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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

(held in public)

25 January 2024

09:30am - 12:15pm

Tower Room, Floral Pavilion Theatre & Conference Centre, Wallasey, CH45 2JS

Public Speaking Time 09:00 - 09:30am

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

Agenda

AGENDA NO & TIME	ITEM	CQC ICS Theme & Quality Statement	Format	Presenter	Action / Purpose	Page No
09:30am	**Meeting Governance**					
ICB/01/24/01	Welcome, Apologies and confirmation of quoracy		Verbal	Raj Jain *Chair*	For information	-
ICB/01/24/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the Board Member Register of Interests)*		Verbal		For assurance	-
ICB/01/24/03	Minutes of the previous meeting: • 30 November 2023.		Paper		For approval	5
ICB/01/24/04	Board Action Log		Paper		For note	24
ICB/01/24/05	Board Decision Log		Paper		For note	25
ICB/01/24/06	Resident Story		Film		For information	-
09:45am	**Leadership Reports**					
ICB/01/24/07	Report of the ICB Chair		Verbal	Raj Jain *Chair*	For note	
ICB/01/24/08 **09:50am**	Report of the ICB Chief Executive		Paper	Graham Urwin *Chief Executive*	For note and approval	32
ICB/01/24/09 **10:00am**	Report of the ICB Director of Nursing and Care		Paper	Chris Douglas *Director of Nursing & Care*	For note	45

AGENDA NO & TIME	ITEM	CQC ICS Theme & Quality Statement	Format	Presenter	Action / Purpose	Page No
ICB/01/24/10 **10:10am**	NHS Cheshire and Merseyside Finance Report Month 9		Paper	Claire Wilson *Director of Finance*	For note	64
ICB/01/24/11 **10:20am**	Highlight report of the Chair of the ICB Finance, Investment and Resources Committee		Paper	Erica Morriss *Non-Executive Member*	For note	92
ICB/01/24/12 **10:25am**	NHS Cheshire and Merseyside Quality and Performance Report		Paper	Anthony Middleton *Director of Performance & Planning*	For note	96
ICB/01/24/13 **10:35am**	Highlight report of the Chair of the ICB Quality and Performance Committee		Paper	Tony Foy *Non-Executive Member*	For note	122
ICB/01/24/14 **10:40am**	Report of the Directors of Place		Paper	Mark Palethorpe *Place Director (St Helens)* Laura Marsh *Place Director (Cheshire West)*	For note	125
10:55am	**Committee AAA Reports - matters of escalation and assurance**					
ICB/01/24/15	Highlight report of the Chair of the ICB Audit Committee		Paper	Neil Large *Non-Executive Member*	For note	155
ICB/01/24/16 **11:00am**	Highlight report of the Chair of the ICB Remuneration Committee		Paper	Tony Foy *Non-Executive Member*	For note and approval	159
ICB/01/24/17 **11:05am**	Highlight report of the Chair of the ICB System Primary Care Committee		Paper	Erica Morriss *Non-Executive Member*	For note	169
ICB/01/24/18 **11:10am**	Highlight report of the Chair of the ICB Transformation Committee		Paper	Clare Watson *Assistant Chief Executive*	For note	172
11:15am	**ICB Business Items & Strategic Updates**					
ICB/01/24/19	NHS Cheshire and Merseyside Board Assurance Framework - Quarter Three Update	QS13	Paper	Clare Watson *Assistant Chief Executive*	For approval	176
ICB/01/24/20 **11:25am**	NHS Cheshire and Merseyside Corporate Risk Register	QS13	Paper	Clare Watson *Assistant Chief Executive*	For note	236

AGENDA NO & TIME	ITEM	CQC ICS Theme & Quality Statement	Format	Presenter	Action / Purpose	Page No
ICB/01/24/21 **11:35am**	Northwest BAME Assembly Anti-Racism Framework	QS4, QS5, QS8, QS10, QS17	Paper	Christine Samosa *Chief People Officer*	For note	270
ICB/01/24/22 **11:45am**	NHS Cheshire and Merseyside ICB Constitutional Amends	All standards	Paper	Clare Watson *Assistant Chief Executive*	For approval	282
ICB/01/24/23 **11:55am**	Updated Terms of Reference for the ICB Women's Services Committee	QS1, QS2, QS3, QS7, QS9, QS10, QS13, QS15	Paper	Christine Douglas *Director of Nursing and Care*	For approval	338
ICB/01/24/24 **12:05am**	NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS)	QS2, QS14, QS15,	Paper	Prof. Rowan Pritchard-Jones *Medical Director*	For approval	365
ICB/01/24/25 **12:15am**	NHS Cheshire and Merseyside Freedom To Speak Up Update	QS12	Paper	Christine Samosa *Chief People Officer*	For endorsement	375
12:25pm	**Any Other Business**					
ICB/01/24/26	Closing remarks, review of the meeting and communications from it		Verbal	Chair / All	For information	-
12:30pm	**CLOSE OF MEETING**					

Consent items

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

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/01/24/27	Confirmed Minutes of ICB Committees: • *Quality and Performance Committee* • *System Primary Care Committee* • *Finance, Investment and Resources Committee* • *Audit Committee* • *Transformation Committee*	For information	406

Date and time of Next Meeting

28 March 2024, 0900 - 12:30, Boardroom, 4th Floor, Lewis' Building, 2 Renshaw Street, Liverpool, L1 2SA
A full schedule of meetings, locations, and further details on the work of the ICB can be found here: www.cheshireandmerseyside.nhs.uk/about

Following its meeting held in Public, the Board will hold a meeting in Private from 12:45pm until 13:45pm.

NHS
Cheshire and Merseyside

Meeting Held in Public of the Board of NHS Cheshire and Merseyside

Held at Macclesfield Town Hall, Market Place, SK10 1EA
Thursday 30th November 2023
9:00am to 12:00pm

Unconfirmed Draft Minutes

MEMBERSHIP		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB (voting member)
Neil Large MBE	NLA	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Prof. Hilary Garratt CBE	HGA	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Graham Urwin	GPU	Chief Executive, Cheshire & Merseyside ICB (voting member)
Claire Wilson	CWI	Executive Director of Finance, Cheshire & Merseyside ICB (voting member)
Christine Douglas MBE	CDO	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Steven Broomhead MBE	SBR	Partner Member, Chief Executive, Warrington Borough Council (voting member)
Adam Irvine	AIR	Partner Member, Chief Executive Office, Community Pharmacy Cheshire, and Wirral (CPCW) (voting member)
Dr Naomi Rankin	NRA	Partner Member, Primary Care (GP) Partner Member (voting member)
Ann Marr OBE	AMA	Partner Member, Chief Executive, Mersey and West Lancashire Teaching Hospital Trust (voting member)
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
IN ATTENDANCE		
Dr Fiona Lemmens	FLE	Associate Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Anthony Middleton	AMI	Director of Performance and Improvement, Cheshire & Merseyside ICB (Regular Participant)
Christine Samosa	CSA	Director of People, Cheshire & Merseyside ICB (Regular Participant)

Clare Watson	CWA	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)
John Llewellyn	JLL	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)
Prof. Ian Ashworth	IAS	Director of Population Health representative (Regular Participant)
Louise Barry	LBA	Chief Executive of Healthwatch Cheshire
Matthew Cunningham	MCU	Associate Director of Corporate Affairs and Governance & Board Secretary
Mark Wilkinson	MW	Place Director, Cheshire East
Sally Thorpe	STH	(Minutes) Executive Assistant, Cheshire & Merseyside ICB

APOLOGIES NOTED		
Name	**Initials**	**Role**
Prof. Rowan Pritchard-Jones	RPJ	Medical Director, Cheshire & Merseyside ICB (voting member)
Councillor Paul Cummins	PCU	Partner Member, Cabinet Member for Adult Social Care, Sefton Council (voting member)
Prof. Joe Rafferty CBE	JRA	Partner Member, Chief Executive Office, Mersey Care NHS Trust, (voting member)

Item	**Discussion, Outcomes and Action Points**	**Action by**
ICB/11/23/01	**Welcome, Introductions and Apologies**	
	All present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. Chair welcomed Ruth Hussey to her first C&M ICB Board meeting. Apologies for absence were noted as above.	
ICB/11/23/02	**Declarations of Interest**	
	There were no declarations of interest made by Members that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.	
ICB/11/23/03	**Minutes of the last meeting – 28th September 2023**	
	Members reviewed the minutes of the meeting held on 28th September 2023 and agreed that they were a true reflection of the discussions and decisions made.	

Item	Discussion, Outcomes and Action Points	Action by
	The Board approved the minutes of the NHS C&M ICB Board meeting of 28th September 2023.	
ICB/11/23/04	**Action Log**	
	The Board acknowledged the completed actions and updates provided in the document. **The Board noted the Action Log.**	
ICB/11/23/05	**Decision Log**	
	Members reviewed the decision log and confirmed that the information presented was an accurate record of substantive decisions made by the Board up to 30th November 2023. It was further noted that there were no emergent actions arising from those decisions that were due for review at this meeting. **The Board noted the Decision Log**.	
	Standing Items	
ICB/11/23/06	**Resident Story**	
	FLE introduced the story, which was from the perspective of a patient on a virtual ward. **The Board thanked all for their contributions.**	
ICB/11/23/07	**Report of the Chair, NHS Cheshire & Merseyside ICB**	
	The report presented by RJA outlined some of the work undertaken by NHS Cheshire & Merseyside ICB (C&M ICB) not reported elsewhere in detail on the Board meeting agenda, including: **Appointment of Ruth Hussey CB, OBE, DL** NHS C&M's fifth Non-Executive Member. Following an expansive advertisement process, the NHS C&M Stakeholder Panel and Appointments panel came to a unanimous conclusion that Ruth demonstrated the requisite enthusiasm, experience, and commitment to becoming a valuable addition to the Board. **Establishment of an additional Ordinary (Partner) Member of the Board** It is recognised that the role and voice of the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector is integral to the successful development of NHS C&M and our Integrated Care System; and we have invited a representative from the	

Item	Discussion, Outcomes and Action Points	Action by
	VCFSE as a regular participant at the Board of NHS C&M so that the perspective of the sector was front and centre in the Board discussions. Now to help further strengthen our commitment to the VCFSE sector and reinforce our position that the VCFSE sector are seen as equal partners in health and care, it is proposed to make the VCFSE Sector representative a named Ordinary (Partner Member) of the Board. In doing so the main change would be that the representative is now considered as part of the voting membership of the Board. *The Board were asked to support the proposal.* **Associate Non-Executive Member establishment.** NHS C&M is taking part in both national and regional programmes to encourage people from a diverse background to consider becoming Non-Executive Members/ Directors of NHS Boards. It was noted that Marc Smith had joined the Board meeting as an observer. Marc is currently on a six-month placement with NHS C&M as part of the Insight Programme, a national programme that aims to support individuals from under-represented groups on their journey to becoming effective Non-Executive Directors. NHS C&M is one of only two ICBs this year that are hosting an Insight placement. In addition to this, a programme to establish two Associate Non-Executive Member positions has been implemented within NHS C&M, further details will be shared in the near future. **Cheshire and Merseyside Health and Care Partnership** Terms of Reference for the Cheshire and Merseyside Health and Care Partnership (HCP) have been considered and approved by each of the nine Local Authorities across Cheshire and Merseyside. As the tenth founding member of the HCP, NHS C&M also needs to approve the TOR. *The Board were asked to approve the Terms of Reference at Appendix 1.* RJA outlined that C&M ICB work as members of the HCP and has spent a number of months working on this, we are the last member partner to receive this work and welcomed the approval of the Board to take these to the next HCP Board meeting. Since the last Chairs update to the Board, it was noted there have been two development sessions held (19/09 and 14/11), these were noted to have been well attended by HCP members. The workshops looked at health and housing issues, and Children & Young People.	

Item	Discussion, Outcomes and Action Points	Action by
	RJA highlighted the challenges raised at the workshops around social care and partnerships of integrated working, that the Board should be aware of those challenges to service users, and to be mindful that we could sit and wait, or we can actively look to how we can challenge and mitigate the issues. The Board were asked to think about how we might achieve this? It was suggested that there would be a meeting arranged with political leaders and healthcare leaders to explore and over time to come up with recommendations for the Board in 2024 and to identify key things that this Board may want to explore further. SBR noted that social care continues to have challenges and is causing councillors to receive bankruptcy notices, he stated that he very much welcomed this work as there are different standards of national care across the Local Authorities. **The Board:** • **noted the updates within the report and the additional comments from the Chair** • **supported the proposal for the establishment of an additional ordinary (partner) member of the Board.** • **approved the Cheshire & Merseyside HCP Terms of Reference.**	
ICB/11/23/08	**Report of the Chief Executive**	
	The report presented by GPU provided a summary of issues not otherwise covered in detail on the Board meeting agenda; including: **Thirlwall Inquiry.** The Terms of Reference for the Inquiry have now been published (link in paper – page 113). NHS C&M has established a Thirlwall Task and Finish Group, chaired by the Chief People Officer; to provide oversight, guidance and assurance to the Board regarding NHS C&M's response to the public inquiry. In addition to this GUR stated that as an organisation we would adapt and adopt the Inquiry, and that the ICB had received a 'rule 9 statement' which asked answers to specific questions. GUR outlined that the legal firm appointed had been chosen specifically as an expert healthcare firm and from outside of the area so as to not conflict with partner organisations also involved in the case. GUR highlighted to the Board that as he was employed by NHSE prior to his appointment with the ICB and in order to ensure complete transparency, Christine Samosa would act as the	

Item	Discussion, Outcomes and Action Points	Action by
	information warden and would chair any necessary group if called upon. **Provider Selection Regime** The Provider Selection Regime (PSR) regulations are intended to come into force on 1 January 2024. These are the much-awaited regulations that will provide us with the ability to determine situations where a collaborative and not a competitive solution may better suite our needs. The PSR will replace the existing procurement rules for NHS and local authority funded health care services. ICB staff from our finance and contracting, commissioning and governance functions are linking in to regional and national events to facilitate learning and preparation for the implementation of PSR. **Addressing Significant Financial Challenges** All NHS Trusts and ICBs received a letter from NHS England in early November entitled *'Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take'* and which outlined the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government – as set out at page 115 of pack. There have been several meetings with system leaders throughout November to agree our system approach and implications. It was noted that this was not just about budgets we directly manage, and that this is about the whole financial system, to support the NHS Trusts and to help them with their control totals. **NHS IMPACT** GPU outlined that prior to the establishment of NHS IMPACT, the ICB had already identified improvement as a priority and are working with colleagues from the NHSE regional improvement team to explore the creation of a C&M Improvement Hub; we have also supported improvement leads from our provider organisations to mobilise as the Cheshire and Merseyside Improvement Network (CaMIN). The NHS IMPACT framework also requires an assessment of NHS Board capability to lead improvement across its five domains and to that end, we will be undertaking a skills audit to plan for improved resilience over the coming months. Alongside this preliminary data, a full report will be brought to the Board in early 2024 that sets out NHS C&M's ambition and plans in more detail. FLE, outlined that this presented a huge opportunity as a system, noting that some progress has been made, and that there was thinking about this before the NHS Impact work came through. It is for Trust and Acute Providers to embed this within primary care and that it is about a cultural shift rather than us measuring, and for	

Item	Discussion, Outcomes and Action Points	Action by
	us to corral and inspire, and that as an Executive team we are ready for this challenge. **Action:** **Paper to come back to Board with a focus on improvement, and how this can be done and resourced. Indicated for early 2024 (March).** **Queens Nurse Award.** GPU passed on congratulations to Christine Douglas, Director of Nursing and Care who will be receiving the Queen's Nurse badge at the Queen's Nursing Institute annual awards ceremony on 8th December. The title of Queen's Nurse is awarded in recognition of a nurse's commitment to ongoing learning, leadership and excellence in healthcare. **HSJ Awards.** Congratulations was also given to the Cheshire and Merseyside Acute and Specialist Trust (CMAST) collaborative for winning the HSJ provider Collaborative of the Year Award at the HSJ Awards night on 16 November 2023. GUR added that when the ICB was formed it was clear from the outset that collaboration and integration was key, and that positive results could be achieved by our providers and working in a new way. This award is therefore rightly deserved and received. **The Board:** • **noted the updates as outlined within the report** • **approved the Terms of Reference for the NHS C&M Thirlwall Inquiry Task and Finish Group.** • **noted the decisions undertaken by the Executive Team.**	RPJ
	NHS C&M Key Update Reports	
ICB/11/23/09	**Report of the Director of Nursing & Care**	
	The report presented to the Board provides an overview of the current risks, issues and highlights impacting on quality and safety within the Cheshire and Merseyside ICS footprint. CDO outlined that we had established several workstreams as referenced in the long-term workforce plan. It was outlined that this plan calls for "urgency" in its recommendation that ICB's and wider system partners prioritise actions that drive recruitment and retention of their "one workforce" across health and care". Across Cheshire and Merseyside, we have put in place several workstreams to raise the profile of social care, encourage student placements, upskill existing staff working in social care and help to provide support networks for new and existing members of the social care staff.	

Item	Discussion, Outcomes and Action Points	Action by
	In terms of the Patient safety care incident framework, 14 of the Trusts have signed off and are ready to implement, outlined that the remaining two will be ready by the end of the year. For the independent sector there are 800 within C&M and there is further work for maternity providers. There is a Task and Finish group which will be signed off with the region in 2024. It was noted that Social Care have done really well with so little. Important to recognise how they must feel to be part of the solution and the collective skill base. It is key to invest in the nurse prescribers and to look at the advanced clinical skills, we can look at this to identify and to look over and above the ambition. Focus is on the continued professional development around the upskilling of staff and the training, working in collaboration with Chester University, taking away from providers to pick up more locally. **Action** **CDO agreed to pick up the volume of apprenticeships.** CDO updated on CHC, recognising that CHC is one of the critical things we are challenged with before we even look at finance. that we are continuing the review of how we inhouse the model, but also the packages of care, from a quality point of view there is further work to do on the workforce. Review is proposed to be completed by end of this financial year, with commencement in April for the new model going forwards. In relation to Infection Prevention and Control (IPC), CDO highlighted that there is a real concern regarding the avoidance of availability, and it was questioned as to what action is being taken, and to give some sense that some is avoidable, additionally whether we are reviewing the data as it appears consistently high. It was further questioned for IPC what is our role as the ICB? In response, CDO outlined that there has been a request for the review and that we, as the ICB, have a legal responsibility as a system. Place reports from all 9 places are received and the data and concerns are fed into the Quality and Performance Committee (QPC), also in terms of what we are doing within place and how we look at this as a system. It is acknowledged there is further work to do, hence why we have asked for the governance review. Members stated that they welcomed the IPC review, and it was noted that for TB screening there were some legacy issues we still have on this, additionally there are lots of challenges around migrant health, and that programmes and poor homes would welcome this as part of the review.	CDO

Item	Discussion, Outcomes and Action Points	Action by
	The Board noted the updates within the report.	
ICB/11/23/10	**NHS C&M Finance Report Month 6**	
	CWI provided an update for Month 6 to the end of September 2023. Noted that we are seeing an adverse variance, £56m of which £39m relates to ICB and £17m to provider positions. This is a continuation related to Industrial Action in providers, excessive inflation and costs within the ICB. Further noted that since the report was written, the plan has been reset. CWI noted that as a result of the conversations and national process £800m national funding has been awarded, with £41m allocated to C&M, and adjustment to the elective recovery funding an additional £17m, which gives us £58m additional funding to support the gap, we are now in a period of rapid review and in a process to agree an updated national plan. CWI outlined that the position was a good one from where we were, however, we still have not got strategic solutions. We have 7 Trusts with a huge deficit, and this is an in-year position, therefore unless we find a way for the underlying issues, we will be in the same position next year. We need to understand what support Trusts may/ may not need and which Trusts can/ cannot help themselves or help others. Work has started to understand the gap and a paper is due to the next Board meeting, this will try to address the big pieces of transformational gap. **The board noted the updates within the report.**	
ICB/11/23/11	**NHS C&M Quality and Performance Report**	
	AMI presented the integrated performance report for November 2023, providing an overview of key metrics drawn from the 2023/24 Operational Plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance. It was outlined that the report has changed format, and the design now shows for provider and place, it has moved away from narrative reporting and is now by exception. These exceptional reports are scribed by the leader of those areas which gives real ownership. It was noted that it was clear to see a physical health metric and that we are already seeing the increased pressures on the system.	

