weeks - No. of appointments at lower threshold	Dec-23	88.4%	88.5%	88.6%	88.9%	N/A	TBC	**90%**	TBC	TBC	TBC	30.03.24		The National IIF ask is 85% (Lower Threshold) and 90% (Upper Threshold) of appointments to take place within 2 weeks of booking.	Provided by BI
	Deliver on appointments within 2 weeks - number of practices delivering on lower threshold	Dec-23	258	260	261	261	N/A	TBC	**430**	TBC	TBC	TBC	30.03.24		Out of 346	Provided by BI
	Practices with GPAD enabled	Jan-24	100%	100%	100%	100%	100%	TBC	**100%**	TBC	TBC	TBC	31.08.23		NHSE supplied data	Not provided by BI
	PCNs – GPAD Enabled	Sep-23	48					TBC	**34**	TBC	TBC	TBC	31.08.23		GPAD enabled but full PCN data is still a challenge as different appt book/system so not all available data may be captured at the moment.	Not provided by BI
	PCNs – GPAD reviewed	Sep-23	48					TBC	**33**	TBC	TBC	TBC	31.12.23		See note above	Not provided by BI
	well being - number of staff who have access offers	Sep-23	40					TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	offer end in March 24 - **seeking updated figure**	Not provided by BI
	ADULT NURSE TRG PLACES: NW Baseline – 3350 approx. NW increase 250 by 2025. 1200 by 2028 and 2700	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC from 24/25	Not provided by BI
	ADVANCED PRACTITIONERS: ACP Baseline NW – 450 approx. – increases of about 100	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC from 24/25	Not provided by BI
	CLINICAL APPRENTICESHIPS: NW Baseline – About 1 in 10, by 2030 aim 1 in 6	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC from 24/25	Not provided by BI
	MED DEGREE APPRENTICESHIPS: At least three providers in the NW interested	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC from 24/25	Not provided by BI
	PHARMACIST UNDERGRADS: Working with Jane Brown (NW Pharmacy Dean on numbers)	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC from 24/25	Not provided by BI
	Number of Pharmacy Technicians	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	Added 02.01.24	Not provided by BI
Primary Care 4. Cutting Bureaucracy	Onward referalls C2C	Jan-24	45,891	56,031	66,254	74,756	84,587	TBC	**TBC**	TBC	TBC	TBC	TBC		This equates to 6.8% of referral to Acute Secondary Care. This number of C2C referrals is an increase on the last 3 years.	Provided by BI
	Clear points of contact: ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly: eg single outpatient department email for GP practices or primary care liaison officers in secondary care.	Sep-23	TBC	0	0	0	1	TBC	**17**	TBC	TBC	TBC	30.11.23		Our Consensus on the Primary Secondary Care Interface and supporting Communications Toolkit are published and have been promoted to all Trusts. Local Primary Secondary Care Interface Groups are established and working on the ground to improve these issues.Only Warrington Place has clear points of contacts agreed.	Not provided by BI
	Roll out online patients registration service to up to 2,000 Nationally practices by December 2023	Jan-24	22%	30.5%	31.6%	33.6%	42.80%	TBC	**32.0%**	TBC	TBC	TBC	31.12.23		C&M fair share target is 32%. Good progress been made within the last month - position 22% @ 14/9/23, current position @ 25/10/23 31.6% (112 practices). NHSE national team attending Digital Primary Care Board meeting 9th November to share examples of good practice amongst C&M practices. **11-03-24- Current position is 43.4%**	Provided by Digital
	Reduce requests for GPs to provide medical evidence for other government	Sep-23	N/A	N/A	N/A	N/A	N/A	TBC	TBC	TBC	TBC	TBC	TBC	TBC	This is a national task / awaiting further guidance.	Not provided by BI
	To establish primary-secondary care interface forums and report progress on AoMRC key asks	Oct-23	6	6	6	6	6	TBC	**6**	TBC	TBC	TBC	TBC		We have a target of 6 PSCI groups and we have 6. They will in due course report on the AoMRC recommendations. Each PSCI group is working on establishing the communications asked for so still amber.	Not provided by BI
Primary Care 5. Other Areas	% of population that understand digital access routes	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	This may be being collated regionally	Not provided by BI
	% of population understand community pharmacy	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	This may be being collated regionally	Not provided by BI
	% of population confident in MDT and triage	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	This may be being collated regionally	Not provided by BI
	Calls to 111 (that could have been managed in primary care)	N/A	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC	TBC	To be confirmed for 24/25	Not provided by BI
	National GP Patient Survey – overall experience 'good' returns to previous levels	Mar-23	72.0%	N/A	N/A	N/A	N/A	TBC	**84.0%**	TBC	TBC	TBC	31.07.23	TBC	For reporting in 24/25 survey	Provided by BI
	Friends and Family Test 'Good'	Dec-23	90.1%	90.0%	90.0%	90.4%	N/A	TBC	**90%**	TBC	TBC	TBC	31.03.24		DK 08/01: 102 Practices with no data (102 in October)	Provided by BI
	Place improvement plan in place and agreed	Sep-23	9	9	9	9	9	TBC	**9**	TBC	TBC	TBC	20.10.23		Complete	Not provided by BI
Primary Care 6. EHIA Indicators	Place EHIA plans in place and agreed	TBC	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC		still in development	
	Number of Practices completed Accessible Information Standard self-assessment (subject to NHSE launch)	TBC	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC		still in development	
	Proportion of population with a recorded ethnicity, in line with census 2011 categories, to establish a ICB baseline	TBC	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC		still in development	
	ICB to develop an improving ethnicity recording and quality strategy for Primary Care	TBC	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC		still in development	
	GP Website Providers meet accessibility standards	TBC	N/A	N/A	N/A	N/A	N/A	TBC	**TBC**	TBC	TBC	TBC	TBC		still in development	

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Terms of Reference for the ICB Research and Innovation Committee

Agenda Item No: ICB/03/24/19

Responsible Director: Professor Rowan Pritchard Jones, Medical Director

Terms of Reference for the ICB Research and Innovation Committee

1. Purpose of the Report

1.1 The paper is asking for the Board to approve the Terms of Reference for the Cheshire and Merseyside ICB Research and Innovation (R&I) Committee.

1.2 It is being presented here as the Committee will report into the Board, as agreed by the Board at its January 2024 meeting.

2. Executive Summary

2.1 At the 25 January 2024 ICB Board meeting, the NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS) report was approved. The R&I Committee was listed in the governance structure of the paper (it was named the R&I Executive Committee at this point but has been changed to R&I Committee on advice). The R&I Committee Terms of Reference now needs to be approved by the Board.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- Approve the Terms of Reference for the C&M ICB R&I Committee.

4. Reasons for Recommendations

4.1 The ICB Board at its 25 January 2024 Board meeting approved the:

- the establishment an Integrated Research and Innovation System, including establishing an R&I Committee of the ICB
- the key aims, objectives, focus areas, and proposed governance structure for IRIS.

5. Background

5.1 It is intended that IRIS will be a **cross-cutting theme** within the ICB and will function within the following structure:

- **R&I Committee:** To make recommendations to the Board. Membership consists of the C&M ICB Research Leadership Team (Rowan Pritchard-Jones, Terry Jones, Greg Irving), Dr Fiona Lemmens, Ian Buchan and Iain

Hennessey and a Non-Executive member from the NHS Cheshire and Merseyside Board (also to be Chair).

- **R&I Steering Group:** Reporting directly to the R&I Committee, ensuring transparency, accountability, and alignment with the overarching healthcare strategy. The Steering Group would initially meet bi-monthly as described in the terms of reference.

- **Working Groups.** Reporting into the R&I Committee. Specialised groups responsible for specific research and innovation areas and initiatives, e.g., knowledge exchange working group.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**

Policy-makers and commissioners need evidence to support their decision-making around the delivery and system-wide transformation of health and care services, including how health inequalities will be reduced. Research can give a better understanding of local populations and the wider determinants of health, and with this the steps to maintain health and narrow health inequalities.

Objective Two: **Improving Population Health and Healthcare**

IRIS will create opportunities for research to inform and be informed by population health management. **Tools such as CIPHA will play key role within IRIS for enabling data integration and population health action.**

Objective Three: **Enhancing Productivity and Value for Money**

The development of IRIS will provide an opportunity to consider research delivery within the ICS and across ICS boundaries, increasing flexibility of workforce or recruitment while reducing bureaucracy and improving research productivity and value for money.

Objective Four: **Helping to support broader social and economic**

An active research ecosystem working in a coordinated way and to national standards brings revenue and jobs to regions. IRIS will leverage and help to improve the scale and pace of commercial contract research and innovation. It will maximise the economic and patient benefits of commercial contract research working closely

with the Innovation Agency North West Coast and NIHR Clinical Research Network North West Coast.

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

7.1 IRIS has the potential to support all objectives stated in the Annual Delivery Plan. The ICB must also report on the discharge of its research duties in its annual report. These inclusions will raise the profile of research at board level and help embed research as a business-as-usual activity.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

There is growing evidence that engaging in research activity can improve a range of patients outcomes such as cancer survival and mortality rates. IRIS will look to expand research across the ICS. Improving the quantity, quality, and diversity of research initiatives. It will cultivate a learning environment, valuing intellectual contributions and encouraging knowledge-sharing. Cultivating a culture that values learning, adaptation, and the pursuit of innovation to promote improvements in quality and safety.

Theme Two: Integration

IRIS will help to collate existing system-wide R&I activities and capacity and by doing so, identify existing strengths that may be leveraged whilst identifying areas for targeted intervention and improvement. It will help to harmonise and coordinate research and innovation activities between localities. Joint Research Offices will play a key role here to support the development and growth of high-quality clinical research portfolio.

Theme Three: Leadership

IRIS will support activity that Well-led framework across the ICS. It will help provides incorporate plans for supporting clinical research activity as a key contributor to best patient care. It will ensure service users and carers given the opportunity to participate in or become actively involved in clinical research studies. IRIS will endeavour to become a national leader in the delivery of R&I in ICS frameworks. This will be achieved by developing targeted exemplars – data integration, population health etc, for example and by national leadership, e.g, via UKRD (TMJ, ICS lead) feeding into NHSE coordinating committees.

9. Risks

9.1 IRIS has the potential to help mitigate all of the principle risks identified in the Board Assurance Framework and can support the associated priority actions and assurance activities.

9.2 While research can address local priorities, it typically operates across ICS boundaries and at national and international levels. Health and social care research is governed by a range of laws, policies, and international, national and professional standards. The ICBs and partner organisations should have processes for the set up and delivery of research that comply with national laws and systems and does not duplicate them.

10. Finance

10.1 For the formation of IRIS no new funding is being requested as funding for the activity of the ICB research leadership team is already in place. However further resource may be required in the future. Were feasible to do so we will look to leverage resource with partner organisations to grow the IRIS agenda.

10.2 It is important to note the financial benefits of supporting the formation of IRIS for the ICB and its potential to directly contribute additional funding to support ICS priorities. For example, between 2016/17 and 2018/19 the NHS received on average £9,000 per patient recruited to a commercial clinical trial and saved over £5,800 in drug costs for each of these patients. This equates to income of £355 million and cost savings of £26.8 million in 2018/19.

11. Communication and Engagement

11.1 The proposal presented here has been co-designed by the C&M ICB Research Leadership Team (Rowan Pritchard-Jones, Terry Jones, Greg Irving), Iain Buchan and Ian Hennessey. It has also input from a wide range of stakeholder including but not limited to the NIHR North West Coast Clinical Research Network, NIHR NWC Applied Research Collaboration, Innovation Agency North West Coast, Liverpool Health Partners, CHAMPS research lead, University of Liverpool, LSTM, Edge Hill University, LJMU, University of Chester, C&M ICB Place-based research leads, NHS Trust Research Lead representative, VCSFE leads and patient and public representatives such as Healthwatch England. They have supported the proposals outlined here and recommended that the Board approves.

11.2 In developing the first system-wide research and innovation strategy we will set out their approach to diverse public and patient involvement (PPI) in relation to research and innovation working closely with partners such as the NIHR Applied Research Collaboration North West Coast.

12. Equality, Diversity and Inclusion

12.1 The Integrated Research and Innovation System (IRIS) will align with both local and national research and innovation priorities on tackling health and social care inequalities.

12.2 CIPHA will play key role within IRIS for demand signaling, designing and delivering research and innovation that takes impactful action on health and social care inequalities.

12.3 We will promote the use of the NIHR Focus On Research and Equity (FOR EQUITY) tools and resources to help make research and innovation evidence more relevant for action to reduce social and health inequalities.

13. Climate Change / Sustainability

13.1 Research and innovation are key enablers to ensuring the sustainability of our health and care system and are critical for achieving improved and joined up health and social care services.

13.2 Many of the priorities and ambitions reported in the Green Plan identify the need for research and innovation. IRIS can help to ensure these priorities are effectively addressed.

14. Next Steps and Responsible Person to take forward

14.1 The R&I Executive Group will commence and dates for the calendar year set.

15. Officer contact details for more information

Professor Rowan Pritchard-Jones, ICB Medical Director
RowanPJ@cheshireandmerseyside.nhs.uk

16. Appendices

Appendix One: Cheshire and Merseyside Research and Innovation Committee draft Terms of Reference

NHS
Cheshire and Merseyside

NHS Cheshire & Merseyside ICB

Research and Innovation Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor

Review due:
(add date)

V (add) approved by the (add approving body) (add date)

Research and Innovation Committee

Terms of Reference

1. Introduction and Purpose

The Research and Innovation Committee (the Committee) is established by NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside') as a Sub-Committee of its Board in accordance with its Constitution.

These terms of reference, which must be published on the NHS Cheshire and Merseyside 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 of NHS Cheshire and Merseyside.

The Committee is a non-executive led forum, and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS Cheshire and Merseyside.

The Committee's main purpose is to exercise the functions of the ICB relating to the legal duties on ICBs, as outlined within the Health and Care Act 2022 (the 2022 Act), regarding the facilitation and promotion of research relevant to health service and the use in the health service of evidence obtained from research.

These duties have been emphasised in NHS England's subsequent guidance to ICBs on Maximising the Benefits of Research[1] which makes a number of recommendations on how best to embed a culture of research and innovation within an Integrated Care System (ICS)

2. Role and Responsibilities

The Committee, through delegated authority from the ICB, will develop recommendations on to the Board of NHS Cheshire and Merseyside in line with the development of an Integrated Research Innovation System (IRIS), which will:

- create the most comprehensively networked system across the Cheshire and Merseyside Integrated Care System (ICS)
- build a system attracting investment and intellectual value because of its straight forward nature
- creates a functional network of research delivery because it is underpinned by the richest data science
- allow research to take place within each of the nine Places across Cheshire and Mersey-side
- cements academic and NHS relationships.

The Committee's duties are as follows:

- to approve an annual workplan

[1] https://www.england.nhs.uk/long-read/maximising-the-benefits-of-research/

- make recommendations to the Board of NHS Cheshire and Merseyside
- to involve and engage NHS and wider partners in IRIS, managing the interdependencies with similar systems across Cheshire and Merseyside (and beyond) and resolving any conflicts
- ensure the development of IRIS has sufficient resources drawn from all partners, with the right skills and capacity to deliver against its objectives
- identify and address risks and issues.
- report on progress, risks, issues and delivery to the Board of NHS Cheshire and Merseyside
- ensure that the voice of patients, public and stakeholders are integral to the programme
- receive and consider reports from the Cheshire and Merseyside Research and Innovation Steering Group, ensuring transparency, accountability, and alignment with the overarching healthcare strategy.
- Establish working Groups (specialised groups responsible for specific research and innovation areas and initiatives) that will also report to the Committee.

3. Authority

The Research and Innovation Committee is authorised by the ICB Board to:

- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICBs (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- obtain 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 constitution of the ICB, standing orders and SoRD but may /not delegate any decisions to such groups without the approval of the ICB Board.
- commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.
- approve the TOR for the IRIS Steering Group.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

4. Membership & Attendance

Membership

The Committee membership shall be confirmed by the Board of NHS Cheshire and Merseyside via approval of the Committee Terms of Reference and in accordance with the NHS Cheshire and Merseyside Constitution.

Membership of the Committee may be drawn from individuals employed by or appointed by NHS Cheshire and Merseyside: individuals drawn from partners within the wider health and social care system; and other individuals / representatives as deemed appropriate for the delivery of the Committees remit.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The Committee Membership will be composed of:

- at least one Non-Executive Member from the NHS Cheshire and Merseyside Board (also to be the Chair)
- ICB Medical Director
- Associate Medical Director for Transformation and Deputy Medical Director
- x2 ICB Directors of Research, Cheshire and Merseyside Integrated Care System
- a representative from University of Liverpool
- a representative from Alder Hey Childrens Hospital.

Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff and individuals to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be regularly attended by the following individuals who are not members of the Committee. Such attendees will not be eligible to vote.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

5. Meetings

5.1Leadership

The Committee shall be chaired by a Non-Executive Member of the NHS Cheshire and Merseyside Board. Committee members may appoint a Deputy Chair from amongst its standing members.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative NHS Cheshire and Merseyside Non-Executive Member or Executive Director to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, the Deputy Chair will be asked to Chair the meeting. On the occasion where both the Chair and Deputy Chair are unable to Chair an item due to a conflict of interest, then another member of the Committee, without any conflicts, will be asked to chair the Meeting for that item. Where these requirements are unable to be met the meeting item will need to be deferred.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

A meeting of the Committee is quorate if the following are present:

- at least four Committee members in total, of which this must consist of
  - the Chair or Deputy Chair
  - at least one ICB Associate Director of Research and Innovation.

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.3 Decision-making and voting

Decisions will be taken in accordance with the Standing Orders and Operational Standing Orders of NHS Cheshire and Merseyside and within the authority as delegated to the Committee and its members. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

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 schedule meeting, the Chair may conduct business on a 'virtual basis through the use of telephone, email or other electronic communication'. Decisions will be recorded and formally minuted and ratified at a subsequent form meeting of the Committee.

5.4 Frequency and meeting arrangements

The Committee will meet in private.

The Committee will meet bi-monthly prior to the Research and Innovation Steering Group.

Additional meetings may take place as required.

At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule").

Members may call for a special meeting of the Committee outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair may, following consultation with the Committee members, confirm the date on which the special meeting is to be held and then issue a notice giving not less than one weeks' notice of the special meeting.

The Committee may meet virtually and members attending using electronic means will be counted towards the quorum.

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 having been agreed by the Chair with the support of the executive lead
- good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

7. Accountability and Reporting

The Committee is accountable to the Board of NHS Cheshire and Merseyside and shall report to the Board on how it discharges its responsibilities.

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.

The Committee will also submit copies of its confirmed minutes to the Board of NHS Cheshire and Merseyside following each of its meetings.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

8. Behaviours and Conduct

Members will be expected to conduct business in line with the NHS Cheshire and Merseyside values and objectives and the principles.

Members of, and those attending, the Committee shall behave in accordance with NHS Cheshire and Merseyside constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the NHS Cheshire and Merseyside Managing Conflicts of Interest Policy at all times. In accordance with the NHS Cheshire and Merseyside policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.

- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- Comply with NHS Cheshire and Merseyside policies on standards of business conduct which include upholding the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary
- Act as 'champions', disseminating information and good practice as appropriate
- Comply with the NHS Cheshire and Merseyside administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

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 Board for approval.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

NHS Cheshire and Merseyside NHS Staff Survey 2023: Results and Actions

Agenda Item No: ICB/03/24/20

Responsible Director: Christine Samosa, Chief People Officer

NHS Cheshire and Merseyside NHS Staff Survey 2023: Results and Actions

1. Purpose of the Report

1.1 To provide Board members with an outline of the ICBs NHS Staff Survey 2023 results and an overview of the activity undertaken to date with our staff.

