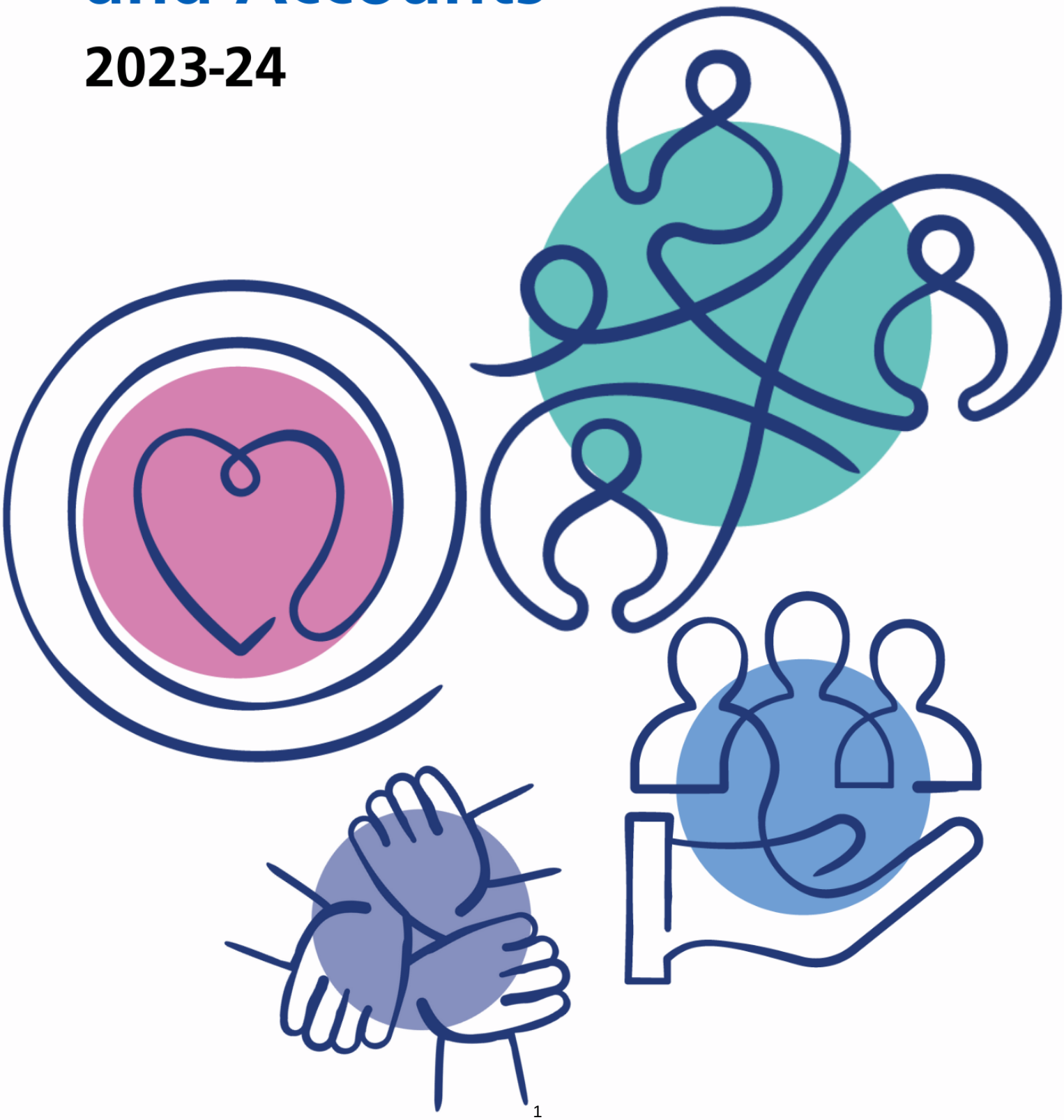
NHS
Cheshire and Merseyside

Annual Report and Accounts

2023-24



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1. Performance Report

1.1.1 Statement from the Accountable Officer

Welcome to the 2023-24 Annual Report and Accounts of NHS Cheshire and Merseyside Integrated Care Board (ICB), which covers the period 01 April 2023 to 30 March 2024.

The Cheshire and Merseyside Health and Care system benefits from strong partnership working, active involvement from our residents and a steadfast commitment by health and care staff for improvement so as to be able to better design and deliver the best possible care, experience and outcomes for our residents.

Like many areas of the country, the demand for health and care services has been rising over time, as a result of an ageing population and more people living with multiple long-term conditions, which has been further exacerbated by local and national workforce shortages, industrial action and the ongoing cost-of-living crisis.

As we have continued to recover from the impact of the COVID-19 pandemic, reducing waiting times for those waiting longest was a major theme of our work during the last year, and we should be particularly proud of the improvements in access to cancer services, and notably we were the first system in the country to deliver, since the pandemic, the six week diagnostic standard.

The challenge of delivering today can often crowd out our ability to make upstream investment in prevention, however we have made significant improvements in reducing paediatric dental waiting lists and launched a major oral health strategy for 2 - 7 year olds.

Set against this, Urgent and Emergency Care performance has been challenging for Cheshire and Merseyside and the entire system continued to experience significant pressures throughout 2023-24. Despite improvement in every aspect of the system, urgent care performance is recognised as our most significant operational challenge as we move into 2024-25.

As well as ambulance response time delays, significant pressure on services also manifested in people being cared for in hospital corridors, or in longer stays in hospital, all of which falls short in terms of our ambitions for patient experience, but which also impacts on productivity. This is why we have an unrelenting focus on:

- reducing the number of hospital attendances by making better use of alternatives like primary and community care services, walk in centres, and virtual wards
- reducing the number of admissions to hospital (particularly for people over the age of 65), and the amount of time people spend in hospital when they do need to be admitted
- improving processes and pathways when people are discharged from hospital
- making our urgent care system (in all its guises) more visible - and easier to understand - for the public and patients.

Despite these numerous challenges, the past year has seen the ICB and its partners in health and care deliver many successes, achieve ambitious targets, be recognised for our innovation and expertise, and demonstrate the ability to continually improve on the work we have done so far.

I invite you to read this Annual Report so as to see the breadth of what has been achieved by the ICB and with partners across the Integrated Care System, and I would welcome your comments on this year's annual report. Please send your comments to communications@cheshireandmerseyside.nhs.uk

1.1.2 Purpose and activities of the organisation

NHS Cheshire and Merseyside was formally established on 01 July 2022 and is one of the largest Integrated Care Boards (ICBs) in England, working across and within nine local authority areas known as Places. **NHS Cheshire and Merseyside is the statutory NHS organisation responsible for planning and arranging for the provision of healthcare services for more than 2.7 million residents whilst supporting the integration of NHS services with our partners.**

NHS Cheshire and Merseyside is responsible for delivering the following activities which are carried out at a Cheshire and Merseyside level and at Place level:

- supporting the Health Care Partnership to develop the **integrated care strategy** through the provision of resources and advising on requirements as set out in national guidance.
- **using joined-up data and digital capabilities** to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes.
- establishing **population health intelligence and analytical** capabilities to generate insight on variable population needs across the system.
- **developing a plan** to meet the health needs of the population including setting out the activities required to deliver the strategy, who is responsible for these, phasing of these activities, monitoring requirements and financial management arrangements.
- **establishing and operating governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance to ensure the plan is implemented effectively within a system financial envelope set by NHS England.
- **establishing and supporting joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan.
- **allocating resources to deliver the plan** across the system, including allocating resources to provider collaboratives and place-based partnerships based on population needs and priorities.
- ensuring annual budget, revenue, capital limits and running cost allowance for NHS Cheshire and Merseyside **are not exceeded, conducting accounting and banking** in line with legal requirements and **providing relevant financial information** to NHS England.
- **commissioning** hospital and community and mental health NHS services, as well as additional services delegated by NHS England (e.g. specialised, primary medical, community pharmacy, ophthalmology and dental).

- working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners, ensuring that the NHS plays a full part in influencing the wider determinants of health such as social and economic development and environmental sustainability.
- **effectively monitoring the quality and safety of services we commission**, working with providers to improve quality
- **supporting the delivery of population health** across the Integrated Care System, taking account of relevant public health laws, regulations and governance structures and advancing public and population health research and investment.
- **arranging for the provision of health services** in line with the allocated resources through a range of Cheshire and Mersey wide and place level activities.
- **planning for, 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 NHS England.
- leading **communications and engagement** to seek public and patient views on experience to inform service planning and redesign.
- **leading system implementation of the People Plan** by aligning partners across the Integrated Care System to develop and support the 'one workforce' approach.
- **leading system-wide action on data and digital** working across the partnership to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care.
- **driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability.
- fulfilling **additional legal duties** of Integrated Care Boards as set out in various Acts.

NHS Cheshire and Merseyside also works closely with the neighbouring Integrated Care Boards of NHS Greater Manchester and NHS Lancashire and South Cumbria, and NHS England in the commissioning of a number of specialised services for patients across the North West.

NHS Cheshire and Merseyside forms part of the wider Cheshire and Merseyside Integrated Care System. Alongside NHS Cheshire and Merseyside, the key components of Cheshire and Merseyside's Integrated Care System are:

- **the Cheshire and Merseyside Health and Care Partnership**: a statutory joint committee between NHS Cheshire and Merseyside and our nine local authorities. The partnership board includes a wide range of partners from across the health and care system and is responsible for producing our Health and Care Partnership Strategy.
- **Nine Place-Based Partnerships**: partners working together on our local authority footprints to support the integration of health and care services, in support of delivery of Joint Health and Wellbeing Strategies.
- **Two NHS Provider Collaboratives**: provider collaboratives are partnerships that bring together multiple NHS trusts (providers of NHS services including hospitals

and mental health services) to work together at scale. In Cheshire and Merseyside, there are two NHS provider collaboratives:
  - Cheshire and Merseyside Acute and Specialist Trust (CMAST)
  - Mental Health, Community and Learning Disability Collaborative (MHLDSC).
- **48 Primary Care Networks**: groups of GP Practices working together, being key building blocks of the NHS Long Term Plan
- **c1,950 Voluntary, Community, Faith and Socical Enterprise sector (VCFSE):** a variety of organisations which controbute to the sector being a key strategic partner for public sector organisations providing research, consultation and commissioning services on top of providing frontline service delivery across a number of themes relating to community need and addressing inequalities.

Working with our partners across the Integrated Care System, NHS Cheshire and Merseyside has led the development and adoption of the Cheshire and Merseyside Health and Care Partnership Interim Strategy and Cheshire and Merseyside Joint Forward Plan, which articulates the following vision, mission and purpose of the Integrated Care System:

The Cheshire and Merseyside Joint Forward Plan sets out the following priorities, which align to the four core purposes of ICBs, and which contribute to making early progress against the ambitions outlined in the interim Health and Care Partnership Strategy:

Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)
- all of Cheshire and Merseyside's nine Places are actively engaged in the All Together Fairer Programme
- supporting the safety of vulnerable Women and Children.

Improve population health and healthcare
In relation to preventing ill health we will focus on:
- increase rates of early detection of cancer
- work towards Making Every Contact Count (MECC)
- encourage 'Healthy Behaviours' with a focus on smoking/alcohol/healthy weight and physical activity
- ensure access to safe, secure, and affordable housing.

Enhancing productivity and value for money

- deliver our agreed financial plans for 2023-24 whilst working towards a balanced financial position in future years.

Helping to support broader social and economic development

- develop as key Anchor Institutions and progress advancing at pace the associated initiatives.
- embed and expand our commitment to Social Value.
- developed focused work in schools around encouraging careers in health and social care
- ensure a health and care workforce that is fit for the future.
- achieve Net Zero for the NHS carbon Footprint by 2040.

1.1.3 Performance Overview

Despite a challenging context for the 2023-24 period, there were a number of notable achievements across the Cheshire and Merseyside region which are outlined further within this report, but in summary:

- **Cancer:** Cheshire and Merseyside Cancer Alliance was the first cancer alliance nationally to reduce the number of patients waiting over 62 days to commence their first definitive treatment to pre-COVID levels.
- **Diagnostics:** Cheshire and Merseyside ICB was the first and so far the only ICB nationally to achieve the national ambition that less than 10% of patients would have waited for more than six weeks for a diagnostic test.
- **Elective:** Whilst it is recognised that the ICB was not successful in eliminating 65 week waits during 2023-24 significant progress was made towards achieving this ambition despite increased demand and the impact of industrial action. At the end of March 2024 there were 365,756 patients on the waiting list in Cheshire and Merseyside, of whom 2,195 patients had been waiting in excess of 65 weeks. This compares to the position in April 2023 when there were 360,819 patients on the waiting list, of whom 4,867 had been waiting in excess of 65 weeks.

System Leadership

Throughout 2023-24, NHS Cheshire and Merseyside worked with partners to establish our system priorities. As part of this work, NHS Cheshire and Merseyside led the development of a refreshed Health and Care Partnership plan, entitled All Together Fairer: Our Health and Care Partnership Plan - which will be published in late July / early August 2024.

This sets out our aim to more closely align the work of our Health and Care Partnership with the recommendations made in All Together Fairer: Health equity and the social determinants of health. These were co-designed with local residents and community organisations within and across our nine Places and have the commitment of the nine Health and Wellbeing Boards across Cheshire and Merseyside.

NHS Cheshire and Merseyside continued to develop its System Co-ordination Centre capabilities throughout 2023-24. This included the implementation of a new reporting system used by partners across the system to respond to pressures in

urgent and emergency care and quickly identify any under-utilised care capacity in to help partners collectively reduce waiting times and improve patient experiences and outcomes.

Collaboration across the system on our continuous improvement journey, will be enabled through our Cheshire and Merseyside Improvement Network and Clinical and Care Professional Leadership Framework.

NHS Cheshire and Merseyside has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with principles of good governance. The Governance Statement at section 2.2.2.1. describes these arrangements in more detail and demonstrates how they have been designed, developed and embedded to ensure that:

- NHS Cheshire and Merseyside has access to a broad range of professional expertise in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health.through the membership of its Board, its committees, sub-committees and underpinning network of partnership, programme, clinical and other advisory networks
- NHS Cheshire and Merseyside is appropriately informed and clear on the impacts of decisions, and responsive to the 'triple aims' of health and wellbeing of the people of England, quality of healthcare services for the purposes of the NHS and sustainable and efficient use of resources by NHS bodies.

Improving Population Health and Healthcare

NHS Cheshire and Merseyside continues to strengthen its overarching quality governance framework to ensure the population of Cheshire and Merseyside have access to services that are safe, effective and have a good experience. This work is informed by a wide range of intelligence and data to assess the quality of services, together with insight and feedback from our Citizen and Insight Group.

Our Elective Recovery Programme, hosted by the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) provider collaborative, has been effective in making significant progress toward eliminating long waits - despite Cheshire and Merseyside experiencing a disproportionate impact from multiple rounds of NHS industrial action. NHS Cheshire and Merseyside and the local system has continued to significantly increase capacity and activity to improve performance in relation to diagnostics and cancer referral and treatment.

Choice and personalisation are integral to our commissioning approach and a fundamental element of our recovery plans. Our Health and Care Partnership Strategy and Joint Forward Plan also set out our ambitions to increase the number and quality of personal health budgets and support to carers.

Our work on improving population health and healthcare is underpinned by our public engagement framework, developed in collaboration with Healthwatch and voluntary community faith and social enterprise organisations. Using this as a foundation, we have built effective involvement governance and infrastructure, in addition to deploying tailored approaches to specific programmes and projects.

Tackling unequal outcomes, access and experience:
The All Together Fairer programme deliberately focuses on the social, economic and environmental conditions in which people are born, grow, live, work and age in to help reduce health inequalities.

Our Joint Forward Plan outlines our commitment to a Population Health programme, focused on early intervention, tackling inequalities, addressing wider determinants and promoting good health.

Our established system-wide Population Health Board oversees our Population Health programme. The aims are to improve health outcomes and reduce health inequalities by embedding a sustainable system-wide shift towards focusing on prevention and health equity.

Utilising data and technology, we continue to use innovative approaches to tackling inequalities and supporting local NHS trusts to restore services in an inclusive way:

- in the last year we have progressed c55 population health projects through the Data into Action programme that use the NHS Cheshire and Merseyside integrated longitudinal data asset (CIPHA) to segment populations and develop stratified cohorts of patients according to their health inequalities.
- structural, economic and social factors can lead to inequalities in the length of time people wait for NHS planned hospital care – such as hip or knee operations – and their experience while they wait. C2-AI's Observatory system, deployed at all acute Trusts in Cheshire and Merseyside, tracks clinical outcomes compared to expected outcomes to identify excellence and opportunities for quality improvement. This analysis will be used by Trusts and NHS Cheshire and Merseyside to develop admission avoidance and anticipatory pathways tailored to the specific needs of patients.

Enhancing productivity and value for money
Financial Performance: NHS Cheshire and Merseyside delivered a surplus of £3.219m for the year to 31 March 2024 against its spending allocation of £6.7 billion. NHS Cheshire and Merseyside has a number of financial duties under the NHS Act 2006 (as amended). For the year to 31 March 2024, NHS Cheshire and Merseyside achieved its financial duties as follows:

Duty	Achieved
Expenditure not to exceed income	Yes
Capital resource use does not exceed the amount specified in Directions	Yes
Revenue resource use does not exceed the amount specified in Directions	Yes
Revenue administration resource use does not exceed the amount specified in Directions	Yes

Research, Technology and Innovation: We have an ambitious vision for research. Our population is recognised to have been poorly served by research opportunities in the past. This, coupled with significant health need, highlights the need to work differently.

The Cheshire and Merseyside Integrated Care System is contributing to the North West Region development of a Secure Data Environment (SDE) for research and clinical trials - utilising funding from NHS England. We are working closely with our academic institutions, Health and Care Partnership partners (including population health), research partners (including National Institute for Health and Care Research, National Cancer Research Institute and Academic Health Science Network) and industry.

The Integrated Research and Innovation System (IRIS), aligned with both local and national research and innovation priorities, adds value to the healthcare environment within Cheshire and Merseyside by attracting research investment, strongly supporting innovation and enabling the Integrated Care System to evolve into a world class system of research and innovation excellence.

In 2023-24, the Integrated Care System Digital and Data Strategy continued to shape our digital and data delivery and transformation priorities. Notably this is supporting system-wide frontline digitisation, empowering patients, expanding shared care records and, through the Data into Action Programme, optimising care and targeting patients according to need and circumstance.

Helping the NHS to support broader social and economic development
In addressing the social determinants of health and inequalities NHS Cheshire and Merseyside has supported seven objectives agreed as system-level areas for action:

- **Objective One**: Increase, and make equitable, funding for social determinants of health and prevention.
- **Objective Two**: Strengthen partnership for health equity.
- **Objective Three**: Create stronger leadership and workforce for health equity.
- **Objective Four:** Co-create interventions and actions with communities.
- **Objective Five:** Strengthen the role of business and the economic sector in reducing health inequalities.
- **Objective Six**: Extend social value and Anchor organisations across the NHS, public service and local authorities.
- **Objective Seven**: Develop social determinants of health in all policies and implement Marmot Beacon Indicators.

NHS Cheshire and Merseyside became the first organisation in the UK to receive a new award for social value in health. Launched in November 2023, the Social Value Quality Mark[1] Bronze Award recognises the efforts that the organisation is making towards achieving its social value goals and its ambition to involve the whole health and care system across Cheshire and Merseyside.

Across Cheshire and Merseyside there is an Anchor Framework in place that brings NHS, Local Authorities and Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations together to explore how social value can be practically and effectively embedded across the region; working together to reduce health

[1] https://www.cheshireandmerseyside.nhs.uk/posts/nhs-cheshire-and-merseyside-first-recipient-of-new-uk-wide-social-value-award/ (last checked on 140624)

inequalities and improve health and wellbeing. The principles of the Framework include paying the real living wage, purchasing locally and for social benefit, using buildings and spaces to support communities, widening access to quality work, working more closely with local partners and reducing environmental impact.

Below is an outline of some additional elements of our All Together Fairer work:

- **Children and Young People Health Equity Collaborative** - Focuses on how our actions can reduce inequalities for children and young people as part of our wider programme, led through our Cheshire and Merseyside Children and Young People Committee.
- **Work Well Partnership** – Service to better integrate local employment and health support for disabled people and people with health conditions.
- **Prevention Pledge** – Assists NHS and partner organisations in Cheshire and Merseyside to strengthen and scale up population-level prevention priorities.
- **Sustainability Programme** - Established across Cheshire and Merseyside to ensure a joined-up approach to delivering on the objectives of the wider sustainability agenda in tackling climate change, overseen by our Sustainability Board.
- **Serious Violence Duty** - Brings partners together to collaborate and plan to prevent and reduce serious violence.
- **Anti-racism and discrimination** – Our members are working collaboratively to spread good practice to help tackle discrimination.
- **Housing and Health** – Work with housing partners to identify how we can collectively have an impact on the availability and quality of housing.

Statutory Duties

The Health and Care Act 2022 conferred a number of statutory duties onto the ICB, which the ICB is committed to fulfilling. The performance analysis report demonstrates how NHS Cheshire and Merseyside has discharged its general duties per sections 14Z34 to 14Z45 and 14Z49 of the National Health Service Act 2006 (as amended), comprising:

- **14Z34 Duty as to improvement in quality of services** – NHS Cheshire and Merseyside views the quality and safety of the services it commissions as its top priority and is a fundamental component of the delivery of all of its objectives and functions. Section 1.2.8.2 sets out in more detail how we continue to strengthen the overarching quality governance framework to ensure people in Cheshire and Merseyside are able to access services that are safe, effective and positively experienced.
- **14Z35 Duty as to reducing inequalities** – it is a core purpose of NHS Cheshire and Merseyside to tackle inequalities in outcomes, experience and access. The activities and progress in delivering this are set out in section 1.2.8.15 and also illustrated through the delivery of the Joint Forward Plan initiatives set out in section 1.2.6 and performance during the year in relation to reducing unwarranted inequalities in outcomes, service experience and access for all people and parts of Cheshire and Merseyside as set out in section 1.2.3.9.
- **14Z36 Duty to promote involvement of each patient** – the involvement of each patient is a fundamental element of our Model for Health and Wellbeing. We want to promote the involvement of each patient in decisions about prevention,

diagnosis and their care or treatment and to involve and work in partnership with our population to design new models of integrated healthcare delivery. It is implicit in our mission for recovering core NHS and care services and integral to our aims in increasing personalisation and support to carers described in more detail in section 1.2.8.2.Sections 1.2.8.5 to 1.2.8.14 describe NHS Cheshire and Merseyside's approach to patient involvement in more general terms.

- **14Z37 Duty as to patient choice** – patient choice wherever possible is a requirement of the services commissioned by NHS Cheshire and Merseyside. We want our population to feel that they are provided with the information to empower them to make choices about their care. It is implicit in our mission for recovering core NHS and care services and integral to our aims in increasing personalisation and support to carers described in more detail in section 1.2.8.2. Equality impact and quality impact assessments of any proposed changes in services ensure that patient choice is considered.
- **14Z38 Duty to obtain appropriate advice** – the corporate governance report at sections 2.2.1.5 and 2.2.2.4 to 2.2.2.15 describes NHS Cheshire and Merseyside's formal governance arrangements, which are supported by an extensive network of partnership, programme, clinical and other advisory networks with a broad range of professional expertise in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health.
- **14Z39 Duty to promote innovation** - we have an ambitious vision for innovation and research in our region. Our population is recognised to have been poorly served by research opportunities in the past. That, when coupled with significant health need, highlights the need to work differently. Section 1.2.8.20 provides details of the innovations pursued and delivered during the year.
- **14Z40 Duty in respect of research** - NHS Cheshire and Merseyside approved the establishment of an Integrated Research and Innovation System (IRIS). Its primary aim is to create a research and innovation driven healthcare ecosystem that benefits the entire population by fostering research and innovation excellence to improve the health and wellbeing of the population. Section 1.2.8.21 describe its purpose and key activities during the year.
- **14Z41 Duty to promote education and training** – NHS Cheshire and Merseyside is committed to applying education and training as an essential lever of an integrated workforce plan that supports the delivery of services in the short, medium and long term. This is illustrated through the performance analysis including specific examples in respect of primary care at section 1.2.3.7, Warrington place at section 1.2.7.8, sustainability at section 1.2.8.17. Our Workforce Strategy described further in section 1.2.8.22 will include an education plan that will articulate the role of education and research in securing healthcare staff supply and responding to changing service models, as well as the role of trainees in service delivery.
- **14Z42 Duty to promote integration** - as part of a mature partnership model in Cheshire and Merseyside, working across sectors, the Joint Forward Plan ensures that NHS Cheshire and Merseyside develops activities and works in ways which promote and enable integration. The integrated approaches adopted in Cheshire and Merseyside ensure that health services, social care and health-related services are designed and delivered in ways which align to support attainment of the whole systems shared outcomes and commitments. This is illustrated throughout sections 1.2.6 and 1.2.7.

- **14Z43 Duty to have regard to wider effect of decisions** - the outcomes defined through the Health and Care Partnership Strategy and Joint Forward Plan, and our underpinning governance and decision making processes described in sections 2.2.1.5 and 2.2.2.4 to 2.2.2.15 ensure NHS Cheshire and Merseyside is clear on the impacts of decisions, and responsive to the 'triple aims' of health and wellbeing of the people of England, quality of healthcare services for the purposes of the NHS and sustainable and efficient use of resources by NHS bodies.
- **14Z44 Duties as to climate change** - across our Integrated Care System, we are committed to achieving net zero by 2040 (or earlier). All our NHS and local authority partners have well established plans to achieve this. NHS Cheshire and Merseyside has a strong Green Plan, that is delivering change and opportunity to deliver services in new and more Sustainability ways, whilst also delivering on the key priorities. Activities and achievements during the year are described in sections 1.2.8.17 to 1.2.8.18.
- **14Z45 Public involvement and consultation by Integrated Care Boards** – NHS Cheshire and Merseyside is committed to harnessing the power of meaningful engagement with our population to develop effective, responsive services. Section 1.2.8.5 to 1.2.8.14 describes the ICB's involvement approach, governance and infrastructure.
- **14Z49 Duty to keep experience of members under review** – the constitution of the NHS Cheshire and Merseyside Board and its supporting committees, described in the governance statement at section 2.2.1.5 and 2.2.2.4 to 2.2.2.15, collectively ensures the skills, knowledge and experience are available for the board effectively to carry out its functions. This has been kept under review and additional members recruited, in addition to regular board development activity during the year.
- **Contribution to the delivery of the Joint Health and Wellbeing Strategy** – the nine Cheshire and Merseyside Health and Wellbeing Boards are consulted on the development and refresh of the Joint Forward Plan. In addition to the at scale delivery across the Integrated Care System described in section 1.2.6, local place based partnership arrangements are charged with the development and delivery of place based plans described in section 1.2.7.

1.1.4 Key issues and risks

The key issues, nationally and locally, impacting on NHS Cheshire and Merseyside in 2023-24, together with the opportunities and actions being taken to mitigate the impact on future delivery and performance are described below:

- a number of periods of NHS industrial action throughout the year has had in particular a significant and continuing impact on the elective programmes for all providers in Cheshire and Merseyside, and on overall delivery of services. Throughout this the NHS Cheshire and Merseyside's Incident Management Team, supported by the Incident Coordination Centre and clinical cells, worked closely with all providers and NHS England to protect and maintain urgent and emergency care.
- the approved 2023-24 system financial plan was a deficit of £51.2m. However in November 2023, NHS England requested that Integrated Care Boards and providers re-submit system 2023-24 plans as part of the national settlement

responding to the significant impact of NHS industrial action. The revised system plan submitted to NHS England was a break-even position.

There remains a number of significant principal risks that continue to be managed and mitigated. Some of these risks continue into 2024-25 and feature in our Board Assurance Framework. The most significant principal risks identified by NHS Cheshire and Merseyside and the mitigating actions being taken are summarised below:

- there is a **critical risk** that NHS Cheshire and Merseyside is unable to achieve a system financial balance. This is a significant strategic challenge described further in section 1.2.8.23 and work continues across the system to develop and agree system-wide financial plans, cost improvement plans and a five-year Financial Strategy.
- there is a **critical risk** that 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. This is a significant strategic challenge described further in section 1.2.3.1 together with the actions taken to establish our System Co-ordination Centre and system-level operational planning and oversight.
- there is an **extreme risk** that demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population. This is a significant strategic challenge described further in section 1.2.3.7 together with the actions taken to develop and deliver the Primary Care Strategic Framework, Primary Care Access Recovery Plan and Dental Improvement Plan.
- there is an **extreme risk** that acute and specialist providers across Cheshire and Merseyside may be unable to reduce backlogs for elective and cancer care. This is driven by capacity constraints related to NHS industrial action, supply side issues and the impact of urgent and emergency care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access and poor clinical outcomes. This is a significant strategic challenge described further in sections 1.2.3.2 to section 1.2.3.4 together with the actions taken through our Elective Recovery Programme and Plans, Diagnostics Programme and Plans and the Cheshire and Merseyside Cancer Alliance work programme.

Whilst not scored as a critical risk on the Board Assurance Framework, there is a recognised risk that the time and resource to deliver against todays priorities, pressures and demands diverts attention and resource away from the delivery of the longer term initiatives outlined within the Health and Care Partnership strategy that will work towards having a long lasting impact on population health and which will help to mitigate financial and activity pressures.

Additionally, in August 2023, former neonatal nurse Lucy Letby was found guilty of seven counts of murder and seven counts of attempted murder while employed at the Countess of Chester Hospital NHS Foundation Trust (COCH) between June 2015 and June 2016. This case had a profound impact on patients, the local community and staff. NHS Cheshire and Merseyside's Chief Executive has provided a witness statement and supporting evidence to the Thirlwall Inquiry, established in

response to the case, on behalf of NHS Cheshire and Merseyside and its predecessor Clinical Commissioning Groups. This took significant time and attention, principally by COCH, but as the legal successor body to the former Cheshire CCGs, there was also significant impact on the ICB.

1.2 Performance Analysis

1.2.1 How performance is measured

Integrated Care Boards have a statutory function to arrange health services for their population and are responsible for performance and oversight of NHS services across their Integrated Care System.

The NHS Oversight Framework (NOF) supports Integrated Care Boards and NHS England to work together and develop proportionate and locally tailored approaches to oversight that reflect:

- a shared understanding of the ambitions, accountabilities and roles between NHS England, Integrated Care Boards, individual Trusts and local partnerships, and how performance will be monitored
- the unique local delivery and governance arrangements specifically tailored to the needs of different communities
- the importance of delivery against both the shared system priorities agreed between local partners and national NHS priorities.

NHS England has statutory accountability for oversight of both Integrated Care Boards and NHS providers. Integrated Care Boards are responsible for ensuring delegations to Place-based partnerships are discharged effectively and for leading the oversight of individual providers within their systems.

Prior to 2023-24 NHS England has historically been responsible for the oversight of Provider Trust's and associated segmentation decisions. A segmentation decision indicates the scale and general nature of support needs each Trust has, from no specific support needs (segment one) to a requirement for mandated intensive support (segment 4). During 2023-24 some of the operational elements of these oversight responsibilities were devolved to NHS Cheshire and Merseyside, working in partnership with NHS England North West, who retain statutory responsibility for the process.

NHS Cheshire and Merseyside has 16 NHS Acute, Specialised, Community and Mental Health Trusts, of these two Trusts are in segment one, which is described as "consistently high performing", nine Trusts are in segment two, which is the default segment and is described as "having plans to address any areas of challenge" and five Trusts are in segment 3 which is described as having "significant support needs" (Table One). There are no Trusts in segment 4, with Liverpool University Hospitals NHS Foundation Trust exiting segment 4 in November 2023.

Oversight of Providers in segment one and two is undertaken via business as usual contract, quality and performance arrangements at Place level, whilst those Trusts in segment 3 are overseen via a dedicated oversight forum, which allow focus on the

organisation's Improvement Plan and the provision of bespoke mandated support where this is required to support the necessary improvements.

Table One

Provider Trust	NOF Segmentation
Liverpool Heart and Chest Hospital NHS Foundation Trust	1
The Walton Centre NHS Foundation Trust	
Alder Hey Children's Hospital NHS Foundation Trust	2
Bridgewater Community Healthcare NHS Foundation Trust	
Cheshire and Wirral Partnership NHS Foundation Trust	
Mid Cheshire Hospitals NHS Foundation Trust	
Mersey and West Lancashire Teaching Hospitals Trust	
Mid Cheshire Hospitals NHS Foundation Trust	
The Clatterbridge Cancer Centre NHS Foundation Trust	
Warrington and Halton Teaching Hospitals NHS Foundation Trust	
Wirral Community Health and Care NHS Foundation Trust	
Countess of Chester NHS Foundation Trust	3
East Cheshire NHS Trust	
Liverpool University Hospitals NHS Foundation Trust	
Liverpool Women's NHS Foundation Trust	
Wirral University Teaching Hospitals NHS Foundation Trust	

The NOF focuses on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of wider Integrated Care Systems.

The oversight framework is built around:

- five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts and Integrated Care Boards: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability.
- a set of high-level oversight metrics, at Integrated Care Board and Trust-level, aligned to these themes.
- a sixth theme, local strategic priorities. This reflects the Integrated Care Board's contribution to the wider ambitions and priorities of its Integrated Care System and recognises:
  - that systems each face a unique set of circumstances and challenges in addressing the priorities for the NHS
  - that each Integrated Care Partnership will set out an integrated care strategy that its Integrated Care Board must have due regard to in planning and allocating NHS resources
  - the continuing ambition to support greater collaboration between partners across health and care, to accelerate progress in meeting the most critical health and care challenges and support broader social and economic development.

1.2.2 Performance monitoring systems and processes

NHS Cheshire and Merseyside has established a Quality and Performance Committee. Its remit includes to:

- receive, review and scrutinise the integrated performance reports for NHS Cheshire and Merseyside with a focus on quality, safety and patient experience and outcomes
- ensure that contract quality performance is monitored on a monthly basis (or other periods as agreed for certain contract types as appropriate)
- identify and scrutinise significant variations from plan of all Key Performance Indicators
- scrutinise the appropriateness and robustness of any management actions to address identified performance issues in relation to the quality of services
- ensure actual and forecast contract over-performance or under-performance is quantified in financial terms and activity terms
- benchmark recovery plans against trajectories
- agree which of the underperforming contracts need to be brought to the attention of NHS Cheshire and Merseyside
- ensure the implementation of the priorities set out in the Operational Planning Guidance
- oversee the ongoing delivery of procurements and any major service change, with a focus on quality, safety and patient experience in line with statutory requirements
- in relation to quality of services, seek assurance that the procurement of services is consistent with relevant laws and that conflicts of interest have been declared, managed and published as required.

The NHS Cheshire and Merseyside Board receives a performance report which provides on overview of key sentinel metrics drawn from the 2023-24 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact, and mitigations.

1.2.3 Performance metrics

1.2.3.1 Urgent and emergency care

Urgent and emergency services across England faced a wide range of pressures impacting the whole health and care system. At the end of 2023-24, the urgent and emergency care system in Cheshire and Merseyside continued to experience significant pressures.

The health and social care system prepared extensively for winter 2023-24, ensuring additional bed capacity that opened in 2022-23 was maintained, along with initiatives to both avoid admission and to facilitate discharge from hospital.

However, as seen the previous winter, a combination of pressures from respiratory illnesses including COVID-19 and issues discharging patients to the most appropriate settings resulted in an extended period of intense pressure.

While performance was marginally better through the winter of 2023-24, these factors resulted in a sustained period of very high bed occupancy - with significant numbers of patients who no longer met the criteria to reside in hospital remaining in acute hospital beds, resulting in reduced 'patient flow' and associated delays for patients in A&E and the community.

The majority of Trusts across Cheshire and Merseyside consistently reported at Operational Pressures Escalation Level (OPEL) 3 for an extended period throughout 2023-24 - defined as 'the local health and social care system is experiencing major pressures compromising patient flow'.

Cheshire and Merseyside's System Co-ordination Centre (SCC) - established in December 2022 - operates at an Integrated Care Board-level to lead and facilitate collaboration through senior system-level operational leadership on a day-to-day basis. It provides visibility of operational pressures and risks across providers and system partners to enable concerted action on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance issues.

NHS Cheshire and Merseyside continued to develop its SCC capabilities throughout 2023-24. A key element of this was the implementation of a new reporting system, SHREWD Resilience, for use by all our partners across Cheshire and Merseyside. This cloud-based tool displays a range of urgent care data in a dashboard view, giving users a real-time overview of what is happening in every part of our urgent care system – including A&Es, hospital wards, social care, community and mental health services, and to respond accordingly.

Our performance over the 2023-24 period, and as at end of March 2024 against the key urgent and emergency care metrics can be seen in Table Two, and which are summarised further in this section.

Table Two

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Urgent and Emergency Care										
Mean average time of all C1 responses	00:08:00	Mar-24	00:08:02	Mar-24	●	00:08:25	April 23 to Mar 24	●	00:08:20	●
Mean average time of all C2 responses	00:30:00	Mar-24	00:30:14	Mar-24	●	00:37:27	April 23 to Mar 24	●	00:33:50	●
Ambulance waiting more than 60 minutes from arrival to handover	0.00%	Mar-24	16.84%	Mar-24	●	15.34%	April 23 to Mar 24	●	10.00%	●
Ambulance waiting less than 30 minutes from arrival to handover	95.00%	Mar-24	43.69%	Mar-24	●	41.64%	April 23 to Mar 24	●	72.00%	●
Ambulance waiting less than 15 minutes from arrival to handover	65.00%	Mar-24	13.34%	Mar-24	●	15.94%	April 23 to Mar 24	●	34.10%	●
Patients waiting for more than four hours from arrival to conclusion in A&E	76.00%	Mar-24	61.10%	Mar-24	●	71.40%	Ave Apr 23 to Mar 24	●	74.40%	●
A&E 12 hour waits from arrival	2.00%	n/a	14.30%	Mar-24	●	15.60%	Ave Apr 23 to Mar 24	●	10.10%	●

Category 1 Ambulance standard: The national target is that these calls should be responded to within eight minutes. During 2023-24 the average performance in Cheshire and Merseyside against this target was eight minutes 25 seconds, which was an improvement on 2022-23 where the average performance was was eight minutes 42 seconds.

Category 2 ambulance standard: The national target is that these calls should be responded to within 18 minutes. A national recovery target of 30 minutes was in place for 2023-24. During 2023-24 the average performance in Cheshire and Merseyside against this recovery target was 37 minutes and 27 seconds, and improvement of 5 minutes from the average performance between 2022-23.
Ambulances waiting more than 60 minutes from arrival to handover: The national target is that no patient should wait longer than 60 minutes from ambulance arrival to handover to hospital staff. On average during 2023-24 15.34% of handovers exceeded this target in Cheshire and Merseyside. This was still an improvement on the 2022-23 average of 16.8%.

Patient waits from arrival in A&E: Based on the NHS Constitution, the national A&E waiting time target remains four hours. A national recovery ambition for 2023-24 expected 76% of patients would be seen within four hours. During 2023-24 the average performance in Cheshire and Merseyside against this target was 71.40%, an improvement on 2022-23 (70.81%).

A&E 12 hour waits from arrival: During 2023-24 on average 15.60% of patients waited in A&E for longer than 12 hours. The primary cause for this has been insufficient bed capacity within our hospitals to admit all patients requiring a hospital bed. This has led to patients having to wait for a bed in A&E or on an assessment unit.

1.2.3.2 Planned care

Planned, or elective care, covers a broad range of non-urgent services, usually delivered in a hospital setting, from diagnostic tests and scans to outpatient care, surgery and cancer treatment.

COVID-19 had a significant impact on the delivery of elective care, meaning that many patients have since been waiting longer for treatment than they were before the pandemic began. NHS hospitals have since been focusing on the recovery of elective services, building capacity back up and working to eliminate the longest waits for treatment.

Elective recovery funding has been made available to each Integrated Care Board to support the delivery of the elective recovery programme. Cheshire and Merseyside's target for 2023-24 initially required the system to deliver 105% of the elective activity delivered during 2019-20. However, this was reduced in year to 101% to account for the impact of industrial action. Despite Cheshire and Merseyside reporting high levels of industrial action, the ICB delivered 107.10% of the elective activity from 2019-20 during 2023-24, exceeding the target.

The Cheshire and Merseyside Acute and Specialist Trusts (CMAST) provider collaborative hosts the Cheshire and Merseyside Elective Recovery Programme. The programme is a key enabler for the elective activity and the reduction of the longest waits for treatment.

The programme has been instrumental in the significant progress made towards eliminating 104 and 78 week waits and has facilitated the provision of mutual aid

between hospitals in Cheshire and Merseyside for more than 7,970 patients in order to expedite their treatment. The programme has also played a key role in driving improvements in theatre productivity and in mobilising additional elective capacity.

Our performance over the 2023-24 period, and as at end of March 2024 against the key planned care metrics can be seen in Table Three, and which are summarised further in this section.

Table Three

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Planned care										
The number of incomplete Referral to Treatment (RTT) pathways (patients waiting to start treatment) of 104 weeks or more at the end of the reporting period	0	Mar-24	2	Mar-24		2	Mar-24		232	
The number of incomplete RTT pathways (patients yet to start treatment) of 78 weeks or more	0	Apr-23	123	Mar-24		123	Mar-24		4,770	
The number of incomplete RTT pathways (patients yet to start treatment) of 65 weeks or more	880	Mar-24	2,195	Mar-24		2,195	Mar-24		48,968	
The number of incomplete RTT pathways (patients yet to start treatment) of 52 weeks or more	Reduction from March 22 (16,604)	Mar-23	15,237	Mar-24		15,237	Mar-24		309,300	
The percentage of patients who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), that were waiting less than 18 weeks at month-end	92%	Mar-24	56.00%	Mar-24		56.00%	Mar-24		57.20%	
Elective recovery - increase elective activity by 10% - overall	106%	Mar-24	111.10%	Mar-24		107.10%	Apr 23 to Mar 24		103.50%	
Elective Recovery - Increase elective activity by 10% - Admitted care	106%	Mar-24	96.70%	Mar-24		102.40%	Apr 23 to Mar 24		101.20%	
Elective Recovery - Increase elective activity by 10% - Daycase	106%	Mar-24	100.80%	Mar-24		110.50%	Apr 23 to Mar 24		106.10%	
Elective Recovery - Increase elective activity by 10% - First outpatient	106%	Mar-24	99.60%	Mar-24		107.50%	Apr 23 to Mar 24		109.10%	
Reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023	-25% reduction	Mar-24	+6.9%	Mar-24		.+0.1%	Apr 23 to Mar 24		+2.9%	
Expanding the uptake of Patient Initiated Follow Up (PIFU) to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023.	5%	Mar-24	2.50%	Mar-24		2.50%	Mar-24		3.00%	

104-week waits: The national ambition was that during 2023-24 no patients waited in excess of 104 weeks and that such waits should only occur in exceptional cases. As at the end of March 2024 there were two patients waiting over 104 weeks in Cheshire and Merseyside, an improvement on the previous year (16 patients as at end of March 2023).

78-week waits: The national ambition was to eliminate waits in excess of 78 weeks by the end of March 2024. Significant progress was made during the course of 2023-24 to achieve this ambition, with there being 123 patients waiting over 78 weeks in Cheshire and Merseyside as at the end of March 2024.

65-week waits: Due to the impact of NHS industrial action and operational challenges more widely, NHS England revised its ambition to eliminate all 65-week waits by March 2024 to September 2024. Significant progress was made over the course of 2023-24 to treat the total cohort of 183,097 patients who could have breached 65 weeks, with only 2,195 patients waiting over 65 weeks in Cheshire and Merseyside (as at end of March 2024).

52-week waits: Prior to the pandemic, waits of more than 52 weeks for elective treatment had been eliminated across Cheshire and Merseyside. The ultimate goal is to return to this position, via achievement of the milestones above for the elimination of 104, 78 and 65 week waits. As at the end of March 2024 there were 15,237 patients waiting over 52 weeks in Cheshire and Merseyside.

1.2.3.3 Diagnostics

Our performance over the 2023-24 period, and as at end of March 2024 against the key diagnostic metrics can be seen in Table Four, and which are summarised further in this section.

Table Four

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Diagnostics										
Increase the number of diagnostic tests to at least 120% of pre-covid baseline	120%	Mar-24	154.10%	Mar-24	●	150.3%	YTD to Mar 24	●	114.20%	●
The proportion of patients waiting more than 6 weeks for a diagnostic test at the end of each month.	Less than 10%	Mar-24	9.95%	Mar-24	●	18.74%	YTD to Mar 24	●	25.09%	●

For diagnostics the national ambition was that by the end of March 2024 less than 10% of patients would have been waiting more than six weeks for a diagnostic test, with a recovery ambition of 95% of patients receiving a test within six weeks by March 2025. This was achieved in Cheshire and Merseyside, by March 2024 9.95% of patients had been waiting for more than six weeks for a diagnostic test.

A further national ambition was set for 2023-24, requiring 120% of 2019-20 activity levels to be delivered across a range of seven common diagnostic modalities. Cheshire and Merseyside is operating at 146% year to date at January 2024, compared to a national average of 111%. During 2023-24 the ICB delivered 154.10% of the diagnostic activity from 2019-20, exceeding the target.

As at the end March 2024, the Cheshire and Merseyside Integrated Care System was the only ICS out of 42 nationally to meet the 90% target for patients seen within six weeks.

Case Study: Diagnostic services win funding to accelerate the use of AI to help diagnose lung cancer patients quicker

NHS Cheshire and Merseyside's Radiology Imaging Network (CAMRIN) has secured funding from the NHS Transformation Directorate's AI Diagnostic Fund to accelerate the deployment of AI to help diagnose lung cancer patients quicker.

Up to £1.2m has been awarded to Cheshire and Merseyside to accelerate the implementation of an AI imaging and support tool which can analyse chest X-ray images and identify possible signs of lung cancer.

The tool, which will be rolled out to nine acute and specialist NHS trusts across Cheshire and Merseyside, can identify nodules and masses on chest X-rays to both ensure those patients can be prioritised and reduce the administrative burden on clinical staff.

CAMRIN's AI for Chest X-Rays Project will help to reduce the time taken for Cheshire and Merseyside patients to receive a diagnosis and treatment, when referred by their GP.

1.2.3.4 Cancer

The Cheshire and Merseyside Cancer Alliance (CMCA) leads on developing and improving NHS cancer services on behalf of NHS Cheshire and Merseyside. The Cancer Alliance oversees a comprehensive portfolio of programmes leading on prevention, earlier diagnosis, improving operational performance, developing the workforce and addressing health inequalities. Its focus is on creating better cancer services, better cancer care and better cancer outcomes for the population of Cheshire and Merseyside, including reducing variation and ensuring the best patient experience across the region. The Cancer Alliance works closely with all Cheshire and Merseyside NHS services supporting improved efficiency and productivity with funding and project resources through the faster diagnosis programme.

Case Study: Initiative to address inequalities - Targeted Lung Health Check (TLHC) programme

Lung cancer disproportionately impacts our most disadvantaged communities, with the incidence of lung cancer being 158% higher in the most deprived quintile neighbourhoods than the least.

Most lung cancers are diagnosed at a late stage (circa 70%) resulting in very poor outcomes. The Targeted Lung Health Check programme offers past and current smokers between the ages of 55 and 74 a free health check with the aim of detecting lung cancer at an early stage before it becomes symptomatic. The programme is being rolled out across all nine Cheshire and Merseyside Places, starting in the Places with the highest levels of deprivation and poorest lung health.

The programme is proving to be a great success, with over 75% of the lung cancers diagnosed through the programme being detected at an early stage, with most patients being treated with curative intent. Cheshire and Merseyside is rolling out the programme faster than most other areas and is expected to cover the whole Cheshire and Merseyside population by 2027 - ahead of the national expectation. To date, over 120,000 screening invitations have been sent out to residents in Cheshire and Merseyside, representing approximately 10% of the number of invitations sent out nationally.