Item	Discussion, Outcomes and Action Points	Action by
	In particular ambulance response times, this is a real challenge in some areas of our patch, as is the criteria to reside in bed and it is expected to peak in January 2024. It was noted that the new report format was really helpful, but it was questioned as to why the patients no longer needed resident to stay (155) within lots of hospitals with high performance, why show this in green if a high level? It was further questioned why were we still having this problem, how are we going to reduce this? AMI reported that it was multifaceted, and that the agreed RAG rating was used when developing the operational plans for this year. Place set their ambitions to achieve 12.8%, but do not feel the confidence was there from the providers so the value was set higher. There has been some improvement, but this has not made a tangible effect, there are challenges for social care, capacity in particular and that we are still working on this place by place, provider by provider, it is key to understand capacity and demand. There is lots of work ongoing in avoiding admissions. HGA questioned that we cannot see what is happening in community services, and whether we have any reablement services in the ICB, additionally questioning if we have invested enough. It was further questioned how long does it take to have a CHC assessment and is this increasing the time in beds unnecessarily. She stated that she would be interested to see the CHC metrics around how much spend there is on independent reviews on CHC. In response, in terms of reablement capacity, at this point in time, there is no granular level of detail, although there is specific work taking place in Warrington and Liverpool, where this is being evaluated and as part of this the team have agreed to do a light touch on other parts of the system. The Board requested to see how we want to average at 19, but that it would be good to see a longer forward view for the board, and how we might get to a more reasonable %. **Action** **AMI agreed that he would take forward this action and bring back a further update to Board** AMA added that we are only in November, and we now have the worst situation we have been in for a very long time in terms of pressure. Taking the average site in A&E, of about 30 wards, six are full of people who do not need to be there. There is general stress on the staff therefore the basics will not be done right, patients are potentially being exposed to infection before they have	AMI

Item	Discussion, Outcomes and Action Points	Action by
	even had chance to triage them. There is grave concern that we are not even in the peak of winter yet. Patient experience and workforce pressure are really tough due to the sheer pressure on the system. It causes us to hold up ambulances due to being inundated with activity of where we can put these patients, lots of things happen because of this one thing and it can only get worse. RHU questioned in terms of children and young people, and them being able to access mental health provision, it is noted that whilst we are making improvements will we hit the targets for 2024? Noted that the blood pressure ambition of 80 by 2029 does not feel like we are scaling interventions by level of need, and therefore what is the reassurance to get much more progress. She added that by saying this we are building in an inequality of 20%. In response NRA stated that there are clear targets in QOF that specifically look at patients with different health inequalities. Within the target there has to be an understanding that some patients do not want to engage with the system, people live complex lives and from a GP perspective yes it should be 100% but we have to recognise that some patients simply do not want it. They are stretched timescales and that it is a cumulative measurement to the end of March next year. Different practices bring patients in in different ways. **The board noted the updates within the report.**	
	Committee Highlight Reports – matters of escalation & assurance	
ICB/11/23/12	**Highlight Report of the Chair of NHS C&M Quality and Performance Committee**	
	TFO presented this report, highlighting in particular maternity and the triage delays, adding that it was the impact of workforce seemingly to be the route cause. Additionally highlighting the questions around children into care. **The board noted the content of the report.**	
ICB/11/23/13	**Highlight Report of the Chair of NHS C&M System Primary Care Committee**	
	EMO presented this report, stating that there was some good news in that a preventative piece of work for oral health has been approved, she invited IAS to update accordingly. IAS stated that the ICB had inherited responsibility for dental and that the biggest hospital admissions for 6-10 year olds is tooth extraction. This leads to loss of school days, and that the children are three times more likely to have dental decay. He stated he was glad to be able to introduce an approved oral health programme and toothbrush campaign (providing free toothbrush and paste). This will build upon relationships with school nurses. It will be mobilised with the	

Item	Discussion, Outcomes and Action Points	Action by
	Beyond Group, and is one of the NHS Core25plus indicators from the next financial year. EMO outlined that the Committee have a watchful eye on dental services and that an audit will come to Board after 6 months of data. **The board:** • **noted the content of the report.** • **approved the Primary Care Access Recovery Improvement Plan**	
ICB/11/23/14	**Highlight Report of the Chair of NHS C&M Finance, Investment and Resources Committee**	
	EMO presented the committee highlight report for the NHS C&M Finance, Investment and Resources Committee. There was nothing further to note other than to assure the Board that the Committee are forensically monitoring the situation. **The board noted the content of the report.**	
	NHS C&M Business Items	
ICB/11/23/15	**NHS C&M Board Assurance Framework – Quarter 2 Update**	
	CWA presented an update on the Board Assurance Framework (BAF) as at Quarter 2 2023/24. It was outlined that Q1 was received in July, and that there are 10 principal risks, P6 is one that we are particularly focussing on. Noted that the change of risks and scores are highlighted and contained within the report. It was noted that the Risk committee is chaired by the Chief Executive, and that there is a consistent check and challenge approach across the ICB. In terms of the P6 risk, TFO stated that he liked the process and the approach shown in summary form, adding that alongside of the performance report it was a good balanced approach to address. **The board:** • **noted the current risk profile, progress in completing mitigating actions, assurances provided and priority actions for the next quarter** • **approved the amended risk description for P3, changes to current risk ratings for P2 and P8 and increased target**	

Item	Discussion, Outcomes and Action Points	Action by
	scores for P6 and P10 as described in section 2.3 (page 187 of pack).	
ICB/11/23/16	**Women's Hospital Services in Liverpool Programme Governance Refresh**	
	FLE presented a report on the proposed refresh of the current Women's Services Programme governance. It was outlined that the proposed Programme Board will report to the four main providers as well as the Women's Services Committee. The overall approach is a risk based approach and will be focussed on medium to long terms approach, whilst the programme will be short term. Clinical teams have demonstrated a genuine desire to work in partnership at both sites, to make services as safe as possible. There is growing awareness of the risks, particularly for pregnant women if attending at different sites, and this will allow a more comprehensive look at this. CWA wanted to reassure the Board and members of the public that it was key to understand people with real lived in experience and to continue to explore the optimum ways of managing this. AMA requested assurance for the tertiary provider and that it was important to take this into account with the population levels, to also consider geography and the effect on patient flows. And that using a centralised model of local provisions as well as the inward looking aspect of trusts in Liverpool is having input into the reviews. Questioned as to how we look to inform Cheshire and others. It was outlined that this will be reported to the ICB Women's Hospital Services in Liverpool Committee where CMAST and wider organisations attend, also that the Women's Services Committee will be aware of all the discussions. **The board:** • **noted the content of the report.** • **approved the proposed changes to the current Women's Services Programme governance as presented in the report.**	
ICB/11/23/17	**National Children & Young Peoples Programme Update**	
	LSH outlined that the main objective of the national programme was how the long term plan for CYP is delivered, given the	

Item	Discussion, Outcomes and Action Points	Action by
	pandemic, what should the remit be for the Board and the government, also how this will be shown locally in C&M. Key highlights; • CYP are facing growing waiting times for vital Community services. The NHS long term plan has increased investment into CYP mental health services. • Within big long-term conditions there have been marked reductions reported in paediatric emergency admissions due to asthma. • Childhood obesity has been increasing, approx. 2.5m in England are affected by excess wight or obesity, and oral health is a real cause for concern. LSH highlighted that there is now a cross organisational Board for CYP, and we have launched the NHS England CYP Board. These formally bring together key programmes across NHSE delivering key national commitments and priorities for CYP and will provide the Strategic Delivery committee with a quarterly update. - Recovery of CYP services - High quality care for major childhood conditions - Demand within urgent care LSH outlined that in C&M we have real pockets of poverty, there are challenges to all of us as an ICS, child mortality, SALT and wait times heading towards 2 years. Access to MH Services compared to national figures we have done well, but still not good enough. Obesity is a real problem, but also underweight issues is very worrying. The HCP have made CYP a priority, and it will be key to work with colleagues across the system, along with the voluntary sector to come together. Additionally, the collaboratives have workstreams looking at CYP in hospital and looking to provide services to provide for them better. We are an exemplar, there are others, but C&M is one of them, and we are now talking to ICBs across the country, so we can take decisions locally and work with colleague to tackle the issues. SBR gave thanks for LSH's lead on this, but raised concerns about this on a national level, stating that the Department of Education and local government are not always joined up. LSH agreed, adding that they were in conversations with the national children's commissioner who is looking to get health and children's health together.	

Item	Discussion, Outcomes and Action Points	Action by
	RJA gave thanks to LSH for this, the national role as well as being CEO of Alder Hey. **The board noted the verbal update.**	
ICB/11/23/18	**Cheshire and Merseyside Children & Young People's Committee Establishment**	
	RJA presented a report on the proposal to formerly establish a Children and Young Peoples Committee. AIR questioned the number of children accessing A&E and to include the education of how they can access care at the right time, he noted there was no representation of Primary Care on the CYP Committee. RHU added that the Department of Education and increasing the school sector is independent and equally suggested the representation of a school or college provider to be on the CYP Committee, this is a big part of a young person's life and is key to giving children the best start in life. RJA agreed with the above suggestions and agreed to explore representation. **The board:** • **noted the content of the report.** • **approved the Terms of Reference of the proposed Committee.**	
ICB/11/23/19	**Cheshire and Merseyside Primary Care Access Recovery Improvement Plan**	
	CWA presented an update on NHS C&M's response to supporting access recovery within Primary Care and proposed Primary Care Access Recovery Implementation Plan. It was outlined that this was an aggregated ICB response, and was primarily a GP access recovery plan, there is nothing about dentistry at this time and there is a small amount on pharmacy. National funding has been invested, this has been protected in the recent communications from NHSE, have worked with LMC and Healthwatch and sought assurance from Places. We have made considerable progress on this, and makes asks of our residents to access primary care in a different way. Chris Leese was welcomed to the table and who outlined the plan to support recovery by focussing on four key areas: - Empower patients - Implement modern General Practice Access	

Item	Discussion, Outcomes and Action Points	Action by
	- Build capacity - Cut bureaucracy Jonathan Griffiths was welcomed to the table, he outlined that cutting bureaucracy was one part of the overall report today, and that it was important that of all aspects in the plan the key one is for primary care to deliver, but that this section can only be done by secondary care. There is lots of work detailed in section 7, and is being seen as one of the leading lights in the country on this being produced, it was outline that we should be proud of this and to build on the conversations to make changes and to improve the pathways for patients. In terms of the system approach on self-referral, services like MSK, audiology and weight assessments etc we are looking at timelines of March next year. NRA added that this was not just for general practice, but that it requires engagement with partner organisations and to educate patients with the real aims and achievements of this plan, it is about seeing the right person at the right time. This is about building capacity, not just about seeing a GP, but about the additional roles, ARRS roles and patient education being done nationally. Patients themselves can request to see a physio or dietician etc. Key to cut the bureaucracy, but also within secondary care to reduce the back and forth communications if there was a dedicated channel for discussions between Consultant to Consultant and between patient to GP. It was noted that this wasn't a fix all but will be great steps forward for general practice. AIR outlined concern that the seven common conditions that will no longer be a referral into GP will need really strong comms out to patients. He added that this plan also includes staff other than pharmacist for blood pressure checks etc, and that we should give more thought on how we deal with this as a system, as if this is driven hard there may well be more pressure on undiagnosed blood pressure issues. Particular thanks was given to the primary care health interface work. RHU stated that this was comprehensive work and a great basis to go forwards, adding that she looks forward to how it progresses. It was questioned when developing the dashboard how to integrate EDI into the dashboard and are there things that can be integrated? LBA stated that they have been very much listened to as Healthwatch when putting this together and have taken on board the comments made by our public, Healthwatch all work differently,	

Item	Discussion, Outcomes and Action Points	Action by
	and this would not necessarily have happened over the other places, we just need to be aware of that. Next steps is a common ownership of the understanding, what is going to be sufficient of this board to our public in seeing a real difference. GUR added that there is no such thing as the average general practice, but this about using targeted monies and a significant investment to stabilise our general practice. Health and Wellbeing Board (HWBB) and the Scrutiny Boards, this is the aggregate, and that each place has their own, it would be better for the local HWBB to receive their own version of this, or it was outlined that we can do an executive summary or comms material to produce a summary document. In summary it was outlined there are lots of really important priorities and good progress is being made, it is the question of how do we support? This is about a system approach, not just relying on the doors of GP or primary care, it is about connecting the dots with secondary and others. **The board:** • **noted the content of the report.** • **approved the Primary Care Access Recovery Improvement Plan.**	
ICB/11/23/20	**Cheshire and Merseyside Joint Forward Plan/ NHS Delivery Plan Development & Reporting 2024/25**	
	CWA presented this, stating that the planning guidance has not yet come out, usually it is late December. It was outlined that this was an alignment of a series of steps to comprise an all together fairer approach, to adopt an HCP strategy and the ICB plan. The discussion is how we move this forward as a Board and to also look at our supporting strategies. What is the role of the Board? Would welcome comments as to how you would like to be engaged in the development of this. We as a Board need to be clear to understand the priorities, and then there is the how, what strategy and enablers are going to deliver these. The Board felt that February would be the right time for a development session.	

Item	Discussion, Outcomes and Action Points	Action by
	To wait for the planning guidelines, and to then look to identify a half day to inform Board of the priorities and the 'how'. Will look to do things offline to support this. Update on current years plan, what is successful, and lessons learned. Put it all together from all the Committees. **The board noted the content of the report.**	
ICB/11/23/21	**Cheshire and Merseyside Winter Plan Update**	
	AMI presented the update, outlining the current situation with our providers, now is not the time to be adding in any new focusses, but to deliver the plan that is already there, there are three core elements, and to focus on two key metrics, 'safer' and 'better winter'. This is about how a performance standard is delivered. And the unknown patient. Key points to note; - Number of patients non criteria to reside - Understanding with the acute providers G&A beds that are open - Approach with Ambulance colleagues, and the number of crews on the road SBA outlined the unscheduled plan and that one of the key components is to get people out of hospital sooner and home first, and that when people are in hospital and waiting on discharge having a key focus on fluids and the reablement. In doing this we need to build into next year the elderly or those with poor mental health. Our need to focus on mental health is starting to roll out via the adult mental health framework, allowing people to flag excessive waits in ED and to have more regular multi agency interventions. Demand in mental health has increased and the number of people presenting has increased around crisis avoidance services, this is playing into the more global crisis. MWI added that the C&M approach has been built from the bottom up, from places and working with care communities and Healthwatch. He outlined the issue in Cheshire East, of fewer beds and the deterioration of the structure in MCHFT, increased no criteria to reside and the need to look at the bed base and the loss of beds has been recognised. Primary Care remains fragile, and it was outlined that a very small change in primary care capacity could have a disproportionate effect on our hospitals.	

Item	Discussion, Outcomes and Action Points	Action by
	Outlined that we are now seeing some initial signs of CHC work and this may reflect some of the pressures local authority colleagues are experiencing. **The board noted the content of the report.**	
	Any Other Business	
ICB/11/23/22	**Closing remarks, review of the meeting and communications from it**	
	RJA summarised that it was a good meeting, with good discussion. Questions have been received from members of the public, responses to the questions will be available on the website.	
	CLOSE OF MEETING	
	Consent Items	
ICB/11/23/23	**Confirmed Minutes of ICB Committees:** - **Quality and Performance** - **SPCC** - **FIRC**	
Date, time and location of next meeting		
25th January 2024, 09:00am – 12:30 pm Tower Room, Floral Pavilion Theatre & Conference Centre, Marine Promenade, New Brighton, Wallasey, CH45 2JS		

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2023 - 2024

Updated: **16.01.24**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-41	27/04/2023	**Cheshire & Merseyside System Month 12 Finance Report**	CWI and SBR to work together on the production of a position paper covering social care provision and funding	Claire & Steven Broomhead	TBC		ONGOING
ICB-AC-22-48	25/05/2023	**ICS Financial Plan for 2023/24 and Proposed Budgets for the ICB**	To assign one of the board development days to provide training on a general overview of system finance.	Claire Wilson	June 2023	Added to Board development forward planner	ONGOING
ICB-AC-22-51	23/06/2023	**Cheshire and Merseyside Mental Health, Community and Learning Disability Provider Collaborative - Annual Work Plan 2023-2024**	JRA to present the delivery plan to the board in autumn 2023	Joe Rafferty	Autumn 2023	On Board forward planner for May 2024	ONGOING
ICB-AC-22-57	27/07/2023	**NHS Long Term Workforce Plan**	CSA to provide a quarterly update to Board on the progress against the NHS LTP	Chris Samosa	Jan-24	Moved to March 2024 Board	ONGOING
ICB - AC-22-58	28/09/2023	**Report of the Chief Executive**	IAS to discuss with Public Health Directors making re-connections to look at good practice around dual diagnosis services.	Ian Ashworth & Joe Rafferty	Nov-23	date tbc	ONGOING
ICB-AC-22-59	28/09/2023	**Report of the Chief Executive**	Right Care Right Place - GPU to return Right Care Right Place to board in due course to understand what we can do as in integrated system through each place.	Graham Urwin	Nov-23	date tbc	ONGOING
ICB-AC-22-62	28/09/2023	**Cheshire and Merseyside Winter Plan**	AMA to work with AMI to discuss how bed occupancy rates have been calculated for Mersey and West Lancashire Teaching Hospital Trust.	AMA / AMI	Jan-24		ONGOING
ICB-AC-22-62	30/11/2023	**NHS Impact**	Paper to come back to Board with a focus on improvement, and how this can be done and resourced	RPJ	Mar-24	Added to Board Forward Plan	ONGOING
ICB-AC-22-62	30/11/2023	**Performance Dashboard**	Further metrics around CHC to be added to Performance dashboard	AMI	Mar-24		ONGOING
ICB-AC-22-62							ONGOING
ICB-AC-22-62							ONGOING
ICB-AC-22-62							ONGOING

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS
Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-01	01-Jul-2022	**ICB Appointments (Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Executive Members of the Integrated Care Board:- 1) Claire Wilson, Director of Finance; 2) Professor Rowan Pritchard Jones, Medical Director 3) Christine Douglas MBE, Director of Nursing and Care.. They also agreed that Marie Boles, Interim Director of Nursing and Care, will fulfil this position until the substantive postholder commences.	
ICB-DE-22-02	01-Jul-2022	**ICB Appointments (Non-Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Non-Executive Members of the Integrated Care Board:- Neil Large MBE, Tony Foy and Erica Morriss.	
ICB-DE-22-03	01-Jul-2022	**ICB Appointments (Partner Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Partner Members of the Integrated Care Board:- Ann Marr OBE and Dr Joe Rafferty CBE.	
ICB-DE-22-04	01-Jul-2022	**ICB Constitution**		The Integrated Care Board approved:- 1) The NHS Cheshire and Merseyside Constitution subject to some agreed updates (see action plan ref: ICB-AC-22-01 for details). 2) The Standards of Business Conduct of NHS Cheshire and Merseyside. 3) The Draft Public Engagement/Empowerment Framework of NHS Cheshire and Merseyside. 4) The Draft Policy for Public Involvement of NHS Cheshire and Merseyside.	
ICB-DE-22-05	01-Jul-2022	**Scheme of Reservation and Delegation**		The Integrated Care Board approved:- 1) The Scheme of Reservation and Delegation of NHS Cheshire and Merseyside. 2) The Functions and Decisions Map of NHS Cheshire and Merseyside. 3) The Standing Financial Instructions of NHS Cheshire and Merseyside. 4) The Operational Limits of NHS Cheshire and Merseyside.	
ICB-DE-22-06	01-Jul-2022	**ICB Committees**		The Integrated Care Board approved:- 1) The core governance structure for NHS Cheshire and Merseyside. 2) The terms of reference of the ICB's committees. It also noted the following:- i) The proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board. ii) The receipt of Place based s75 agreements which govern defined relationships with and between specified local authorities and the ICB in each of the 9 Places.	
ICB-DE-22-07	01-Jul-2022	**ICB Roles**		The Integrated Care Board agreed the lead NHS Cheshire and Merseyside roles and portfolios for named individuals, noting that the Medical Director will be the SIRO and the Executive Director of Nursing and Care will be the Caldicott Guardian.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

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ICB-DE-22-08	01-Jul-2022	**ICB Policies Approach and Governance**		The Integrated Care Board:- 1) Noted the contractual HR policies that will transfer to the ICB alongside the transferring staff from former organisations. 2) Endorsed the decision to adopt NHS Cheshire CCG's suit of policies as the ICB policy suite from 1st July 2022. 3) Agreed to establish a task and finish group to set out a proposed policy review process, using the committee structure for policy approval. 4) Noted the intention to develop a single suite of commissioning policies to support an equitable and consistent approach across Cheshire and Merseyside.	
ICB-DE-22-09	01-Jul-2022	**Shadow ICB Finance Committee Minutes Approval**		The Board agreed that the minutes of the Cheshire and Merseyside Shadow ICB Finance Committee held on 30th June 2022 can be submitted to the first meeting of the ICB's established Finance, Investment and Our Resources Committee.	
ICB-DE-22-10	04-Aug-2022	**Cheshire & Merseyside ICB Financial Plan/Budget**		1) The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. 2) The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	
ICB-DE-22-11	04-Aug-2022	**Cheshire & Merseyside System Month 3 (Quarter One) Finance Report**		The Board noted the Month 3 Financial Report.	
ICB-DE-22-12	04-Aug-2022	**Cheshire & Merseyside Month 3 (Quarter One) Performance Report**		The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB-DE-22-13	04-Aug-2022	**Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire**		The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB-DE-22-14	04-Aug-2022	**Virtual Wards – update on their expansion across Cheshire and Merseyside**		The Board noted the Virtual Wards update.	
ICB-DE-22-15	04-Aug-2022	**Responses to questions raised by Members of the Public in relation to items on the agenda**		The Board agreed to respond to all public questions raised prior to the August meeting.	
ICB-DE-22-16	29-Sep-2022	**Chief Executive Report**		1) The Board approved entering into the Sefton Partnership Board Collaboration Agreement 2) The Board approved the recommendation to delegate authority to the Chief Executive and the Assistant Chief Executive to sign off collaboration agreements or memorandum of understanding from other places noting that any arrangements requiring S75 or pooled budget agreements would be submitted to the ICB Board for approval.	
ICB-DE-22-17	29-Sep-2022	**Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal**		1) The Board approved the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation 2) The Board noted the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.	
ICB-DE-22-18	29-Sep-2022	**Developing the Cheshire and Merseyside Integrated Care Partnership (ICP)**		1) The Board approved the appointment of Louise Gittins as the designate Chair of the ICP 2) The Board approved the process for the appointment of a vice chair	
ICB-DE-22-19	29-Sep-2022	**Report of the Audit Committee Chair**		1) The Board approved the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee 2) The Board approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role 3) The Board approved ICB Information Governance Policies and statements / Privacy notices and their subsequent publication	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

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NHS
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Updated: 20 November 2023

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ICB-DE-22-20	29-Sep-2022	**Report of the Chair of the ICB Quality and Performance Committee**		The Board approved the proposed amendments to the revised Terms of Reference for the ICB Quality & Performance Committee	
ICB-DE-22-21	29-Sep-2022	**Report of the Chair of the ICB System Primary Care Committee**		The Board approved the proposed amendments to the Committees Terms of Reference subject to membership from LPS being included.	
ICB-DE-22-22	27-Oct-2022	**Chief Executive Report**		1) The Board noted the contents of the report. 2) The Board approved the recommendation change in the ICB's named Freedom to Speak Up Guardian.	
ICB-DE-22-23	27-Oct-2022	**Welcome to Cheshire East**		The Board noted the contents of the report and presentation.	
ICB-DE-22-24	27-Oct-2022	**Residents Story Update - Social prescribing**		The Board noted the presentation.	
ICB-DE-22-25	27-Oct-2022	**Cheshire & Merseyside System Month 6 Finance Report**		1) The Board noted the contents of this report in respect of the Month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. 2) The Board requested CWA and CDO provide a Workforce Update at the next Board Meeting.	
ICB-DE-22-26	27-Oct-2022	**Cheshire & Merseyside ICB Quality and Performance Report**		The Board noted the contents of the report and take assurance on the actions contained.	
ICB-DE-22-27	27-Oct-2022	**Executive Director of Nursing and Care Report**		1) Noted the content of the report. 2) Noted that CDO would be taking the Kirkup recommendations to the ICB Quality and Performance Committee for consideration. 3) Noted that a Workforce update will be provided within the next Director of Nursing and Care report to the Board Meeting.	
ICB-DE-22-28	27-Oct-2022	**Continuous Glucose Monitoring**		1) The Board approved the retirement of the current Cheshire & Merseyside Continuous Glucose Monitoring (CGM) policy, and 2) The Board approved the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28. 3) Requested that in 12 months' time the Board be provided with a progress update.	
ICB-DE-22-29	27-Oct-2022	**Provider Collaborative update**		1) Noted the content of the report. 2) Agreed that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration.	
ICB-DE-22-30	27-Oct-2022	**System Finance Assurance Report**		The Board noted the contents of the report and the development of the financial accountability framework.	
ICB-DE-22-31	27-Oct-2022	**Winter Planning 2022-23**		1) The Board noted the contents of this report for information. 2) The Board agreed that an updated position on winder resilience plans is reported to the Board at a future meeting	
ICB-DE-22-32	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee**		1) The Board noted the items covered by the Remuneration Committee. 2) The Board approved the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).	
ICB-DE-22-33	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**		The Board noted the contents of the report.	
ICB-DE-22-34	27-Oct-2022	**Report of the Cheshire & Merseyside Chair of the ICB Transformation Committee**		1) The Board noted the report 2) Approved the revised terms of reference attached to the paper.	
ICB-DE-22-35	28-Nov-2022	**Cheshire and Merseyside ICS Digital Strategy**		Endorsed the ICS Digital and Data Strategy with a view to formal approval at a subsequent ICB Board meeting.	
ICB-DE-22-36	28-Nov-2022	**Consensus on the Primary Secondary Care Interface**		Endorsed the consensus Agreed on the proposed actions for implementation: ongoing promotion to Secondary Care via the Trust Medical Directors recommendation for the formation of Primary Secondary Care Interface Groups based around Acute Trusts across Cheshire and Merseyside	
ICB-DE-22-37	28-Nov-2022	**Report of the Chair of the Finance, Investment and Resources Committee**		Approved the revised terms of reference attached to the paper	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