2. Executive Summary

2.1 This paper and supporting presentation (Appendix One) provides an overview to Board of the ICBs NHS staff survey results for 2023. The results are presented against the 7 areas of the national People Promise and the key themes of staff engagement and morale.

2.2 The presentation and report also provide an overview of activity to date in respect of sharing the survey results with staff, their feedback in regard to the emerging themes and the development of resultant action areas.

2.3 The presentation also includes a high-level overview of the staff engagement scores for organisations across the Cheshire and Merseyside system with identification in movement from the previous survey year. Organisations are currently sharing their own results and developing localised action plans in line with staff feedback. Further overview of system results will be discussed at the May meeting of the Board.

2.4 A presentation on the results for the ICB was delivered to the Executive Team on 15 February 2024 by our independent survey provider. This was supported by the engagement activity as detailed above. A dedicated session of We Are One was held on 13 March 2024 to share the results and engage with staff to help inform areas of improvement and plans for future engagement.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- note the ICB staff survey results
- endorse the actions taken to review, disseminate and respond to the NHS Staff Survey results 2023.

4. Background

4.1 The national Staff Survey was undertaken during the period September to November 2023 and follows an agreed national format with questions aligned to

areas of the People Promise and the themes of staff engagement and morale. As a new organisation and although not mandated at the time, the ICB ran the survey in 2022 to ascertain staff opinion and to establish a baseline of staff views for future benchmarking and comparison.

4.2 In 2023 our response rate was 74% compared to our 2022 response rate of 65% with staff also providing free text comments. The embargo on the national reporting and publication of the Staff Survey Results was lifted on 08 March 2024.

5. NHS Staff Survey Results 2023

5.1 The ICB results are detailed in the complementary staff survey presentation (Appendix One). At a high level, the ICB staff engagement score is 6.65 and staff morale is 5.74. The ICB score against the 7 areas of the People Promise are detailed below with comparison scores for 2022 also detailed:

	People Promise Area	Score 2023	Score 2022
1	We are compassionate and inclusive	7.48	7.55
2	We work flexibly	7.28	7.21
3	We are a team	7.19	7.16
4	We have a voice that counts	6.81	6.85
5	We are recognised and rewarded	6.67	6.52
6	We are safe and healthy	6.35	6.39
7	We are always learning	5.23	5.27

5.2 The ICB scored higher than the peer group average in all People Promise Themes including Staff Engagement and Morale. In addition, within the within the sub themes; our scores for Diversity and Inclusion were significantly higher compared to other similar ICB's.

5.3 Following review of the results and engagement with staff, a number of key areas were identified for further development:

- Enhance the appraisal process.
- Elevate commitment to wider EDI agenda.
- Implement reward & recognition schemes.
- Strengthen health & wellbeing conversations.
- Further development of local listening mechanisms to hear staff voice.

5.4 Narrative free text comments were also submitted from staff in support of the structured questions within the survey. We have conducted a thematic review of the feedback with key themes emerging around: -

- Teamworking: Disconnect with Place/ICB
- Structures and organisational change
- Workloads and feelings of burnout
- Need to feel valued and recognised
- Impact of vacancies.

5.5 Following the initial sharing of our high-level results (under embargo conditions), the following actions have been undertaken to share, review and action plan in relation to the feedback.

- Presentation by the Survey Provider to the Executive Team
- Individual review meetings with Leaders of respective teams with full involvement of Team representatives from both the People Operations Group and Staff Engagement Forums
- Presentation and dissemination at both the People Operations Group and Staff Engagement Forum
- Presentation to the We Are One session in March
- Workshop sessions with Place / Corporate Directors, Staff Engagement Forum Members and staff.

5.6 Our priorities for the coming year are centred around each of the 7 People Promises plus Staff Engagement and Morale. Owners will be assigned to each of these priorities, and we will continue to work with each of Place/Departments and Staff Engagement Forum members to drive continuous improvement.

Theme	Priorities
We Are Compassionate and Inclusive	We will identify opportunities to enhance our commitment to the wider EDI Agenda through our staff networks and workplace accreditations.
We are recognised and rewarded	We will ensure we have robust and transparent reward and recognition policies and processes.
We each have a voice that counts	We will continue developing mechanisms for staff to be heard and grow our 'Freedom to Speak Up' culture.
We are safe and healthy	We will support and encourage localised wellbeing discussions with staff regarding workloads and capacity
We are always learning	We will work to enhance appraisal processes with a focus on personal career and skills development.
We work flexibly	We will revisit and enhance policies and practices in relation to flexible working.
We are a team	We will facilitate and encourage 'People Promise' engagement sessions aimed at promoting a 'One Team' collaborative approach.
Staff engagement and morale	We will continue to work in collaboration with Leaders and Staff Engagement Representatives to agree and develop local priorities for the next 12 months based on survey data and regular staff feedback related to staff engagement, morale and the promotion of organisational values.

6. Cheshire and Merseyside ICS Results and Progress

6.1 The national embargo was recently lifted and results for our 16 Trusts are now available. The Engagement score for the C&M ICS increased from 6.85 in 2022 to 6.95 in 2023. When compared to overall National Scores, C&M ICS scored above the national average for engagement with Liverpool Heart & Chest

scoring highest nationally compared to their peer group. Out of our 16 Trusts, 11 saw an increase in their engagement score and 4 showed a very minor deterioration compared to 2022, however, their scores remained fairly consistent with previous year. For Mersey and West Lancashire Trust, this was their first survey following the re-organisation in 2022, their engagement score of 7.05 was above the national average for their peer group.

6.2 With regard to the other themes of the People Promise, the results are shown below. Scores for 'We are safe and healthy' remain under the national embargo due to a national technical issue.

			2022	2023
1	People Promise 1:	We are compassionate and inclusive	7.33	7.40
2	People Promise 7:	We are a team	6.73	6.85
3	People Promise 3:	We each have a voice that counts	6.78	6.81
4	People Promise 6:	We work flexibly	6.08	6.24
5	People Promise 2:	We are recognised and rewarded	5.84	6.06
6	People Promise 5:	We are always learning	5.24	5.58
	People Promise 4:	We are safe and healthy	6.10	TBC

6.3 Our collaborative efforts in relation to delivering the People Promise are reflected in in the work undertaken by our Staff Retention Forum. The forum is facilitated by NHS Cheshire and Merseyside and brings together HR and Operational Leaders from our 16 Trusts; working in partnership to develop new and innovative ways to retain staff. The elements of the 'People Promise are well embedded within the group and regular updates are provided by our 'People Promise' Exemplar Leads which has now grown to a total of 8 following the receipt of additional funding from NHSE. In addition, the North West ICB's has also benefitted from this funding and recently appointed a 'People Promise' Manager to explore ways in which ICB's can work collaboratively and deliver long lasting change as part of their legacy. We are currently exploring how we can extend this work across the system to incorporate the wider ICS to include Primary and Social Care partners.

7. Next Steps

- Publish the organisation's staff survey action plan in early April 2024
- Assurance reporting to the People Committee in April with reporting to the Finance & Investment Committee
- Ongoing reporting and monitoring to People Operations Group and Staff Engagement Forum
- Further analysis as more benchmarking information becomes available and areas for ongoing review and deep dive are identified.

- Undertake mid-year review of progress against our actions and conduct regular check ins with Place/Departments to support progress against local 'People Promise' activities and priorities
- Continue to work with our ICS partners to encourage collaboration and share learning

8. Officer contact details for more information

Paul Martin, Workforce Programmes Manager via
Paul.Martin@cheshireandmerseyside.nhs.uk
or
Suzanne Barker, Head of Staff Experience, Engagement & Wellbeing via
Suzanne.burrage@cheshireandmerseyside.nhs.uk

9. Appendices

Appendix One: Staff Survey 2023 Results Presentation

NHS
Cheshire and Merseyside

Staff Survey 2023

March 2024

Staff Survey 2023

Timeline/Communication Cascade

NHS
Cheshire and Merseyside

Implementation of plans and priorities for 2024

April 2024
Assurance report delivered to People Committee (ICB) 29/04/23

March 2024
Following 'embargo lift'
Detailed presentations at:
'We Are One' 13/03/23
People Board (ICS) 28/03/23

Feb 2024
Detailed presentation to Executive Team by survey provider 15/02/23

Jan / Feb 2024
Preparation and planning.
High level data sharing with Place/Dept Senior Leaders/ SEF/POG members to support development of action plans.
Management reports due 31/01/24

Dec 2023
NHS C&M received 1st release high level results

Nov 2023
Survey closed

Oct 2023
Survey opened

Staff Survey 2023

Response Rates/Content

NHS
Cheshire and Merseyside

Response Rate

74%

Compared to 65% in 2022

Participation

809

Compared to 688 in 2022

Survey Content

7	21	107		
Themes	Sub- categories	Survey Questions	Organisation	Place/Department
7 Elements of the 'People Promise' plus an engagement and morale score	Questions directly related to sub-categories of each of the 'People Promise themes'	• Your job • Your team • People in your organisation • Your managers • Your health, Wellbeing and Safety at work • Your personal development • Your organisation • Background information	Themes/sub scores presented as a whole organisation	Themes/sub scores/questions, broken down for areas with a minimum of 10 respondents

ICB Staff Survey 2023

Response Rates/Content

NHS
Cheshire and Merseyside

Key Measures and Scores

74%	180	6.65	5.74
Response Rate	Comments	Engagement	Morale

Ranked People Promises for your organisation

		Score
1	People Promise 1: We are compassionate and inclusive	7.48
2	People Promise 6: We work flexibly	7.28
3	People Promise 7: We are a team	7.19
4	People Promise 3: We each have a voice that counts	6.81
5	People Promise 2: We are recognised and rewarded	6.67
6	People Promise 4: We are safe and healthy (Under Embargo)	6.35
7	People Promise 5: We are always learning	5.23

Key Findings

Areas of Positive Feedback:

- All themes scored above the national average for ICB's
- Within the sub themes; Diversity and Inclusion scored significantly higher compared to other similar ICB's
- The key performance indicators of Staff Engagement and Morale remain constant and in line with sector scores

Opportunities for Development:

- Elevate commitment to wider EDI Agenda
- Reward & Recognition
- Health & Wellbeing conversations with Staff
- Enhance the Appraisal Process
- Further development of mechanisms for staff to be heard

Top 5 Themes - Staff Comments:

- Teamworking: Disconnect with Place/ICB
- Structures and organisational change
- Workloads and feelings of burnout
- Need to feel valued and recognised
- Impact of vacancies

Staff Survey 2023

Sharing, Listening & Action

NHS
Cheshire and Merseyside

335

Staff Attended ‘We Are One’ Staff Survey Briefing’
Others were able to view recording online

18

Staff Survey Presentations Delivered to:

Place/Department Directors
Staff Engagement Representatives
People Operations Group Leads

9

Places/Departments *(So Far)* Signed Up for Staff Led ‘People Promise’ Events

80%

Stretch Target For Number of ICB Staff Participating in Staff Led ‘People Promise’ Events

Staff Survey 2023

Priorities For 2023/24

NHS
Cheshire and Merseyside

To elevate our commitment to the wider EDI Agenda through our staff networks and workplace accreditations

To ensure we have robust and transparent reward and recognition policies and processes

To continue developing mechanisms for staff to be heard and grow our 'Freedom To Speak Up' culture

To support and encourage localised wellbeing discussions with staff regarding workloads and capacity

To enhance appraisal processes with a focus on personal career and skills development

To revisit and enhance policies and practices in relation to flexible working

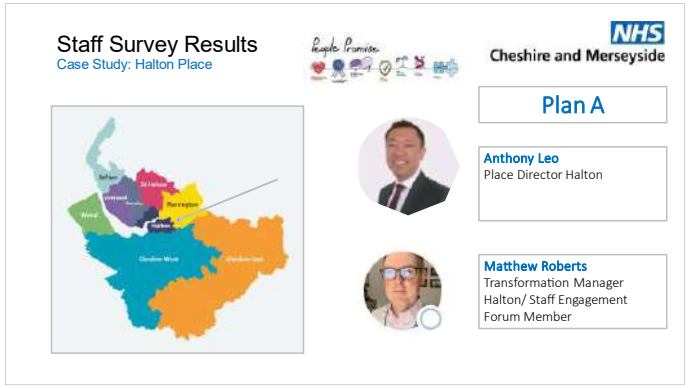
To facilitate 'People Promise' engagement sessions aimed at promoting a 'One Team' collaborative approach

To continue to work in collaboration with Leaders and Staff Engagement Representatives to agree and develop local priorities for the next 12 months based on survey data and regular staff feedback related to staff engagement, morale and the promotion of organisational values

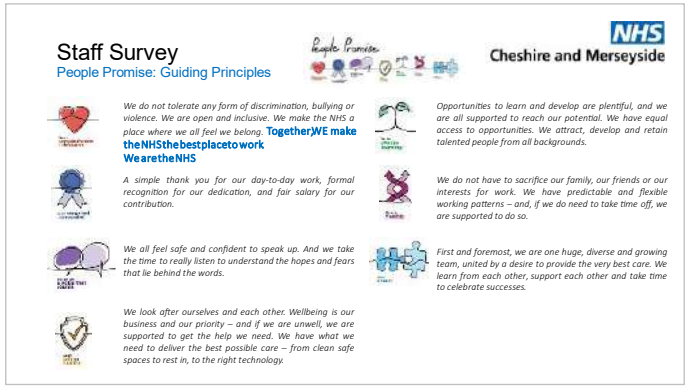
Staff Survey 2023

Case Study: Halton Place

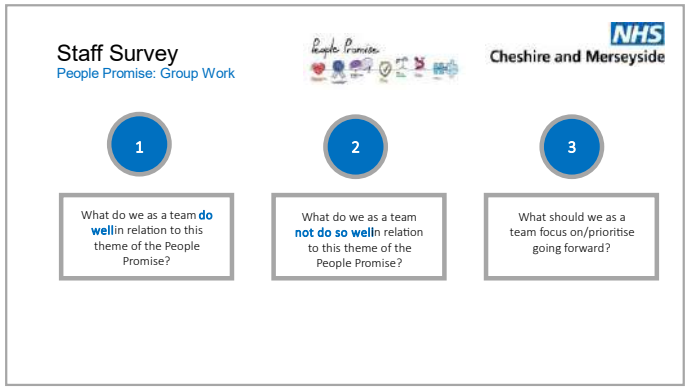
NHS
Cheshire and Merseyside



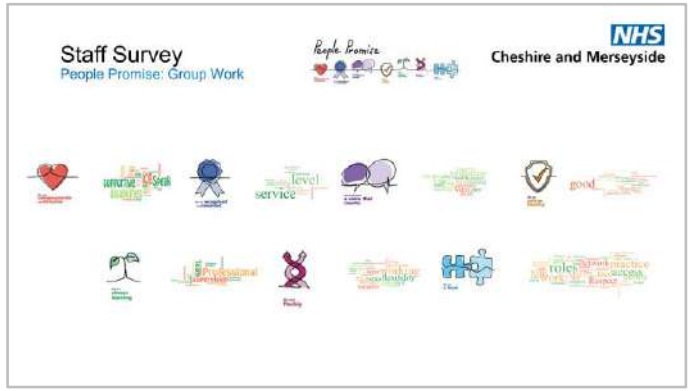
Developed in partnership with Staff Engagement Forum Representatives



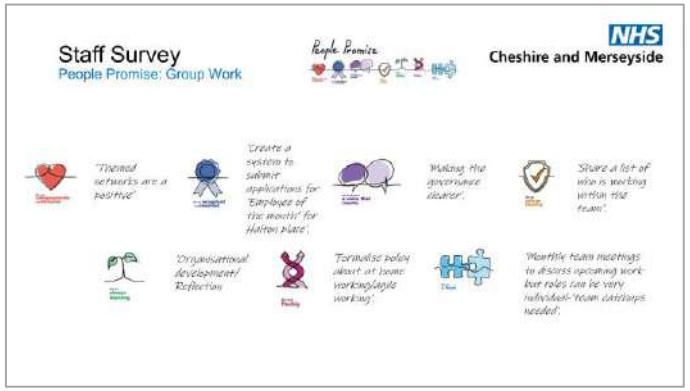
Based on the ‘People Promise’ Guiding Principles



Focus on what we do well/not so well & priorities for the coming year



Team discussed each theme of the’ People Promise’ plus Engagement & Morale



All discussions captured and recommendations developed

Team developing their priorities for 2023/24

NHS
Cheshire and Merseyside

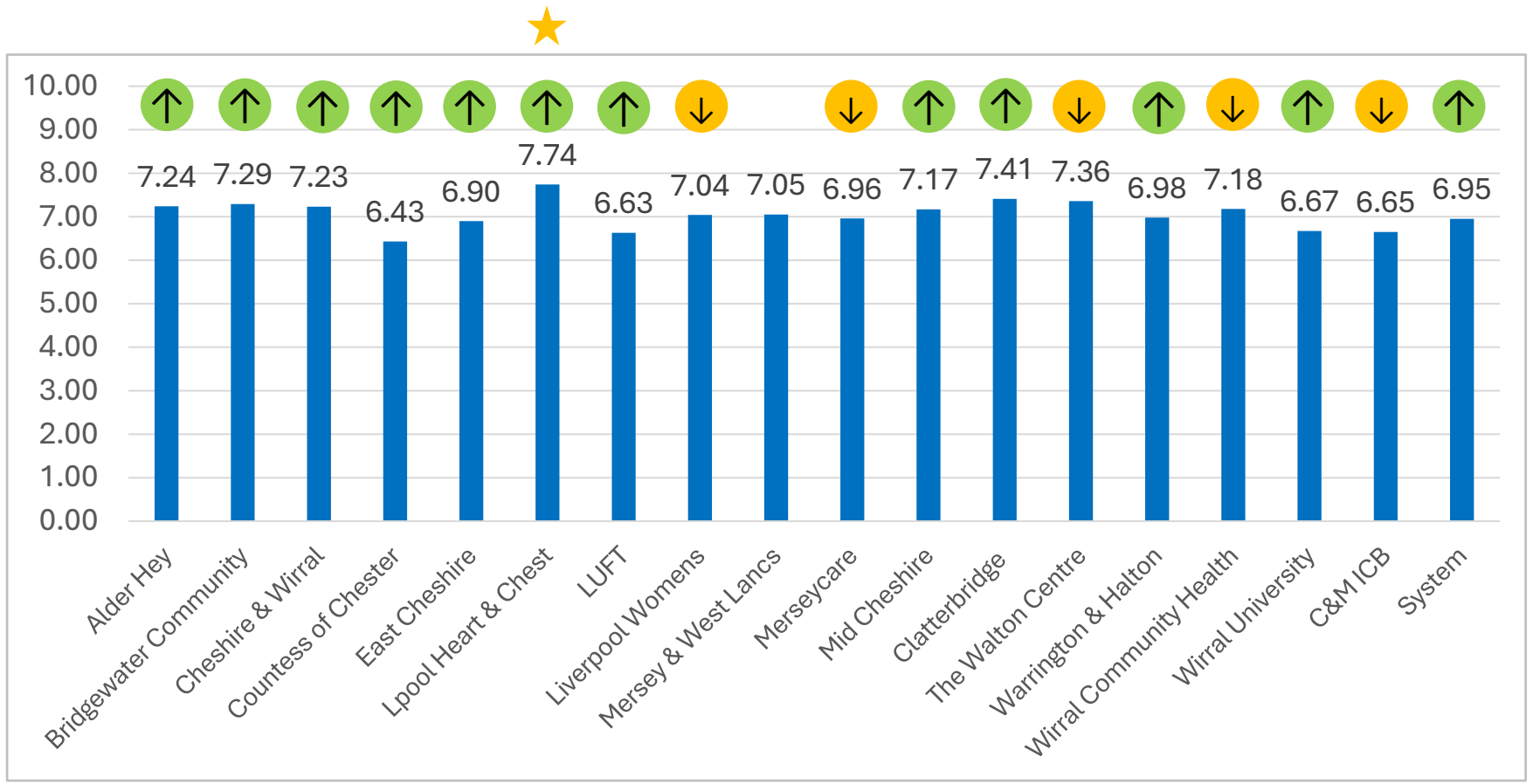
Staff Survey 2023

Cheshire & Merseyside ICS Results

Staff Survey 2023

ICS Trust Engagement Scores

NHS Cheshire and Merseyside



Key Points:

Engagement score for the C&M ICS increased from 6.85 in 2022 to 6.95 in 2023

When compared to overall National Scores, C&M ICS scored above the national average for Engagement

Liverpool Heart & Chest scored highest nationally for engagement compared to their peer group ★

Organisations highlighted in orange saw very minor deterioration in scores compared to 2022 with scores remaining fairly consistent with previous year

Staff Survey 2023

ICS People Promise Themes Ranked

NHS
Cheshire and Merseyside

		2022	2023
1	People Promise 1: We are compassionate and inclusive	7.33	7.40
2	People Promise 7: We are a team	6.73	6.85
3	People Promise 3: We each have a voice that counts	6.78	6.81
4	People Promise 6: We work flexibly	6.08	6.24
5	People Promise 2: We are recognised and rewarded	5.84	6.06
6	People Promise 5: We are always learning	5.24	5.58
	People Promise 4: We are safe and healthy	6.10	TBC

Key Points:

In 2023, scores across all themes showed encouraging increases compared to 2022.