Our performance over the 2023-24 period, and as at end of March 2024 against the key cancer metrics can be seen in Table Five, and which are summarised further in this section.

Table Five

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Cancer										
Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	75%	Mar-24	76.00%	Mar-24	●	70.00%	Ave 12 months to Mar 24	●	77.30%	●
2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	85%	Mar-24	75.40%	Mar-24	●	69.80%	Ave 12 months to Mar 24	●	68.70%	●
1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	96%	Mar-24	92.40%	Mar-24	●	93.80%	Ave 12 months to Mar 24	●	91.00%	●

Overall, 75% of patients should receive a diagnosis or ruling out of cancer within 28 days of referral, however some cancer pathways consistently achieve above 75% (e.g. skin and breast), whilst other, more complex pathways consistently dip below 75% (e.g. urology and lower GI). NHS England has recommended tumour-specific goals for Faster Diagnosis Standard performance for these four main cancer types.

It should be noted that ever higher numbers of patients are being referred and diagnosed or having cancer ruled out. On average during 2023-24 in Cheshire and Merseyside the overall percentage of patients who had cancer diagnosed or ruled out on a 28-day Faster Diagnosis Standard pathway was 70.00% compared to 77.30% of patients nationally. As of March 2024, Cheshire and Merseyside exceeded the national target by ensuring 75% of patients received a diagnosis or ruling out of cancer within 28 days of referral. It is expected that this performance will be maintained throughout 2024-25.

First definitive treatment for cancer within 62 days of referral: The national ambition for 2023-24 was that 85% of patients should receive a first definitive treatment for cancer within 62 days of referral. On average during 2023-24 in Cheshire and Merseyside the overall percentage of patients who had a first definitive treatment for cancer within 62 days was 69.80% compared to 68.70% nationally. **Wait from a decision to treat/earliest clinically appropriate date to first or subsequent treatment of cancer: The national ambition for 2023-24 was that 96% of patients should receive definitive treatment for cancer within 31 days of a decision to treat/earliest clinically appropriate date.** On average during 2023-24 in Cheshire and Merseyside the overall percentage of patients who were treated within 31 days of a decision to treat in Cheshire and Merseyside was 93.80% compared to 91.00% nationally.

Case Study: Da Vinci Robot

Our Cheshire and Merseyside Surgical Centre at Clatterbridge Hospital is treating even more patients, including those with cancer, thanks to a new, state-of-the-art £2m Da Vinci robot.

Funded through Cheshire and Merseyside Cancer Alliance (CMCA), the initiative uses advanced technology to enable surgeons to operate with greater accuracy. As well as resulting in better outcomes for patients, it also supports faster recovery times with most people being able to go home the very next day.

Following the introduction of more of the latest equipment and the opening of two more theatres, more than 6,000 **more** patients from across Cheshire and Merseyside will now be treated at the centre each year. Patients will also benefit via faster access to care.

1.2.3.5 Mental Health

Mental health providers across Cheshire and Merseyside experienced significant service pressures in 2023-24, both as a direct result of winter pressures and as a symptom of challenges across the wider system.
Increased demand, acuity and complexity of cases resulted in system-wide pressure and adverse impacts on mental health acute care flow. Mental Health Delayed Transfers of Care remain on an ongoing challenge, predominantly as a result of limited supported housing, nursing homes and suitable community placements.

Continued progress is being made in implementing new integrated models of community care and further developing crisis models to improve patient flow.

Our performance over the 2023-24 period, and as at the end of March 2024 against the key Mental Health metrics can be seen in Table Six, and which are summarised further in this section.

Table Six

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Mental Health										
The number of IAPT Referrals Entered Treatment	Ave 18,181 per quarter; 6,060 ave per month	Mar-24	4,305	Mar-24		68,880	April 23 to Mar 24		n/a	
Inappropriate use of out of area Mental Health bed days	900 in quarter, 3600 in year	Mar-24	325	3 months to Feb 24		8,070	Apr 23 to Feb 24		n/a	
Dementia Diagnosis Rate	67.00%	Mar-24	67.00%	Mar-24		66.20%	Ave 12 months to Mar 24		64.80%	
Proportion of children with Eating Disorder (routine cases) that start treatment within 4 weeks	95.00%		94.00%	Q4 2023/24		93.25%	Ave 12 months to Mar 24		79.10%	
Proportion of children with Eating Disorder (Urgent cases) that start treatment within 1 week	95.00%		100.00%	Q4 2023/24		100.00%	Ave 12 months to Mar 24		73.30%	
People with severe mental illness having a full physical health check in the previous 12 months	75.00%	Mar-24	57.80%	Q4 23/24		48.40%	Ave 12 months to Mar 24		68.50%	
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services	20,600		24,885	Mar-24		24,885	rolling 12 months to Mar 24		n/a	
People with a first episode of psychosis beginning treatment within 2 weeks	60.00%	Mar-24	78.00%	Mar-24		71.00%	Ave 12 months to Mar 24		69.80%	
Children and young people accessing mental health services as % of LTP trajectory (planned number)	100%	Mar-24	90.00%	Mar-24		87.80%	Ave 12 months to Mar 24		94.00%	
Talking Therapies recovery rate	50.00%	Mar-24	51.00%	Mar-24		50.16%	Ave 12 months to Mar 24		48.10%	
Women accessing perinatal Mental Health services	100%	Mar-24	106%	Mar-24		106%	Mar 24 YTD		83.00%	

Talking Therapies: The aim for Cheshire and Merseyside was that an average of 6,060 patients referred to the IAPT service entered treatment each month. This was not achieved during 2023-24, when the average monthly number of patients entering treatment was 5,740. Work is ongoing to increase awareness of talking therapies services, supported by a national campaign, and simplified self-referral pathways and pathways for people with long-term conditions and cancer.

The national aim is that 100% of the planned number of women expected to access perinatal mental health services in the LTP trajectory will access services. This target was achieved by July 2023 and as of March 2024 performance was 106%. The service is fully meeting the extended period of care of 24 months and offering partner assessment, as outlined in the NHS Long Term Plan.

Dementia Diagnosis: The national ambition for 2023-24 was that 67% of people with dementia in England should have a diagnosis, with appropriate post-diagnostic support. On average during 2023-24 in Cheshire and Merseyside the overall

percentage of people who met this standard was 66.20% compared to 64.8% nationally.

Inappropriate use of Out Of Area bed days: During the first three quarters of 2023-24, NHS Cheshire and Merseyside was unable to meet the national ambition of eliminating out of area placements for adults in acute inpatient care due to pressures across the system. However, despite continued high demand, there were no inappropriate out of area admissions by the end of the year.

Eating Disorders: The national ambition for 2023-24 was that 95% of routine and urgent cases of Children and Young People with an Eating Disorder would be seen within 4 weeks and 1 week respectively.

On average during 2023-24 in Cheshire and Merseyside the overall percentage of routine cases that started treatment within 4 weeks was 93.25% compared to 79.10% nationally.

Case Study: Utilising Experts by Experience

Cheshire and Merseyside residents with direct experience of services for eating disorders and specialist children and young people's mental health are playing a central role in helping to shape and improve care for future patients.

Our NHS-led provider collaborative for mental health has established Experts by Experience forums to ensure patients, their families and carers are involved in work programmes to improve services.

With the aim of delivering care closer to home, investing in community services and driving improvements in patient outcomes and experience, eating disorders support is available via EmpowerED Adult Eating Disorders North West and Level Up Cheshire and Merseyside Young People and Families.

Molly, EmpowerED forum member, said: "It really is empowering to be a part of the forum and I love doing the work we do because it feels like we're making progress and making real change. Everything I say feels like it's listened to and gets taken forward and taking seriously."

Georgia, Level Up forum member, said: "It gives me a purpose, and as an ex-service user for inpatient services it gives me a unique perspective and I feel like I'm truly able to give back and act as a voice for people who have previously not felt heard."

People with severe mental illness having a full physical health check in the previous 12 months: The national ambition for 2023-24 was that 75% of people with severe mental illness would have undergone a full physical health check in the previous 12 months. An increase in the number of health checks completed was

occurred during quarter 4, at which point 57.80% of people had undergone a health check. A recovery plan is being developed for 2024-25.

People with a first episode of psychosis beginning treatment within 2 weeks: The national ambition for 2023-24 was that 60% of people with a first episode of psychosis would begin treatment within two weeks. On average during 2023-24 in Cheshire and Merseyside the overall performance against this ambition was 71.0% compared to 69.8% nationally.

Children and young people accessing mental health services as % of LTP trajectory (planned number): The national ambition is that 100% of the planned number of children and young people expected to access mental health services in the LTP trajectory will access services. Nationally published data indicated that the Children and Young People access target for NHS Cheshire and Merseyside was not met. However, access increased throughout the year to 87.8% on average during 2023-24 compared to 94.00% nationally.

Case Study: Increasing uptake of NHS Health Checks in target groups

By working innovatively, we have seen significant increases in the uptake of preventative health checks amongst priority groups who are at highest risk of dying from heart disease (CVD).

Thanks to NHS England's Prevention Programme and Core20PLUS5 funding, a series of local pilots were launched to increase the uptake of NHS Health Checks and Annual Physical Health Checks for patients with severe mental illness, who are among those with the highest health needs.

Pilots were established in Cheshire West, Halton, Wirral, Liverpool, Sefton and St Helens and worked directly with patients from local target groups to co-design approaches to increase uptake of preventative health checks. Sites worked with eligible patients in areas of higher deprivation, including with minority ethnic groups and people who misuse alcohol.

Local insights from communities, patients and GP practices highlighted barriers to uptake in target groups which has helped to inform locally developed solutions in a number of settings.

Talking Therapies recovery rate: The national ambition is that at least half of people who complete a course of treatment should recover. On average during 2023-24 50.16% of people met this ambition compared to 48.10% nationally.

Women accessing perinatal Mental Health services: The national aim is that 100% of the planned number of women expected to access perinatal mental health services in the LTP trajectory will access services. This target was achieved by July 2023 and as of March 2024 performance was 106%. The service is fully meeting the extended period of care of 24 months and offering partner assessment, as outlined in the NHS Long Term Plan.

Case Study: Urgent Community Response for Mental Health

In August 2023, a new service was launched to help support children and young people experiencing a mental health crisis in Warrington, Halton, St Helens and Knowsley.

The 24/7 crisis response team is delivered by Mersey Care NHS Foundation Trust's Child and Young People's Mental Health Service. It provides an emergency response and full risk assessment to vulnerable children and their families within four hours. The service works closely with social care, schools and other professionals to help to provide a rapid response alternative staffed by mental health specialists – thereby reducing pressure on A&E.

The service had an immediate impact, with 144 emergency referrals made to the service within its first month, rising to 217 in the following month.

1.2.3.6 Learning disability and autism

Cheshire and Merseyside has a Transforming Care Partnership, comprising the nine local authorities in Cheshire and Merseyside, NHS Cheshire and Merseyside and the two NHS mental health and disability providers. This partnership aims to reduce admissions and inpatient numbers of those with a learning disability and / or autism of all ages, reduce health inequalities and improve provision and support available in the community.

Our performance over the 2023-24 period, and as at the end of March 2024 against the key Learning Disability and Autism metrics can be seen in Table Seven, and which are summarised further in this section.

Table Seven

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Learning disability & autism										
Learning disability registers and annual health checks delivered by GPs	75%	Mar-24	91.40%	Mar-24	●	91.40%	Apr 23 to Mar 24	●	88.20%	●
Inpatient care for people with learning disability and/or autism	60	Mar-24	96	Mar-24	●	107.4	Avg Apr 23 to Mar 24	●	84	●

Learning Disabilities Health Checks: The national ambition is that by year end for 2023-24 at least 75% of people aged 14+ with a learning disability will have an Annual Health Check. This was achieved in Cheshire and Merseyside by February 2024.

Inpatient care for people with learning disability and / or autism (adult): For 2023-24 Cheshire and Merseyside were set a target that by March 2024 60 or fewer adults with learning disability and/or autism will be receiving inpatient care (Integrated Care Board and Specialised Commissioning combined figures).

There are currently 96 adult inpatients, of which 51 inpatients are commissioned by NHS England's Specialised Commissioning Team and 45 by the Integrated Care

Board. Excluding patients on Section 17 leave there were 61 inpatients at the end of Q4 2023-24.

1.2.3.7 Community and Primary Care

Our performance over the 2023-24 period, and as at the end of March 2024 against the key Community and Primary care metrics can be seen in Table Eight, and which are summarised further in this section.

Table Eight

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Community and Primary Care										
Number of appointments in General Practice	1,325,309	Mar-24	1,266,049	Mar-24		1,267,143	Avg Apr to Mar 24		n/a	
The number of extended access appointments booked excluding did not attends	58,567.5 (Ave qtr)		45,820	Q4 23/24		39,692	April to Mar 24		n/a	
The number of people discharged by location and discharge pathway per month	21,967	Mar-24	17,108	Mar-24		178,516	April to Mar 24		n/a	
Hospital discharge pathway activity - pathway 0	20,648	Mar-24	14775	Mar-24		155,788	April to Mar 24		n/a	
Hospital discharge pathway activity - pathway 1	545	Mar-24	1125	Mar-24		10,515	April to Mar 24		n/a	
Hospital discharge pathway activity - pathway 2	377	Mar-24	602	Mar-24		5985	April to Mar 24		n/a	
Hospital discharge pathway activity - pathway 3	397	Mar-24	606	Mar-24		6,228	April to Mar 24		n/a	
The number of patients that the virtual ward is able to simultaneously manage	590	Mar-24	448	Mar-24		448	Mar-24		n/a	
Number of patients waiting at a point in time aggregated for a, in scope CYP and b, in scope Adult services	163,586	Mar-24	66,508	Mar-24		66,508	Mar-24		n/a	
Number of CYP (0-17 years) on community waiting lists per system	51,446	Mar-24	20,826	Mar-24		20826	Mar-24		n/a	
Number of Adults (18+ years) on community waiting lists per system	112,140	Mar-24	45,682	Mar-24		45,682	Mar-24		n/a	
Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	70.00%	Mar-24	80.00%	Mar-24		83.40%	Avg Apr to Mar 24		83.50%	

Appointments in general practice and extended access: The target for 2023-24 was to provide 14,987,776 appointments in general practice over the year. This standard was met, with a total of 15,133,022 appointments in the 2023-24 financial year. For Extended Access, a provision of 135,405 was made for the 2023-24 financial year, which equates to 33,851 per quarter. This did not meet the standard of an average of 58,567.5 extended access appointments per quarter. The number of appointments has also increased significantly since 2022 and there are now more ways to access general practice services. Work continues to build capacity across Cheshire and Merseyside including through investment in additional roles, improvements in technology and investment in premises, and to address inequalities in access.

Continued development of Urgent Community Response (UCR): The national ambition for 2023-24 was that the service responded to least 70% of calls within two hours. This standard was met in Cheshire and Merseyside throughout 2023-24, with an average response rate of 83.40%. Furthermore, the performance rate has been maintained through a period of growth for Cheshire and Merseyside's UCR services where the total number of referrals accepted by the service increased by almost 1,000 referrals per month.

Increase the delivery of Virtual Wards: Virtual Ward 'bed' capacity was planned to increase on a phased basis from 340 to 590 during 2023-24. Currently the focus of

Cheshire and Merseyside virtual wards is on respiratory, frailty, heart failure and cancer. This aim was not met during 2023-24, as of March 2024 virtual wards within Cheshire and Merseyside were able to care for 448 patients simultaneously.

Case Study: Community Home First in Cheshire West

A partnership of charities across Cheshire West is working together to provide the Community Home First service, alongside NHS staff at the Countess of Chester Hospital.

Community Home First is a new initiative which not only helps medically fit people get ready to leave the hospital, but also assists with arranging comprehensive support to prevent readmission once they are home.

Cheshire Community Action employs community connector staff - based at both the Countess of Chester Hospital and Leighton Hospital. Their role is to talk to people in the hospital who are well enough to leave and help them to tackle any practical problems that may prevent discharge.

After discharge, the local social enterprise Snow Angels also offers six weeks of support at home for older patients identified as at risk with the help of clinical staff. This includes social check-ins, shopping and prescription drop-offs. Scheme partner Age UK Cheshire also offers dedicated home visits to newly discharged patients who require a more holistic and comprehensive level of support to aid their recovery and maintain independence. Cheshire and Warrington Carers Trust completes the service by providing specialist support at a vital time to carers.

1.2.3.8 Quality and Safety

Performance against a range of national and locally agreed performance data including waiting times, infection rates and patient experience metrics is monitored to assess the system's quality and safety performance. Our performance over the 2023-24 period, and as at the end of March 2024 against the key quality and safety metrics can be seen in Table Nine, and which are summarised further in this section.

Table Nine

	Latest performance					Year to Date performance			Comparison to England	
	Target	By when	Latest position	Period		YTD performance	Period		England Average	
Quality										
Mixed sex accommodation breaches	0	Mar-24	36	Mar-24		315	April 23 to Mar 24		n/a	
HCAI - MRSA (all cases) (provider aggregation - Count)	0	Mar-24	1	Mar-24		32	April 23 to Mar 24		n/a	
HCAI - C-diff (all cases) rolling 12 month against threshold value (provider aggregation)	100%	Mar-24	138%	rolling 12 months to Mar 24		138%	rolling 12 months to Mar 24		132.20%	
HCAI - E-coli (all cases) rolling 12 month against threshold value (provider aggregation)	100%	Mar-24	157%	rolling 12 months to Mar 24		157%	rolling 12 months to Mar 24		125.00%	
Still birth per 1,000 (rolling 12 months)	n/a	Mar-24	2.69	Feb-24		2.69	rolling 12 months to Feb 24		3.33	
Summary Hospital-level Mortality Rate (SHMI)	0.887 to 1.127	Mar-24	1.017	Dec-23		1.029	Average April to Dec 23		1.000	
Never Events	0	Mar-24	3	Mar-24		25	April 23 to Mar 24		n/a	
21+ day Length of Stay	1541	Mar-24	1413	Mar-24		1320	Average April 23 to March 24		n/a	

Never Events
Never Events are defined as 'Serious Incidents that are preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'. From 01 April 2023 - 31 March 2024 there were 26 Never Events recorded across Cheshire and Merseyside - 11 due to wrong site surgery, six retained foreign objects, four wrong implant or prothesis, three administrations of medicines by the wrong route, one unintentional incompatible blood transfusion and one fall from a window.

Health Care Acquired Infections - Clostridium Difficile(Cdifficile)
Healthcare-associated infections can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. Despite the Cheshire and Merseyside Cdifficile rate being above trajectory (578 cases) and higher than the national rate of 439 within a 12-month reporting period (January 2023 to January 2024) the rate of Cdifficile has seen a reduction month on month.

Summary Hospital Level - Deaths associated with hospitalisation (SHMI)
The SHMI is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on average England figures, given the characteristics of patients treated there. The SHMI rate as at October 2023 for Cheshire and Merseyside is 1.035. This is within the upper control limit of 0.887 to 1.127.

There is one outlier in Cheshire and Merseyside - NHS East Cheshire Trust. A review was undertaken via quality surveillance processes and NHS Cheshire and Merseyside will continue to monitor mortality rates throughout 2024-25 as part of its oversight responsibilities.

21-day+ length of stay - Reducing a patient's stay in hospital supports better outcomes for patients and enables people to return to their previous place of residence. NHS Cheshire and Merseyside have a local trajectory of 1,573 average bed days and have been working within this trajectory since April 2023. The latest figure in February 2024 is 1,396 average bed days.

Neonatal deaths per 1,000 - The latest local data[2] from the North West Neonatal Operational Delivery Network (NWNODN) dashboard covering the financial year 2023-24 (data source: BadgerNet) reports the following for Cheshire and Merseyside:

- Neonatal Intensive Care Unit (NICU) mortality rate of 2.5 per 1,000 live births compared to the North West average of 2.4
- Neonatal non NICU mortality rate of 0.6 per 1,000 live births compared to the North West average of 0.7.

[2] Latest published data available (data source: MBRRACE-UK) is for 2021

Whenever NHS Cheshire and Merseyside, and its component maternity providers, are identified as having higher than expected neonatal mortality rates in two consecutive quarters there is a detailed assurance process undertaken.

Due to Cheshire and Merseyside having a slightly higher NICU mortality rate than the North West average enhanced assurance work has been undertaken to better understand the underlying contributors for this rate. This has included internal and external reviews of mortality rates, alongside external network/peer review to ensure objectivity in reviewing the standards of care provided. The actions and recommendations from these reviews are monitored via the NWNODN, alongside oversight at Integrated Care Board level at the Local Maternity and Neonatal System (LMNS) Assurance Board. There were no singular/ specific causes for increased mortality identified through these review processes.

Ongoing work is focused on 'in-utero' transfers of care from Cheshire and Merseyside/North West providers into the largest tertiary Trust within Cheshire and Merseyside, and will be reviewed across 2024-25 to understand the potential impact on NICU mortality rates of correct antenatal pathways and transferring high-risk women.

In addition, the University of Liverpool alongside the NWNODN is researching the impact of demographics on pre-term birth mortality, with findings expected to be published within the financial year of 2024-25 with focus on region disparity in rates.

Stillbirth rate per 1,000 - Year to October 2023 data[3] (data source: SUS) reports a stillbirth rate of 3.0 per 1,000 births for Cheshire and Merseyside which is below the England rate of 3.7 for the same period.

All providers of maternity and neonatal care have declared full compliance with all 10 actions from the Maternity Incentive Scheme (Year 5) which includes all elements of the Saving Babies Lives Care Bundle:

- reducing smoking in pregnancy
- fetal growth
- reduced fetal movement
- effective fetal monitoring during labour
- reducing preterm births and optimising perinatal care
- management of pre-existing diabetes in pregnancy.

In addition, latest data for pre-term births (October 2023) shows that the national ambition to reduce the rate of pre-term births to 6% by 2025 has been achieved for Cheshire and Merseyside, against an England average of 6.3% for the same period. To improve performance against the metrics, the LMNS:

- continues to monitor and have oversight of the safety ambition trajectories and outlier status of providers
- support trusts in the delivery of the annual Maternity Incentive Scheme (including Saving Babies Lives Care Bundle) actions

[3] Hospital stillbirths only

- support providers in delivering effective Pre-term Birth Clinics
- provides C&M leadership to the North West Maternal Medicine Network and supports the Cheshire and Merseyside Maternal Medicine Centre (MMC) at Liverpool Women's Trust
- works closely with the NWNODN in order to progress the safety ambition to reduce serious intrapartum brain injury
- be responsive to emerging themes from Patient Safety Incident Response Framework, the Cheshire and Merseyside maternity single Serious Incidents Panel, complaints and feedback
- have real-time oversight of emerging threats and continue mutual aid support via an electronic SitREP data tool.

This is further supported by the progress made and planned to deliver on the Three-year delivery plan for maternity and neonatal services, including:

- enhanced and targeted continuity of carer (CoC) model – 13 teams have been rolled out by three providers across C&M, and 30.3% of women are on a CoC pathway, of which 35.5% are of Black, Asian, or mixed ethnicity and of which 29.1% are in the bottom decile of deprivation. The LMNS will continue to support all trust with plans to develop continuity of carer teams as the default model for all women, prioritising those in the most deprived areas and in the populations where there are high numbers of Black, Asian, and ethnic minority women and families.
- Cheshire and Merseyside LMNS were successful in securing investment to transform Perinatal Pelvic Health Service (PPHS) provision. As a result PPHS have successfully been rolled out across all maternity sites in advance of the national deadline, with a total of 6,686 referrals received during 2023 -24. A key element of this new service has been raising awareness and engagement around pelvic health amongst women from ethnic backgrounds, and addressing inequity of access.
- a Personalised Care Task and Finish Group has been established to support providers to ensure that all women in C&M are offered a Personalised Care and Support Plan (PCSP) as part of their maternity journey. The outcomes of audit activity, listening events, and quality improvement work will inform the further development and improvement of services during 2024-25.
- Cheshire and Merseyside LMNS has funded breavement services and as at April 24 all providers were compliant with this three year plan commitment. A Bereavement Care Task and Finish Group to support providers to achieve full compliance against the National Bereavement Care Pathway (NBCP) standards for pregnancy and baby loss by March 2025.
- the LMNS has a dedicated and experienced Engagement Team made up of local women, with lived experience, utilising networks and local community links and speaking five languages, the team works with women and families to understand barriers to care.

1.2.3.9 Health Inequalities and Improvement

Health inequalities and Improvement performance has been regularly provided to NHS Cheshire and Merseyside, with crucial metrics aligned with the NHSCORE20PLUS5 approach to tackling health care inequalities.

Quarterly reviews are submitted to NHS England Regional teams, providing significant detail and assurance on the range of Healthcare Inequalities Improvement areas and NHS Long Term Plan Prevention Programmes.

Hypertension Case Finding
The overall performance on optimising blood pressure testing demonstrates significant variation across Cheshire and Merseyside's nine Places. Overall performance has remained at 66% compared to a national target of 77%.

A new population health management enhanced case finding tool for primary care was introduced and expanded, including detection and case finding via new pathway partners (e.g. North West Ambulance Service and Cheshire Fire & Rescue). The Cheshire and Merseyside Happy Hearts website https://happy-hearts.co.uk/ (last checked on 14.06.24) has been refreshed in collaboration with the British Heart Foundation to include a blood pressure information toolkit for clinicians and patients. Place-level prevention plans have been developed to maximise local working between NHS, public health and Voluntary, Community, Faith and Social Enterprise sector leads.

Both the Board of NHS Cheshire and Merseyside and its Quality and Performance Committee receive performance updates on hypertension case-finding and interventions.

Children and Young People's Mental Health Access Rates
Children and Young People's (CYP) Mental Health Access rates continue to improve month on month. In January 2024 nationally reported access for NHS Cheshire and Merseyside showed that 33,065 children and young people had received at least one contact by a community mental health support service – compared to 27,995 12 months earlier.

NHS Cheshire and Merseyside is also engaging children and young people, parents and carers to better understand from them what works well and where improvements can be made. This is supporting a refresh of our Children and Young People Mental Health Plan and includes under-represented voices from the deaf community, LGBT+ and those living in areas of high deprivation.

All Together Smoke Free Cheshire and Merseyside
Radically reducing smoking prevalence remains the single greatest opportunity to reduce health inequalities and improve healthy life expectancy.

Reducing smoking prevalence is integral to Cheshire and Merseyside's approach to tackling inequalities - ensuring fair health for all and responding to NHS England's Core20Plus5 approach. Becoming Smokefree by 2030 creates a unique opportunity to reduce health inequality with the Office of National Statistics estimating that healthy life expectancy would increase by more than six years for men and seven years for women if Cheshire and Merseyside meets this target.

The Integrated Care System's development of an All Together Smokefree Cheshire and Merseyside Framework commenced during 2023-24, ensuring integration with

an effective NHS Treating Tobacco Dependency programme alongside community smoking cessation services. NHS Cheshire and Merseyside has led on new system-wide Tobacco Control Plan alongside the CHAMPS public health collaborative.

A Treating Tobacco Dependency (TTD) Forum has been established to support this work in our maternity and adult hospital trusts and NHS Cheshire and Merseyside continues to work with mental health services and a specialist TTD provider on a pilot programme for hospitalised mental health patients.

Tackling System Wide Health Inequalities
Oversight of our system-wide response to tackling health inequalities and social determinants of ill health is retained by Cheshire and Merseyside Health and Care Partnership. To baseline and monitor progress against the All Together Fairer recommendations, 22 Beacon indicators were established alongside health inequality dashboards for each Place to help monitor progress.

An annual stocktake and audit of All Together Fairer was published in January 2023. Progress against each of the Beacon Indicators was identified and led to the development of a refreshed strategy - All Together Fairer: Our Health and Care Partnership Plan for 2024-29.

In response to a national Health Inequalities statement duty to publish data against health inequality metrics, an interactive health inequalities dashboard is in development. Additionally, a Health Inequalities Annual Report 2023-24 has been produced, available on the ICB website at: www.cheshireandmerseyside.nhs.uk/latest/publications/reports/annual-reports/ (last checked on 14.06.24)

1.2.3.10 Emergency Preparedness, Resilience and Response

NHS Cheshire and Merseyside is a Category 1 responder under the Civil Contingencies Act 2004. The Act ensures that all NHS-funded organisations are prepared to respond to incidents and emergencies that threaten health and patient safety within the services it provides.

NHS Cheshire and Merseyside undertook a self-assessment against the Emergency Preparedness, Resilience and Response (EPRR) Core Standards in October 2023 and declared a position of non-compliance, with 28 out of 47 standards requiring further action to meet full compliance. While this does not automatically indicate poor preparedness, 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.

During 2023-24, the Director of Performance and Planning was also NHS Cheshire and Merseyside's Accountable Emergency Officer, supported by the Head of EPRR for the delivery of the EPRR Work Programme. To meet its statutory duties as a Category 1 responder, NHS Cheshire and Merseyside holds a portfolio of emergency and business continuity plans developed in consultation with corporate teams, Place teams and key stakeholders.

To support the system during multiple rounds of NHS industrial action during 2023-24, NHS Cheshire and Merseyside's EPRR Team developed an operational contingency plan to effectively prepare for, respond to and recover from each round of Industrial Action - with an aim to minimise disruption and support patient care. NHS Cheshire and Merseyside worked with Trusts to triangulate risks ahead of each day of proposed action and stood up an Incident Coordination Centre and Command-and-Control Structure.

Debriefs were undertaken after each round of industrial action to highlight lessons identified and notable practice. This was shared with multi-agency partners and used to inform the planning and response arrangements for upcoming industrial action and future incident response.

In total, NHS Cheshire and Merseyside led the response for Cheshire and Merseyside for 67 days during the period of 1 April 2023 - 31 March 2024.

Other incident responses co-ordinated by NHS Cheshire and Merseyside during 2023-24 include:

- loss of 999 system (25 June 2023) - a degradation was observed in the national 999 system by BT, which led to emergency service control rooms and users being warned that some 999 calls may be lost, resulting in delays connecting 999 calls to the ambulance service. All A&E departments were asked to take the required steps to ensure that no patient is held in an ambulance and immediate transfer of their care to the A&E department occurred upon arrival. The ICB Tactical Commander on the day participated in Local Resilience Forum (LRF) teleconferences which had been stood up. NHS 111 was utilised as a contingency option and normal service was resumed the same day.
- Amber Heat Health Alert (September 2023) – attendance to LRF meetings by the EPRR team throughout the health alert period
- M53 Road Traffic Collision (September 2023) - NHS Cheshire and Merseyside Tactical Commander and Strategic Commander attended Tactical Command Group (TCG) and Strategic Command Group (SCG) meetings respectively along with EPRR Team support throughout the day.
- Storm Babet (October 2023) – resulting in flooding across parts of Cheshire and road closures. Cheshire TCG stood up and attended by NHS Cheshire and Merseyside Tactical Commander along with EPRR Team support.
- Firearms incident - Showcase Cinema, Liverpool (January 2024)
- Unknown Contaminant Belle Vale Park, Liverpool (January 2024).

The EPRR team also played an important role in multi-agency planning for high-profile events across Cheshire and Merseyside, such as Eurovision, Creamfields and the 151st Golf Open.

NHS Cheshire and Merseyside developed and delivered two training exercises in 2023-24 and participated in 18 further multi-agency exercises, to test and validate plans. The team has also delivered 19 EPRR-specific training sessions.

1.2.3.11 Workforce

As at 31 March 2024, NHS Cheshire and Merseyside employed 1,081 staff. The headcount has increased by 46 compared to last year's headcount which was reported as 1,035 on 31 March 2023. There have been several TUPE transfers into the organisation over the last 12 months, the Local Maternity and Neonatal System service transferred in 27 staff during July 2023 followed by a number of NHS England and Midlands and Lancashire Commissioning Support Unit staff who transferred in over July and August 2023. There was a smaller TUPE of Mersey Internal Audit Agency staff which further increased the headcount in October 2023.

The sickness absence data for NHS Cheshire and Merseyside in the calendar year 2023 was whole time equivalent (WTE) days available of 215,681 and WTE days lost to sickness absence of 7,354 and average working days lost per employee was 7.67 which was managed through the absence management policy.

The Human Resources (HR) team worked closely with managers during Quarter Three and Quarter Four to help reduce the number of long-term absences which has seen a reduction in long-term cases during March 2024. HR skills workshops for absence management are in progress.

NHS Cheshire and Merseyside's Staff Turnover Rate for 2023-24 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The Total FTE Leavers in year was 126.94. The Average FTE Staff in Post during the year was 971.41 (2022-23 - 948.45). The Staff Turnover Rate for the year was 13.07% (2022-23 – 13.49%).

NHS Cheshire and Merseyside's staff turnover rate was reported regularly to its Board and Executive Team. Workforce data provided to NHS Cheshire and Merseyside by Midlands and Lancashire Commissioning Support Unit outlined all recorded reasons for staff leaving NHS Cheshire and Merseyside with the top three reasons being:

- Mutually Agreed Resignation Scheme
- Voluntary Resignation – Promotion
- Retirement Age.

A Mutually Agreed Resignation Scheme was initiated during Quarter Three of 2023-24 and a proportion of the leavers during Quarter Four were those who left as part of the scheme.

1.2.4 NHS Oversight Framework

The NHS Oversight Framework aligns to the priorities set out in the 2023-24 priorities and operational planning guidance and the legislative changes made by the Health and Care Act 2022 - including the formal establishment of Integrated Care Boards.

The purpose of the NHS Oversight Framework is to align priorities across the NHS and wider system partners, identify where Integrated Care Boards and / or NHS

providers may benefit from, or require, support and provide an objective basis for decisions about when and how NHS England will intervene.

The NHS Oversight Framework (NOF) supports Integrated Care Boards and NHS England to work together and develop proportionate and locally tailored approaches to oversight that reflect:

- a shared understanding of the ambitions, accountabilities and roles between NHS England, Integrated Care Boards, individual Trusts and local partnerships, and how performance will be monitored
- the unique local delivery and governance arrangements specifically tailored to the needs of different communities
- the importance of delivery against both the shared system priorities agreed between local partners and national NHS priorities.

NHS England has statutory accountability for oversight of both Integrated Care Boards and NHS providers. Integrated Care Boards are responsible for ensuring delegations to Place-based partnerships are discharged effectively.

Prior to 2023-24 NHS England has historically been responsible for the oversight of Provider Trust's and associated segmentation decisions. A segmentation decision indicates the scale and general nature of support needs each Trust has, from no specific support needs (segment one) to a requirement for mandated intensive support (segment 4). During 2023 - 24 some of the operational elements of these oversight responsibilities were devolved to NHS Cheshire and Merseyside, working in partnership with NHS England North West, who retain statutory responsibility for the process.

NHS Cheshire and Merseyside has 16 NHS Acute, Specialised, Community and Mental Health Trusts, of these two Trusts are in segment one, which is described as "consistently high performing", nine Trusts are in segment two, which is the default segment and is described as "having plans to address any areas of challenge" and five Trusts are in segment 3 which is described as having "significant support needs". Oversight of Providers in segment one and two is undertaken via business as usual contract, quality and performance arrangements at Place level, whilst those Trusts in segment 3 are overseen via a dedicated oversight forum, which allow focus on the organisation's Improvement Plan and the provision of bespoke mandated support where this is required to support the necessary improvements.

Upon establishment of Integrated Care Boards on 01 July 2022, NHS England allocated all Integrated Care Boards and Trusts into one of four ‘segments’. This segmentation is determined by assessing the level of support required based on a combination of objective criteria and judgement. Upon establishment NHS Cheshire and Merseyside was allocated to segment 3. This is defined as there being:

- significant support needs against one or more of the six oversight themes
- significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an Integrated Care Board

The six NHS Oversight Framework themes are:

- five national themes that reflect the ambitions of the NHS Long Term Plan and apply across Trusts and Integrated Care Boards: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability.
- a sixth theme, local strategic priorities. This reflects the Integrated Care Board's contribution to the wider ambitions and priorities of its Integrated Care System.

During 2023-24 NHS England and NHS Cheshire and Merseyside worked together to develop exit criteria to clarify what steps are required to deliver an improvement from segment three to segment two.

Quarterly review meetings are held with NHS England. The exit criteria issued in September 2023 in Table Ten:

Table Ten

Theme	Criteria
Quality of Care, Access and Outcomes	• delivery against 2023-24 operational plan objectives in line with segment two ICBs. • demonstrate sustained improving trajectory and no longer an outlier against England average for Urgent and Emergency Care (UEC)
Finance and use of resources	• plan to achieve financial balance • in-year (23/24) delivery of plan and an improving overall financial position over 2 quarters
Leadership and Capability	• the ICB has established quality governance assurance mechanisms, to oversee the constituent segment 3 organisations, and can demonstrate support has been provided to them to drive improvement. • the ICB can demonstrate a shared understanding of risks to the segmentation improvement plan and has robust mitigations in place. • the ICB has dedicated oversight arrangements to monitor the plan and sufficiently resourced delivery mechanisms (capacity and capability) to ensure improvement. As part of this, the system has agreed the post-exit support package and the regional team are satisfied that an appropriate level of support is in place.

The list of NHS Oversight Framework Metrics showing Cheshire and Merseyside performance, for the latest reporting period available, can be found in Appendix Two on pages 211 - 213.

As per the latest extract, NHS Cheshire and Merseyside fell within the highest performing quartile (top 25%) for six metrics, the interquartile range for 30 and were rated as being in the lowest performing quartile (bottom 25%) for 12 metrics under the following categories:

- elective care: Patients waiting more than 65 days to start consultant-led treatment
- healthcare acquired infections, E. coli and MRSA
- percentage of beds occupied by patients who no longer meet the criteria to reside
- cancer performance: Proportion of patients meeting the Faster Diagnosis Standard

- sickness absence rate for the NHS Cheshire and Merseyside workforce.
- learning disability and / or autism inpatients per million head of population (Adult)
- neonatal deaths per 1,000 live births.
- direct patient care staff in GP Practices and Primary Care Networks per 10,000 weighted population.
- antimicrobial resistance – prescribing of antibiotics in primary care.

For wider context about the work in each of these areas, please refer to the relevant sections in this report.

1.2.5 Health and Care Partnership Strategy

In January 2023, Cheshire and Merseyside Health and Care Partnership (HCP) - the sub-region's statutory Integrated Care Partnership - published a draft Interim HCP Strategy[4] with the intention of undertaking further work with stakeholders, including the public, to refine the strategy during the summer of 2023. This work enabled us to identify the priority focus areas within our Joint Forward Plan and to influence the scale of focus and investment into the various transformation programmes described in the document.

Having a consistent approach to planning across the system helps us to:
- proactively identify and communicate the alignment of all our plans both internally and externally
- prioritise plans and assign financial resources across our system more effectively
- provide cross-system visibility of plans to reduce duplication and assign our combined workforce more efficiently
- align resources to support public engagement and co-production within the plans.

NHS Cheshire and Merseyside has played a significant role in the development of the refreshed Health and Care Partnership plan, ***All Together Fairer: Our Health and Care Partnership Plan*** which is due to be published in June 2024.

This plan sets out our aim to even more closely align the work of our Health and Care Partnership with the recommendations made in All Together Fairer: Health equity and the social determinants of health.

Acting on the drivers of ill health, as well as treating ill health is helping to reduce inequalities and improve outcomes.

Throughout 2023-24 we worked with partners to establish our system priorities, with the endorsement of all nine Cheshire and Merseyside Health and Wellbeing Boards. These recommendations can be summarised into three core principles which will be embedded into our ongoing NHS Cheshire and Merseyside plans:
- shifting investment to prevention and equity
- anti-poverty work
- Health and Equity in All We Do.

[4] https://www.cheshireandmerseyside.nhs.uk/media/hxqpdrot/cheshire-merseyside-draft-interim-hcp-strategy-2023.pdf (last checked on 14.06.24)

Importantly, the All Together Fairer Report and recommendations were co-designed with local residents and community organisations in our nine Places.

1.2.6 Joint Forward Plan

The 2023-28 Joint Forward Plan was developed in response to nationally defined statutory and advisory requirements identified in the related NHS England guidance. A summary Annual Delivery Plan[5] was also developed and published which provided detail on the work taking place to progress the core themes and outlining the main outcomes from each of the priority programmes.

In developing our Joint Forward Plan, we adopted a collaborative approach, engaging with all nine Places and drawing on the wide range of expertise, knowledge and experience of health and care leaders and partners. We believe that all services should be co-produced with service users and / or carers as well as health and care professionals and system partners.

The Joint Forward Plan and associated Annual Delivery Plan were approved by the NHS Cheshire and Merseyside Board in June 2023. It was agreed that the existing Board sub-committees would be supported to ensure that their current reporting adequately describes progress against the Annual Delivery Plan.

Health and Care Partnership members have collaboratively used a Data into Action and segmentation approach to define several areas where we have poorer outcomes than other parts of England. These form priorities for improvement.

Diagram One provides a summary of the areas which our analysis tells us that our population experience worse outcomes when compared to the “England average”, and where our people have told us their experience of accessing care does not meet their expectations:

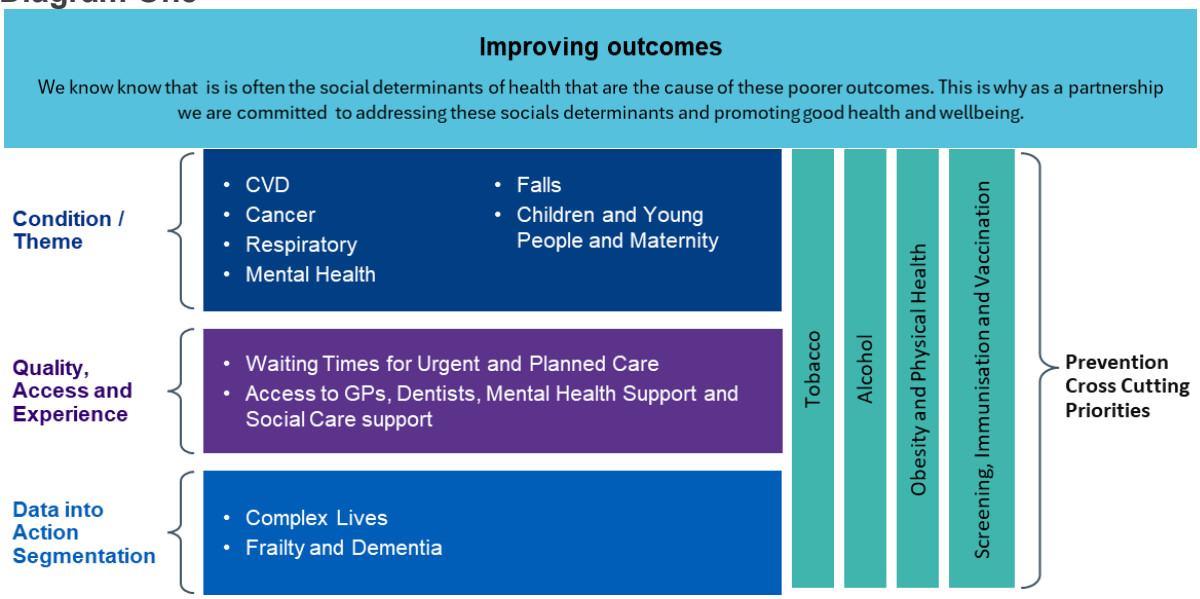
These priorities are threaded throughout the 2023-28 Joint Forward Plan and form the basis of our 2024-29 refresh.

The Joint Forward Plan also outlines how NHS Cheshire and Merseyside and its partners have supported the development of additional supporting strategies and plans for example the Cheshire and Merseyside Children and Young People’s Mental Health Transformation Plan, Digital and Data Strategy, Sustainability and Green Plans and our Efficiency at Scale Programme.

The remaining sections of the Performance Analysis describe the delivery of our Joint Forward Plan and key achievements during 2023-24.

[5] https://www.cheshireandmerseyside.nhs.uk/media/2kvcnuzm/summary-version-of-the-jfp-delivery-plan-260623.pdf (last checked on 140624)

Diagram One



Continuous Improvement

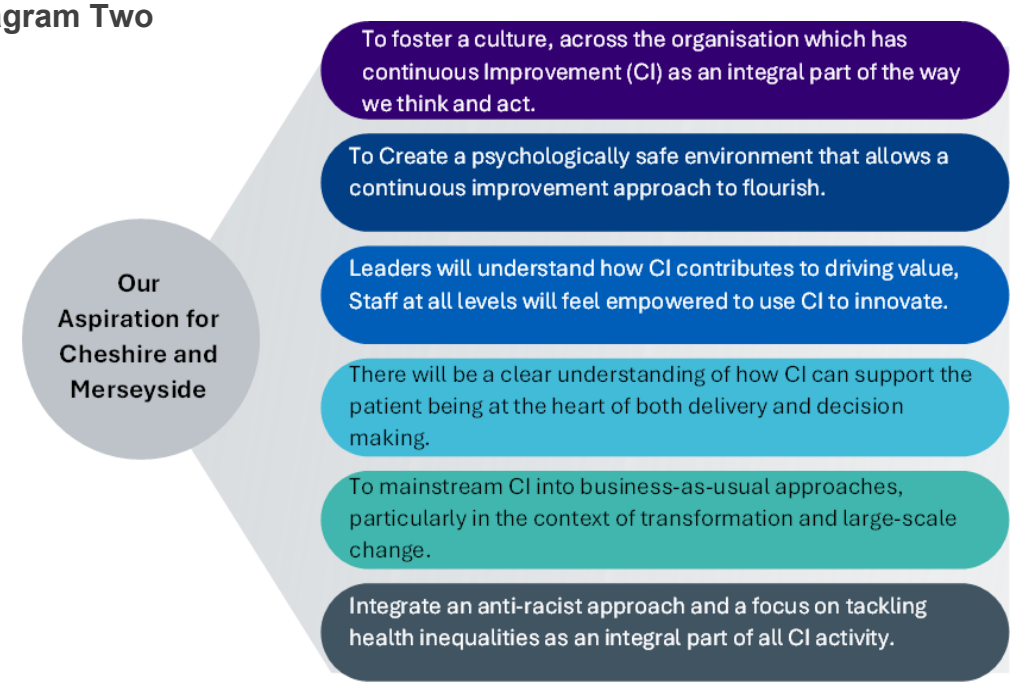
Our ambition is for NHS Cheshire and Merseyside to lead the way in health and care improvement and to be seen as a beacon of excellence locally, regionally and nationally. There is compelling evidence that diverse and multi-faceted benefits can flow from improvement approaches, and the critical role improvement culture can play in shaping the future of health and care.

We are at an early stage of adoption of continuous improvement techniques. While there are good examples of progress and best practice there is not yet a mature infrastructure to promote and support the adoption of Continuous Improvement systematically and consistently across the organisation.

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.

Our aspiration is 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 NHS Cheshire and Merseyside will play a vital role in this journey.

Diagram Two



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. In addition, the NHS IMPACT self-assessment 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.

Prior to the establishment of NHS IMPACT, NHS Cheshire and Merseyside had already embarked on various improvement activities, including:

- identifying improvement as a priority and exploring the creation of a Cheshire and Merseyside Improvement Hub.
- establishing 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.
- bringing together improvement leads from all provider organisations under the Cheshire and Merseyside Improvement Network (CaMIN) with a view to expanding the membership to include primary care and social care.
- establishing the Clinical and Care Professional Leadership Framework and aligning this with the continuous improvement agenda.

NHS Cheshire and Merseyside is ideally placed to drive Continuous Improvement across the sub-region. In a complex environment, an Integrated Care Board 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.

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, Primary Care Networks, Providers and wider system.

A key vehicle to enable this will be through the Clinical and Care Professional Leadership framework which is designed to empower our people to focus on innovation and improvement outcomes through strong leadership, shared learning and collaboration. The CCPL will build on the expertise of existing clinical and care professional networks, will be inclusive of all health and care services and will reflect the diversity of our workforce and population.