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Cheshire and Merseyside

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ICB-DE-22-38	23-Jan-2023	**Report of the Chief Executive - Harmonising Clinical Commissioning Policies Update**		Approved the revised Legal statement as detailed within Appendix Two, as reviewed by Hill Dickinson	
ICB-DE-22-39	23-Jan-2023	**Review of Liverpool Clinical Services**		Noted the content of the report Agreed all the recommendations within the report; however with regards those recommendations to be overseen by CMAST the Board removed from the recommendations the sentence 'the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool.' Only once tangible progress is made within this scope should it be broadened to a wider geography Agreed the implementation plan and associated timescales	
ICB-DE-22-40	23-Jan-2023	**Cheshire & Merseyside Integrated Care Partnership Interim Draft Strategy 2023-24**		Noted the contents of the draft interim strategy Endorsed the next steps agreed by the Health and Care Partnership at the meeting of 17 January 2023; including the ICB using the priorities within the draft interim strategy to inform development of the ICB Five Year Joint Forward Plan	
ICB-DE-22-41	23-Jan-2023	**NHS 2023/24 Priorities and Operational Planning Guidance**		Noted: The content of the 2023-24 NHS planning guidance, including the need to develop both 2-year operational plans and an ICB Joint Forward Plan The approach to developing our Cheshire and Merseyside plans including the role of providers in developing and approving plans as well as the need to engage with the HCP partners and HWB in developing the content of the plans. That the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023. The need for review by the ICB Executive Team and Provider Collaboratives before submission and review, and ratification at the February Board meeting which takes place on the day of submission. That the final submissions would be presented to the Board for approval in March 2023	
ICB-DE-22-42	23-Jan-2023	**Report of the Chair of the Cheshire & Merseyside ICB Audit Committee, including amendments to the ICB SORD & SFIs**		Noted the items covered during the Audit Committee of 13 December 2022 report. Approved the Operational Scheme of Delegation Update, December 2022	
ICB-DE-22-43	23-Feb-2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**		Approved the annual ICB proposed Equality Objectives 2023 to 2024 (Appendix One, section six) subject to the amendment the fourth Equality objective (Empower and engage our leadership and workforce) explicitly showing 'to address overall inequalities'.	
ICB-DE-22-44	23-Feb-2023	**Cheshire & Merseyside ICB Risk Management**		Approved the Risk Management Strategy attached at Appendix One Approved the proposed Board Assurance Framework report format Approved the core statement and risk appetite definitions included in the draft Risk Appetite Statement	
ICB-DE-22-45	23-Feb-2023	**Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB**		Noted and supported the work undertaken to date in relation to the delegation of Ophthalmic and Dental Services on 1 April 2023	
ICB-DE-22-46	23-Feb-2023	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**		Approved the legacy policies as described at Section 5 of the report	
ICB-DE-22-47	23-Feb-2023	**Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Our Resources Committee**		Approved the updated Committee Terms of Reference	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-48	30-Mar-2023	**Northwest Specialised Commissioning Joint Working Agreement (Clare Watson)**		• noted the contents of the report • approve the ICB entering into a Joint Working Agreement and progressing the work to establish statutory joint committee arrangements with NHSE and NHS Greater Manchester and NHS Lancashire and South Cumbria ICBs for the 2023/24 period • approve delegating authority to the Assistant Chief Executive to sign the Joint Working Agreement on behalf of NHS Cheshire and Merseyside to enable these commissioning arrangements to 'go live' from April 2023 • note that further engagement will be undertaken with members of the three ICB Boards in developing and agreeing the Joint Committee Terms of Reference.	
ICB-DE-22-49	30-Mar-2023	**Cheshire and Merseyside Cancer Alliance Update**		•noted the contents of this report and ongoing efforts to improve operational performance and outcomes. •approved ongoing constructive conversations with colleagues at place and at corporate ICB around sustaining and embedding some of the improvements discussed. •noted that the alliance is keen to explore how it may support the ICB with its new commissioning duties for specialised cancer services which are to be delegated to the ICB from NHS England.	
ICB-DE-22-50	27-Apr-2023	**Intelligence Into Action: Continued provision of ICS digital and data platforms**		The Integrated Care Board •approved the allocation of funds to support option 2, which will allow for: othe continued provision of the existing population health and data platform and associated shared care record over a transition period of two years. othe continued provision of the integrated (within CIPHA) C2Ai PTL tool across the 10 acute Trusts to support risk-adjusted triage and prioritisation of the Patient Treatment List (PTL).	
ICB-DE-22-51	27-Apr-2023	**NHS Cheshire and Merseyside ICS NHS Staff Survey 2022-23: Results and Actions**		The Integrated Care Board •noted the staff survey results and •endorsed the actions taken to review and respond to the Staff Survey results 2022.	
ICB-DE-22-52	27-Apr-2023	**Briefing on the national maternity and neonatal services delivery plan**		The Integrated Care Board noted the report and endorsed the terms of reference for the Women's Committee.	
ICB-DE-22-53	25-May-2023	**Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative - Annual Work Plan 2023-2024**		•noted the approach and progress made by CMAST •endorsed the commitments made in the workplan as part of C&M's wider delivery undertakings.	
ICB-DE-22-54	25-May-2023	**Cheshire & Merseyside ICB Board Assurance Framework (BAF)**		•approved the adoption of the principal risks proposed at appendix A for inclusion in the Board Assurance Framework and consider whether any further risks should be included. •noted the current risk profile, proposed mitigation strategies and priority actions for the next quarter and consider any further action required by the Board to improve the level of assurance provided. •noted the establishment of the ICB Risk Committee.	
ICB-DE-22-55	25-May-2023	**Marking NHS@75 years and NHS Cheshire and Merseyside@ 1 year**		•noted the content of the report, acknowledging that it represented work in progress •supported related communications and staff engagement activity in line with plans outlined, particularly through key internal meetings and meetings in public, as well as a series of informal gatherings across the ICS estate	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-56	29-Jun-2023	**Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24**		The Integrated Care Board •Approved the publication of the 2023-28 Joint Forward Plan on 30 June, including the 2023-24 delivery plan subject to any changes of non-material nature being delegated to GPU •Endorsed developing the Joint Forward Plan for 2024-2028 to be a document more aligned as a delivery plan for the final Cheshire and Merseyside HCP Strategy with the use of an annual NHS Cheshire and Merseyside ICB delivery plan to reflect any additional NHS specific content which sits outside of the shared priorities within the HCP Strategy	
ICB-DE-22-57	29-Jun-2023	**NHS Cheshire and Merseyside ICB Annual Report and Accounts 2022-23 & Cheshire and Merseyside CCG 3 Month Reports 2022-23**		The Integrated Care Board •approved the nine CCG Annual Reports and Accounts for submission to NHS England by 30 June 2023. •approved the ICB Annual Report and Accounts for submission to NHS England by 30 June 2023.	
ICB-DE-22-58	29-Jun-2023	**Primary Care Strategic framework and update on the Cheshire and Merseyside delivery plan for recovering access to primary care**		The Integrated Care Board: •noted the paper and draft Primary Care Strategic Framework and comment on the content •noted the engagement that has taken place and comment on this, describing any potential gaps •approved the first two chapters of the Framework subject to minor changes. CWA would report on these at Primary Care Committee •approved ongoing work to develop the final two chapters •approved the development of a workplan based on the Framework to inform ongoing plans •noted that the final Framework with all chapters be brought to Board within the next 6 months. •noted the presentation on the Primary Care Access recovery Plan	
ICB-DE-22-59	29-Jun-2023	**Winter Debrief and Urgent Emergency Care Improvement Programme**		The Integrated Care Board noted the contents of this report, in particular the establishment of the Urgent Care Improvement Programme and associated governance.	
ICB-DE-22-60	29-Jun-2023	**Northwest Specialised Commissioning Joint Committee Terms of Reference**		The Integrated Care Board •noted the update provided on the first meeting of the shadow North West Specialised Services Joint Committee •approved the Terms of Reference for the North West Specialised Services Joint Committee •approved the recommendation regarding delegating authority to the Assistant Chief Executive to approve any minor amendments to the Terms of Reference that may be required following consideration by the other two North West ICB Boards.	
ICB-DE-22-61	27-Jul-2023	**Northwest BAME Assembly Anti-Racism Framework**		The Integrated Care Board •approved the adoption of the Northwest BAME Assembly Anti-racism Framework by the ICB and the proposed approach for implementation. •acknowledged that the framework would be used during the development of the 2024-25 (commissioning) Planning Round •noted that the involvement of our clinical leaders, around accountability, was key to success	
ICB-DE-22-62	27-Jul-2023	**Transformation Committee**		The Integrated Care Board: •noted the contents of this report •approve delegated authority to the Transformation Committee to formally approve the Specialised Services PDAF submission being made in September.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-63	28-Sep-2023	**Executive Director of Nursing & Care Update Report (Sept 2023)**		The Integrated Care Board noted the content of the report. • East Cheshire - will be returned to via the Quality Committee. • SEND - partnerships are required for improvement. • Help the Board to understand through a periodic report to triangulate and identify key topics and trends emergent across the region.	
ICB-DE-22-64	28-Sep-2023	**Report of the Chair of the Cheshire and Merseyside ICB Audit Committee (September 2023)**		The Integrated Care Board approved the terms of reference and noted the content of the reports.	
ICB-DE-22-65	28-Sep-2023	**Report of the Chair of the Cheshire and Merseyside ICB Remuneration Committee (August & September 2023)**		The Integrated Care Board noted the content of the report with the caveat to the Terms of Reference.	
ICB-DE-22-66	28-Sep-2023	**Cheshire and Merseyside ICS Digital and Data Strategy Update**		The Integrated Care Board endorsed and noted the content of the report.	
ICB-DE-22-67	28-Sep-2023	**Amendments to the Cheshire and Merseyside ICB Operational Scheme of Reservation and Delegation**		The Integrated Care Board were all in agreement for approval and noted the report.	
ICB-DE-22-68	30-Nov-2023	**September 2023 Board Meeting Minutes**		The Board approved the minutes of the NHS C&M ICB Board meeting of 28th September 2023.	
ICB-DE-22-69	30-Nov-2023	**ICB Chairs Report**		The Board supported the Chair recommendation for the establishment of an additional Ordinary (Partner) Member of the Board (VCFSE)	
ICB-DE-22-70	30-Nov-2023	**ICB Chairs Report**		The Board approved the Terms of Reference of the Cheshire and Merseyside Health and Care Partnership	
ICB-DE-22-71	30-Nov-2023	**ICB Chief Executive Reports**		The Board approved the Terms of Reference for the ICB Thirlwall Inquiry Task and Finish Group	
ICB-DE-22-72	30-Nov-2023	**Board Assurance Framework Q2 Update**		The Board noted the BAF Q2 update and approved the amended risk description for P3, changes to current risk ratings for P2 and P8 and increased target scores for P6 and P10 as described	
ICB-DE-22-73	30-Nov-2023	**Women's Hospital Services in Liverpool Programme Governance Refresh**		The Board approved the proposed changes to the current Women's Services Programme governance as presented in the report.	
ICB-DE-22-74	30-Nov-2023	**Cheshire and Merseyside Children & Young People's Committee Establishment**		The Board approved the Terms of Reference of the ICB Children and Young People Committee	
ICB-DE-22-75	30-Nov-2023	**Primary Care Access Recovery Plan**		The Board approved the Cheshire and Merseyside Primary Care Access Recovery Improvement Plan	

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Report of the Chief Executive

Agenda Item No: ICB/01/24/07

Responsible Director: Graham Urwin, Chief Executive

Report of the Chief Executive (January 2024)

1. Introduction

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

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **note** the updates as outlined within the report
- **approve** the recommendation to delegate authority to the ICB Transformation Committee to approve on behalf of the ICB the Specialised Commissioning documentation and agreements as outlined in 3.17.

3. Showcasing our Staff

3.1 Working with our Staff Engagement Forum (SEF) we have developed a Campaigns Calendar to support and engage our staff. The aim of the calendar is to engage our staff in a number of national and local Health & Well-Being, Equality, Diversity and Inclusion campaigns and events throughout the year.

3.2 To support this initiative we are currently promoting two awareness campaigns with our staff, Disability History Month and LGBT History month, with the aim of celebrating our diverse staff and supporting our staff with information, resources and the opportunity to share their stories.

3.3 More information can be found in this month Director of Nursing and Care report to Board, and I am delighted that we will be hearing from Owen Ashworth, Commissioning Support Officer and co-Armed Forces Place Lead for Halton Place and the Chair of our Disability and Neurodiverse Network as part of the Boards resident/staff story section.

4. System Pressures

4.1 The latest industrial action periods took place between 20 December 2023 to 23 December 2023 (BMA and HCSA Junior Doctors) and 03 January 2024 to 09 January 2024 (BMA Junior Doctors). In addition, Clinical Support Workers at Wirral University Teaching Hospital NHS Foundation Trust, are taking industrial action every Monday-Saturday throughout December 2023 and January 2024.

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

4.3 Ahead of the industrial action the ICB worked closely with all providers and with NHS England to assess plans including the ability to cover and maintain urgent and emergency care, along with key outpatient and inpatient services, across elective care, cancer care, maternity and specialised services.

4.4 Broadly speaking, provider plans and mitigations focused on protecting urgent and emergency care, along with the highest priority elective and cancer surgeries. In order to do this, the majority of providers needed to curtail outpatient activity and some elective activity in order to fulfil these priorities. The impacts of this are detailed in Table One.

Table One

Dates of industrial action	Sum of Inpatient	Sum of Outpatient	Total Cancelled
20 Dec – 23 Dec 2023	374	4656	5030
03 Jan – 09 Jan 2024	558	5392	5950
Total for last 2 periods of industrial action	**932**	**10048**	**10980**

4.5 During the periods of industrial action, no derogations were requested, and no significant areas of concern relating to the industrial action itself were escalated. However, this is not to diminish the impact of the industrial action in particular on the elective programmes for all providers, and on overall delivery, given that it is widely understood that December and January are times of significant pressure within Urgent and Emergency Care.

5. Thirlwall Inquiry

5.1 The Thirlwall Inquiry has commenced and the ICB received a Rule 9 Request on 09 November 2023. The Rule 9 Request is a witness statement from myself as the ICB Chief Executive and covers both the ICB and our legal predecessors, specifically NHS Cheshire CCG (in existence from 1 April 2020 – 30 June 2022) and NHS West Cheshire CCG (in existence from 1 April 2013 – 31 March 2020), due to their commissioning responsibilities and liaison with the Countess of Chester Hospital.

5.2 A draft copy of the ICB witness statement and supporting evidence was requested to be submitted on 10 January 2024 but the deadline did not allow us the adequate time to ensure that all relevant information is provided. A formal request was submitted for a two week extension which was accepted by the

Inquiry. The revised deadline for submission of the draft ICB witness statement and supporting evidence is 24 January 2024.

5.3 The ICB is on track to meet this deadline, with the final draft being signed off by the Thirlwall Inquiry Task and Finish Group on 22 January 2024. The Inquiry have advised they will make a decision on whether the ICB will be named a Core Participant following the review of our witness statement.

5.4 We continue to support our staff who are directly involved, and have a staff session scheduled with our Solicitors on 22 January 2024.

5.5 The Inquiry have advised that they will not start hearing evidence until September 2024 due to ongoing police investigations, Lucy Letby lodging an application for leave to appeal against her convictions and the retrial on a count of attempted murder.

6. Board to Board with Mid Cheshire Hospitals NHS Foundation Trust

6.1 On 11 January 2024, a number of ICB Board members had the opportunity to visit and meet with Board colleagues from Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) at the Leighton Hospital site in Crewe. This meeting provided opportunity for members of the ICB Board to tour the facilities at the hospital site as well as to acknowledge the quality improvements and substantial efforts of the local system in coping with the pressures brought on by the latest round of industrial action.

6.1 The meeting also provided opportunity for ICB Board members to hear more about MCHFTs involvement in the national New Hospital Programme and the planning work currently underway. Further information on this will be provided to the Board at a future date however there will be an item on this at the March 2024 ICB Board meeting where MCHFT will be seeking a letter of support from the ICB Board to their strategic outline case prior to submission to NHS England. An outline business case is due by summer 2025.

6.2 Specialised Commissioning. In December 2023 the NHS England Board approved the three North West ICBs taking full delegated responsibility from April 2024 for the 59 defined specialised services with a condition that delegated specialised commissioning allocations 2024/25 will be ringfenced to be spent only on specialised commissioning services. Full details of the recommendations NHS England Board considered and approved can be found here.[1]

6.3 The North West Specialised Services Committee (NWSSC) continue to oversee the preparation for this delegation with the following workstreams established to develop the future Target Operating Model (TOM), and as part of this using the nationally developed Safe Delegation Checklist:

- Governance (including risk management)

[1] https://www.england.nhs.uk/long-read/meeting-of-the-board-of-nhs-england-7-december-2023-agenda/

- Finance and Contracting
- Quality
- Strategy, Commissioning and Transformation
- Pharmacy
- Data and Intelligence.

6.4 The TOM will be used to inform how the NHS England Team work with, and on behalf of the three ICBs in discharging our responsibilities. In support of this we are reviewing not only how we work at a North West level but also within the ICB through the development, in advance of April, of an operational sub group of the Transformation Committee which would also link into both the Quality and Performance Committee and Finance, Investments and Resources Committee where appropriate.

6.5 In advance of finalising the TOM more integrated ways of working are already being embedded through the working groups described above, for example in relation to the development of shared commissioning intentions through Strategy, Commissioning and Transformation facilitating NHS England team members working closely with the relevant ICB Programmes to align plans. These arrangements will be reflected in updates to the existing Joint Working and Collaboration Agreements between the North West ICBs and NHS England, as outlined below:

Agreement	Description (note all documents based on national template with local information included)
NWSSC Terms of Reference	Update of the existing Terms of Reference to recognise the formal delegation of services
Commissioning Team Agreement (previously called MOU for Commissioning Hub)	Describes the responsibilities that will be undertaken by the NHS England North West Specialised Commissioning Team on behalf of the ICBs and will reflect the agreed North West TOM.
Delegation Agreement	This replaces the existing Joint Working Agreement and enacts delegation and transfers statutory commissioning responsibility for delegated specialised services from NHS England to the ICB.
ICB Collaboration Agreement	Describes how the North West ICBs work together in commissioning specialised services at a regional footprint.

6.6 It is proposed that the revisions to these agreements, alongside the TOM, are considered and approved at the March 2024 ICB Transformation Committee with a summary paper produced outlining the key points brought to the ICB Meeting at the end of March 2024. **The Board is asked to:**

- **approve** the delegation to the Transformation Committee for the review and approval of the:
  - North West Specialised Services Target Operating Model
  - NWSSC Terms of Reference
  - Commissioning Team Agreement
  - Delegation Agreement

- ICB Collaboration Agreement.

6.7 A summary paper outlining the key points from the TOM and the final agreements described above will be brought to the March 2024 ICB Board Meeting, including copies of the agreements.

6.8 **Update on Liverpool University Hospitals FT (LUFHT) progress around Electronic Patient Records.** In December 2023 the ICB provided a letter of support to LUFHT towards their application for Public Dividend Capital funding for the Electronic Patient Record (EPR). Subsequently I am pleased to say that after a great deal of work from the LUHFT team with support from ICB and Regional colleagues, the Trust's Outline Business Case was presented to the Frontline Digitisation Programme's Fundamental Criteria Review Panel and successfully met the requirements of that stage review. It has now moved on to the next phase, which is a Subject Matter Expert detailed review. This represents a more detailed examination of the case and will generate a query of log of questions. The Trust will have one week commencing 01 February 2024 to respond. Subject to successfully addressing any queries raised, the case will be finally considered at the national EPRIB committee scheduled for 13 March 2024. The Trust has resources aligned to respond to query phase and is planning to go to market immediately if the full case is approved in March.

6.9 LUHFT aim to procure an EPR that realises the following objectives:

- eliminate variation in process.
- reduce delays.
- deliver better outcomes.
- improve staff & patient experience and satisfaction.
- increase efficiency.
- make better use of data.

6.11 NHS Cheshire and Merseyside ICB support the principles and objectives of an EPR, benefiting patients and staff, which align with system wide strategies. Successful implementation will meet the Secretary of State commitment for all Trusts to have an EPR by March 2025 and achieve Frontline Digitisation Digital Capability Framework Core Capabilities and meet the What Good Looks Like Criteria. The ICB will also be involved with the appropriate governance board which will be overseeing the procurement and implementation of the EPR.

7. Death Certification

7.1 Death Certification Reforms are expected to be implemented by April 2024. Legislation is in final preparation to go before Parliament.

7.2 It has long been established that, following a death, the case will either follow the path of medical certification by a medical practitioner or investigation by a coroner. This will remain the case in the new system, but with important differences.

7.3 NHS England and NHS Wales Shared Services Partnership started implementing the medical examiner system on a non-statutory basis in 2019. Medical examiners are now scrutinising almost all deaths in acute trusts and a growing proportion of deaths in all other healthcare settings (including the community). This includes multiple other care settings – care homes, intermediate settings and community care. General Practitioners who attend to patients then work with the medical examiner to manage certification and make decisions about the role of the coroner for each individual case.

7.4 It has increasingly become standard practice for medical examiners to provide independent scrutiny of deaths not taken for investigation by a coroner. Medical examiner scrutiny is not mandated in the non-statutory system. However, once the new death certification reforms come into force, there will be an independent review of all deaths in England and Wales, without exception. This will either be provided by independent scrutiny by a medical examiner or by investigation by a coroner.

7.5 The main change is that attending practitioners must share the death certificate and proposed cause of death with a medical examiner, who will scrutinise these before submission to the registrar.

7.6 Medical examiners have been carrying out independent scrutiny of causes of death since implementation of the non-statutory medical examiner system. They will continue to carry out these activities in the same way in the new death certification process, but independent scrutiny by a medical examiner will become a statutory requirement prior to the registration of all non-coronial deaths in England and Wales.