When compared to overall National Scores, C&M ICS scored above the national average for Engagement and Morale

Scores for 'We Are Always Learning' showing the greatest increase.

Liverpool Heart & Chest scored highest nationally across all themes compared to their peer group ★

Staff Survey 2023

Our Continuous Commitment

NHS
Cheshire and Merseyside

16

Trusts Participating In Our System Wide Staff Retention Forum

'People Promise' well embedded within this agenda and wider Retention Strategy

8

'People Promise' Exemplars Now in Place Across C&M System

Cheshire & Wirral Partnership
Countess of Chester
East Cheshire
LUFT
Liverpool Women's
Merseycare
Warrington and Halton
Wirral Community

1

New 'People Promise' Manager Role Created for NW ICB'S funded by NHSE

Cheshire & Merseyside
Greater Manchester
South Lancs Position Host*

Staff Survey 2023

Delivering Better Outcomes

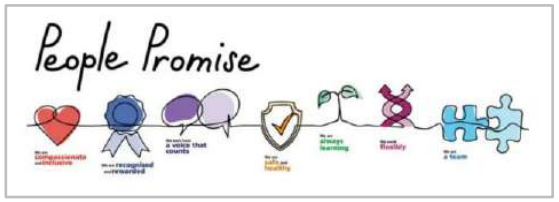
NHS
Cheshire and Merseyside

Research suggests better staff engagement leads to better patient outcomes. Staff survey results across C&M support this.

High Scores Across All Themes

Lower Rates of Turnover

Bank & Agency Spend Within Target



Inspected and rated Outstanding
Care Quality Commission

Lower rates of sickness absence

Less vacancies

Effective FTE Utilisation

Better outcomes for our community and service users

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Building a Continuous Learning and Improvement Culture

Agenda Item No: ICB/03/24/21

Responsible Director: Dr Fiona Lemmens, Deputy Medical Director

Building a Continuous Learning and Improvement Culture

1. Purpose of the Report

1.1 This paper sets out our ambition for NHS Cheshire and Merseyside to be seen as a beacon of excellence in Continuous Improvement.

1.2 It sets out how the ICB intends to leverage our unique position as leaders and convenors of the health and care system for Cheshire and Merseyside to create the conditions for impactful change by inspiring, role modelling and encouraging a systematic Improvement approach to deliver better outcomes for our population.

2. Executive Summary

2.1 Within Cheshire and Merseyside ICB, we are at an early stage of adoption of continuous improvement techniques; while there are good examples of progress and best practise there is not yet a mature infrastructure to promote and support the adoption of Continuous Improvement systematically and consistently across the organisation.

2.2 The ICB is ideally placed to drive Continuous Improvement across Cheshire and Merseyside. In a complex environment the ICB can use its unique position with responsibility for the whole system to create the conditions that enable individuals, teams, and organisations to choose to act with a shared purpose of improving outcomes and tacking inequalities for our population.

2.3 It is important to emphasise our aspiration to create a culture where "**improvement is everyone's business**" providing the right environment, conditions, and capability to support, empower and enable all colleagues across multidisciplinary settings to play an active role in our improvement journey.

2.4 Fostering a culture of improvement takes time and requires dedicated focus and effort to embed but we also recognise the need for action to address our immediate big challenges. We will, therefore, take opportunities to align and enable existing improvement capability to deliver "rapid" improvement focussed on addressing the complex problems of today, whilst we build the culture and capability to improve tomorrow.

2.5 We intend to build on existing assets both within the ICB's current staffing establishment, the NHSE regional team and across the ICS providers however, real success will only be possible with executive leadership and a dedicated core team. We will use a defined systematic approach not just as a mechanism to problem solve, but as a way of integrating our teams to work on improvement beyond our current organisational functional boundaries.

3. Ask of the Board

3.1 **The Board is asked to:**

- **Endorse** the ambition for NHS Cheshire and Merseyside to "**lead the way in health and care improvement and to be seen as a beacon of excellence locally, regionally and nationally**" and to play a strategic role in shaping, stretching, and delivering the ambition.
- **acknowledge** the multi-year commitment required to fully embed a culture of continuous learning and improvement, recognising the ownership required by each Board member.
- **Endorse** the proposal for the adoption of Continuous Improvement as an integral part of our business-as-usual approach in all our directorates and the delivery of our Strategic objectives.
- **Approve** the "invest to save" approach required and the establishment of a core team (circa £500k) to include Executive Leadership.
- **Support** the proposal that, once our Improvement resource has been established, All Age Continuing Healthcare (AACHC) is our first programme area for intensive support and the implementation of systematic improvement approaches.
- **Endorse** the recommendation to establish a Continuous Improvement Programme and for this to report to the Transformation Committee.
- **Recognise** that we must set the right pace and expectations by which an improvement approach can be successfully implemented and sustained.
- **Endorse** the proposal for the adoption of Continuous Improvement as an integral part of our business-as-usual approach in all our directorates and the delivery of our Strategic objectives
- **Acknowledge** the role of the Board to co-design and fully embed a culture of continuous learning and improvement, recognising the ownership required by each Board member to enable this to be a success.

4. Background Context: Why Improvement and why now?

4.1 There is compelling evidence that illustrates the diverse and multi-faceted benefits that can flow from improvement approaches and the critical role improvement culture can play in shaping the future of health care.

4.2 When implemented and embedded effectively they can be used to achieve systematic measurable improvements in the quality and outcomes of care for patients as well as achieving productivity and efficiency gains.

4.3 In addition, evidence shows[1] that every NHS provider that has achieved a rating of "outstanding" from the CQC has employed a systematic approach to quality improvement.

4.4 Done well, organisation-wide or system wide quality improvement leads to sustainable improvements in:

- the quality, experience, and outcomes of care
- use of resources
- health equity
- the wellbeing of people who work in the system
- levels of engagement

- connections and collaborations for better outcomes.

4.5 There are many challenges facing Cheshire and Merseyside ICS that are complex and require multidisciplinary, multi organisation and cross sector collaboration, and that would benefit from a systematic improvement approach. For example, there are Trusts within NOF 3 and considerable challenges across Urgent Care, All Age Continuing Health Care, and the primary secondary care interface, as well as significant financial challenges. These issues mean the ICS itself is in NOF segment 3. These issues are complex and call for integrated and joined up working between organisations and traditionally siloed disciplines such as quality, organisational development, transformation, operational and financial functions.

4.6 As part of the National Improvement Board, NHS England has developed NHS IMPACT (IMproving PAtient Care Together) Framework as a single improvement approach to support organisations, systems, and providers to shape their strategy, underpinning this with continuous improvement, sharing of best practice and learning from one another. See Appendix One for more details.

4.7 Whilst the IMPACT Framework has not been mandated by NHSE, it nevertheless, advocates the opportunity to streamline approaches to achieve longer term sustainability and longevity of transformative change efforts. NHS IMPACT sets out five components that form the 'DNA' of all evidence-based improvement methods, which underpin a systematic approach to continuous improvement:

1. A shared purpose and vision which are widely spread and guide all improvement effort.
2. Investment in people and in building an improvement focused culture.
3. Leaders at every level who understand improvement and practise it in their daily work.
4. The consistent use of an appropriate suite of improvement methods.
5. The embedding of improvement into management processes so that it becomes the way in which we lead and run our organisations and systems.

4.8 When these five components are consistently used, systems and organisations create the right conditions for continuous improvement and high performance, responding to today's challenges, and delivering better care for patients and better outcomes for communities.

5. Cheshire and Merseyside ICS Improvement Journey

5.1 It is important to acknowledge that prior to the establishment of NHS IMPACT, the ICB had already embarked on various improvement activities, some of which are noted below:

- identified improvement as a priority and, with colleagues from the NHSE regional improvement team, explored the creation of a C&M Improvement Hub with a dedicated NHS Futures Page.
- Established programmes including the Urgent and Emergency Care Improvement Group, CMAST Elective Recovery and Clinical Pathways Programmes, and Advanced Care Planning in Primary Care; all of which are using recognised Improvement methodology.

- Improvement leads from all provider organisations have come together as the Cheshire and Merseyside Improvement Network (CaMIN) with a view to expanding the membership to include primary care and social care colleagues. In addition, we have created a shared MS Teams space for use within this Network.
- Established the Clinical and Care Professional Leadership Framework (CCPL) and now aligning this with the continuous improvement agenda.

5.2 This work will continue and add value to our plans to facilitate the adoption of the IMPACT framework. Although this work has been taking place to support system improvement, it is acknowledged that it is not yet being delivered in a systematic way or anchored to a set improvement approach and methodology.

6. The role of the ICB

6.1 The ICB is ideally placed to drive Continuous Improvement across Cheshire and Merseyside. In a complex environment the ICB can use its unique position with responsibility for the whole system to create the conditions that enable individuals, teams and organisations to choose to act with a shared purpose of improving outcomes and tacking inequalities for our population.

6.2 As a trusted partner and system convenor we will encourage integrated efforts to improve by helping to connect people, working collaboratively across the system to inspire, encourage and support our Places, PCNs (primary care networks), Providers and the whole ICS.

6.3 The ICB can leverage the benefits of our whole system use of data, and our digital, clinical, and financial strategies to focus on what we can do together as a system to improve and to tackle our most wicked problems.

6.4 Internally we will embed the adoption of Continuous Improvement as an integral part of our business-as-usual approach in all our directorates, developing a culture that goes beyond traditional Quality Improvement. We will ensure it plays a role in all strategic decision making and underpins the delivery of our Strategic objectives, and the ICB and Health Care Partnership Strategies.

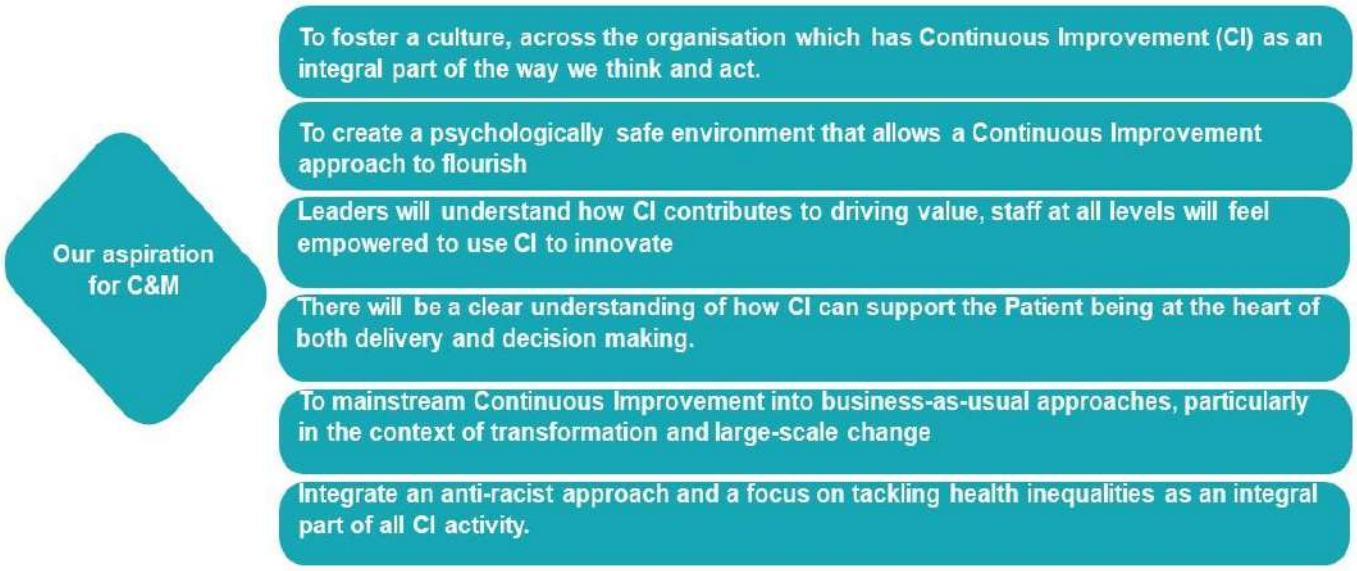
6.5 We will improve the ICB's own efficiency and Continuous Improvement capability by developing our staff, embedding a continuous improvement culture within the ICB, and seeking out opportunities for improvement.

7. Our ambition

7.1 **Our ambition is for NHS Cheshire and Merseyside to lead the way in health and care improvement and to be seen as a beacon of excellence locally, regionally and nationally.** There are core elements to setting the ambition for the ICS and we will explore these as part of the Board Development session planned for late April.

7.2 The initial thinking includes the following core components outlined within Figure One.

Figure One



7.3 As we embark on a long-term multiyear journey of cultural transformation, we will provide a way of working to drive continuous learning, improvement and innovation across health and care in Cheshire and Merseyside. We will look for quick wins and undertake "rapid improvement" to build momentum and address the immediate challenges of today in parallel to the longer-term approach to build the culture and capability to improve tomorrow.

7.4 It is important to emphasise our aspiration to create a culture where **"improvement is everyone's business"**, providing the right environment, conditions, and capability to support, empower and enable all colleagues to play an active role within our improvement journey. All Places, departments, and functions across the ICB will play a vital role in this journey, with our People and OD team, Performance and Planning and Intelligence team and Integrated Research, and Innovation (IRIS) functions being integral to the delivery of this approach.

8. The ICB as an Organisation: "Where are we now?"

8.1 We are at an early stage of adoption of continuous improvement techniques. While there are good examples of progress and best practise there is not yet a mature infrastructure to promote and support the adoption of Continuous Improvement systematically and consistently across the organisation.

8.2 Building on the existing baseline assessment undertaken for NHS IMPACT, further analysis work, supported by AQUA, is underway which will provide further insight to the "current state" view.

8.3 In addition, the NHS IMPACT self-assessment ***(see Appendix One)*** is a helpful tool that can help to determine "where we are now" and support the planning and development components required to successfully embed the five dimensions of the framework.

8.4 Our intention is to fully understand the current maturity by using this tool alongside other techniques to identify our current strengths and opportunities for development across multiple layers of the organisation including:

- Board and Executive Leadership Team
- Senior Leadership Forum
- Transformation Teams
- Across Places and Directorates.

8.5 By doing so, we can thematically use this as a barometer of the "current state" and build and tailor the planning approach accordingly.

8.6 To understand our current assets and capability, we intend to undertake a "skills audit" across all levels of the organisation so we can effectively plan and embed a training and continuous learning strategy.

9. Cheshire and Merseyside Improvement Network (CaMIN)

9.1 There is already considerable Improvement capability across Cheshire and Merseyside. The ICB has several senior staff who are trained and experienced in the use of Continuous Improvement methodology, but we have not yet established a formal leadership structure that supports these experts to work with colleagues in teams other than their own or to fully realise the potential of them working more widely across the system.

9.2 Across the system, all Acute, Specialist, Community and Mental Health providers have dedicated teams to deliver improvement activity at an organisation level, but these vary in size and scale. A Cheshire and Merseyside Improvement Network (CaMIN) has grown organically and has representation from all Providers as well as the ICB. This network provides a mechanism to share best practise, discuss approaches and challenges and offer peer support. Discussions have started to explore further opportunities to support CaMIN to be a substantive and recognised network, and there is appetite to work collaboratively to share resources and work "at scale" to undertake improvement across the system.

9.3 There is much that the ICB can learn from the members of CaMIN and is our intention to use the expertise and experience in this group to build the capability and capacity of our collective system including the ICB's own staff and particularly in Primary Care where Continuous Improvement capability is less well established.

9.4 All organisations have already completed the NHS IMPACT baseline and have started to interpret this at a local level. As a system partner AQUA are supporting analysis work of this baseline along with a view of Primary Care and this will provide further insight of the current state to inform the development plans required.

10. Understanding the "current state" and building the foundation for improvement

10.1 To support the development of the approach outlined, we plan to undertake collaborative workshops across all Places and directorates to ensure that we:

- create energy, build insight, and work together as a system.
- acknowledge and celebrate the existing strengths and assets of our system for learning and improvement.
- agree actions and co-design the plan with our teams.
- put our people and patients at the heart of shaping and developing this approach.
- identify early adopters to undertake "Rapid Improvement Workshop" approaches to build momentum and identify early quick wins.
- identify functions that would benefit from early intensive improvement support to solve core problems such as All age Continuing Healthcare.
- identify opportunities to support Place Development Plans
- analyse and evaluate our impact and value added.

10.2 This approach will build confidence in generating ideas for improvement, together with fostering a more collaborative approach to involving our staff, patients, carers, and key stakeholders in delivering the improvements.

10.3 The intention is for the adoption of Continuous Improvement to be an integral part of our business-as-usual approach in all our directorates. It will also underpin the delivery of the ICB and HCP Strategic plans. This is a cultural shift from improvement being viewed primarily in a clinical or quality context towards a more widespread adoption of consistent improvement methodology being applied in all disciplines.

10.4 We will develop a Training and Continuous Learning Strategy (building from the NHS C&M ICB Leadership Flagship Programme already developed – **see Appendix Two)** that will provide staff with dedicated time to develop skills and to apply their new knowledge. We will determine the development, support and skills development needed across all levels of the organisation, drawing on the maturity and current state insight gathered.

10.5 The intention is to adapt the AQUA Capability Pyramid and apply it to the staffing establishment of the ICB ***(see Appendix Three).*** This will ensure that improvement is embedded at every level of the ICB supporting a culture where **"improvement is everyone's business".** This will need to be supported by individuals with deeper knowledge and understanding working as part of a Cheshire and Merseyside wide team with the capability and capacity to lead, support and inspire.

10.6 This approach requires a shared commitment from both the employee and the ICB. It is important that each individual employee takes responsibility for their own learning and development and that we provide opportunities for continuous learning and improvements in practice.

10.7 Drawing on the expertise of our Communication and Engagement Team, and using the structures they have already established, we will develop plans to involve the public and patients within this improvement journey and co-produce solutions and new ways of working.

10.8 As our approach becomes established it will be important to recognise and celebrate our successes. We are exploring options for how to do this including a staff improvement skills and training recognition scheme aligned to the AQUA Capability Pyramid.

10.9 The journey of cultural transformation is not an easy or quick fix; it is a challenging endeavour to change behaviour in our complex organisation, developing and embedding sustainable, and effective leadership and an organisational approach to continuous improvement. We can achieve this together through engaging and empowering our staff, harnessing our creativity to solve problems and innovate as part of our daily roles and by having the commitment to the multi-year journey ahead.