1.2.7 Health and Wellbeing Strategies and Place Delivery Plans

NHS Cheshire and Merseyside delivers some of its functions and makes some of its decisions about NHS funding in its nine Places - coterminous with Cheshire and Merseyside's nine Local Authority footprints of Cheshire East, Cheshire West, Halton Knowsley, Liverpool, Sefton, St Helens, Warrington, Wirral.

NHS Cheshire and Merseyside remains accountable for how NHS resources are spent in Places and we are represented by Place Directors and their teams within wider place partnerships.

Collaboration between the NHS, local government and the voluntary, community and faith sector is underpinned by the duty for NHS bodies and local authorities to co-operate.

1.2.7.1 Cheshire East

In 2023-24 Cheshire East published a Joint Local Health and Wellbeing Strategy and Five-Year Delivery Plan 2023-28, which set out the actions required to improve four core outcomes.

To maximise the health and wellbeing of Cheshire East's residents, the plan established that it will not be sufficient to just deliver good quality health and care services - but that there must be an improvement to the environment in which people live, learn and work.

The Plan focuses on describing eight principles which all partners have now subscribed to embed within their organisations. These eight P's in diagram three are:

Diagram Three

Progress has been achieved on the development of a single joint outcomes framework which has been taken forward through enabling workstreams. Phase One, published in the summer of 2023, focused on measuring success against 14 indicators - barometers of cross-system working to improve outcomes.

Of these, Cheshire East is significantly worse than the England average in three:

- smoking status at the time of maternal delivery
- emergency hospital admissions for intentional self-harm
- admission episodes for alcohol specific conditions.

These outlying metrics have now formed our key programmes of transformation at a community level through to 2026.

Progress has been achieved on taking forward the recommendations of the All Together Fairer and Living Well in Crewe reports - with Health and Wellbeing Board endorsement on the single Cheshire and Merseyside approach to progressing these actions. Progress is also underway against the All Together Active and Healthy Weight Implementation plans following Health and Wellbeing endorsement.

A single Place approach to quality and safety improvement has been adopted through the creation of a Place Quality and Performance Group; attended by all statutory partners. The group has held focused sessions on serious and patient

safety incidents and has acted on Healthwatch feedback. The group has also deep-dived quality risks for the Crewe population to create tangible operational tasks to improve outcomes.

Finally, Cheshire East Place has developed its system blueprint, which visualises what the health and care ecosystem should look and feel like for our residents and workforce. This is now at the heart of all system redesign – for example it is at the core of the philosophy to develop the new hospital programme in Leighton as we seek to empower and develop our eight care communities to ensure that care is accessible in the most appropriate setting and closer to home where possible.

Performance 2023-24
There have been many operational challenges and achievements across Cheshire East during 2023-24. These have included reviewing mortality rates at East Cheshire Hospital Trust, swiftly responding to the Reinforce Autoclaved Aerated Concrete (RAAC) issues in Leighton Hospital through to the successful return of Maternity Services to Macclesfield Hospital in June 2023 following their closure during the COVID pandemic.

We have seen a significant increase in GP access performance to high-quality services. This has been reflected in the excellent patient experience feedback Cheshire East's General Practice has achieved, along with all GP Practices receiving a CQC Rating of good or above.

Diagnostic access has been greatly improved through the development of a new Community Diagnostic Centre in Congleton, with plans to develop further Community Diagnostic capacity in Crewe.

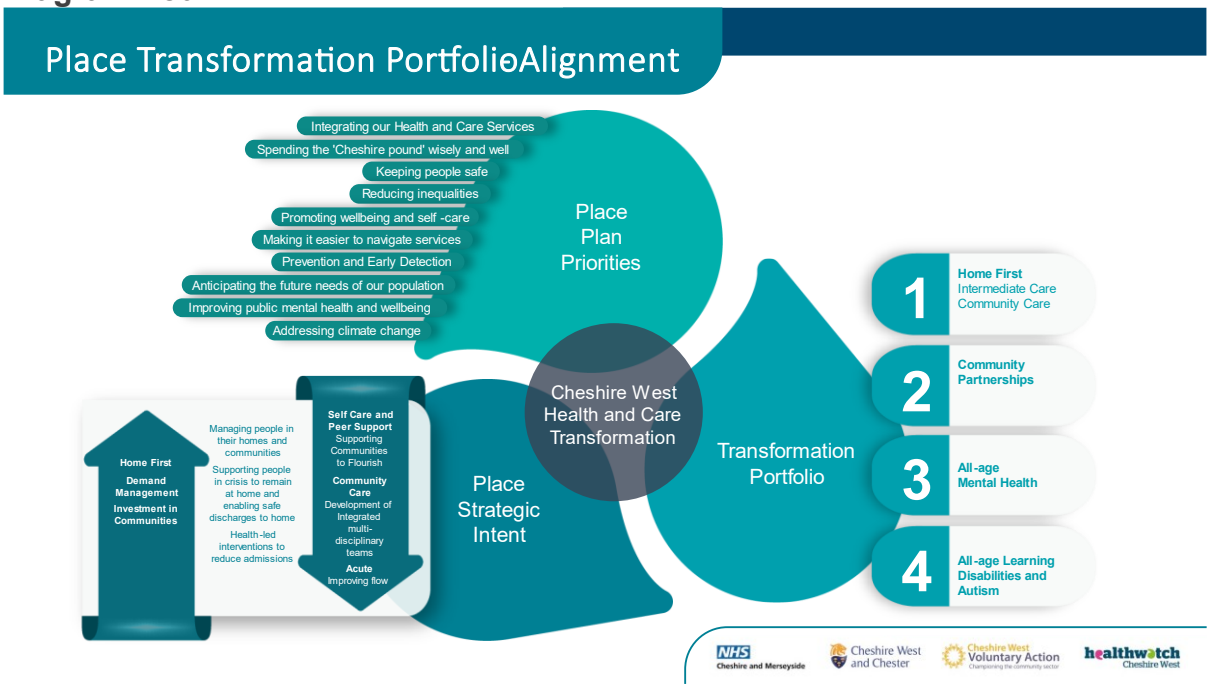
Another notable success has been the ongoing development of our eight care communities, which demonstrate the best of grassroots, patient-focused integration. The end of the year saw a well-attended celebration event of excellence within our Care Communities, which enabled frontline workers to learn and engage with each other. The event was supported and praised by Professor Fuller, of the Fuller Stocktake Report on Integrating Primary Care.

1.2.7.2 Cheshire West

Cheshire West Place has a priority work programme that is jointly managed and delivered by all health and care partners. Four key priorities have been agreed.

In summary, the focus areas for our Integration Programme are Home First, ensuring we keep our population independent and within their own home for as long as possible, Community Partnerships, working collaboratively with the Third Sector to tackle health inequalities, Mental Health, and finally, Learning Disabilities and Autism.

Diagram Four



This Programme is overseen by a Senior Leadership Team, supported by four key subgroups to help deliver transformational change and operational resilience:

- Urgent Care Board
- Integrated Operational Delivery Group
- Integrated Transformation Steering Group
- West Cheshire Children's Trust Executive.

NHS Cheshire and Merseyside's Joint Forward Plan outlines a number of strategic intentions including demand management, Home First and investment in 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 above are supported by a set of enabling workstreams including People, Finance / Resources, Communications and Engagement (including the development of a Local Voices Framework), Estates, Business Intelligence and Digital.

Our Cheshire West Place key objectives are to:

- reduce avoidable admissions through use of step-up services and outreach
- maximise effective working of community care teams including social care, primary care and the third sector to avoid deteriorating and crisis
- integrated discharge, minimising delayed discharges and enabling patient flow

- develop Community Partnerships across the footprint that have a clear health / care support offer
- enhance early intervention and emotional wellbeing
- integrated offer for those with autism particularly pre and post diagnosis
- reduce out of area placements
- develop and maintain a Healthy Work Action Plan
- create a Social Isolation and Loneliness Action Plan
- develop an Age Friendly Commnunity in line with our population needs.

Performance 2023-24
Cheshire West has continued to deliver the NHS Long-Term Plan priorities, whilst also focusing efforts on a joint transformation programme spanning NHS, Local Authority and third sector Place partners.

This work is already starting to demonstrate the achievement of population outcomes, supporting our joint Health and Wellbeing Strategy through the Cheshire West Place Plan, and achievement towards the Cheshire and Merseyside Joint Forward Plan. In summary:

- **Home First -** The Home First integrated programme, with the aim of supporting people within Cheshire West to stay at home for longer, has implemented a number of schemes that have already demonstrated impact:
  - **Community Response Hubs** are community teams working collaboratively to "pull" patients out of hospital and improve their chances of living independently within their own homes. Successfully rolled-out in Winsford and Northwich, they will soon be expanded across the rest of Cheshire West. In addition, a Digital System called "Gateway" has been launched within these areas to enable real-time access to data from NHS and Social Care Teams:
    - **30% of patients accesing CRH require no ongoing support following initial intervention**
    - **Average length of stay for patients referred into this service has decreased by over 40 days**
  - **An Integrated Brokerage programme** has been developed and launched to ensure discharge teams and social care teams work cohesively to expedite discharge and create a stable market for care home beds. This has achieved:
    - Roll-out of an E-Brokerage System to improve efficiency
    - Hospital and Community Social Workers joined as one virtual team
    - Care Connectors in place and aligned to communities and hospitals
    - Reducing the mean time for arranging care packages
    - Implementation of a Performance Dashboard giving regular reporting to teams and Place partners.
  - **Integrated Community Teams** offer a collaborative approach to understanding patient needs within the community, and the resource required to meet this. A more collaborative approach to cross-sector working has been agreed by a newly drafted Strategic Intent document, with clear links to the third sector established.
- **Community Partnerships -** The Community Partnerships Programme (formerly Care Communities) has taken a brave turn, with leadership of priorities and ongoing delivery moving away from Primary Care Network clinicians, towards the

third sector. Clear system priorities are still being delivered at a local level, with a developing dashboard that will demonstrate how Social Value and other indicators can support Place priorities. Achievements to date include:
  - more than 50 Community Projects have been launched, focussed on the priorities of the local population
  - priorities have been mapped against population need and health inequalities via the Council's Ward Profile data
  - senior Responsible Officer for Programme from the Third Sector, with innovative working that has lead to new investment from outside of the traditional funding routes.
- **All Age Mental Health and Learning Disabilities -** The Mental Health Programme is broad, relying heavily on collaborative working across all partners to achieve a joint delivery plan. For Learning Disability and Neuro-Diversity, joint working has been key to agree suitable accommodation models to enable people to live independently and focus on assets.In summary:
  - **Mental Health -** Joint delivery plan agreed with leads on each area identified across Partner organisations. Key focuses of this include:
    - Children and Young People – self-help and third sector
    - Adults Community Health and Crisis
    - Inpatients – reducing out of area placements
  - **Learning Disabilities and Neurodiversity –** This programme is complemented by joint working around complex accommodation and care models, ensuring this is meeting national aims and influencing the Local Authority's housing strategy.

In addition to these four key priority areas, Cheshire West Place continues to work collaboratively on NHS priorities identified through the Joint Forward Plan. A summary of some of the key successes include:

Starting Well

- The work of the Starting Well Programme is driven by joint performance data. To this end, a number of priorities have been identified:
  - A review of the needs and access to services of Children in Care is currently being undertaken to ensure Health Inequalities are minimised.
  - In addition, in order to reduce waitring times and increase the ability to manage issues for families, a focussed piece of work around continence is being undertaken.
  - Finally, further work to develop the Starting Well data-set has been identified as a key priority, particularly around Maternitry and Paediatrics, at a more granular level.

Living Well

- through identifying Cardio-Vascular Disease (CVD) as a priority, joint work has taken place across the sector to launch a CVD symposium, upskilling the health and care workforce, and developing a joint workplan to focus on health inequalities.
- a pilot of Long-Term Condition Management Remote Monitoring has achieved a high uptake, with over 70% of patients using this, stating they would recommend

the system to friends and family. To date, over 1,000 alerts have been dealt with remotely and have avoided clinical action.
- a Cheshire West Cancer workplan has been launched, clarifying target areas and input by all partners. This has led to a number of initiatives, including the launch of teledermatology.
- focussed work on Dementia and End of Life is leading to a review of current pathways to ensure community provision is equitable and sustainable going forward.

Primary Care
- Cheshire West continues to experience higher than average levels of performance in multiple GP Survey indicators.
- in addition, all Cheshire West Practices exceed the number of appointments delivered compared to the England average
- the percentage of patients seen within two weeks is higher than the national average and GP appointments have increased by 2% compared to last year
- however, the proportion of patients seen by other professionals than a GP is at an all time high, demonstrating that the focus on Additional Roles and Primary Care Access is having a positive impact.

Urgent Care and Ageing Well
- although the position for Urgent Care within Cheshire West is challenged, close joint working is providing assurance towards a positive way forward
- not only does this come from the Home First priority, but also from the work of the joint System Improvement and Recovery Plans
- joint support is provided to these programmes via the Integrated Operational Steering Group.
- a joint programme of work supporting **Falls Prevention and Rehabilitation** has been launched, with the development of an Integrated Business Case, ensuring that our work against this priority is joined up and impactful. Extensive work has been undertaken to analyse need, where the evidence tells us we can have the most impact:
  - Emergency Admissions due to falls within Cheshire West have increased by 12%
  - these are likely to increase by 33% in the next 10 years
  - women over the age of 80 are more likely to fall
  - these falls are most likely to happen in areas of high index of deprivation
  - particular areas of focus will be Winsford and Northwich
  - the Falls Programme will be multi-factorial and targeted at those areas of inequality. This will include the completion of risk assessments, a two Hour Urgent Community Response, Virtual Wards, collaboration with the Ambulance Service via the Acute Visiting Service, and finally closely working with the Third Sector around prevention and rehabilitation
  - this work aims to reduce falls by 40%.

All Age Mental Health, LD and Autism:
- as described above, a joint Delivery Plan has been developed, ensuring integrated work around the key priorities for Mental Health

- this work is being strongly supported by the development of a Mental Health Dashboard. Particular focus includes:
  - significant system collaboration and reduction in Out of Area Placements.
  - the current development of a Crisis Alternative Model for Children and Young People, and an improved Crisis Model for Adults.
  - the succesful Cheshire West bid to expand Mental Health Support Teams into Secondary Schools, Special Schools and 6th Form.
  - working in collaborative with HealthJunction to tackle health inequalities and ensure Serious Mental Illness health checks achieve at least the 75% national target.
  - working with the third sector to supply consistent early help and prevention to adults facing low level mental health issues.
    working collaboratively with the Police to launch the Right Care Right Person approach.
- in addition, specific work over and above the **Joint Priority of Accomodation,** is being undertaken by the Learning Disabilities and Autism Team.
- not only does this include a recovery plan to ensure access to services within an appropriate timescale, but also working with Place Partners to launch the Oliver McGowan principles. Within 2023-24, the Cheshire West Place Committee undertook a targeted development session, hearing patient stories and agreeing a joint action plan.
- finally, dashboards are being developed that will help target LD and Autism performance, including for those with Special Educational Needs and who could benefit from LD Health Checks.

1.2.7.3 Halton

The strategic ambition of Halton's Joint Health and Wellbeing Strategy (JHWS) is to improve the health and wellbeing of the population. It sets out to achieve this by supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community-based support and ensuring high-quality services for those who need them.

The JHWS comprises four strategic priorities:
- tackling the wider determinants of health
- supporting our community in starting well
- supporting our community in living well
- supporting our community in ageing well.

The JHWS recognises the benefit of more collaborative approaches, bringing together colleagues from across health, local government, third sector and the community, to work together to improve the experience and outcomes of local people within a sustainable health and care system. As such, a fifth strategic priority has been agreed – an Integrated Neighbourhood Model.

Plan development and delivery update
Throughout 2023-24, Halton's Place team worked with the One Halton Place Based Partnership Board and other local partners to progress the development and implementation of local plans that will deliver our strategic ambition.

Joint Senior Responsible Officers were appointed from across the partners for each of the strategic priorities to lead a multi-partner delivery group tasked with developing their strategic priorities' work programme. Their work has been informed by a detailed review of the aims and objectives of the JHWS; the Joint Strategic Needs Assessment; and other contemporaneous data and insights, to identify a focussed programme of work to improve the health and wellbeing of the people of Halton.

Performance 2023-24

Core20PLUS5 Community Connector Programme
Part of an NHS England pilot, the programme recruited 10 Connectors to act as conduits with their communities, helping to identify community needs and inform priorities. Work during the year included running neighbourhood-focussed workshops; developing case studies; running lived experience sessions for care-experienced young adults; supporting the development of a Crew Room for veterans; working with Onward Homes and supporting residents to develop a Community Café.

Research Ready Communities
A joint project between National Institute of Health Research (NIHR), Power in Partnership (PIP), Halton Borough Council (HBC) and local NHS colleagues. The project utilises participation in research as a method to reduce health inequalities in underserved communities. Halton recruited six care-experienced young adults, who carried out research in their neighbourhoods, bravely sharing their lived experience with a number of public sector partners.

These researchers are unique within the footprint of NHS Cheshire and Merseyside and have quickly become a valuable asset to NHS partners that wish to engage with care-experienced people. The young adults supported NHS Cheshire and Merseyside colleagues with the development of an NHS employment workshop in October 2023 as part of Carers Covenant Week.

Family Hubs
During 2023-24, Halton opened two family hubs, one in each town. Family Hubs support families with children and young people aged 0-19 or up to 25 years with special educational needs and disabilities. The hubs provide a mix of physical and virtual spaces, as well as outreach, where families can easily access non-judgmental support for the challenges they may be facing. They bring services together in one place so that all families have access to the information and support they need, when they need it. Family Hubs will also play an integral role in delivering our improvement ambitions for services for local children and young people with special educational needs and disabilities.

Urgent and Emergency Care
The two-hour Urgent Community Response service and other admission avoidance schemes were well used by general practice and other Halton partners. Targeted quality improvement work with local care homes is returning improvements in the outcomes and experience of residents. The benefits of these and other schemes are evidenced by the Better Care Fund national performance measures where Halton is on target to achieve 4 out of 5, with levels of avoidable admissions; emergency hospital admissions due to falls; permanent admissions to residential care; and the proportion of older people still at home 91 days after discharge into reablement performing better than targets.

Integrated Neighbourhood Model
One Halton Partnership Board agreed the purpose, features and principles of the Integrated Neighbourhood Model and this is being used to inform integrated neighbourhood working across the Borough. Led by Halton's two Primary Care Networks, partners came together to develop an NHS Cheshire and Merseyside Transformation Fund bid for integrated community Same Day Access, initially across general practice and Halton's two Urgent Treatment Centres with other services to follow in further phases.

1.2.7.4 Knowsley

NHS Cheshire and Merseyside in Knowsley set out its vision, local system infrastructure and objectives for health within its Plan for 2023-25. This is informed by national, regional, and local objectives and priorities: NHS Long Term Plan, NHS Planning Guidance, NHS Cheshire and Merseyside objectives, Joint Health and Wellbeing Strategy, Joint Strategic Needs Strategy and Knowsley 2030 Strategy.
Integrated Care Boards have a shared statutory duty with Local Authorities to produce a Joint Strategic Needs Assessment for each place, identifying the health and wellbeing needs of the population. Summaries are available at www.knowsleyknowledge.org.uk.

Key Performance Achievements
Despite Knowsley's health challenges and level of deprivation, NHS Cheshire and Merseyside in Knowsley has made tangible progress in key delivery areas, working alongside key partners:

Admission avoidance
Our 2-hour Urgent Care Response (UCR) service is in operation 8am-8pm, seven days a week, seeing an average of 150 referrals per month. Around 64 admissions were avoided per month during 2023-24. Virtual wards have capacity for up to 70 Knowsley patients at a time and this will increase in 2024-25.

Cancer
Faecal Immunochemical Test (FIT) testing programme is being implemented across Knowsley. All 104-week elective waits have been eliminated.

Primary Care and Digital
From July 2023 Knowsley reduced to 24 GP practices, following the merger of Trentham Medical Centre and Tower Hill Surgery. Practices continue to see more patients than before the pandemic, both face-to-face and digitally. All practices are Care Quality Commission (CQC) rated 'good'. The number of registered patients using with the NHS App has increased from 49% to 55% since December 2023.

Mental Health
Early Intervention in Psychosis percentage of service users experiencing a first episode of psychosis, who commenced a National Institute for Health and Care Excellence (NICE) concordant package of care within two weeks of referral is meeting target.

Childrens
Pathway improvements are being reviewed against the Neuro Developmental Pathway (NDP). Funding for a Tics and Tourette's service in Knowsley has been identified.

Intermediate Care
A wider review in Knowsley is planned during 2024-25, working collaboratively with partners to review Pilch Lane development.

Women's Health Hubs
Knowsley is working in partnership with the wider Cheshire and Merseyside network to reduce the fragmentation of Women's Health and access to services.

Reducing Inequalities
To date, 28 Northwood community members have taken part in themed sessions or events, proactively setting the direction of improvement initiatives for the programme, which they have named 'Your Northwood'.

Falls pick up service
Comparative data for one month, December 2023, shows that this service successfully lifted 39 patients, resulting in fewer ambulance callouts and hospital admissions, and reduced the need for packages of care due to decompensation (compared to 15 less patients in December 2022).

Living Well Bus
Continued to maximise the use of a roving health service across Knowsley in 2023-24, delivered by Cheshire and Wirral Partnership NHS Trust, incorporating flu vaccines into the services provided.

Urgent Community Response team
This team saw an average of 150 referrals per month, mostly referred by local GPs. On average, approximately 64 unnecessary admissions to hospital were avoided every month.

Quality
Three MRSA cases reported between April 2023 – January 2024 against a zero tolerance, which are subject to Root Cause Analysis (RCAs) to identify learning. 43 C-Difficile cases reported between April 2023 – January 2024 against a 2023-24 target of 47 for the full year. 33 E-Coli cases reported between April 2023 – January 2024 (six hospital onset cases and 27 community onset). Knowsley's Quality Team continue to collaborate with Place regarding the oversight of quality across all Cheshire and Merseyside Providers.

Antimicrobial Resistance (AMR)
Knowsley Place priorities align with those identified for NHS Cheshire and Merseyside and are regularly reviewed with partners.

All Age Continuing Care (AACC)
The Knowsley AACC team continue to provide additional support to local District Nursing Liaison Services as part of discharge processes from acute services and to comply with NHS England guidance regarding the number of referrals concluded within 28 days; Q3 2023.24, 92% (33/36) compliance and the number of Continuing Healthcare cases exceeding 28 days; Q3 2023-24, 3 cases.

Safeguarding Children and Adults
The safeguarding team at Knowsley consists of a Safeguarding Adults Professional, Safeguarding Children and Children in Care Nurse, Named GP for Safeguarding and Named Doctor. The team work closely with the Safeguarding Adult Board, Safeguarding Children Partnership, Domestic Abuse Board and aligned sub-groups to ensure communication and governance processes are in place. The designated nurse / professional has oversight of statutory functions for safeguarding adults, safeguarding children and looked after children. The designated doctor / named GP for Safeguarding has worked innovatively with commissioned services and partner agencies to ensure that safeguarding support and activity is a significant feature.

Medicines Management
The Knowsley Medicines Management Team (MMT) continues to ensure prescribing across Knowsley is safe and cost effective.

The MMT engaged with practices throughout 2023-24 through the completion of the MMT workplans that are agreed on a quarterly basis with authorisation sought from each practice.

The Knowsley MMT continue to prioritise reducing inappropriate polypharmacy and reducing inappropriate prescribing of antibiotics and high dose opiates for chronic pain. The team have collaborated with public health colleagues on shared priorities including reducing opiate prescribing in collaboration with our substance misuse service, Change Grow Live (CGL).

1.2.7.5 Liverpool

Liverpool has a diverse and complex health and care system, which encompasses 83 GP practices collaborating across 10 Primary Care Networks: seven NHS Trusts, including one of the largest adult acute hospitals in England, a children's acute trust, a women's acute trust and three specialist trusts serving the wider region.

One Liverpool is the city's health and care strategy, supported by all system partners. The One Liverpool vision is for A Healthier, Happier, Fairer Liverpool for All, which reflects a shared aim to improve health outcomes for our population.

Liverpool is the third most deprived local authority in England, with 63% of residents living in the most deprived areas of England, with 3 in 10 children living in poverty. The COVID-19 pandemic has exacerbated inequalities between Liverpool and England, which are caused in large part by higher mortality rates from COVID-19, cancer, cardiovascular and respiratory diseases.

One Liverpool Strategy

The overarching aim of One Liverpool is to re-balance the health and care system, with a greater focus on prevention and early intervention. This shared aim comes with significant challenges in a city with high deprivation, constrained funding and rising health demand.

The strategy has five themes:

- **Theme One:** Targeted action on inequalities
- **Theme Two:** Radical upgrade in prevention and early intervention
- **Theme Three**: Health creating communities
- **Theme Four**: Integrated and sustainable health and care services
- **Theme Five:** A financially sustainable health and care system.

Despite the challenges, the Liverpool health and care system is delivering significant improvements and integrated partnership approaches:

Urgent Care

NHS Cheshire and Merseyside was one of two Integrated Care Boards in the North-West allocated into a Tier One system by NHS England due to pressures in the Liverpool place urgent and emergency care (UEC) system. Key insights driving urgent care pressures include:

- 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

A whole-system programme is being implemented, informed by these findings.

Population Health Programmes
The Liverpool Place system recognises the importance of a Population Health Management Approach, with a focus on preventing ill health and addressing health inequalities. Liverpool has established five population segment delivery programmes across all sectors, settings and services.

Complex Lives: people with complex lives face mental, social and physical risk factors such as homelessness, abuse, deprivation and substance. Priorities for this programme include:

- **Homelessness health;** addressing the needs of a significantly increasing number of people with a wide range of complex health and social needs
- **High Intensity Users of A&E:** identifying and shaping health and social support around the needs of high users of acute services
- **Perinatal Resilience / Resilient Families:** improving access to anti-poverty and wellbeing support for families who face distress and hardship

Healthy Children and Families
Our aim is to give children in the city the best start to life. Programmes focus on supporting families during the early years; an emphasis on emotional and mental health; speech and language and school readiness. There is a specific focus on healthy weight, breastfeeding, oral health and vaccination and immunisation. Lung health is a service priority, developing respiratory hubs to integrate primary, secondary care teams, community spirometry and asthma.

Long Term Conditions
Cardiovascular, respiratory disease and diabetes are leading causes of mortality and morbidity in Liverpool. This programme incorporates prevention and recognises the need to shape services around people's needs, particularly those with multiple long-term conditions. Current priorities include IV diuretics in the community and direct access to mental health support in diabetes and respiratory pathways.

Frailty & Dementia
Around 40% of people over 65 in Liverpool have moderate or severe frailty. Targeted support enables people to stay well and avoid hospital admissions. Priorities include appropriate prescribing and falls prevention in homes and care homes.

Disabilities
Life expectancy for people with learning disabilities is significantly lower than the general population. There is underdeveloped provision for people with autism and ADHD in terms of diagnosis and support. Our priorities include ensuring more people can access services and are supported to reach their full potential.

Closely aligned to the population health model, Liverpool City Council also launched its Neighbourhood Model in 2023 which incorporates 13 neighbourhoods across the city. Each neighbourhood works on the basis of a “team around a neighbourhood” consisting of council staff and partners, including health, housing, Police, education and the voluntary sector.

Liverpool Clinical Services Review
A review of acute and specialist services in the city was conducted in 2023, the objective of which was to identify opportunities for greater collaboration between acute and specialised trusts to optimise clinical pathways in acute care in Liverpool.

The city is unusual in the number of acute and specialist provider trusts which provide - creating challenges due to fragmentation of services, variation in quality, financial positions, experiences of care, workforce capacity and sustainability.

The review made 12 recommendations which the whole Liverpool health and care system, along with the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Alliance, is working to implement. Although the majority of actions from the review are longer-term, progress has been made in 2023-24 with a number of initiatives, including:

- pilot nurse-led in-reach cardiac assessment to Aintree Hospitals A&E
- pilot scheme to enable shared access to patient data between Liverpool Heart and Chest Hospital and Liverpool University Hospital to improve patients flow, efficiency for workforce and improved diagnostics
- Liverpool Women’s Services – a provider-led Programme Board is in place tasked with making quality and patient safety improvements and developing longer term proposals for the future of women’s hospital services
- implementation of a new ‘wrap round’ out of hours falls lifting service which has seen 95% of users remaining at home.

Women’s Health Hubs
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. This model is a first nationally and has informed the roll out of hubs nationally.

1.2.7.6 Sefton

NHS Cheshire and Merseyside in Sefton sets out its vision, local system infrastructure and objectives for health within its Plan for 2023-25. This is informed by national, regional, and local objectives and priorities: NHS Long Term Plan, NHS Planning Guidance, NHS Cheshire and Merseyside objectives, Joint Health and Wellbeing Strategy, Joint Strategic Needs Strategy and Sefton Place Plan.

The Sefton Place Plan delivers its key priorities through life course approach and integrated working practices which include the following programmes: Urgent Care, long term conditions, General Practice, Primary Care Networks (PCNs), Integrated Care Teams, Children and Young People, Mental Health, Health Inequalities, Community First and Estates.

Performance 2023-24

Start Well

- reducing health inequalities runs throughout our partnership work. Key examples include Child Poverty Strategy work led by public health with partners to develop and launch the parent champion respiratory pilot.
- Primary Care Network-led work on Complex Lives in central Southport and an Adverse Childhood Experiences programme with Sefton Council.
- building Attachment and Bonds (BABS) service in Sefton offers clinical and therapeutic support to families. The service accepts referrals from parents and carers who are pregnant or have a baby aged up to six months, who are struggling with their own wellbeing and / or struggling in their relationship with their baby.
- Children and Adolescent mental health Services (CAMHS) enhanced pathway for cared for children / young people - provides timely access to expert clinical assessment, support and therapy.

Live Well

- working in partnership with Sefton Council we have been implementing the Delivering Better Value programme – ensuring there is a development of a graduated offer for emotional health and wellbeing and speech and language therapy (SEND).
- Sefton has introduced a pilot scheme to reduce inequalities regarding access to Long Acting Reversible Contraception.
- Sefton-wide high intensity user service is being rolled out across Trusts.

Age Well

- development of Enhanced Home First. During 2023-24 this programme was developed to increase the number of patients discharged directly to their own homes.
- right-sizing the Sefton intermediate care bed base.
- direct access for all care homes into the 2hr Urgent Community Response via Acute Visiting Service. Step-up available into Frailty Virtual Ward for all care home patients.
- Frailty Virtual Ward: Live in North Sefton for admission avoidance and early supported discharge.
- risk stratification tool created to identify frail patients at risk of admission and targeted interventions planned.

All Age

Sefton's Place team has worked closely with Primary Care Networks to ensure alignment with community service providers. This configuration enables effective working relationships on shared priorities such as Medicines Management, Social

Prescribing, Mental Health, Complex Lives, Enhanced Health at Home and in Care Homes, Cancer and children and young people immunisations.

During 2023-24, Sefton continued to develop its growth and strategic investment programme focused on Bootle Strand which has been repurposed to include a Health and Wellbeing hub / Health on the high street model. Community First is an undercutting theme in our plan, led by the VCFSE sector to progress co-design with communities. In 2023-24 obesity remained a significant area for action.
Shaping Care Together is a large-scale transformation programme in the north of the borough and into West Lancashire. During 2023-24 there was a reset and refocus of this programme to focus on urgent and emergency care whilst planning for further stages aligning with Mersey and West Lancs transformation programme.

1.2.7.7 St Helens

St Helens Place-based Partnership Plan has a vision to "Improve people's lives in St Helens together". The four key priority areas are mental wellbeing, healthy weight, care communities and tacking inequalities.

During 2023-24 many programmes have contributed to improving these areas, across all partners including primary care, secondary care, Local Authority and the voluntary sector:

Mental Wellbeing
System partners meet monthly including councillors, health, public health, housing, and voluntary sector partners. Achievements include:

- implementation of the A&E self-harm pilot pathway at Whiston Hospital hosted by Mersey Care to provide a two-week intensive intervention for people who present at A&E with significant self-harm. This has resulted in a reduction in admissions across all ages associated with self-harm from 685 in 2022-23 to 511 in 2023-24.
- progression of the Mental Health Concordat action plan, prioritising actions across our partners to improve the mental wellbeing of the population through initiatives including a suicide prevention strategy, rollout of suicide awareness training, the OK to Ask campaign, increasing access to specialist perinatal mental health services, addressing social isolation and loneliness and increasing the capability and capacity of the voluntary sector.

St Helens has a varied Thrive offer to support its Children and Young Peoples (CYP) mental health and emotional wellbeing, developed by NHS Cheshire and Merseyside, Local Authority and various Provider partners. In 2023-24 we will exceed our Access Target for the second year running and further positive trends are emerging, such as a reducing trend in CYP mental health admissions (2023-24 forecast of 47 compared to 56 in 2022-23) and CYP self-harm admissions (2023-24 forecast of 70 compared to 150 in 2022-23).

Key schemes supporting these improving outcomes include 65% of schools with a Mental Health Support Team or Resilience Service; a Key Worker service to support some of our children and young people registered with a Learning Disability or Autism; introduction of a Tourette's Pathway; investment in third sector partners to deliver programmes such as Parents in Mind, Reflective Parenting and Parents in Mind Partners; and the establishment of a multi-agency Childrens Health and Maternity Hub (Lowe House) and Family Hubs (Sutton, Central Link and Newton) to improve access and support.

Case Study: Meeting the mental health needs of our school children

Mental health support teams (MHSTs) promote early detection and prevention of emotional health and wellbeing problems across whole school communities. They are one of the ways that we are working to increase access to mental health support for children and young people.
Cheshire and Merseyside was amongst the first areas to develop and adopt MHSTs and continued to invest in more MHST teams in 2023-24 to ensure as many children and school staff as possible benefit from their support.

As a relatively new initiative working across several partner organisations, we are also assessing the data behind the work of all our teams. This will help us to better understand how we can continually improve these services and their outcomes for our children and young people across Cheshire and Merseyside.

Our local Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) has a large number of providers who offer support for mental health and wellbeing issues. Working through the VCFSE Mental Health Alliance they work to ensure that the system has a clear understanding of the VCSFE offer.

Healthy Weight
A Healthy Weight and Active Lives Strategy group met throughout the year and hosted a wider stakeholder event in July 2023 to reaffirm commitments to deliver the Healthy Weight Declaration. Active Lives partners have delivered four community mass participation events, and the innovative CYCLOPS junction was launched to increase pedestrian and cyclist safety and encourage active travel. Health, Exercise and Nutrition for the Really Young (HENRY) training has been delivered and an eight-week rolling programme parenting course was launched, with resource from Family Hubs and as a partner in a national research study.

The Community and Voluntary Action have co-ordinated the delivery and roll out of additional volunteer-run static and mobile food pantries to ensure access in key wards with highest need. Successful delivery of 'Why Weight to Talk' training for frontline practitioners with excellent attendance from 0-19 service, primary care, and partner agencies. Additional NHS England national funding secured for a two-year Wegovy weight management pilot in primary care.

Care Communities
During 2023-24 St Helens has focussed on developing relationships between providers that will enable them to work in a wider multi-disciplinary way to focus on the holistic needs of complex patients. Each Primary Care Network area has formed a Care Community, with named professionals aligned to it from across health and care. Care communities consist of multi-disciplinary GP practice staff, mental health, social care, voluntary sector and 0-19 services.

Care communities are focusing on frequent service users and 18-31 year olds, known to multiple health and care services, from the most deprived parts of our borough and providing increasingly proactive care.

St Helens North Care Community was the first to pilot this approach, starting to triage patients in February, with a view to wider roll out in 2024-25 to all other areas of the borough. The next phase of the programme will be to include services from wider areas than health and care, such as education and housing.

The timescales to implement the programme have been challenging as the basis of this programme is complete culture change, and embedding the relationships to enable this has taken longer than planned. This is a 3–5 year programme to fully embed, with 2023-24 being year 1, so despite these challenges, significant progress has been made.

Tackling Inequalities
The Inequalities Commission has continued to work on tackling inequalities in St Helens, through supporting the ongoing three key workstreams: “best start in life”, with two family hubs opened in 2023-24, tackling food poverty, expanding the food pantry network from 3 to 11 sites as of March 2024, as well as fuel poverty, with the affordable warmth team assisting residents in over 1,000 individual enquiries providing support through various regional and national schemes, while collaborating with the commission in providing ‘winter well packs’ to 6,000 vulnerable residents.

Case Study: Cheshire and Merseyside uses innovative data-led approach to help more than 1,000 vulnerable people cope with fuel poverty

Cheshire and Merseyside Integrated Health and Care Partnership is using population health technology and targeted support to help more than 1,000 people facing fuel poverty.
To date, 1,317 people identified as being at risk of developing serious health issues due to fuel poverty have been identified via Cheshire and Merseyside’s population health platform. Resulting support has included more than £41,000 in household support funding, as well as fuel vouchers, replacement boilers, medication reviews, Winter Warm Packs, and referrals to health and care teams. A series of localised initiatives have been rolled out as part of the fuel poverty project. Patients with severe COPD, residing in deprived areas, have been prioritised, as they are at high risk of a hospital admission if living in a cold, damp home.

The next priority group is pre-school children aged 0-4 with a respiratory wheeze - a group that has been identified as being at risk of negative health implications (including asthma) due to cold homes. The COPD programme will also be expanded and rolled out further across Cheshire and Merseyside.

Jo, who lives in St Helens, has a dual diagnosis of COPD with primary condition pulmonary fibrosis and requires high-flow oxygen 24-hours per day. Living in a cold home, he can't afford rising energy bills.
Jo was referred to the St Helens Affordable Warmth Team for a household assessment, referred for an occupational therapist assessment for a stairlift and ramp, and assisted to register on the Priority Services Register with an energy provider. Jo also received a medication review, which resulted in an oxygen saturation probe, oxygen concentrator and provision of a fan for fan therapy.
Jo received a replacement boiler and installation of a bespoke ramp. He is managing his condition better; using his more efficient oxygen equipment for eight hours per day, which is more cost effective; and he has been able to access the £500 household warmth fund towards improvements.
Jo said: "I had to choose between my oxygen or heating the home - but not anymore."

The work of the Inequalities Commission was recognised via success in the 2023 Municipal Journal (MJ) award for "a whole council approach to tackling inequalities".

Other
St Helens has developed many other local services during the year. The urgent care system has been enhanced by creating extra capacity in key areas, such as COPD, specialist palliative care, urgent community two-hour response, virtual wards in frailty, respiratory and cancer specialties and additional pathways through the same day emergency care team. However urgent care remains one of the biggest challenges. Despite new and successful admissions avoidance schemes, and increased numbers of discharges year on year, the number of admissions continues to grow, placing pressure on the whole urgent care system.

Long-term condition management has been enhanced by improvements in digital care, especially in teledermatology, improved use of advice and guidance between clinicians, telehealth pathways in Heart Failure and Chronic Obstructive Pulmonary Disease (COPD). Proactive management of COPD has been enhanced by expanding the capacity of the COPD hub, and targeted work has been undertaken to support those with COPD in being able to live in warm homes to avoid exacerbation due to living conditions.

Projects to support patients with Fibromyalgia and Multiple Sclerosis are also underway, while children's urgent care has been enhanced with a new Children's A&E at Whiston Hospital.

Primary Care Access remains one of the biggest challenges. Each GP practice has developed a plan to improve access over a two-year period - including adopting

better IT such as telephony systems and call back, and by recruiting new staff across PCNs under the Additional Roles Reimbursement Programme. Each practice is well on the way to implementing the plans, with 16 of our practices showing that they are ready to Implement Modern General Practice, and change their ways of working, by 31st March 2024.

ADHD demand presents perhaps one of the biggest challenges to St Helens. This is replicated regionally and nationally. In particular, Adult waiting lists have grown significantly in year, and St Helens are working with partners on developing a model in 2024-25 that can increase capacity within the available resource.

1.2.7.8 Warrington

NHS Cheshire and Merseyside in Warrington set out its vision, local system infrastructure and objectives for health within its Plan for 2023-25. This is informed by national, regional, and local objectives and priorities: NHS Long Term Plan, NHS Planning Guidance, NHS Cheshire and Merseyside objectives, Joint Health and Wellbeing Strategy, Joint Strategic Needs Strategy and Warrington Together Partnership priorities.

Starting Well

- significant and measurable impact has been made across the five thematic priority areas outlined within the 2022-25 Starting Well delivery plan.
- examples include:
  - Outperforming the National Access and Waiting Times target for Mental Health services
  - A reduction in self-harm admissions to hospital.
- business case submitted to establish a ‘Complex Needs Hub’: a therapeutic short stay and outreach provision to support prevention of avoidable admission of complex children and young people to care, custody and inpatient provisions.
- undertaking a Paediatric Respiratory pilot programme, aiming to improve respiratory outcomes and management for children and young people in our most deprived communities through embedding best practice, including holistic assessments and interventions.

Staying Well

- encouraged sign-up to the Healthy Weight declaration across Warrington, including implementation of a healthy weight delivery plan.
- groups identified to operationalise identified Mental Health themes and priorities.
- learning disabilities strategy launched and a draft autism strategy developed.
- Warrington is responding to the cost-of-living crisis and is in the process of setting up a Poverty Truth Commission for people with lived experience to co-produce poverty prevention strategies.

Ageing Well

- implemented a 'Single Front Door', taking calls for Adult Social Care, Urgent Community Response and the 24-hour Carecall service.
- development of Integrated Community Teams through stakeholder engagement and relationship building with partners at a neighbourhood level.
- re-established the Dementia Transformation Board and identified priority themes to support the development of a Strategic Delivery Plan.
- undertaking work to reduce the number of falls, conveyance to hospital, admissions, falls during an inpatient stay, mean length of stay and post-discharge falls. Has led to a reduction in falls-related admissions to Warrington Hospital.
- established Dying Well with Dignity priorities and approved the System End of Life Care Education Strategy and associated 2024 training schedule.

Finance Investment and Resource Group (FIRC)

A greater understanding of the drivers of the Warrington Place deficit, across both commissioning and provision, has been achieved through partners sharing financial performance issues via FIRC. Opportunities to pool resources / jointly commission services have been taken, including the joint plan for the Adult Social Care Discharge Funding (managed through the Better Care Fund) to optimise the application and provide system-based support to our local NHS Trust. Additionally, the Adaptive Reserve, used to pump-prime new initiatives / financially sustainable models of care, has been maintained.

Quality and Performance Group

Monthly meetings have been held to gain system quality oversight. Healthwatch have shared patient experience with a focus on women's health and hospital discharge. Deep dives have taken place for specific services, with reference being given to patient experiences, a patient story of a child with complex needs, and service collaboration and recommendations have been made. The experience of patients and practitioners has been shared in relation to ward closures at St Mary's Hospital.

Communications and Involvement Network

Delivered focused communications and engagement work across Warrington, including work on NHS industrial action, demand management, measles, the Living Well programme (including the Living Well Hub) and Warrington's Health and Wellbeing Strategy.

Enabling workstreams

Workforce and Organisational Development

- phase one of the development of a Workforce Delivery Plan for Warrington has been completed and has now moved onto the following key areas:
- the delivery of a Place-based Workforce Dashboard.
- the development of a Place-based Staff Health and Wellbeing Offer, including the production of a Staff Health and Wellbeing Directory.
- Care Leaver Internships, including commitments and pledges to the national Care Leaver Covenant (linked to NHS Cheshire and Merseyside workforce objectives).

Digital

- developed and launched the local digital Place plan in connection with Channel 3.

- worked with the digital team to agree a shared care digital solution.
- digital inclusion projects progressed as part of the local Transformation funding, which funded Warrington Disability Partnership to work with residents to upskill in terms of digital access and technology.
- ongoing work to increase NHS App usage amongst residents – NHS App usage among Warrington residents currently higher than the national and Cheshire and Merseyside averages.

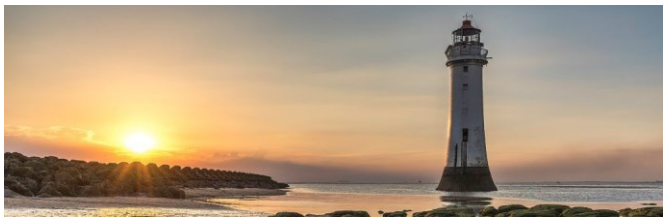
Estates

- reviewed all organisations' estates strategies to develop Warrington Place priorities.
- baseline of public sector estate completed.
- Living Well Hub opened, integrating services from 25 different organisations and redeveloping town centre estate via Town Deal funding to support town centre regeneration, as well as improved health outcomes.

Intelligence and Analytics

- produced the Warrington Joint Strategic Needs Assessment, providing a wealth of information regarding the behavioural and socioeconomic factors that impact on population health and wellbeing. It has informed the priorities and ambitions of the Health and Wellbeing Strategy.
- provided data-led support including updating the Health and Wellbeing Strategy dashboard, supporting identification of appropriate metrics and data sources and developing dashboards and reporting mechanisms to support monitoring of system progress in improving population health and reducing inequalities.
- used a Population Health Management Tool to identify a cohort of patients at risk of becoming frail and design new models of care in response.

1.2.7.9 Wirral



Wirral's Health and Care Plan sets out how health and care organisations work together to progress with agreed priorities areas of work, and focuses on key priorities for delivery. Achievements in 2023-24 include:

- the introduction of blood pressure checks which identified 1,907 patients with high blood pressure having no previous history.
- a Housebound hypertension pilot improved support for patients to blood pressure monitoring for housebound patients.
- a Community waiting list management tool to include a health inequalities approach.
- the living well bus has attending targeted locations to deliver health checks in areas of deprivation.

Elective Care

Wirral University Teaching Hospitals (WUTH) attained an overall Elective Recovery performance of 105% against plan for outpatients and an overall performance of 98% against plan for elective admissions.

Cancer
Achievement of performance targets continued to be challenging, but continual pathway improvements and collaborative working are supporting recovery - including Rapid Diagnostic Services. New pathways were launched for non-site specific patients and Faecal Immunotherapy diagnostic Testing (FIT) for symptomatic patients at the start of the colorectal pathway, further supporting patients in early diagnosis.

Diagnostics
Throughout the year secondary care continually reviewed processes and implemented improvements including; review of referral forms to enable robust referral for specialist diagnostics.The Clatterbridge Diagnostic Centre has supported secondary and primary care by increasing capacity for diagnostics such as ECGs, echoes, spirometry, FIT.

Maternity
Wirral Hospital's maternity service was rated 'good' by the Care Quality Commission in-year with some areas achieving 'excellent'. A Smoke-free pathway in Wirral's maternity services has been established. Significant reductions in smoking quit rates were delivered for women on the maternity pathway.

Unscheduled Care
Urgent and Emergency Care transformation reduced the No Criteria to Reside (NCTR) from 30% to 18% of general and acute beds at WUTH by improving discharge processes and access to community services. These included roll out of the HomeFirst service which supports people with rehabilitation and reablement needs to return home. An Urgent Crises Response (UCR) service supported people who would have otherwise been admitted to hospital.

Primary and Community Care
The Primary and Community programme has established its programme structure and agreed to incorporate the Ageing Well agenda into the programme. The first Primary and Community programme development workshop took place in January 2024.

Children and Young People
A new model for Neurodevelopment has been co-produced which will see a strengthened support offer and a multi-disciplinary team approach to diagnosis. Implementation will begin early summer 2024. The graduated response in schools was launched in September 2023 which encompasses a broad range of support and early intervention to promote inclusion. A refreshed local offer site SENDLO was launched in November 2023.

'My Happy Minds' Programme has now been rolled out to all schools in Wirral and strengthens the whole school approach to mental health. The mental health gateway and dynamic support database have been streamlined with one place to identify and support children with complex needs. The last 12 months has seen a number of children better supported alongside the planning and development of new provision to better support children and families.