7.7 In England, the role of Integrated Care Boards (ICBs) will be to contact all healthcare providers in their area and require them to establish processes to refer relevant deaths to medical examiner offices for independent scrutiny. This will be undertaken and overseen by the Medical Directorate of the ICB.

8. Social Value in Health Bronze Award

8.1 NHS Cheshire and Merseyside has become the first organisation in the UK to receive a new award for social value in health. The Social Value Quality Mark (SVQM): Health Award[2] was launched in November 2023 through a partnership with the Social Value Quality Mark CIC and NHS Arden and GEM Commissioning Support Unit.

8.2 The Bronze Award recognises the efforts that the ICB is making towards achieving its social value goals and its ambition to involve the whole health and care system in Cheshire and Merseyside. SVQM Auditors particularly noted the organisation's progress in introducing a new Anchor Framework, which is bringing NHS, Local Authorities and Voluntary, Community, Faith and Social Enterprise sector (VCFSE) organisations together to explore how social

[2] https://socialvaluequalitymark.com

value can be practically and effectively embedded across the region; working together to reduce health inequalities and improve health and wellbeing.

9. Community Diagnostics Centre – Congleton

9.1 Just prior to Christmas, the 10th Community Diagnostics Centre (CDC) in Cheshire and Merseyside was opened on the site of Congleton War memorial Hospital, Congleton, Cheshire, and run by East Cheshire NHS Trust.

9.2 Cheshire and Merseyside Cancer Alliance[3] has been working with hospital trusts and NHS Cheshire and Merseyside to create a network of CDCs, which bring greater capacity to carry out vital NHS tests and scans in locations away from the pressures of a busy acute hospital providing emergency care, but close to where patients live. They offer tests to people referred by their GP or other health professionals to check for a wide range of conditions, including cancer.

10. AI Diagnostic Funding

10.1 NHS Cheshire and Merseyside's Radiology Imaging Network (CAMRIN)[4] has been successful in securing c£820,000 funding from the NHS Transformation Directorate's AI Diagnostic Fund[5], to accelerate the deployment of an AI imaging and decision support tool that will help ten of our Acute and Specialists Trusts across the Network in Cheshire and Merseyside to diagnose lung cancer patients more quickly, to improve their outcomes.

10.2 The funding will be used to implement a new AI tool to analyse chest X-Ray images, where it will be able to identify nodules and masses, on Chest X-Ray radiographs, which can indicate possible lung cancer. Then images that contain these abnormalities will be prioritised for reporting, enabling radiologists and reporting radiographers, to ensure patients who need further diagnostics and care will receive this as soon as possible, to improve their outcomes

10.3 The funding will enable imaging services within the Trusts to become more efficient and effective, helping to reduce the rising demand for diagnostics, and the growing backlog, whilst also minimising the administrative burden on clinical staff, to better maximise the use of their time.

[3] Home :: Cheshire & Merseyside Cancer Alliance (cmcanceralliance.nhs.uk)
[4] https://www.cheshireandmerseyside.nhs.uk/your-health/provider-collaboratives/cmast/diagnostics/radiology-imaging-network/
[5] https://transform.england.nhs.uk/ai-lab/ai-lab-programmes/ai-in-imaging/ai-diagnostic-fund/

11. Brick by Brick: Resources to support mental health hospital-to-home discharge planning for autistic people and people with a learning disability

11.1 NHS England published *Brick by Brick: Resources to support mental health hospital-to-home discharge planning for autistic people and people with a learning disability*[6] was in October 2023.

11.2 *Brick by Brick* provides resources to support mental health hospital-to-home discharge planning for autistic people and people with a learning disability. The protocol will help practitioners such as social workers, occupational therapists, clinicians, Care (Education) and Treatment Review (C(E)TR) leads, and commissioners working in local health and social care systems to identify housing options for autistic people and people with a learning disability, who are inpatients in mental health hospitals. The aim is to ensure that housing is planned and sourced much earlier within discharge process, to enable people to be discharged in a timely manner into community-based housing settings.

11.3 NHS Cheshire and Merseyside's *Transforming Care* programme already provides support to health and care professionals to facilitate effective hospital-to-home discharge planning for autistic people and people with a learning disability. Actions to date include:

- commissioning a housing needs analysis with our nine Places to understand the needs of all people with a learning disability and/or autism, whether living in the community or being cared for as an inpatient.
- employing a Housing Lead to support the response to the housing needs analysis, which includes a Cheshire and Merseyside Housing Strategy for people with a learning disability and/or autism.
- tracking the care journey of every person with a learning disability and/or autism who are resident in an inpatient setting, identifying their housing requirements on discharge.
- supporting local authorities to access capital funding to support housing developments and ensuring transition costs are also covered.
- ensuring that local health and care services are available to support discharge, formally reviewing these four weeks post discharge to ensure these arrangements are sufficient.

11.4 In response to *Brick to Brick* the *Transforming Care* team will be working with health and care professionals and housing providers to:

- ensure that housing need applications are completed as soon as possible after admission if it is known the person requires a house or alternative accommodation.
- identify whether the individual is a person has been evicted or has lost or is at risk of losing their current property.
- incorporate the recommendations from *Brick by Brick* into the existing Discharge Preparation Tool and C(E)TR documentation and processes.

[6] https://www.england.nhs.uk/long-read/brick-by-brick-resources-to-support-hospital-to-home-discharge-planning/#:~:text=download%20and%20adaptation.-,Aims%20and%20objectives,housing%20that%20meets%20their%20needs.

- support culture change to ensure MDTs are proactive in considering housing needs when someone is admitted to hospital.
- continue to invest into the areas of most need as appropriate
- continue to access capital funding through NHS England and other sources.
- work with local authorities on their Supported Housing Strategies formed under the Supported Housing (Regulatory Oversight) Act 2023 to identify gaps for the cohort of people currently placed out of area.

12. NHS App

12.1 The NHS App allows anyone over the age of 13, registered with a GP Practice, to access a range of NHS services. People can download the NHS App on a phone or a tablet, and people can also access the same services in a web browser by logging in through the NHS website. Starting this week (w/c 15 January 2024), public awareness campaigns will also start to be communicated through the app. Over 1.2million people (54%) across Cheshire and Merseyside are registered with the NHS App and practices across the ICB are making functionality available to allow our citizens to order repeat prescriptions, view medical records, receive secure messages and book appointments online as part of the Primary Care Access Recovery Plan. Digital Inclusion initiatives are in place across Cheshire and Merseyside to support people with downloading, registering and using the NHS App.

12.2 Additionally, in secondary care, Trusts are implementing patient portal functionality which allows patients to access hospital letters, view appointment details, receive messages, and access other information relevant to their care and treatment. Trust-based portals will also integrate with the national NHS App, helping to provide a 'single digital front door'. NHS organisations in Cheshire and Merseyside are also planning work with NHS England to refine test result functionality in the NHS App for future roll out

13. Enhancing GP direct access to diagnostic tests for patients with suspected chronic obstructive pulmonary disease, asthma, or heart failure guidance

13.1 NHS England have recently published guidance[7] which requires us to ensure that there is GP direct access to three key tests (a Fractional Enhaled Nitric Oxide (FeNo) test, Spirometry and NT pro-BNP blood tests) which will support earlier detection of COPD, asthma or heart failure. Achieving compliance with this national guidance is critical to support the ICS deliver on it's CORE20PLUS5 priorities, reduce health inequalities and ensure that conditions are detected and managed to prevent further health decline. For this reason, this is a key objective for the Cheshire and Merseyside Diagnostics Programme.

[7] https://www.england.nhs.uk/long-read/enhancing-gp-direct-access-to-diagnostic-tests-for-patients-with-suspected-chronic-obstructive-pulmonary-disease-asthma-or-heart-failure/

13.2 The Cheshire and Merseyside Diagnostics Programme is working collaboratively with the Cheshire and Merseyside Respiratory and Cardiac Networks to enhance GP access to these tests. Planning meetings with the networks commenced in December 2023. A diagnostic test mapping survey was previously commissioned by the Diagnostics Programme to baseline diagnostic test service provision availability, which included these key tests. NT pro-BNP, Spirometry and Reversibility testing is available in across all 9 places in C&M. Accessibility for patients is variable.

13.3 FeNo testing for asthma is available in three places currently. Proposals and mobilisation expansion plans are being drawn up. **Heart Failure.** NT pro BNP testing is available across all nine places in C&M. The C&M Pathology Network has committed to provide a NTpro-BNP service within 48 hours for primary care. A review on the service provided for Acute Heart Failure is under review, with plans under development for full implementation in Q3 of 2024/45. A best-practice heart failure clinical pathway has also been produced in Cheshire and Merseyside to develop services and improve clinical outcomes for people with, or at risk of, heart failure. This pathway supports case-finding and early diagnosis of heart failure within primary care.

13.4 Spirometry and Reversibility testing for diagnosing COPD is available across all nine Places in Cheshire and Merseyside. The level of service provision and access to testing varies though between Places. The availability of FeNo testing for asthma is lower than the COPD provision, due to the priority focus being placed upon COPD patients. The next steps are to progress plans to increase the spread and adoption of FeNo, spirometry and reversibility testing across all nine Cheshire and Merseyside places.

14. Congratulations

14.1 **2024 New Year Honours List.** I would like to express my congratulations to the 26 people from across the Cheshire and Merseyside system who received well-deserved recognition for the services to our patients and communities in the 2024 New Year Honours List. The single most important driver of Cheshire and Merseyside's health and care system is the expertise and dedication of its people. More details on the recipients of New Years Honours from across Cheshire and Merseyside can be found at: https://www.cheshireandmerseyside.nhs.uk/posts/health-and-care-leaders-among-those-recognised-in-2024-new-year-honours-list/

14.2 **Healthcare Financial Management Association (HFMA) Presidency**. Congratulations also to Claire Wilson our ICB Director of Finance who has taken on the position of HFMA president from December 2023. Claire has been a Trustee on the Board of the association for the last five years and has taken on the role of president for the 2024 term. The HFMA is the professional body for finance staff working in healthcare. It is a charitable organisation that promotes best practice and innovation through its local and national networks. The association

analyses and responds to national policy and aims to exert influence in shaping the healthcare agenda with the aim of supporting better quality health and social care through effective use of resources.

14.3 Claire has set the theme of 'Working as One' for her year in office. Core to this is emphasising the important role that finance professionals have in the NHS in building unity of vision and purpose across all partners in the system, across different professions and across the finance function. We are incredibly supportive of Claire in undertaking this prestigious role and believe that there are strong synergies with our work in Cheshire and Merseyside and an opportunity for us to share and learn from innovative work from across the UK as she carries out her duties. Claire also chairs the HFMA ICB CFO forum which includes Finance Directors from most ICBs across the country with the aim of supporting members and sharing learning and best practice.

15. Decisions taken at the Executive Committee

15.1 Since the last Chief Executive report to the Board in November 2023, the following items have been considered by the Executive Team for assurance or for discussion:

- **People Services Update:** this report provided the Executive Team with a monthly overview of the organisation and system workforce, and the activities of the People Team related to these. The Executive Team supported the recommendations to introduce a staff recognition scheme and a staff suggestion scheme, and noted progress around the development of a standard organisational induction programme.
- **C&M Directors of Childrens Services Change and Integration Programme**: this report provided an update to the Executive Team on the work underway across the region within this programme to make an impact on and deliver improvements for children in the areas of emotional wellbeing and mental health, Early Help and Prevention, Childrens Workforce, Residential Commissioning Sufficiency and SEND. The Executive Team noted the report and the progress made, risks outlined as well as future plans.
- **All-Age Continuing Care (AACC) Review Update Report:** this report provided an update to the Executive Team on the AACC review currently underway, and which outlined progress of the review implementation, timelines for mobilisation of a new hybrid model, anticipated resource requirements to achieve this, risks and issues. The Executive Team noted the update report and agreed for a formal paper to come to the ICB Board at a future meeting.
- **Mental Health and Learning Disability (MHLDC) Provider Collaborative Update:** this report provided the Executive Team with a detailed update on the workplan areas of the collaborative, key contacts leading programmes of work and recent developments within the collaborative which included the development of an intermediate care dashboard, adoption of delivering the Virtual Ward programme on behalf of the ICS and its improvement strategy, the establishment of the Collaborative Board and development of a Community Services Strategy. The Executive Team noted the report and thw

intention of the collaborative to bring an update to the ICB Board in May 2024.

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

16. Officer contact details for more information

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Meeting of the Board of NHS Cheshire and Merseyside

24 January 2024

The Director of Nursing and Care Report

Agenda Item No: ICB/01/24/09

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

The Director of Nursing and Care Report

1. Purpose of the Report

1.1 The report offers a position update to the Board of safeguarding activity across our nine Places through a brief overview of highlights, progress, achievements, and challenges in accordance with our statutory responsibilities.

1.2 The report also provides Board with an update on highlights, progress, achievements, and plans in relation to the ICB workforce.

2. Executive Summary

2.1 During December 2023 the national guidance "Working Together to Safeguard Children"[1] was updated and offers a statutory blueprint for a system wide approach to supporting (and safeguarding) children and young people.

2.2 The main amendment to the updated guidance is the addition of a new chapter focused on the importance of partnership working in prevention of neglect or harm (*including exploitation, serious violence +/or homelessness*) for children and young people up to their 18th birthday and the role of all agencies in offering proactive Help, Support and Protection. The inclusion of a new chapter clearly emphasises a shared responsibility by all agencies and focuses on the principles of working with parents and carers to offer tailored support.

2.3 This paper offers an initial overview of the amendments to "*Working Together to Safeguard Children* "and an outline action plan detailing actions required by the organisation. Linked to the shift in system wide approaches to protecting children and young people, the paper also offers summary position on Independent Health Assessments for Children in Care and the Serious Violence duty.

2.4 A detailed safeguarding position update was presented to the System Oversight Board in January 2024, which is a sub-committee of the Quality & Performance Committee, receiving assurance on the delivery of ICB safeguarding statutory duties. This paper also offers a succinct overview of our current position, identifies key risks and proposed mitigation through a clear workplan of activities during Quarter 4 2023/24, and incorporates Children in Care (access to health assessments), Serious Violence Duty, and workforce challenges (compliance with Intercollegiate and legislative requirements)

[1] Working together to safeguard children - GOV.UK (www.gov.uk)

2.5 Over the past year, arrangements have been put in place within the ICB to respond to the feedback from the NHS Staff Survey Results (2022), including significant engagement activity to share and discuss the results, seeking information, feedback, and wider intelligence.

2.6 The ICB People Sub-Committee is now established and receives a range of data which is subsequently reported through to the Finance, Investment and Resources Committee. A monthly dashboard is produced and shared with Directors and shared locally to drive targeted improvements.

2.6 The Integrated Care System (ICS) has several nationally mandated workforce responsibilities, targets and outputs and these are being developed through the activities of the Cheshire and Merseyside People Board, through the Provider Collaborative Workforce Boards and via the HR Director/Chief People Officers of our NHS Provider Trusts.

2.7 This paper also provides the following updates on the ICB Workforce, focussing on:

- Staff Experience and Engagement
- Staff networks
- HR Dashboard
- Cheshire & Merseyside system focus
- Retention
- Workforce Dashboard
- The NHS Long Term Workforce Plan
- Workforce Planning
- Social Care Workforce.

3. Ask of the Board and Recommendations

3.1 The Board is asked to note the content of the report for information.

4. Reasons for Recommendations

4.1 This is current work that is taking place within NHS Cheshire and Merseyside related to safeguarding and ICB workforce and it important that Board continues to be sighted on key issues as well as progress being made against our duties, strategic priorities and ambitions.

SAFEGUARDING UPDATE

5. Working Together to Safeguard Children 2023

5.1. Amendments made to both Children and Social Work Act 2017[2] and Children Act 2004 [3] placed new duties for police, Integrated Care Boards (ICB) and the Local Authority (LA), as statutory safeguarding partners. The document[1] replaces "*Working together to safeguard children" (*2018) and offers a framework for statutory partners to establish (*and further build on*) partnership arrangements to safeguard and promote the welfare of local children, including identifying and responding to their needs and that of their families.

5.2 The main amendment to the updated guidance is the addition of a new chapter focused on the importance of partnership working in prevention of neglect or harm (*including exploitation, serious violence +/or homelessness*) for children and young people up to their 18th birthday and the role of all agencies in offering proactive Help, Support and Protection.

5.3 From a workforce perspective, the guidance also recommends ICBs crossing multiple LA areas should consider 'lead' or 'hosting' arrangements for their designated health professionals, or a clinical network arrangement with the number of designated doctors and nurses for child safeguarding equating to the size and complexity of the child population.

5.4 The framework also offers clear guidance for the two child death review partners (LA and ICB) to ensure arrangements are in place[4] to review all deaths of children normally resident in the local area, and (*when appropriate*), for those not normally resident in the area.

5.5 The framework is explicit that multi agency working in prevention of harm, supporting families, and protecting children is key. The framework focuses on 3 tiers within systems that will need to work together to meet the needs of our population (Strategic, Senior Middle Managers and Direct Practitioners).

5.6 In recognising implementation of "*Working together to safeguard children"* requires whole system thinking, we are currently engaged with statutory partners to scope a Pan Merseyside approach to partnership agreements to improve the outcomes for children in Cheshire & Merseyside and assist partners in delivering services effectively.

5.7 Our proposed approach will initially focus on improving a cross-partnership approach to harm outside the home where exploitation is likely to cross Local Authority boundaries. Further areas for consideration being early help and children as victims of domestic abuse.

5.8 Our outline workplan is detailed overleaf.

[2] Children and Social Work Act 2017 (legislation.gov.uk)
[3] Children Act 2004 (legislation.gov.uk)
[4] Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk)

Working together to safeguarding children: Outline workplan	
Area	**Action required.**
1.Each Safeguarding children`s partnership board to set strategic direction, vision, and culture of the local safeguarding arrangements within their Place.	• Clarify expectations of Associate Directors of Quality (ADQ) in each of the 9 places attending Local Safeguarding Partnerships (LSP) on behalf of the Executive (report by exception to System Oversight Board)
2.Lead Safeguarding Partner to agree and review shared priorities and the resources required to deliver services effectively.	• JSNAs be aggregated to inform CYP strategy, using Beyond program
3.Joint functions of lead safeguarding partners	• LSP should agree on the level of funding needed to deliver the multi-agency safeguarding arrangements. • ICB Funding contributions to the statutory safeguarding partners is equitable across all 9 places (based on actual population) • Review funding formula to ensure equitable provision and present options to relevant Executive committee for review and approval
4.Local criteria for providing help, support, and protection	• Multi-agency approach to understand the causes and consequences of serious violence, focusing on prevention and early intervention, and informed by evidence. • LSPs ensure all partners and staff involved in direct practice are confident in identification of extra-familial harm (Contextual safeguarding, serious violence agenda) • Use of existing local structures and partnerships to prevent and reduce serious violence and ultimately improve community safety and safeguarding.

Working together to safeguarding children: Outline workplan	
Area	**Action required.**
5.Statutory requirements for children in Care (CiC)	• Independent review of current approaches and develop options appraisal within the ICS for improvement in practice (reducing inequalities for CiC) • Review current activity and actual performance within each Place and prepare briefing for the Executive (present at System Oversight Board)
6.Designated health practitioners	• The number of designated doctors and nurses for child safeguarding are equivalent to the size and complexity of the child population within each PLACE. • Training Needs Analysis (TNA) to be completed for all practitioners to ensure working to 'top of license' (and in line with ICD requirements). • Workforce review and options for succession planning to be developed and costed. • Safeguarding Workforce strategy to be approved by Executive.
7.Learning from serious child safeguarding incidents	• Evidence from direct practitioners practice that lessons from local and national reviews are implemented. • Transparent oversight of activity and trends in reporting of themes • Review Child death overview panel/ arrangements within footprint of the ICB
8.Training	• Review of TNA for Board members and develop training package regarding responsibility for safeguarding arrangements
9. Culture	• Clear whistleblowing procedures in place which reflect the "Freedom to Speak up Review.

6. Statutory Safeguarding partnership boards and ICB contribution

6.1 *Working together to safeguard children* [3] is clear that the ICB as one of 3 statutory partners must contribute towards the effective management of the local safeguarding boards and requires complete transparency regarding publishing contributions.

6.2 Financial contribution by statutory partners supports Boards business and analytical support, independent scrutiny, infrastructure, commissioning of safeguarding practice reviews, multi-agency training and learning events.

6.3 For complete transparency, there are two mechanisms for reporting on service delivery and leadership at each partnership board:

- publication of arrangements (including partner financial contribution)
- preparation of annual report

6.4 Local Safeguarding Partnerships for Children are currently reviewing partnership contributions from the 3 statutory leads. An initial review indicates legacy arrangements from Clinical Commissioning Groups towards children`s partnership which is not based on a formula of need or population (with potential inequity in these contributions)

6.5 Partner contribution towards Safeguarding Adult Boards is enshrined in law [5] but no clear formula in place to support modelling of financial contributions.

6.6 Crude analysis of data regarding financial contribution estimates circa £550,000 NHS contribution towards the eighteen (18) Local Safeguarding partnership Boards within the ICB footprint.

6.7 **Action:**

- Associate Director of Nursing and Care (Safeguarding) will request support from Public Health teams and finance to develop modelling (finance and assets) based on population an area of deprivation (in line with Joint Strategic Needs Assessment from each Place)
- Full engagement with partner agencies regarding any potential review of contributions (Local Safeguarding Partnership for children)
- Assess value for money from current contributions.

[5] Care Act 2014 (legislation.gov.uk)

7. Looked After Children and Care Leavers

7.1 The central piece of legislation guiding Children`s social care is the 1989 Children Act[6]. Core to this legislation is the focus on a 'Child in need' and a 'Child in need of protection'.

7.2 A child is legally defined as '*Looked After'* by a Local Authority if they are:

- accommodated by local authority for a continuous period of more than 24 hours.
- subject to a Care Order (to put the child into the care of the local authority)
- subject to a Placement Order (child placed for adoption)
- unaccompanied asylum-seeking minors (under the age of 18 years)

7.3 Most children become "*looked after*" due to various forms of abuse +/or neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences [7] with an estimated half of children in care having a diagnosable mental health disorder and two-thirds with special educational needs [8].

7.4 When a child or young person is removed from their families to go into foster or residential care, they are required by law to be offered an initial health assessment (IHA)[9] which is completed within twenty-eight (28) days of coming into care. The local authority that "*looks after*" the child must arrange for them to have a health assessment[10] (with the initial one being completed by a registered medical practitioner). Subsequent health assessments can be completed by a registered nurse or registered midwife.