11. Methodology

11.1 In respect of our role as leaders and convenors of the ICS it is not our intention to mandate a particular improvement methodology. This is in keeping with the approach of NHS IMPACT and the national team, which merely encourages the consistent use of an organisation's preferred methodology. Each of our providers has an established approach, most of which have the same underlying core principles of Plan, Do, Check, Act Cycle for improvement.

11.2 When we are considering Improvement at scale across the whole ICS it is our intention to use the “Improving Across Health and Care Systems Framework” recently developed by the Health Foundation (see Appendix Four).

11.3 For the ICB’s organisational plans it is our intention is to use a well-defined improvement approach like that set out in Figure Two1, drawing on tools from the Institute for Healthcare Improvement (IHI), LEAN thinking, and KAIZEN methodologies such as Rapid Process Improvement (RPI).

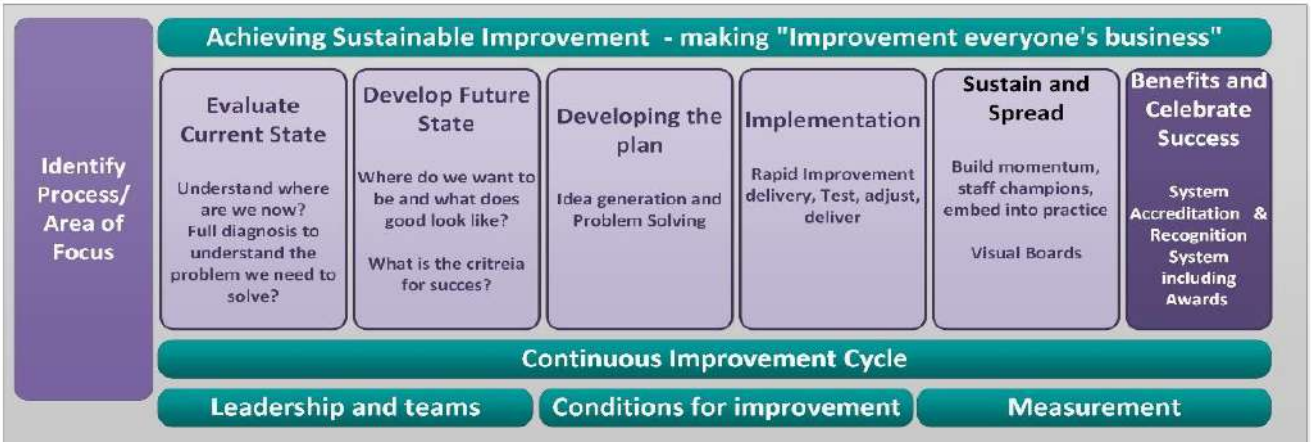


Figure Two

11.4 This will be complemented by an underpinning Improvement and Project Management toolkit, enabling the right tool and method to be applied based upon the specific conditions and requirements. This will allow a flexible and tailored approach whist still operating with a systematic method for improvement. We will undertake further work to develop the methodology and approach and look to keep this consistent with the methodology followed by

many our Providers within the C&M improvement Network (CaMIN) to further enable a common approach to solving system issues and problems.

12. High-level plan and required Next Steps

12.1 A plan on a page is included below in figure 2, setting out key first steps in establishing the ICB approach to Continuous Improvement. It is our intention to select an area for early intensive improvement support once our improvement resource has been established. This will allow us to showcase the benefits of using systematic improvement methodology at the same time as tackling one of our most difficult challenges.

12.2 It is recognised that Urgent and Emergency Care, the financial position and All Age Continuing Health Care are all areas of challenge for the ICB that would benefit from a systematised approach. Urgent and Emergency Care and finance have established forums to support improvement with considerable energy and resource already focused on them. It is therefore proposed that we select All Age Continuing Health Care as our first area for intensive support. This suggestion has the support of the Director of Nursing and Care who is executive lead for AACHC.

12.3 An important next step is identifying the appropriate resource to ensure that the ICB approach to Continuous Improvement is successful. We intend to build on existing assets both within the ICB's current staffing establishment, the NHSE regional team and across the ICS providers however, real success will only be possible with executive leadership and a dedicated core team.

12.4 Once we have prioritised and aligned our existing resources into Improvement and considered new investment through the corporate budget setting process, we anticipate an investment of circa £500k is required to create this core team. This will fund the Senior Leadership required as well as OD practitioners and Quality and Continuous Improvement expertise.

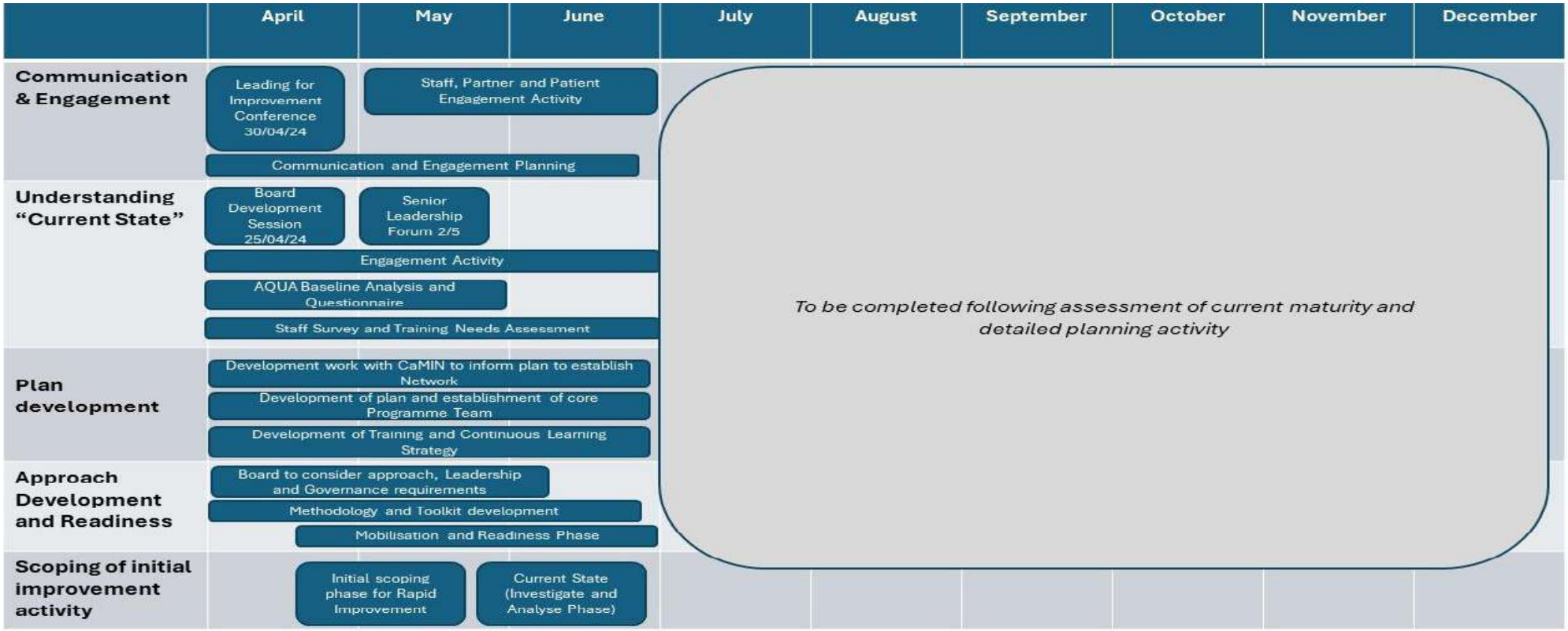
12.5 It is anticipated that this can be funded on a "invest to save" basis and offset by supporting and accelerating anticipated £20.4m savings within delivery of the Cost Improvement Programme target for AACHC initially and sustained by a programme of improvement projects in the future.

12.6 We intend to use our Leading for Improvement Conference on the 30th of April to share our ambition and commitment to Continuous Improvement. The keynote speakers at this event include John Ashworth who is a member of the National IMPACT Board and Dr Amar Shah, the National Clinical lead for Improvement. We also have speakers from The Health Foundation Q Community and NICE.

12.7 On endorsement of the approach outlined, it is recommended that a Continuous Improvement Programme is established with executive leadership and that this reports to the ICB Transformation Committee.

12.8 Figure Three describes the high level next steps to develop the more detailed plan in accordance with the current state maturity assessment work

Figure Three



13. Appendices

Appendix One: Self-assessment and link to NHS Impact website

Appendix Two: NHS C&M ICB Leadership Flagship Programme

Appendix Three: AQUA Capability Pyramid

Appendix Four: Health Foundation Q_Framework

Sources of evidence [1]**:**

- Braithwaite (2019) *Health systems improvement across the globe: success stories from 60 countries*
- Burgess (2022) *Leading change across a healthcare system: How to build improvement capability and foster a culture of continuous improvement*
- Fulop and Ramsay (2019) *How organisations contribute to improving the quality of healthcare*
- Institute for Healthcare Improvement (2021) *Whole system quality: a unified approach to building responsive, resilient health care systems.*
- Shah and Course (2018) *Building the business case for quality improvement: a framework for evaluating return on investment*
- *The Health Foundation (2021) Quality Improvement made simple*
- The Strategy Unit (2022) *What matters when waiting? – involving the public in NHS waiting list prioritisation*

Appendix One: Self-assessment and link to NHS Impact website

- https://www.england.nhs.uk/nhsimpact/
- https://www.england.nhs.uk/nhsimpact/self-assessment/

Appendix Two: NHS C&M ICB Leadership Flagship Programme

NHS Leadership Academy North West · NHS Clinical Leaders Network · Innovation Agency · North West Employers · aqua · NHS Cheshire and Merseyside

NHS Cheshire and Merseyside ICB Leadership Programme

Leading with compassion, curiosity and collaboration

What: an active learning programme for cohorts of leaders
Why: to strengthen and empower leaders in our system
Who: for anyone leading teams, projects, services or across systems at C&M ICB
When: half and full-day sessions delivered March-March 2025
Where: in-person (supported by Future NHS)

Module 1: Values-Based Leadership

Bring our NHS C&M ICB values to life in your everyday practice, putting compassion, inclusion, working together, and accountability at the heart of your interaction with others.

Module 2: Leading with Cultural Competence

Plan for inclusive approaches to tackle inequalities in the workplace and in health services to sustain inclusive ways of working and planning for care.

Module 3: Leading in Systems

Actively lead integration and joined up working through collaboration with key partners, stakeholders, and populations.

Module 4: Leading Continuous Improvement

Translate the NHS England IMPACT model of continuous improvement into ways of working to integrate with your approach to leading change and transformation.

Module 5: Clinical Leadership

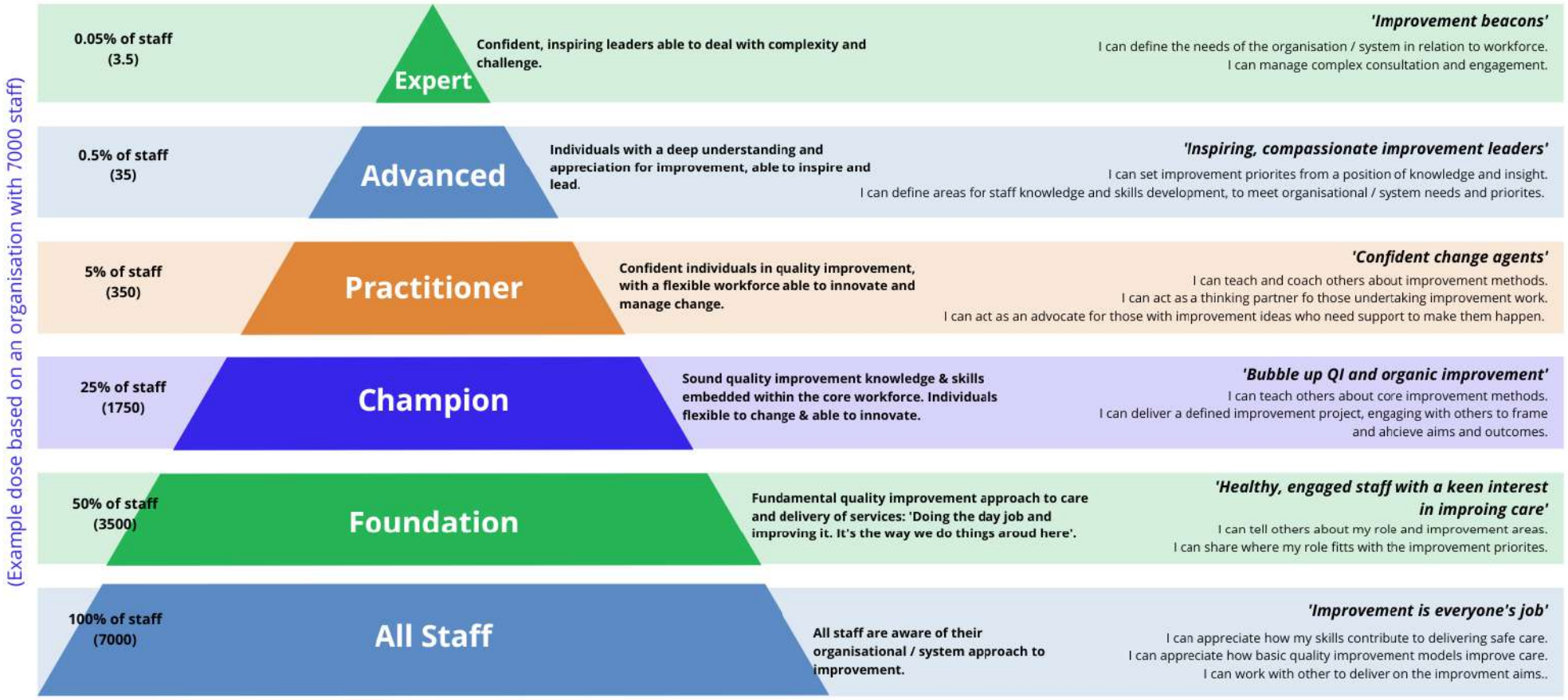
Explore the role of clinical leaders leading integrated care in context of the CCPL Framework, ensuring the quality and safety agenda sits at the forefront of decision making in health and care systems.

All bookings can be made via the staff hub

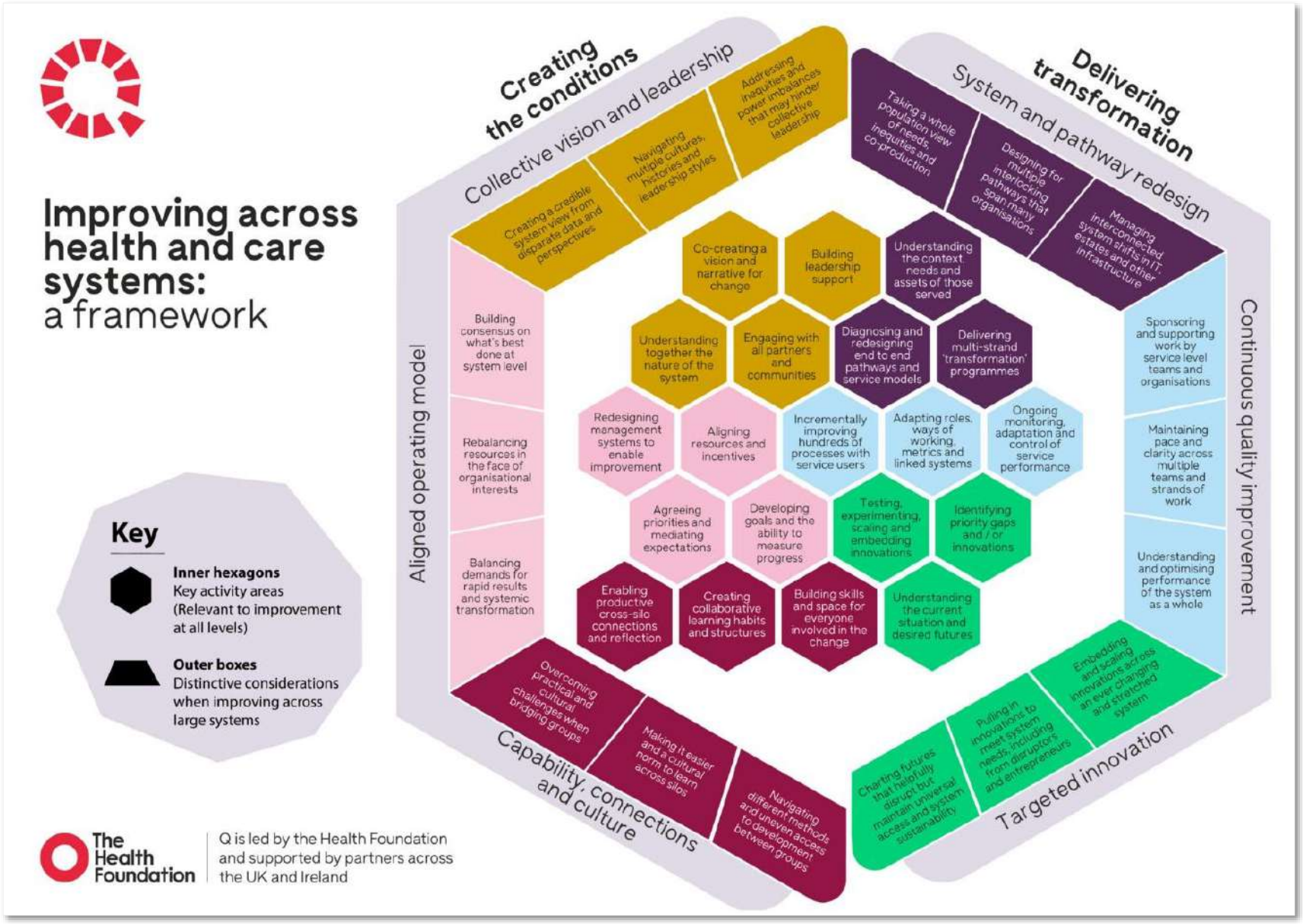
Appendix Three: AQUA Capability Pyramid

aqua
Shape Change Inspire Quality Transform Care

Below is an illustration of Aqua's adapted 'dosing formula'



Appendix Four: Health Foundation Q Framework



NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Emergency Preparedness Resilience and Response Core Standards 2023-24 Assurance Report

Agenda Item No: ICB/03/24/22

Responsible Director: Anthony Middleton: Director of Performance and Planning

Emergency Preparedness Resilience and Response Core Standards 2023-24 Assurance Report

1. Purpose of the Report

1.1 The purpose of this report is to inform the Board of NHS Cheshire and Merseyside's self-assessment against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards, and subsequent actions to improve compliance over the coming year.

2. Executive Summary

2.1 The EPRR Core Standards 2023-24 Assurance Report, see Appendix One, provides the Board with NHS Cheshire and Merseyside's self-assessment against the NHS England EPRR Core Standards and subsequent actions to improve compliance from non-compliant to at least partial compliance by September 2024.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- note the contents of the report
- acknowledge the current position with assurance that plans are in place to support the Integrated Care System, to work towards full compliance with the NHS England EPRR Core Standards.

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

5.1 The EPRR Core Standards 2023-24 Assurance Report is considered at the NHS Cheshire and Merseyside Quality and Performance Committee.

5.2 In line with contractual requirements as a Category 1 responder under the Civil Contingencies Act (2004), NHS Cheshire and Merseyside are required to provide an annual assurance of compliance with the NHS England EPRR Core Standards. This report provides the detail of the process and subsequent outcomes of the annual assurance.

5.3 The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2022 underpin EPRR within health. Both Acts place EPRR duties on the NHS in England.

5.4 Under the CCA 2004, NHS Cheshire and Merseyside are Category 1 responders, which are recognised as being the core of emergency response and are subject to the full set of civil protection duties including risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements and a requirement to share information and cooperate with other agencies.