Learning Disability and / or Autism
The Learning Disabilities programme has co-produced strategies for All Age disabilities, Autism and supported employment which are on trajectory to deliver in March 2024. A remote monitoring scheme for people with Learning Disabilities in residential homes has been piloted in two Primary Care Networks (PCNs). An agreement has been reached for the Strategy and Transformation Group to increase the scope of the programme to include All Age disabilities.

Mental Health
Acute patient flow work has made good progress in reducing the number of out of area beds. Four 'SuperMADE' events were initiated, with success in supporting discharge for patients where difficulties have previosuly been experienced. Improvements in communication and information flows have been identified as part of an Integrated Housing Project.

1.2.8 Delivering on our statutory duties

1.2.8.1 Introduction

NHS Cheshire and Merseyside is confident that it meets its statutory duties. The following sections provide details of the arrangements in place to facilitate delivery, including roles and responsibilities, governance structures; strategies and plans; partnership and joint working arrangements; engagement and participation mechanisms.

1.2.8.2 Improving quality

NHS Cheshire and Merseyside continues to strengthen its overarching quality governance framework to ensure the population of Cheshire and Merseyside have access to services that are safe and effective and offer a good patient experience.

Oversight of quality is retained within Cheshire and Merseyside's nine Places, to ensure it remains as close to the local population as possible. Each of the Places have established formal routes to connect with local partner organisations of NHS commissioned services to discuss and agree how services can be accessed and improved. These processes, and the information generated, is shared via the Quality and Performance Committee - a sub-committee of the NHS Cheshire and Merseyside Board.

NHS Cheshire and Merseyside reviews a wide range of intelligence and data to assess the quality of services, including Friends and Family Test information, Healthwatch feedback, Care Quality Commission inspection reports, freedom to speak up (FTSU) and survey data. A performance and quality dashboard acts as the central source of quality and performance data and includes information relating to national and locally agreed performance data including waiting times, infection rates and patient experience metrics.

Place-based quality reports detail how, when risks to quality are identified, work is undertaken in collaboration with system partners to improve the quality of service provision.

Examples in 2023-24 include:

- implementation of the Patient Safety Incident Response Framework (PSIRF) in Autumn 2023 across all NHS Providers to provide effective systems and processes for responding to patient safety incidents.
- establishment of a Citizen and Insight Group to provide insight and feedback from a range of sources to support improvements to the quality of commissioned services. Initially it has only included information captured by the ICB (via PALs and Complaints data) but the ambition is to expand this during 2024-25 to incorporate information from other sources such as Healthwatch and the Voluntary, Community, Faith and Social Enterprise Sector.
- establishment of the system oversight framework process to support organisations to improve their oversight rating by jointly assessing the quality improvement work undertaken and ensuring its positive impact for both staff and service users.
- the System Quality Group (SQG) has led a quality improvement on maintaining the safety of people experiencing long A&E waits. This has been adopted across Cheshire and Merseyside and is due to be replicated across the North West.
- transformation work within the All Age Continuing Care (AACC) programme including a review of the Target Operating Model and alignment of policies and procedures. These changes will be implemented from 1st April 2024 and will help to reduce unwarranted variation across Cheshire and Merseyside, ensure compliance with the NHS National Framework and improve quality of care and reduce costs.
- development of a Cheshire and Merseyside Quality schedule for the 2024-25 contracting round to ensure consistency in approach with all NHS commissioned services.
- organising a cross-system Never Event Summit, facilitated by AQUA, is planned for May 24 to facilitate system-wide learning and sharing of best practice.

NHS Cheshire and Merseyside continues to focus on work on improving access to diagnostic, cancer, and planned care services in line with national standards. The number of incomplete pathways in NHS Cheshire and Merseyside is 3.4% higher than at the end of April 2023 compared with 2.5% nationally.

There is ongoing monitoring of diversity in NHS Cheshire and Merseyside in the senior leadership tiers at Board, Executive and succession lines of senior leadership. Tackling workforce inequalities includes the development of cultural competence across the organisation to drive a just culture and inclusive leadership development to further improve staff experience and opportunities.

The Freedom to Speak Up mechanism was strengthened in 2023-24 with additional Freedom to Speak Up guardians and the establishment of the Freedom to Speak Up ambassador's network to raise awareness and promote the value of speaking up, listening and following up.

Promoting choice and personalisation for patients and their carers: the Cheshire and Merseyside Strategic Carers Partnership Group was established in spring 2023. It is chaired by the ICBs Associate Director of Strategy and Partnerships and the Cheshire and Merseysude ADASS lead for Carers, with

membership also including Local Authorities, Acute and Mental Health NHS Trusts, primary care and carer organisations, bringing together key stakeholders from across the system.

This partnership is a key vehicle for sharing information, learning and good practice, and driving forward the ambitions outlined in the Health and Care Partnership Strategy and Joint Forward Plan.
Key achievements include:

- a Carers Charter for Cheshire and Merseyside published on Carers Rights Day (23 November 2023).
- aim to increase the number of carers identified year on year by 5% for the period of our Joint Forward Plan (2023-28) was met in 2023-24 with an increase of carers registered with GPs across Cheshire & Merseyside between Q1 and Q3 2023-24 of 5.21% (compared to all England average of 3.95%).

A Strategic Personalised Care Group with representation from across Cheshire and Merseyside was formed to focus initially on increasing the number and quality of personal health budgets (PHB).
Key developments and achievements include:

- the completion of a member survey to support the development of an NHS Cheshire and Merseyside action plan for presentation to Health and Wellbeing Boards in 2024.
- a dashboard is being created to measure and demonstrate the progress in each Place in increasing provision of PHBs.
- presentations have been given to a number of provider trusts focused on the evidence around the impact of a personalised approach to health care.
- NHS Cheshire and Merseyside will include targets related to personalisation in the NHS contract in 2024-25.

Case Study: ‘Harvey’s Story’

Personalised care supports a patient’s mental health, aims to prevent readmission and potentially assists with future job options.

Harvey became unwell and was admitted to Tier 4 Child and Adolescent Mental Health (CAMHS) for care and treatment for his mental health. He was eligible for Section 117 aftercare on discharge.

During discharge planning Harvey’s case manager identified how important dance is to him and so used the Commissioning Policy and Personal Health Budget to consider ways to support his recovery in a personalised manner.

His case manager used the exceptional circumstances procedure to balance a range of factors and we agreed to jointly fund £136 per week, 50% split with the Local Authority – (£68 cost to NHS Cheshire and Merseyside) to enable Harvey to attend two dance lessons per week.

This enabled Harvey to continue to develop his lifelong passion, supporting his Mental Health, despite continued struggles, with an aim to reduce and prevent readmissions.

Harvey has now gained a place at Leeds university to study musical theatre.

1.2.8.3 Safeguarding

NHS Cheshire and Merseyside has a statutory duty to ensure arrangements are in place to safeguard, protect and promote the welfare of children, young people, and adults at risk of abuse and harm.

The Children Act (1989-2004), Working Together to Safeguard Children (2018-23) and Care Act (2014) underpin the work of the Safeguarding and Children in Care teams which supports NHS Cheshire and Merseyside in discharging its duties for adults at risk, children and families living across Cheshire and Merseyside. Section 11 of the Children Act (2004) places a legal duty on all health organisations, including Integrated Care Boards to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

NHS Cheshire and Merseyside has Place-based safeguarding teams covering each of the nine Places. The team includes Associate Director of Safeguarding, Head of Safeguarding, Associate Directors of Quality and Safety Improvement at Place, Designated Nurses and Professionals, Named GPs, Designated Doctors for Child Protection and Child Death and Children in Care and safeguarding administrators.

NHS Cheshire and Merseyside's governance is via the System Oversight Board, which is chaired by the Executive Director of Nursing and Care and reports to the Quality and Performance Committee.

The Safeguarding Oversight Group has delegated responsibility from the System Oversight Board which sets the NHS strategic context for our statutory functions: Child death overview; safeguarding children; children in care and adults at risk.

This Group provides assurance, scrutiny, and exceptions about NHS practice for these functions in each of the nine Places, reviewing associated learning and health inequalities within safeguarding or children in care, against the Safeguarding Children, Young People and Adults at Risk NHS: Safeguarding Accountability and Assurance Framework 2022 (SAAF). This group reports to the System Oversight Board to give assurance that NHS Cheshire and Merseyside is meeting its statutory duties against these functions.

There is a Designated Professionals and Named GP Group which is held quarterly to share best practice, provide peer supervision, and embed local, regional, and national safeguarding learning into practice. This group reports into the NHS Cheshire and Merseyside Safeguarding Oversight Group.

During 2023-24, assurance of commissioned NHS trusts and other health providers using the contractual process via quality schedules, safeguarding Key Performance

Indicators, NHS England commissioning standards, Section 11 audits, action plans and self-evaluation frameworks.

Safeguarding is a joint responsibility within the NHS, Local Authority and Police. Place teams drive improvements through local and regional partnership working to ensure there is a responsive safeguarding practice to address national and local priorities.

The safeguarding team is an active participant in multi-agency statutory reviews commissioned by the nine Safeguarding Childrens Partnership and Safeguarding Adults Boards. In 2023-24 there were 71 open statutory reviews across Cheshire and Merseyside, of these there were 16 Child Safeguarding Practice Reviews, 21 Safeguarding Adult Reviews and 34 Domestic Homicide Reviews. The themes from the reviews include neglect, self-neglect, professional curiosity, and exploitation.

Several multi-agency audits have been undertaken in 2023-24 including domestic abuse, elected home education, neglect and 'was not brought' for children and adults as well as oversight of the Safeguarding Childrens Partnerships Section 11 Audits.

In line with the SAAF guidance, health workstreams across Cheshire and Merseyside include:

- Child Protection Information Sharing (CP-IS) which assists information sharing between local authorities and health providers
- Serious Violence Duty
- Prevent
- Child Death Overview Panel and local and regional Safe Sleep campaigns
- Working Together; supporting interagency working to safeguard and promote the welfare of children
- Asylum seekers housed in hotels including unaccompanied children: working with the Home Office and Serco with regards to safeguarding
- Domestic Abuse
- Mental Capacity Act and Liberty Protection Safeguards.

The safeguarding team continues to promote effective joint working across the Integrated Care System. NHS Cheshire and Merseyside has representation on other statutory partnerships including Child Death Overview Panels, Corporate Parenting Boards, Channel Panels, Multi-Agency Public Protection Arrangements Boards, Domestic Abuse Partnership Boards and Community Safety Partnerships.

In line with statutory guidance, Children in Care should receive an initial health assessment to evaluate the child's physical health and any requirement for access to specialist behavioural, mental, and emotional health assessment within 20 working days of becoming a child in care. In 2023-24 performance against this measure has been challenging due to several reasons, this is a focus for improvement in 2024-25.

Workshops have taken place throughout the reporting period for care leavers to promote working in the NHS which has led to the implementation of the Cheshire and Merseyside Care Leavers Covenant.

NHS Cheshire and Merseyside have contributed to each of the safeguarding partnership/boards annual reports which outline key achievements and priorities for each Place. Safeguarding governance routes within each Place and wider governance ensure continued oversight and contribution to the work of partnerships and boards is maintained. Each Place Safeguarding Childrens Partnership and Safeguarding Adults Board annual report can be found on the websites given in Table 11:

Table 11 (links last checked on 140624)

Place	Safeguarding Childrens Partnership links	Safeguarding Adults Board links
Cheshire East	Cheshire East Safeguarding Children's Partnership (CESCP)	Cheshire East Safeguarding Adults Board
Cheshire West	Cheshire West Safeguarding Children Partnership	Cheshire West and Chester Safeguarding Adults Board
Halton	Halton Children & Young People Safeguarding Partnership	Halton Safeguarding Adult Board
Knowsley	Knowsley Safeguarding Children Partnership	Knowsley Safeguarding Adults Board
Liverpool	Liverpool Safeguarding Children Partnership (LSCP)	Liverpool Safeguarding Adults Board (LSAB)
Sefton	Sefton Local Safeguarding Children Partnership	Sefton Safeguarding Adults Board
St Helens	St Helens Safeguarding Children Partnership	St Helens Safeguarding Board
Warrington	Warrington Safeguarding Partnerships	Warrington Safeguarding Partnerships
Wirral	Wirral Safeguarding Childrens Partnership	Wirral Safeguarding Adults Partnership Board

1.2.8.4 Special Educational Needs and Disabilities (SEND)

NHS Cheshire and Merseyside has a statutory duty to comply with the Children and Families Act (2014) and SEND Code of Practice (2015) which provide legislative guidance to ensure a holistic approach is taken to identify, assess and meet the education, health and social care needs of children and young people aged 0-25 years with SEND.

Places in Cheshire and Merseyside are required, via local area partnerships, to develop appropriate provision to meet the needs of children and young people with SEND, to ensure positive experiences and outcomes.

NHS Cheshire and Merseyside has established clear SEND leadership and governance in compliance with statutory guidance regarding executive lead roles within Integrated Care Boards.

Prior to the publication of this statutory guidance, NHS Cheshire and Merseyside appointed a Senior Responsible Officer for SEND and a Head of SEND post within its corporate structures. These are additional to increased capacity of Designated

Clinical Officers (SEND) at Place-level and ensure oversight and assurance of consistent, high-quality, SEND practices across Cheshire and Merseyside.
Work is progressing to collate a Cheshire and Merseyside-wide core data dashboard for SEND 0-25, managed and validated by our Business Intelligence Team. The dashboard will be used by Place leadership teams, the SEND Collaborative Unit and Senior Responsible Officer for SEND.

This data provides robust evidence of incidence, prevalence, performance and waiting times for key areas related to this population cohort.

The effectiveness of local area partnerships is assessed via Joint Ofsted / Care Quality Commission Area Inspection.

There are three possible outcomes of area SEND inspection:

Inspection outcome
Positive experiences and outcomes for CYP with SEND. The local area partnership is taking action where improvements are needed.
Inconsistent experiences and outcomes for CYP with SEND. The local area partnership must work jointly to make improvements.
Widespread and/or systematic failings leading to significant concerns about the experiences and outcomes of CYP with SEND which the local area partnership must address urgently.

To date, there have been two inspections in Cheshire and Merseyside under the new framework. The first was found to demonstrate inconsistent experiences and outcomes, with a more recent one finding widespread and / or systematic failings.

In both, the improvements required of health partners was important but not the most significant shortcomings within the local area. It is clear that service specifications for health commissioned services are not compliant with legislation. Children and Young People commissioners across the Cheshire and Merseyside footprint have been alerted to this area of weakness.

The SEND Collaborative Unit has advised commissioning managers of what is needed and provided guidance and examples of the content required in service specifications - together with the data required and the SEND core data dashboard.

One area retains a Written Statement of Action and continues to receive additional scrutiny by NHS Cheshire and Merseyside's Senior Responsible Officer and Head of SEND in order to support and challenge progress against improvement plans.

1.2.8.5 Engaging people and communities

This section of the annual report sets out how NHS Cheshire and Merseyside delivered its statutory duties for involving people during 2023-24, and the plans we are putting in place to harness the power of meaningful engagement with our population to develop effective, responsive services.

The main duties on integrated care boards to make arrangements to involve the public are set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022: section 14Z45.

NHS England's *Working in partnership with people and communities: statutory guidance* (published July 2022)[6] provides further information about meeting these duties.

1.2.8.6 Our involvement approach

In spring 2022, local Healthwatch and voluntary community faith and social enterprise (VCFSE) organisations were involved in producing a draft public engagement framework for NHS Cheshire and Merseyside. It explained our intentions as a new organisation (established on 1 July 2022) for involving the public. Using the draft framework as a foundation, we are now moving to an annual involvement plan: a practical overview of how we will work with people and communities. We began developing this during early 2024, and it will be presented to NHS Cheshire and Merseyside Integrated Care Board for approval in Spring 2024.

1.2.8.7 Involvement governance

Recognising the importance of a robust governance process for involvement, during 2023-24 a new People and Communities Insight and Experience Group was established. Reporting to NHS Cheshire and Merseyside's Quality and Performance Committee, the group's responsibilities include considering involvement plans and outputs. It has provided input to the new involvement plan, ahead of it being presented to the committee for recommendation to NHS Cheshire and Merseyside. The People and Communities Insight and Experience Group sits within a wider involvement governance infrastructure. During 2024-25, we will finalise and agree these arrangements, ensuring a clear approach to both agreeing plans and reporting on activity.

1.2.8.8 Involvement infrastructure

In general, our involvement approach is designed around the specific needs of each piece of work, and how best to engage with the audience we want to reach. However, there are several key mechanisms which underpin our involvement infrastructure.

[6] https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/ (last checked on 140624)

1.2.8.9 NHS Cheshire and Merseyside Citizens' Panel

Established in October 2022, our Citizens' Panel is designed to gather insights about peoples' views and experiences, and anyone living in Cheshire and Merseyside can join. Panel members are regularly sent short online questionnaires on a range of subjects, with response levels typically high. Topics members were invited to share views on during 2023-24 included:

- **The Cheshire and Merseyside Health and Care Partnership draft interim strategy:** Panel feedback was reviewed and used to develop the final interim strategy, as well as a more detailed delivery plan, the Cheshire and Merseyside Joint Forward Plan.
- **GP access:** Panel feedback about people's views on the role of other healthcare professionals in the GP practice team will be used to help ongoing communications activity about accessing primary care.

Different methods have been used to recruit to the panel since its launch, including social media promotion and face-to-face events. Currently, there are several hundred people registered to take part, but we plan to expand membership during 2024-25, as part of a recruitment and retention programme.

1.2.8.10 Communications channels

NHS Cheshire and Merseyside oversees a range of different channels for communicating with the public and stakeholders, including:

- our social media accounts: X (formerly Twitter), Facebook, Instagram and YouTube
- monthly NHS Cheshire and Merseyside and Cheshire and Merseyside Health and Care Partnership newsletters, which people can sign up for via our website.
- a dedicated fortnightly newsletter for people working in Cheshire and Merseyside's 349 GP practices.
- bi-monthly meetings of NHS Cheshire and Merseyside Integrated Care Board, held in public, including a public question time session at the start of the meeting.
- our corporate website: www.cheshireandmerseyside.nhs.uk includes an involvement section, which is currently being redeveloped to better highlight opportunities for people to share their views in engagements or public consultations.

Like many organisations, our core communications channels are largely online, and during 2024-25, we will explore how we better reach those who are not digitally engaged, particularly during specific engagement and public consultation activity. To do this we will work with partners, such as Healthwatch and NHS trusts, to make the most of existing groups and networks.

1.2.8.11 Working with partners

As an organisation serving a population of 2.7 million people, it is critical that our involvement approach recognises the huge number of existing groups and networks that exist across Cheshire and Merseyside.

Healthwatch

A key partner, at both Place and system level, Healthwatch organisations occupy a unique position as local health and care champions. NHS Cheshire and Merseyside is working with Healthwatch colleagues to establish an ongoing dialogue around communications and engagement. Two meetings were held during 2023-24, and we plan to build on this over the next year, to maximise the benefits of working together, and utilise our collective reach and experience. In addition, Healthwatch representatives have been invited to take part in communications and engagement groups to support specific projects and pieces of work, including the Women's Hospital Services in Liverpool Programme.

Place communications and engagement collaboratives

During 2023-24, NHS Cheshire and Merseyside produced draft guidance to help inform the development of communications and engagement collaboratives – groups that bring together different partners at place to plan and deliver local communications and engagement activity. We have also focussed on supporting the initial set up of groups in areas where there are not existing arrangements. An NHS Cheshire and Merseyside representative will join each collaborative, providing an important link for our NHS Cheshire and Merseyside programmes of work. This recognises that NHS Cheshire and Merseyside is part of our wider Health and Care Partnership, and we view collaboration on engaging and involving people as essential to achieve consistency in approaches and sharing best practice.

NHS provider organisations

During 2023-24, NHS Cheshire and Merseyside co-ordinated and took the lead for several system priority areas of work, recognising our role as a system leader. We worked with colleagues from NHS trusts, local authorities, and others to lead communications on a range of issues, including NHS industrial action, winter pressures, and measles communications. By facilitating a system approach, we were able to make the best use of resources, reduce duplication, and most importantly, ensure clear, consistent messaging for our population.

1.2.8.12 Working with elected representatives

Throughout 2023-24, NHS Cheshire and Merseyside has developed and improved its approach to political engagement – with particular emphasis on MPs as representatives of 26 constituencies across Cheshire and Merseyside and, collectively, 2.7 million people.

In addition to streamlined processes to respond to MP and constituent enquiries both comprehensively and in a timely manner, a rhythm of regular touchpoints between NHS Cheshire and Merseyside's senior leaders and MPs are in place. These are supported by bi-monthly written briefings which share key updates about cross-cutting areas of work which are typically subject to political scrutiny – including elective recovery, cancer, children's services and NHS Dentistry.

Bespoke briefings are also developed on an issue-by-issue basis to keep MPs – and therefore impacted constituents – appraised of key updates.

1.2.8.13 Primary care communications and engagement

Building capacity

As most people's main touchpoint with NHS services, general practice presents an important opportunity to engage with people, but skills and capacity to support this work can be limited.

In 2023-24, NHS Cheshire and Merseyside rolled out a programme aimed at helping practices and primary care networks (PCNs) to improve the way they involve patients. Recognising that there is already some great involvement work taking place in general practice across Cheshire and Merseyside, we also wanted to encourage practices to routinely share best practice and learning. A series of online and face-to-face events for practices and PCNs took place during March 2024, and we worked with primary care teams to develop a toolkit for supporting patient participation group (PPG) development.

Initial feedback from those involved has been positive, and a peer network has been established to continue discussions and learning. An evaluation is currently being developed, and during 2024-25 we will look at whether there are elements of the programme that could be extended to other parts of primary care.

Access

In Autumn 2023, a programme of communications activity got underway to support NHS Cheshire and Merseyside's Primary Care Access Improvement Plan. This has included utilising national campaign assets highlighting the range of professionals now working as part of GP practice teams; promotion the NHS app; and the launch of the new Pharmacy First service in early 2024. We have also worked with GP practices in Cheshire and Merseyside to develop our own localised content, and during 2024-25 we will continue to look for new routes to share information and advice about using services.

Practice changes

Over the past year we have worked with colleagues in a number of GP practices to ensure that patients are involved in proposed changes to services, including branch closures, providing guidance and support around communications materials, and briefing wider local stakeholders.

1.2.8.14 Projects and programmes

Women's Hospital Services in Liverpool Programme

Involvement activity will form a key element of this programme, which is considering the issues facing hospital maternity and gynaecology services in Liverpool.

During 2023-24, we focussed on identifying communications and engagement requirements for the programme, in line with the development of a wider programme plan. Alongside this, a series of regular updates have been provided on the women's

services page of the NHS Cheshire and Merseyside website and featured in our monthly email newsletter.

In March 2024, we shared plans to recruit two public advisors, a lived experience panel, and a virtual reference group. These arrangements are due to be put in place from May 2024.

We have established a communications and engagement group, reporting to the programme board, which brings together key NHS organisations involved with the programme and Healthwatch, to plan and deliver involvement activity.

Children and young people's mental health
In early 2024, engagement took place to support the development of a refreshed Children and Young People's Mental Health Transformation Plan.

Feedback was received from ten existing groups for children, young people, parents and carers across Cheshire and Merseyside, and more than 200 health professionals. This will be used to inform the plan, which is due for publication in summer 2024, subject to governance timescales.

Harmonisation of clinical policies
In March 2024, NHS Cheshire and Merseyside published a further 35 clinical policies for treatments and procedures that have been updated in line with the latest evidence of what works best, in the second phase of its harmonisation programme to also ensure equal access for patients no matter which part of the area they live in. This second phase brought the total of completed policies up to 84, and we are now in the process of working with partners to harmonise the remaining 29 policies. This includes looking at the level of public involvement needed for each harmonised policy, in terms of how we both share information and invite feedback where it is required.

Pulmonary rehabilitation
During Autumn 2023, we engaged with patients around a Cheshire and Merseyside-wide specification for pulmonary rehabilitation. The outcome of the engagement was extremely positive and reinforced our thinking on the draft service specification. The feedback also allowed teams to develop their own patient panels which will support future engagement work.

1.2.8.15 Reducing Health Inequalities

Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)
The All Together Fairer programme deliberately and specifically focuses on the social determinants of health - the social, economic and environmental conditions in which people are born, grow, live, work and age in to reduce inequality in health. The eight Marmot principles are:

- **Marmot Principle One:** Give every child the best start in life
- **Marmot Principle Two:** Enable all children, young people and adults to maximise their capabilities and have control over their lives
- **Marmot Principle Three:** Create fair employment and good work for all

- **Marmot Principle Four:** Ensure a healthy standard of living for all
- **Marmot Principle Five:** Create and develop healthy and sustainable places and communities
- **Marmot Principle Six:** Strengthen the role and impact of ill health prevention
- **Marmot Principle Seven:** Tackle racism, discrimination and their outcomes
- **Marmot Principle Eight:** Pursue environmental sustainability and health equity together.

Although the implementation of the Marmot All Together Fairer programme formally began after the report was launched in May 2022, there was already implementation of activity on the social determinants of health underway across Cheshire and Merseyside.

The All Together Fairer programme clarified the scale of the challenge by:
- providing detailed data analysis
- setting out the evidence of what works and best practice elsewhere.
- providing the context to inspire existing programmes of work and initiate specific new programmes to address inequality through the social determinants of health.

Examples of good practice include:
- the Liverpool City Region Fair Employment Charter preceded the Marmot final report but is clearly working to the Marmot theme on “Create fair employment and good work for all”. There are now a total of 100 Aspiring Level Fair Employment Charter organisations in the City Region, and 11 healthcare and nine social care organisations have completed an application form to become part of the Fair Employment Charter
- the NHS Prevention Pledge programme is successfully working with NHS Trusts across Cheshire and Merseyside to support, inspire and challenge trusts to adopt employment practices that recruit people from the poorest areas in the sub-region
- the Beyond children and young people programme is working with Barnardo’s and two other Integrated Care Systems to develop and implement a Children and Young People’s Health Equity Framework, specifically focussed on social determinants of health.
- the Cheshire and Merseyside NHS Anchors programme is supporting Trusts to look at their wider societal role and a group of GPs have initiated an initiative to support those practices working with the most deprived populations
- new strategies and excellent work have been initiated in boroughs and includes the Sefton Child Poverty Strategy, Liverpool Housing and Health programme, Halton Wider determinants programme and more.

Each of Cheshire and Merseyside’s nine Places has a dedicated All Together Fairer lead. A stocktake took place around the delivery of All together Fairer each of the eight Marmot themes and the seven system recommendations this identified significant:
- Cheshire and Merseyside level activity
- Cheshire and Warrington level activity
- Liverpool City Region (LCR) Combined Authority level activity
- Borough / Place-level activity.

There is good practice on the social determinants of health at all levels. Each Place was able to note innovation in family hubs, employment workshops, movement towards paying a real living wage for social care work and a child poverty strategy.

Work at the next administrative level includes fair employment charters, work in Foundation Trusts co-ordinated and inspired through the NHS Prevention Pledge, and the development of the healthy equity framework for children and young people.

Improving population health and healthcare
Our Joint Forward Plan outlines our commitment to improving the health of our population through our Population Health programme, focusing on early intervention, tackling inequalities, addressing wider determinants and promoting good health.

Our system is diverse, containing both urban and rural communities including areas of high deprivation and ethnically diverse communities. Consequently, we need to adapt our approaches to respond to local need, and a wide range of activities are already happening at both Cheshire and Merseyside and Place-level.

Our established system-wide Population Health Board oversees our Population Health programme of work. The aims are to improve health outcomes and reduce health inequalities by embedding sustainable system-wide shift towards focusing on prevention and health equity. Our Director of Population Health plays a key leadership role in this work.

Case Study: Wellpoint Kiosks help prevent strokes and heart attacks

Cardiovascular disease (CVD) is one of the leading causes of ill health, premature death and health inequalities in Cheshire and Merseyside.
Initiatives to reduce CVD have been running in Cheshire and Merseyside for several years and a recent success has been the wider roll out of Wellpoint Kiosks.

Eight touchscreen self-serve Wellpoint Kiosks, funded by Integrated Care System transformation funding via the CVD Prevention Group, were placed in a range of community locations across areas of Cheshire and Merseyside with high levels of deprivation. Locations included leisure, retail and workplace settings, such as bus depots, with the aim of increasing access to blood pressure testing.
The kiosks have been freely available to the public to measure blood pressure (BP), weight, body mass index (BMI) and other metrics.

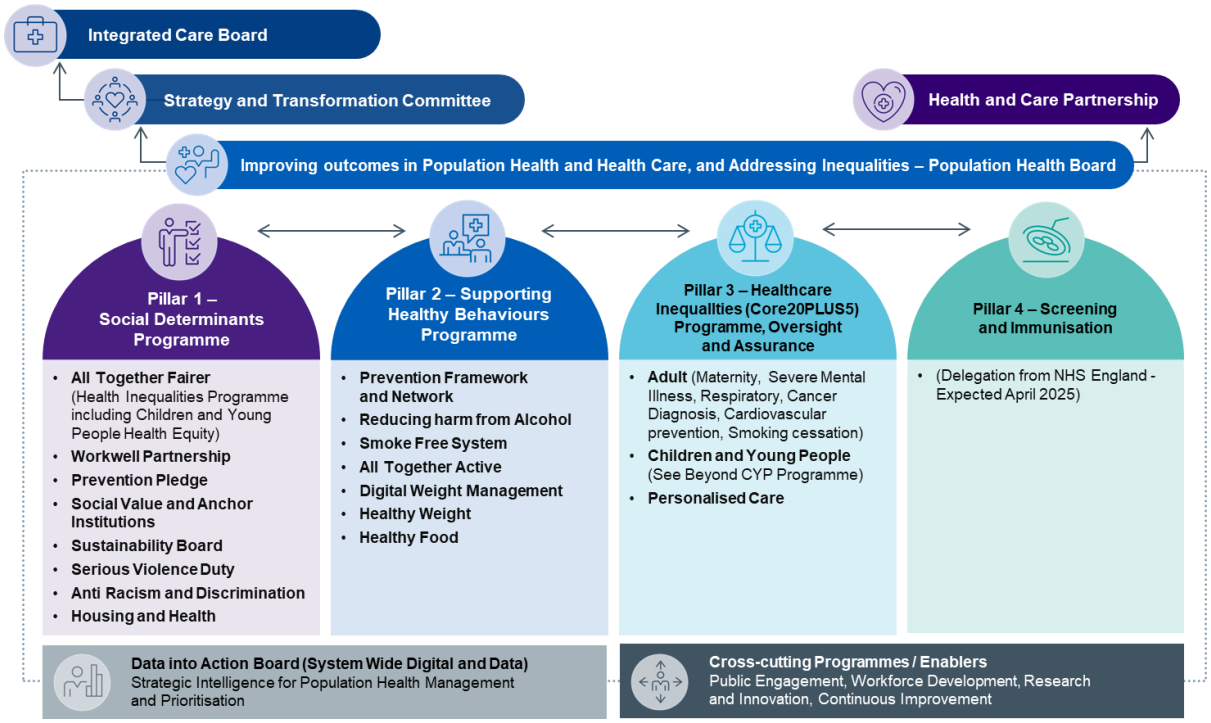
In line with the Hewitt Review recommendations, as an Integrated Care Board we intend to increase year-on-year the proportion of our budget being spent on prevention. Multiple agencies invest in the prevention agenda, and we will work with partners to map existing investment to allow a holistic assessment of how to best invest resources in future.

Population health programme priorities are as follows:

- **Priority One:** Build system-wide population health capability and capacity
- **Priority Two:** Improve our strategic business intelligence capabilities
- **Priority Three:** Address the social determinants of health
- **Priority Four:** Promote community-centred approaches to improving Population Health
- **Priority Five:** Deliver the Core20PLUS5 priorities across the system
- **Priority Six**: Focus on prevention at scale and Making Every Contact Count
- **Priority Seven**: Roll out and implement the NHS Prevention Pledge
- **Priority Eight**: Strengthen screening, vaccination and immunisation uptake
- **Priority Nine**: Co-ordinate work across the Integrated Care System through appropriate governance, assurance and oversight arrangements.

We have continued to develop our approach in relation to Population Health and addressing inequalities our developing NHS Delivery Plan for 2024-29 describes our ambitious plans focusing on four core pillars (Diagram Five).

Diagram Five



1.2.8.16 Equality, diversity and inclusion

The Public Sector Equality Duty (PSED) as set out in the Equality Act 2010, requires public authorities, in the exercise of their functions:

- to eliminate unlawful discrimination, harassment and victimisation.
- advance equality of opportunity between people who share a protected characteristic and those who do not and

- foster good relations between people who share a protected characteristic and those who do not.

The protected characteristics include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

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

For NHS Cheshire and Merseyside, strategic Equality, Diversity and Inclusion (EDI) leadership sits within the corporate director and senior leadership structures. The Chief People Officer acts as Senior Responsible Officer for EDI, Workforce and Organisational Development at Board level.

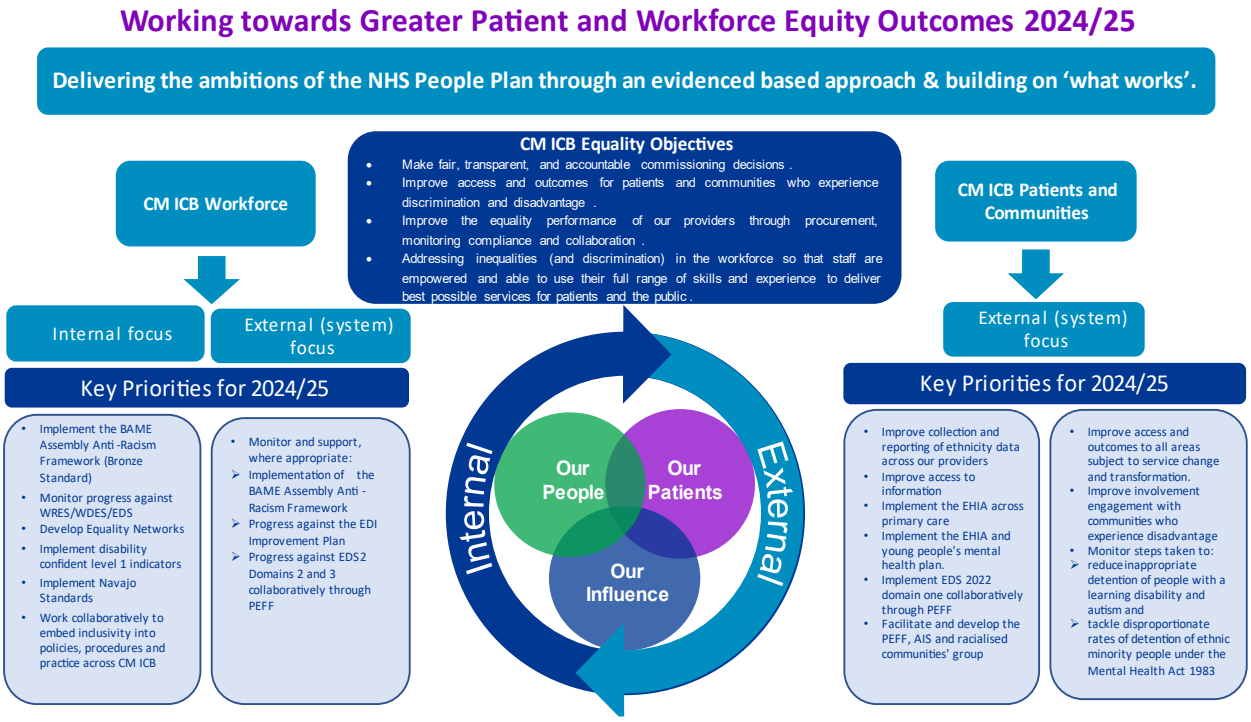
From a patient and commissioning perspective, the Senior Responsible Officer for EDI is the Assistant Chief Executive Officer. The Associate Director of EDI also provides strategic leadership across the organisation.
To support NHS Cheshire and Merseyside to evidence how it is meeting its PSED and its specific duties an Annual Equality, Diversity and Inclusion report (2023-24)[7], has been produced which provides a:
- summary of how equality of service delivery to different groups has been promoted through the organisation.
- equality information relating to our workforce and patients including customer satisfaction scores broken down by protected characteristics.
- performance against equality of service delivery systems 2022 implementation.
- activities undertaken to promote equality of service delivery.

The Equality Objectives (2024-27) to support the organisation to meet priorities as its role as a leader, employer and a commissioner are to:
- make fair, transparent, and accountable commissioning decisions.
- improve access and outcomes for patients and communities who experience discrimination and disadvantage.
- improve the equality performance of our providers through procurement, monitoring compliance and collaboration.
- address inequalities (and discrimination) in the workforce so that staff are empowered and able to use their full range of skills and experience to deliver best possible services for patients and the public.

[7] https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/ (last checked on 140624)

To support us with our equality objectives and priorities, we have developed an EDI Plan on a Page (Diagram Six). This plan is aligned to the NHS Cheshire and Merseyside priorities and strategies including the All Together fairer strategy, Health and Care Partnership strategy and Joint Forward Plan.

Diagram Six



NHS Cheshire and Merseyside's commitment to being an anti-racist organisation and to implement the North West anti-racism framework

North West Region – Anti-Racism Statement

NHS England North West supports the commissioning and delivery of high-quality services across Cheshire and Merseyside, Greater Manchester and Lancashire and South Cumbria. NHS England North West also works closely with Integrated Care Boards and NHS Trusts, who have been integral in the development of an Anti-Racism Statement.

NHS England North West are taking a strategic approach to embed equity and inclusion to help improve the experiences of Black and Ethnic Minority patients and staff, which will ultimately improve the patient care we provide and the experiences of our workforce.

NHS England North West are currently implementing the North West BAME Assembly Anti-Racist Framework, a key driver to us becoming Anti-Racist. We will use our resources and partnerships effectively to influence and collaborate with others, challenging each other to eradicate racism in our organisations as we openly acknowledge negative experiences of patients and staff within the North West Region.

What we plan to do
We will not be afraid to address systemic racism within the North West Region and align this statement with our core values, BAME Assembly Anti-racism Framework, the NHS Long-Term Workforce Plan, EDI Improvement Plan and People Promise. Staff are encouraged to speak up safely without fear of reprisal. Patients, staff, and leaders should be able to identify, discuss and challenge racism and we will change policies and practices, taking measurable actions to support this work.

We will eradicate the behaviours and beliefs perpetuating racism. Our commitment is to develop a region where everyone's culture and difference is celebrated, where racism is not tolerated and patients and staff do not experience discrimination in any form. As a region we are united in opposing and dismantling racism in all its forms, creating a welcoming and supportive environment where colleagues' careers flourish and where we are relentless in reducing health inequalities by improving access, experience and outcomes.

How will we drive this?
- we will take action to tackle racism and wider health inequalities that affect our patients and staff.
- have a consistent approach across the North West Region.
- senior leaders will be held accountable, key processes will be introduced to ensure there is a strategic approach to measure improvements.
- we will develop robust mechanisms for our patients and staff to speak up.
- we will understand the lived experience of our patients and staff (listening and learning with regular engagement sessions).
- we will tackle and diminish inequalities.
- we will grow and develop inclusive leaders.
- we will regularly measure progress, setting clear trajectories.

EDI Workforce and leadership (EDI Annual Report)
The Associate Director for Workforce Equality, Diversity and Inclusion is currently reviewing organisational data, processes and policies in line with the legal frameworks, the Equality Delivery System (inclusive leadership and health and wellbeing), Equality Standards, staff survey information, Gender Pay gap reporting and equality analysis. This will inform our priority areas of development.

Emerging work strands include:
- establishment of eight staff networks, including a BAME, Disability and LGBTQ staff support networks. All staff support networks are sponsored by NHS Cheshire and Merseyside executive officers
- ensuring effective and robust EDI fundamental policies and processes in place.
- review of all current people polices through an EDI lens
- review workplace adjustment processes
- review equality analyses processes
- review and identify workforce EDI Accreditations / standards.

Freedom to Speak Up (FTSU)
We are currently refreshing our organisational arrangements for Freedom to Speak up in line with the national self-assessment guidance and current best practice from the National Guardian Office. This includes a review of our organisational strategy, handling and recording processes, FTSU Guardian arrangements, staff training and awareness and ambassadorial roles to support, develop and promote a supportive and safe cultural climate.

It is proposed that a new FTSU Summit is established to review reporting of FTSU data (anonymised) and triangulation with other business intelligence to inform actions and share learning across the organisation and system to support the development of an open culture.

The Executive Team have received an update in respect of this work with assurance reporting to the People Committee and Audit Committee (for effectiveness of our arrangements).

NHS Cheshire and Merseyside have agreed to a Board level Freedom to Speak up Executive sponsor and appointed an FTSU guardian.

EDI patient-focused headline information
NHS Cheshire and Merseyside supported providers on the implementation of Equality Delivery Systems 2022 (EDS 2022) for 2023-24. EDS 2022 is a mandated requirement, which comprises of three specific domains:
1. Commissioned and provider services
2. Workforce health and wellbeing
3. Inclusive leadership.

NHS Cheshire and Merseyside ratings for domain one is **Achieving** across each outcome. This is the **mode** rating, as taken from all of the NHS provider Trusts' individual service review ratings following early adoption of a related toolkit.

Other headline information includes:
- established Accessible Information Standard Partnership to establish community-focused racialised community groups and support commissioners to improve access and outcomes for racially marginalised patients
- ethnicity and inclusion data advisory group to improve ethnicity data recording and data quality across the system
- clinical care constitution - agreements between NHS Cheshire and Merseyside clinicians and decision-makers to guide future working with a primary focus on reducing health inequalities
- digital inclusion approach[8]

[8] https://www.cheshireandmerseyside.nhs.uk/about/digital-and-data-strategy/digital-inclusion-in-cheshire-and-merseyside/ (last checked on 140624)

- Primary Care recovery and improvement Equality and health inequality assessment.[9]

1.2.8.17 Sustainable Development

NHS Cheshire and Merseyside is committed to ending its contribution to climate change by 2040 (or earlier) in line with the national ambitions of NHS England.[10]

Our Green Plan[11] produced in 2022 detailed our commitment and opportunities for a transition to net zero and is aligned with the eight Marmot priorities[12].

That means progressing our work as an Anchor Institution and further embedding social value, working in partnership with our stakeholders and local populations to build greener communities, improve patient pathways, create less waste, utilise energy from sustainable sources and create green jobs, develop sustainable skills and nurture good mental health and wellbeing.

Case Study: Tackling air quality to improve health

NHS Cheshire and Merseyside's sustainability team is working with a range of partners on pioneering projects to tackle poor air quality and its effects on health.

A pilot to monitor air quality at the Royal Hospital in Liverpool is helping to assess how healthy our hospital environments are for staff, patients and visitors alike. This will help to prioritise action to better protect health, such as scheduling clinics to times of day when air pollution is generally lower, along with identifying polluting sources and taking steps to mitigate them. Additionally, the pilot will help to raise awareness of the effects of air pollution and encourage staff, patients and visitors to use active travel or public transport and reduce their carbon footprint to help tackle global emissions and climate change.

As our work on air quality gains momentum, more and more partners from across Cheshire and Merseyside are joining us to consider what more we can achieve together.

Along with Liverpool John Moores University, this includes primary care colleagues, further hospital trusts, voluntary, community and faith organisations and Liverpool City Region Combined Authority.

In 2023 we worked with Alder Hey Children's Hospital to pilot the NHS England 'Healthy Hospital Street' initiative and we will be supporting colleagues to redesign the asthma treatment pathway for Cheshire and Merseyside.

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[9] https://www.cheshireandmerseyside.nhs.uk/media/4gcettof/updated-board-meeting-pack-public-nov23-v11.pdf (last checked on 140624)
[10] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ (last checked on 140624)
[11] Green Plan - NHS Cheshire and Merseyside (last checked on 140624)
[12] https://www.instituteofhealthequity.org/resources-reports/all-together-fairer-health-equity-and-the-social-determinants-of-health-in-cheshire-and-merseyside (last checked on 140624)

Understanding our Carbon Footprint
NHS Cheshire and Merseyside has been engaged in carbon footprinting work to establish an emissions baseline to support a decarbonisation trajectory. For example, scope one and scope two emissions[13] have been calculated for NHS. Cheshire and Merseyside's activity in Wirral Place in line with the Greenhouse Gas (GHG) Protocol[14], and the results (due for publication in May 2024) will inform NHS Cheshire and Merseyside's wider strategy.

1.2.8.18 Green Plan Delivery

Adaptation
In addition to the four nationally mandated Greener NHS priorities: estates and facilities, medicines and anaesthetic gases, supply chain, and travel and transport, the North West region Integrated Care Boards collectively prioritised Climate Adaptation for the years 2022-23 and 2023-24 and have done so again for 2024-25.

Priority areas of action across Cheshire and Merseyside include coastal flooding, mitigation against sustained high temperatures and heatwaves, air quality and preparation for the threat of vector-borne diseases.

Chief Sustainability Officer's Clinical Fellows Scheme
This scheme was established to identify and support clinicians who want to develop as sustainability champions of the future. NHS Cheshire and Merseyside successfully applied to host a clinician – a public health registrar - from September 2023 to August 2024.

Digital Transformation
Our digital strategy aligns with the sustainability agenda in facilitating delivery of alternative models of care with a lower carbon footprint. Examples include reducing unnecessary face-to-face appointments by providing increased access to virtual consultations, health monitoring and virtual wards.

Estates and Facilities
The Integrated Care System's Energy Sub-Group has made collective bids to the Lower Carbon Skills Fund[15] and alongside the Liverpool City Region Combined Authority (LCRCA) for Public Sector Decarbonisation Scheme[16] monies.

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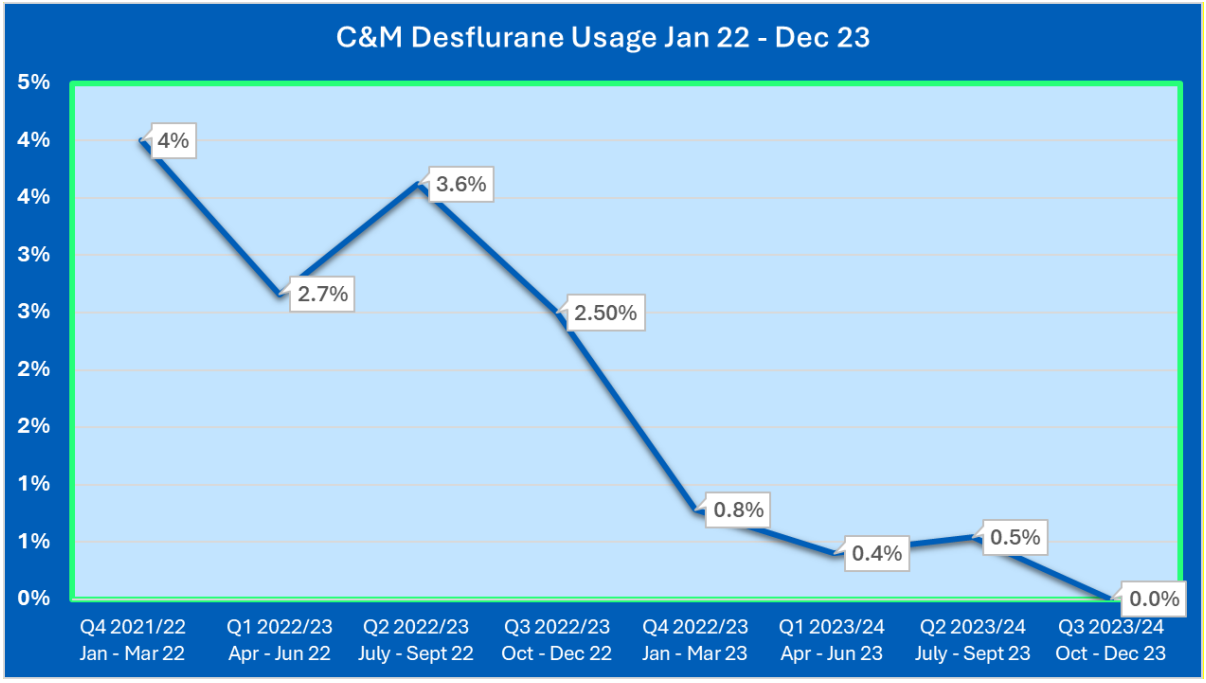
[13] https://www.ons.gov.uk/economy/environmentalaccounts/methodologies/measuringukgreenhousegasemissions#:~:text=Climate%20Change%202013.-,Scopes%201%2C%202%20and%203,including%20the%20full%20supply%20chain (last checked on 140624)
[14] https://ghgprotocol.org/guidance-0 (last checked on 140624)
[15] https://www.gov.uk/government/publications/public-sector-low-carbon-skills-fund-phase-5#:~:text=The%20Public%20Sector%20Low%20Carbon,heat%20decarbonisation%20on%20their%20estate (last checked on 140624)
[16] https://www.gov.uk/government/collections/public-sector-decarbonisation-scheme (last checked on 140624)

HR and Organisational Development
Since April 2023, all NHS Cheshire and Merseyside staff have been required to complete the "Becoming a Net Zero NHS" module as part of their statutory and mandatory training.