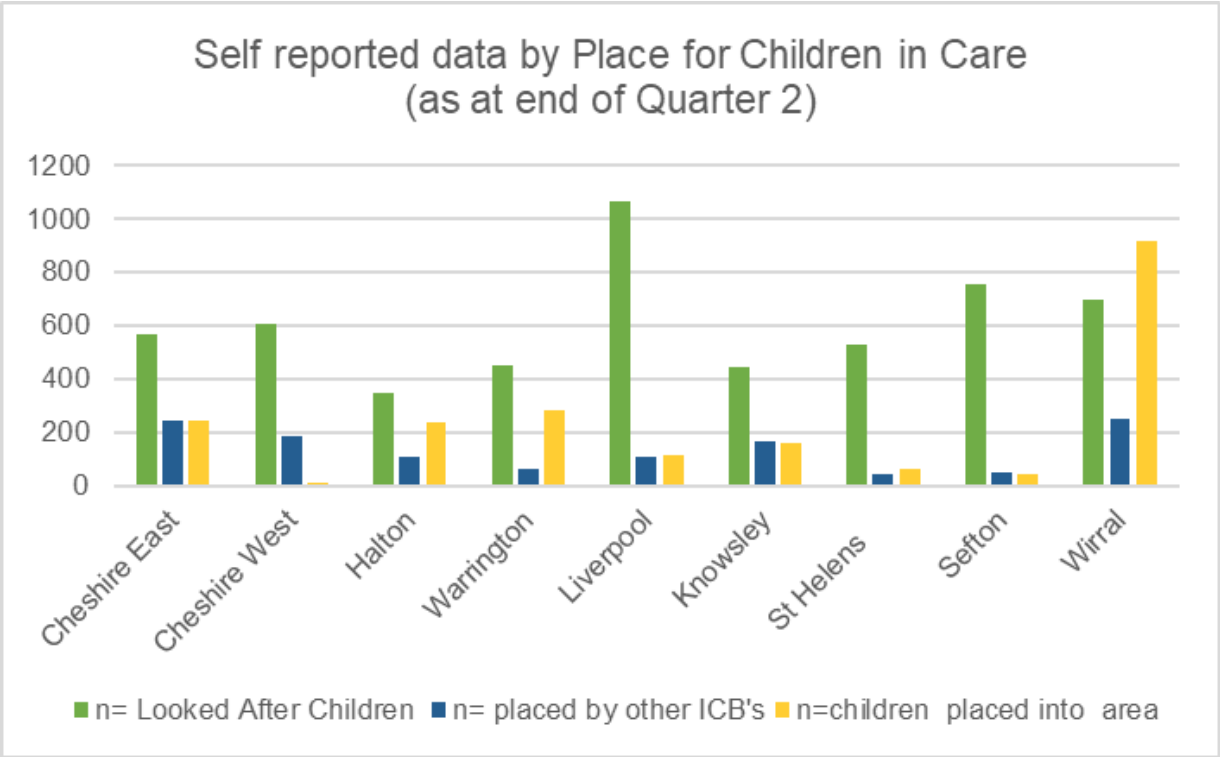
7.5 An overview of our Children in Care Annual report was presented to the Quality and Performance committee (November 2023) and referenced variation in models due to capacity and demand issues which were flagged as risks. The main pressure points were reported as:

- children in care experiencing delays in their Initial health assessments once placed by Local Authority
- variance in practice based on complexity of need across all 9 Places.
- estimated half of unaccompanied asylum seekers placed within our footprint are placed in Liverpool.
- compliance with completion of Initial Health Assessments within 28 days has been challenging.
- workforce challenges as operational modelling is different within 9 areas.

7.6 Crude data based on self-reporting from Place offers an overview in Table One of Children in Care within our 9 Places.

[6] Children Act 1989 (legislation.gov.uk)
[7] Looking after 'looked after' children and young people: how to do an initial health assessment that counts – PaediatricFOAM
[8] Promoting the health and well-being of looked-after children - update note added to start in August 2022 (publishing.service.gov.uk)
[9] Children Act 1989 (legislation.gov.uk)
[10] The Care Planning, Placement and Case Review (England) Regulations 2010 (legislation.gov.uk)

Table One



7.7 Our ability to ensure children in care are offered an initial health assessment within the statutory 28 days are noted below in Table Two with the following caveats**:**

Table Two

Initial Health Assessments: Overall percentage returned to the Local Authority within 28 days.		
PLACE	Qtr. 1	Qtr. 2
Liverpool	2%	5%
Cheshire East	71%	62%
Cheshire West	93%	85%
Halton	70%	6%
Warrington	48%	44%
Sefton	9%	8%
St Helens	68%	29%
Knowsley	27 %	13%
Wirral	14%	4%

1.We currently do not have an overview of actual numbers of IHA (rather than %) to quantify unmet need.

2.Further work required to review data from a partnership lens with Local Authority colleagues to understand pressure points within the system.

3.No exception reporting in place to quantify IHAs completed (but outside 28-day target)

7.8 The ICB Associate Director of Nursing and Care (Safeguarding) commenced post in January 2024 and will lead on an independent review of commissioning arrangements for Children in Care health services across the ICB. This work will benchmark actual practice against statutory guidance, seek examples of best practice from other regions in England to ensure we achieve equitable

investment and a standardised service for all our children and young people in care.

7.9 In response to increasing numbers of unaccompanied asylum seekers, we will also provisionally scope availability of services across the ICB to begin standardisation of pathways and care model/pathways.

8. Serious Violence Duty (position update)

8.1 We reported in August to the Executive group our contribution and ongoing support to the Serious Violence Duty[11] which is led by our Director of Population Health.

8.2 We have continued to support the agenda but note the challenges of attending serious violence meetings in addition to overseeing the statutory safeguarding agenda.

8.3 We reported that the duty takes a multi-agency approach to understand the causes and consequences of serious violence, focusing on prevention and early intervention, and informed by evidence. The duty does not require new multi-agency structures but encourages the use of existing local structures and partnerships to prevent and reduce serious violence and ultimately improve community safety and safeguarding.

8.4 During December, additional amendments were made to "*Working together to safeguard children"* [12] . The main amendment was the addition of a new chapter focused on the importance of partnership working in prevention of neglect or harm (including exploitation, serious violence +/or homelessness) for children up to their 18th birthday and the role of all agencies in offering proactive Help, Support and Protection.

8.5 The focus on early identification of vulnerabilities and increased risk factors of exploitation is clear throughout the document and places responsibilities on Local Safeguarding Partnerships to develop protocols for children considered at risk of exploitation from extra familial abuse (including serious violence and association with organised crime groups).

8.6 There is clear overlap of themes between various statutory partnerships within the ICB footprint, in particular the Safeguarding Partnerships (children and adults), Community Safety Partnerships, Domestic Abuse Partnership Boards and Violene Reduction Partnerships. This challenge to overlapping roles arguably moves agencies away from reactive practice and focuses on the wider public protection agenda within our communities which includes prevention of crime and disorder and community safety.

8.7 The recently announced Joint Targeted Area Inspections (JTAI) for Serious Violence within the ICB footprint will evaluate the effectiveness of local multi-

[11] Serious Violence Duty - GOV.UK (www.gov.uk)
[12] Working together to safeguard children - GOV.UK (www.gov.uk)

agency responses to serious youth violence, in particular statutory partnership response to setting clear strategic vision and multi-agency practitioners understanding of early identification and response.

8.8 Adverse outcomes associated with past histories of child abuse and neglect are often interrelated with the diagram below contextualising these issues and incorporating factors that cross the age continuum.

8.9 To ensure full oversight of the agenda at an organisational system level, the population health team have been approached to develop an internal working group for serious violence (extra familial harm). This approach will ensure we have full oversight of actions from all statutory partnerships to ensure our strategic vision is clear and that those attending our strategic partnerships have a full picture of the actions underway

8.10 The Pan Merseyside approach referred to within sections 5.16 and 5.1.7 will focus on ensuring statutory partnerships (in particular, Safeguarding) have access to datasets noting incidence of extra familial harm focusing on extra familial harm.

9. Safeguarding workforce

9.1 A scoping exercise is currently underway to review pressure points within the safeguarding workforce creating inequity in cover arrangements (based on actual need of the population). Once complete, a paper will be presented to the

System Oversight Board with options for future workforce modelling and succession planning.

ICB WORKFORCE UPDATE

10. Staff Experience & Engagement

10.1 Over the past year, arrangements have been put in place to respond to the feedback from the Staff Survey results (2022), including significant engagement activity to share and discuss the results, seeking further information, feedback, and wider intelligence. This resulted in the development of a comprehensive action plan themed around the key areas of engagement, morale and the seven areas of the NHS People Promise.

10.2 The work has led to the establishment of an integrated work programme entitled "Improving Staff Experience" with cross functional leadership across People, Communications, Estates, Information Technology and Governance. The work programme is being delivered across 5 pillars below:

10.3 A year on and the ICB had a response rate of 77% in the 2023 staff survey will provide a robust platform from which we can continue to engage with staff and make improvements. Whilst the staff survey results are embargoed until the Spring, the ICB has already started to develop its plans for 2024.

10.4 Working with our Staff Engagement Forum (SEF) we have also developed a Campaigns Calendar for 2024, to support and engage our staff in several national and local Health & Well-Being, Equality, Diversity and Inclusion campaigns and events throughout the year. To support this initiative, we have recently promoted two awareness campaigns with our staff - Disability History Month and LGBT History month

10.5 During Disability History Month the focus was on how to lead the change to tackle discrimination and support disabled people working across the health and care sector. It was an exciting opportunity to recognise and celebrate the 1 in 5 NHS staff who bring personal lived experience of disability and long-term health conditions to their careers, teams, leadership, and patient care.

Internally we took the opportunity to celebrate the achievements of staff with disabilities, shared resources, raised awareness of what a disability is. It is recognised that not all disabilities are visible or immediately apparent and staff were encouraged to record their disability on ESR and have open conversations with their managers. There is now a dedicated page on the staff intranet offer support to our disabled staff.

11. Staff networks

11.1 Since the last Board update, the ICB has established a range of staff networks. Each network has an Executive Director sponsor to provide support. The networks are:

- BAME staff network
- Disability and neurodiverse staff network
- Menopause /Women's health network
- LGBTQ network
- Working Carers network
- Veterans/ military families' network
- Early Career Network.

11.2 I am delighted that at the March 2024 Board meeting we will hear from one of our staff members about their experiences in the ICB.

12. HR Dashboard

12.1 The ICB People Sub-Committee is now well established and receives a range of data which is subsequently reported through to the Finance, investment, and resources committee. A monthly dashboard is now produced and is also shared with all Directors and discussed at Executive Team meetings, with more detailed reports shared locally to drive targeted improvements.

12.2 Staff in post currently stands at 980 WTE but this has slowly increased throughout the year due predominantly to the transfer of services from NHSE, Mersey Internal Audit Agency and the local midwifery and neonatal service (LMNS) into the ICB. Robust vacancy control is in place to ensure that the ICB will meet its running cost reduction target.

12.3 Sickness levels remain under 3%, however sickness levels have increased throughout the year and is now the subject of additional focus to enable managers to support people into getting people back into work effectively and in a supported way.

12.4 Workforce risks are reviewed at each meeting of the People Committee.

13. Cheshire and Merseyside System Focus

13.1 The ICS has a number of nationally mandated workforce responsibilities, targets, and outputs and these are being delivered through the activities of the Cheshire and Merseyside People Board, through the Provider Collaborative Workforce boards and via the HR Directors/ Chief People Officers of our Provider Trusts.

14. Scaling People Services

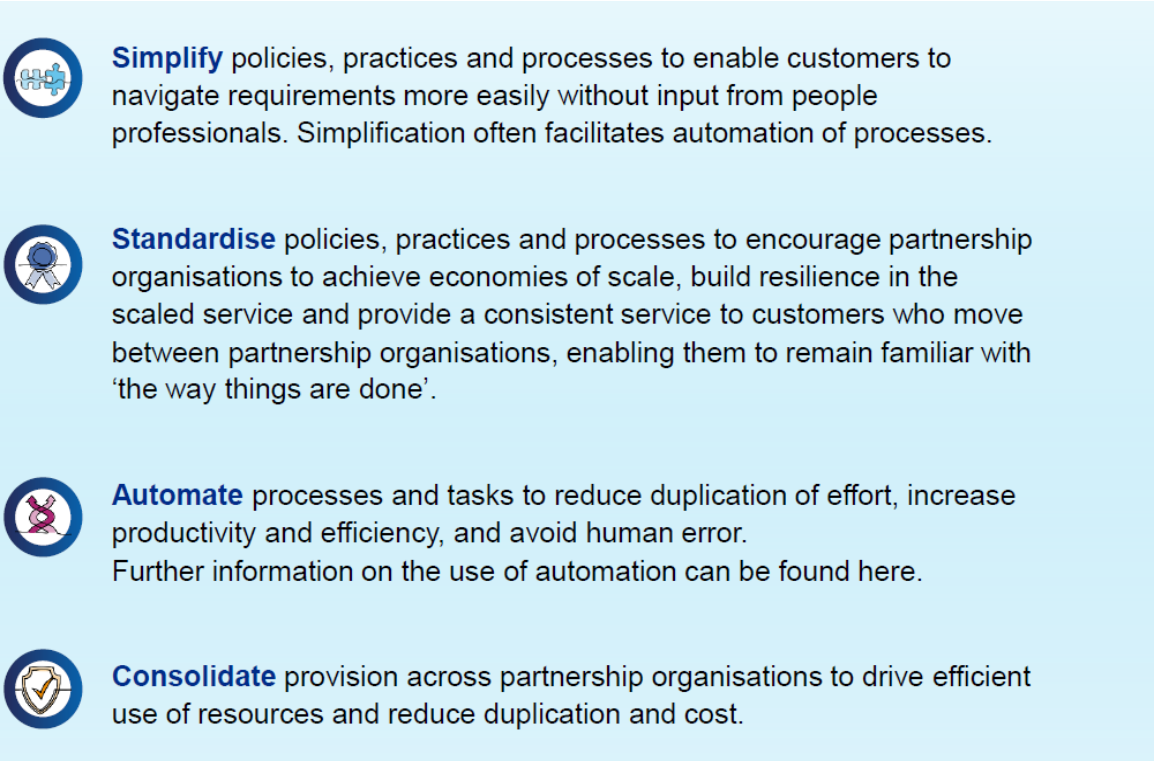
14.1 In 2021, the Future of NHS HR and OD report[13], outlined the 10-year strategy for HR and OD in the NHS and focused on the following areas:

Prioritising the **health** and **wellbeing** of all **our people**	We take a positive and proactive approach in supporting the health, safety and wellbeing of our NHS people, ensuring that work has a positive impact. We address health inequalities at work and in our communities.
Creating a **great employee experience**	We understand the diverse needs, expectations and experiences of our NHS people, and use that insight to tailor our people services. We attract and retain people in health and care, creating a positive impact on our communities.
Ensuring **inclusion** and **belonging** for all	We use our expertise and influence to create an inclusive culture, which values and celebrates our diversity. We listen to our people and take action to ensure there is equity for everyone.
Supporting and **developing** the **people profession**	We support everyone working in the people profession to be their very best and reach their full potential. Together we provide outstanding people practices.
Harnessing the **talents** of all our **people**	We help all our people to fulfil their ambition and potential. We build strong leadership and management capability at all levels.
Leading **improvement, change** and **innovation**	The people profession is productive, efficient and responsive. Our operating model delivers transformation and embeds innovation across organisations and systems.
Embedding **digitally** enabled **solutions**	We make best use of technology and digital solutions to deliver great people services. We develop our digital capability to equip ourselves for the future.
Enabling new ways of **working** and **planning** for the **future**	We enable our people to work differently, to support new models of care. We anticipate the needs of the health and care system, and play our part in creating a sustainable supply of workforce which meets the needs our patients now and for the future.

[13] https://www.england.nhs.uk/wp-content/uploads/2021/11/B0659_The-future-of-NHS-human-resources-and-organisational-development-report_22112021.pdf

14.2 In order to identify system opportunities for collaboration and potential for 'scaling people services' a significant information gathering exercise was undertaken across C&M in the Autumn of 2023 and HRD's/CPOs identified 14 areas where collaborative working would reap benefit, by improving quality and the employee experience, removing duplication, inconsistency and creating efficiencies, maximising use of specialist skills and building resilience, or maximising technological developments (RPA).

14.3 To maximise the opportunity that scaling provides, the national scaling programme states that it should be built around four principles which will underpin the work we do in this area: simplify, standardise, automate, and consolidate.



14.4 Having identified the priority areas, scoping documents are now being developed by lead organisations for the following scaling programmes:

Time Scale	Programme
Quick wins (April 2024)	Board Development
	Policies
Short Term	AfC Job evaluation
	HR systems /E Roster
	Workforce information/analytics
	EDI
	Leadership Development
Medium/ Longer term	Apprenticeships
	Recruitment
	Employment services
	Bank staffing

15. Retention

15.1 The ICB has a dedicated retention lead who supports Trusts to address the challenges of staff retention. We are fortunate to have two of the national People promiser/retention exemplar Trusts in Cheshire and Merseyside (Mersey Care NHS FT and Liverpool University Hospitals NHS FT) and there is evidence that a focus on this area can result in reduced turnover. The current rate of turnover across Cheshire and Merseyside is 11.3% compared with 13.2% at the start of the financial year.

15.2 East Cheshire NHS Trust and the Countess of Chester NHS FT have now been confirmed as new 'People Promise' Exemplar Sites.

15.3 Across all of the Trusts we will continue to introduce and support the 'legacy mentors' programme, provide advice on pensions, menopause support etc so that the employee experience is improved, and staff feel able to continue to work for the sector. This is a key focus of the national Long Term Workforce Plan.

16. Workforce Dashboard

16. The ICB has developed a workforce dashboard which is issued on a monthly basis to all providers, detailing staff in post, (headcount and whole time equivalent,) bank and agency use, turnover, sickness absence, vacancies etc and monitors month on month changes, variation from plans etc.

16.2 During this financial year we have seen substantive staff numbers steadily increasing, whilst agency staff has reduced significantly, and bank staff usage has reduced slightly.

17. The NHS Long Term Workforce Plan

17.1 The national long term workforce plan was published in the summer of 2023 and has three areas of focus:

- Train
- Retain
- Reform.

17.2 The Government announced an additional £2.4bn to support the expansion of training places, introduction of new apprenticeship programmes and creation of new volunteering opportunities. Universities are now actively planning for increased training provision, however at a local level there is a need to ensure that there are appropriate expansion of good quality, clinical placements, supervision, and appropriate development. The ICB works in partnership with NHSE (previous HEE teams) to ensure that the Cheshire and Merseyside Multi-professional Education and Training Investment Plan (METIP) informs any training place expansion and commissioning of new training programmes.

17.3 All systems have previously received national Workforce Development monies to support a range of initiatives including the development of Allied Health Professionals, skilling up of advance practitioners, workforce planning, equality and diversity training, Making Every Contact Count training. In Cheshire and Merseyside this funding has also supported a range of developments in Social Care and across primary care colleagues. However, this funding will no longer be available from 2024 and accordingly local work on the Long-Term Workforce Plan will not be funded and will need to be absorbed by local teams.

18. Workforce Planning

18.1 The annual workforce planning process has commenced across all NHS providers and in Primary Care. There is a requirement to triangulate the workforce, finance, and activity data. The workforce plans will also identify plans for bank and agency staffing together. Variance form plans are now monitored monthly.

19. Social Care Workforce

19.1 The annual Skills for Care 'State of the Adult Social Care Sector and Workforce in England 'report[14] was published in October 2023 which provided data on the challenges faced by social care colleagues. It also described the changing demographics of the social care workforce with more males joining the workforce. There remains significant challenges in retention and turnover remains high at 28% nationally. In the Northwest the vacancy rate remains at circa 8%. Skills for Care held a launch event for the guidance in early November 2023.

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

20.1 The current workplan for Safeguarding complements the objectives set within the annual delivery plan, in particular:

- how we work as partners for the benefit of our population by ensuring we continue to safeguard our population with a focus on Safe at Home, Safe in our Communities and Safe Safeguarding Systems across Cheshire and Merseyside.

[14] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

21. Link to meeting CQC ICS Themes and Quality Statements

21.1 This report provides evidence towards the following themes and statements:

Theme One (T1) - Quality and Safety	
QS1	Supporting to People to live healthier lives. We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support
QS2	Learning culture. We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
QS3	Safe and effective staffing. We make sure there are enough qualified, skilled, and experienced people, who receive effective support, supervision, and development. They work together effectively to provide safe care that meets people's individual needs
QS6	Safeguarding. We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm, and neglect. We make sure we share concerns quickly and appropriately
Theme Two (T2) - Integration	
QS7	Safe systems, pathways and transitions. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services
QS8	Care provision, integration and continuity. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity
QS9	How staff, teams and services work together. We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services
Theme Three (T3) - Leadership	
QS10	Shared direction and culture. We have a shared vision, strategy, and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these
QS11	Capable, compassionate and inclusive leaders. We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty
QS14	Partnerships and communities. We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
QS15	Learning, improvement and innovation. We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

22. Risks

22.1 Current risks within safeguarding require review and will be presented at System Oversight Board for approval.

23. Next Steps and Responsible Person to take forward.

23.1 The next steps are to continue with proposed workplan identified within this paper and present to System Oversight Board by exception and for approval of actions once complete.

23.2 To ensure the implementation of Working together to safeguarding children with our system partners to ensure safe and effective safeguarding practice for children and young people.

23.3 To present findings of the workforce review (once completed) to System Oversight Board for ratification.

23.4 To continue to develop the associated plans which are considered by the People Committee for internal ICB matters and the Cheshire and Merseyside People Board for system workforce matters and plans.

24. Officer contact details for more information

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Cheshire and Merseyside System Finance Report Month 9

Agenda Item No: ICB/01/24/10

Responsible Director: Claire Wilson, Director of Finance

Cheshire and Merseyside System Finance Report Month 9

1. Purpose of the Report

1.1 This report provides an update to the Board of NHS Cheshire and Merseyside on the financial performance of the Cheshire and Merseyside ICS ("the ICS") at Month 9, in terms of relative position against its financial plan to NHS England ("NHSE"), and alongside other measures of financial performance (e.g. efficiency, agency) and utilisation of available 'capital' resources for the financial year.

1.2 The report provides an update on the 2023/24 forecast position since NHSE's announcement in November 2023 of additional funding and the actions required to address the financial challenges created by industrial action between April 2023 and October 2024, and the impact of the subsequent industrial action over December 2023 and January 2024 reported by providers.

2. Executive Summary

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

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

2.3 In November 2023 NHSE requested that ICBs and providers resubmit system 2023/24 plans to live within their re-baselined system allocation as part of the national settlement responding to the significant impact of industrial action from April to October 2023. The revised system plan submitted to NHSE was a breakeven position, consisting of £63.9m surplus on the ICB side offsetting the aggregate NHS Provider deficit position of £63.9m. The revised plan was set based on no further industrial action between December 2023 and March 2024 Further details on the resubmitted plans are in section 3.1.