5.5 NHS England implemented a revised EPRR assurance process in the Midlands during 2022. The review included a request for supporting evidence and a detailed analysis of organisations self-assessments against each of the EPRR core standards. The results demonstrated that there was a significant disparity between self-assessment scores and those of NHS England. The revised assurance process identified opportunities to strengthen and improve the evidential base that would stand the test of public scrutiny.

5.6 Driven by the aim of undertaking an open and transparent review, the same model was applied within the North West in 2023.

5.7 In line with contractual requirements, NHS Cheshire and Merseyside provided an annual assurance of compliance with the EPRR Core Standards, with a 2023-24 submission on Saturday 30 September 2023. This submission compromised of a Statement of Compliance, EPRR Core Standards Self-Assessment, evidence and associated action plan.

5.8 The introduction of the new EPRR assurance process resulted in our overall rating remaining at non-compliant. This rating should not be used as a comparison on last year's compliance (non-compliant at 60%), due to the change in parameters experienced. A significant amount of work has been undertaken since the 2022-23 submission with 19 EPRR core standards compliance ratings increasing for 2023-24.

5.9 The final compliance ratings for the ICB and Cheshire and Merseyside Trusts can be found in Table One.

Table One: 2023-24 Compliance Ratings

Core Standard	Fully Compliant	Partially Compliant	Non-Compliant	Overall Percentage
Alder Hey Childrens Hospital NHS Foundation Trust	5	57	0	8%
Bridgewater Community Trust	1	55	2	2%
Cheshire and Wirral Partnership NHS Foundation Trust	12	46	0	21%
Clatterbridge Cancer Centre	10	49	0	17%
Countess of Chester Hospital NHS Foundation Trust	5	57	0	8%
East Cheshire NHS Trust	18	44	0	29%
Liverpool Heart and Chest NHS Foundation Trust	9	50	0	15%
Liverpool University Hospitals NHS Foundation Trust	11	51	0	18%
Liverpool Women's Hospital NHS Foundation Trust	4	54	1	7%
Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust	27	32	3	44%
Mersey Care NHS Foundation Trust	19	39	0	33%
Mid Cheshire Hospitals NHS Foundation Trust	23	39	0	37%
NHS Cheshire and Merseyside	19	25	3	40%
The Walton Centre NHS Foundation Trust	9	48	2	5%
Warrington and Halton Teaching Hospital NHS Foundation Trust	3	59	0	5%
Wirral Community Health and Care NHS Foundation Trist	3	55	0	5%
Wirral University Teaching Hospital NHS Foundation Trust	1	61	0	2%

6. NHS Cheshire and Merseyside EPRR Core Standards Self-Assessment

6.1 There are 47 standards applicable to the NHS Cheshire and Merseyside which is self-assessed based on 4 levels of compliance.

Full	Substantial	Partial	Non-Compliant
Compliant with **all** standards	The organisation is **89-99%** compliant	The organisation is **77-88%** compliant	The organisation is compliant with **76% or less**

6.2 Based on NHS Cheshire and Merseyside's self-assessment and NHS England Panel Review; 19 standards were declared as full compliance, 25 standards

were declared as partial compliance and 3 standards were declared as non-compliance, resulting in an overall EPRR compliance assurance rating of non-compliant (40%) for 2023/24. NHS Cheshire and Merseyside's compliance with the EPRR Core Standards can be found in Appendix A.

6.3 Peer Reviews were undertaken with neighbouring ICB's as a benchmarking tool and both Greater Manchester and Lancashire and South Cumbria, also declared non-compliance for 2023-24.

6.4 NHS Cheshire and Merseyside receiving a rating of non-compliant should not be perceived as a poor assurance rating as the EPRR Team are delivering against each NHS Core Standard for EPRR, including additional assurance requirements which came into place in June 2023. However, it does indicate there are significant opportunities for the organisation to further improve over the coming year, through the implementation and monitoring of effective action plans.

6.5 Actions to address the organisations partial and non-compliant standards are in place and will be overseen by the Accountable Emergency Officer.

7. Next Steps

7.1 NHS England are due to schedule a structured debrief for the North West, to review the EPRR Core Standards Assurance process initiated for 2023-24 and ensure lessons identified are learned as part of the assurance process for 2024-25.

7.2 Cheshire and Merseyside Local Health Resilience Partnership Strategic Group held a local debrief in December 2023 to review the assurance process for 2023-24 and are keen to implement the learning and subsequent actions for the 2024-25 assurance process.

7.3 To support the Integrated Care System, a monthly Local Health Resilience Partnership Core Standards Assurance Task and Finish Group has been established, facilitated by the NHS Cheshire and Merseyside EPRR Team to improve preparation and engagement.

7.4 Monitoring of compliance for Cheshire and Merseyside will be managed by the Local Health Resilience Partnership Strategic Group.

7.5 NHS Cheshire and Merseyside EPRR Team will continue to deliver the agreed action plan and improve the organisations compliance from non-compliant to at least partial by September 2024. This will be overseen by NHS Cheshire and Merseyside Quality and Performance Committee.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience
Reviewing the EPRR Core Standards action plans of providers enables the ICB to set system plans that support improvement against health inequalities.

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

Objective Three: Enhancing Productivity and Value for Money
The report does not directly address this objective.

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

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

9.1 The EPRR Core Standards 2023-24 Assurance Report provides the organisational position of NHS Cheshire and Merseyside, against the NHS EPRR Core Standards.

10. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
The report provides organisational visibility against all NHS EPRR Core Standards and confirmation of our compliance rating for 2023-2024.

Theme Two: Integration
The report addresses elements of partnership working across multi-agency partners, Acute, Specialist, Mental Health and Community Trusts across Cheshire and Merseyside, in relation to EPRR and Business Continuity.

Theme Three: Leadership
The report supports the ICB leadership in decision making in relation to EPRR and Business Continuity issues.

11. Risks

11.1 The report provides a breakdown of the NHS England EPRR Core Standards and the organisations compliance rating. Those core standards identified as Partial or

Non-compliance, have full and robust action plans in place to work towards full compliance.

12. Finance

12.1 The report does not directly provide an overview of financial information.

13. Communication and Engagement

13.1 The report has been completed with input from all Cheshire and Merseyside Trusts and is made public through presentation to the Board.

14. Equality, Diversity and Inclusion

12.1 The report does not provide an overview of equality, diversity, and inclusion.

15. Climate Change / Sustainability

13.1 This report addresses the NHS EPRR Core Standards and does not currently include the ambitions of the ICB regarding the delivery of its Green Plan / Net Zero obligations.

16. Next Steps and Responsible Person to take forward

14.1 Actions and feedback will be taken by Anthony Middleton, Director of Performance and Planning / Accountable Emergency Officer. Actions will be shared with and followed up by the ICB EPRR Team. Feedback will support future reporting to the Quality and Performance Committee.

17. Officer contact details for more information

17.1 Beth Warburton: Head of EPRR:
Beth.Warburton@cheshireandmerseyside.nhs.uk

18. Appendices

Appendix One: EPRR Core Standards 2023-24 Assurance Report.

Appendix A
NHS Cheshire and Merseyside Compliance with EPRR Core Standards

Fully Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
Governance	EPRR Policy	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
	EPRR Board Reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.
	EPRR Work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.
	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
	Continuous Improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Duty to risk assess	Risk Assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.
	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.

Fully Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
Command and Control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.
Training and exercising	EPRR exercise and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
	Responder Training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership meetings.
	Arrangements for multi-agency response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

Partially Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer responsible for EPRR. This individual should be a board level director within their individual organisation, and have the appropriate authority, resources, and budget to direct the EPRR portfolio.
Duty to maintain plans	Infectious Diseases	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic.
	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment.
	Evacuation and Shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
Command and Control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Training and Exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
	Staff Awareness and training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
Response	Incident Coordination Centre	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards.
	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports and briefings during the response to incidents including bespoke or incident dependent formats.

Partially Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Cooperation	LRF/BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.
	Mutual Aid Arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership meets at least once every 6 months.
	Information Sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.
Business Continuity	BC Policy Statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.

Partially Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
	Business Impact Analysis	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
	Business Continuity Plans	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover, and manage its services during disruptions to people, information and data, premises, suppliers and contractors and IT and infrastructure.
	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
	Assurance of commissioned providers/suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.

Non-Compliant Standards		
Domain	**Standard Name**	**Standard Detail**
Business Continuity	Monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
	BC Audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.

NHS
Cheshire and Merseyside

Meeting of the Integrated Care Board of NHS Cheshire and Merseyside

28 March 2024

Formalising the Data Into Action Programme

Agenda Item No: ICB/03/24/23

Responsible Director: Professor Rowan Pritchard-Jones, ICB Executive Medical Director

Formalising the Data Into Action Programme

1. Purpose of the Report

1.1 The purpose of this paper is to:

- update the Board on governance arrangements for the Data into Action (DIA) Programme both internally and with multiple stakeholders
- provide assurance to the Board that the DIA Programme is ensuring that the ICB is appropriately prioritising the importance of the use of the Cheshire and Merseyside ICS data asset, to deliver against its strategic intentions and statutory responsibilities.

2. Executive Summary

2.1 An earlier version of this paper has been to the ICB Corporate Executives meeting where it was endorsed with a recommendation that an update on arrangements was brought to the Board.

2.2 In April 2023, a paper was brought to the ICB Board entitled 'Intelligence Into Action: continued provision of ICS digital and data platforms'. The paper included a request to fund the population health platform tooling and associated analytic and transformation resources for the next 2 financial years, which was was approved. This funding included costs for Graphnet, System P and C2Ai Patient Treatment Lists.

2.3 The aforementioned paper also described newly emerging governance arrangements around the intelligence into action agenda and since April 2023 significant inroads have been made in establishing this programme of work. This is now called Data Into Action (DIA) and has been meeting in shadow form since October 2023 with the ICB Executive Medical Director, Professor Rowan Pritchard-Jones, as Chair. (Approved Terms of Reference in Appendix)

2.4 Professor Rowan Pritchard-Jones, ICB Medical Director has been leading this emerging DIA programme of work, which brings together a wide range of established data, analytics and transformation programmes. DIA has established an Operational Delivery Group which ties together all disparate areas of work into one over-arching plan. It also has sub-groups which are managing the access and secure management of data as well as the technical and design components of a secure data environment. There is a spectrum of work in progress around patient and public engagement and involvement which will coalesce around a shared agenda via a new sub-group, to be established in up-and-coming weeks. This will enhance the current University of Liverpool Civic Data Co-operative work and strengthen connections around interrelated projects. Similarly, a DIA Multi-Professional Steering Group will be established to steer the utilisation of population health management outputs across the ICS, linked to a population health Academy, that will ensure consistency of

application of approaches to the use of data assets for the Cheshire and Merseyside population.

2.5 The DIA programme will build upon progress to date from the multitude of programmes and projects of which it is comprised. There are in excess of 60 individual projects identified within scope to date, requiring a new level of strategic co-ordination that has previously been absent. This co-ordination is essential if we are to optimise the potential of these projects in a way which ensures the collective impact adds substantial impact across the CM ICS. To do this, DIA must draw upon the existing expertise within the system which has been instrumental in creating the right environment for intelligence led transformation.

3. Ask of the Board and Recommendations

3.1 **The Board of NHS Cheshire and Merseyside is asked to:**

- Note and support the proposed Governance arrangements:
  - twice yearly updates to NHS Cheshire and Merseyside Board to provide assurance on delivery and updates on progress.
  - the development of an agreement with Mersey Care NHS Foundation Trust that continues to draw on the thought leadership from the Trust in this area, whilst the ICB develops its in-house skills.

- Note that the leadership of the DIA Programme is drawn from three areas
  - ICB Exec sponsor: ICB Medical Director
  - Provider Exec sponsor: CEO Mersey Care NHS FT
  - Academia sponsor: Associate Vice Chancellor for Innovation, University of Liverpool.

- Note that the Programme will report its progress routinely through:
  - The Transformation Committee
  - The CM Health and Care Partnership
  - The Population Health Board
  - The Clinical Effectiveness Group
  - The Digital Transformation and Clinical Improvement Assurance Board.

4. Rationale for governance arrangements

4.1 The DIA Programme will report twice yearly to the Board due to the direct correlation of the work of the programme to the ICB delivering on its strategic intentions and fulfilling its statutory responsibilities. The programme will work across

- the ICS corporate infrastructure
- C&M programmes of work
- Provider Collaboratives

- All nine Places.

4.2 The DIA programme supports the ICB functions directly in delivering against its core purposes: an evidence based approach to improving outcomes in population health and healthcare; using risk stratification and other models to tackle health inequalities; enhancing productivity by taking a population health approach with segmentation to identify and address high spend against need; helping the NHS support broader social and economic development through the delivery of a research and innovation secure data environment. In meeting the core purposes, the DIA Programme therefore also supports the clinical constitution and the joint forward plan and in supporting the core purpose will provide detail of activities and projects through

- The Transformation Committee
- The CM Health and Care Partnership
- The Population Health Board
- The Clinical Effectiveness Group
- The Digital Transformation and Clinical Improvement Assurance Board

4.3 The significant leadership that Mersey Care Trust brings to this agenda is recognised in the governance of the DIA Programme to reflect the background, context and leadership to date described in the section below. Where it is beneficial for Mersey Care to provide leadership, expertise and infrastructure to support the delivery of DIA priorities their support will be sought accordingly. This may involve activities such as hosting some of the DIA programme staff, directing elements of the programme budget, sourcing external expertise and drawing upon internal capacity to enable work to progress. During the year the ICB will develop its own expertise and skills in this area.

5. Background

5.1 During the Covid pandemic groundbreaking progress was made between component organisations in sharing crucial person-centred data, making a demonstrable impact on the containment and management of the disease in the population. The CIPHA platform, which was deployed and enhanced during this period, has now significantly evolved in both its scope and its application.

5.2 The thought leadership and practical leaning-in within Mersey Care Trust was instrumental in the development of CIPHA in those initial weeks and months of the pandemic and has led a wide range of intelligence led approaches since that period. Mersey Care have helped make this a ‘business as usual’ approach both internally within the Trust, but also as a key leader within their local systems and networks. The Trust has developed strong and effective relationships with the University of Liverpool which has helped the system position itself well for external funding and build upon its reputation as an area of innovation and excellence.

5.3 Mersey Care led the roll out, and hosted the budget for System P which is partially a forerunner to the DIA programme. As part of that hosting

arrangement, added value was contributed to the System P programme, for example system leadership, strategy expertise, advanced analytics input, and system design support.

5.4 By working in close partnership with Mersey Care, the ICS will continue to benefit from this expertise and support, which has significantly contributed to moving the programme into the current phase of readiness.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience

The Population Health Management deliverables and products that DIA has created to date and are in the future pipeline, enable an intelligence led approach to targeting the most vulnerable cohorts of the population. These draw upon a range of factors such as deprivation, age, gender, ethnicity and unequal access to services and allow end users to interrogate multifaceted datasets to explore solutions to addressing root causes.

Objective Two: Improving Population Health and Healthcare

The correlation of a range of interventions to improving population outcomes is central to the research component within DIA and will be instrumental in helping to determine the best return of investment when assessing the potential interventions for improving life expectancy, quality of life and experience. Inequity in the provision of appropriate interventions, either through different models of care, timeliness of support or integration with other clinical or broader determinants services can be effectively analysed using the linked dataset. This in turn can be used for strategic planning and service redesign purposes.

Objective Three: Enhancing Productivity and Value for Money

Within DiA we can assess the level of fragmentation and duplication that exists both within and across different sectors across health and care provision. The scope of this will expand over time as broader datasets are onboarded into the central platform. However, even based on the current scope, the opportunity to streamline, integrate and decommission parts of the C&M system, is considerable.

Objective Four: Helping to support broader social and economic development

The DIA Programme will help to demonstrate to external funding agencies that the C&M system is a place which has the governance and experience to optimise large research grants and intelligence infrastructure investments. These investments will have a direct link to changing the health and care landscape, configuration of services, system financial planning and population outcomes and as such will be an attractive proposition to a range of external stakeholders/investors.

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

7.1 The DIA Programme has the potential to align with all of the objectives within the Annual Delivery Plan. It clearly links to the population health and partnership working for the benefit of our population objectives. It also touches upon others such as diabetes and children and young people, but we expect the reach to increase with the proposed governance arrangements, in order that existing programmes optimise the DIA assets within their areas of work.

8. Risks

8.1 Formalising the DIA governance and creating a direct line of reporting with the ICB will help mitigate Risk P2 within the ICB Board Assurance Framework 2023/4, regarding the use of digital and data to improve population health and reduce inequalities. It will also contribute to reducing risks in other areas such as access to services, productivity and value for money for example, which will become more demonstrable throughout the last quarter of 2023/4 and 2024/5.

9. Finance

9.1 There is no additional request for funding.

10. Communication and Engagement

10.1 Work has been underway since September 2023 to develop communications collateral for the use of data and the development of a secure data environment. This work has been targeted at both data controllers across CM and also with patients and the public. A number of deliberative events have taken place and presentations have been made for the public to gauge their understanding of the use of their health and care data and to seek their views.

10.2 There is also a raft of engagement work underway via the University of Liverpool Civic Data Cooperative. There are a range of patient and public networks already established which feed into the design of research projects and health and care interventions. This is due to be formalised under the DIA governance with the creation of a Patient & Public Engagement Group. As part of this, DIA will be providing a public telephone contact line for anyone wishing to opt their data out of any research or health care interventions informed by linked data.

10.2 DIA has also created a website where local stakeholders can access clear information on what data is available, how they can access it, what it is being used for and the insight and value that this brings. This is a work in progress and will become more detailed over up and coming months.

11. Equality, Diversity and Inclusion

11.1 An Equality Impact Assessment (EIA) has been developed to understand the breakdown of the population to have insight on the underrepresented groups that would benefit form being part of the wider public awareness on the use of data. Through the digital programme extensive work has been conducted through Places on digital exclusion

12. Climate Change / Sustainability

12.1 Consistent with United Nations Sustainable Development Goals the programme endeavours to ensure that Goal 3 – Ensure healthy lives and promote well-being for all at all ages – is a principle of the work undertaken through the programme. Of particular resonance through the segmentation work is the need to safeguard the health of 'vulnerable population groups and individuals living in areas burdened by high disease prevalence'

13. Next Steps and Responsible Person to take forward

13.1 To establish a DIA Programme Team with appropriate skills and capacity

13.2 To deploy the budget in priority areas for the remainder of this financial year and develop a comprehensive plan for Programme Spend for 2024/5

13.3 To conduct a prioritisation exercise for the programme which will take account of current and future population health needs and challenges, the Joint Forward Plan, research and academic priorities/planned outputs and civic priorities identified in the PPIE work stream. This will establish a roadmap of planned activity for the programme for this year and next

13.4 To establish the remaining sub-groups to report into the DIA Operational Delivery Group

13.5 The above actions will be led by Jim Hughes, SRO for DIA with support from the interim DIA Programme Team and the Associate Director of of Digital Transformation and Clinical Improvement

14. Officer contact details for more information

Jim Hughes DIA Programme Senior Responsible Officer

15. Appendices

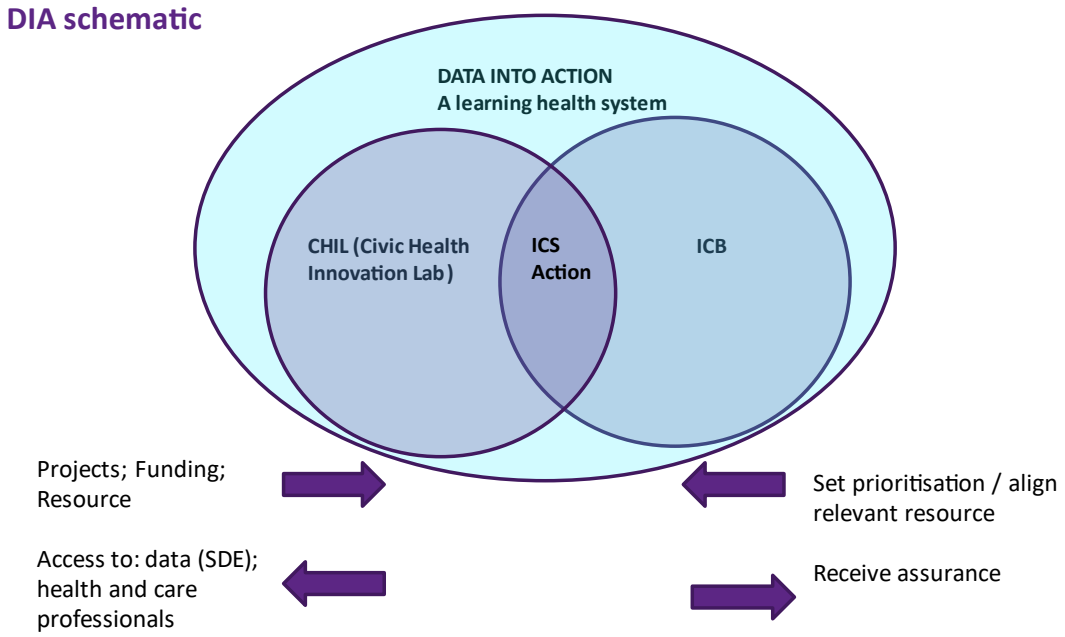
Appendix One: Terms of reference for the Shadow Data into Action Programme

Data Into Action Programme

Terms of Reference

1 Purpose

The aim of the programme is to ensure that data is translated into impactful action; realising clear benefits for our patients, communities, key stakeholder organisations and wider partners through measurable change across the system.