Medicines, Prescribing and Anaesthetic Gases
During 2023-24 work to decrease emissions arising from medicines, prescribing and anaesthetic gases increased exponentially across NHS Cheshire and Merseyside, secondary care and primary care. Significant decreases have been initiated by provider Trusts in the use of the most potent anaesthetic gases: in particular desflurane and nitrous oxide.

Figure One charts the reduction in use of desflurane as a percentage of all Anaesthetic gases used from baseline in 2021-22 up to and including December 2023.



Travel and Transport
The first NHS Cheshire and Merseyside staff travel and transport survey took place in Autumn 2023 and was completed by 221 staff - highlighting the barriers and opportunities for NHS Cheshire and Merseyside to reduce carbon emissions associated with staff commuting and business travel.

Current initiatives:
- system-wide deal with Arriva buses for NHS staff to offer discounted rates on monthly bus travel passes.
- cycle to work scheme
- ultra-low and zero emission vehicles (ULEVs and ZEVs) included in staff car lease scheme

- transport and travel sub-group of the Sustainability Board has defined priorities relating to promoting active travel and the use of public transport.

1.2.8.19 Anchor Institutions and Social Value

Whilst recycling, investing in renewable energy and switching to LED lighting and other planet friendly initiatives are hugely important in our journey to net zero, we know that – alone - they are insufficient to achieve the scale of decarbonisation required.

Working as an Anchor Institution involves using the size and influence of the Integrated Care Board to leverage wider health, financial, societal, and environmental benefits.

Since becoming an NHS England social value accelerator site in 2018, Cheshire and Merseyside has developed a Social Value Charter[17] and established the Cheshire and Merseyside Social Value Award.[18] All this work has been co-produced with organisations from across the system, and, importantly, with members of local communities.

NHS Cheshire and Merseyside became the first signatory to the Anchor Institute Framework.[19]

Anchor Work

Anchor institutions are large organisations that have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development and buildings and land use.

Progress in 2023-24 included:

- growing the numbers that have signed to the Anchor Framework
- expanding the sectors that have signed to the Anchor Framework
- establishing an Anchor Assembly
- creating the Anchor Measurement Tool, enabling data to be collected

Social Value

The Public Services (Social Value) Act20 requires those who commission public Services to deliver wider social, economic and environmental benefits through their procurements and activities.

NHS Cheshire and Merseyside has implemented a system-wide social value framework to collectively and consistently measure the social value that we are delivering through a collective set of system themes, outcomes, and measures (TOMs).

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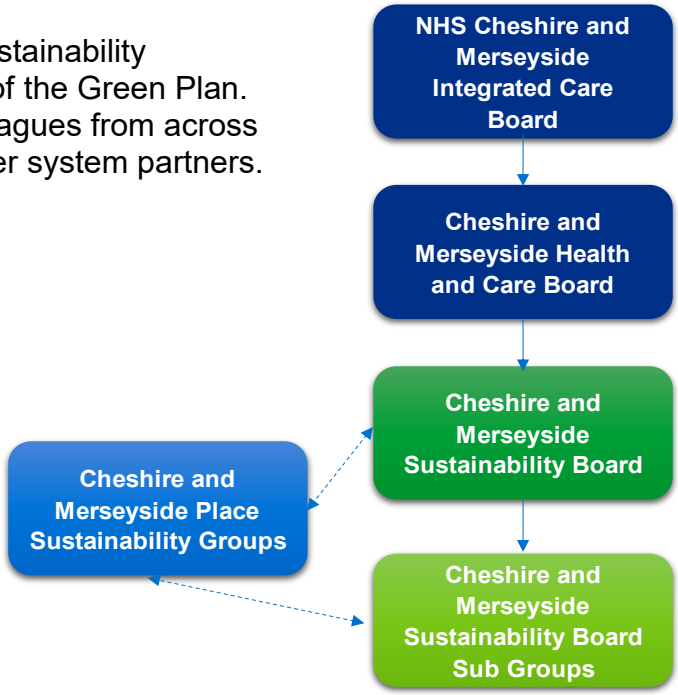
[17] https://www.cheshireandmerseyside.nhs.uk/media/dftnomvj/social-value-charter.pdf (last checked on 140624)
[18] https://www.cheshireandmerseyside.nhs.uk/about/sustainability/social-value/social-value-award/ (last checked on 140624)
[19] https://www.cheshireandmerseyside.nhs.uk/about/sustainability/anchor-institution-framework/ (last checked on 140624)
[20] https://www.legislation.gov.uk/ukpga/2012/3/enacted (last checked on 14.06.24)

NHS Cheshire and Merseyside was the first Integrated Care Board in the country to embark upon this as an entire system - alongside local authorities, NHS Trusts, and the voluntary, community, faith and social enterprise sector.

All organisations will have access to a dashboard with tools including reporting functions and will be able to track progress at a project or organisational level.

Governance
NHS Cheshire and Merseyside's Sustainability Board has oversight of the delivery of the Green Plan. The Board is a collaboration of colleagues from across the health and care system and wider system partners.



1.2.8.20 Promoting Innovation

In 2023-24, the Integrated Care System Digital and Data Strategy[21] continued to shape our digital and data delivery and transformation priorities. We also responded to several emerging national and local priorities.

IT for NHS Cheshire and Merseyside staff
NHS Cheshire and Merseyside was formed from eight predecessor organisations, serviced by three different IT service providers, and has subsequently taken on additional services from NHS England - adding to the complexity of IT service provision across the organisation. In 2023-24, progress was made in standardising IT service provision across corporate and Place-based staff.

- to enable effective online communication and collaboration across our Place and corporate departments, all staff were moved to a Cheshire and Merseyside email address and migrated to a new Microsoft 365 tenant.
- IT service providers worked together on support arrangements to improve cross-agency interfaces and, ultimately, staff experience.

[21] https://www.cheshireandmerseyside.nhs.uk/about/digital-and-data-strategy/ (last checked on 140624)

- c200 new members of staff transferred into NHS Cheshire and Merseyside from other NHS bodies and had their individual and team IT arrangements migrated.
- work to standardise workplace and home office equipment purchasing and wider digital procurement was started.
- supported the IT and digital equipment elements of commissioning and decommissioning NHS Cheshire and Merseyside estates.
- piloted an MS Teams telephony solution.
- standardised the digital elements of the starters and leavers process.

Primary Care Digital Transformation
In November 2023, NHS Cheshire and Merseyside set out its response to supporting recovering access to Primary Care following the publication of the national Recovery Plan. Digital tools and services are a key element of these plans.

Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.

***TARGET*:** Enable patients in more than 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions via the NHS App by March 2024.

As of December 2023, NHS Cheshire and Merseyside is meeting all targets:
- Records: 99.4%
- Appointments: 96%
- Messages: N/A (reporting not currently available)
- Prescribing: 98.57%

Implement modern general practice access to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.

TARGET: Support all practices on analogue lines (35 in Cheshire and Merseyside) to move to digital telephony, including call back functionality, by March 2024.

Target on track to be achieved. An additional cohort of practices with suboptimal digital telephony are also being supported to upgrade.

Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed. We continue to ensure that staff are provided with the appropriate IT and digital equipment to do their jobs.

Cut bureaucracy and reduce the workload across the interface between primary and secondary care. Work is ongoing to develop plans for digital tools and platforms which can support collaboration and communication across the primary / secondary care interface.

In addition, under the delivery plan for recovering access to primary care (PCARP), the expansion of pharmacy services is being digitally enabled via referrals and information transfers between GP and pharmacy clinical systems.

System-wide frontline digitisation – Continued focus on ensuring we have the right digital foundations in place, including universal Electronic Patient Records (EPR) and scaling up Digital Social Care Records. Five NHS provider Trusts are currently embarking on major EPR programmes and are being supported by NHS Cheshire and Merseyside in business case development to secure external investment.

2023-24 brought a significant focus on **stakeholder engagement** across a wide range of major Integrated Care System programmes and initiatives which involve digital and data requirements and developments. This groundwork now provides the **foundations for several major areas of digital priorities to be progressed**, including digital and data support for elective recovery; an Integrated Care System-wide shared care record and a developing digital sub-strategy for maternity. There has also been significant support for the digital elements of a Liverpool Clinical Services Review.

Shared care records are a safe and secure way of bringing electronic patient records from different health and care organisations together digitally in one place. In Cheshire and Merseyside, almost all NHS organisations and some Local Authorities are connected to shared care record solutions. This currently supports around 175,000 patient records accesses per month.

"I feel the difference when we have an out of area or unknown patient now – ability to cross-reference self-reported medical history and medications is hugely beneficial and steadily becomes more so as average patient age and complexity increases." ***EMERGENCY DEPARTMENT CONSULTANT***

"Shared Care Records is an essential service that enables timely access to information (especially out of hours) that supports patient care as well as hospital admission avoidance where appropriate" ***CLINICAL DIRECTOR, PALLIATIVE MEDICINE***

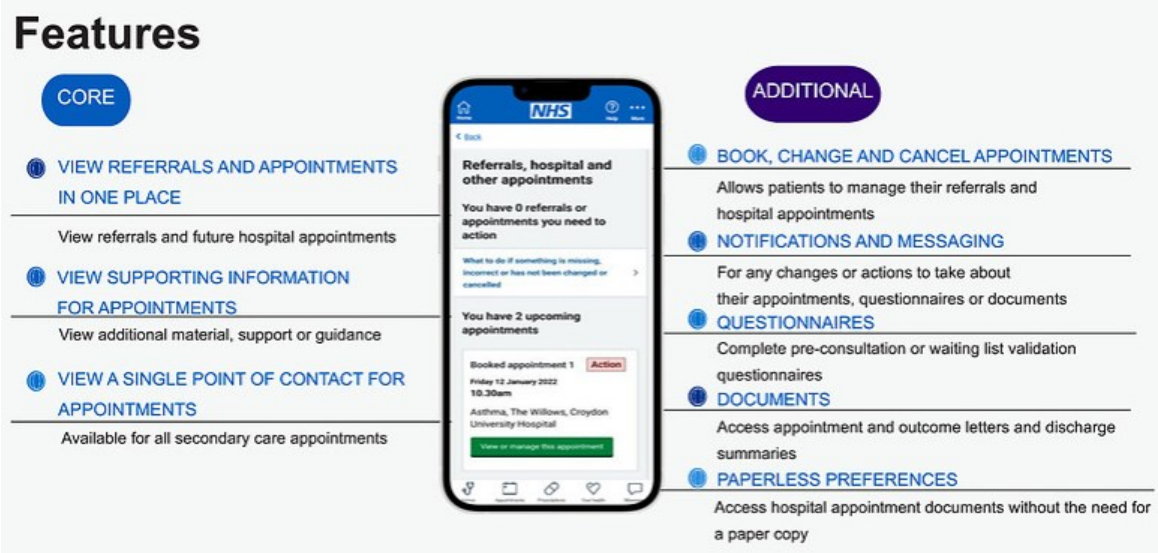
"Working within a responsive service such as District Nursing Out of Hours, we do not carry a caseload. Patients and families self-refer often in a crisis. Occasionally referrals are made by Paramedics. Having access to vital information is imperative in assisting us to better support patients and those important to them in accessing the right care at the right time. Hospital admission is avoided, and patients receive a timely response. More importantly for patients and families, they are not repeating information to numerous HCP as it is available to the reader and therefore improves communication, reduces family/carer anxiety, and provides timely support at bereavement." ***DISTRICT NURSING COMMUNITY SERVICES***

An Integrated Care System-wide **Digital Design Authority** was established in 2023-24. This group is a key enabler and governance mechanism for future digital and

data developments within the Integrated Care System and will support our infrastructure and architecture objectives.

Patient portals – new investments secured in 2023-24 accelerated the deployment of online patient portal technology in secondary care. Portals are being rolled out incrementally and will enable patients seen by hospitals across Cheshire and Merseyside to manage their care and interact digitally with healthcare services.

Figure Two



The Diagnostics Programme is leading the development of a common digital infrastructure. Digital Diagnostics supports pathway redesign, increased efficiency, and productivity through end-to-end connected digital diagnostics provision. The aims are to ensure safety, reduce variation and increase the capability to use technologies such as AI / machine learning, clinical decision support, robotic process automation and intelligent scheduling.

Cyber Security – A five-year Integrated Care System Cyber Security Strategy is currently being ratified through internal governance. The strategy is also aligned to the national Cyber Security pillars with the overall aim to reduce the risk of a Cyber-attack.

Digital Inclusion - There is an Integrated Care System-wide collaborative workstream bringing together good practice, ideas and work to tackle digital inclusion. A digital adoption campaign was delivered from July-September 2023. Post-campaign research showed that those who saw the campaign were 50% more likely to have become more positive about accessing NHS services online. Additionally, 75% of our target group said that the campaign encouraged them to go online.

Population Health - addressing Health Inequalities
In the last year we have progressed c55 population health projects through the Data into Action programme that use the NHS Cheshire and Merseyside integrated data

asset (CIPHA) to segment populations and develop stratified cohorts of patients according to health inequalities.

Data into Action Programme
In April 2023 NHS Cheshire and Merseyside's Board approved an investment case for the continued support for the NHS Cheshire and Merseyside data asset (CIPHA) and the supporting programmes of work. This work was developed into an overarching programme, 'Data into Action', that co-ordinated, and consolidated all of the existing programmes, groups, and organisations that used the data asset. This included teams across NHS Cheshire and Merseyside, public health teams, and academia (the largest of which was the University of Liverpool).

During its first shadow year the programme has developed: a prioritisation process for evidence-based population health projects; overseen the development of a secure data environment to support research; established a population health academy; initiated a public patient involvement and engagement group; and developed a learning health system approach alongside the University of Liverpool.

From April 2024 the Data into Action programme will report directly into the NHS Cheshire and Merseyside Board.

Confidentiality Group Approvals – The CAG is an independent body which provides expert advice on the use of confidential patient information. In 2023-24 NHS Cheshire and Merseyside undertook three separate CAG applications with the following outcomes: risk stratification (approved); population health without explicit consent (approved); research without explicit consent (approved with conditions).

Clinical Policy Harmonisation Programme - Clinical Policy Harmonisation work commenced in 2023-24 to develop a single suite of commissioning policies across Cheshire and Merseyside. The programme has 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 Finance, Investments and Resourcing and 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/ (last checked on 14.06.24)

The programme work is being undertaken by a multidisciplinary team and overseen by the Programme Steering Group under the Executive Sponsorship of Medical Director Prof Rowan Pritchard Jones.

The policy development team analyse the latest evidence including NICE guidance, EBI, clinical research, etc. in order to produce a draft policy. These are then reviewed by clinical teams including GPs, pharmacists, secondary care specialist clinicians, as well as commissioners and business intelligence - and shared widely through clinical networks. Feedback from the clinicians is considered and reflected as appropriate.

Each policy is also subject to an Equality Impact Assessment and a Quality Impact Assessment, with recommendations reported through the Quality and Performance Committee.

1.2.8.21 Research

NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS)

In line with NHS England's guidance on Maximising the Benefits of Research as well as the statutory responsibility for Integrated Care Boards to deliver research and innovation under the Health and Social Care act 2022, NHS Cheshire and Merseyside approved the establishment of an Integrated Research and Innovation System (IRIS) that aligns with both local and national research and innovation priorities.

The primary aim of IRIS is to create a research and innovation driven healthcare ecosystem that benefits the entire population by fostering research and innovation excellence to improve the health and wellbeing of the population of Cheshire and Merseyside and further afield. IRIS will identify, address, and prioritise local and national research and innovation needs and priorities. This will lead to improved healthcare outcomes, the promotion of evidence-based practices, expanded research efforts, and enhanced collaboration across the healthcare system.

IRIS will:

- **Collate** existing system-wide research and innovation activities, identify existing strengths and areas for targeted intervention and improvement.
- **Convene Stakeholders**: Act as a central entity to bring together a wide range of key stakeholders from across the Integrated Care System.
- **Research and Innovation Planning**: Develop a coherent research plan aligned to maximise the benefits of research and deliver the Health Care Partnership Strategy.
- **Identify and Address Research and Innovation Priorities**: Collaboratively identify and address both local, national and international research and innovation priorities, ensuring evidence-based healthcare decisions.
- **Influence the National and International Research and Innovation Agenda**: Proactively participate in shaping the research agenda to align with local priorities and needs.
- **Expand Research and Innovation**: Increase the quantity, quality, and diversity of research initiatives, encompassing primary care, community care, mental health services, public health and social care across the life course.
- **Promote Evidence-Based Practice**: Advocate the use of research evidence to drive commissioning, quality improvement and evidence-based practices in line with the NHS Cheshire and Merseyside Clinical and Care Constitution.
- **Harmonise and Coordinate Research and Innovation Activities**: Enhance coordination and standardisation of research setup and delivery within and between localities. Joint Research Offices will play a key role.
- **Cultivate a learning environment**: Foster an environment valuing intellectual contributions and encouraging knowledge-sharing.

- **Leverage Commercial Contract Research and Innovation**: Maximise the economic and patient benefits of commercial contract research working closely with the Innovation Agency North West Coast and NIHR Clinical Research Network Northwest Coast.
- **Develop the Research and Innovation Workforce and Infrastructure:** Co-ordinate and develop the research workforce and infrastructure across all health and social care settings within each Place, ensuring strategic alignment with the NHS Cheshire and Merseyside Joint Forward Plan.
- **Sustainability**: Co-ordinate research and evaluation of interventions to support a more sustainable health and care system. Ensuring, where appropriate, sustainability is considered in funding applications and research activity.
- **Improve Healthcare Quality and Outcomes:** Utilise research evidence to enhance the quality of health and care services, benefiting all residents across Cheshire and Merseyside.

IRIS contributed to the Primary Care Strategic Framework, a component of the Fuller Stocktake action point, which underscores primary care's key strength: its adaptability to change.

This framework advocates the use of innovation to foster sustainable health systems, enhance service integration and address disparities by transforming service delivery for marginalised populations. It also emphasises the need for support and resources at various levels - Local, Primary Care Network, Place, Integrated Care System - to facilitate the adoption of research and innovative practices within Primary Care.

IRIS supports action on health inequalities by providing policymakers with evidence for decision-making on health and care service transformation, focusing on reducing disparities in access, outcomes, and experience.

Additionally, IRIS can enhance productivity and value for money in research delivery across Integrated Care Systems, while supporting economic growth and job creation through a co-ordinated research ecosystem and by accelerating commercial contract research and innovation.

Key activity within IRIS includes:

Civic Health Innovation Labs (CHIL)
NHS Cheshire and Merseyside (via IRIS) is connected with all our local Universities. In particular our relationship with the University of Liverpool sees the Civic Health Innovation Lab (CHIL) as our delivery partner in research and innovation in population health initiatives. The missions are: mental health, infection resilience, medicines optimisation, public health, and methods and Infrastructure.
The Civic Health Innovation Lab (CHIL) brings together leading experts from academia, the NHS, local government, charities and industry to forge a new model for progressive data use and responsible artificial intelligence in civil society.

This collaboration drives innovations for health, social, and economic progress, enabling scientists, engineers, professionals and residents to co-create and co-evaluate data-driven technologies.

The Integrated Care System Research Engagement Network Development Programme

This programme, led by NHS Cheshire and Merseyside and supported by the Clinical Research Network (CRN) and Applied Research Collaboration (ARC), launched four Research Engagement Network (REN) bids in the 2023-24 period, totalling £420K.

These bids aim to involve communities traditionally excluded from research and are based within both the Cheshire and Merseyside and Lancashire and South Cumbria Integrated Care Systems.

Each of the projects, led by Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations focus on different aspects of community engagement and research:

REN 1.0 targets mental health and asylum seekers in Liverpool, aiming to develop research-ready communities. Funded by NHS England, this initiative seeks to reduce health inequalities by increasing diversity in research engagement, with £100K awarded to two VCFSEs for building community research hubs in Liverpool and Morecambe Bay.

REN 1.2 collaborates with VCFSE to map and develop pathways, events, and a toolkit for research engagement with the Chinese and Irish traveller communities, focusing on identifying community research priorities.

REN 2 aims to support more ethnic diversities in setting research priorities, working with One Knowsley / Phoenix Way to map networks and identify research priorities.

REN 3 focuses on primary school children with disabilities, organising engagement events and focus groups to look at research agendas and building links with Higher Education Institutions.

NIHR Applied Research Collaborations (ARC) Northwest Coast

ARC Northwest Coast contributes to improving the quality and efficiency of health and social care services, reducing health inequalities, and fostering a more equitable region. This mission aligns with the NHS Cheshire and Merseyside Integrated Care System Clinical and Care Constitution pledges, which emphasise quality (using evidence and data), collaboration (co-production and equity), health (addressing wider determinants and equity), and value (focusing on health inequalities, prevention, and improvement methodologies).

The following tailored sessions were workshop areas for the ARC's quarterly member meetings in the 2024 calendar:

- 'Joining the Dots' by delivering a system-wide approach for Children at Risk, to facilitate collaboration and sharing of knowledge, including regional strategies, current research to reduce risks/inequalities, and practical insights into current initiatives.
- 'Public Involvement and Engagement in Action', leading by example on how public advisers are working across the collaboration on projects to improve health equity and applied health research through the voice of the population.
- 'Social Care Research Capacity Building Programme', for which ARC NWC has been awarded £260k funding to support social care research and implementation, underpinned by supporting capacity across relevant members of the collaboration.

NIHR Clinical Research Network (CRN Northwest Coast)
Primary care research enjoyed significant expansion across Cheshire and Merseyside in 2023-24, with 15,623 participants recruited from primary care settings, marking an increase of 5,643 from the previous year. This recruitment spans 43 studies, comprising 35 non-commercial and eight commercial studies.

Notably, not all primary care studies are led by primary care as a specialty but are supported by 15 other specialties this financial year, with care homes, hospices, dental practices, schools, and local authorities also contributing to recruitment.

19 practices were funded through the Research Site Initiative (RSI) and a workforce equivalent to 8.49 full-time employees (FTE). The roles funded include research nurses, administrators, healthcare assistants, clinical pharmacists and research assistants, with GP leadership provided by a senior specialty research lead.

Applications for refurbishment and equipment funding were received from six GP practices in Cheshire and Merseyside. Successful bids included Central Liverpool Primary Care Network, Wirral's Civic Medical Centre, Eastham Group Practice, and Spital Surgery, as well as Kiltearn Medical Centre in Cheshire.

Innovation Agency Northwest Coast
NHS Cheshire and Merseyside has established strong links with our local Health Innovation Network, Health Innovation Northwest Coast, and developed an effective programme of activity designed to accelerate the spread and adoption of innovation across Cheshire and Merseyside.

The range of initiatives reflects national priorities, including the MedTech Funding Mandate, with identified products and pathway changes adopted across our system, with local projects demonstrating improvements in outcomes in areas such as cardiovascular and respiratory diseases and elective care recovery.

Medicines Management and Optimisation
Medicines Management and Optimisation developed considerably in 2023-24. The introduction of the governance structure for Medicines Optimisation has provided a robust framework for effective decision-making, accountability and transparency.

The structure includes two new NHS Cheshire and Merseyside groups; the Medicines Optimisation Group and the Medicines Improvement Group - bringing together colleagues to oversee and support working groups and transformation projects, including a QIPP programme estimated to have saved £17.5m in 2023-24.

Within the scope of the Medicines Improvement Group is the Direct Oral Anticoagulants (DOAC) programme of work which has evidenced quality and cost-improvement opportunities across primary and secondary care.

Resources were consolidated to create a single Cheshire and Merseyside Area Prescribing Group (APG) to work on the harmonisation of formulary guidance from the legacy Pan Mersey Area Prescribing Committee and Cheshire Area Prescribing Group.

Initial development of the Operating Model for Medicines Management and Optimisation across NHS Cheshire and Merseyside influenced the in-housing of three commissioned medicines management teams on 01 April 2024.

Case Study: Transforming the "waiting list" into a "preparation list"

A ground-breaking initiative led by NHS Cheshire and Merseyside is using risk stratification technology (C2-Ai) combined with digital perioperative care (Surgery Hero) to identify individuals at high risk of post-op complications on the waiting list and provide targeted support.

How it works:

1. High-risk individuals are referred for individualised prehabilitation.
2. Patients are assigned a personal health coach
3. Health coaches help members set individual health behaviour change goals and support them in improving all areas of their health and wellness. Including exercise, healthy eating, sleep and mental wellbeing

Findings for the first 400 members to have undergone prehabilitation support indicate a significant impact on the reducing rates of post-operative complications as well as a reduction in the length of hospital stay.

Lesley – Surgery Hero member said:
"I felt like my health coach was prepared to help me with anything that was important to me, or anything that was going on in my life - surgery related or not. I noticed that people around me who hadn't prepared properly for surgery seem to be recovering slower - it's just three weeks after my knee replacement and I'm up and about and have been since being discharged!"

1.2.8.22 Education and Training

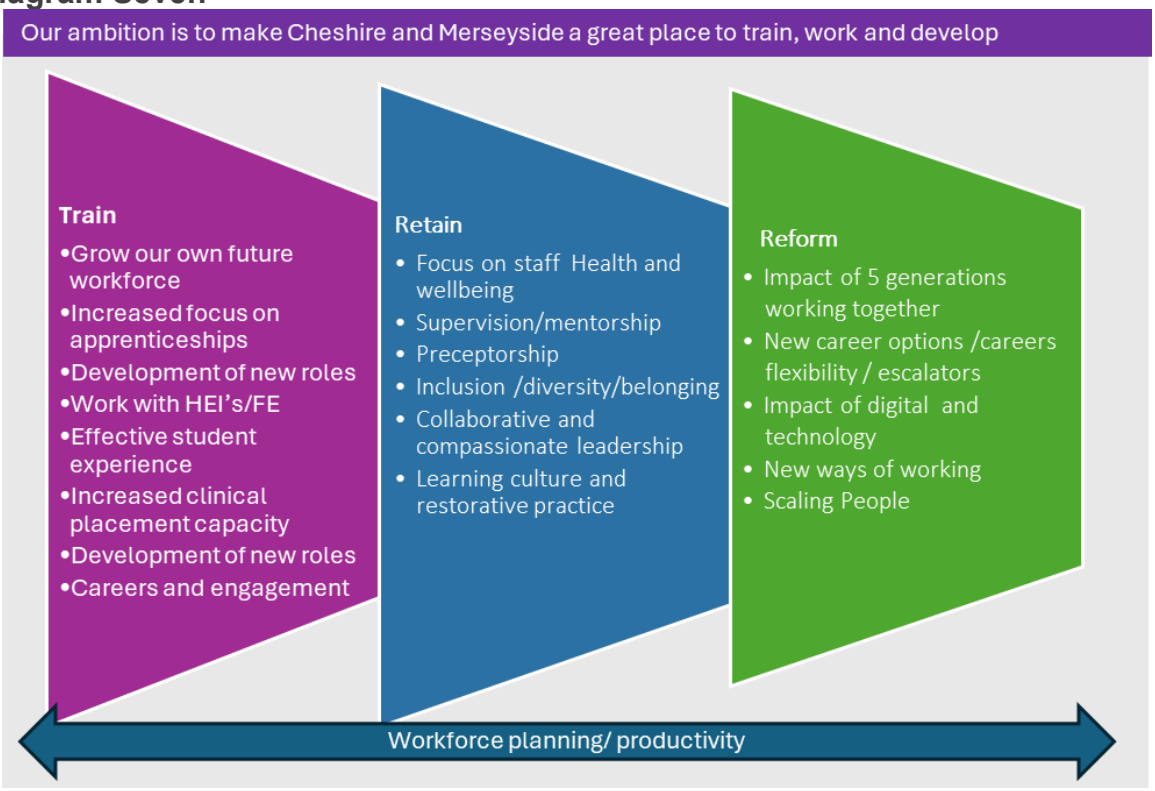
NHS Cheshire and Merseyside recognises that one of our health and care system's greatest assets is its dedicated, skilled and knowledgeable workforce.

We recognise that many staff consistently go above and beyond to deliver outstanding care for our communities - irrespective of what part of the service they work in. Many of our staff are also carers and have to balance the needs of their families and dependents with managing challenging and busy roles.

We want Cheshire and Merseyside to be a great place to work and an outstanding place for care; whether in the community, in one of our hospitals or online.

Our Workforce strategy outlines how we will work together to build an even stronger workforce.

Diagram Seven



Our work in this area has focused on a number of key themes:

Cultural Transformation

- organisational and system redesign for integration
- competency and capability development
- team cohesion to drive resource optimisation
- growth mindset to stimulate system leadership thinking
- a shared cultural identity, values and behaviours.

Talent Management

- robust succession planning for business critical and hard to fill roles
- reward and recognition strategies to ensure success is recognised.

Equality, Diversity and Inclusion

- deliver our public sector equality duty (2010 Act) to be an employer of choice, investing in positive action to attract, retain staff from under-represented groups and to achieve the ambition to be an Anti-racist organisation and system.

Digital upskilling of the workforce

- digital and data skills training at scale
- developing Digital and Data champions
- identifying future clinical and care digital and data leaders.

1.2.8.23 Financial Review

Statutory Duties

NHS Cheshire and Merseyside has a number of financial duties under the NHS Act 2006 (as amended):

Table 12

Duty	Achieved
Expenditure not to exceed income	Yes
Capital resource use does not exceed the amount specified in Directions	Yes
Revenue resource use does not exceed the amount specified in Directions	Yes
Revenue administration resource use does not exceed the amount specified in Directions	Yes

NHS Cheshire and Merseyside has achieved its financial duties for the year to 31 March 2023.

Financial Performance

Table 13 summarises NHS Cheshire and Merseyside's financial performance for the year to 31 March 2024:

Table 13

Area of Expenditure	2023-24		
	In Year Allocation £000s	Expenditure £000s	Surplus/ (Deficit) £000s
Programme	6,652,056	6,650,715	1,341
Running Costs	53,436	51,558	1,878
Total	**6,705,492**	**6,673,070**	**3,219**

NHS Cheshire and Merseyside delivered a surplus (underspend) of £3.219m against its spending allocation for the year to 31 March 2024.

During the year NHS Cheshire and Merseyside spent, net of disposals, £1.115m on capital items compared to an allocation of £1.127m. This expenditure relates to

premises lease costs that are treated as capital items under accounting standards when leases commence, are extended or rental values change.

NHS Cheshire and Merseyside receives a capital allocation for these specific items based on expenditure forecasts submitted to NHS England during the financial year. For 2023-24 NHS Cheshire and Merseyside had an efficiency target of £57.9m which was delivered in full for the financial year.

Financial Analysis
The analysis in Table 14 provides further information regarding NHS Cheshire and Merseyside expenditure for the year to 31 March 2024.

Table 14

Expenditure Area	**2023-24 £000s**
Acute Provision	3,404,780
Community Services	648,203
Primary Care Other Services	99,521
Prescribing incl. Associated Costs	545,338
Primary Care Delegated Services	790,188
Mental Health Services	683,303
Continuing Healthcare	402,512
Other	76,870
Total Programme Expenditure	**6,650,715**
Running costs	51,558
Total Expenditure	**6,702,273**

Diagram 8 shows the relative percentage of NHS Cheshire and Merseyside expenditure against the reporting categories:

Diagram 8

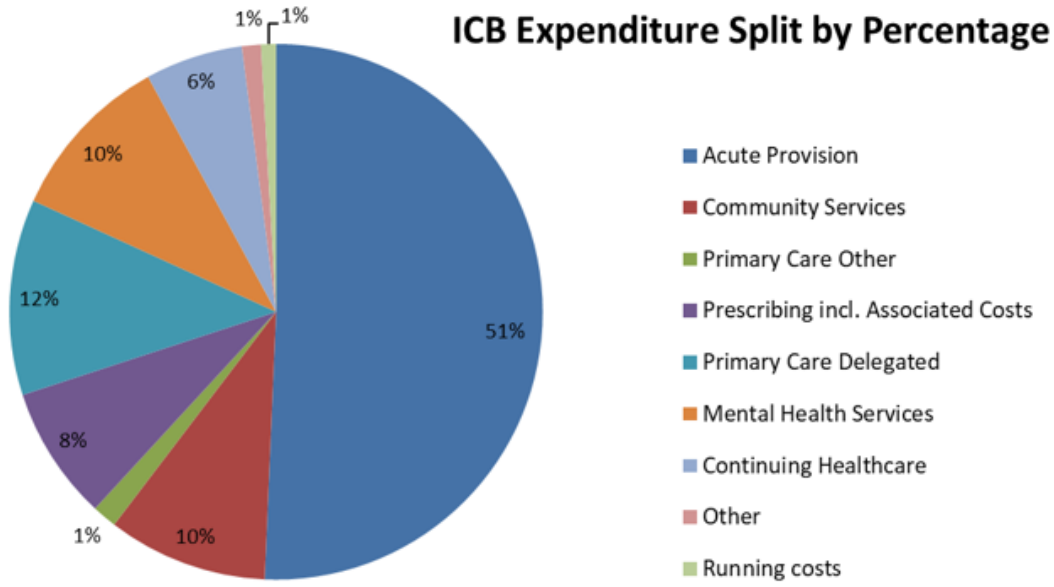


Table 15 provides information on NHS Cheshire and Merseyside's programme expenditure with the top 15 NHS providers for the year to 31 March 2024. These providers account for £3.982bn or 60% of NHS Cheshire and Merseyside Programme expenditure.

Table 15

Provider	**£000s**
Liverpool University Hospital NHS Foundation Trust	794,645
Mersey & West Lancashire Teaching Hospitals NHS Trust	610,218
Mersey Care NHS Foundation Trust	450,401
Wirral University Teaching Hospital NHS Foundation Trust	396,301
Mid Cheshire NHS Foundation Trust	329,951
Warrington NHS Foundation Trust	291,779
Countess of Chester Hospital NHS Foundation Trust	263,245
Cheshire and Wirral Partnership NHS Foundation Trust	186,342
East Cheshire NHS Foundation Trust	160,808
North West Ambulance Service NHS Trust	134,557
Alder Hey Children's NHS Foundation Trust	107,116
Liverpool Women's NHS Foundation Trust	98,738
Wirral Community Health and Care NHS Foundation Trust	60,610
Bridgewater Community Healthcare NHS Foundation Trust	59,123
Clatterbridge Cancer Centre NHS Foundation Trust	38,277
Total Programme Expenditure Top 15 NHS providers	**3,982,110**
Other Programme Expenditure	2,668,605
Total Programme Expenditure	**6,650,715**
Running costs	51,558
Total Expenditure	**6,702,273**

Mental Health
Table 16 shows the percentage of mental health spend (as defined by the Mental Health Investment Standard) as a proportion of overall programme spend.

Table 16

	2023-24 £000s
Mental Health Expenditure	544,876
NHS Cheshire and Merseyside Programme Allocations excluding Delegated Services	5,833,410
Mental Health Spend as a proportion of NHS Cheshire and Merseyside Programme Allocation	9%

Graham Urwin

Graham Urwin
Accountable Officer
20 June 2024

Accountability Report

Compassionate

Inclusive

Working Together

Accountable

2. Accountability Report

2.1 Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2023 to 31 March 2024, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

2.2 Corporate Governance Report

2.2.1 Members Report

2.2.1.1 Chair and Chief Executive

Raj Jain is the Chair of NHS Cheshire and Merseyside and Graham Urwin is the Chief Executive. Both have been in post since the creation of the Integrated Care Board on 1 July 2022.

2.2.1.2 Board

The Board of NHS Cheshire and Merseyside directs and controls the major activities of the organisation and is collectively accountable for the performance of its functions.

The membership of the Board during 2023-24 is set out in Table 17.

Table 17

Name	Position	From	To
Raj Jain	Chair	1 July 2022	Present
Tony Foy	Non-Executive Member	1 July 2022	Present
Erica Morriss	Non-Executive Member	1 July 2022	Present
Neil Large MBE	Non-Executive Member	1 July 2022	Present
Professor Hilary Garrett CBE	Non-Executive Member	18 January 2023	Present
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member	1 November 2023	Present
Dr Naomi Rankin	Partner Member	1 January 2023	Present
Adam Irvine	Partner Member	1 July 2022	Present
Professor Stephen Broomhead MBE	Partner Member	1 July 2022	Present
Cllr Paul Cummins	Partner Member	1 July 2022	May 2024
Ann Marr OBE	Partner Member	1 July 2022	Present
Professor Joe Rafferty CBE	Partner Member	1 July 2022	Present
Graham Urwin	Chief Executive	1 July 2022	Present
Claire Wilson	Executive Director of Finance	1 July 2022	Present
Professor Rowan Pritchard-Jones	Medical Director	1 July 2022	Present
Christine Douglas MBE	Executive Director of Nursing and Care	1 August 2022	Present

2.2.1.3 Directors

NHS Cheshire and Merseyside's directors, in addition to those on the Board listed 2.2.1.2, for the 2023-24 period are set out in Table 18.

Table 18

Corporate Directors			
Name	**Position**	**From**	**To**
Clare Watson	Assistant Chief Executive	1 July 2022	Present
Chris Samosa	Chief People Officer	1 July 2022	Present
Anthony Middleton	Director of Performance and Planning	1 July 2022	Present
Dr Fiona Lemmens	Deputy Medical Director	1 July 2022	Present
John Llewellyn	Chief Digital Officer	17 October 2022	Present

Place Directors			
Name	**Position**	**From**	**To**
Mark Wilkinson	Place Director – Cheshire East	1 July 2022	Present
Delyth Curtis	Place Director – Cheshire West	1 July 2022	21 Nov 2023
Laura Marsh	Interim Place Director – Cheshire West	22 Nov 2023	Present

Place Directors			
Name	**Position**	**From**	**To**
Anthony Leo	Place Director – Halton	1 July 2022	Present
Alison Lee	Place Director – Knowsley	1 July 2022	Present
Jan Ledward	Place Director – Liverpool	1 July 2022	31 March 2023
Mark Bakewell	Interim Place Director - Liverpool	01 April 2023	05 Feb 2024
Mark Bakewell	Place Director – Liverpool	06 Feb 2024	Present
Deborah Butcher	Place Director – Sefton	1 July 2022	Present
Mark Palethorpe	Place Director – St Helens	1 July 2022	Present
Carl Marsh	Place Director – Warrington	1 July 2022	Present
Simon Banks	Place Director – Wirral	1 July 2022	Present

Further information regarding NHS Cheshire and Merseyside's current Board members and directors can be found on our website.[22]

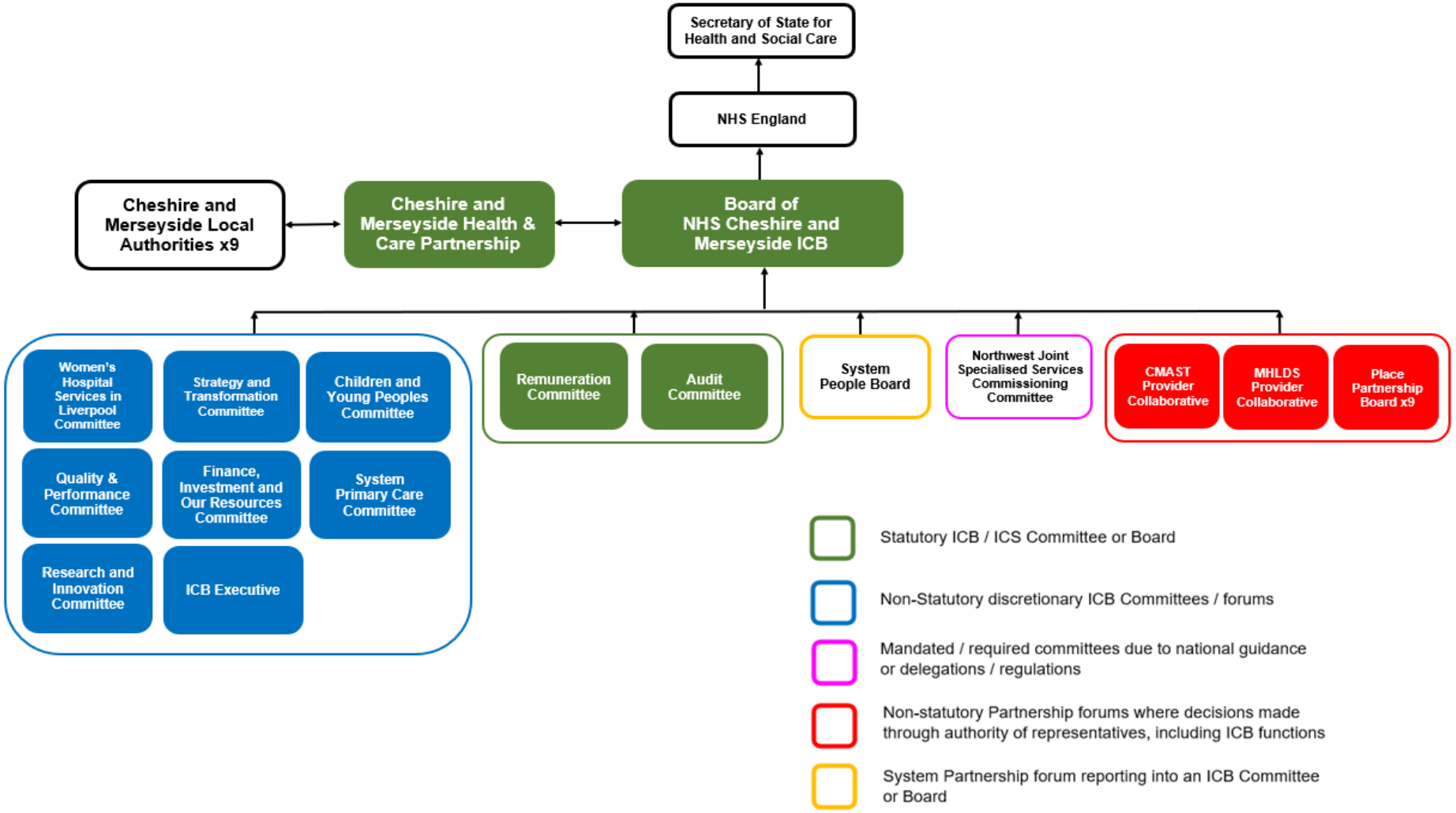
2.2.1.4 Committee(s), including Audit Committee

The members of the Audit Committee during the period covered by this report are set out in Appendix One on page 201.

NHS Cheshire and Merseyside's governance and committee structure is set out in Diagram 9 on page 110. The membership of, and attendance at each committee is provided in Appendix One.

[22] https://www.cheshireandmerseyside.nhs.uk/about/nhs-cheshire-and-merseyside/leadership-team/ (last checked on 14.06.24)

Integrated Care Board Governance and Committee Structure **(Diagram 9)**



2.2.1.6 Register of Interests

NHS Cheshire and Merseyside currently maintain three separate registers which are published on its public website:

- Declarations of Interests
- Gifts, Hospitality and Sponsorship
- Conflict of Interest Breaches Log.

These registers can be found on our website.[23]

NHS Cheshire and Merseyside has in place a Conflicts of Interest Policy which sets out the approach to managing conflicts of interest (including gifts, hospitality, and sponsorship), and has been approved by the Board. A copy of the policy can be found on our website.[24]

During 2023-24 there were no reported breaches of the ICBs Conflicts of Interest policy and procedures.

2.2.1.7 Personal data related incidents

NHS Cheshire and Merseyside's arrangement for information governance are described in the Governance Statement on page 131.

There were no personal data related incidents during the year which required formal reporting to the Information Commissioner's Office (ICO). A precautionary report was made to the ICO in relation to a cyber-attack suffered by a contracted provider, but it was subsequently confirmed that this did not affect ICB data.

2.2.1.8 Modern Slavery Act

NHS Cheshire and Merseyside fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2024 is published on our website.[25]

[23] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/ (last checked on 140624)
[24] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/ (last checked on 140624)
[25] https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/modern-slavery-act-statement/ (last checked on 140624)

2.2.2 Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Cheshire and Merseyside and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Chief Executive, who is the Accountable Officer, is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- prepare the accounts on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Cheshire and Merseyside. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding NHS Cheshire and Merseyside's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Cheshire and Merseyside's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Graham Urwin

Graham Urwin
Accountable Officer
20 June 2024

2.2.2.1 Governance Statement

2.2.2.2 Introduction and context

NHS Cheshire and Merseyside is a body corporate established by NHS England on 01 July 2022 under the National Health Service Act 2006 (as amended).
NHS Cheshire and Merseyside's statutory functions are set out under the National Health Service Act 2006 (as amended).

NHS Cheshire and Merseyside's general function is arranging the provision of services for persons for the purposes of the health service in England. It is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 01 April 2023 and 31 March 2024, NHS Cheshire and Merseyside was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

2.2.2.3 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS Cheshire and Merseyside's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Cheshire and Merseyside's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Cheshire and Merseyside is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within NHS Cheshire and Merseyside as set out in this governance statement.

2.2.2.4 Governance arrangements and effectiveness

The main function of the Board is to ensure that NHS Cheshire and Merseyside has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

NHS Cheshire and Merseyside's governance arrangements described below have been designed, developed and embedded to ensure that:

- through the membership of the board, its committees and underpinning network of partnership, programme, clinical and other advisory networks, it has access to a broad range of professional expertise in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health.
- it is appropriately informed and clear on the impacts of decisions, and responsive to the 'triple aims' of health and wellbeing of the people of England, quality of healthcare services for the purposes of the NHS and sustainable and efficient use of resources by NHS bodies.

The Integrated Care Board constitution[26] commits NHS Cheshire and Merseyside to, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England. NHS Cheshire and Merseyside has agreed standards of business conduct. These set out the expected behaviours that members of the Board and its committees will uphold while undertaking NHS Cheshire and Merseyside business, and principles that will guide decision making.

The constitution commits NHS Cheshire and Merseyside to demonstrating its accountability to local people, stakeholders, and NHS England in a number of ways. These include a set of principles for involving people and communities, meetings and publications, the appointment of five non-executive members to the Board, transparent decision-making, compliance with procurement rules and the publication of an annual report and accounts.

The constitution describes the arrangements for the exercise of its functions, which may be through delegation internally, externally or jointly with another body, where permitted by legislation.

NHS Cheshire and Merseyside has published a functions and decision map,[27] which provides a high-level structural chart setting out which decisions are delegated and taken by which parts of the system.

NHS Cheshire and Merseyside has also published a scheme of reservation and delegation,[28] which sets out those decisions which are reserved to the Board and those which have been delegated.