2.4 As of 31 December 2023 (Month 9), the ICS 'System' is reporting a YTD deficit of £72.2m against a planned YTD deficit of £31.3m resulting in an adverse YTD variance of £40.8m. Contained within the Month 9 YTD provider position are £7.1m of incremental costs and lost income relating to the in-month impact of industrial action in December 2023.

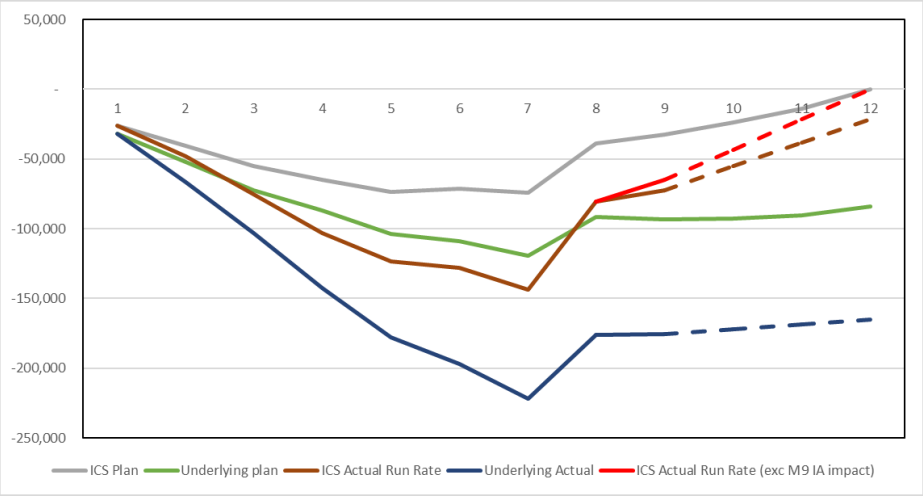
2.5 At month 9 the System reported its expected forecast in line with its revised November 2023 plan but with the additionality of the forecast impact of industrial action over December 2023 and January 2024. The Month 9 reported forecast system position was £21.5m deficit against the breakeven plan, with the £21.5m adverse variance relating entirely to the forecast impact of December and January industrial action. ICSs have been advised not to reflect any additional funding in their forecast to mitigate this new industrial action impact. Excluding the impact of industrial action, the system is forecasting to deliver a breakeven position. The system financial position as at Month 9 is set out in Table 1:

Table 1 – Financial Performance Month 9 YTD and FOT

	M9 YTD			2324 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	44.6	22.3	(22.3)	59.4	63.3	3.9
Total Providers	(75.9)	(94.4)	(18.5)	(59.5)	(84.8)	(25.4)
Total System	(31.3)	(72.2)	(40.8)	(0.0)	(21.5)	(21.5)
Impact of M9 and M10 Industrial Action (IA)	0.0	(7.1)	(7.1)	0.0	(21.5)	(21.5)
Total Sytem (excluding IA)	(31.3)	(65.1)	(33.8)	(0.0)	(0.0)	0.0

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

Chart 1 – Plan Profile and Run Rate



2.7 The system has identified £47.5m of unmitigated risk, primarily relating to operational pressures across Continuing Health Care (CHC) packages and prescribing, as well as efficiency risks within a handful of providers. This risk value is reported to NHS England and discussed via the monthly regulator assurance meetings. The risk position does not include any further impact of any potential industrial action beyond January 2024. Work is ongoing at Place to ensure these outstanding risks are mitigated, which includes the appointment of an external organisation to support the review of CHC and ongoing review of the ICB Balance Sheet.

3. Financial Performance Month 9

2023/24 Plan resubmission (November 2023)

3.1 The ICS's original 2023/24 financial plan was set on the basis that there would not be significant ongoing industrial action through the year. In November 2023 NHSE wrote to all ICBs recognising the impact of industrial action from April to October 2023 (M1-M7) by allocating nationally £800m across all systems sourced from new funding and re-prioritisation of national budgets. NHSE also reduced the elective activity target for 2023/24 to a national average of 103% and retained the main existing principles of the Elective Recovery Fund. For the C&M ICS this represented additional funding of £41.2m to cover the impact of Industrial Action and a revised elective activity target from 103% to 101%. In addition, the ICS also secured additional non recurrent national funding to cover the incremental costs of the New Hospital at Liverpool University Hospitals NHS Foundation Trust.

3.2 NHSE requested that ICBs and providers resubmit plans in November to live within their re-baselined system allocation and reflecting the impact of the reduced elective activity goal. The revised plan for 2023/24, approved by ICB and provider boards in November, is set out in Table 2**.**

Table 2 – Revised 2023/24 Plan

Organisation	Original 23/24 Plan £m	Key Movements to revised plan			Revised Nov 23 reset £m
		LUFT New Hospital £m	Operational Pressures £m	Improvement to FOT £m	
C&M ICB	69.0	(9.0)	0.0	3.8	63.8
Alder Hey Children's NHS Foundation Trust	12.3	0.0	0.0	0.7	13.0
Bridgewater Community Healthcare NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0
Countess of Chester Hospital NHS Foundation Trust	(25.2)	0.0	0.0	0.0	(25.2)
East Cheshire NHS Trust	(4.4)	0.0	0.0	0.0	(4.4)
Liverpool Heart and Chest Hospital NHS Foundation Trust	9.8	0.0	0.0	1.3	11.1
Liverpool University Hospitals NHS Foundation Trust	(60.7)	57.5	0.0	3.2	0.0
Liverpool Women's NHS Foundation Trust	(15.4)	0.0	(7.2)	0.0	(22.6)
Mersey Care NHS Foundation Trust	6.4	0.0	0.0	2.0	8.4
Mid Cheshire Hospitals NHS Foundation Trust	(18.9)	0.0	0.0	0.0	(18.9)
Mersey and West Lancashire NHS Trust	5.6	0.0	0.0	0.0	5.6
The Clatterbridge Cancer Centre NHS Foundation Trust	0.4	0.0	0.0	1.5	1.9
The Walton Centre NHS Foundation Trust	4.1	0.0	0.0	2.8	6.9
Warrington and Halton Teaching Hospitals NHS Foundation Tr	(15.7)	0.0	(5.5)	0.0	(21.2)
Wirral Community Health and Care NHS Foundation Trust	0.2	0.0	0.0	0.5	0.7
Wirral University Teaching Hospital NHS Foundation Trust	(18.6)	0.0	(0.3)	0.0	(18.9)
Subtotal Providers	***(120.1)***	**57.5**	***(13.0)***	**11.9**	***(63.8)***
Subtotal ICB	**69.0**	***(11.0)***	**0.0**	**5.8**	**63.8**
Total ICS System	**(51.2)**	**46.5**	**(13.0)**	**17.7**	**0.0**

3.3 The net deterioration in provider positions of £3.8m was taken into the ICB, on the understanding that Providers would still work collaboratively to address this gap. Improvements from Providers are being delivered through a combination of slippage, increased elective income arising from the change in target, additional elective activity and efficiency delivery.

ICB financial performance – M9

3.4 The ICB has reported a YTD surplus of £22.3m compared to a revised planned surplus of £44.6m, resulting in an adverse variance to plan of £22.3m as per Table 3.

Table 3 – ICB Financial Performance M9 YTD

	M9 YTD Plan £m	M9 YTD Actual £m	M9 YTD Variance £m	M9 YTD Variance %
TOTAL ICS Surplus/(Deficit)	**(31.3)**	**(72.2)**	**(40.8)**	**(0.8%)**
ICB Net Expenditure:				
Acute Services	2,490.9	2,495.2	(4.3)	(0.2%)
Mental Health Services	483.6	496.3	(12.7)	(2.6%)
Community Health Services	492.2	494.5	(2.3)	(0.5%)
Continuing Care Services	258.0	291.3	(33.3)	(12.9%)
Primary Care Services	458.1	466.8	(8.6)	(1.9%)
Other Commissioned Services	10.0	10.3	(0.3)	(2.5%)
Other Programme Services	41.8	36.8	4.9	11.8%
Reserves / Contingencies	12.2	0.0	12.2	100.0%
Delegated Primary Care Commissioning	608.2	587.9	20.3	3.3%
Primary Medical Services	*392.8*	*389.6*	*3.1*	*0.0%*
Dental Services	*142.3*	*127.7*	*14.7*	*10.3%*
Ophthalmic Services	*20.3*	*18.7*	*1.6*	*7.6%*
Pharmacy Services	*52.8*	*51.9*	*0.9*	*1.8%*
ICB Running Costs	38.5	36.9	1.7	4.3%
Total ICB Net Expenditure	**4,893.6**	**4,915.9**	**(22.3)**	**(0.5%)**
Allocation adjustment for reimbursable items		0.0	0.0	
TOTAL ICB Surplus/(Deficit)	**44.6**	**22.3**	**(22.3)**	**(0.5%)**

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

a) Mental Health Services – overspend relating to packages of care linked to cost and volume of service users.
b) Continuing care - overspend relating to increases to volume and price for continuing care including the impact of inflation above national planning assumptions. This is an area of significant focus and by each place team.
c) Prescribing – estimated overspend based on October 2023 prescribing data (latest available) and reflecting inflationary pressure above national planning assumptions.
d) Efficiency savings are built into the position and are forecasting a £2m shortfall on achievement against the plan.

3.6 Details of ICB performance split by place is shown below, and more detail is provided in **Appendix One.** ICB central budgets are currently showing a positive variance to plan due to slippage on centrally funded programmes and the release of previously ringfenced funds as per government guidance. Place recovery plans have been put in place and mitigations are required in the final quarter of the year in order for the ICB plan to be achieved. Table 4 sets out in summary the Month 9 Place performance:

Table 4 – Place M9 – Financial Performance

	M9 YTD Plan £m	M9 YTD Actual £m	M9 YTD Variance £m	Annual Plan £m	M9 Forecast Actual £m	M9 Forecast Variance £m
Cheshire - East	(27.3)	(38.5)	(11.2)	(36.4)	(53.2)	(16.8)
Cheshire - West	(20.5)	(33.7)	(13.3)	(27.3)	(45.0)	(17.7)
Halton	(6.4)	(5.3)	1.1	(8.6)	(8.8)	(0.2)
Knowsley	8.4	6.5	(1.9)	11.2	7.9	(3.3)
Liverpool	5.4	(4.5)	(9.9)	7.2	(5.9)	(13.1)
Sefton	(4.3)	(10.0)	(5.8)	(5.7)	(13.7)	(8.0)
St Helens	(6.4)	(9.8)	(3.4)	(8.6)	(13.3)	(4.8)
Warrington	(5.9)	(8.1)	(2.2)	(7.8)	(11.4)	(3.5)
Wirral	(5.4)	(18.3)	(12.9)	(7.2)	(24.9)	(17.8)
ICB	107.0	144.1	37.1	142.6	231.7	89.1
Total ICB	**44.6**	**22.3**	**(22.3)**	**59.4**	**63.3**	**3.9**

NHS Provider - Financial Performance – M9

3.7 Table 5 summarises the combined NHS Provider position to the end of December 2023, reflecting a year-to-date cumulative deficit position of £94.4m compared to a deficit plan of £75.0m, giving an adverse variance of £18.5m. The YTD impact of Industrial Action over December is reported by providers as £7.1m, therefore the adverse variance to plan excluding December industrial action is £11.5m.

3.8 Providers have formally changed their forecasts at Month 9 reflecting the agreed November 2023 re-forecast position but also for providers' assessment of industrial action over December and January. At month 9 the reported FOT is £25.4m adverse variance to plan; £21.5m of the change relates to providers assessment of the impact of industrial action and £3.9m relates to the agreed system changes as part of the November submission. **Table 5** below sets this out in more detail:

Table 5 – NHS Provider M9 – Financial Performance

	M9 YTD			2324 Forecast		
	Plan	Actual	Variance	Plan	Current	Variance
	£m	£m	£m	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	3.5	3.0	(0.5)	12.3	11.5	(0.8)
Bridgewater Community Healthcare NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	(0.1)	(0.7)	(0.6)	0.0	0.0	(0.0)
Countess of Chester Hospital NHS Foundation Trust	(18.9)	(21.1)	(2.2)	(25.2)	(27.6)	(2.4)
East Cheshire NHS Trust	(4.0)	(4.7)	(0.6)	(4.4)	(5.3)	(0.9)
Liverpool Heart and Chest Hospital NHS Foundation Trust	7.4	8.5	1.1	9.8	10.9	1.1
Liverpool University Hospitals NHS Foundation Trust	(18.3)	(21.8)	(3.5)	0.0	(4.4)	(4.4)
Liverpool Women's NHS Foundation Trust	(12.0)	(14.7)	(2.7)	(15.4)	(23.4)	(8.0)
Mersey Care NHS Foundation Trust	5.2	5.2	0.0	6.4	8.4	2.0
Mid Cheshire Hospitals NHS Foundation Trust	(14.9)	(18.8)	(3.9)	(18.9)	(21.1)	(2.2)
Southport And Ormskirk Hospital NHS Trust	(2.0)	(2.0)	0.0	(2.0)	(2.0)	0.0
Mersey and West Lancashire Teaching Hospitals NHS Trust	4.1	3.0	(1.0)	7.6	4.6	(3.0)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.3	1.4	1.1	0.4	1.9	1.5
The Walton Centre NHS Foundation Trust	3.3	5.6	2.3	4.1	6.9	2.8
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(14.2)	(18.5)	(4.4)	(15.7)	(22.8)	(7.1)
Wirral Community Health and Care NHS Foundation Trust	0.2	0.4	0.2	0.2	0.7	0.5
Wirral University Teaching Hospital NHS Foundation Trust	(15.7)	(19.3)	(3.7)	(18.6)	(23.1)	(4.5)
Total Providers	**(75.9)**	**(94.4)**	**(18.5)**	**(59.5)**	**(84.8)**	**(25.4)**
Impact of Industrial Action - Month 9 & 10	0.0	(7.1)	(7.1)	0.0	(21.5)	(21.5)
Total Providers (excluding IA impact)	**(75.9)**	**(87.4)**	**(11.5)**	**(59.5)**	**(63.4)**	**(3.9)**

3.9 There are 2 trusts reporting a year-to date adverse variance to plan relating entirely to the impact of industrial action over December 2023:

- Alder Hey Children's NHS Foundation Trust - £0.5m
- Mersey and West Lancashire Teaching Hospitals NHS Trust - £1.0m

3.10 There are 8 Trusts reporting a year-to-date adverse variance to plan, a combination of industrial action over December and other operational issues as set out below.

- **Cheshire and Wirral Partnership NHS Foundation Trust**
  £0.6m adverse variance YTD, forecast to plan.
  Operational issues continue within inpatient areas linked to staffing difficulties (vacancies, sickness & acuity of patients) with high levels of agency/bank costs to ensure safe staffing levels. There are several patients clinically ready for discharge to the community, resulting in delays to admissions and placement in the independent sector. Unfortunately, this has also resulted in a high number of Out of Area placements causing a cost pressure of £4.5m. The main cost pressures facing the Trust are: £0.6m excess inflation costs, £0.6m undelivered CIP, and £1.1m staffing cost pressures. The Trust have identified £6.4m of mitigations that partially offset the cost pressures. Forecast is in line with the November 2023 revised plan to breakeven.

- **Countess of Chester NHS Foundation Trust**
  £2.2m adverse variance YTD, £2.4m adverse variance forecast
  £1.4m of the YTD variance is attributable to industrial action. Key drivers of the remaining £0.8m YTD deficit are: undelivered CIP of £2.6m, increased activity and acuity through A&E has led to £4.2m increased staffing costs (a combination of premium and bank costs), £1m energy and other excess inflation costs, and £1.4m pay award costs in excess of funding received. The Trust has undertaken a review and has been able to attribute £8.1m to partially mitigate against the key drivers identified. The forecast variance is entirely attributable to industrial action costs in December 2023 and January 2024.

- **East Cheshire NHS Trust**
  £0.6m adverse variance YTD, £0.9m adverse variance forecast
  £0.3m of the YTD variance is attributable to industrial action. Key drivers of the remaining £0.3m YTD deficit are: £2.5m excess inflation and estates costs, and £0.8m pay award costs in excess of funding received. The Trust has exceeded YTD efficiency targets by £0.8m and have undertaken a review of the balance sheet and utilise £3m to partially mitigate the losses identified. The forecast variance is entirely attributable to industrial action costs in December 2023 and January 2024.

- **Liverpool University Hospitals NHS Foundation Trust**
  £3.5m adverse variance YTD, £4.4m adverse variance forecast
  £1.5m of the YTD variance is attributable to industrial action. Key drivers of the remaining £2m YTD deficit are: undelivered CIP of £6.7m, £10.8m energy and other excess inflation costs and £16.1m pay related costs (including pay award costs in excess of funding received). The Trust has been able to identify £31.9m of mitigations to partially offset the key drivers identified at month 9. A recovery programme to support achievement of the plan is in place, with the risks to delivery highlighted. The forecast variance is entirely attributable to industrial action costs in December 2023 and January 2024.

- **Liverpool Women's NHS Foundation Trust**
  £2.7m adverse variance YTD, £8.0m adverse variance forecast
  £0.3m of the YTD variance is attributable to industrial action. Key drivers of the remaining £2.4m YTD deficit are: undelivered CIP of £1.5m and £1.6m prior year investments. The Trust has been able to attribute £2.7m, from non-recurrent non-pay benefits and income, to partially mitigate against the key drivers identified. Revised forecast from November return is a £7.2m worsening (to a deficit of £22.6m) and £0.8m industrial action costs in December 2023 and January 2024.

- **Mid Cheshire Hospitals NHS Foundation Trust**
  £3.9m adverse variance YTD, £2.2m adverse variance forecast
  £0.6m of the YTD variance is attributable to industrial action. Key drivers of the remaining £3.3m YTD deficit are: pay related costs of £4.9m (including pay award pressures above the funding received), £0.9m estates related

pressures and other operational related pressures of £1.2m. The Trust has additional income of £3.7m that partially mitigates against the pressures identified. The forecast variance is entirely attributable to industrial action costs in December 2023 and January 2024.

- **Warrington and Halton Teaching Hospital NHS Trust**
  £4.4m adverse variance YTD, £7.1m adverse variance forecast
  £0.5m of the YTD variance is attributable to industrial action. Key drivers of the remaining £3.9m YTD deficit are: undelivered CIP of £0.3m, emergency care pressures of £2m, special-ling care pressures of £2.3m, excess inflation costs of £0.4m, reduced TIF and CDC activity generated £0.8m less income and there are other pressures with a combined value of £1m. The Trust are utilising non recurrent non pay underspends of £2.9m to partially mitigate the pressures identified above. Revised forecast from November return is a £5.5m worsening (to a deficit of £21.2m) and £1.6 industrial action costs in December 2023 and January 2024.

- **Wirral University Hospitals NHS Foundation Trust**
  £3.7m adverse variance YTD, £4.5m adverse variance forecast
  £1.5m of the YTD variance is attributable to industrial action. Key drivers of the remaining £2.2m YTD deficit are: undelivered CIP of £1.3m, lower than anticipated activity levels (not related to industrial action) have generated an income loss of £5.6m, pay award pressures of £0.9m above the funding received and £0.4m energy inflation costs. The forecast variance is entirely attributable to industrial action costs in December 2023 and January 2024.

3.11 Further analysis of the year-to-date position, as per the Table 6, demonstrates that the adverse position is a result of pay costs being £170.5m higher than anticipated and non-pay costs being £87.2m higher than budgeted. This is partially offset by income being £224.6m higher than expected and non-operating items being £14.6m lower than budgeted. It should be noted that the variance on pay compared to plan reflects the additional costs of the pay award agreed shortly after the planning submission, but this is funded by NHSE and reflected on the overachievement in reported income. Other items such as industrial action and the provider drivers of the YTD adverse position set out in section 3.10 are also contributing to this position.

Table 6 – NHS Provider – Income and Expenditure vs Plan

	Plan £m	M9 YTD Actual £m	Variance £m	%
Total Income	**(4,487.7)**	**(4,712.3)**	**(224.6)**	**(5.0%)**
Pay	2,983.5	3,153.9	170.5	(5.7%)
Non Pay	1,506.7	1,593.9	87.2	(5.8%)
Non Operating Items (excl gains on disposal)	73.5	58.9	(14.6)	19.8%
Total Expenditure	**4,563.6**	**4,806.7**	**243.1**	**(5.3%)**
Total Provider Surplus/(Deficit)	**(75.9)**	**(94.4)**	**(18.5)**	**(24.4%)**

3.12 All Providers are forecasting achievement of plan, but collectively have identified an estimated £188m of risk, relating to unachieved efficiencies, industrial action, ERF, and escalation beds open. It is anticipated that these risks are likely to be partially mitigated, leaving an unmitigated risk of £12m.

NHS Provider Agency Costs

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

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

3.15 At Month 9, year to date agency spend is £97.2m (£7.2m above plan), equating to 3.10% of total pay. 10 Trusts are reporting a year-to-date adverse variance to plan. Trust level information on agency spend can be found in **Appendix 2**.

3.16 Trusts are forecasting agency spend to be £126.7m, which is a £9.1m adverse variance to a plan of £117.6m. This is below the overall ICS agency ceiling of £127.3m. 9 Trusts are forecasting a full year adverse variance to plan for agency spend.

System Efficiencies

3.17 Table 7 show the ICS is not achieving its planned CIP, at month 9 the system is £16m adverse against its YTD plan and is forecasting a £3.8m adverse variance against full year plan and is more dependent on non-recurrent efficiencies than planned. This increases the risk in the underlying financial position of the ICS.

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

Table 7 – System efficiencies performance M9 and FOT

YTD Efficiency Performance	YTD Recurrent			YTD Non Recurrent			YTD Total		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	31.6	25.7	(5.9)	10.5	14.4	3.9	42.1	40.1	(2.0)
Total Providers	184.7	133.3	(51.4)	50.3	87.7	37.4	235.0	221.0	(14.0)
Total System	216.3	159.0	(57.3)	60.8	102.1	41.3	277.1	261.1	(16.0)

FOT Efficiency Performance	2324 FOT Recurrent			2324 FOT Non Recurrent			2324 FOT Total		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	43.8	39.2	(4.6)	14.1	18.6	4.4	57.9	57.8	(0.1)
Total Providers	260.8	202.2	(58.7)	70.0	125.0	55.0	330.8	327.1	(3.7)
Total System	304.6	241.4	(63.2)	84.1	143.5	59.4	388.7	384.9	(3.8)

ICB Efficiencies

3.19 The ICB is reporting an adverse position against efficiency plan of £2.0m year to date for unidentified efficiencies but is forecast to achieve the full £57.8m for the year.

3.20 Key schemes are focussed on Continuing Health Care and Prescribing costs in each of the 9 places. Enhanced reporting of place level plans is being developed and will be reported in more detail in future Committee papers.