The programme will co-ordinate and have joint accountability for the set of activities that currently operate across Cheshire & Merseyside (CM) to improve the health and well-being of the population. The programme is predicated on the access to the Cheshire and Merseyside data asset – the CM Secure Data Environment (SDE), that was previously called CIPHA - with the aim of delivering data into action through a unified programme. The component elements include contributions from:

- CM Integrated Care Board (ICB) Combined Intelligence for Population Health Action (CIPHA)
- System P (programmable prevention, precision and payment)
- Mental Health Research for Innovation Centre (M-RIC) and other NIHR projects with a large component of ICB priority innovation
- The CM component of the North West Sub-National Secure Data Environment (SDE) for Research and Development
- The University of Liverpool Civic Health Innovation Labs (CHIL)
- The University of Liverpool Civic Data Co-operative (CDC)

Delivery is supported by organisations and functions involved in these programmes:

- CM Health and Care Partnership analytical and transformation functions; the ICB; provider collaboratives; and Places

- All health and care providers
- VCFSE organisations
- Champs (CM Public Health Collaborative)
- Health Innovation North West Coast
- Academia (coordinated by University of Liverpool)
- Mid Lancashire (ML) and Arden and Gem (AGEM) Commissioning Support Units (CSUs)

2 Functions of the Programme Board

The core function is for partners to ensure that each component programme works to a common purpose and shared objectives with clear prioritised deliverables for each element.

The Board will:

- Develop an at-scale population health management approach to support the delivery of better health and well-being outcomes for the population.
- Generate the system intelligence to inform the relevant 'into action' transformation model
- Inform the priorities of the Transformation Committee for areas to be supported by the data into action agenda
- Develop CM system-wide capability and capacity for data analytics
- Develop a sustainable commercial model to appropriately value data assets, platform usage and intellectual property
- Provoke collective strategic leadership across all Data into Action programmes listed in this TOR
- Ensure that strategies and plans align effectively
- Develop an operating model that connects and drives forward the areas of work
- Agree shared priorities in order to achieve more significant collective impact
- Promote shared messaging and communications between each component, as is most appropriate, with an expectation that this will adapt over time
- Develop effective mechanisms for communications
- Promote the use of collective resources to best effect and working beyond the boundaries of distinct organisations, where this offers shared value
- Ensure that the work of the sub-groups aligns to a collective work plan
- Unblock any issues that the sub-groups encounter which need more strategic support
- Influence and advise the ICB on a consistent data architecture to support the activities of the group
- Represent a collective view of the organisations represented as 'customers' / 'users' of data

3 Scope - enabling an 'action' approach

Through the combination of DIA operational processes and ICB governance a rigorous process of assurance and accountability will be established. This will ensure that the actions emanating from the programme are delivered and actioned at the relevant scale and to the benefit of the relevant cohorts of the population. This will provide for reduction in unwarranted variation, improved allocative efficiencies and improved outcomes. All of which will have a strong evidence base.

It is proposed that within the programme this is achieved as follows:-

3.1 Prioritisation

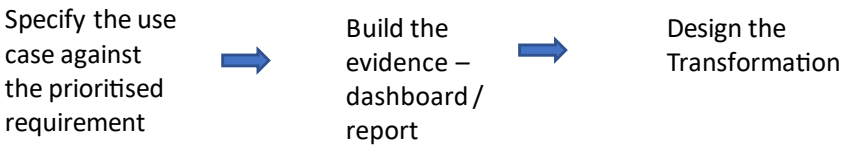
The DIA Programme takes its priorities to form a workplan from the following ICB groups/boards

a. The CM ICB Board
b. The CM Health and Care partnership
c. The Population Health Board
d. The Clinical Effectiveness Group
e. The Digital Transformation and Clinical Improvement Assurance Board

The prioritised workplan is formalised and approved through the ICB Transformation Committee.

3.2 Assurance and scrutiny

The DIA Programme will deliver against the prioritised workplan



For any use case requiring new access to data not already covered through the standard agreed data sharing agreements then the use case will be presented to the Data Access and Asset Group (DAAG) for approval

A standing item of the Transformation Committee will be to review the dashboards, and the proposed transformation design from the DIA Programme. For every approved piece of work the Transformation Committee will hold the relevant part of the system – providers, provider collaboratives, clinical networks, transformation programmes, Places – to act on the transformation design and will hold them to account for delivery against the proposed timescales.

3.3 Delivering the 'action' through a delivery partner

Delivery partners will be engaged with expertise in delivering evidence-based transformations into health and care settings. These delivery partners will support the adoption of the transformation into the relevant part of the system. Eg to deploy a Fuel Poverty dashboard and agree the intervention set in each of the 9 Places.

3.4 Delivering the 'action' through self-serve

For a number of products – typically dashboards – a transformation programme or provider will access the product through the processes defined through the DIA Data Access and Asset Group (DAAG)

4 Membership

DIA Board Members are:

- Rowan Pritchard-Jones, ICB Executive Sponsor for Data Into Action, Medical Director CM ICB

- Iain Buchan, Academic Sponsor for Data Into Action, Pro Vice Chancellor for Innovation University of Liverpool
- Joe Rafferty –Executive Provider Sponsor Data into Action; CEO Mersey Care FT
- Jim Hughes, Interim Senior Responsible Officer Data into Action
- Andrea Astbury - interim Programme Director DIA, Deputy Director of Strategy, Liverpool Place
- Ian Ashworth – CM ICB Director of Population Health
- Claire Wilson – CM ICB Director of Finance
- John Llewelyn – Chief Digital and Information Officer CM ICB
- Louise Edwards – SRO for System P, Exec Director of Strategy Mersey care NHS FT (representative of MHLDC collaborative)
- Gary Leeming – Director, LCR Civic Data Cooperative
- Natalia Armes – Associate Director of Digital Transformation C&M ICB
- Ifeoma Onyia - Director of Public Health Halton & Local Authority Intelligence Lead
- AGEM (strategic data management partner)
- Wes Baker - Director of Strategic Analytics, Economics and Population Health Management, Mersey Care
- Tony Woods, Director of Business Development, Health Innovation NWC
- Becky Williams – Interim Associate Director of Business Intelligence C&M
- Other health and care provider representation – nominated through provider collaboratives and Local Authorities

A broader representation of all health and care providers, academia and others will be established through the multi professional steering group (see below)

Absent members are asked to provide an appropriate update to the group in their absence or send a suitable representative.

5 Chairing

The Data Into Action Board will be chaired by the CM ICB Medical Director

6 Frequency of Meetings

The Data Into Action Board will meet every two months (monthly in the first 6 months of running)

7 Accountability

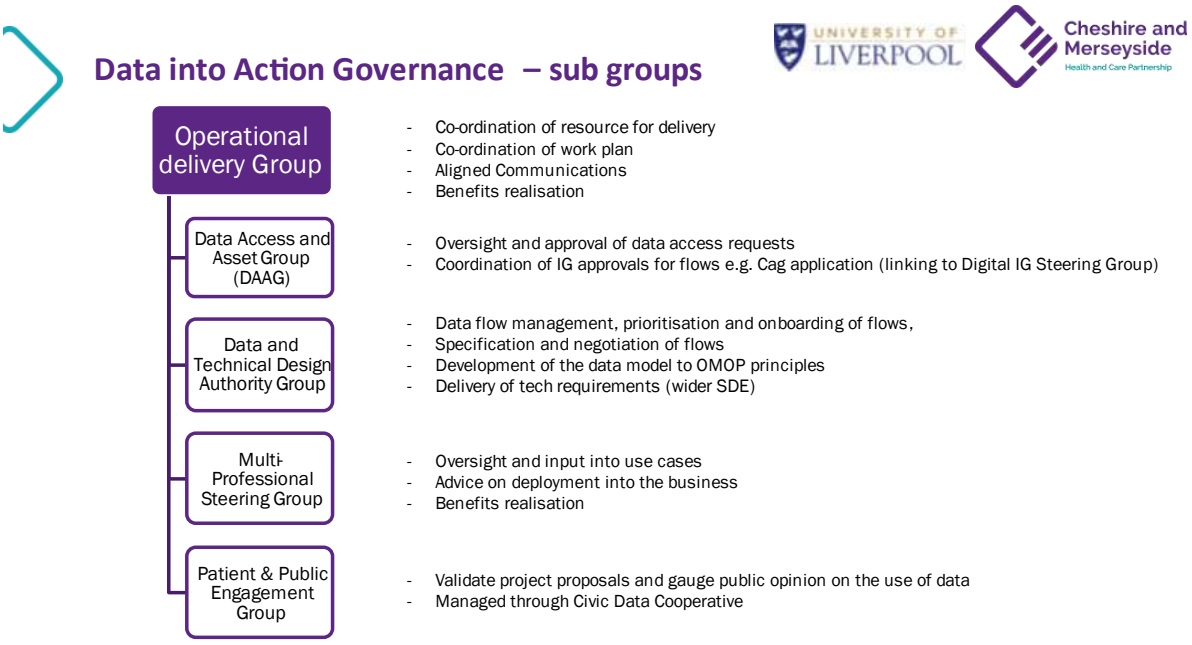
The programme will be within the governance of the Executive Medical Director of the ICB reporting into

- ICB Board
- Digital Transformation and Clinical Improvement Board
- Population Health Board
- Clinical Effectiveness Group

The workplan and priorities of the programme will be agreed between these Boards and they will receive assurance on delivery of the workplan.

8 Relationship to other Groups

The sub governance to drive the programme is below



The Terms of Reference (ToR) for all sub-groups are embedded below:

8.1 Operational Delivery Group ToR

DIA_Operational Delivery Group _TOF

8.2 Data Access & Asset Group ToR – (currently under review)

DAAG TOR 2020.docx

DAAG also reports into ICB IG steering group

8.3 Data & Technical Design Authority Group ToR

DIA_Data and Technical Deisgn Au

8.4 Multi-Professional Steering Group ToR

DIA_Multi-Professio
nal Advisory Group

8.5 Patient & Public Engagement Group ToR

DIA_Patient and
Public Engagement

9 Benefits (high level)

The overarching aim of the Data Into Action Group is to transform health data into actionable insights that drive improved outcomes in healthcare delivery, patient care, research, and system efficiency. The resulting benefits span a variety of domains.

Financial Benefits

- Improved Resource Allocation: By generating comprehensive intelligence, the group aids in better resource allocation, thereby ensuring financial efficiency.

People / Public Benefits

- Enhanced Patient Care: The combined intelligence derived from various data sources enables targeted and personalised care, ultimately benefiting patients and the public at large.

Operational Benefits

- Enhanced Decision Making: The group's activities will provide stakeholders with a more holistic view of the health system, enabling evidence-based decision-making.

Infrastructure Benefits

- Harmonised Data Infrastructure: By bringing various programmes under a single umbrella, the Group is creating a harmonised data infrastructure, which will streamline data management and accessibility, promoting a more efficient and effective use of data resources.

- Secure and Ethical Data Use: The establishment of secure data environments and a commitment to ethical data use means that data is not only safeguarded but used responsibly, enhancing trust among stakeholders and users.

10 Administration

The Data Into Action Group will be administered through a Programme Office arangement. All members may suggest agenda items. Agendas and supporting papers will be circulated in advance of each meeting. Formal minutes will not be taken; summary of discussion and key actions will be noted as appropriate.

11 Review

TBC

NHS
Cheshire and Merseyside

Meeting Held in Public of the Board of NHS Cheshire and Merseyside

Held at the Tower Room, Floral Pavilion, Marine Drive, New Brighton, Wirral, CH45 2JS

Thursday 25th January 2024
09:30am – 12:30pm

Unconfirmed Draft Minutes

Recording available at: https://www.youtube.com/watch?v=hP3lHISzYGw

MEMBERSHIP	
Name	**Role**
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Claire Wilson	Executive Director of Finance, Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member, Chief Executive Office, Community Pharmacy Cheshire, and Wirral (CPCW) (voting member)
Councillor Paul Cummins	Partner Member, Cabinet Member for Adult Social Care, Sefton Council (voting member)
Ann Marr, OBE	Partner Member, Chief Executive, Mersey and West Lancashire Teaching Hospital Trust (voting member)
Erica Morriss	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
IN ATTENDANCE	
Dr Fiona Lemmens	Associate Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Anthony Middleton	Director of Performance and Improvement, Cheshire & Merseyside ICB (Regular Participant)
Christine Samosa	Director of People, Cheshire & Merseyside ICB (Regular Participant)
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)

Rev Canon Dr Ellen Loudon	VS6 Chair & Vice Chair, Cheshire and Merseyside Health and Care Partnership
Prof. Ian Ashworth	Director of Population Health representative (Regular Participant)
Karen Prior	Chief Executive of Healthwatch Wirral
Gareth Prytherch	Chief Executive, Wirral CVS
Warren Escadale	Chief Executive, Voluntary Sector North West (Regular Participant)
Mark Palethorpe	St Helens Place Director, Cheshire and Merseyside ICB
Laura Marsh	Cheshire West Place Director, Cheshire and Merseyside ICB
Jennie Williams	(Minutes) Senior Executive Assistant, Cheshire & Merseyside ICB

External Speakers in attendance	
Name	**Role**
Thomasina Afful	Associate Director - Equality, Diversity & Inclusion, Cheshire and Merseyside ICB
Vicky Wilson	Associate Director of Workforce, Cheshire and Merseyside ICB
Professor Greg Irvine	Director of Research, Cheshire and Merseyside Integrated Care System
Professor Terry Jones	Director of Research, Cheshire and Merseyside Integrated Care System

APOLOGIES NOTED	
Name	**Role**
Prof. Hilary Garratt, CBE	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Prof. Joe Rafferty, CBE	Partner Member, Chief Executive Office, Mersey Care NHS Trust, (voting member)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)
Prof. Steven Broomhead, MBE	Partner Member, Chief Executive, Warrington Borough Council (voting member)
Dr Naomi Rankin	Partner Member, Primary Care (GP) Partner Member (voting member)
Neil Large, MBE	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Cllr Louise Gittins	Chair, Cheshire and Merseyside Health and Care Partnership

Item, Discussion, Outcomes and Action Points
ICB/01/24/01 Welcome, Apologies and Confirmation of Quoracy
All present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. **Action - Following the public speaking time The Chair confirmed an action for the Chief Executive, Medical Director and Director of Nursing and Care to bring a paper to a future Board meeting explaining how we have the right staff, at the right quantity at the right time for our patients across the system.** Apologies for absence were noted as above.
ICB/01/24/02 Declarations of Interest
There were no declarations of interest made by Members that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.
ICB/01/24/03 Minutes of the last meeting – 30th November 2023
The Board reviewed the minutes of the meeting held on 30th November 2023. The following corrections to the minutes were requested - • the final paragraph on page 10 to be amended and will forward a form of words to the Board Administrator. • the paragraph on page 17 regarding Liverpool Women's Services Committee to be amended and will forward a form of words to the Board Administrator. • Ruth Hussey to be confirmed as being present at the meeting. • spelling mistake against agenda item ICB/11/23/12 with a change from route cause to root cause needed. **The minutes of the NHS C&M ICB Board meeting of 30th November 2023 were approved subject to the changes being made as above.**
ICB/01/24/04 Action Log
The Board acknowledged the completed actions and updates provided in the document. **Action – The Chair asked the Board to review the usefulness of the action log which in its current form does not allow the Chair, on behalf of the Board, to track actions. Comments to be given to The Chair and for the Chair to work with the Chief executive and Board Secretary to review in readiness for the March 2024 Board meeting.** The Chair reiterated that the action log is used for the significant issues the Board are to focus on. The Director of Population Health asked for an action number 58 to be closed as complete. **The Board noted the Action Log.**
ICB/01/24/05 Decision Log
The Board reviewed the decision log and confirmed that the information presented was an accurate record of substantive decisions made by the Board up to 25th January 2024.

Item, Discussion, Outcomes and Action Points
It was further noted that there were no emergent actions arising from those decisions that were due for review at this meeting. **The Board resolved noted the Decision Log**.
ICB/01/24/06 Resident Story
The Board were introduced to the video of Owen Ashworth, Chair of the ICB Disability and Neurodiverse Network. https://www.youtube.com/watch?v=SGEeYjllSeE **The Board thanked Owen for his contribution.**
Leadership Reports
ICB/01/24/07 Report of the ICB Chair
The Chair provided an update on the work undertaken by NHS Cheshire & Merseyside ICB (C&M ICB) not reported elsewhere in detail on the Board meeting agenda, including - • Thanking the many tens of thousands of staff from the NHS, Local Authorities and the charitable and faith sector who are working in the most challenged time of the year. • A bronze award for Social Value was received by the ICB, who are the first ICB to achieve this award. The award reflects the time, effort, focus and ingenuity of the people across Cheshire and Merseyside working on the social determinants of health. • The Chair has recently visited Wirral Community Trust and witnessed staff supporting patients living in some of the most deprived areas, who are isolated in their homes and are enabling patients to go to warm centres and meet friends, which has a positive impact on their mental health. **The Board noted the update.**
ICB/01/24/08 Report of the ICB Chief Executive
The Chief Executive asked the ICB Director of Population Health to provide an update to the Board regarding the work and actions underway to prepare and respond to the measles outbreak national incident **Measles Outbreak** There has been a significant outbreak of measles in the West Midlands which has been declared as a national incident by the UK Health Security Agency. Current vaccination rates for Cheshire and Merseyside are 89% for the first dose and 79% for the second dose. There are approximately 10,500 individuals across Cheshire and Merseyside unvaccinated, with low areas of uptake in Liverpool, Sefton and Knowsley; teams are working in local communities to encourage the uptake of vaccination. A planned national call is due to take place 1st February 2024 to recall people unvaccinated. The update presented by The Chief Executive provided a summary of issues not otherwise covered in detail on the Board meeting agenda. The Chief Executive highlighted the following areas within the report:

Item, Discussion, Outcomes and Action Points

Industrial Action
Junior doctors' industrial action is timed to take place at the most significantly busy time of the year for the NHS. The rights of staff to take such action is respected and the staff who have put measures in place in order to keep patients safe during this time are commended. The number of planned procedures cancelled during that time is declared in the board papers. No further strike action can take place until further ballot of membership.

Thirlwall Inquiry
The draft statement to the Thirlwall Inquiry was submitted on 24th January 2024. The statement could change once inquiry solicitors have reviewed and challenged the content. It is unknown if the ICB will be called to give evidence, which will be in Autumn 2024.