NHS Cheshire and Merseyside's Governance Structure Chart is in the Members Report on page 110. Check Details of the membership and attendance at the Board and each of its committees is provided in Appendix One. The key responsibilities of the Board and each of its committees, highlights of their work, and assessment of their performance and effectiveness over the year is provided in sections 2.2.2.5 to 2.2.2.15.

2.2.2.5 Board of NHS Cheshire and Merseyside

NHS Cheshire and Merseyside sets out to use its resources and powers to achieve demonstrable progress against the four core purposes of Integrated Care Systems. These are as follows and are set by NHS England:

- 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.

[26] https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/constitution/ (last checked on 140624)
[27] https://www.cheshireandmerseyside.nhs.uk/media/gkikz0x5/functions-and-decisions-map.pdf (last checked on 140624)
[28] https://www.cheshireccg.nhs.uk/media/w5fhoxoy/cm-icb-sord-v11-march2024-approved.pdf (last checked on 140624)

The Board of NHS Cheshire and Merseyside remains accountable for all of the functions of the Integrated Care Board, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place forming part of agreed terms of delegation. Each NHS Cheshire and Merseyside Committee provides a frequent assurance update to the Board on the areas it has considered and which are within the scope and authority of each respective committee terms of reference.

During 2023-24, the Board has met eight times and was quorate on each occasion. Key activities of the Board included:

- receiving update and assurance reports from all committees with delegated authority
- receiving leadership reports from the Chair, Chief Executive, Director of Nursing and Care, and Directors of Place
- scrutinising quality and performance and financial reports
- approving the quarterly ICB Board Assurance Framework and the Corporate Risk Register
- approving the Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24 and receiving an update on the progress of the plan and the proposed development of the 2024-25 plan
- approving the NHS Cheshire and Merseyside Financial Plan / Budget 2023-24
- approving the NHS Cheshire and Merseyside Annual Report and Accounts 2022-23 and Cheshire and Merseyside CCG three Month Reports 2022-23
- endorsing the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative - Annual Work Plan 2023-24
- endorsing the Cheshire and Merseyside Mental Health, Community and Learning Disability Provider Collaborative - Annual Work Plan 2023-24
- noting the Winter Debrief and establishment of the Urgent Emergency Care Improvement Programme, and the context and process for developing the 2023-24 Winter Plan and receiving update and assurance on plan delivery
- approving the Primary Care Strategic framework and the Cheshire and Merseyside Primary Care Access Recovery Improvement Plan
- noting the Health Inequalities and Population Health Programme Update
- noting the national maternity and neonatal services delivery plan and the actions being taken by the NHS Cheshire and Merseyside Local Maternity and Neonatal System in response
- noting an update on the National Children and Young People's Programme and the issues and action being taken in Cheshire and Merseyside
- approving Intelligence into Action, the continued provision of Integrated Care System digital and data platforms
- approving the NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS)
- endorsing the Cheshire and Merseyside Integrated Care System Digital and Data Strategy Update
- noting the results of the NHS Cheshire and Merseyside Staff Survey 2022-23 and endorsing the actions to respond
- approving the Northwest BAME Assembly Anti-Racism Framework and receiving an update on progress and the proposed implementation plan

- noting the publication of the NHS Long Term Workforce plan and the implications for the future supply and training of staff
- noting the results of the NHS Cheshire and Merseyside Staff Survey 2022-23 and endorsing the actions to be taken in response
- endorsing the NHS Cheshire and Merseyside Freedom to Speak Up Update.
- approving amendments to the NHS Cheshire and Merseyside Constitution for submission to NHS England.
- approving Amendments to the Cheshire and Merseyside Operational Scheme of Reservation and Delegation.
- approving the Terms of Reference for the North West Specialised Services Joint Committee.
- approving a governance refresh of the Women's Hospital Services in Liverpool Programme and updated Terms of Reference for the Women's Services Committee.
- approving the Cheshire and Merseyside Children and Young People's Committee Establishment.
- endorsing the Cheshire and Merseyside Clinical and Care Constitution.

2.2.2.6 Audit Committee

The Audit Committee is accountable to the Board and provides an independent and objective view of NHS Cheshire and Merseyside's compliance with its statutory responsibilities. The Committee is responsible for arranging appropriate internal and external audit.

The Committee provides oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within NHS Cheshire and Merseyside.

During 2023-24, the Committee has met six times and was quorate on each occasion. Key activities of the Committee included:

- receiving updates on the arrangements for management of conflicts of interest
- approving the ICB Conflicts of Interest policy on behalf of the ICB
- endorsing the investment case for an electronic Conflicts of Interest Management system for the ICB
- receiving updates on the arrangements for risk management and the development of the Board Assurance Framework.
- approving the Terms of Reference for the Risk Committee and receiving update and assurance reports.
- reviewing the Audit Committee risk report and considering the level of assurance that can be provided to the Board.
- receiving updates on arrangements for Freedom to Speak Up
- receiving updates on the arrangements for information governance, progress and submission of the Data Security and Protection Toolkit (DSPT).
- receiving the Information Governance Annual Report 2022-23 and FOI and SARS Annual Report 2022-23.
- approving information governance, finance and procurement policies for the ICB.
- recommending to the Board proposed changes to the Operational Scheme of Reservation and Delegation (SORD)

- receiving updates on approvals of NHS Cheshire and Merseyside procurement tender waivers
- receiving updates on losses and special payments.
- reviewing the draft NHS Cheshire and Merseyside Annual Report and Accounts for 2022-23 and nine CCG Annual Reports and Accounts for April-June 2022.
- receiving the draft and final Head of Internal Audit Opinion.
- approving the 2022-23 External Audit Plan and receiving updates on progress.
- receiving the Audit Findings Reports for NHS Cheshire and Merseyside and the nine former CCGs and Auditors Annual Report, External Audit Opinion and Representation Letters, and External Audit Annual Report 2022-23.
- approving the 2023-24 Internal Audit Plan and receiving updates on progress and outcomes.
- receiving the Anti-Fraud Services Annual report 2022-23, approving the Fraud Service Work Plan 2023-24 and receiving progress reports.
- reviewing the committee effectiveness and terms of reference and approving the 2022-23 Committee Annual Report.

2.2.2.7 Remuneration Committee

The Remuneration Committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to NHS Cheshire and Merseyside.

During 2023-24, the Committee has met four times and was quorate on each occasion. Key activities of the Committee included:

- receiving a report on ICB Executive Director and Place Director appraisal and noting that all directors have had a formal appraisal, developed objectives for the next year, and have a development plan
- considering the approach to reducing NHS Cheshire and Merseyside's running costs and receiving updates on the mutually agreed resignation scheme
- receiving an update on the ICB and Very Senior Manager pay frameworks
- approving a single on-call arrangement replacing the former CCG arrangements
- receiving an update, supporting proposals and approving policy in respect of the requirements of the Fit and Proper Persons Test
- approving the establishment of Associate Non Executive Member positions and associated terms and conditions
- considering a report on succession planning for executive and senior level roles.

2.2.2.8 Integrated Care Board Executive Committee

The NHS Cheshire and Merseyside Executive Team Committee is responsible for effective operational management of NHS Cheshire and Merseyside, through the provision of effective leadership and direction to the work of the organisation. It also supports the Board in setting the vision and the organisations' strategic objectives.

In addition, the NHS Cheshire and Merseyside Executive Team Committee will provide direction, as a Category one responder and that NHS Cheshire and Merseyside supports its Partners with system and borough-wide planning and activity. It will also make decisions in respect of system Quality Innovation Productivity and Prevention (QIPP) and financial recovery, any such decision shall

be reported to the next meeting of the Board for ratification.

During 2023-24, the Committee has met weekly. Key activities from the meetings included:

- receiving regular updates on financial performance and progress towards developing the Financial Plan and submission to NHS England
- receiving regular updates on quality issues identified across the system
- receiving regular updates on industrial action and plans and mitigation being put in place across the system
- approving, discussing and receiving assurance in respect of ICB operating models, policies and ways of working, including hosting and in-housing proposals for specific functions
- approving, discussing and receiving assurance regarding staffing matters including development, communications, efficiencies and cost reductions, and wellbeing
- considering an update on the progress of the corporate estates programme, including planned efficiencies and cost reduction, and confirming Number One Lakeside as the designated headquarters for the ICB
- approving the submission for a Defence Employee Recognition Scheme silver award
- discussing and receiving assurance regarding urgent emergency care, Non-Criteria to Reside and patient flow, and reviewing and approving the Winter Planning Submission to NHS England
- discussing and receiving assurance regarding Neurodevelopment Pathways for Children and Young People
- discussing and receiving assurance regarding virtual wards.
- endorsing the plans for the ICB to recognise and celebrate the achievements of the NHS on its 75th anniversary
- discussing and receiving assurance regarding observational Support for Mental Health Patients in Emergency Departments
- discussing and receiving assurance regarding Autism Services and the implementation of the All-Age Autism Pathway National Framework and Operational Guidance
- discussing and receiving assurance regarding Freedom to Speak U
- endorsing the revised long COVID-19 pathways and the delivery plan for 2023-24
- discussing and receiving assurance regarding the Cheshire and Merseyside Joint Forward Plan
- discussing and receiving assurance regarding the sustainable hospital services programme
- discussing the Merseyside Police Serious and Organised Crime summit
- discussing and receiving assurance regarding the Cheshire and Merseyside Single Integrated Service Specification for Pulmonary Rehabilitation
- discussing and receiving assurance regarding Cheshire and Merseyside Change and Integration Programmes
- discussing the proposed operating model for implementation of the NHS Oversight Framework across Cheshire and Merseyside and the process to agree a plan with NHS England to be able to move the ICS rating from SOF 3 to SOF 2
- discussing and receiving assurance regarding the Children and Young Peoples Elective Care Recovery Plan, recognising that

waiting lists for children have grown to a greater extent than the waiting list for adults
- receiving an update on the launch of the Anti-Racism Framework
- receiving an update and proposals in respect of the Wegovy Weight Loss Pilot
- discussing and receiving assurance regarding Women's Health Hub
- discussing and receiving assurance regarding the Serious Violence Duty
- discussing and receiving assurance regarding Commissioning Intentions
- receiving updates and assurances regarding the Provider Collaboratives' programmes and work plans.

2.2.2.9 Finance, Investment and Our Resources Committee (FIRC)

The Finance, Investment and Our Resources Committee (FIRC) provides NHS Cheshire and Merseyside with a vehicle to support assurance, risk management, system engagement, delivery and collaborative resolution in finance and investment (including capital and resources, for NHS Cheshire and Merseyside as an employer.

During 2023-24, the Committee has met eight times and was quorate on each occasion. Key activities of the Committee included:

- reviewing and agreeing committee terms of reference and an annual committee workplan
- approving the establishment of a Peoples Committee as a sub-committee of FIRC, and associated terms of reference and workplan, and receiving regular chair's reports
- approving the high-level budgets and capital plan for 2023-24 and reviewing and supporting the financial plan submissions
- endorsing place section 75 agreements
- receiving and discussing a presentation on the proposed approach to financial recovery and strategy and regular updates on the progress of 2024-25 planning and the long term financial strategy
- reviewing the ongoing financial positions in respect of both revenue and capital allocations
- receiving and approving regular procurement updates and decisions, including a briefing on the revised provider selection regime
- reviewing the Committee risk reports and considering the level of assurance that can be provided to the Board
- reviewing proposals and recommending to the Board funding of the overall financial impact of the clinical policy harmonisation programme
- receiving updates on the financial implications of the wholescale review of the commissioned support services delivered by Midlands and Lancashire Commissioning Support Unit
- endorsing the long COVID pathway and delivery plan and distribution of funding for 2023-24.

2.2.2.10 Quality and Performance Committee

The Quality and Performance Committee provides the Board with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021.

The Committee scrutinises the robustness of, and gains and provides assurance to the Board, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Committee focuses on quality performance data and information and considers the levels of assurance that NHS Cheshire and Merseyside can take from performance oversight arrangements within the Integrated Care System and actions to address any performance issues.

During 2023-24, the Committee has met 10 times and was quorate on each occasion. Key activities of the Committee included:

- receiving and reviewing regular quality and performance dashboards
- receiving regular patient safety reports by exception across a range of services.
- receiving regular aggregated and place specific key issues reports
- receiving regular exception reports for SEND, All Age Continuing Care Programme and Safeguarding
- receiving reports on the outrcome of rapid quality reviews in respect of a number of services through the year
- reviewing the Committee risk reports and considering the level of assurance that can be provided to the Board
- reviewing and amending the ICB's Complaints Policy prior to approval and providing oversight of the numbers and types of complaints, MP enquiries and PALS enquiries received by the ICB
- receiving an update on future reporting of primary care and quality assurance
- receiving local maternity and neonatal system exception reports
- receiving an assurance and action report in respect of never events at Countess of Chester Hospital
- receiving a presentation on mortality and subsequent rapid quality review from the ICB Medical Director
- receiving and noting the outcomes of the clinical plicy harmonisation quality impact assessments
- receiving an update on the re-energised Care Home Collaborative Forum and the outputs from the Enhancing Health in Care Homes and Beyond Collaborative Event
- an annual review workshop considering role, purpose and effectiveness of the committee and agreeing the next steps in its development
- received an update on the local delivery of the LeDeR programme: Learning from lives and deaths – People with a learning disability and autistic people
- approved enhanced oversight arrangements in respect of key issues relating to Liverpool Women's Hospital raised at an Emerging Concern Group
- receiving a report on medicines shortages and supporting actions proposed to mitigate the effects and risks arising from this.

2.2.2.11 System Primary Care Committee

The System Primary Care Committee has been established to enable collective decision-making on the review, planning and procurement of primary care services in relation to GP primary medical services and community pharmacy as part of NHS Cheshire and Merseyside's statutory commissioning responsibilities across Cheshire

and Merseyside under delegated authority from NHS England.

During 2023-24, the System Primary Care Committee has met five times and was quorate on each occasion. Key activities of the Committee included:

- receiving updates on system pressures
- receiving updates and assurance in respect of key national commissioning and contract policy and related local actions in respect of the four primary care contractor groups
- receiving updates from the Primary Care Workforce Workstreams and Steering Group
- receiving updates on Primary Care Estates Workstreams
- receiving updates on the primary care financial position.
- receiving updates on the Primary Care Digital Programme and approving bids for national primary care digital funding.
- agreeing the approach for reporting and escalation in relation to primary care quality and performance and core performance metrics.
- reviewing the Primary Care Committee risk reports and considering the level of assurance that can be provided to the Board.
- approving the Dental Improvement Plan 2023-25 and receiving updates on delivery progress.
- receiving updates and assurances on progress in delivering the local Access Improvement Plan for 'Recovering Access to Primary Care'.
- receiving the results of the national GP Patient Survey.
- receiving and reviewing the developing Primary Care Strategic Framework.
- approving Cheshire and Merseyside involvement in the national community pharmacy independent prescribing pathfinder programme and commissioning of pathfinder sites locally.

2.2.2.12 Transformation Committee

The Transformation Committee has been established to support NHS Cheshire and Merseyside 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.

The purpose of the Committee is to ensure a leadership forum is in place to consider the development and implementation of the commissioning strategy and policy of NHS Cheshire and Merseyside in securing continuous improvement of the quality of services. It also ensures alignment of system programmes and referral of issues for clinical consideration, while ensuring that health inequalities and improved outcomes are continuously considered.

During 2023-24, the Transformation Committee has met five times and was quorate on each occasion. Key activities of the Committee included:

- receiving regular updates on the progress of all the Cheshire and Merseyside transformation programme delivery vehicles, and key issues or risks
- receiving regular reports from the Cheshire and Merseyside Transformation Group
- receiving an update on the progress in implementing the Integrated Care System Data and Digital Strategy
- endorsing the draft Cheshire and Merseyside ICS Cyber Security Strategy

- receiving an update on the development and implementation of a prioritisation framework for Cheshire and Merseyside
- approving transformation funding arrangements, requests and allocations
- approving four specialised commissioning priorities of renal service transformation, neurorehabilitation, optimisation of the stroke pathway, and transition from specialised paediatric services to adult services
- approving and overseeing the preparation and progression of plans for the delegation of specialised commissioning from NHS England to the ICBs
- receiving an update and providing assurance in respect of the implementation of the maternity treating tobacco dependency programme
- receiving a presentation on the urgent and emergency care improvement programme
- endorsing the children and young people's mental health strategy
- approving the target operating model and implementation of an in house individual funding requests service
- considering and supporting proposals to increase the use of personal health budget
- approving the business plan for pulmonary rehabilitation
- receiving an update on the development of the NHS Delivery Plan and the associated 2024-29 Joint Forward Plan, and the progress on the development of All Together Fairer: our Health and Care Partnership Plan
- receiving updates and providing assurance in respect of the risks assigned to the committee.

At its meeting on 28 March 2024, the Board of NHS Cheshire and Merseyside approved changes to the Terms of Reference of the Transformation Committee. Changes reflected the role of the Committee in becoming, from 01 April 2024, the decision making Committee of the ICB in relation to delegation from NHS England of some specialised commissioning services activity, changes to the Chair arrangements, and a change to the name of the Committee to that of the Strategy and Transformation Committee.

2.2.2.13 Women's Hospital Services in Liverpool Committee

The Women's Hospital Services in Liverpool Committee was established, following the Liverpool Clinical Services Review report published in January 2023, to oversee a programme of work to address the clinical sustainability of hospital services for women and the clinical risk in the current model of care.

Over the next five years, the Committee will oversee and assure the development and implementation of a future care model that will ensure that women's hospital services delivered in Liverpool provide the best possible care and experience for all women, babies, and their families. The scope will include tertiary services for Cheshire and Merseyside and proposed solutions may therefore impact on the care of patients across Cheshire and Merseyside and beyond and these populations will be fully considered in the programme.

During 2023-24, the Committee has met three times and was quorate on each occasion. Key activities of the Committee included:

- approving the terms of reference and establishment of the working groups to deliver aspects of the Women's services programme reporting to the committee
- receiving an overview of the history and context around the clinical sustainability issues relating to women's services in Liverpool and the work undertaken in recent years to seek solutions
- approving parameters to guide the development of options and discussing key indicators of safety and improving engagement with stakeholders
- receiving a briefing on the NHS England three-year delivery plan for maternity and neonatal services, the gap analysis conducted locally, and action planned
- receiving provider, programme and finance updates
- developing, receiving updates and providing assurance in respect of the risks assigned to the committee
- reviewing and agreeing a refresh of the governance arrangements for the Women's Services Programme, comprising a narrower terms of reference for the Committee and the establishment of a provider-led Programme Board

2.2.2.14 Children and Young People's Committee

The Children and Young People's Committee was established during 2023-24 to have oversight of, shape and provide assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for children and young people (aged 0 to 25), children and young people with special educational needs and disabilities, and safeguarding (children and young people), including looked after children.

The Committee oversees the development and delivery of the Cheshire and Merseyside Children and Young People's Strategy and ensure effective system focus on Children and Young People as a population cohort. The Committee will also be responsible for oversight of the delivery of the ambitions and priorities within the Cheshire and Merseyside Joint Forward Plan, in relation to Children and Young People.

During 2023-24, the Committee has met four times and was quorate on each occasion. Key activities of the Committee included:

- discussing the current baseline and ambition and vision for children and young people's health, wellbeing and care, and a sustainable approach
- approving the committee's terms of reference and forward plan
- discussing the development of the CYP Strategy and CYP intelligence dashboard and the key areas of focus
- developmental workshops to support and inform the work of the committee
- receiving regular high-level overview, assurance and escalation in respect of key functions, programmes and services across the Cheshire and Merseyside system impacting on the lives of CYP
- receiving an update and assurance in relation to the appropriate places of care programme
- receiving a presentation on the CYP neurodiversity pathway.

2.2.2.15 Cheshire and Merseyside Health and Care Partnership

The Cheshire and Merseyside Health and Care Partnership (HCP) is formally a joint Committee between NHS Cheshire and

Merseyside and the nine Local Authorities of Cheshire and Merseyside, however it is a broad alliance of a diverse range of organisations and representatives concerned with improving the care, health, and wellbeing of the population. Its meetings are jointly convened by local authorities and the NHS as equal partners in order to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care.

The HCP, as an Integrated Care Partnership, has a statutory responsibility to prepare, approve and publish an Integrated Care Strategy for the Cheshire and Merseyside Integrated Care System, setting out how the assessed needs in relation to Cheshire and Merseyside are to be met by the exercise of functions of the Integrated Care Board, NHS England, and the nine local authorities whose areas coincide with the Cheshire and Merseyside area.

During 2023-24, the Health and Care Partnership has met four times and was quorate on each occasion. Key activities of the Health and Care Partnership included:

- endorsing the Cheshire and Merseyside HCP Draft Interim Strategy.
- receiving a presentation on All Together Fairer: Healthy work and fair employment.
- receiving an update on the Marmot Beacon Indicators
- receiving a presentation on the financial plan and endorsing the approach to developing our financial strategy
- receiving a presentation and update on Sustainability, including the Green Agenda, Social Value and Anchor Organisations
- receiving a presentation on the All together Fairer year end review
- refreshing and endorsing revised Terms of Reference
- receiving a presentation on All Together Active
- receiving an update on ICB finance and health inequalities funding.

2.2.2.16 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

2.2.2.17 Discharge of Statutory Functions

NHS Cheshire and Merseyside has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that NHS Cheshire and Merseyside is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of NHS Cheshire and Merseyside's statutory duties.

2.2.2.18 Risk management arrangements and effectiveness

NHS Cheshire and Merseyside's Risk Management Strategy sets out its statement of intent, organisational arrangements, systems and processes for risk management and assurance. It was developed based on best

practice and subject to consultation within NHS Cheshire and Merseyside and with its internal auditors. It has been reviewed and updated reflecting feedback and experience following the first year of NHS Cheshire and Merseyside operation.

Risks arise from a range of external and internal factors, and the identification of risks is the responsibility of all NHS Cheshire and Merseyside staff.

This is done proactively, via regular planning and management activities and reactively, in response to inspections, alerts, incidents and complaints.

All risks are assessed to determine:

- a clear description identifying the cause, effect and impact on NHS Cheshire and Merseyside
- 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 NHS Cheshire and Merseyside's risk matrix to arrive at an inherent and current risk rating
- risk proximity indicating whether the impact will be immediate, within or beyond the current year
- appropriate risk treatment and further mitigation action based on risk tolerance and cost effectiveness
- sources of assurance in respect of key control measures.

The control framework and mechanisms aim to provide a holistic system for prevention, deterrence and management of risks including:

- governance structures, with clearly defined terms of reference, roles and explicit responsibilities for scrutiny and assurance
- an accountability and reporting framework, with clearly defined roles and responsibilities
- clear strategies and plans with associated monitoring and review mechanisms
- policies, procedures and guidance, supported by communication, training and development
- robust contracts and service level agreements and effective contract management processes
- robust and effective performance, financial, risk, and project management
- an internal control framework, including independent, external assurance.

The Board has developed and agreed the following core statement of risk appetite:

'NHS Cheshire and Merseyside'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.
NHS Cheshire and Merseyside 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.'

NHS Cheshire and Merseyside has implemented a comprehensive strategy and robust processes for risk management. All of which can be found on a dedicated risk management section on the ICBs website.

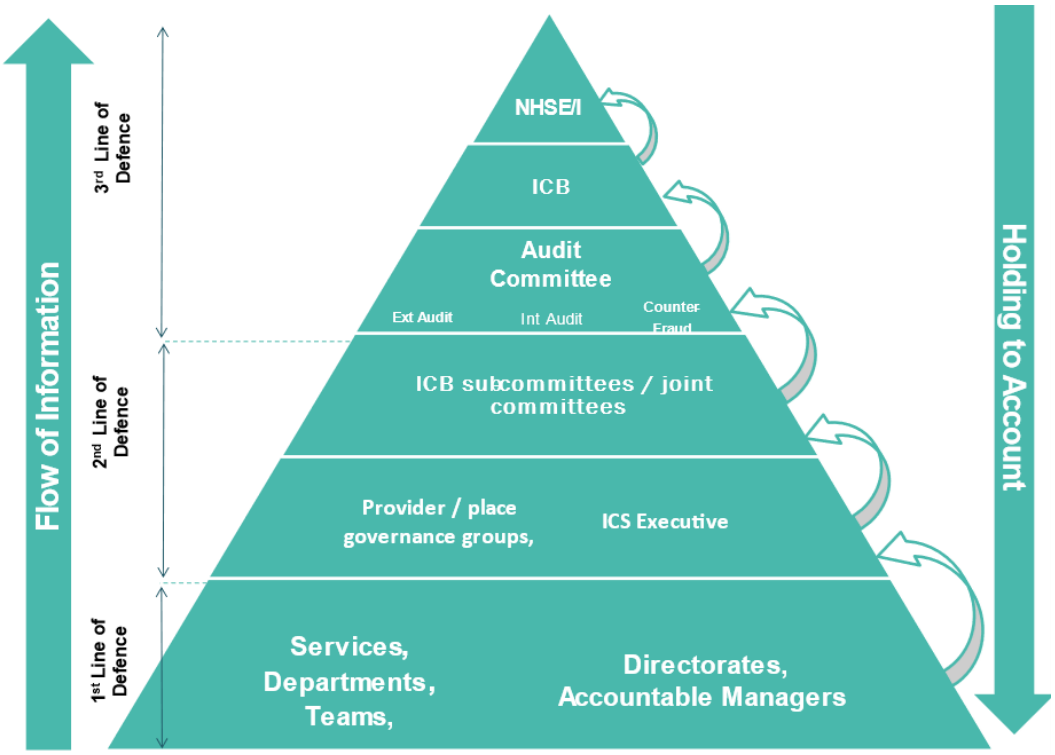
2.2.2.19 Capacity to Handle Risk

NHS Cheshire and Merseyside's Risk Management Strategy sets out specific accountabilities, roles and responsibilities for risk management and provides a structure that supports the integrated approach to risk and governance. These include the responsibilities of:

- the **Board** for providing the resources and support systems necessary and for assuring itself that the organisation has properly identified the risks it faces and has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders
- the **Audit Committee** for providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within NHS Cheshire and Merseyside
- the **Risk Sub-Committee**, established on an interim basis to support the Audit Committee, in overseeing the successful development and embedding of risk management systems
- all **committees and sub-committees** for providing assurance on key controls and ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed
- NHS Cheshire and Merseyside's **governance lead** for the development and delivery of the Risk Management Strategy and associated operational procedures
- a **senior responsible lead** for each identified risk accountable to the Chief Executive, the relevant committee and the board for ensuring that the risk is appropriately managed.

NHS Cheshire and Merseyside's Risk Management Strategy incorporates the three lines of defence model as illustrated in Figure 3.

Figure 3



This includes:

- 1st line - Senior Responsible and Operational Leads have ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.
- 2nd line - strategic leadership and oversight through the Board, its committees, place boards and reporting groups, leadership teams, and corporate monitoring and reporting activity.
- 3rd line - external review and oversight, including reporting, by auditors to the Audit Committee and the Board as appropriate, and supplemented through NHS England oversight and/or regulatory returns and reporting.

The Board Assurance Framework was presented to the Board at its May 2023, July 2023, November 2023, and January 2024 meetings. The refreshed Board Assurance Framework for 2024-25 will be presented to the July 2024 meeting for approval. The committees of the Board of NHS Cheshire and Merseyside receive quarterly risk reports for review and consideration of the level of assurance that can be provided to the Board. Their actions and conclusions are reported to the Board through committee highlight reports.

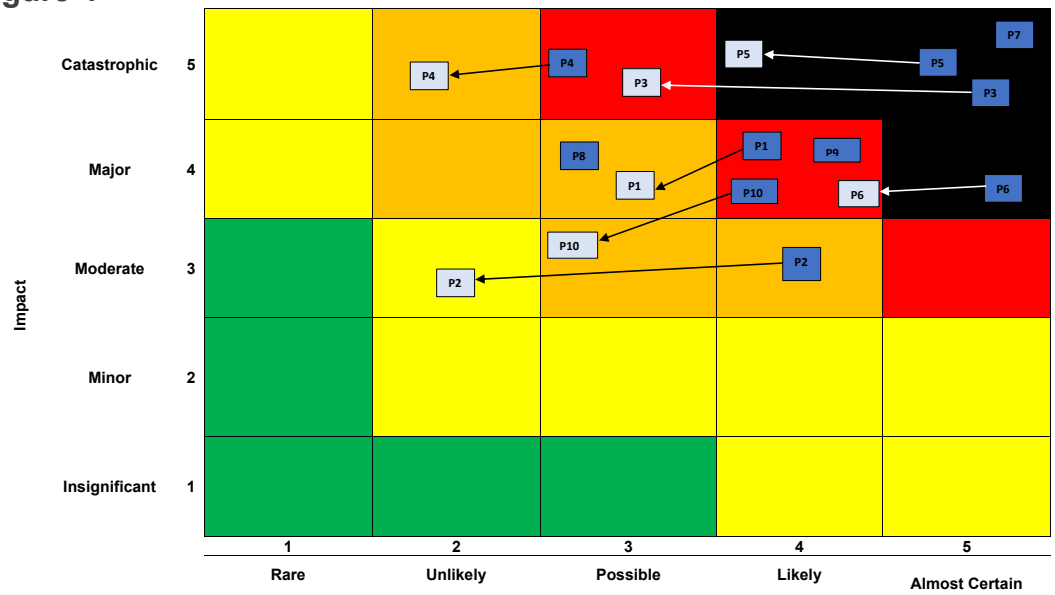
A risk management training programme has been completed during 2023-24, targeted at risk owners and senior risk leads across NHS Cheshire and Merseyside. In addition, guidance materials and resources, including signposting to expertise, support and advice across the organisation are available to all staff on the NHS Cheshire and Merseyside Staff Hub. Feedback from the training programme and through engagement with committee members, risk owners and governance leads

has informed the first-year review and update of the Risk Management Strategy and toolkit.

2.2.2.20 Risk Assessment

NHS Cheshire and Merseyside's Board Assurance Framework identifies 10 principal risks to the delivery of NHS Cheshire and Merseyside's strategic objectives, the most significant of which are summarised in section 1.1.4 of the performance report. The level and spread of NHS Cheshire and Merseyside's strategic risks is indicated in Figure 4.

Figure 4



Risks to governance, risk management and internal control are summarised in Table 19. There are controls in place, including policies, processes, communications, training, information security systems and effective contracts and contract management in relation to commissioning support services. Assurance is provided through regular scrutiny and reporting at the Audit Committee and NHS Cheshire and Merseyside Executive Committee.

Table 19

Risk	Risk Rating
Non-compliance with information governance policies leads to reportable data security and protection incident resulting in financial loss and / or reputational damage	**Moderate (6)**
Commissioning support or other data processors acting on NHS Cheshire and Merseyside's behalf breach statutory or regulatory requirements resulting in financial loss and / or reputational damage	**High (9)**
Business continuity incident impairs NHS Cheshire and Merseyside's ability to deliver statutory duties and functions resulting in reputational damage and / or financial loss	**High (8)**
Inconsistent adherence to core set of governance, financial and operational policies and procedures across NHS Cheshire and Merseyside leads to control failures, poor audit outcomes and reputational damage	**High (9)**
Incident arising from unsafe working practices or environment leads to death or injury for which NHS Cheshire and Merseyside is liable resulting in financial loss and / or reputational damage	**High (12)**
Major Incident causes disruption to NHS Cheshire and Merseyside and commissioned services	**High (10)**
Re-procurement of information governance services de-stabilises existing arrangements resulting in adverse financial and reputational impacts	**High (9)**
Ineffective public and patient involvement in the women's services programme could lead to challenge and / or failure to pass NHS England assurance processes	**High (12)**

2.2.2.21 Internal Control Framework

A system of internal control is the set of processes and procedures in place in NHS Cheshire and Merseyside to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

NHS Cheshire and Merseyside's internal control framework comprises:

- the Board Assurance Framework, which is framed around NHS Cheshire and Merseyside's strategic objectives. This is reviewed and managed by NHS Cheshire and Merseyside's Executive Team, reported quarterly to the Board and scrutinised by the Risk Sub-Committee
- an internal audit service commissioned from Mersey Internal Audit Agency (MIAA) and delivering a comprehensive and balanced audit plan which is approved and monitored by the Audit Committee. This provides an objective challenge and valuable insight into risks, control weaknesses and opportunities for improvement
- anti-fraud arrangements described in paragraphs 2.2.2.30
- the governance framework described in paragraphs 2.2.2.4 to 2.2.2.15
- the NHS Cheshire and Merseyside Executive Team and Non-Executive Directors

- the application of agreed policies and procedures, principally the corporate governance handbook including schemes of reservation and delegation and standing financial instructions.

This internal control framework is informed and assured by external scrutiny and review, including the NHS England System Oversight Framework and External Audit.

2.2.2.22 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support Integrated Care Boards to undertake this task, NHS England has published a template audit framework.

The ICBs internal Auditors, Mersey Internal Audit Agency (MIAA) has conducted, as part of its Annual Audit Plan for 2023-24, an audit on the ICBs arrangements for managing declarations of interest. This encompassed our systems and controls around conflicts of interest, and declarations regarding gifts, sponsorship and hospitality. Internal Audit identified 17 areas of good practice being demonstrated by the ICB and reported a significant assurance rating outlining that the ICB has a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

The report made one medium risk recommendation and three low risk recommendations regarding areas for enhancement for the ICB to consider, and which included the more timely updating of registers on the ICB's website and ensuring all members submit a declaration on time, enhancing the declaration process for new starters, and ensuring processes are in place to confirm that declarations recorded on ICB registers that are made regarding sponsorship from pharmaceutical companies mirror (where relevant) that which are reported on the Association of the British Pharmaceutical Industries Disclosure UK website.

2.2.2.23 Data Quality

The importance of data quality is well recognised by NHS Cheshire and Merseyside and is critical in the production of accurate analysis which underpins and influences commissioning decisions, priorities, contractual performance and assurance activities. NHS Cheshire and Merseyside has identified and specified the data requirements for both effective monitoring of the performance, quality and safety of commissioned services and to support its plans to redesign and re-commission services. These form the basis of regular reporting to NHS Cheshire and Merseyside, and its committees.

Data quality standards and requirements from commissioned providers are set out in data and quality contract schedules. The service agreements with NHS Cheshire and Merseyside's commissioning support providers include requirements for data validation and quality control.

NHS Cheshire and Merseyside has worked in partnership with its commissioning support providers to further develop the quality and design of reports and other business intelligence products. Performance data has been supplemented by intelligence from patient feedback, quality

monitoring visits, audits, and contract monitoring activity to provide a broader view of performance than solely quantitative metrics.

The NHS Cheshire and Merseyside Business Intelligence team produces a routine data quality briefing report. This reviews the key contractual and performance data sets required to be submitted by providers either to meet national data requirements e.g., Secondary Users Services (SUS), Community Services Data Set (CSDS) or any local data requirements to support contracts e.g. SLAM. The monthly report includes the timeliness of data submissions, data quality, data validity e.g., a recent focus on the ethnicity coding to enable analysis to support targeted action to reduce health inequalities.

The report provides benchmarking of the national datasets against peers in addition to a regular overview of the Data Quality Maturity Index which provides an overview of data quality in the NHS by provider across the numerous data sets submitted. Actions to pick up on the findings from the report are led by the Business Intelligence team, working with providers through the respective information subgroups, which form part of the contractual governance structure.

2.2.2.24 Information Governance

NHS Cheshire and Merseyside has a robust information governance framework, which includes:

- the roles of Senior Information Responsible Officer (SIRO), Caldicott Guardian, and the Information Governance Lead, who advise and support NHS Cheshire and Merseyside's Executive Team in relation to information governance matters
- the roles of Deputy SIRO and Caldicott Guardian for each of our nine place directorates, who advise and support place teams in relation to information governance matters
- the Information Governance Management Group whose purpose is to support and drive the broader IG agenda and provide the Audit Committee, and ultimately the Board with assurance that effective IG is in place within the organisation
- an information governance handbook and code of conduct, data protection and security policy, supported by briefings and training for all Board members and staff, and resources on our Staff Hub
- an information asset register, and data flows map which record the nature and security arrangements for the data held and transmitted, including sensitive and confidential data, and the risks and security arrangements, which are regularly assessed and reviewed
- access to specialist expertise and advice, including scrutiny, challenge and spot checks, through commissioning support arrangements
- quarterly reports on compliance which are reported to the Audit Committee and an annual review by internal audit.

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to NHS Cheshire and Merseyside, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

NHS Cheshire and Merseyside completed the data security and protection toolkit self-assessment in 2022-23 providing evidence to demonstrate that it meets the Data Security and Protection Standards for health and care relevant to Integrated Care Boards. The 2022-23 DSPT audit conducted by Mersey Internal Audit Agency provided substantial assurance of NHS Cheshire and Merseyside's self-assessment and moderate assurance overall across all 10 standards. NHS Cheshire and Merseyside has an action plan to respond to the recommendations made by MIAA and will submit a further self-assessment for 2023-24 at the end of June 2024.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures, and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

2.2.2.25 Business Critical Models

The data and intelligence provided through NHS Cheshire and Merseyside's commissioning support provider to inform needs analysis and service commissioning is subject to robust quality assurance both internally by the provider and by NHS Cheshire and Merseyside. NHS Cheshire and Merseyside's plans and forecasts are also subject to external scrutiny and sign-off by NHS England.

2.2.2.26 Third party assurances

NHS Cheshire and Merseyside relies on a number of third-party service provider organisations such as Capita (for primary care support / payments), NHS Shared Business Services Limited (for the provision of general ledger finance and accounting services - including invoice payment), Mersey and West Lancashire Teaching Hospitals NHS Trust (for payroll services), NHS Midlands and Lancashire Commissioning Support Unit (for Human Resources Support).

Typically, each area except for the Capita primary care support services and NHS Shared Business Services Limited, which are the responsibility of NHS England and Improvement, has a lead officer who maintains a client relationship with the service provider.

Those relations extend to regular contact and meetings with the providers, participation in client satisfaction ratings and where required intervention where performance falls below a satisfactory level. As appropriate, external standards and service delivery levels are monitored and by exception any assurance failings brought to the immediate attention of NHS Cheshire and Merseyside.

Assurance on these services is gained by independent service audits on the controls operated by these service providers which is commissioned directly by the contract holder, in most cases NHS England. NHS Cheshire and Merseyside reviews the independent audit reports for control issues at those service providers to assess whether there are adequate compensating controls to mitigate any risks to NHS Cheshire and Merseyside that might arise. After reviewing compensating controls operated by the NHS Cheshire and Merseyside, the issues identified in reports relating to the period to 31 March 2024 do not present a significant risk that would impact on NHS Cheshire and Merseyside directly.

2.2.2.27 Control Issues

A number of significant control issues in relation to quality and performance have or are impacting the ICB's achievement of priorities as follows:

- improvements made during the earlier part of the year towards the national ambition to eliminate long waits in excess of 65 weeks have been offset by the impact of financial restrictions and industrial action. NHS England, at the end of March 2024, changed the taget date for the elimination of 65 week wait to the end of September 2024 in recognition of this national challenge. The ICB continues to work with the provider collaboratives on the elective recovery programme.
- significant demand, capacity and flow challenges in the urgent and emergency care system impacted on the ability of patients to access care at the right time in the right place and resulted in Cheshire and Merseyside not meeting the national ambition of metting 76% 4 hour A&E waiting times by March 2024, with an achievement of 71.9% by end of March 2024, however with an average achievement of 71.4% across the 2023-24 period.
- following a Care Quality Commission inspection, a Section 29A Warning Notice was issued to Liverpool Women's Hospital Trust requiring significant improvements to maternity assessment and triage. In February 2024, as a result of improved maternity performance, the Section 29A notice was lifted.
- regulatory and quality oversight issues in respect of Liverpool University Hospital Foundation Trust, East Cheshire Trust and Cheshire and Wirral Partnership Trust are subject to improvement plans and ICB continues to provide oversight.
- at the end of April 2024, Liverpool Womens Hosital was placed in Tier One for cancer performance. The ICB will support the Trust in working collaboratively with the Cheshire & Merseyside Cancer Alliance and the regional NHS England team so as to accelerate performance improvements, with progress being tracked and monitored via Improvement Plan reports to the Trust Board.

2.2.2.28 Review of economy, efficiency and effectiveness of the use of resources

NHS Cheshire and Merseyside's constitution requires it to ensure that it receives value for money. To ensure that resources are used economically, efficiently and with effectiveness:

- the Board provides active leadership of the organisation within a framework of prudent and effective controls that enable risk to be assessed and managed.
- the Audit Committee, as a committee of the Board, is pivotal in advising the Board on the effectiveness of the system of internal control. Any significant issues would be reported to the Board via the Audit Committee.

- NHS Cheshire and Merseyside's committees' responsibilities include overseeing the development and review of: strategy and commissioning plans, annual commissioning intentions, financial plans (including delivery), undertaking detailed scrutiny of performance, contract monitoring and financial management on behalf of NHS Cheshire and Merseyside, and also review and monitor the organisational improvement plan. NHS Cheshire and Merseyside's committees formally report to the Board, escalating issues as required.
- Directors' roles and responsibilities are aligned to ensure systems of internal control are in place and implemented effectively throughout the organisation.
- the constitution includes a Scheme of Reservation and delegation which sets out the procurement processes and financial limits that are delegated to management.
- a procurement strategy and procurement processes have been developed in the year that includes securing both quality services and value for money as key criteria.
- as explained throughout this report, extensive partnership working with local councils and with service providers in undertaken through our place structure which helps ensure that local services are designed and delivered with economy, efficiency and effectiveness as a key priority.
- processes are monitored through risk assessment and through regular reports on procurement, including any tender waivers together with the reasons for those waivers.
- Internal Audit provides reports to each meeting of the Audit Committee and full reports to the Executive Director of Finance. The Audit Committee also receives details of any actions that remain outstanding from the follow up of previous audit work. The Executive Director of Finance also meets regularly with the Audit Manager.
- External Audit provides external audit annual management letter and progress reports to the Audit Committee.

External auditors are required to be satisfied whether the Integrated Care Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. In September 2023, our external auditors provided a report on the arrangements to deliver value for money in the nine months to 31 March 2023 covering arrangements for financial sustainability, governance, and improving economy, efficiency, and effectiveness. A further report was issued in June 2024 relating to arrangements for the financial year 2023-24.

In the June 2024 report on 2023-24, our external auditors identified no significant weaknesses in arrangements identified for governance, and improving economy, efficiency, and effectiveness, noting that improvement arrangements that had been recommended in the 2022-23 report had been addressed.

On financial sustainability, while acknowledging that NHS Cheshire and Merseyside was operating with an annual budget surplus, the June 2024 report noted that the Cheshire and Merseyside health system as a whole had a deficit for 2023-24 and had submitted a deficit financial plan for 2024-25. The auditors reported no significant weaknesses regarding arrangements for achieving financial sustainability and raised improvement recommendations that the ICB should continue to develop the Cheshire and Merseyside system medium term financial plan with system

partners and work with partners to develop and deliver recurrent savings schemes.

Recommendations regarding financial sustainability are addressed through the development of the medium-term financial plan alongside system partners, including a review of the approach to the development delivery of efficiencies, sharing best practice across the system to ensure the delivery of recurrent efficiencies scale across the system. External auditors acknowledged that these steps to address the recommendations and considered the timescales provided to be appropriate.

The NHS Oversight assurance framework is aligned to the ambitions set out in the NHS Long Term Plan and in operational planning and contracting guidance issued for 2023-24. Metrics in relation to Finance and Use of resources include Financial Efficiency, Financial Stability, Achievement of the Mental Health Investment Standard and Agency Spending. These are also areas of focus for the Board.

ICSs are required to demonstrate how, as organisations, we unite to reduce inequalities. The ICB is committed to use the scale and funding of partners to improve how our local economies flourish. Sustainability leaders throughout C&M are working with social value experts to do just this. In 2024, we are embarking on a transformational approach to maximise every penny of social value. All procurement includes a 10% social value requirement, based on a set of co-produced target operating models aligned with our Marmot principles.

Our procurement processes facilitates connections between prospective bidders and our voluntary sector as the recipient of this added value to ensure this goes directly into our communities.

2.2.2.29 Delegation of functions

NHS Cheshire and Merseyside has delegated responsibility for some of its functions to committees and this is set out in terms of reference and the scheme of reservation and delegation. The Board remains accountable for these functions and has put in place reporting and assurance arrangements requiring all committees to:

- submit regular reports of their business to NHS Cheshire and Merseyside
- make minutes of their meetings available to NHS Cheshire and Merseyside
- prepare an annual report outlining how it has delivered its responsibilities and submit this to NHS Cheshire and Merseyside.

NHS Cheshire and Merseyside has also entered into individual Section 75 arrangements with each of the nine Local Authorities across Cheshire and Merseyside.

Through these individual arrangements NHS Cheshire and Merseyside has delegated decision making authority to each Place through the formation of Section 75 Joint Committees with the Local Authorities, and authority given to NHS Cheshire and Merseyside representatives on budgets and functions that fall under the individual Section 75 Agreement, for example in relation to the Better Care Fund.

NHS Cheshire and Merseyside has also discharged significant decision-making authority to several key posts within the organisation which enables these individuals to have the authority to make decisions on behalf

of NHS Cheshire and Merseyside on functions and budgets within a number of forums across all nine Places in Cheshire and Merseyside.

This authority is outlined within the NHS Cheshire and Merseyside Scheme of Reservation and Delegation and Standing Financial Instructions.

2.2.2.30 Counter fraud arrangements

Each year, the NHS is vulnerable to over £1 billion worth of fraud, money lost out of the system that would otherwise pay for more doctors, more nurses, and much more else. Fraud has a significant impact on the NHS. It is not a victimless crime.

NHS Cheshire and Merseyside is fully committed to promoting an anti-fraud, bribery and corruption agenda and takes a zero-tolerance approach towards it.

NHS Cheshire and Merseyside contracts Mersey Internal Audit Agency (MIAA) to deliver anti-fraud, bribery and corruption services on its behalf. A nominated Local Counter Fraud Specialist (LCFS) delivers a programme of work in collaboration with key stakeholders to help raise staff and public knowledge and awareness of fraud, bribery and corruption, prevent and detect it and maintain strong governance arrangements around it.

The Executive Director of Finance is the senior responsible officer for fraud, bribery and corruption at NHS Cheshire and Merseyside and, along with the Audit Committee, has responsibility for approving and monitoring the programme of work undertaken. The Associate Director of Finance – Planning and Reporting is the nominated Counter Fraud Champion and provides support to the LCFS. All anti-fraud, bribery and corruption work undertaken by NHS Cheshire and Merseyside is completed in accordance with the Government Functional Standard 013 for Counter Fraud.

In 2023-24, the LCFS has conducted a number of activities to raise awareness, including circulating articles and newsletters and promoting International Fraud Awareness Week.

Regarding prevention and detection, a number of activities have been undertaken, including, participation in the National Fraud Initiative data-matching exercise to identify fraud, and the circulation of local and national alerts in relation to specific identified fraud threats.

All allegations of fraud, bribery and corruption received by NHS Cheshire and Merseyside are dealt with and investigated in line with the organisation's Anti-Fraud, Bribery and Corruption Policy and all staff are actively encouraged to report any concerns or suspicions to the LCFS or the national Fraud and Corruption Reporting Line.

2.2.2.31 Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2023 to 31 March 2024 for NHS Cheshire and Merseyside, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS Cheshire and Merseyside's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

"The overall opinion for the period 1st April 2023 to 31st March 2024 provides ***Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.***

This opinion is provided in the context of the ICB's organisational maturity following its formation in July 2022 and like other organisations across the NHS it is facing a number of challenging issues and wider organisational factors particularly with regards to workforce challenges, financial challenges and increasing collaboration across organisations and systems.

In providing this opinion we can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. We also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

The purpose of our Head of Internal Audit (HoIA) Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of Internal control. As such, it is one component that the Board takes into account in making its Annual Governance Statement (AGS).