Provider Efficiencies

3.21 Provider efficiency schemes have delivered efficiencies of £221m year to date. £133.3m of this has been delivered recurrently. Providers are forecasting a £58.7m shortfall against the recurrent efficiency plan, which raises concerns over the underlying financial position.

System Risks & Mitigations

3.22 The System is currently forecasting that the financial plan will be delivered by year-end. However, several risks have been highlighted namely:

a. **Identification and delivery of recurrent CIPs** – this is subject to focussed System wide review to identify areas for acceleration and improvement.

b. **Industrial action disruption** - impact of any potential further industrial action beyond January 2024.

c. **Inflation** – specifically; food and energy inflation for providers and prescribing and continuing care for the ICB.

d. **Maintenance of escalation beds year-round** – targeted improvement plan in development across the System in response to recommendations identified by National team.

e. **Non-achievement of ERF / activity requirements** – progress has been significantly impacted by industrial action but otherwise remained good. NHSE National Team have reduced ERF targets by a further 2 percentage points, total of 4 year-to-date, to allow for the impact of industrial action.

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

g. **Pay claims** – situation being monitored closely by HR directors.

Provider Capital

3.23 The 'Charge against Capital Allocation' represents the Systems performance against its operational capital allocation, which is wholly managed at the Systems discretion. The Secondary Care allocation in 2023/24 is £250.1m.

3.24 Spend in relation to IFRS16 changes (movement of Operating leases from revenue to capital recognition) were previously administered by the national team, on behalf of Systems, but this has been devolved to the System in Month 8. The ICS has been given an allocation of £28.3m for 2023/24, current year-to-date spend is £21.5m. It is expected that any leases that are internal to the NHS within the DHSC Group will be netted off and excluded against system allocations. Discussions are ongoing with regional and national team regarding the forecast position in this area.

3.25 Table 8 represents the Month 9 YTD and FOT position against notified allocations. The current forecast is a £1m underspend against the combined allocation of £278.4m. The £0.4m forecast overspend against the operational capital allocation is expected to the resolved by Month 10. Further work is required with providers to validate the forecast position, particularly with IFRS16 operating leases. The core provider operational capital and IFRS16 plan, actual and forecast by provider are set out in Appendix 4A and 4B.

Table 8 – Financial Performance against ICS capital allocations.

	Plan YTD £m	Actual YTD £m	Variance YTD £m	Plan FOT £m	Forecast FOT £m	Variance FOT £m
Provider Operational Capital						
Operational Capital Expenditure against allocation	140.6	113.3	27.4	234.7	245.8	(15.8)
ICS Provider Capital allocation					**245.4**	
FOT variance to allocation					(0.4)	
Allocation met					No	
Provider IFRS16 Leases						
IFRS16 leases expenditure against allocation	14.1	21.5	(7.4)	20.5	36.8	(16.3)
Expected leases internal to DHSC Group to net off*					(9.9)	
Net IFRS16 leases against allocation					26.9	
ICS Provider IFRS16 allocation					**28.3**	
FOT variance to allocation					1.4	
Allocation met					Yes	
Combined Capital Position						
Combined Op Ex Capital & Leases against allocation	154.7	134.8	20.0	255.2	272.7	(32.1)
Combined ICS Capital Allocation					**273.6**	
FOT variance to allocation					1.0	
Allocation met					**Yes**	

*based on reported M8 FOT by providers - requires further validation of M9 position.

3.26 Spend in relation to National programmes (PDC Spend) and other items chargeable to the Capital Direct Expenditure Limit (CDEL) are effectively administered on the behalf of Systems, and therefore under/overspending does not score against System's Capital performance. This is also for information only as it includes national schemes, such as CDCs, diagnostics, digital diagnostics, Frontline Digitisation, New Hospital Programmes and Elective Recovery.

3.27 At Month 9, providers have spent £151.3m against a FOT of £370m. This covers the entirety of operational capital, IFRS16 leases and nationally PDC funded schemes. Detail by provider is set out in Appendix 4C.

Primary Care Capital

3.28 The ICB has been allocated £4.7m in 23/24 and £4.7m in 24/25, for Primary Care Capital to cover GP Improvement Grants and GP BAU digital.

3.29 There has been £1.1m spend year to date in 23/24 against Primary Care Capital allocation, and the ICB is forecasting to utilise the remaining £3.6m over quarter 4 on further improvement grants and IT investments.

Cash and the Better Payment Practice Code (BPPC)

3.30 NHS Providers are currently finalising their detailed Month 9 accounts position as part of NHSE reporting requirements and therefore the Month 9 cash and BPPC position will be available later in January.

3.31 The provider cash position at Month 8 was £514.7m, with the detail set out in Appendix 5. This is £147.9m lower than at the end of 22/23 and £128.2m higher than at the end of 2019/20.

3.32 4 Trusts have requested cash support from the ICS, the total value to date is £82.6m. Liverpool Women's £19.4m, Countess of Chester £22.7m, Mersey and West Lancashire £4.5m, Mid Cheshire £25m. Trusts are in the process of repaying back cash support to the ICB and are now requesting national cash support via NHSE.

3.33 The BPPC monitors public sector organizations on the timeliness of their financial payments both in terms of volume and value. Guidance recommends that 95% of payments are made within 30 days, the BPPC position at Month 8 for each Provider is set out in Appendix 6.

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

4. Ask of the Board and Recommendations

4.1 The Board is asked to note the financial position reported at month 9, the forecast impact of industrial action, and the risks to delivery of the financial plan which are described in the paper.

5. Officer contact details for more information

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6. Appendices

Appendix 1:	**ICB Place Performance split by Programme Area M9**
Appendix 2:	**Agency Spend: Current Performance and Forecast Outturn M9**
Appendix 3A:	**System Efficiencies: Current Performance and Forecast Outturn M9**
Appendix 3B:	**System Efficiencies: Recurrent/Non-recurrent split of YTD CIP**
Appendix 3C:	**System Efficiencies Recurrent/Non-recurrent split of FOT CIP**
Appendix 4A:	**Provider Capital: Current & Forecast Performance M9**
Appendix 4B:	**Provider Capital: Current & Forecast Impact of IFRS16 M9**
Appendix 4C:	**Provider Capital: Total CDEL M9**
Appendix 5:	**Current Provider Cash Position as at M8**
Appendix 6:	**Provider BPPC: Actual & YTD Total BPPC Position M8**

Appendix 1

ICB Place Performance split by Programme Area as at 31st December 2023

ICB CENTRAL	C&M ICB Default - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	479	480	(1)	596	597	(0)
Community	38	38	(0)	51	51	0
CHC	(0)	0	(0)	0	0	(0)
Mental Health - Packages of Care	0	0	(0)	0	0	(0)
Mental Health - Contracts	39	39	(0)	53	53	(0)
Other Commissioned Services	1	1	0	1	1	(0)
Other Programme	11	11	1	17	16	0
Reserves	12	0	12	72	16	56
Primary Care - Delegated GP	(0)	(1)	1	0	(1)	1
Primary Care - Delegated Other	217	199	18	288	262	27
Prescribing	0	(3)	3	0	(3)	3
Primary Care - Other	4	1	3	5	2	3
Sub Total - Programme Expenditure	**801**	**765**	**35**	**1,083**	**995**	**88**
Running Costs	39	37	2	51	50	1
TOTAL EXPENDITURE	**839**	**802**	**37**	**1,134**	**1,045**	**89**
Surplus / (Deficit) Plan	*107*	*0*	*107*	*143*	*0*	*143*
Sub Total - Net Surplus / (Deficit) Reported	***946***	***802***	***144***	***1,276***	***1,045***	***232***

CHESHIRE EAST	Cheshire East Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	267	268	(1)	353	354	(1)
Community	60	60	(0)	80	80	(1)
CHC	48	55	(8)	63	74	(10)
Mental Health - Packages of Care	16	17	(1)	22	24	(2)
Mental Health - Contracts	35	35	(0)	47	47	(1)
Other Commissioned Services	1	1	(0)	2	2	(0)
Other Programme	1	1	0	2	2	0
Reserves	1	0	1	2	1	2
Primary Care - Delegated GP	57	57	0	74	73	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	53	56	(3)	71	75	(4)
Primary Care - Other	11	12	(0)	15	15	(0)
Sub Total - Programme Expenditure	**551**	**562**	**(11)**	**730**	**747**	**(17)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**551**	**562**	**(11)**	**730**	**747**	**(17)**
Surplus / (Deficit) Plan	*(27)*	*0*	*(27)*	*(36)*	*0*	*(36)*
Sub Total - Net Surplus / (Deficit) Reported	***524***	***562***	***(38)***	***694***	***747***	***(53)***

CHESHIRE WEST	Cheshire West Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	274	274	(1)	363	364	(1)
Community	47	47	(0)	63	63	(0)
CHC	37	46	(9)	49	62	(13)
Mental Health - Packages of Care	16	17	(1)	22	23	(1)
Mental Health - Contracts	38	38	(0)	50	50	(0)
Other Commissioned Services	2	2	(0)	2	2	(0)
Other Programme	2	1	1	2	2	0
Reserves	(1)	0	(1)	0	0	0
Primary Care - Delegated GP	54	54	(0)	69	70	(1)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	52	54	(2)	69	72	(3)
Primary Care - Other	11	11	0	15	14	1
Sub Total - Programme Expenditure	**531**	**544**	**(13)**	**704**	**722**	**(18)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**531**	**544**	**(13)**	**704**	**722**	**(18)**
Surplus / (Deficit) Plan	*(20)*	*0*	*(20)*	*(27)*	*0*	*(27)*
Sub Total - Net Surplus / (Deficit) Reported	***510***	***544***	***(34)***	***677***	***722***	***(45)***

HALTON	Halton Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	110	110	0	145	145	0
Community	27	28	(1)	36	37	(1)
CHC	13	11	1	17	16	1
Mental Health - Packages of Care	7	7	(1)	9	10	(1)
Mental Health - Contracts	18	17	0	24	23	1
Other Commissioned Services	0	0	0	1	1	(0)
Other Programme	1	0	1	1	0	1
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	20	20	(0)	25	26	(0)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	21	21	(0)	28	28	(1)
Primary Care - Other	3	3	0	3	3	0
Sub Total - Programme Expenditure	**219**	**217**	**1**	**289**	**290**	**(0)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**219**	**217**	**1**	**289**	**290**	**(0)**
Surplus / (Deficit) Plan	*(6)*	*0*	*(6)*	*(9)*	*0*	*(9)*
Sub Total - Net Surplus / (Deficit) Reported	***212***	***217***	***(5)***	***281***	***290***	***(9)***

KNOWSLEY	Knowsley Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	135	136	(0)	179	180	(0)
Community	44	43	1	58	56	2
CHC	9	12	(3)	12	17	(5)
Mental Health - Packages of Care	5	5	1	7	7	0
Mental Health - Contracts	25	25	0	34	33	0
Other Commissioned Services	1	1	(0)	1	1	(0)
Other Programme	3	3	0	4	4	(0)
Reserves	0	0	0	0	0	0
Primary Care - Delegated GP	32	31	0	40	40	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	27	28	(1)	35	37	(1)
Primary Care - Other	2	2	0	2	2	0
Sub Total - Programme Expenditure	**283**	**284**	**(2)**	**374**	**377**	**(3)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**283**	**284**	**(2)**	**374**	**377**	**(3)**
Surplus / (Deficit) Plan	*8*	*0*	*8*	*11*	*0*	*11*
Sub Total - Net Surplus / (Deficit) Reported	***291***	***284***	***6***	***385***	***377***	***8***

LIVERPOOL	Liverpool Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	414	415	(1)	548	549	(1)
Community	92	93	(1)	123	124	(1)
CHC	41	46	(5)	56	61	(5)
Mental Health - Packages of Care	23	25	(2)	31	34	(4)
Mental Health - Contracts	79	79	(1)	106	106	(1)
Other Commissioned Services	3	3	0	4	3	0
Other Programme	7	7	0	10	9	0
Reserves	1	0	1	1	0	1
Primary Care - Delegated GP	82	81	1	104	103	1
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	73	77	(4)	97	103	(5)
Primary Care - Other	21	21	0	28	27	0
Sub Total - Programme Expenditure	**835**	**845**	**(10)**	**1,106**	**1,120**	**(13)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**835**	**845**	**(10)**	**1,106**	**1,120**	**(13)**
Surplus / (Deficit) Plan	*5*	*0*	*5*	*7*	*0*	*7*
Sub Total - Net Surplus / (Deficit) Reported	***841***	***845***	***(5)***	***1,114***	***1,120***	***(6)***

SEFTON	Sefton Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	223	224	(1)	295	297	(1)
Community	55	54	1	73	72	1
CHC	30	32	(1)	40	43	(2)
Mental Health - Packages of Care	11	16	(5)	15	21	(7)
Mental Health - Contracts	39	39	(0)	52	53	(0)
Other Commissioned Services	1	1	(0)	1	2	(0)
Other Programme	11	10	1	15	14	1
Reserves	1	0	1	3	1	2
Primary Care - Delegated GP	37	37	0	49	49	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	42	45	(2)	56	59	(3)
Primary Care - Other	9	8	1	12	11	1
Sub Total - Programme Expenditure	**460**	**466**	**(6)**	**612**	**620**	**(8)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**460**	**466**	**(6)**	**612**	**620**	**(8)**
Surplus / (Deficit) Plan	*(4)*	*0*	*(4)*	*(6)*	*0*	*(6)*
Sub Total - Net Surplus / (Deficit) Reported	***456***	***466***	***(10)***	***607***	***620***	***(14)***

ST HELENS	St. Helens Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	160	160	1	212	212	1
Community	39	40	(1)	52	53	(1)
CHC	18	20	(2)	24	26	(2)
Mental Health - Packages of Care	13	15	(2)	17	20	(3)
Mental Health - Contracts	25	25	(0)	33	33	(0)
Other Commissioned Services	1	1	(0)	1	1	(0)
Other Programme	3	3	0	4	4	0
Reserves	0	0	0	1	0	1
Primary Care - Delegated GP	30	30	0	39	39	0
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	32	32	(0)	43	43	(0)
Primary Care - Other	4	4	0	5	5	0
Sub Total - Programme Expenditure	**324**	**328**	**(3)**	**430**	**435**	**(5)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**324**	**328**	**(3)**	**430**	**435**	**(5)**
Surplus / (Deficit) Plan	*(6)*	*0*	*(6)*	*(9)*	*0*	*(9)*
Sub Total - Net Surplus / (Deficit) Reported	***318***	***328***	***(10)***	***422***	***435***	***(13)***

WARRINGTON	Warrington Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	158	159	(0)	209	209	(0)
Community	29	30	(0)	39	40	(1)
CHC	21	22	(1)	27	30	(2)
Mental Health - Packages of Care	10	9	1	13	12	0
Mental Health - Contracts	26	26	0	35	34	0
Other Commissioned Services	1	1	0	1	1	0
Other Programme	2	1	1	3	2	1
Reserves	(0)	0	(0)	0	0	0
Primary Care - Delegated GP	30	30	(0)	38	38	(0)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	27	29	(2)	37	39	(3)
Primary Care - Other	4	4	(0)	5	6	(0)
Sub Total - Programme Expenditure	**308**	**310**	**(2)**	**407**	**410**	**(4)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**308**	**310**	**(2)**	**407**	**410**	**(4)**
Surplus / (Deficit) Plan	*(6)*	*0*	*(6)*	*(8)*	*0*	*(8)*
Sub Total - Net Surplus / (Deficit) Reported	***302***	***310***	***(8)***	***399***	***410***	***(11)***

WIRRAL	Wirral Place - Month 9 Position			Annual	M1 to M12 Forecast	
	Budget	Actual	Variance	Budget	Outturn	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	270	271	(1)	359	360	(1)
Community	61	61	(1)	81	82	(1)
CHC	42	48	(6)	56	66	(10)
Mental Health - Packages of Care	18	20	(3)	24	28	(4)
Mental Health - Contracts	42	42	0	56	55	0
Other Commissioned Services	1	1	(0)	1	1	(0)
Other Programme	0	(0)	0	0	0	0
Reserves	(2)	0	(2)	(1)	(0)	(1)
Primary Care - Delegated GP	50	51	(0)	65	65	(0)
Primary Care - Delegated Other	0	0	(0)	0	0	(0)
Prescribing	55	56	(1)	73	74	(2)
Primary Care - Other	9	8	1	12	11	1
Sub Total - Programme Expenditure	**545**	**558**	**(13)**	**723**	**741**	**(18)**
Running Costs	0	0	(0)	0	0	(0)
TOTAL EXPENDITURE	**545**	**558**	**(13)**	**723**	**741**	**(18)**
Surplus / (Deficit) Plan	*(5)*	*0*	*(5)*	*(7)*	*0*	*(7)*
Sub Total - Net Surplus / (Deficit) Reported	***539***	***558***	***(18)***	***716***	***741***	***(25)***

Appendix 2 - Agency Spend: Current Performance and Forecast Outturn M9

	M9 YTD			2324 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Alder Hey Children's NHS Foundation Trust	(0.8)	(1.4)	(0.6)	(1.1)	(2.0)	(0.9)
Bridgewater Community Healthcare NHS Foundation Trust	(3.5)	(4.1)	(0.6)	(4.2)	(4.2)	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	(5.0)	(7.2)	(2.2)	(6.7)	(9.4)	(2.7)
Countess of Chester Hospital NHS Foundation Trust	(5.2)	(4.9)	0.3	(6.9)	(6.5)	0.5
East Cheshire NHS Trust	(7.1)	(6.3)	0.8	(9.5)	(9.6)	(0.1)
Liverpool Heart and Chest Hospital NHS Foundation Trust	(0.9)	(0.7)	0.2	(1.1)	(0.9)	0.2
Liverpool University Hospitals NHS Foundation Trust	(13.9)	(13.8)	0.1	(15.7)	(15.7)	0.0
Liverpool Women's NHS Foundation Trust	(1.8)	(0.5)	1.3	(2.3)	(0.6)	1.7
Mersey Care NHS Foundation Trust	(14.5)	(14.9)	(0.4)	(19.3)	(19.9)	(0.6)
Mid Cheshire Hospitals NHS Foundation Trust	(9.1)	(9.6)	(0.4)	(12.6)	(13.2)	(0.6)
Southport And Ormskirk Hospital NHS Trust	(1.6)	(1.8)	(0.2)	(1.6)	(1.8)	(0.2)
Mersey and West Lancashire Teaching Hospitals NHS Trust	(11.3)	(14.7)	(3.3)	(15.7)	(19.7)	(4.0)
The Clatterbridge Cancer Centre NHS Foundation Trust	(1.3)	(1.4)	(0.1)	(1.8)	(1.8)	(0.0)
The Walton Centre NHS Foundation Trust	0.0	(0.4)	(0.4)	0.0	(0.6)	(0.6)
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(9.1)	(7.3)	1.8	(11.6)	(9.8)	1.8
Wirral Community Health and Care NHS Foundation Trust	(1.1)	(1.1)	0.1	(1.5)	(1.4)	0.1
Wirral University Teaching Hospital NHS Foundation Trust	(4.3)	(7.8)	(3.5)	(5.7)	(9.5)	(3.8)
Total Providers	**(90.7)**	**(97.9)**	**(7.2)**	**(117.6)**	**(126.7)**	**(9.1)**
as a proportion of Total Pay	3.04%	3.10%		2.96%	4.02%	

System agency ceiling is £127.3m

Appendix 3A - System Efficiencies: Current Performance and Forecast Outturn M9

	M9 YTD			23/24		
	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
ICB	42.1	40.1	(2.0)	57.9	57.8	(0.1)
	42.1	**40.1**	**(2.0)**	**57.9**	**57.8**	**(0.1)**
Providers:						
Alder Hey Children's NHS Foundation Trust	12.4	10.9	(1.5)	17.7	17.7	0.0
Bridgewater Community Healthcare NHS Foundation Trust	3.9	3.9	0.0	5.1	5.1	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	9.4	8.9	(0.6)	12.8	12.8	0.0
Countess of Chester Hospital NHS Foundation Trust	15.6	13.0	(2.6)	20.8	20.8	0.0
East Cheshire NHS Trust	6.7	7.5	0.8	10.3	10.5	0.2
Liverpool Heart and Chest Hospital NHS Foundation Trust	6.7	6.1	(0.6)	9.0	9.0	0.0
Liverpool University Hospitals NHS Foundation Trust	56.9	50.3	(6.7)	81.7	81.7	0.0
Liverpool Women's NHS Foundation Trust	5.7	4.2	(1.5)	8.3	7.3	(1.0)
Mersey Care NHS Foundation Trust	27.9	27.9	0.0	37.2	37.2	0.0
Mid Cheshire Hospitals NHS Foundation Trust	14.7	14.7	0.0	21.2	21.1	(0.1)
Southport And Ormskirk Hospital NHS Trust	2.8	2.8	0.0	2.8	2.8	0.0
Mersey and West Lancashire Teaching Hospitals NHS Trust	27.9	27.9	0.0	38.8	38.8	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	6.2	6.3	0.1	8.2	8.3	0.1
The Walton Centre NHS Foundation Trust	5.9	5.9	0.0	7.5	7.5	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	10.7	10.4	(0.3)	17.9	17.9	0.0
Wirral Community Health and Care NHS Foundation Trust	4.0	4.0	0.0	5.3	5.3	0.0
Wirral University Teaching Hospital NHS Foundation Trust	17.7	16.4	(1.3)	26.2	23.3	(2.9)
Total Providers	**235.0**	**221.0**	**(14.0)**	**330.8**	**327.1**	**(3.7)**
Total System	**277.1**	**261.1**	**(16.0)**	**388.7**	**384.9**	**(3.8)**