Board to Board with Mid Cheshire Community Trust
On 11 January 2024, a number of ICB Board members had the opportunity to visit and meet with Board colleagues from Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) at the Leighton Hospital site in Crewe. The meeting provided opportunity for members of the ICB Board to tour the facilities at the hospital site as well as to acknowledge the quality improvements and substantial efforts of the local system in coping with the pressures brought on by the latest round of industrial action. It is anticipated that a proposal will be brought to the March 2024 Board meeting from Mid Cheshire Hospital Trust to support their business case for a new hospital.

The Assistant Chief Executive made the Board aware of issues in item 6.2 of the report regarding specialised commissioning which details progress and updates on receiving the fifty-nine services as a part of safe delegation. It also asks that Board delegates authority to the Transformation committee at its next meeting in March 2024 to oversee a review and sign off documentation.

The Board discussed –

- The roll out of the enhanced access for GPs to some very specific diagnostic tests and when it is anticipated there will be full and timely access to those tests for GP's in Cheshire and Merseyside. **Action – The Chief Executive to bring a written response on the roll out of enhanced access to GPs for specific diagnostic tests to the March 2024 Board meeting**.
- The bronze award for social value, was welcomed. VCFSE representative highlighted caution that some of the organisations involved in the Bronze Award will be looking at a process of redundancy in April 2024 because of shortfalls in funding, and asked whether the Board was aware of where VCFSE partners are at the moment and the risks being faced by these organisations in terms of collapsing. The Chief Executive highlighted that he will be meeting with the Chief Executives of the VCSE infrastructure organisations together.
- Communications to the public regarding measles outbreak – confirmation as provided that communications have been provided to partners and will continue to send out further communications.

The Board resolved to:

- **note the updates as outlined within the report.**
- **approve the recommendation to delegate authority to the ICB Transformation Committee to approve on behalf of the ICB the Specialised Commissioning documentation and agreements as outlined in para 6.6 of the report.**

Item, Discussion, Outcomes and Action Points
ICB/01/24/09 Report of the ICB Director of Nursing and Care
The Director of Nursing and Chief People Officer provided an update to the Board. During December 2023 the national guidance "Working Together to Safeguard Children" was updated and offers a statutory blueprint for a system wide approach to supporting (and safeguarding) children and young people. An outline action plan is required by the ICB; the safeguarding position was presented to the System Oversight Board, a sub-committee of the Quality and Performance Committee, which will receive assurance on the delivery of the ICB statutory duties. The ICB has appointed the ICB Associate Director for Nursing and Care with specific responsibility for safeguarding. The Integrated Care System has several nationally mandated workforce responsibilities, targets and outputs which are being developed through the activities of the Cheshire and Merseyside People Board, through the Provider Collaborative Workforce Boards and via the HR Director / Chief People Officers of our NHS Provider Trusts. The Chief People Officer provided updates on the ICB Workforce, focussing on – • Staff Experience and Engagement • Staff networks • HR Dashboard • Cheshire & Merseyside system focus • Retention • Workforce Dashboard • The NHS Long Term Workforce Plan • Workforce Planning • Social Care Workforce. The Chair highlighted that he felt in order for the Board to be able to discharge its responsibilities it needed to understand how productive and how well looked after our staff are. **Action: Chief People Officer to bring an annual report on ICB staff, including outcomes of Staff Survey, to the May 2024 Board meeting**. **Action: Chief People Officer to bring to update report on the strategic direction of the C&M System Workforce Board, including details on system workforce.** **The Board noted the contents of the report.**
ICB/01/24/10 NHS Cheshire and Merseyside Finance Report – Month 9
The Executive Director of Finance provided an update to the Board for Month 9 to the end of December 2023 and highlighted – • In May 2023 the System plan submitted was a combined £51.2m deficit, consisting of £68.9m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £120.1m. This plan was set on the basis that there would not be significant ongoing industrial action through the year. • In November 2023 NHSE requested that ICBs and providers resubmit system 2023/24 plans to live within their re-baselined system allocation as part of the national settlement responding to the significant impact of industrial action from April to October 2023. • The revised system plan submitted to NHSE was a breakeven position, consisting of £63.9m surplus on the ICB side offsetting the aggregate NHS Provider deficit position of £63.9m. The

Item, Discussion, Outcomes and Action Points

revised plan was set based on no further industrial action between December 2023 and March 2024.

- As of 31 December 2023 (Month 9), the ICS 'System' is reporting a year to date deficit of £72.2m against a planned year to date deficit of £31.3m resulting in an adverse year to date variance of £40.8m. Contained within the Month 9 year to date provider position are £7.1m of incremental costs and lost income relating to the in-month impact of industrial action in December 2023.
- At month 9 the System reported its expected forecast in line with its revised November 2023 plan but with the additionality of the forecast impact of industrial action over December 2023 and January 2024. The Month 9 reported forecast system position was £21.5m deficit against the breakeven plan, with the £21.5m adverse variance relating entirely to the forecast impact of December and January industrial action. ICSs have been advised not to reflect any additional funding in their forecast to mitigate this new industrial action impact. Excluding the impact of industrial action, the system is forecasting to deliver a breakeven position.

The Board discussed –

- the opportunity to review financial pressures at the same time as changing the operating model for continuing health care at Place.
- deep dives within CHC being a significant ICB issue; the Assistant Chief Executive advised the Board that a third party has been engaged to initially to review backlog, waiting lists around fast track and one to one care packages. Also work underway being led by the Director of Nursing and care regarding in-housing of CHC teams to the ICB.

The Board noted the financial position reported at Month 9, the forecast impact of industrial action, and the risks to delivery of the financial plan.

ICB/01/24/11 Highlight Report of the Chair of the ICB Finance, Investment and Resource Committee

The Board received an update from the Chair of the ICB Finance, Investment and Resource Committee highlighting that the Committee considered an update paper on the Health Care Services (Provider Selection Regime) Regulations 2023. The committee had been assured by the Committee risk report.

A deep dive on Place budgets will take place in March 2024 to review recovery plans.

The Board noted the contents of the report.

ICB/01/24/12 NHS C&M Quality and Performance Report

The Director of Performance and Improvement provided the Board with an overview of the integrated performance report for January 2024, which included a summary of key metrics drawn from the 2023/24 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

- **Urgent Care system** – this has been the busiest and most challenging period of time exacerbated by industrial action, cold spells and seasonal flu. North West Ambulance Service increased vehicles on the road by 30%. The system continues to remain under pressure.

Item, Discussion, Outcomes and Action Points

- **Elective Recovery** – there are approximately 130,000 planned activities impacted by industrial action this year. The system is running approximately 4% higher than the same period last year. Currently working to achieve 65-week maximum wait by the end of March 24. The objective for this year is to have no more than 10% of patients waiting longer than six weeks, clinically categorised, currently running at 15%.
- **Cancer performance** – Cheshire and Merseyside have returned the backlog of patients treated within two months of referral, back to pre-pandemic levels, four months ahead of schedule. There are challenges with the new faster diagnosis standards, referral to consultation, diagnostics and either confirmation or ruling out of cancer within 28 days.

The Chief Executive outlined the wok being undertaken around the All Together Fairer report and the Marmot Indicators, and committed to bring to the Board an update eon progress against the Marmot Indicators. There was also a commitment to include in future reports information of secondary prevention measures.

There was also a question raised around whether we have a systematic way of looking at patient reported outcomes and using the information to shape and improve health services.

The Board acknowledged -

- dementia targets and the challenges to do better for the care given to patients.
- the work undertaken across the combined system during incredibly pressured times to keep elective activity as high as possible despite the non-elective pressure.
- the pressure that staff are facing and the consequences on patients.

The Board noted that the Medical Director of the ICB has met with all Cheshire and Merseyside Medical Directors to discuss never events and thematic learning across the NHS. Medical Directors, Surgical Clinical Directors and senior operational leader will come together to understand themes and approaches.

Action: on an annual basis the Board receives a report on progress against the Marmot indicators
Action: Board to receive information on secondary prevention measures.
Action: The Director of Performance and Improvement to investigate the data we currently collect regarding Patient Reported outcomes and incorporate into future reports to Board.

The Board noted the contents of the report and took assurance on the actions contained.

ICB/01/24/13 Highlight Report of the Chair of the ICB Quality and Performance Committee

The Chair of the ICB Quality and Performance Committee provided an update to the board and highlighted that the Committee continues to focus on midwifery issues. There is recognition that despite staffing shortages, delays in labour have decreased. The committee continue to review All Age Continuing Care support and the variance across Place. The Boards attention was drawn to the positive, yet challenging work undertaken on antimicrobial resistance.

The Board noted the contents of the report.

Item, Discussion, Outcomes and Action Points
ICB/01/24/14 Report of the Directors of Place
The report provided to the Board has been considered by the members of both the St Helens and Cheshire West Place Partnership Board. The report outlined updates on key areas of work being delivered by the ICB within each Place as well as work underway with wider partners. Place are working in partnership, on an innovative model regarding community response hubs, with additional staff working around the community health teams with health, care and voluntary sector. A joint brokerage team has been established to broker all packages of care for hospital discharge. Reports are taken to nine individual Place Partnership Boards, with links to the Health and Care Partnership plan, planning guidance, health and wellbeing strategies, Marmott and Core Twenty Plus Five. The Board discussed hospital discharge and maximising all partners role, and the issues caused with cross boarder hospital discharge. **The Board resolved to:** • **note the Place Director update reports** • **agreed to receive a report at its November 2024 meeting on the Target Operating Model (TOM) for Place, an understanding of the maturity of each Place against the TOM, the learning across each Place and a focus on the priorities of each Place to decrease unwarranted variation** **Action: The Chief Executive to agree with the Chair the scope of future Place Director reports to Board** **Action: the Chief executive to agree with the Chair the scope of November 2024 Target Operating Model update paper in order to meet the Boards expectations.**
Committee AAA Reports – Matters of Escalation & Assurance
ICB/01/24/15 Highlight Report of the Chair of the ICB Audit Committee
The highlight report of the Chair of the ICB Audit Committee was presented to the Board. Board were updated that for the four risks that had been assigned to audit and were initially assigned at escalation score of 20, that three have now moved to a score of 9 and one has moved to 6, due evidence that systems to mitigate have now been implemented. **The Board noted the contents of the report.**
ICB/01/24/16 Highlight Report of the Chair of NHS C&M Remuneration Committee
The Chair of the Remuneration Committee asked that the board approve the change to the terms of reference. **The Board resolved to:** • **note the contents of the report** • **approve the amended Committee Terms of Reference.**
ICB/01/24/17 Highlight Report of the Chair of NHS C&M System Primary Care Committee

Item, Discussion, Outcomes and Action Points
The Chair of the Committee highlighted one alert area, in that there has been a change from NHS England of four new providers have come into the Electronic Patient Records market and has been marked as a risk. **The Board noted the contents of the report.**
ICB/01/24/18 Highlight Report of the Chair of NHS C&M Transformation Committee
The report presented to the Board by the Committee Chair advised of an alert regarding pulmonary rehabilitation programme funding. There are ongoing risks to the system in delivering the long-term plan commitments due to the changes in NHS England and the reorganisation and funding of the clinical networks. The Board heard concerns regarding clinical networks on a local ICS footprint, including the stroke, diabetes, respiratory and cardiac networks. Clinical networks have had staffing levels reduced by between 30% and 50% and have reorganised to a North West Coast footprint, meaning a shared resource across two Cheshire and Merseyside ICS and Lancashire and South Cumbria ICS which is being managed and discussed through the Transformation Committee. The Board were informed that amendments to the Committee Terms of reference were considered and agreed by the Committee and that they will come back to the March 2024 board for approval. **The Board noted the contents of the report.**
ICB Business Items & Strategic Updates
ICB/01/24/19 NHS C&M Board Assurance Framework – Quarter 3 Update
The Assistant Chief Executive provided an update to the board and informed that the 2023-24 BAF and principal risks were approved by the Board in May 2023 and updates were received in July and November 2023. The principal risks are those which, if realised, will have the most significant impact on the delivery of the ICB's strategic objectives. There are currently 10 principal risks, including four extreme risks, five high risks, and one moderate risk. There have been no changes to the risk scores since the November 2023 report. **The Board noted the content of the report.**
ICB/01/24/20 NHS Cheshire and Merseyside Corporate Risk Register
The Assistant Chief Executive provided an update to the board and informed that the ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 12+ in relation to ICB wide impact. This will include any risks aggregated from multiple places and having a current score of 12+ in relation to ICB wide impact. There are currently 8 risks on the CRR, highlighted within Appendix one, including 5 extreme risks and 3 high risks. Board were reminded of the organisational risk committee chaired by the Chief Executive and reports to the audit committee.

Item, Discussion, Outcomes and Action Points
Action - The Chair asked the Executive Team to review the score of 6 for 'P2 inadequate diagnostic and data infrastructure' along with the Chair of the Risk Committee. **The Board noted the content of the report.**
ICB/01/24/21 Northwest BAME Assembly Anti-Racism Framework
The Chief People Officer welcomed Thomasina Afful, Associate Director – ICB Equality, Diversity & Inclusion, who presented to the Board an update on the Northwest BAME Assembly Anti Racism Framework. Highlights from the report include – • a 50% response rate to a self-assessment sent out to ICB staff to gain an understanding of what was already in place to implement the anti-racism framework. The results of which were poor in terms of understanding and activities in place to meet criteria. • Recommendation to the Board is to nominate the ICB to achieve the Bronze level of the anti-racism framework. • Within the system the majority of trusts have indicated their commitment to the framework at Bronze Level. • A BAME staff network has been established in the ICB and Primary Care. There are low numbers of BAME colleagues within the ICB as an organisation, numbers are expected to increase. Next steps for the agenda are to progress the implementation of deliverables under the bronze level which will require developing the staff networks capacity to engage with the agenda. It will take 18 months to achieve the silver award. The Board discussed – • The framework being difficult to complete and suggested changes to future iterations. • The anti-racism framework to be extended to the three contractor groups in Primary Care. • GPU is the Executive Champion for the BAME network. • Primary Care Leaders in the NHS have approached the ICB to become involved in the anti-racist framework, which can be used to both learn from and support. The Chair again thanked Thomasina for her hard work and concluded how pleasing it was to hear of the ambitions within the ICB and in Primary Care. The Board thanked Thomasina for her presentation of the report, work being undertaken and her attendance today. **The Board noted the content of the report.**
ICB/01/24/22 NHS Cheshire and Merseyside ICB Constitutional Amends
The Assistant Chief Executive informed the Board that every Integrated Care Board (ICB) must have a Constitution approved by NHS England, it must be published on its website and made available to members of the public. It sets out various matters including the arrangements to allow NHS Cheshire and Merseyside including its Board to discharge its functions. It includes details on the establishment and composition of NHS Cheshire and Merseyside, its Board and

Item, Discussion, Outcomes and Action Points
relevant committees and includes the Standing Orders for the ICB. Cheshire and Merseyside ICB constitution came into effect on 1st July 2022. A number of changes to the constitution have been made. NHS England is due to instruct further amendments following provider selection regime regulations; the amendments will be implemented following a receipt of texts to be included. It is considered that the amendments are not significant enough to warrant engagement with the Health and Care Partnership Board or wider partners. Subject to approval of the amendments, application for variation to the constitution to NHS England will proceed and approval sought for the recommendation that the Board delegates responsibility to the Chief Executive to approve any further minor amendments to the constitution that may come from NHSE feedback. The Board discussed the constitutional amends, where it was highlighted that there was inconsistency throughout the document regarding explanation of VCFSE. **The Board resolved to:** • **Consider the proposed amendments to the ICB Constitution** • **Support the view that the proposed amendments are such that engagement with the Cheshire and Merseyside Health and Care Partnership and other stakeholders is not required.** • **Approve the proposed amendments to the Constitution.** • **Approve the intent to submit an application to vary the Constitution to NHS England.** • **Note that there will be additional amendments to the Constitution following receipt of guidance from NHS England.** • **Approve the recommendation to delegate authority to the Chief Executive to approve any minor changes to the Constitution following any feedback from NHS England.**
ICB/01/24/23 Updated Terms of Reference for the ICB Women's Services Committee
The Director of Nursing provided an update to the Board on the updated terms of reference for the ICB Women's Services Committee. A paper had previously been received at the November Board meeting, the Women's Services Committee met on 17th January 2024 and approved the terms of reference. **The Board resolved to:** • **note the establishment of the Programme Board and the Programme Definition and Governance Arrangements.** • **approve the revised Terms of Reference for the Women's Hospital Services in Liverpool Committee.**
ICB/01/24/24 NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS)
The Medical Director introduced Professor Greg Irving and Professor Terry Jones to the meeting as guest speakers and provided the Board with an update with an overview of NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS) which plans to establish a Cheshire and Merseyside Integrated Research and Innovation System (IRIS) that aligns with both local and national research and innovation priorities.