The opinion does not imply that we have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. It should be noted that the planned reviews relating to Serious Incident Management, Continuing Healthcare and Workforce Planning were deferred into 24/25 at the request of the ICB.

The basis for forming our opinion is in Figure 5 as follows:

Figure 5

Basis for the Opinion
1. An assessment of the design and operation of the underpinning Assurance Framework, risk management systems and supporting processes.
2. An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.

3. An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Commentary

The commentary in Figure 6 provides the context for our opinion and together with the opinion should be read in its entirety. Our opinion covers the period 1 April 2023 to 31 March 2024 inclusive and is underpinned by the work conducted through the risk based internal audit plan.

Assurance Framework (AF)

Figure 6

Opinion

Structure	The organisation's AF is structured to meet the NHS requirements.
Risk Appetite	The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the AF.
Engagement	The AF is visibly used by the organisation.
Quality and Alignment	The AF clearly reflects the risks discussed by the Board.

Overall, the Assurance Framework is continuing to be developed and embedded.

Core and Risk-Based Reviews Issued

We issued:

2 **high** assurance opinions:	• General Ledger • Treasury Management
7 **substantial** assurance opinions:	• Complaints Management • Patient Involvement & Engagement • Accounts Receivable • Healthcare Contract Management • Conflicts of Interest • Risk Management Core Controls • Data Security & Protection Toolkit (DSPT) – Phase 2 2022-23
4 **moderate** assurance opinions:	• Accounts Payable • Safeguarding • Primary Care Contracts • QiPP Efficiencies Programme
0 **limited** assurance opinions:	N/A
0 **no assurance** opinions:	N/A
5 reviews without an assurance rating	• Assurance Framework • Post Integration: IG / Digital Governance • DSPT – Phase 1 2023-24 • Risk Appetite Workshop • Briefing on the outcomes from Risk Management Training

Follow Up
During the course of the year, we have undertaken follow up reviews and can conclude that the organisation has addressed all legacy recommendations with the majority of 2023-24 recommendations not yet due.

Chris Harrop
Managing Director, MIAA
March 2024

Louise Cobain
Assurance Director, MIAA
March 2024

2.2.2.32 Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within NHS Cheshire and Merseyside who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to NHS Cheshire and Merseyside achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- the Board of NHS Cheshire and Merseyside
- the Audit Committee
- the Risk Sub-Committee
- the Quality and Performance Committee
- the NHS Cheshire and Merseyside Executive Team Committee
- Internal audit.

The role and conclusions of each have been considered in the Corporate Governance Report from 2.2.

During the year the Board and Audit Committee have kept under regular review the application of the system of internal control. With the support of Internal Audit where areas for improvement have been identified, prompt appropriate actions have been taken to address any gaps in control and changes made to ensure that the systems in place remain robust and effective.

The establishment of the Risk Sub-Committee has supported the implementation and embedding of the Board Assurance Framework, Corporate Risk Register and effective systems of risk management across NHS Cheshire and Merseyside's corporate and place directorates.

2.2.2.33 Conclusion

The receipt of a Substantial Assurance Opinion from our Internal Auditors demonstrates the progress that has been achieved during the year in continuing to develop and strengthen our governance and assurance framework.

The report identifies significant challenges in relation to delivering within the resources available and increasing productivity in 2024-25. NHS Cheshire and Merseyside is planning on making some changes to its operating model during 2024-25 to focus on the most important short-term priorities in terms of improving care and outcomes, whilst at the same time, making the best of our limited resources.

While recognising this immediate financial challenge, the longer-term focus on getting upstream, improving population health and building systems for integration and collaboration remains the solution for long-term financial sustainability.

2.3 Remuneration and Staff Report

Introduction

The remuneration and staff report sets out NHS Cheshire and Merseyside's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers.

The Government Financial Reporting Manual requires NHS bodies to prepare a Remuneration Report containing information about directors' remuneration. In the NHS, the report will be in respect of the Senior Managers of the NHS body. 'Senior Managers' are defined as: *'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of NHS Cheshire and Merseyside as a whole, rather than the decisions of individual directorates or departments.'* For the purposes of this report, this includes NHS Cheshire and Merseyside's Board.

2.3.1 Remuneration Report

This report:

- sets out the process under which the Chair, Executive Directors, Directors and Non-Executive Members were remunerated for the financial year to 31 March 2024
- sets out tables of information showing details of the salary and pension interests of all directors for the financial year to 31 March 2024.

2.3.1.1 Remuneration Committee

The Remuneration Committee is established by NHS Cheshire and Merseyside as a Committee of the Board in accordance with its Constitution. The Remuneration Committee is responsible for determining the remuneration and terms and conditions of the Chief Executive, Executive Directors and non-voting directors. The Committee is chaired by a Non-Executive Member and membership comprises all other ICB Non-Executive Members. Committee meetings are quorate when a minimum of two Non-Executive Members are present.

The Chair undertakes the annual appraisal of the Non-Executive Members and the Chief Executive, who in turn is responsible for assessing the performance of the Executive Directors.

As reported in the Governance Statement at 2.2.2.7, the Committee convened four times during the year and its work has included following matters of business:

- ICB Executive Director and Place Director Appraisal Summary
- ICB Pay Framework
- Report on ICB senior managers who have yet to secure Suitable Alternative employment.
- ICB On-Call Payments
  - Committee approved the proposed remuneration of £1,000 per annum for staff who participate on the ICB tactical on-call rota.
- Establishment of the post of ICB Deputy Chief Executive
  - Committee approved the proposed recommendation to appoint/designate one of the ICBs Statutory Directors as the named ICB Deputy Chief Executive, with an additional remuneration of 2.5% payable.
- Pharmacy, Optometry and Dentistry (POD) roles Terms and Conditions
  - Committee supported the recommendation to continue with the current terms and conditions of engagement from 1st September 2023 for those POD individuals in scope who had TUPED into the ICB from NHS England, noting that work would progress to agree a new set of terms of engagement for these roles, to be implemented from 1st April 2024.
- Annual Report of the Committee
  - Committee approved its 2022-23 Annual Report
- ICB MARS Updates
- Fit and Proper Persons Test (FPPT) Requirements from September 2023
  - Committee approved recommendations around the internal approach to implementing and managing the internal FPPT requirements.
  - Committee approved the development of an ICB FPPT policy.
  - Committee approved the ICBs Fit and Proper Persons Policy and Processes.
- Terms and Conditions of GP Clinical Advisors for Primary Care Complaints
  - Committee approved the proposed Terms and Conditions for GP Clinical Advisors to support the ICB Complaints team.
- Committee Terms of Reference Review and Committee Effectiveness Survey results
  - Committee endorsed proposed amendments to its Terms of Reference
- VSM Pay Framework 2023-24
  - Committee approved the recommendation regarding a pay case application to NHS England for the ICB Medical Director in line with national guidance.
- VSM Pay Award to ICB Director of Population health.
  - Committee approved the application of the national 2023-24 pay increase award for VSM staff to the salary of the ICBs Director of Population health.
- ICB Associate Non-Executive Member Terms and Conditions
  - Committee approved the Terms and Conditions of the ICB Associate Non-Executive Member roles.
- Conclusion of ICB On-Call Consultation
- Report on succession planning/bench strength of ICB Associate and Deputy Directors.

The Chief Executive, the Chief People Officer and the Associate Director of Governance and Corporate Affairs (Company Secretary) are normally in attendance at meetings of the Committee, to provide advice

and expertise except when their positions are being discussed and the Committee has the option to seek further professional advice as required.

The work of the Committee is subject to an independent level of scrutiny. In compliance with Article 21 of the General Data Protection Regulation (GDPR) each member of the Board, detailed in the tables 2.3.1.2 to 2.3.1.6, have given their consent for their information to be included.

2.3.1.2 Fair Pay Disclosure - AUDITED

Percentage change in remuneration of highest paid director

The percentage change in remuneration of the highest paid director (based on that director's midpoint banding) is a comparison to the previous financial year is set out below together with the average The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole.

Table 20

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	6%	6%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5%	5%

Pay ratio information

The banded remuneration of the highest paid director in NHS Cheshire and Merseyside in the year to 31 March 2024 was £272,500 (2022-23 - £257,500). The relationship to the remuneration of the organisation's workforce is disclosed Table 21.

Table 21

2023-24	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£34,581	£45,996	£58,972
Salary component of total annual remuneration (£)	£34,581	£45,996	£58,972
Pay ratio information	7.88 : 1	5.92 : 1	4.62 : 1
2022-23 (for period 1 July 2022 to 31 March 2023)			
Total annual remuneration (£)	£34,943	£46,040	£58,748
Salary component of total annual remuneration (£)	£34,943	£46,040	£58,748
Pay ratio information	**7.37 : 1**	**5.59 : 1**	**4.38 : 1**

In 2023-24, no employee received remuneration more than the highest-paid director (nine months to 31 March 2023 - no employee). Remuneration ranged from £21,932 to £272,500 (2022-23 - £22,383 to £257,500).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

As can be seen, pay multiples for the highest paid director against 25th Centile, the median pay centile and 75th centile increased. The biggest factor was that in 2022-23, the ICB included non-consolidated pay rises in calculation of the salary for staff, much of which related to periods prior to the inception of the ICB.
This one-off payment means that the actual amounts paid as salary in 2022-23 for staff on many grades was higher than in 2023-24. Additionally pay for very senior managers, which would include the highest paid director, increased by 6% against an average for employees of 5%).

2.3.1.3 Policy on the remuneration of senior managers

In determining and reviewing remuneration for Executive Directors, NHS Cheshire and Merseyside's Remuneration Committee considers relevant benchmarking with other NHS organisations, guidance from NHS England, national inflationary uplifts recommended for other NHS staff and any variation or change to the responsibilities of Directors and the financial circumstances relating to NHS Cheshire and Merseyside.

For the purposes of the Annual Report Senior Managers are defined as those in Board level positions. Senior managers at NHS Cheshire and Merseyside do not receive performance-related pay or bonuses. All Executive Directors / Other Board Directors have employment contracts which are usually awarded on a permanent basis unless the post is for a fixed period of time. Executive Directors (including the Chief Executive) have a 6-month notice period within their contracts of employment.

2.3.1.4 Remuneration of Very Senior Managers

In respect of those senior managers who are paid more than £170,000 per annum, NHS Cheshire and Merseyside, via its Remuneration Committee takes steps to ensure such remuneration is reasonable and commensurate with the individual's experience, by way of reference to the VSM Pay Framework and guidance issued to Integrated Care Boards and considering benchmarking data from other similar organisations.

2.3.1.5 Senior manager remuneration (including salary and pension entitlements) - AUDITED

Table 22

1 April 2023 to 31 March 2024							
Name	**Title**	**Salary (bands of £5,000)**	**Expense payments (taxable) to nearest £100****	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)**	**TOTAL (bands of £5,000)**
		£000	**£**	**£000**	**£000**	**£000**	**£000**
Raj Jain	Chair	75 - 80	-	-	-	-	75 - 80
Tony Foy	Non-Executive Member	20 - 25	-	-	-	-	20 - 25
Erica Morris	Non-Executive Member	15 - 20	200	-	-	-	15 - 20
Neil Large MBE	Non-Executive Member	15 - 20	200	-	-	-	15 - 20
Hilary Garratt CBE	Non-Executive Member	10 -15	100	-	-	-	10 - 15
Ruth Hussey CB, OBE, DL	Non-Executive Member	5 - 10	-	-	-	-	5 - 10
Dr Naomi Rankin	Partner Member	10 - 15	-	-	-	-	10 - 15
Adam Irvine	Partner Member	20 - 25	-	-	-	-	20 - 25
Professor Stephen Broomhead MBE	Partner Member	-	-	-	-	-	-
Cllr Paul Cummins	Partner Member	10 - 15	-	-	-	-	10 - 15
Ann Marr OBE	Partner Member	-	-	-	-	-	-
Joe Rafferty CBE	Partner Member	-	-	-	-	-	-
Graham Urwin	Chief Executive	270 - 275	100	-	-	57.5 - 60	330 - 335
Claire Wilson	Executive Director of Finance	180 - 185	-	-	-	25 - 27.5	205 - 210
Professor Rowan Pritchard-Jones	Medical Director	175 - 180	-	-	-	50 - 52.5	225 - 230
Christine Douglas MBE	Executive Director of Nursing & Care	175 - 180	300	-	-	-	175 - 180

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

1. Where an executive member sacrifices salary which is then used to lease a motor vehicle and the salary sacrificed amount is included within salary and fees because the ICB considers these as salary earnt which has then been used by the employee to lease motor vehicles.
2. The Chief Executive, Executive Director of Finance, Executive Director of Nursing and Care and Executive Medical Director are engaged under contracts of services and are employees.
3. The value of pension benefits accrued during the period is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
4. The pension benefit table provides further information on the pension benefits accruing to the individual.
5. Ann Marr OBE, Joe Rafferty CBE and Professor Steven Broomhead MBE are Partner Board Members and are not remunerated by the ICB.

Table 23

1 July 2022 to 31 March 2023							
Name	**Title**	**Salary (bands of £5,000)**	**Expense payments (taxable) to nearest £100****	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)**	**TOTAL (bands of £5,000)**
		£000	**£**	**£000**	**£000**	**£000**	**£000**
Raj Jain	Chair	55 - 60	-	-	-	-	55 - 60
Tony Foy	Non-Executive Member	15 - 20	300	-	-	-	15 - 20
Erica Morris	Non-Executive Member	10 - 15	300	-	-	-	10 - 15
Neil Large MBE	Non-Executive Member	15 - 20	500	-	-	-	15 - 20
Hilary Garrett CBE (from 18 January 2023)	Non-Executive Member	0 - 5	-	-	-	-	0 - 5
Dr Naomi Rankin	Partner Member	0 - 5	-	-	-	-	0 - 5
Adam Irvine	Partner Member	5 - 10	-	-	-	-	5 - 10
Professor Stephen Broomhead MBE	Partner Member	-	-	-	-	-	-
Cllr Paul Cummins	Partner Member	5 - 10	-	-	-	-	5 - 10
Ann Marr OBE	Partner Member	-	-	-	-	-	-
Joe Rafferty CBE	Partner Member	-	-	-	-	-	-
Graham Urwin	Chief Executive	190 - 195	-	-	-	-	190 - 195
Claire Wilson	Executive Director of Finance	130 - 135	-	-	-	180 – 182.5	310 - 315
Professor Rowan Pritchard-Jones	Medical Director	130 - 135	-	-	-	147.5 - 150	275 - 280
Christine Douglas MBE (from 1 August 2022)	Executive Director of Nursing and Care	110 - 115	-	-	-	-	110 - 115
Marie Boles (from 1 July 2022 to 31 August 2022)	Interim Executive Director of Nursing and Care	35 - 40	-	-	-	-	35 - 40

**Notes: Taxable expenses and benefits in kind are expressed to the nearest £100.

a) The Chief Executive, Executive Director of Finance, Executive Director of Nursing and Care and Executive Medical Director are engaged under contracts of services and are employees.

b) The value of pension benefits accrued during the period is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

c) NHS Cheshire and Merseyside existed in shadow form from 1 April 2022. Non-Executive members Neil Large (£0-5k), Tony Foy (£0-5k) and Erica Morris (£0-5k) were appointed on 1 July 2022 and were remunerated by NHS Cheshire and Merseyside for the period 1 April 2022 to 30 June 2022. This remuneration has been included table.

d) NHS Cheshire and Merseyside existed in shadow form from 1 April 2022. Raj Jain was appointed on 1 July 2022 and was remunerated by NHS Cheshire CCG (£15-20k) for work in the shadow form period. That remuneration is not included in the table above as it was paid by another party.

e) Marie Boles was appointed as interim Executive Director of Nursing and Care for the period 1 July 2022 - 30 August 2022 on a secondment basis from NHS England. The above table represents the basic salary recharged to NHS Cheshire and Merseyside which includes the period 1 March 2022 to 30 June 2022 (£15-20k).

f) Anne Marr OBE, Joe Rafferty CBE and Professor Steven Broomhead MBE are Partner Board Members and are not remunerated by NHS Cheshire and Merseyside.

g) Claire Wilson received £0-£5k for work carried out prior to the establishment of NHS Cheshire and Merseyside. The remuneration for this has been included in the table above.

2.3.1.6 Pension benefits as at 31 March 2024 -AUDITED

All salaried Board members, except for our Non-Executive members, had access to the NHS Pension Scheme. Details of each pension scheme can be found online.[29] (see note 4.5 of the Annual Accounts for further information).

Table 24

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age 31 March 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 31 March 2023	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Graham Urwin – Chief Executive	2.5 – 5	-	75 - 80	220 - 225	1,713	73	1,993	-
Professor Rowan Pritchard-Jones – Medical Director	0 - 2.5	40 - 42.5	55 - 60	155 - 160	872	275	1,259	-
Claire Wilson – Executive Director of Finance	0 - 2.5	17.5 - 20	50 - 55	135 - 140	801	206	1,112	-

a) The pension entitlement above is the total pension entitlement for Board member and is not reduced for the effect contributions made in employment for other entities.
b) A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.
A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
c) Real Increase in Cash Equivalent Transfer Value is the increase in CETV that is funded by the Employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).
d) Graham Urwin rejoined the pension scheme in the year. Christine Douglas is retired from the NHS Pension Scheme.

[29] https://www.nhsbsa.nhs.uk/member-hub (last checked on 140624)

Pension benefits as at 31 March 2023 were:

Table 25

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age 31 March 2023 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 July 2022	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2023	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Professor Rowan Pritchard-Jones – Medical Director	7.5 - 10	15 - 17.5	50 - 55	105 - 110	718	121	872	-
Claire Wilson – Executive Director of Finance	7.5 - 10	17.5 - 20	45 - 50	105 - 110	630	139	801	-

a) The pension entitlement above is the total pension entitlement for each Board member and is not reduced for the effect contributions made in employment for other entities.
b) Cash equivalent transfer values: A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.
A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.
c) Real Increase in Cash Equivalent Transfer Value is the increase in CETV that is funded by the Employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).
d) Graham Urwin chose not to be covered by the pension arrangements during the reporting year. Christine Douglas is retired from the NHS Pension Scheme.
e) NHS Cheshire and Merseyside was in operation from 1 July 2022 to 31 March 2023. As such the real increase figures have been apportioned to reflect the period it has been in operation.

2.3.1.7 Compensation on early retirement or for loss of office

There were no payments for compensation on early retirement or for loss of office in 2023-24 (2022-23 – none).

2.3.1.8 Payments to past directors

No payments have been made to past senior managers in 2023-24 (2022-23 – none).

2.3.1.9 Exit Packages

There were no exit packages for members of the Board. Exit packages for other staff are set out in the staff report.

2.3.2 Staff Report

As at 31 March 2024, NHS Cheshire and Merseyside employed 1,081 staff. The headcount has increased by 46 compared to last year's headcount which was reported as 1,035 on 31 March 2023. There have been several TUPE transfers into the organisation over the last 12 months, the LMNS service transferred in 27 staff during July 23 followed by a number of NHS England and CSU staff who transferred in over July and August 2023. There was a smaller TUPE of MIAA staff which further increased the headcount in October 2023.

2.3.2.1 Number of senior managers and gender split

At 31 March 2024, the headcount, including the board members, at NHS Cheshire and Merseyside consisted of the following breakdown:

Table 26

	Headcount by Gender		
Staff Grouping	**Female**	**Male**	**Totals**
Board (including office holders)	7	9	**16**
Other Senior Management (Band 8C+)	120	64	**184**
All Other Employees	707	174	**881**
Grand Total	**834**	**247**	**1,081**

The percentage split by gender was as follows:

Table 27

	% by Gender	
Staff Grouping	**Female**	**Male**
Board (including office holders)	43.8%	56.3%
Other Senior Management (Band 8C+)	65.2%	34.8%
All Other Employees	80.2%	19.8%
Grand Total	**77.15%**	**22.85%**

2.3.2.2 Staff numbers and costs - AUDITED

Average staffing numbers, on a full-time equivalent basis, by occupation during the year are summarised in the Table 28:

Table 28

Staff Grouping	Permanent	Other	Total
Administrative and Estates	676	42	718
Medical and Dental	10	3	13
Nursing and Midwifery	132	8	140
Scientific/ Therapeutic / Technical	116	4	120
Total	**934**	**57**	**991**

Total staffing costs are summarised in Table 29:

Table 29

	Permanent Employees £000s	Other £000s	Total £000s
Salaries and wages	49,742	2,002	51,745
Social security costs	5,694	-	5,694
Employer contributions to the NHS Pension Scheme	9,547	-	9,547
Other pension costs	29	-	29
Apprenticeship Levy	222	-	222
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	1,425	-	1,425
Gross Employee Benefits Expenditure	**66,659**	**2,002**	**68,662**

A breakdown of staff Headcount, excluding Non-Executive members, by band at 31 March 2024 is outlined in Table 30:

Table 30

Pay Band	Headcount
Band 2	8
Band 3	43
Band 4	80
Band 5	125
Band 6	145
Band 7	208
Band 8A	153
Band 8B	119
Band 8C	74
Band 8D	19
Band 9	39
Medical	30
VSM	27
Total	**1,078**

2.3.2.3 Sickness absence data

The sickness absence data for NHS Cheshire and Merseyside in the calendar year 2023 was whole time equivalent (WTE) days available of 215,681 and WTE days lost to sickness absence of 7,354 and average working days lost per employee was 7.67 which was managed through the absence management policy (Table 31).

Table 31

Staff sickness absence 2023	Number
Total days lost	7,354
Total staff years	959
Average working days lost	7.67

2.3.2.4 Staff turnover percentages

NHS Cheshire and Merseyside's Staff Turnover Rate for 2023-24 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The Total FTE Leavers in year was 126.94. The Average FTE Staff in Post during the year was 971.41 (2022-23 - 948.45). The Staff Turnover Rate for the year was 13.07% (2022-23 – 13.49%) (Table 32).

Table 32

Staff turnover	Number
Average FTE employed	971.41
Total FTE leavers	126.94
Turnover rate	13.07%

Throughout the period NHS Cheshire and Merseyside's staff turnover rate was reported regularly to its Board and Executive Team. Workforce data provided to NHS Cheshire and Merseyside by Midlands and Lancashire Commissioning Support Unit outlined all recorded reasons for staff leaving NHS Cheshire and Merseyside with the top three reasons being:

- Mutually Agreed Resignation Scheme
- Voluntary Resignation – Promotion
- Retirement Age.

A MARS scheme was run during Q3 and a proportion of the leavers during Q4 will have been those who left as part of the scheme.

2.3.2.5 Staff Survey

Through the months of September and November 2023, NHS Cheshire and Merseyside participated in their second annual staff survey. Response rates increased considerably from the previous year from 65% to 74%.

In addition to the detailed organisational reports, for the first time we have place/department level reports that will enable us to work with senior leaders and their teams to identify areas of good practice and agree local priorities for the coming year.

Our results against the seven areas of the NHS People Promise are detailed in Table 33:

Table 33

People Promise Area		Score (out of 10)
1	We are compassionate and inclusive	7.48
2	We work flexibly	7.28
3	We are a team	7.29
4	We have a voice that counts	6.81
5	We are recognised and rewarded	6.67
6	We are safe and healthy	6.35
7	We are always learning	5.23

In addition to the People Promise Themes, the survey also produces reports related to staff morale and engagement.

Staff morale is measured across 3 sub themes in relation to staff thinking about leaving, work pressures and stressors. Our score in this area of the survey was 5.74 and showed a modest increase from the previous year.

Staff engagement is measured across three sub themes relating to staff motivation, their involvement in work and advocacy in relation to recommending the organisation as a place to work and the NHS as place to treated. Our score in this area of the survey was 6.75 again a modest positive increase from the year.

Overall, an encouraging set of results with evidence of positive growth in themes relating to teamwork and working flexibility coupled with positive scores in relation to staff reporting negative experiences, equality and diversity, perceptions of line management and compassionate leadership.

Some of the key areas of focus for the coming year relate to staff wellbeing as far as feedback from staff around time and work pressures and a review of our appraisal system and process.

A communication cascade under the terms of the NHS England embargo will be rolled out between January and April. During this time meetings with each of our Place Directors and Departmental leaders are planned throughout February to share their high-level reports and discuss plans for the coming year. Our Staff Engagement Forum Representatives and People Operations Group members are also engaged in these meetings with a view to promote inclusion and collaboration and embed the People Promise across the organisation.

A detailed presentation of the survey results was delivered to our Executive Team in February and following the lifting of the NHS England embargo on sharing information in mid-March, a dedicated session for all staff will be delivered at the first available' We Are One' Staff Town Hall Meeting.

Upon completion of the communication cascade, an Assurance Report detailing our actions and plans for the coming year will be delivered to the NHS Cheshire and Merseyside, 'People Committee' in April 2024.

2.3.2.6 Staff policies

NHS Cheshire and Merseyside is committed to creating an environment in which people can feel valued, where people are treated fairly and with dignity and respect. Since its establishment in July 2022, NHS Cheshire and Merseyside's has reviewed its HR policies in line with a policy review schedule. This process ensures all staff policies are regularly reviewed and this is done in partnership with staff side colleagues.

NHS Cheshire and Merseyside conducts Equality Impact Analysis for all strategies, policies and processes to ensure it treats people fairly and does not undermine their rights.

Policy reviews in 2023-24 have been reflective of legislative changes and any changes to NHS Employment terms within the Agenda for Change framework, cognisant of the ongoing development of a suite of people policy frameworks being undertaken by NHS England with the intention of more substantial future review of current policies being undertaken given the commitment of the ICB is to review its policies in detail against the national people policy frameworks to ensure alignment and a focus on policies being simple and easy to read, staff-centric, inclusive and accessible and reflective of best practice.

The adoption of the national people policy frameworks will mean our staff are supported by managers and colleagues and will help build a culture of compassion and inclusion across the service and:

- improve inclusion and diversity.
- ensure consistency across the system and NHS, improving staff experience and saving time.
- reduce absence, staff turnover, grievances and disputes, improving your staff survey results.
- reduce duplication of effort across your organisation, enabling the scaling of people services and cross-system working.
- ensure your organisation continues to align to the NHS Long term Workforce Plan and People Promise.

NHS Cheshire and Merseyside is committed to creating an environment that promotes equality and embraces diversity in its performance as an employer. It adheres to legal and performance requirements and mainstreams its equality and diversity principles through its policies, procedures and processes. Policies are equality impact assessed during the policy development processes to ensure that our policies do not have an adverse impact in response to the requirements of The Equality Act 2010. NHS Cheshire and Merseyside will act when necessary to address any unexpected or unwarranted disparities and monitor workforce and employment practices to ensure that employment policies are fairly implemented.

NHS Cheshire and Merseyside has a Recruitment and Selection Policy which aims to ensure compliance with current legislation for employing staff in accordance with the Equality Act, Immigration Rules and the Disclosure and Barring Service (as applicable). It operates a fair and objective system for recruiting, which places emphasis on individual skills, abilities and experience. Selection criteria contained within our Job Descriptions and Person Specifications are reviewed to ensure that

they are justifiable and so do not unfairly discriminate directly or indirectly and are essential for the effective performance of the role.

NHS Cheshire and Merseyside is positive about employing people with disabilities and all applicants who declare that they have a disability and who meet the essential criteria for a post are shortlisted and invited to interview. We are committed to making reasonable adjustments in the workplace, including appropriate training, to support the continuation of employment. Recruitment and selection training is available for managers and regular support, advice and guidance is provided to recruiting managers by the Recruitment Team.

We strive to enable all staff to achieve their full potential in an environment of dignity and mutual respect. Support for staff who become disabled is provided under the Management of Attendance Policy and Performance Management Policy. Where medical advice recommends temporary or permanent changes, managers will consider how we can support our employees to continue in their present role or where more appropriate to an alternative role. Redeployment may be on a temporary or permanent basis depending on the needs of the individual and the requirements of the role.

NHS Cheshire and Merseyside is committed to ensuring that its education, training and development offer is accessible to all and currently offers a range of learning opportunities through Midlands and Lancashire CSU.

2.3.2.7 Equality, Diversity and Human Rights

Gender Pay Gap (GPG) is a statutory requirement for all NHS organisations who have 250 or more staff. The Gender Pay Gap results are an important driver of our equality and inclusion activity in relation to improving gender equality. NHS Cheshire and Merseyside submitted its gender pay gap reporting for 2023-24.
Currently, the NHS Cheshire and Merseyside profile for gender representation across senior pay bands can be viewed in the NHS Cheshire and Merseyside EDI Annual report.[30]

Workforce Race Equality Standard (WRES) - NHS Cheshire and Merseyside submitted its WRES data return in August 2023 and published its report and action plan, as required. The nine WRES indicators cover recruitment and pay; access to training; disciplinary; discrimination, bullying and harassment and NHS Cheshire and Merseyside Board membership. The current NHS Cheshire and Merseyside ethnicity profile can be viewed in section seven of the EDI Annual Report.[31]

The main purpose of the WRES as outlined by NHS England is to:

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

[30] https://www.cheshireandmerseyside.nhs.uk/media/ycrmg45x/2022-2023-nhs-cheshire-merseyside-icb-annual-edi-report-final.pdf (last checked on 140624)
[31] https://www.cheshireandmerseyside.nhs.uk/media/exfj0lgi/nhscm-annual-edi-report-2324-final-3323.pdf (last checked on 140624)

The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures to improve the experiences of disabled staff in the NHS. The WDES was mandated by the NHS Standard Contract and became applicable to all NHS trusts and foundation trusts in April 2019.

Mandatory reporting on WDES is restricted to NHS trusts and foundation trusts however, in accordance with its commitment to best practice beyond compliance, NHS Cheshire and Merseyside reviewed its workforce disability data for the first time in 2023. More detailed information relating to NHS Cheshire and Merseyside can be viewed in the EDI Annual Report.[32]

NHS Cheshire and Merseyside has embarked on a journey to develop an inclusive culture.

During Spring/Summer 2023 NHS Cheshire and Merseyside undertook a significant engagement programme to work with staff to help shape the values and behaviours of the organisation and to influence how we all work better together and to further inform the development of a Value and Behaviours Framework. The work included a series of workshops, surveys and engagement and input from the Staff Engagement Forum and Senior Leadership Forum. In September 2023, the framework was formally adopted by NHS Cheshire and Merseyside.

Also, in September 2023 Cheshire and Merseyside ICB Board issued and published an anti-racism statement, articulating its commitment to race equality in the Cheshire and Merseyside ICS.[33]The ICB Chief Executive was identified as the champion/sponsor for the anti-racism agenda and the Board approved the implementation of the of Northwest BAME Assembly's Anti Racism Framework.

In March 2024, the CM ICB signed up to the Disability confident scheme and is working towards accreditation of the Navajo Scheme to ensure the needs of our LGBTQ+ staff and patients are fully understood and improved upon.

Three equality networks for BAME Disability and LGBTQI+ are in the process of forming and developing their respective memberships whilst at the same time supporting the identification of actions to progress work needed to achieve the three equality standards that the ICB has committed to achieving. This includes understanding from the networks what is needed to support the talent management and progression of the workforce populations that they represent/champion.

2.3.2.8 Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 which took effect from 1 April 2017, require all public-sector organisations that employ more than 49 full-time employees, and have at least one trade union representative, to submit data relating to the use of facility time in their organisation.

[32] https://www.cheshireandmerseyside.nhs.uk/media/ycrmg45x/2022-2023-nhs-cheshire-merseyside-icb-annual-edi-report-final.pdf (last checked on 140624)
[33] https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/anti-racism-pledge/ (last checked on 140624)

Facility time is paid time-off during working hours for trade union representatives to carry out trade union duties. The reporting period is 01 April to 31 March with submissions due by 31 July.

Reporting covering the period 1 April 2023 to 31 March 2024 will be published on the NHS Cheshire and Merseyside website by 31 July 2024 as per statutory regulations.

2.3.2.9 Consulting with staff

NHS Cheshire and Merseyside utilises the Staff Partnership Forum facilitated by Midlands and Lancashire CSU to discuss a range of issues affecting staff. It is recognised that NHS Cheshire and Merseyside has undergone a significant period of organisational change and has sought to engage with staff in local meetings and hold additional extra meetings to consult, discuss, debate and inform staff where changes are planned that impact on them directly.

The ICB is committed to staff engagement and 'Listening Well' and we have adapted NHS England's Listening Well Guidance. We have many mechanisms as part of our staff engagement strategies including NHS Staff Survey, Pulse Survey and local listening including Freedom to Speak Up Guardians and Ambassadors, mapping of teams' local staff briefings and away days, new starter questionnaires, exit interviews and our monthly We Are One all staff broadcasts.

Two of our other main methods of staff engagement are our Staff Engagement Forum and our Staff Networks.

Our Staff Engagement Group has been established since May 2023 with the aim to provide two-way communication, an opportunity to engage and involve staff in developments, work programmes and enabling them to contribute to the success of the organisation in delivering our values, vision and strategy objectives. The Forum meet monthly, with representatives from each team.

Topics the forum have been involved in included supporting our NHS Staff Survey action plan, discussing a staff suggestion scheme, temperature checks and listening activities and our health and wellbeing offer.

Recognising the diversity of our staff, we have established several Staff Networks to provide a safe space for our staff, raise awareness of issues within the wider ICB and provide a support for staff who may be facing challenges. We had seven staff networks established by April 2024, these were Menopause, working carers, BAME, LGBTQI+, early careers, disability and neurodiverse and armed forces family support network.

Practical examples supporting us in hearing the voice of our diverse staff and improving staff experience are below.

- Defence Employer Recognition Scheme (ERS) – NHS Cheshire and Merseyside is one of only three ICBs in the country to have received the silver accreditation status under the Defence Employer Recognition Scheme. The ERS recognises the commitment and support from UK employers for defence personnel. In gaining the silver accreditation the ICB has demonstrated they have adjusted corporate policies and workplace culture to ensure our Armed Forces community and their families are supported and not disadvantaged. The ICB have now committed to Step into Health to ensure our

recruitment processes are fair and armed forces candidates are not disadvantaged.

- Disability History Month – As part of the month, we used the national messages to celebrate the achievements of our staff with disabilities, including a blog and a video from the Chair of our staff network, raised awareness of what a disability is to staff, encouraged staff to record their disability on ESR and have open conversations with their managers and reviewed our recruit processes to ensure that they were inclusive and accessible. The ICB, supported by the staff network, is now working towards Level 1 of the Disability Confidence Standard.
- Anti Racist Framework – Working internally and with our partners we are championing the Northwest BAME Assembly Anti-racism Framework. The framework is a tool designed to support NHS organisations to become intentionally anti-racist by tackling structural racism and discrimination through collaboration, reflective practice and accountability. We recognise that our commitment to this journey will require continuous review of our progress and our intentional actions for change. As part of our commitment we asked our staff to pledge how they will be actively anti-racist and we held a 'Power of the Pledge' event, for all staff to hear from our Chair and staff about their life experiences, learn more about the anti-racist framework and how we can all support each other. The ICB is now working towards the Bronze level of the Anti – Racist Framework.

2.3.2.10 Expenditure on consultancy

Consultancy is the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the 'business as-usual' environment when in-house skills are not available and will be of no essential consequence and time-limited. Consultancy may include the identification of options with recommendations, or assistance with (but not delivery of) the implementation of solutions.

During the nine months ending 31 March 2024, £802k (nine months to 31 March 2023 - £535k) was spent on external consultancy comprising:

- £600k, which was funded by a specific allocation from NHS England, relates to work on improving the urgent and emergency care system
- £114k for an independent financial review of the key drivers of deficits and development of a model for the financial strategy across the Integrated Care System in Cheshire and Merseyside
- £58k for a strategic review of patient records and
- £30k on other matters.

2.3.2.11 Off-payroll engagements

Off payroll engagements are payments made by NHS Cheshire and Merseyside to employees outside of its payroll system that are for more than £245 per day and that last for longer than six months.

Table 34: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2024 for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2024	49
Of which, the number that have existed:	
for less than 1 year at the time of reporting	13
for between 1 and 2 years at the time of reporting	36
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

Existing off payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary, that assurance has been sought.

Table 35: Off-payroll workers engaged at any point during the financial year
For all off-payroll engagements between 1 April 2023 and 31 March 2024, for more than £245* per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 31 March 2023	73
Of which:	
No. not subject to off-payroll legislation	-
No. subject to off-payroll legislation and determined as in-scope of IR35	26
No. subject to off-payroll legislation and determined as out of scope of IR35	47
the number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 36: Off-payroll engagements / senior official engagements
For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	-
Total no. of individuals on-payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on-payroll and off-payroll engagements.	16

2.3.2.12 Exit packages, including special (non-contractual) payments - AUDITED

Table 37: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000			5	34,803	5	34,803	-	-
£10,000 - £25,000			6	117,556	6	117,556	-	-
£25,001 - £50,000			10	338,098	10	338,098	-	-
£50,001 - £100,000			10	614,195	10	614,195	-	-
£100,001 - £150,000								
£150,001 – £200,000	2	320,000			2	320,000	-	-
>£200,000								
TOTALS	2	£320,000	31	£1,104,652	33	£1,424,652	-	-

Redundancy and other departure cost have been paid in accordance with the terms Agenda for Change Terms and Conditions. Exit costs in this note are accounted for in full in the year of departure. Where NHS Cheshire and Merseyside has agreed early retirements, the additional costs are met by NHS Cheshire and Merseyside and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 38: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	31	1,104
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
TOTAL	**31**	**1,104**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match.
No exit packages related to individuals disclosed in the Remuneration Report.

2.3.2.13 Parliamentary Accountability and Audit Report

NHS Cheshire and Merseyside is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at pages 169 to 200.

An audit certificate and report is also included in this Annual Report at pages 161 to 166.

Graham Urwin

Graham Urwin
Accountable Officer
20 June 2024

Independent auditor's report to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board

Independent auditor's report to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Cheshire and Merseyside Integrated Care Board (the 'ICB') for the period ended 31 March 2024, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2024 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2023-24 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Corporate Governance Report does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2023-24 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Corporate Governance Report addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023-24; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24).
- We enquired of management and the Audit committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the Audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and any other fraud risks identified for the audit. We determined that the principal risks were in relation to:
  - Large and unusual journal entries, particularly those entered around or after the period-end or reducing expenditure;
  - where expenditure could potentially be manipulated through over/under accruing or reversing brought forward accruals. The risk is understatement of such expenditure to achieve financial targets.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual items and those falling within identified risk criteria including; journals posted by senior management, material journals, year-end journals including accruals, journals posted after 31 March 2024 and off ledger adjustments;
  - challenging assumptions and judgements made by management in its significant accounting estimate in respect of the prescribing accrual;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in expenditure recognition. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2024.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Corporate Governance Report the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of NHS Cheshire and Merseyside ICB in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Michael Green

Michael Green, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester

21 June 2024

3. Annual Accounts

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	Year ended 31 March 2024 £'000	9 months ended 31 March 2023 £'000
Income from sale of goods and services	2	(94,328)	(31,616)
Other operating income	2	-	(270)
Total operating income		**(94,328)**	**(31,885)**
Staff costs	4	68,662	49,749
Purchase of goods and services	5	6,718,986	4,549,011
Depreciation and impairment charges	5	1,132	904
Provision expense	5	-	(1,379)
Other operating expenditure	5	7,757	3,835
Total operating expenditure		**6,796,536**	**4,602,120**
Net Operating Expenditure		**6,702,208**	**4,570,235**
Finance expense	8	65	19
Other Gains & Losses	7	0	14
Net expenditure for the period		**6,702,273**	**4,570,268**
Net (Gain)/Loss on Transfer by Absorption	9	-	413
Total net expenditure for the financial period		**6,702,273**	**4,570,681**
Comprehensive expenditure for the period		**6,702,273**	**4,570,681**

Notes 1 to 25 form part of these financial statements.

Statement of Financial Position as at 31 March 2024

	Note	31 March 2024 £'000	31 March 2023 £'000
Non-current assets:			
Property, plant and equipment	10	216	510
Right-of-use assets	10a	3,066	2,777
Intangible assets	11	(0)	12
Total non-current assets		**3,282**	3,300
Current assets:			
Trade and other receivables	12	95,965	50,775
Cash and cash equivalents	13	1	1
Total current assets		**95,966**	**50,776**
Total assets		**99,248**	54,076
Current liabilities			
Trade and other payables	14	(400,842)	(390,913)
Lease liabilities	10a	(809)	(672)
Borrowings	15	(8,129)	(3,783)
Total current liabilities		**(409,780)**	(395,369)
Non-Current Assets less Net Current Liabilities		**(310,532)**	(341,293)
Non-current liabilities			
Lease liabilities	10a	(2,215)	(2,068)
Total non-current liabilities		**(2,215)**	**(2,068)**
Assets less Liabilities		**(312,747)**	(343,361)
Financed by Taxpayers' Equity			
General fund		(312,747)	(343,361)
Total taxpayers' equity:		**(312,747)**	(343,361)

Notes 1 to 25 form part of these financial statements.

The financial statements on pages 169 to 200 were approved by the Board on 20 June 2024 and signed on its behalf by:

Graham Urwin

Graham Urwin
Chief Executive
Date: 20 June 2024

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2024

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for year ended 31 March 2024		
Balance at 1 April 2023	(343,361)	(343,361)
Changes in taxpayers' equity for year ended31 March 2024		
Net operating expenditure for the financial year	**(6,702,273)**	**(6,702,273)**
Net Recognised Expenditure for the Financial year	**(6,702,273)**	**(6,702,273)**
Net funding	6,732,888	**6,732,888**
Balance at 31 March 2024	**(312,747)**	**(312,747)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for nine months ended 31 March 2023		
Balance at 1 July 2022	-	**-**
Transfer of assets and liabilities from closed NHS bodies	(327,090)	**(327,090)**
Adjusted balance at 1 July 2022	**(327,090)**	**(327,090)**
Changes in taxpayers' equity for nine months ended 31 March 2023		
Total transition adjustment for initial application of IFRS 16	-	-
Net operating costs for the financial period	(4,570,268)	(4,570,268)
Transfers by absorption (from) NHS England	(413)	(413)
Net Recognised Expenditure for the Financial Period	**(4,570,682)**	**(4,570,682)**
Net funding	4,554,410	4,554,410
Balance at 31 March 2023	**(343,361)**	**(343,361)**

Notes 1 to 25 form part of these financial statements.

Statement of Cash Flows for the year ended 31 March 2024

	Note	Year ended 31 March 2024 £'000	9 months ended 31 March 2023 £'000
Cash Flows from Operating Activities			
Net expenditure for the period		(6,702,273)	(4,570,268)
Depreciation and amortisation	5	1,132	904
Movement due to transfer by Modified Absorption		-	(326,790)
Interest paid		28	-
Other Gains & Losses	7	-	14
(Increase) in trade & other receivables	12	(45,190)	(50,775)
Increase/(decrease) in trade & other payables	14	9,928	390,913
Provisions utilised	16	-	(3)
Increase/(decrease) in provisions	16	-	(1,539)
Net Cash Inflow (Outflow) from Operating Activities		**(6,736,375)**	(4,557,544)
Cash Flows from Investing Activities			
Interest paid	8	-	(19)
Proceeds from disposal of assets held for sale: property, plant and equipment	10	-	(14)
Proceeds from disposal of other financial assets		-	8
Net Cash (Outflow) from Investing Activities		**-**	(25)
Net Cash (Outflow) before Financing		**(6,736,375)**	(4,557,569)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		6,732,888	4,554,410
Repayment of lease liabilities	10a	(860)	(623)
Net Cash Inflow (Outflow) from Financing Activities		**6,732,028**	4,553,787
Net (Decrease) in Cash & Cash Equivalents	13	**(4,347)**	(3,782)
Cash & Cash Equivalents at the beginning of the Financial Year		**(3,782)**	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(8,129)**	(3,782)

Notes 1 to note 25 form part of these financial statements.

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of NHS Cheshire & Merseyside Integrated Care Board (the ICB) shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the GAM 2023-24 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
The financial statements for the ICB are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Joint arrangements**

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The ICB includes within its financial statements its share of the assets, liabilities, income and expenses.

1.4 **Pooled Budgets**

The ICB has entered into pooled budget arrangements with local authorities in Cheshire and Merseyside in accordance with section 75 of the NHS Act 2006. Under the arrangements, funds are pooled for Better Care Funds with local authorities in which a programme is funded to deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. Note 21 provides details of the schemes and the expenditure.

The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.5 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note. All operating segments carry out commissioning of healthcare services and consequently, as allowed under IFRS 8, these are reported in aggregate.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles. Significant terms include all amounts being due within thirty days of the invoice.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees. There is no performance pay.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Some employees are members of National Employment Savings Trust, which is a defined contribution pension scheme. The cost to the ICB of participating in the scheme is the contributions payable to the scheme for the accounting period.

1.8 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 **Intangible Assets**

1.11.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.11.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.
Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

Notes to the financial statements

1.11.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.
At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is, or contains a lease, at inception of the contract.

1.14.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year; and 4.72% to new leases commencing in 2024 under IFRS 16.
Lease payments included in the measurement of the lease liability comprise:

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.15 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.16 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 4.26% (2022-23: 3.27%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.03% (2022-23: 3.20%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 4.72% (2022-23: 3.51%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 4.40% (2022: 3.00%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.17 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

Notes to the financial statements

1.18 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.19 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.20 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income; and
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.20.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.20.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.20.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.20.4 **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

Notes to the financial statements

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.21 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.21.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.21.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.21.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.23 **Foreign Currencies**

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.24 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.25 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

Notes to the financial statements

1.26.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

• Assessment of Right of Use assets and liabilities for inclusion as a result of the implementation of IFRS 16 including the judgements that assets used by the ICB should be capitalised and a consequent liability recognised, and that assets which the ICB funds for third parties, where no right of use of the asset for the ICB exists, are not capitalised.

1.26.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

•Certain right of use property does not have fully documented leases but the ICB expects that they will have a continuing right to use such properties until notice is given to the holder of the lease. Management has estimated the lease length for such arrangements based upon the expected period which the ICB estimates it will occupy those properties.