Item, Discussion, Outcomes and Action Points
The plan is in line with NHS England's guidance on Maximising the Benefits of Research and highlights the statutory responsibility for ICBs to deliver research and innovation under the Health and Social Care Act 2022. The plans have had considerable input from a wide range of stakeholders including patient and public involvement and highlights how IRIS will add value to the healthcare environment within Cheshire and Merseyside by attracting research investment, strongly supporting innovation and enabling the Cheshire and Merseyside Integrated Care System to evolve into a world class system of research and innovation excellence. IRIS will support the formation of a research and innovation strategy for Cheshire and Merseyside, will help bring together the legal and other duties around research and innovation in a coherent way, and help the ICS understand its local research and innovation capability, workforce, activity, and needs. It will set ambitions around research and innovation and maximise the benefits associated with commercial research. The Board discussed – • The work of IRIS and connecting it to the Transformation Committee and the Five Year forward plan. • Noted there was no business case and financial implications were unknown; guest speakers identified that there was limited resource at ICB level. The Medical Director informed the Board that research grants have been awarded as an Integrated Care System. • The governance proposal in the appendix was different to the governance proposal in the papers. • Ensuring that equality and diversity are embedded into the principles and that EDI is embedded into the language. • The Associate Medical Director would like to link continuous improvement with IRIS. • When future iterations are brought back to this Board, it would like to see extensive mapping of existing resources and policy development. The Chair asked for a timescale for a research strategy and plan, which will need to be costed, to be brought back to this Board. **The Board resolved to:** • **note the report.** • **Approve the establishment an Integrated Research and Innovation System, including establishing a Research and Innovation Committee of the ICB** • **Approve the key aims, objectives, focus areas, and proposed governance structure for IRIS** • **Note that the Terms of Reference for the Research and innovation Committee will come to the March 2024 Board meeting for approval.**
ICB/01/24/25 NHS Cheshire and Merseyside Freedom to Speak Up Update
The Chief People Officer introduced Vicki Wilson, Associate Director of Workforce to the Board as guest speaker to update on Cheshire and Merseyside Freedom to Speak Up. NHS England has outlined its current expectations of integrated care boards and integrated care systems in relation to Freedom to Speak Up. The ICB is working with the National Guardians Office and plan to share further information by 31st March 2024 about the precise expectations of

Item, Discussion, Outcomes and Action Points
ICBs in regard to Freedom to Speak Up for primary care workers and workers across their system. This focuses on the ICB's organisational responsibilities. The ICB must ensure that their own staff have access to routes to speaking up including FTSU guardian and have appropriate arrangement for reporting in place. Updates have been regularly provided to the ICBs People Committee and Audit Committee explaining the organisation's responsibilities in relation to FTSU and setting out the intended approach to developing FTSU arrangements across the ICB, and progress made against those plans. It is of note that staff in the ICB have not come forward to speak up, a survey and focus groups have been set up to explore this further. Priorities are enabling a culture in the organisation for staff to feel comfortable in speaking up which will require senior leaders and the Board to embrace speaking up activity, and role model behaviours. It is important to develop a culture where staff feel included, valued and psychologically safe. The Board Discussed – • The triggers and gaps for freedom to speak up. • The importance of staff working in Place being able to raise issues impacting patient care, as well as their own personal situations. **The Board resolved to:** • **Note the overall progress in relation to developments of FTSU.** • **Note current reporting for FTSU cases within the organisation.** • **Note the self-assessment, in particular the areas where further development has been identified.** • **Endorse the action plan to further develop the position in relation to FTSU.** • **Agree it would receive annual updates on progress against the identified actions.**
Any Other Business
ICB/01/24/26 Closing remarks, review of the meeting and communications from it
The Chair summarised that it was a good meeting, with good discussion. The Chair thanked Board members for their continued contributions and support, and thanked members of the public for their attendance. The Chair noted that questions have been received from members of the public, responses to the questions will be available on the website.
ICB/01/24/27 Consent Items
Confirmed Minutes of ICB Committees: - **Quality and Performance Committee** - **System Primary Care Committee** - **Finance, Investment and Resource Committee** - **Audit Committee** - **Transformation Committee.**
CLOSE OF MEETING

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2023 - 2024

Updated: **01/03/2024**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-22-11	28/11/2022	**Cheshire & Merseyside System Month 7 Finance Report**	In the absence of a comprehensice provider organisational integrated performance report, members would be sent dashboards that provided the wider financial position and workforce information.	Claire Wilson	Jan 2023	The revised performance report contains this information for both place and providers	COMPLETED	Board is asked to approve closure of the Action
ICB-AC-22-33	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	The ICB relative performance compared to other ICBs in the Northwest had not improved as much as they have, yet we continue to invest and put a lot of time and attention. Deep dive into this to be undertaken in April, place-based response to the information presented today in the private meeting. Further report to be brought back to the Board at a future meeting.	Andy Thomas	date tbc	*Deep dive occurred in April 2023 and that Integrated Performance reports to Board now feature a much greater range of data showing activity across system and places??*	COMPLETED	Board is asked to approve closure of the Action
ICB-AC-22-41	27/04/2023	**Cheshire & Merseyside System Month 12 Finance Report**	CWI and SBR to work together on the production of a position paper covering social care provision and funding	Claire & Steven Broomhead	TBC	Claire to discuss further with	ONGOING	
ICB-AC-22-48	25/05/2023	**ICS Financial Plan for 2023/24 and Proposed Budgets for the ICB**	To assign one of the board development days to provide training on a general overview of system finance.	Claire Wilson	June 2023	Identified on Board Development programme for April session	COMPLETED	Board is asked to approve closure of the Action
ICB-AC-22-51	23/06/2023	**Cheshire and Merseyside Mental Health, Community and Learning Disability Provider Collaborative - Annual Work Plan 2023-2024**	JRA to present the delivery plan to the board in autumn 2023	Joe Rafferty	Autumn 2023	On the Forward Plan for May 2024 meeting	ONGOING	
ICB-AC-22-57	27/07/2023	**NHS Long Term Workforce Plan**	CSA to provide a quarterly update to Board on the progress against the NHS LTP	Chris Samosa	Jan-24	No update nationally yet on LTP	ONGOING	
ICB-AC-22-59	28/09/2023	**Report of the Chief Executive**	Right Care Right Place - GPU to return Right Care Right Place to board in due course to understand what we can do as in integrated system through each place.	Graham Urwin	Nov-23		ONGOING	
ICB-AC-22-60	28/09/2023	**Cheshire and Merseyside Clinical and Care Constitution**	RJA asked RPJ, if in the diagram in appendix 2 of the report could be changed so it, as it can be read as though there is a top down approach to system place down to neighbourhoods on the left of the diagram.	Rowan Pritchard-Jones	Nov-23	Diagram has been amended	COMPLETED	Board is asked to approve closure of the Action
ICB-AC-22-62	28/09/2023	**Cheshire and Merseyside Winter Plan**	AMA to work with AMI to discuss how bed occupancy rates have been calculated for Mersey and West Lancashire Teaching Hospital Trust.	AMA / AMI	Nov-23	Issue discussed and BI sources and data quality resolved	COMPLETED	Board is asked to approve closure of the Action
ICB-AC-22-63	25/01/2024	**Welcome, Apologies and Confirmation of Quoracy**	Following on from the Public speaking time RJA confirmed an action for GPU / RPJ / CDO to bring a paper to a future Board meeting explaining how we have the right staff, at the right quantity at the right time for our patients.	GPU / RPJ / CDO	May-24		ONGOING	
ICB-AC-22-64	25/01/2024	**Action Log**	RJA asked the Board to review the usefulness of the action log which in its current form does not allow the Chair, on behalf of the Board, to track actions. Comments to be given to RJA and for RJA / GPU / MCU to review in readiness for the March 2024 Board meeting	RJA/MCU/GPR	Mar-24		ONGOING	
IBC-AC-22-65	25/01/2024	**Report of the ICB Chief Executive**	The Chief Executive to bring a written response on the roll out of enhanced access to GP's for the three new specific diagnostic tests to the March Board meeting.	GPU	Mar-24	Update to be circulated to Board following March meeting	ONGOING	
IBC-AC-22-66	25/01/2024	**Report of the ICB Director of Nursing and Care**	Chief People Officer to bring an annual report on ICB staff, including outcomes of Staff Survey, to the May 2024 Board meeting	CSO	May-24	On May 2024 Board Agenda	ONGOING	

Action Log 2023 - 2024

Updated: **01/03/2024**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
IBC-AC-22-67	25/01/2024	**Report of the ICB Director of Nursing and Care**	Chief People Officer to bring to update report on the strategic direction of the C&M System Workforce Board, including details on system workforce	CSO	Mar-24	Will be incorporated into Action 66	ONGOING	
IBC-AC-22-68	25/01/2024	**NHS C&M Quality and Performance Report**	Marmot Indicators: Board to receive a governance map of what is reported where and when, and on an annual basis the Board receives a report on progress against the Marmot indicators	IAS, AMI	May-24		ONGOING	
IBC-AC-22-69	25/01/2024	**NHS C&M Quality and Performance Report**	Board to receive information on secondary prevention measures in primary care (link to QOF)	CWA	May / July 24		ONGOING	
IBC-AC-22-70	25/01/2024	**NHS C&M Quality and Performance Report**	The Director of Performance and Improvement to investigate the data we currently collect regarding Patient Reported outcomes and incorporate into future reports to Board	AMI	May-24		ONGOING	
IBC-AC-22-71	25/01/2024	**Report of the Directors of Place**	Board to receive a high level summary report at its November 2024 meeting on the Target Operating Model (TOM) for Place, an understanding of the maturity of each Place against the TOM, the learning across each Place and a focus on the priorities of each Place to drive out unwarranted variation	GPU, CWA	Nov-24	On Board Forward Plan and due at November 2024 meeting	ONGOING	
IBC-AC-22-72	25/01/2024	**NHS Cheshire and Merseyside Corporate Risk Register**	Executive Team to review the score of 6 for 'P2 inadequate diagnostic and data infrastructure' along with the Chair of the Risk Committee	GPU, AMI, RPJ	May-24		ONGOING	

CHESHIRE MERSEYSIDE INTEGRATED CARE BOARD

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-22**	**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-22**	*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*	CLOSED
ICB-AC-22-02	**01-Jul-22**	**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**	*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*	CLOSED
ICB-AC-22-03	**27-Oct-22**	**Cheshire & Merseyside System Month 6 Finance Report**	Requested CWA and CDO provide a Workforce Update at the next Board Meeting.	Claire Wilson	**28-Nov-22**	*Workforce Update report included within the Director of Nursing and Care Report*	CLOSED
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	CLOSED

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	*Action completed*	CLOSED
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		CLOSED
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	Update report on March Board	CLOSED
ICB-AC-22-12	28/11/2022	**Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton)**	RJA requested that the Cheshire and Merseyside Cancer Alliance be invited to the January 2023 meeting to explain its work programme	Rowan Pritchard-Jones	Jan 2023	Update report on March Board	CLOSED

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-22-16	28/11/2022	**Winter Planning 2022-2023 Update**	Requested that Cllr Louise Gittins, as Chair of the Cheshire and Merseyside Health and Care Partnership, receive a report on Place Based Winter Planning	Anthony Middleton	TBC	*Completed. Report circulated to Cllr Gittens*	CLOSED
ICB-AC-22-17	28/11/2022	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee**	An update on dentistry and optometry. A full formal report on dentistry would be presented to Board in February 2023.	Clare Watson	Feb 2023	Came to February Board	CLOSED
ICB-AC-22-19	23/01/2023	**Cheshire & Merseyside System Month 9 Finance Report**	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.	Claire Wilson	01-Feb-2023	CWI confirmed that the reports now included this information	CLOSED
ICB-AC-22-26	02/03/2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**	CWA confirmed that the following would be would be amended to reflect the conversation and forwarded to Members following the meeting for their approval: 'Empower and engage our leadership and workforce'. Needed to be more explicit to say addressing overall inequalities.	Clare Watson	March 2023	Amendments made and approved by Board members following the meeting	CLOSED
ICB-AC-22-24	23/02/2023	**Cheshire & Merseyside System Month 10 Finance Report**	CSA/CDO to bring further information to the Board around non-contracted staff to allow for a better understanding of the issue	Christine Douglas	Not specified	Further information relating to bank and agency staff provided to the Board in March the People Board update	CLOSED
ICB-AC-22-25	23/02/2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**	CWA to present on the results of the Staff Survey at the April Board meeting.	Clare Watson	April 2023	Update provided at March Board on ICB Staff and report on the April agenda	CLOSED

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-22-34	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	RPJ to bring forward proposals such as the intelligence into action so we can be clear how we are using the information around health inequalities to make a difference	Rowen Pritchard-Jones	April 2023	On the Board agenda for April. Therefore action completed	CLOSED
ICB-AC-22-35	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	Following the publication of the primary care recovery plan, AIR and NRA will think through a broader range of indicators and will get a collaborative view through Primary Care Committee to inform this board of a more holistic look at primary care	Adam Irvine & Dr Naomi Rankin	tbc	National Primary Care Recovery Plan has not yet been published. Item can be combined with Board Action No ICB-AC-22-18 following consideration at SPCC.	CLOSED
ICB-AC-22-27	23/02/2023	**Cheshire & Merseyside ICB Risk Management**	The proposed format of the BAF and the final Risk Appetite document would be considered at the April 2023 Board meeting.	Matthew Cunningham	April 2023	On May Board Agenda	CLOSED
ICB-AC-22-31	30/03/2023	**Cheshire & Merseyside System Month 11 Finance Report (Claire Wilson)**	Overall operational planning process - A formal report would be brought to a subsequent board meeting once final plans have been submitted to the regulators.	Claire Wilson	date tbc	On May Board Agenda	CLOSED
ICB-AC-22-38	27/04/2023	**Decision Log**	MCU to circulate the full decision to members	Matthew Cunningham	TBC	full log circulated and action completed	CLOSED
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.	Rowan Pritchard-Jones	01-Oct-2023	Added to the forward plan for October 2024	CLOSED
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	Added to work plan for May 2023	CLOSED
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	Added to work plan for May 2023	CLOSED

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-22-14	28/11/2022	**Consensus on the Primary Secondary Care Interface**	RPJ confirmed that discharge medicines services were crucial for patients and a future paper would be required at Board to review	Rowen Pritchard-Jones	TBC	Has been added to the Board Forward Plan - date tbc	CLOSED
ICB-AC-22-15	28/11/2022	**Consensus on the Primary Secondary Care Interface**	An update report would then be presented to Board over the next 12 months	Rowen Pritchard-Jones	TBC	Has been added to the Board Forward Plan	CLOSED
ICB-AC-22-18	28/11/2022	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee**	The Primary Care Strategy. This would be presented to the Board in March 2023	Clare Watson	TBC	National Plan has been published. Update coming to June Board with ICB Plan coming in October 2023	CLOSED
ICB-AC-22-20	26/01/2023	**NHS 2023/24 Priorities and Operational Planning Guidance**	That the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023 and as such there was a need for review by the ICB Executive Team and Provider Collaboratives. The final submissions would be presented to the Board for approval in March 2023	Clare Watson	March 2023	Added to work plan for June 2023	CLOSED
ICB-AC-22-21	26/01/2023	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**	The Committee had received an Urgent Care presentation and the intention was to return to the Board meeting in March with a full Urgent Care report	Anthony Middleton	March 2023	Added to work plan for May 2023	CLOSED
ICB-AC-22-22	26/01/2023	**Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee**	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. A report relating to this would be presented to the Board at a future meeting	Clare Watson	March 2023	Added to work plan for May 2023	CLOSED

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-22-23	02/03/2023	**Report of the Chief Executive**	CWA confirmed that a further report would be presented to the Board in March 2023 that would include the terms of reference for these new Committees	Clare Watson	01-Mar-2023	Womens Services Committee and Risk Committee TOR being presented at May Board. North West Specialsied Commissioning Joint Committee TOR to come to June Board.	CLOSED
ICB-AC-22-28	23/02/2023	**Cheshire & Merseyside ICB Prioritisation Framework**	CWA confirmed that that the Prioritisation Framework would be presented to the ICB Board in at its April 2023 meeting.	Clare Watson	April 2023	Date tbc	CLOSED
ICB-AC-22-30	30/03/2023	**Report of the Chief Executive (Graham Urwin)**	With regard to the suggestion of a learning event following the end of the industrial action RJA asked RPJ to look into developing this.	Rowen Pritchard-Jones	date tbc	Industrial action is still on-going	CLOSED
ICB-AC-22-37	30/03/2023	**Sub-Committee Reports**	RJA questioned the format of the report used for this type of committee and would like to follow this up with CWA outside of the meeting.	Raj Jain & Clare Watson	tbc	RJA, CWA and MCU to meet to review committee report format. Meeting to be arranged.	CLOSED
ICB-AC-22-39	27/04/2023	**Report of the Chief Executive**	Operational System Pressures - no criteria to reside (NCTR) improvement plan to be presented to the Board in June 2023.	Graham Urwin	Jun-23	On June Board Agenda	CLOSED
ICB-AC-22-42	27/04/2023	**Intelligence Into Action: Continued provision of ICS digital and data platforms**	Responses to the tabled questions had been drafted and would be shared following the meeting and added to the ICB website	John Llewellyn	TBC		CLOSED
ICB-AC-22-43	25/05/2023	**Report of the Chief Executive**	review the communications around the minor ailment scheme and work with Healthwatch and other Third Sector colleagues	Clare Watson	TBC		CLOSED
ICB-AC-22-46	25/05/2023	**Executive Director of Nursing & Care Update Report**	There was an acknowledgement that progress regarding internal ICB staff would be monitored through the people board but that the Board requested a direct quarterly update report. Add to work progrmme	Chris Samosa	June 2023	Added to workplan of the Board	CLOSED

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-22-49	25/05/2023	**Marking NHS@75 years and NHS Cheshire and Merseyside@ 1 year**	Windrush was fundamental to the start of the NHS and Windrush Day was the same day as the ICB July Board meeting. The patient/staff story should focus on this.	Clare Watson	June 2023		CLOSED
ICB-AC-22-52	23/06/2023	**Winter Debrief and Urgent Emergency Care Improvement Programme**	the Board requested that a winter assurance report was presented at the September meeting	Anthony Middleton	September 2023	On the agenda for September 2023	CLOSED
ICB-AC-22-53	27/07/2023	**Report of the Chief Executive - Right Care Right Person**	Simon Banks (Wirral Place Director) was leading on this and attending multi agency strategy meetings. GPU would provide an update at the next Board meeting.	Graham Urwin	September 2023	Within the September Chief Execs Report to Board	CLOSED
ICB-AC-22-13	28/11/2022	**ICB Equality, Diversity and Inclusion Update Report**	Members discussed how data collected via WRES, WDES, CORE20, EDS2 and other system would be used and shared with the Board. IAS agreed to bring a further report on Core20Plus to a future Board meeting in relation to this.	Ian Ashworth	TBC	Date to be confirmed when Director of Population Health starts with ICB Discussed at 280923 meeting - agreed to close action	CLOSED
ICB-AC-22-29	23/02/2023	**Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB Update**	A further update report on delegated services would be presented to the Board in six months	Clare Watson	September 2023	Update to be provided at November 2023 meeting	CLOSED
ICB-AC-22-40	27/04/2023	**Resident/Staff Story**	CWA to report to be Board on the findings and actions leading from the GP review of unpaid carers/patients	Clare Watson	TBC	To be taken through system primary care committee	CLOSED
ICB-AC-22-44	25/05/2023	**Report of the Chief Executive**	to bring the Primary Care Strategic Framework to the June 2023 Board meeting	Clare Watson	June 2023	Due to be pressented at the November 2023 Board	CLOSED
ICB-AC-22-45	25/05/2023	**Resident/Staff Story - Learning Disabilities Health Checks**	IAS to work with colleagues to determine if it was possible to develop a standardised way of displaying life course statistics across Cheshire and Merseyside	Ian Ashworth	TBC		CLOSED

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-22-47	25/05/2023	**Cheshire & Merseyside ICB Quality and Performance Report**	Most indicators listed in the report related to symptoms not the cause of the symptoms. These were discussed at committee level and would be incorporated into future Board reports	Anthony Middleton	June 2023	Linked by performance report to be brought to board in November 23	CLOSED
ICB-AC-22-55	27/07/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report**	AMI to consider how to represent dementia diagnosis in the performance report.	Anthony Middleton	September 2023		CLOSED
ICB-AC-22-56	27/07/2023	**Cheshire & Merseyside System Month 3 Finance Report**	GPU to arrange a meeting with chief officers across C&M to discuss best practice in reaching CIP targets	Graham Urwin	September 2023	Financial strategy session was completed with all Chief Executives across the patch	CLOSED
ICB-AC-22-54	27/07/2023	**Report of the Chief Executive - Give digital a go' campaign**	JLL to consider what specific actions the ICC were taking for those digitally excluded	John Llewellyn	September 2023	Have a series of measures in toolkit that address the risk of leaving services users unable to access services; approached is outlined in toolkit	CLOSED
ICB-AC-22-61	28/09/2023	**Cheshire and Merseyside Clinical and Care Constitution**	A board development session to be set aside to discuss the Clinical and Care Constitution with lessons learned from the past.	MCU	Nov-23	Added to Board development forward planner	CLOSED
ICB - AC-22-58	28/09/2023	**Report of the Chief Executive**	IAS to discuss with Public Health Directors making re-connections to look at good practice around dual diagnosis services.	Ian Ashworth & Joe Rafferty	Nov-23	date tbc	CLOSED
ICB-AC-22-50	25/05/2023	**Reports of the Chairs of the Cheshire & Merseyside ICB Committees**	RJA requested that when items were escalated to Board that the risk template was used. This would highlight where and how risks were being mitigated.	All committee chairs	June 2023	Updated Board paper template strengthens links to ICB risk management	COMPLETED
ICB-AC-22-32	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	With regard to the Core20plus5 there were a range of 22 indicators that would be reported through the HCP but could also be presented to this Board.	Andy Thomas	date tbc	*metrics being developed and will festur ein future reports*	COMPLETED

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

28 March 2024

Consent Items

Agenda Item No: ICB/03/24/28

Minutes of ICB Committees

Click on the links below to access the minutes:

- Quality and Performance Committee – February 2024 **(CLICK HERE)**
- System Primary Care Committee – December 2023 **(CLICK HERE)**
- Finance, Investment and Our Resources Committee – January 2024 **(CLICK HERE)**
- Audit Committee - December 2023 **(CLICK HERE)**
- Transformation Committee - March 2024 **(CLICK HERE)**
- Children and Young Peoples Committee - November 2023 **(CLICK HERE)**
- Women's Hospital Services in Liverpool Committee – January 2024 **(CLICK HERE)**