1.27 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

2. Other Operating Revenue

	Year ended 31 March 2024 Total	9 months ended 31 March 2023 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	135
Non-patient care services to other bodies	**10,579**	3,581
Prescription fees and charges	**38,380**	27,288
Dental fees and charges	**44,131**	-
Other Contract income	**1,239**	612
Total Income from sale of goods and services	**94,328**	**31,616**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	**-**	143
Non cash apprenticeship training grants revenue	**-**	127
Total Other operating income	**-**	**270**
Total Operating Income	**94,328**	**31,885**

2.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	7,759	-	-	1,094
Non NHS	2,820	38,380	44,131	145
Total	**10,579**	**38,380**	**44,131**	**1,239**

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	10,579	38,380	44,131	1,239
Over time	-	-	-	-
Total	**10,579**	**38,380**	**44,131**	**1,239**

3. Cost allocation and setting of charges

NHS England, which sets charges on behalf of the ICB, certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

		Year ended 31 March 2024			Nine months ended 31 March 2023		
	Note	Income £000	Full cost £000	Surplus/ (deficit) £000	Income £000	Full cost £000	Surplus/ (deficit) £000
Prescription	2 & 5	38,380	531,613	(493,233)	27,288	397,982	(370,694)
Dental	2 & 5	44,131	171,306	(127,175)	-	-	-
Total fees and charges		**82,511**	**702,919**	**(620,408)**	**27,288**	**397,982**	**(370,694)**

The fees and charges information in this note is provided in accordance with section 3.2.12 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2023/24, the NHS prescription charge for each medicine or appliance dispensed was £9.65 (2022/23 £9.35). However, around 90% of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £31.25 for 3 months (2022/23 - £30.25) or £111.60 for a year (2022/23 - £108.10) for a year. On 1 April 2023, a new HRT prepayment certificate was introduced at £19.30 for a year. A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into 3 bands depending on the level and complexity of care provided. From 23 April 2023, the charge for Band 1 treatments was £25.80 (previously £23.80), for Band 2 was £70.70 (previously £65.20) and for Band 3 was £306.80 (previously £282.80). Before this increase, dental patient charges had not changed since 14 December 2020.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		31 March 2024
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	49,742	2,002	**51,745**
Social security costs	5,694	-	**5,694**
Employer Contributions to NHS Pension scheme	9,547	-	**9,547**
Other pension costs	29	-	**29**
Apprenticeship Levy	222	-	**222**
Termination benefits	1,425	-	**1,425**
Gross employee benefits expenditure	**66,659**	**2,002**	**68,662**

4.1.2 Employee benefits

	Total		9 months ended 31 March 2023
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	36,342	1,726	**38,068**
Social security costs	4,430	-	**4,430**
Employer Contributions to NHS Pension scheme	6,738	-	**6,738**
Other pension costs	19	-	**19**
Apprenticeship Levy	175	-	**175**
Termination benefits	319	-	**319**
Gross employee benefits expenditure	48,024	1,726	**49,749**

4.2 Average number of people

	31 March 2024			31 March 2023		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**933.88**	**57.92**	**991.80**	**861.00**	**110.00**	**971.00**

4.3 Exit packages agreed in the financial year

	31 March 2024 Compulsory redundancies		31 March 2024 Other agreed departures		31 March 2024 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	5	34,803	5	34,803
£10,001 to £25,000	-	-	6	117,556	6	117,556
£25,001 to £50,000	-	-	10	338,098	10	338,098
£50,001 to £100,000	-	-	10	614,195	10	614,195
£150,001 to £200,000	2	320,000	-	-	2	320,000
Total	**2**	**320,000**	**31**	**1,104,652**	**33**	**1,424,652**

	31 March 2023 Compulsory redundancies		31 March 2023 Other agreed departures		31 March 2023 Total	
	Number	£	Number	£	Number	£
£150,001 to £200,000	3	480,000	-	-	3	480,000
Total	**3**	**480,000**	**-**	**-**	**3**	**480,000**

There were no departures where special payments were made.

Analysis of Other Agreed Departures

	31 March 2024 Other agreed departures		31 March 2023 Other agreed departures	
	Number	£	Number	£
Mutually agreed resignations (MARS) contractual costs	31	1,104,652	-	-
Total	**31**	**1,104,652**	**-**	**-**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

The Mutually agreed resignations (MARS) scheme detailed in the table above was endorsed by NHS England.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as at 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

Some employees are members of National Employment Savings Trust, which is a defined contribution pension scheme. The cost to the ICB of participating in the scheme is the contributions payable to the scheme for the accounting period.

5. Operating expenses	Year ended 31 March 2024 Total £'000	9 months ended 31 March 2023 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	15,880	10,269
Services from foundation trusts	3,316,751	2,324,809
Services from other NHS trusts	952,121	677,291
Services from Other WGA bodies	2	0
Purchase of healthcare from non-NHS bodies	864,561	556,328
Purchase of social care	95,471	72,620
General Dental services and personal dental services	171,306	-
Prescribing costs	531,613	397,982
Pharmaceutical services	109,745	79,873
General Ophthalmic services	25,533	319
GPMS/APMS and PCTMS	568,211	389,399
Supplies and services – clinical	2,594	1,723
Supplies and services – general	16,623	10,055
Consultancy services	802	535
Establishment	20,290	10,842
Transport	33	22
Premises	19,303	13,041
Audit fees	299	552
Other non statutory audit expenditure		
· Other services	103	158
Other professional fees	5,992	1,737
Legal fees	1,559	819
Education, training and conferences	193	512
Non cash apprenticeship training grants	-	127
Total Purchase of goods and services	**6,718,986**	**4,549,011**
Depreciation and impairment charges		
Depreciation	1,120	825
Amortisation	12	79
Total Depreciation and impairment charges	**1,132**	**904**
Provision expense		
Provisions	-	(1,379)
Total Provision expense	**-**	**(1,379)**
Other Operating Expenditure		
Chair and Non Executive Members	215	185
Grants to Other bodies	2,953	3,058
Research and development (excluding staff costs)	4,599	1,662
Expected credit loss on receivables	(19)	(1,134)
Other expenditure	9	64
Total Other Operating Expenditure	**7,757**	**3,835**
Total operating expenditure	**6,727,875**	**4,552,370**

Audit fees of £299k relate to ICB only and include Value Added Tax. 'Other non statutory audit expenditure - other services' includes fees in relation to the Mental Health Investment Standard (MHIS) audits.

In accordance with SI 2008 No. 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where an ICB's contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed. The contract for the provision of external audit services is held by Grant Thornton UK LLP. This limitation has been confirmed as £311,400. External audit fees include Value Added Tax (VAT).

Internal audit services during the year were provided by Mersey Internal Audit Agency and hosted by Liverpool University Hospitals NHS Foundation Trust.

6. Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	**31 March 2024 Number**	**31 March 2024 £'000**	31 March 2023 Number	31 March 2023 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	159,197	1,684,096	117,419	1,152,253
Total Non-NHS Trade Invoices paid within target	157,314	1,642,252	115,390	1,113,844
Percentage of Non-NHS Trade invoices paid within target	**98.82%**	**97.52%**	**98.27%**	**96.67%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	7,615	4,334,594	3,356	3,077,151
Total NHS Trade Invoices Paid within target	7,593	4,333,942	3,316	3,070,353
Percentage of NHS Trade Invoices paid within target	**99.71%**	**99.98%**	**98.81%**	**99.78%**

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of the receipt of a valid invoice, whichever is later. The Better Payment Practice Code sets out target compliance of 95%.

7. Other gains and losses

	31 March 2024 £'000	31 March 2023 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	0	14
Total	**0**	**14**

8. Finance costs

	31 March 2024 £'000	31 March 2023 £'000
Interest		
Interest on lease liabilities	28	19
Other interest expense	36	-
Total interest	**65**	**19**

9. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

	31 March 2024				31 March 2023
	Total	NHS England Parent Entities	NHS England Group Entities (non parent)	Non NHSE Group	
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Transfer of property plant and equipment	-	-	-	-	739
Transfer of Right of Use assets	-	-	-	-	3,052
Transfer of intangibles	-	-	-	-	94
Transfer of receivables	-	-	-	-	44,782
Transfer of payables	-	-	-	-	(368,148)
Transfer of provisions	-	-	-	-	(1,542)
Transfer of Right Of Use liabilities	-	-	-	-	(3,011)
Transfer of borrowings	-	-	-	-	(3,056)
Transfer of PUPOC liability	-	-	-	-	(413)
Net loss on transfers by absorption	**-**	**-**	**-**	**-**	**(327,503)**

10. Property, plant and equipment

31 March 2024	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2023	685	179	2,640	56	3,560
Disposals other than by sale	-	(27)	(1,811)	(67)	(1,904)
Cost/Valuation at 31 March 2024	**685**	**152**	**829**	**(11)**	**1,656**
Depreciation 1 April 2023	400	179	2,415	56	3,050
Disposals other than by sale	-	(27)	(1,811)	(67)	(1,904)
Charged during the year	137	0	157	-	294
Depreciation at 31 March 2024	**537**	**152**	**761**	**(11)**	**1,440**
Net Book Value at 31 March 2024	**148**	**-**	**68**	**-**	**216**
Purchased	148	-	68	-	216
Total at 31 March 2024	**148**	**-**	**68**	**-**	**216**
Asset financing:					
Owned	148	-	68	-	216
Total at 31 March 2024	**148**	**-**	**68**	**-**	**216**

31 March 2023	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 July 2022	-	-	-	-	-
Transfer (to)/from other public sector body	685	179	2,640	56	3,560
Revised cost or valuation at 1 July 2022	685	179	2,640	56	3,560
Cost/Valuation at 31 March 2023	**685**	**179**	**2,640**	**56**	**3,560**
Depreciation 1 July 2022	-	-	-	-	-
Transfer (to)/from other public sector body	297	178	2,290	56	2,821
Charged during the period	103	1	125	0	229
Depreciation at 31 March 2023	**400**	**179**	**2,415**	**56**	**3,050**
Net Book Value at 31 March 2023	**285**	**-**	**225**	**-**	**509**
Purchased	285	-	225	-	510
Total at 31 March 2023	**285**	**-**	**225**	**-**	**510**
Asset financing:					
Owned	285	-	225	-	510
Total at 31 March 2023	**285**	**-**	**225**	**-**	**510**

10.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	5	20
Plant & machinery	5	5
Information technology	2	3
Furniture & fittings	5	5

10a. Leases

10a.1 Right-of-use assets

	Buildings £'000	Total £'000
Cost or valuation at 1 April 2023	3,495	3,495
Additions	701	701
Modifications	473	473
Disposals on expiry of lease term	(69)	(69)
Cost/Valuation at 31 March 2024	**4,601**	**4,601**
Depreciation 1 April 2023	718	718
Charged during the year	825	825
Disposals on expiry of lease term	(10)	(10)
Depreciation at 31 March 2024	**1,534**	**1,534**
Net Book Value at 31 March 2024	**3,067**	**3,067**

NBV by counterparty	**£'000**
Leased from DHSC	1,884
Leased from NHS Providers	686
Leased from external bodies	497
Net Book Value at 31 March 2024	**3,067**

10a.2 Lease liabilities

	31 March 2024 £'000	31 March 2023 £'000
Lease liabilities at 1 April 2023	(2,741)	-
Additions purchased	(701)	(537)
Interest expense relating to lease liabilities	(28)	(19)
Repayment of lease liabilities (including interest)	860	623
Lease remeasurement	(473)	-
Disposals on expiry of lease term	59	203
Transfer (to) from other public sector body	-	(3,011)
Lease liabilities at 31 March 2024	**(3,024)**	**(2,741)**

10a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2024	**Of which:**	31 March 2023	Of which:
	Total £'000	**Leased from DHSC group bodies £'000**	Total £'000	Leased from DHSC group bodies £'000
Within one year	(857)	(509)	(695)	(470)
Between one and five years	(1,679)	(1,564)	(1,486)	(1,486)
After five years	(662)	(662)	(644)	(644)
Balance at 31 March 2024	**(3,198)**	**(2,735)**	**(2,825)**	**(2,600)**

Balance by DHSC group counterparty		
Leased from DHSC	(1,937)	(2,600)
Leased from NHS Providers	(798)	-
Balance as at 31 March 2024	**(2,735)**	**(2,600)**

10a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	31 March 2024 £'000	31 March 2023 £'000
Depreciation expense on right-of-use assets	825	595
Interest expense on lease liabilities	28	19
Expense relating to short-term leases	28	37

10a.5 Amounts recognised in Statement of Cash Flows

Total cash outflow on leases under IFRS 16	860	623

10.a Leases cont'd

Leases are recognised under the leasing standard IFRS 16, applied from 1 April 2022. Under IFRS 16 leases are recognised as a right of use asset with a corresponding lease liability on the Statement of Financial Position. Each lease payment is allocated between a reduction of the liability and the interest expense. The interest expense is charged to the Statement of Comprehensive Net Expenditure over the lease period. The right of use asset is depreciated over the shorter of the asset's useful life and the lease term on a straight line basis. The ICB has applied the exemption for short-term leases (less than 12 months) and low value assets. In these cases, the lease payments associated with them are recognised as an expense in the Statement of Comprehensive Net Expenditure.

As at 31st March 2024 the ICB holds the following leases which fall within the scope of IFRS 16:

Name	Lessor	Use
1829 Building, Chester	NHS Property Services	ICB administrative building
Magdalen House, Bootle	Sefton Council	ICB administrative building
Lakeside, Warrington	Herbert Street Properties	ICB administrative building
Nutgrove Villa, Huyton	NHS Property Services	ICB administrative building
Curzon Road, Southport	NHS Property Services	ICB administrative building
The Ellis Centre, Huyton	NHS Property Services	Community services building
The Department, Liverpool	Tandem Property Assest Management	ICB administrative building
Cunard Building, Liverpool	Liverpool City Council	ICB administrative building
Infinity House, Crewe	Mid Cheshire Hospitals NHS Foundation Trust	ICB administrative building

Health Partnerships (CHP) and NHS Property Services (NHSPS), and for space occupied by NHS providers in buildings run by CHP and NHSPS. These do not fall within the definition of a lease and as such are not included in this note.

11. Intangible non-current assets

31 March 2024	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 1 April 2023	**755**	**755**
Disposals other than by sale	(527)	**(527)**
Cost / Valuation at 31 March 2024	**227**	**227**
Amortisation 1 April 2023	**743**	**743**
Disposals other than by sale	(527)	**(527)**
Charged during the year	12	**12**
Amortisation at 31 March 2024	**227**	**227**
Net Book Value at 31 March 2024	**-**	**-**

31 March 2023	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 1 July 2022	**-**	**-**
Transfer (to)/from other public sector body	755	755
Revised cost or valuation at 1 July 2022	755	755
Cost / Valuation At 31 March 2023	**755**	**755**
Amortisation at 1 July 2022	**-**	**-**
Transfer (to) from other public sector body	664	664
Revised amortisation at 1 July 2022	**664**	**664**
Charged during the period	79	79
Amortisation At 31 March 2023	**743**	**743**
Net Book Value at 31 March 2023	**12**	**12**

11.1 Economic lives

Intangible assets held by the ICB are fully amortised in the year 2023-24 and therefore economic lives are deemed to be nil.

12. Trade and other receivables	Current 31 March 2024 £'000	Current 31 March 2023 £'000
NHS receivables: Revenue	5,295	4,715
NHS prepayments	-	7
NHS accrued income	14,685	5,072
NHS Contract Receivable not yet invoiced/non-invoice	2,185	10
NHS Non Contract trade receivable (i.e pass through funding)	-	16
Non-NHS and Other WGA receivables: Revenue	20,461	12,807
Non-NHS and Other WGA prepayments	4,265	3,665
Non-NHS and Other WGA accrued income	39,330	17,051
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	4,682	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	273
Expected credit loss allowance-receivables	(168)	(186)
VAT	686	882
Other receivables and accruals	4,543	6,466
Total Trade & other receivables	**95,965**	**50,775**
Total current and non current	**95,965**	**50,775**

There were no non-current receivables in 2023-24 (2022-23: Nil)

12.1 Receivables past their due date but not impaired

	31 March 2024 DHSC Group Bodies £'000	31 March 2024 Non DHSC Group Bodies £'000	31 March 2023 DHSC Group Bodies £'000	31 March 2023 Non DHSC Group Bodies £'000
By up to three months	2,800	1,808	372	3,714
By three to six months	63	779	143	1,367
By more than six months	189	4,024	20	3,809
Total	**3,052**	**6,610**	**535**	**8,890**

12.2 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 1 April 2023	**(186)**	**(186)**
Lifetime expected credit loss on credit impaired financial assets	-	**-**
Lifetime expected credit losses on trade and other receivables - Stage 2	19	**19**
Allowance for credit losses at 31 March 2024	**(168)**	**(168)**

13. Cash and cash equivalents

	31 March 2024 £'000	31 March 2023 £'000
Balance transferred at 1 July 2022		(3,056)
Balance at 1 April 2023	(3,782)	
Net change in year	(4,347)	(726)
Balance at 31 March 2024	**(8,129)**	**(726)**
Made up of:		
Cash in hand	1	1
Bank overdraft: Government Banking Service	(8,129)	(3,783)
Total bank overdrafts	**(8,129)**	**(3,783)**
Balance at 31 March 2024	**(8,128)**	**(3,782)**

The bank overdraft shown above is all due within one year and includes BACS payment runs which have been approved in March 2024 but which were paid in April 2024. These outstanding payments give rise to a technical overdraft which is classified as borrowing in accordance with International Financial Reporting Standards. If these payments had not been made the closing cash balance at 31 March 2024 would be £2,588,403.

14. Trade and other payables	Current 31 March 2024 £'000	Current 31 March 2023 £'000
NHS payables: Revenue	6,553	7,684
NHS accruals	69,766	50,725
NHS deferred income	-	59
Non-NHS and Other WGA payables: Revenue	51,342	53,562
Non-NHS and Other WGA accruals	257,575	254,757
Non-NHS and Other WGA deferred income	484	834
Social security costs	781	744
Tax	841	679
Other payables and accruals	13,500	21,869
Total Trade & Other Payables	**400,842**	**390,913**
Total current	**400,842**	**390,913**

There were no non-current payables in 2023-24 (2022-23: Nil)

Other payables include £4.615m outstanding pension contributions at 31 March 2024

15. Borrowings	Current 31 March 2024 £'000	Current 31 March 2023 £'000
Bank overdrafts:		
· Government banking service	8,129	3,783
Total Borrowings	**8,129**	3,783
Total current	**8,129**	3,783

There were no non-current borrowings in 2023-24 (2022-23: Nil)

15.1 Repayment of principal

All amounts are repayable within one year (31 March 2023 - one year).

16. Provisions

The ICB does not have any provisions in 2023-24 (2022-23: Nil).

17. Contingencies

The ICB does not have any contingencies in 2023-24 (2022-23: Nil).

18. Capital Commitments

The ICB had no capital commitments as at 31 March 2024.

19. Financial instruments

19.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Cheshire and Merseyside Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS integrated care board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS integrated care board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS integrated care board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS integrated care board and internal auditors.

19.1.1 Currency risk

The NHS integrated care board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS integrated care board has no overseas operations and therefore has low exposure to currency rate fluctuations.

19.1.2 Interest rate risk

The ICB does not ordinarily borrow and therefore has low exposure to interest rate fluctuations.

19.1.3 Credit risk

Because the majority of the NHS integrated care board revenue comes parliamentary funding, NHS integrated care board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

19.1.4 Liquidity risk

NHS integrated care board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS integrated care board draws down cash to cover expenditure, as the need arises. The NHS integrated care board is not, therefore, exposed to significant liquidity risks.

19.1.5 Financial Instruments

As the cash requirements of NHS integrated care board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS integrated care board's expected purchase and usage requirements and NHS integrated care board is therefore exposed to little credit, liquidity or market risk.

19. Financial instruments cont'd

19.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2024 £'000	**Total 31 March 2024 £'000**	Financial Assets measured at amortised cost 31 March 2023 £'000	Total 31 March 2023 £'000
Trade and other receivables with NHSE bodies	4,017	4,017	2,722	2,722
Trade and other receivables with other DHSC group bodies	57,479	57,479	23,675	23,675
Trade and other receivables with external bodies	29,518	29,518	19,826	19,826
Cash and cash equivalents	1	1	1	1
Total at 31 March 2024	**91,014**	**91,014**	**46,223**	**46,223**
Non-financial instruments				
Non-NHS and other WGA Prepayments	4,266	4,266	3,665	3,665
VAT	686	686	882	882
Total current assets as at 31 March 2024 (as per Statement of Financial Position)	**95,966**	**95,966**	**50,776**	**50,776**

19.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2024 £'000	**Total 31 March 2024 £'000**	Financial Liabilities measured at amortised cost 31 March 2023 £'000	Total 31 March 2023 £'000
Loans with external bodies	8,129	8,129	3,783	3,783
Trade and other payables with NHSE bodies	1,921	1,921	1,312	1,312
Trade and other payables with other DHSC group bodies	75,279	75,279	60,113	60,113
Trade and other payables with external bodies	324,560	324,560	329,913	329,913
Total at 31 March 2024	**409,889**	**409,889**	**395,121**	**395,121**
Non-financial instruments				
NHS deferred income	-	-	59	59
Non-NHS and Other WGA deferred income	484	484	834	834
Social security costs	781	781	744	744
Tax	841	841	679	679
Total liabilities as at 31 March 2024 (current and non current) as per Statement of Financial Position	**411,995**	**411,995**	**397,437**	**397,437**

20. Operating segments

International Financial Reporting Standards (IFRS) require financial performance to be analysed across key decision making segments.

The ICB operates nine segments across nine places all of which commission Health Care Services. As permitted by IFRS 8 information for segments with similar economic characteristics may be presented in aggregate and therefore these segments are included in aggregate below as the commissioning of healthcare services.

	Gross expenditure £'000	**Income £'000**	**Net expenditure £'000**	**Total assets £'000**	**Total liabilities £'000**	**Net assets £'000**
Commissioning of Healthcare Services	6,796,536	(94,328)	**6,702,208**	99,248	(411,995)	**(312,747)**
Total	**6,796,536**	**(94,328)**	**6,702,208**	**99,248**	**(411,995)**	**(312,747)**

20.1 Reconciliation between Operating Segments and SoCNE

	31 March 2024 £'000
Total net expenditure reported for operating segments	6,702,208
Reconciling items:	
Finance Expense	65
Total net expenditure per the Statement of Comprehensive Net Expenditure	**6,702,273**

21. Joint arrangements - interests in joint operations

21.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 31 March 2024				Amounts recognised in Entities books ONLY Nine months to 31 March 2023			
			Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Better Care Fund	Cheshire East Council	Pooled budget arrangement for Carers Breaks, Local Authority s256, BCF Home First, Community Equipment and discharge funding	-	-	-	32,987	-	-	-	28,131
Better Care Fund	Cheshire West & Chester Council	Pooled budget arrangement for Carers Breaks, Local Authority s256, BCF Home First, Community Equipment and discharge funding	-	-	-	32,590	-	-	-	25,164
Integrated pooled fund for adult continuing healthcare	St Helens Council	Pooled budget arrangement for the provision of care packages for adults who qualify for CHC/FNC, are S117 or joint funded.	2,241	2,241	-	38,728	2,294	1,691	-	23,166
Better Care Fund	St Helens Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	20,081	-	-	-	14,571
Better Care Fund	Sefton Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	16,604	-	-	-	22,691
Better Care Fund	Wirral Council	Pooled budget arrangement for the commissioning service for the provision of health and social care.	-	-	-	35,915	-	-	-	24,081
Better Care Fund	Halton Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	16,568	-	-	-	9,058
Integrated pooled fund for adult continuing healthcare	Halton Council	Pooled budget arrangement for the provision of care packages for adults who qualify for CHC/FNC, are S117 or joint funded.	338	338	-	3,807	800	2,680	-	3,696
Better Care Fund	Warrington Borough Council	Pooled budget arrangement for the integration of Health & Social Care	-	-	-	25,245	-	-	-	16,646
Better Care Fund	Knowsley Metropolitan Borough Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	19,259	-	-	-	1,658
Integrated pooled fund for Mental Health, Community Support Services, Disability	Knowsley Metropolitan Borough Council	Pooled budget arrangement for the provision of Mental Health Services, Community Support Services, Disability Services and Discharge Fund	1,293	1,293	-	25,759	1,174	1,174	-	12,477
Better Care Fund	Liverpool City Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	81,122	-	-	750	59,195
Integrated Community Equipment and Disability Advice Services (ICEDAS)	Liverpool City Council	Pooled budget arrangement for Community equipment	-	-	1,077	1,077	-	-	796	796
TOTAL			**3,872**	**3,872**	**1,077**	**349,742**	**4,268**	**5,545**	**1,546**	**241,330**

21. Joint arrangements - interests in joint operations cont'd

Cheshire
Cheshire has two pooled budget arrangements with Cheshire East Council and Cheshire West and Chester Council. Under the arrangements, funds are pooled for Cheshire East Better Care Fund and for Cheshire West and Chester Better Care Fund. The pools are hosted by Cheshire East Council and Cheshire West and Chester Council under section 75 agreements between the ICB and the other party. The agreements require that plans are jointly agreed and that services under the agreements are jointly commissioned. Regular meetings are held to monitor plans and commissioning arrangements. This is a joint arrangement and the ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Knowsley

Knowsley has a pooled budget arrangement with Knowsley Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The Better Care Fund is a plan for the ICB and Local Authority to work closely together, driving integration and improved outcomes for the three core initiatives being Localities, Safe Supported Discharge and Access Knowsley. The pool is hosted by KMBC. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

Liverpool
Liverpool has a pooled budget arrangement with Liverpool City Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Integrated Community Equipment and Disability Advice Services (ICEDAS) and to operate a pooled budget for the required Better Care Fund arrangements. The Better Care Fund is hosted by Liverpool City Council. The ICEDAS is hosted by the ICB. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Halton
Halton has a pooled budget arrangement with Halton Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The pool is hosted by Halton Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

St Helens
St Helens has a pooled budget arrangement with St Helens Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the majority of Continuing Health Care and the Better Care Fund. The pool is hosted by St Helens Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

Sefton
Sefton has a pooled budget arrangement with Sefton Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Self Care, Wellbeing and Prevention, Integrated Care at locality level building on Virtual Ward and Care Closer to Home Initiatives and Intermediate Care and Reablement. The pool is hosted by Sefton Metropolitan Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Warrington
Warrington has a pooled budget arrangement with Halton Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The pool is hosted by Halton Borough Council The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Wirral
Wirral has a pooled budget arrangement with Wirral Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for health and social care activities. The pool is hosted by Wirral Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

22. Related party transactions

Details of related party transactions are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Sefton CVS (Paul Cummins is also Trustee of Sefton CVS)	485	-	-	-
Community Pharmacy Cheshire & Wirral LPC (Adam Irvine is also CEO of Community Pharmacy Cheshire & Wirral LPC)	41	-	-	-
Allen & Partners (Naomi Rankin is also a GP Partner at Belle Vale Medical Centre)	1,193	-	-	-
iGPC Primary Care Network (Naomi Rankin is also a Clinical Director and Shareholder of iGPC Primary Care Network)	2,270	-	-	-
The Health Foundation (Dr Ruth Hussey is also Deputy Chair of the The Health Foundation)	-	100	-	-
Accurx LTD is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	987	-	-	-
Alzheimers Society is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	383	-	9	-
Milton Keynes University Hospital NHS Trust is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	47	-	-	-
NHS Confederation is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	49	-	-	-

Transactions with the parties above were on the same trading terms as other suppliers and providers.

The Department of Health and Social Care is a related party and the parent body. During the year the ICB has had a significant number of material transactions with entities which the Department is regarded as the parent.
The main parties in the public sector with which the ICB had dealings were:

NHS England
NHS Business Services Authority
Alder Hey Children's Hospital NHS Foundation Trust
Bridgewater Community Healthcare NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
East Cheshire NHS Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust
Liverpool University Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Manchester University NHS Foundation Trust
Mersey Care NHS Foundation Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust (Following the merger of St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust)
Mid Cheshire Hospitals NHS Foundation Trust
North West Ambulance Service NHS Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Countess of Chester Hospital NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Warrington and Halton Hospitals NHS Trust
Wirral Community NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Cheshire East Council
Cheshire West and Chester Council
Halton Borough Council
Knowsley Council
Liverpool City Council
Metropolitan Borough Council of Sefton
St Helens Borough Council
Warrington Borough Council
Wirral Council

23. Events after the end of the reporting period

There have been no events after the end of the reporting period which would have a material effect on the financial statements of the ICB.

24. Losses and special payments

The ICB did not have any losses or special payments in 2023-24 (2022-23: 1 case at £35k)

25. Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).
NHS Integrated Care Board performance against those duties was as follows:

	31 March 2024 Target £000s	**31 March 2024 Performance £000s**	31 March 2023 Target £000s	31 March 2023 Performance £000s
Expenditure not to exceed income	6,799,820	6,796,601	4,614,899	4,602,153
Capital resource use does not exceed the amount specified in Directions	1,127	1,115	550	543
Revenue resource use does not exceed the amount specified in Directions	6,705,492	6,702,273	4,583,014	4,570,268
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	53,436	51,558	42,220	41,350

Appendix One – Board and Committee Membership and Attendance

The Board of NHS Cheshire and Merseyside

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Raj Jain (Chair)	Chair of NHS Cheshire and Merseyside ICB	8 (8)
Graham Urwin	Chief Executive of NHS Cheshire and Merseyside ICB	8 (8)
Tony Foy (Deputy Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	7 (8)
Erica Morriss	Non-Executive Member of NHS Cheshire and Merseyside ICB	6 (8)
Neil Large MBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	7 (8)
Professor Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	7 (8)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside ICB	2 (2)
Professor Steven Broomhead MBE	Partner Member, Local Authority of NHS Cheshire and Merseyside ICB	5 (8)
Councillor Paul Cummins	Partner Member, Local Authority of NHS Cheshire and Merseyside ICB	6 (8)
Ann Marr OBE	Partner Member, Provider Trust of NHS Cheshire and Merseyside ICB	7 (8)
Professor Joe Rafferty CBE	Partner Member, Provider Trust of NHS Cheshire and Merseyside ICB	5 (8)
Adam Irvine	Partner Member, Primary Medical Services of NHS Cheshire and Merseyside ICB	7 (8)
Dr Naomi Rankin	Partner Member, Primary Medical Services of NHS Cheshire and Merseyside ICB	6 (8)
Claire Wilson	Director of Finance of NHS Cheshire and Merseyside ICB	8 (8)
Professor Rowan Pritchard-Jones	Medical Director of NHS Cheshire and Merseyside ICB	7 (8)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside ICB	8 (8)

The quorum for meetings of the Board will be a majority of members (8) including: The Chair and Chief Executive (or designated deputies), at least one Executive Director, at least one Non-Executive Director, at least one Partner Member and at least one member who has a clinical background or qualification.

Audit Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Neil Large MBE (Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	6 (6)
Tony Foy (Deputy Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	4 (6)
Erica Morriss	Non-Executive Member of NHS Cheshire and Merseyside ICB	6 (6)
Professor Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	2 (2)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside ICB	2 (2)

For a meeting to be quorate, a minimum of two Non-Executive members of the Board are required, including the Chair or Deputy Chair of the Committee.

Remuneration Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Tony Foy (Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	4 (4)
Erica Morriss (Deputy Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	3 (4)
Neil Large MBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	4 (4)
Professor Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	3 (4)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside ICB	0 (1)

For a meeting to be quorate, a minimum of two of the Non-Executive members of the Board are required, including the Chair or the Deputy Chair of the Committee.

Finance, Investment and Our Resources Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Erica Morriss (Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	8 (8)
Tony Foy	Non-Executive Member of NHS Cheshire and Merseyside ICB	2 (8)
Neil Large MBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	6 (8)
Claire Wilson	Director of Finance of NHS Cheshire and Merseyside ICB	7 (8)
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside ICB	8 (8)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside ICB	7 (8)
Christine Samosa	Chief People Officer of NHS Cheshire and Merseyside ICB	8 (8)
Anthony Middleton	Director of Performance and Planning of NHS Cheshire and Merseyside ICB	4 (8)
Attendance by Alex Mitchell, Alan Howgate and Mark Wilkinson	Associate Director of 'Place' Finance representative	6 (8)
Adam Irvine	Primary Care Representative	7 (8)
Jane Tomkinson	Partner CEO Cheshire and Merseyside provider collaboratives	5 (8)
Rob Collins	Integrated Care System Provider Finance Director	7 (8)
Susannah Lynch	Chief Pharmacist of NHS Cheshire and Merseyside ICB	7 (8)

For a meeting to be quorate, at least 50% of the membership must be present (six). This should include two NHS Cheshire and Merseyside Executives, one Non-Executive member of the Board and one Partner Member.

Quality and Performance Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Tony Foy (Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	10 (10)
Professor Hilary Garratt CBE (Deputy Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	5 (10)
Dr Naomi Rankin	Primary Care Member (Primary Care) of NHS Cheshire and Merseyside ICB	7 (8)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside ICB	7 (10)
Professor Rowan Pritchard-Jones	Medical Director of NHS Cheshire and Merseyside ICB	8 (10)
Anthony Middleton	Director of Planning and Performance of NHS Cheshire and Merseyside ICB	7 (10)
Councillor Paul Cummins	Partner Member (Local Authority) of NHS Cheshire and Merseyside ICB	8 (10)

For a meeting to be quorate, there must be one Non-Executive member of the Board present, including one other Non-Executive member of the Board or Partner Member and either the Medical Director or Director of Nursing and Care.

System Primary Care Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Erica Morriss (Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	5 (5)
Tony Foy (Deputy Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	4 (5)
Adam Irvine	Primary Care Professional Group representative – Pharmacy / Primary Care Partner Member for NHS Cheshire and Merseyside ICB	5 (5)
Dr Rob Barnett / Dr Daniel Harle	Primary Care Professional Group representative – Primary medical care	5 (5)
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside ICB	5 (5)
Chris Leese	Associate Director of Primary Care of NHS Cheshire and Merseyside ICB	5 (5)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside ICB	4 (5)
Professor Rowan Pritchard-Jones	Medical Director of NHS Cheshire and Merseyside ICB	3 (5)
Anthony Leo	Halton Place Director of NHS Cheshire and Merseyside ICB	4 (5)

Name	Position & Organisation	Attendance (eligible to attend)
Laura Marsh	Cheshire West and Chester Acting Place Director of NHS Cheshire and Merseyside ICB	1 (5)
Mark Bakewell	Liverpool Place Director of NHS Cheshire and Merseyside ICB	1 (5)
Tom Knight	Head of Primary Care of NHS Cheshire and Merseyside ICB	5 (5)
Dr Jonathan Griffiths	Associate Medical Director	4 (5)
Dr Naomi Rankin	Primary Care Member for C&M ICB	4 (5)

For a meeting to be quorate, there must be at least five committee members present including, at least one Non-Executive member of the Board or Partner Member, at least one clinical member and at least two NHS Cheshire and Merseyside Directors.

Transformation Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Clare Watson (Chair)	Assistant Chief Executive of NHS Cheshire and Merseyside ICB	5 (5)
Neil Large MBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	4 (5)
Christine Douglas MBE	Director of Nursing and Care of NHS Cheshire and Merseyside ICB	4 (5)
Dr Fiona Lemmens	Associate Medical Director of NHS Cheshire and Merseyside ICB	5 (5)
Carl Marsh	Warrington Place Director of NHS Cheshire and Merseyside ICB	4 (5)
Mark Bakewell	Liverpool Place Director of NHS Cheshire and Merseyside ICB	2 (2)
Professor Ian Ashworth	Director of Population Health of NHS Cheshire and Merseyside ICB	4 (5)
Hilary Brooks	Director of Children and Young People Services, St Helens Council, Local authority representative	0 (5)
Tony Mayer	Managing Director, MHLDC provider Collaborative Representative	4 (5)
Linda Buckley	Managing Director, CMAST Provider Collaborative Representative	4 (5)

For a meeting to be quorate, there must be at least five committee members present including, at least one Non-Executive member of the Board or Partner Member, at least one clinical member and at least two NHS Cheshire and Merseyside Directors.

Children and Young People's Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Raj Jain (Chair)	Chair, NHS Cheshire and Merseyside ICB	3 (4)
Denise Roberts	Associate Director of Quality and Safety Improvement, Halton Place, NHS Cheshire and Merseyside ICB	4 (4)
Louise Shepherd CBE	Chief Executive, Alder Hey Childrens Hospital NHS FT	3 (4)
Christine Douglas MBE	Executive Director of Nursing & Care, NHS Cheshire and Merseyside ICB	4 (4)
Simon Banks	Wirral Place Director, NHS Cheshire and Merseyside ICB	3 (4)
Val McGee	Wirral Community Health and Care NHS FT	2 (4)
Clare Watson	Assistant Chief Executive, NHS Cheshire and Merseyside ICB	4 (4)
Dani Jones	Chief Strategy & Partnerships Office, Alder Hey Childrens Hospital NHS FT	4 (4)
Dave Packwood	Voluntary Sector North West	3 (4)
Dr Elizabeth Crabtree	Programme Director, Alder Hey Childrens Hospital NHS FT	3 (4)
Carly Brown	Change and Integration Director, Children's Services, Cheshire and Merseyside	4 (4)
Kelly Taylor	Head of Children & Young People Transformation Programme, NHS England – North West	3 (4)
Professor Ian Ashworth	Associate Director of Population Health, NHS Cheshire and Merseyside ICB	4 (4)
Mark Palethorpe*	St Helens Place Director, NHS Cheshire and Merseyside ICB	1 (4)
Amanda Perraton	Director, Children's Social Care (DCS), Warrington Borough Council	2 (4)
Bev Morgan	CEO, Koala North West	2 (4)
Sinead Clarke	Associate Medical Director for System Quality & Improvement, NHS Cheshire and Merseyside ICB	3 (3)
Phil Porter*	Chief Executive, Sefton Council	1 (4)
Kath O'Dwyer	Chief Executive, St Helens Borough Council	2 (4)
Gill Bainbridge*	Chief Executive, Merseyside Youth Association	1 (4)
Jenny Turnross*	Corporate Director of Children & Young People's Services, Liverpool City Council	1 (4)

For a meeting or part of a meeting to be quorate a minimum of 50% of the membership must be present, including the Chair or Deputy Chair.

Women's Hospital Services in Liverpool Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Raj Jain (Chair)	Chair of NHS Cheshire and Merseyside ICB	2 (3)
Professor Hilary Garratt CBE (Deputy Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	3 (3)
Christine Douglas MBE	Executive Director of Nursing & Care of NHS Cheshire and Merseyside ICB	3 (3)
Claire Wilson	Executive Director of Finance of NHS Cheshire and Merseyside ICB	0 (3)
Dr Fiona Lemmens	Deputy Medical Director of NHS Cheshire and Merseyside ICB	2 (3)
Dr Naomi Rankin	Primary Care Partner Member (Primary Care) NHS Cheshire and Merseyside ICB	3 (3)
Mark Bakewell	Liverpool Place Director of NHS Cheshire and Merseyside ICB	3 (3)
Alison Lee	Knowsley Place Director of NHS Cheshire and Merseyside ICB	2 (3)
Deborah Butcher	Sefton Place Director of NHS Cheshire and Merseyside ICB	1 (3)
James Sumner	Chief Executive, Liverpool University Hospitals Foundation Trust and Liverpool Womens Hospital Foundation Trust	2 (2)
Mandish Dhanjal	Independent Clinical Senior Responsible Officer	1 (2)
Dr Lynn Greenhalgh	Chief Medical Officer, Liverpool Women's Foundation Trust	2 (2)
Catherine McClennan	Director, Cheshire & Merseyside Local Maternity and Neonatal System	1 (1)
Andrew Bibby	Regional Director of Health & Justice and Specialised Commissioning, NHS England representative	2 (2)
Sheena Khanduri	Medical Director, Clatterbridge Cancer Centre Foundation Trust	0 (1)
Thomas Pharoah	Director of Strategy, Clatterbridge Cancer Centre Foundation Trust	1 (1)
Louise Shepherd	Chief Executive, Alder Hey Children's Hospital Foundation Trust	2 (3)

For a meeting or part of a meeting to be quorate a minimum of five Committee members need to be present, including, the Committee Chair or Deputy Chair, at least one NHS Trust representative, at least one clinically qualified member, at least one ICB Executive member.

North West Specialised Services Joint Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside ICB representative	6 (7)
Rob Bellingham	Director of Primary Care and Strategic Commissioning of NHS Greater Manchester ICB Representative	4 (7)
Professor Craig Harris	Chief of Health and Care Integration of NHS Lancashire and Cumbria ICB Representative	5 (7)
Andrew Bibby	Regional Director of Health & Justice and Specialised Commissioning of NHS England representative	7 (7)

For a meeting to be quorate, there must be the authorised officer (or substitute) nominated by NHS England, and each of the authorised officer (or substitutes) appointed by each of the three ICBs.

Cheshire and Merseyside Health Care Partnership

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Councillor Louise Gittins (Chair)	Political Representative, Cheshire West and Chester Council	4 (4)
Rev Ellen Loudon (Vice Chair)	Director of Social Justice & Canon Chancellor, Diocese of Liverpool	4 (4)
Raj Jain (Vice Chair)	Chair of NHS Cheshire and Merseyside ICB	4 (4)
Graham Urwin	Chief Executive of NHS Cheshire and Merseyside ICB	2 (4)
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside ICB	4 (4)
Claire Wilson	Director of Finance of NHS Cheshire and Merseyside ICB	3 (4)
Councillor Christine Bannon	Political representative, Knowsley Metropolitan Borough Council	4 (4)
Councillor Marlene Quinn	Political representative, St Helens Borough Council	4 (4)
Councillor Paul Warburton	Political representative, Warrington Borough Council	4 (4)
Councillor Ian Moncur	Political representative, Sefton Council	2 (4)
Councillor Jane Corbett	Political representative, Liverpool Council	1 (4)
Councillor Sam Corcoran	Political representative, Cheshire East Council	4 (4)

Name	Position & Organisation	Attendance (eligible to attend)
Councillor Marie Wright	Political representative, Halton Borough Council	4 (4)
Councillor Angela Coleman	Political representative, Liverpool Council	0 (4)
Cllr Jean Robinson	Political Representative, Wirral Council	2 (4)
Professor Ian Ashworth	Director of Population Health of NHS Cheshire and Merseyside ICB	3 (3)
Margaret Jones	Director of Public Health, Sefton Council	1 (4)
Darren Mochrie	Chief Executive Officer, North West Ambulance Service	2 (4)
Gareth Lee	Detective Chief Superintendent, Cheshire Police	1(4)
Jennifer Wilson	Chief Superintendent, Merseyside Police	3 (4)
Lee Shears	Deputy Chief Fire Officer, Cheshire Fire and Rescue	4 (4)
Phil Garrigan	Chief Fire Officer, Merseyside Fire and Rescue	3 (4)
Alison Cullen	Chief Executive Officer, Warrington Voluntary Action, Voluntary, Community and Faith Sector Representative (Cheshire)	1 (4)
Racheal Jones	Chief executive Officer, One Knowsley, Voluntary, Community and Faith Sector Representative (Merseyside)	4 (4)
Adam Irvine	Primary Care Representative	3 (4)
Dame Jo Williams	Chair of Alder Hey Children's Hospital Trust - Provider Collaborative	4 (4)
Isla Wilson	Chair of Cheshire & Wirral Partnership Foundation Trust - Provider Collaborative Representative (MHLDSC)	4 (4)
Paul Warburton	Group Director of Housing, TORUS, Housing Representative	4 (4)
Diane Blair	Chief Executive, Sefton Healthwatch	1 (1)
Sarah Thwaites	Chief Executive, Liverpool Healthwatch	3 (4)
Karen Prior	Chief executive, Wirral Healthwatch	0 (4)
Professor Tom Walley	University of Liverpool – University/Higher Education representative	2 (4)
Professor Angela Simpson	University of Chester –	1 (4)

Name	Position & Organisation	Attendance (eligible to attend)
	University/Higher Education representative	
Amanda Perraton	Director of Adult Childrens Services, Warrington Council – DSC Group representative	2 (2)
Gideon Ben Tovim	Health Innovation Chair of LCR Climate Partnership	1 (1)
Mark Bakewell	Liverpool Place Director of NHS Cheshire and Merseyside ICB	1 (10
Carl Marsh	Warrington Place Director of NHS Cheshire and Merseyside ICB	1 (1)
Deborah Butcher	Sefton Place Director of NHS Cheshire and Merseyside ICB	1 (1)
Nicky Freaney	Partnership Manager, Department of Work and Pensions	1 (1)

For the Health and Care Partnership to be quorate, there must be 50% of the membership present.

Appendix Two – NHS Oversight Framework - Organisational Detail

Metric ID	NHS OF Metric Name Full	Aggregation Source	Period	NHS C&M Performance	Quartile Ranking
S000a	NHSOF Segmentation	ICB	2024 03	3	3
S000d	UEC Tier	ICB	2024 03	1	1
S124a	Percentage of beds occupied by patients who no longer meet the criteria to reside	Provider	2024 03	20.30%	4.76
S009d	Total patients waiting more than 65 weeks to start consultant-led treatment	ICB	2024 02	3,736	7.14
S009d	Total patients waiting more than 65 weeks to start consultant-led treatment	Provider	2024 02	3,512	7.14
S068a	Sickness absence rate	ICB	2023 11	5.84%	11.90
S029a	Adult inpatients with a learning disability and/or autism per million adult population	ICB	2023-24 Q3	53	14.29
S042a	E. coli bloodstream infection rate	Provider	2024 02	152.10%	14.29
S012a	Proportion of patients meeting the faster cancer diagnosis standard	ICB	2024 02	74.80%	16.67
S128a	Virtual ward - percentage capacity occupied.	ICB	2024 03	56.50%	16.67
S040a	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Sub ICB	2024 02	30	19.05
S042a	E. coli bloodstream infection rate	Sub ICB	2024 02	130.40%	19.05
S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Sub ICB	2024 01	103.60%	21.43
S075a	Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	ICB	2023-12	7.12	23.81
S127a	A&E - percentage of patients managed within 4 hours.	ICB	2024 03	71.90%	26.19
S047a	Proportion of people over 65 receiving a seasonal flu vaccination	Sub ICB	2023 02	80.00%	28.57
S107a	Proportion of Urgent Community Response referrals reached within two hours	ICB	2024 01	80.00%	28.57
S053b	% of hypertension patients who are treated to target as per NICE guidance (S053b)	Sub ICB	2023-09	65.80%	29.03
S040a	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Provider	2024 02	9	33.33
S046a	Population vaccination coverage: MMR for two doses (5 year olds)	ICB	2023-24 Q3	85.70%	35.71
S050a	Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	Sub ICB	2023-24 Q2	70.30%	38.10
S081a	Access rate for IAPT services	ICB	2024 02	66.00%	40.48
S123a	Adult general and acute type 1 bed occupancy (adjusted for void beds)	Provider	2024 03	96.00%	40.48

Metric ID	NHS OF Metric Name Full	Aggregation Source	Period	NHS C&M Performance	Quartile Ranking
S011a	Cancer: 62 days backlog	Provider	w/e 07/04/2024	93.90%	42.86
S037a	Percentage of patients describing their overall experience of making a GP appointment as good	ICB	2023	53.80%	42.86
S072a	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	ICB	2023	5730%	45.24
S041a	Clostridium difficile infection rate	Provider	2024 02	132.60%	50.00
S084a	Children and young people (ages 0-17) mental health services access (number with 1+ contact)	ICB	2024 02	91.00%	54.76
S109a	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	ICB	2024 03	92.80%	54.76
S030a	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	ICB	2023-24 Q3	44.40%	57.14
S041a	Clostridium difficile infection rate	Sub ICB	2024 02	122.40%	59.52
S069a	Staff survey engagement theme score	ICB	2023	6.95	59.52
S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins (S053c)	Sub ICB	2023 09	59.60%	61.29
S063a	Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	ICB	2022	10.10%	64.29
S067a	Leaver rate	ICB	2024 01	7.05%	64.29
S086a	Inappropriate adult acute mental health placement out -of-area placement bed days	ICB	2024 01	435	64.29
S130a	Dementia diagnosis rate	ICB	2024 02	66.80%	64.29
S022a	Stillbirths per 1,000 total births	ICB	2022	2.83	71.43
S121a	NHS Staff Survey compassionate culture people promise element sub-score	ICB	2023	7.2	71.43
S131a	Women accessing specialist community perinatal mental health services	ICB	2024 02	108.40%	71.43
S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Sub ICB	2024 01	7.30%	73.81
S104a	Neonatal deaths per 1,000 total live births	ICB	2022	1.28	73.81
S063c	Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users, their relatives or other members of the public	ICB	2022	24.90%	76.19

Metric ID	NHS OF Metric Name Full	Aggregation Source	Period	NHS C&M Performance	Quartile Ranking
S129a	GP appointments - percentage of regular appointments within 14 days.	Sub ICB	2024 02	90.60%	76.19
S133a	Staff survey - compassionate and inclusive theme score.	ICB	2023	7.4	80.95
S063b	Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	ICB	2022	17.00%	83.33
S121b	NHS Staff Survey raising concerns people promise element sub-score	ICB	2023	6.6	83.33
S110a	Access rates to community mental health services for adult and older adults with severe mental illness	ICB	2024 02	117.00%	85.71
S126a	Diagnostic activity waiting percentage of patients on the waiting list who have been waiting more than 6 weeks	Provider	2024 02	9.80%	90.48
S126a	Diagnostic activity waiting percentage of patients on the waiting list who have been waiting more than 6 weeks	Sub ICB	2024 02	9.80%	92.86
S007c	Elective Activity - value weighted elective activity growth vs. target	ICB	2023 12	400.00%	97.62