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

	YTD Recurrent			YTD Non Recurrent			YTD Total		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	31.6	25.7	(5.9)	10.5	14.4	3.9	42.1	40.1	(2.0)
	31.6	**25.7**	**(5.9)**	**10.5**	**14.4**	**3.9**	**42.1**	**40.1**	**(2.0)**
Alder Hey Children's NHS Foundation Trust	12.4	4.1	(8.3)	0.0	6.7	6.7	12.4	10.9	(1.5)
Bridgewater Community Healthcare NHS Foundation Trust	3.9	1.4	(2.5)	0.0	2.5	2.5	3.9	3.9	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	4.8	3.6	(1.2)	4.6	5.3	0.7	9.4	8.9	(0.6)
Countess of Chester Hospital NHS Foundation Trust	7.8	6.3	(1.5)	7.8	6.7	(1.1)	15.6	13.0	(2.6)
East Cheshire NHS Trust	6.7	4.5	(2.3)	0.0	3.1	3.1	6.7	7.5	0.8
Liverpool Heart and Chest Hospital NHS Foundation Trust	6.7	3.9	(2.9)	0.0	2.3	2.3	6.7	6.1	(0.6)
Liverpool University Hospitals NHS Foundation Trust	42.6	25.1	(17.5)	14.3	25.2	10.9	56.9	50.3	(6.7)
Liverpool Women's NHS Foundation Trust	5.7	2.8	(2.9)	0.0	1.4	1.4	5.7	4.2	(1.5)
Mersey Care NHS Foundation Trust	12.6	19.1	6.5	15.3	8.8	(6.5)	27.9	27.9	0.0
Mid Cheshire Hospitals NHS Foundation Trust	14.7	7.3	(7.4)	0.0	7.4	7.4	14.7	14.7	0.0
Southport And Ormskirk Hospital NHS Trust	0.0	2.8	2.8	2.8	0.0	(2.8)	2.8	2.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	22.7	22.7	0.0	5.2	5.2	0.0	27.9	27.9	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	6.2	3.8	(2.4)	0.0	2.5	2.5	6.2	6.3	0.1
The Walton Centre NHS Foundation Trust	5.9	4.6	(1.3)	0.0	1.3	1.3	5.9	5.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trus	10.7	4.0	(6.7)	0.0	6.4	6.4	10.7	10.4	(0.3)
Wirral Community Health and Care NHS Foundation Trust	3.8	1.2	(2.5)	0.2	2.7	2.5	4.0	4.0	0.0
Wirral University Teaching Hospital NHS Foundation Trust	17.7	16.2	(1.5)	0.0	0.2	0.2	17.7	16.4	(1.3)
Total Providers	**184.7**	**133.3**	**(51.4)**	**50.3**	**87.7**	**37.4**	**235.0**	**221.0**	**(14.0)**
Total System	**216.3**	**159.0**	**(57.3)**	**60.8**	**102.1**	**41.3**	**277.1**	**261.1**	**(16.0)**

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

	2324 Recurrent			2324 Non Recurrent			2324 Total		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	43.8	39.2	(4.6)	14.1	18.6	4.4	57.9	57.8	(0.1)
	43.8	**39.2**	**(4.6)**	**14.1**	**18.6**	**4.4**	**57.9**	**57.8**	**(0.1)**
Alder Hey Children's NHS Foundation Trust	17.7	10.1	(7.6)	0.0	7.6	7.6	17.7	17.7	0.0
Bridgewater Community Healthcare NHS Foundation Trust	5.1	2.4	(2.8)	0.0	2.8	2.8	5.1	5.1	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	6.6	5.8	(0.8)	6.2	6.9	0.8	12.8	12.8	0.0
Countess of Chester Hospital NHS Foundation Trust	10.4	12.8	2.4	10.4	8.0	(2.4)	20.8	20.8	0.0
East Cheshire NHS Trust	10.3	6.9	(3.4)	0.0	3.6	3.6	10.3	10.5	0.2
Liverpool Heart and Chest Hospital NHS Foundation Trust	9.0	5.4	(3.6)	0.0	3.6	3.6	9.0	9.0	0.0
Liverpool University Hospitals NHS Foundation Trust	58.8	37.2	(21.6)	22.9	44.5	21.6	81.7	81.7	0.0
Liverpool Women's NHS Foundation Trust	8.3	5.4	(2.9)	0.0	1.9	1.9	8.3	7.3	(1.0)
Mersey Care NHS Foundation Trust	16.8	25.4	8.7	20.4	11.7	(8.7)	37.2	37.2	0.0
Mid Cheshire Hospitals NHS Foundation Trust	21.2	10.5	(10.7)	0.0	10.6	10.6	21.2	21.1	(0.1)
Southport And Ormskirk Hospital NHS Trust	0.0	2.8	2.8	2.8	0.0	(2.8)	2.8	2.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	31.8	31.8	0.0	7.0	7.0	0.0	38.8	38.8	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	8.2	5.1	(3.2)	0.0	3.2	3.2	8.2	8.3	0.1
The Walton Centre NHS Foundation Trust	7.5	6.2	(1.3)	0.0	1.3	1.3	7.5	7.5	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trus	17.9	9.4	(8.5)	0.0	8.5	8.5	17.9	17.9	0.0
Wirral Community Health and Care NHS Foundation Trust	5.0	1.8	(3.2)	0.3	3.5	3.2	5.3	5.3	0.0
Wirral University Teaching Hospital NHS Foundation Trust	26.2	23.1	(3.1)	0.0	0.2	0.2	26.2	23.3	(2.9)
Total Providers	**260.8**	**202.2**	**(58.7)**	**70.0**	**125.0**	**55.0**	**330.8**	**327.1**	**(3.7)**
Total System	**304.6**	**241.4**	**(63.2)**	**84.1**	**143.5**	**59.4**	**388.7**	**384.9**	**(3.8)**

Appendix 4A - Provider Capital: Current & Forecast Performance M9

	YTD Charge vs Capital Allocation			FOT Charge vs Capital Allocation		
	Plan	Actual	Variance	Plan	Actual	Var
	£m	£m	£m	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	8.4	8.0	0.5	14.6	15.6	(1.0)
Bridgewater Community Healthcare NHS Foundation Trust	1.8	0.8	1.0	2.1	2.1	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	3.1	1.1	1.9	4.5	4.5	0.0
Countess of Chester Hospital NHS Foundation Trust	27.6	16.2	11.4	45.3	35.9	9.3
East Cheshire NHS Trust	2.7	2.3	0.4	3.5	3.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	5.1	3.3	1.9	6.1	10.1	(4.0)
Liverpool University Hospitals NHS Foundation Trust	13.0	20.5	(7.5)	39.4	49.2	(9.8)
Liverpool Women's NHS Foundation Trust	4.6	3.2	1.3	5.0	5.2	(0.3)
Mersey Care NHS Foundation Trust	10.9	11.0	(0.1)	16.0	19.6	(3.6)
Mid Cheshire Hospitals NHS Foundation Trust	25.3	25.1	0.2	31.0	39.5	(8.5)
Southport And Ormskirk Hospital NHS Trust	0.7	0.4	0.3	0.7	0.4	0.3
Mersey and West Lancashire Teaching Hospitals NHS Trust	15.2	5.7	9.5	23.8	24.1	(0.3)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	1.9	(1.9)	7.3	7.3	0.0
The Walton Centre NHS Foundation Trust	3.5	1.5	1.9	4.8	4.8	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	7.8	5.9	1.9	8.9	8.9	0.0
Wirral Community Health and Care NHS Foundation Trust	3.5	1.4	2.0	4.4	2.3	2.1
Wirral University Teaching Hospital NHS Foundation Trust	6.5	3.7	2.8	12.6	12.7	(0.1)
Total Providers	**139.6**	**112.2**	**27.4**	**230.0**	**245.8**	**(15.8)**
ICS Allocation					**245.4**	
Variance to Allocation					**(0.4)**	

Appendix 4B - Provider Capital: Current & Forecast Impact of IFRS16 M9

	YTD Impact of IFRS16			FOT Impact of IFRS16		
	Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0
Bridgewater Community Healthcare NHS Foundation Trust	(0.7)	3.7	(4.4)	(0.7)	4.2	(5.0)
Cheshire and Wirral Partnership NHS Foundation Trust	0.4	0.9	(0.5)	0.4	1.1	(0.7)
Countess of Chester Hospital NHS Foundation Trust	2.0	0.0	2.0	2.0	1.5	0.5
East Cheshire NHS Trust	0.2	0.1	0.1	0.2	0.3	(0.1)
Liverpool Heart and Chest Hospital NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0
Liverpool University Hospitals NHS Foundation Trust	0.1	7.0	(6.9)	2.0	7.0	(5.0)
Liverpool Women's NHS Foundation Trust	0.1	0.0	0.1	0.1	0.1	0.0
Mersey Care NHS Foundation Trust	4.0	4.4	(0.4)	6.0	6.0	0.0
Mid Cheshire Hospitals NHS Foundation Trust	2.5	0.9	1.6	3.4	3.0	0.4
Southport And Ormskirk Hospital NHS Trust	0.0	0.0	0.0	0.0	0.0	0.0
Mersey and West Lancashire Teaching Hospitals NHS Trust	0.7	1.0	(0.3)	0.7	5.9	(5.2)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	0.1	(0.1)	0.1	0.1	(0.0)
The Walton Centre NHS Foundation Trust	0.0	0.0	0.0	1.4	0.6	0.8
Warrington and Halton Teaching Hospitals NHS Foundation Trust	4.8	1.8	3.0	5.0	5.5	(0.5)
Wirral Community Health and Care NHS Foundation Trust	0.0	1.6	(1.6)	0.0	1.6	(1.6)
Wirral University Teaching Hospital NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0
Total providers	**14.1**	**21.5**	**(7.4)**	**20.5**	**36.8**	**(16.3)**
Expected internal leases to DHSC Group to net off (based on M8)					(9.9)	
TOTAL (excluding internal leases)				**20.5**	**26.9**	**(6.4)**
ICS Allocation					**28.3**	
Variance to Allocation					**1.4**	

Appendix 4C – Provider Capital: Total CDEL M9

	YTD Charge vs Capital Allocation			FOT Charge vs Capital Allocation		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Var £m
Alder Hey Children's NHS Foundation Trust	12.1	8.9	3.2	21.1	20.9	0.2
Bridgewater Community Healthcare NHS Foundation Trust	1.4	4.5	(3.2)	1.6	6.6	(5.0)
Cheshire and Wirral Partnership NHS Foundation Trust	5.0	2.9	2.2	8.3	9.0	(0.7)
Countess of Chester Hospital NHS Foundation Trust	29.6	16.2	13.4	47.5	39.5	8.1
East Cheshire NHS Trust	10.9	8.9	1.9	12.9	16.1	(3.2)
Liverpool Heart and Chest Hospital NHS Foundation Trust	5.1	3.3	1.9	6.1	10.1	(4.0)
Liverpool University Hospitals NHS Foundation Trust	30.6	36.9	(6.3)	80.3	71.4	8.9
Liverpool Women's NHS Foundation Trust	4.7	3.2	1.5	5.2	5.4	(0.3)
Mersey Care NHS Foundation Trust	45.3	31.7	13.6	61.4	42.4	19.0
Mid Cheshire Hospitals NHS Foundation Trust	38.0	31.8	6.2	47.9	59.7	(11.8)
Southport And Ormskirk Hospital NHS Trust	0.7	(25.6)	26.3	0.7	(25.6)	26.3
Mersey and West Lancashire Teaching Hospitals NHS Trust	18.8	(6.7)	25.5	32.5	39.3	(6.8)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	2.2	(2.2)	7.4	7.6	(0.2)
The Walton Centre NHS Foundation Trust	3.5	1.5	1.9	6.2	5.4	0.8
Warrington and Halton Teaching Hospitals NHS Foundation Trust	20.8	12.5	8.3	24.8	31.3	(6.5)
Wirral Community Health and Care NHS Foundation Trust	3.5	3.1	0.4	4.4	3.9	0.5
Wirral University Teaching Hospital NHS Foundation Trust	20.6	15.9	4.7	26.8	27.0	(0.2)
Total providers	**250.6**	**151.3**	**99.3**	**395.1**	**370.0**	**25.1**

Appendix 5

Provider Cash: Current Cash Position as at Month 8*

	M8 ACTUAL £m	M7 ACTUAL £m	M6 ACTUAL £m	M5 ACTUAL £m	M4 ACTUAL £m	M3 ACTUAL £m	M2 ACTUAL £m	M1 ACTUAL £m	M7 to M8 CHANGE £m	31/03/2023 BALANCE £m	31/03/2022 BALANCE £m	31/03/2021 BALANCE £m	31/03/2020 BALANCE £m
Alder Hey Children's NHS Foundation Trust	78.2	79.3	78.7	84.5	79.8	85.1	83.1	83.1	(1.1)	83.5	91.5	92.7	90.0
Bridgewater Community Healthcare NHS Foundation Trust	17.8	17.7	18.7	19.2	18.0	20.5	20.7	20.7	0.1	24.3	26.2	17.9	3.6
Cheshire and Wirral Partnership NHS Foundation Trust	24.5	24.7	24.8	27.6	27.6	32.8	32.7	37.6	(0.2)	37.5	41.1	33.9	21.2
Countess of Chester Hospital NHS Foundation Trust	15.0	16.0	16.4	9.1	2.8	8.7	10.9	10.9	(1.0)	22.9	40.9	32.7	12.2
East Cheshire NHS Trust	17.5	21.0	20.8	23.8	26.7	28.3	30.6	31.4	(3.5)	30.3	37.3	27.4	11.4
Liverpool Heart and Chest Hospital NHS Foundation Trust	46.1	47.2	45.8	45.9	50.1	46.2	46.2	45.0	(1.1)	41.3	42.7	49.0	30.2
Liverpool University Hospitals NHS Foundation Trust	49.0	54.6	46.9	61.5	76.4	89.8	100.6	100.6	(5.6)	99.3	211.4	167.5	43.6
Liverpool Women's NHS Foundation Trust	6.5	9.0	6.3	3.8	1.3	3.0	4.8	8.7	(2.5)	9.8	11.2	4.2	4.6
Mersey Care NHS Foundation Trust	87.2	91.6	88.7	92.0	94.4	95.4	93.8	94.0	(4.4)	83.3	84.2	90.8	59.6
Mid Cheshire Hospitals NHS Foundation Trust	10.8	10.1	8.4	11.3	11.2	17.4	14.4	12.1	0.7	8.4	26.7	33.1	14.0
Mersey and West Lancashire Teaching Hospitals NHS Trust	3.0	2.5	3.0	6.1	28.0	67.7	67.8	40.8	0.5	25.6	54.2	51.4	7.3
The Clatterbridge Cancer Centre NHS Foundation Trust	75.9	75.9	76.0	74.0	72.5	75.2	67.9	67.9	0.1	70.0	80.7	60.2	35.4
The Walton Centre NHS Foundation Trust	47.7	45.7	46.5	49.6	46.1	45.4	47.0	48.7	1.9	47.7	40.7	35.7	26.7
Warrington and Halton Teaching Hospitals NHS Foundation Trust	9.5	17.3	19.4	22.1	25.3	30.4	28.8	32.3	(7.7)	34.9	44.7	47.9	2.2
Wirral Community Health and Care NHS Foundation Trust	15.2	10.3	14.0	12.3	10.0	13.0	13.9	17.4	4.8	19.5	23.8	26.2	18.3
Wirral University Teaching Hospital NHS Foundation Trust	10.7	22.6	14.5	22.6	26.5	30.3	29.1	29.1	(11.9)	24.3	36.4	21.3	5.9
Total Providers	**514.7**	**545.6**	**529.1**	**565.5**	**596.7**	**689.2**	**692.0**	**680.0**	**(30.9)**	**662.6**	**893.7**	**791.9**	**386.4**
Cash Advances from ICB to Providers	**(82.6)**	**(72.6)**	**(52.9)**	**(42.8)**	**(36.6)**	**(33.6)**	**(14.0)**	**(14.0)**	**(10.0)**	-	-	-	-
Net Provider Cash Balance	**432.1**	**473.0**	**476.2**	**522.7**	**560.1**	**655.6**	**678.0**	**666.0**	**(40.9)**	**662.6**	**893.7**	**791.9**	**386.4**

**Month 9 not yet able available due to extended reporting deadline for M9 accounts for providers*

Appendix 6

A. System BPPC: Actual & YTD Total BPPC Position as at Month 8*

	Month 8		Month 8 YTD	
	Total by Value %	Total by Number %	Total by Value %	Total by Number %
ICB	99.8%	99.8%	99.3%	99.3%
Alder Hey Children's NHS Foundation Trust	90.4%	92.5%	93.5%	94.3%
Bridgewater Community Healthcare NHS Foundation Trust	92.8%	91.1%	96.7%	96.4%
Cheshire and Wirral Partnership NHS Foundation Trust	97.3%	100.1%	96.8%	97.5%
Countess of Chester Hospital NHS Foundation Trust	87.5%	91.4%	84.0%	83.9%
East Cheshire NHS Trust	95.1%	96.8%	95.1%	94.8%
Liverpool Heart and Chest Hospital NHS Foundation Trust	99.5%	96.1%	98.1%	96.4%
Liverpool University Hospitals NHS Foundation Trust	92.8%	80.3%	93.0%	83.9%
Liverpool Women's NHS Foundation Trust	89.5%	93.6%	94.3%	91.0%
Mersey Care NHS Foundation Trust	96.5%	95.1%	91.1%	95.2%
Mid Cheshire Hospitals NHS Foundation Trust	92.8%	89.0%	93.8%	86.3%
St Helens And Knowsley Teaching Hospitals NHS Trust	91.5%	90.7%	94.4%	91.0%
The Clatterbridge Cancer Centre NHS Foundation Trust	99.9%	97.5%	99.5%	97.7%
The Walton Centre NHS Foundation Trust	96.5%	94.4%	91.4%	89.5%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	91.6%	87.7%	90.5%	91.7%
Wirral Community Health and Care NHS Foundation Trust	98.2%	91.4%	90.4%	90.0%
Wirral University Teaching Hospital NHS Foundation Trust	87.8%	77.6%	94.8%	92.2%

**Month 9 not yet able available due to extended reporting deadline for M9 accounts for providers*

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Highlight report of the Chair of the ICB Finance, Investment & Our Resources Committee

Agenda Item No: ICB/01/24/11

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

Highlight report of the Chair of the ICB Finance, Investment & Our Resources Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	09 January 2024

Key escalation and discussion points from the Committee meeting

Alert

The Committee considered an update paper on the Health Care Services (Provider Selection Regime (PSR)) Regulations 2023

This paper informed the Committee on the updated PSR Regulation introduced from 01 January 2024 and outlined the greater emphasis on the governance surrounding decision-making and increased transparency requirements. Training is being made available for all affected ICS staff. Committee was alerted to the following key risks:

- No run-in period – regulations commenced 01 January 2024
- Full transparency of every decision – no monetary limit
- Short term increase in workload but should result in a better approach. Volume will even out in the mid-term.

Advise

The Committee considered the following in relation to procurement:

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

- **Approved** the award of the Non-Emergency Patient Transport Service contract for the Cheshire and Merseyside area following the North West wide procurement. The contract will commence on 01 April 2025 for 5 years with scope to extend for a further 3 years.

- **Approved** the commencement of a procurement process for the Social Model of Health, taken on behalf of Liverpool Place.

- **Approved** the award of contract for the provision of bed based intermediate care for a contract start date of 01 April 2024 for Sefton Place.

- **Approved** the award of contract for the provision of medical cover for bed based intermediate care with a contract start date of 01 April 2024 for Sefton Place

Assure

The Committee considered the following papers:

- **Risk Report:** report received and discussed - detail summarised below. FIRC to carry out deep dives into Place financial positions in March FIRC.

- **HR update:** robust review of HR dashboard, noting that it is also presented to the Executive Committee. Also noted current ICB agency spend and risk noted regarding identification of agency appointments. The risk associated with the

underuse of the apprenticeship levy has been withdrawn.

- **Month 8 Finance Report:** Noted that the forecast outturn has been adjusted for the additional non-recurrent funding obtained for Liverpool University Teaching Hospitals Foundation Trust, with respect to the opening of the new Royal, but has not been adjusted to reflect the November H2 reset.

- **Month 9 Finance Report:** figures not available as reporting timetable out of sync with FIRC in January. Paper to be submitted to Board. Forecast outturns are expected to be in line with the November H2 reset, adjusted for estimated Industrial Action costs related to December 2023 and January 2024 only.

- **Overview of planning:** Overview of guidance published to date. Noted that some guidance from 2023/24 is relevant to 2024/25 and that we are awaiting further guidance in areas such as targets (financial and activity) and finer detail for areas including, but not exclusively, Service Development Funds (SDF), convergence, Cost Uplift Factor and capital charges support.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
F2 - Health inequalities continue to drive increased demand for services with financial pressures resulting in failure to achieve financial duties, currently rated as extreme (16)	Current rating of 16 agreed.
F4 – Lack of clarity in respect of operating model and corresponding financial delegation to place based partnerships reduces financial control and flexibility resulting in failure to achieve financial duties	Previous rating of 15 has been mitigated to 8 through the completion and approval of detailed financial policies and update to the SORD. Revised rating agreed.
F5 – Scale of procurement requirements exceeds available capacity resulting in legal challenge and increased costs.	Previous rating of 12 has been mitigated to 9 through completion go ICB procurement policy and plan for 23/24. Revised rating agreed.
F7 – The ICB does not allocate the operational capital budget in a way that address capital investment risks across secondary and primary care.	Current rating of 10 agreed. Risk expanded to consider risk associated with the size of the operational capital budget allocated to the ICB.

Corporate Risk Register risks	
W8 – Lack of workforce diversity may impair the effectiveness of the ICB response to our population's needs, exacerbating health inequalities and damaging our reputation	Mitigated from extreme (20) to high (12) through policy commitments, processes and plans. Revised rating agreed.
Place Financial Risks above 15	Reviewed and considered. Noted that a number of risks associated with financial performance are still in the pipeline. Deep Dives into Place deficits will be conducted in the March FIRC.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P7: The Integrated Care System is unable to achieve its statutory financial duties. (16)	Current rating of 16 agreed.
BAF P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives.	Current rating of 12 agreed

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Development and delivery of a Cheshire and Merseyside system-wide financial strategy during the first half of 2023-24	Strategy paper presented
Delivery of the Finance Efficiency & Value Programme	Performance on CIP for Providers and ICB noted in month 8 finance report. Part of work required for "Delivering the 23/24 plan".
Development and delivery of the Capital Plans.	Spend to date noted in month 8 finance report.
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	N/a to be considered at a future meeting.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Integrated Quality and Performance Report

Agenda Item No: ICB/01/24/12

Responsible Director: Anthony Middleton: Director of Performance and Planning

Integrated Quality and Performance Report

1. Purpose of the Report

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

2. Executive Summary

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

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

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

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

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

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

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

9. Risks

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

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

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

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Quality & Performance Report

25th January 2024

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

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

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

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

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

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

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

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time	Dec-23	65.2%	72.7%	72.0%	72.0%	73.5%	73.7%	74.5%	73.6%	73.2%	71.0%	69.7%	68.9%	69.4%	71.1%	**76%** by Year end	67.7%	69.4%	23/42
	Ambulance category 2 mean response time	Dec-23	01:53:03	00:41:20	00:28:00	00:43:54	00:24:39	00:25:30	00:32:55	00:31:56	00:35:13	00:39:13	00:39:41	00:43:45	01:04:31	00:33:00	**00:30:00**	00:32:04	00:38:30	-
	A&E 12 hour waits from arrival	Dec-23	16.4%	16.3%	15.5%	16.2%	13.9%	13.6%	13.9%	14.0%	14.6%	16.5%	17.0%	16.6%	16.1%	-	-	14.4%	11.3%	38/42
	Adult G&A bed occupancy	Dec-23	96.2%	97.3%	97.0%	97.2%	95.8%	95.3%	95.40%	94.7%	95.0%	96.0%	96.5%	96.9%	95.3%	93.9%	**92.0%**	95.2%	95.7%	28/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Dec-23	19.3%	19.9%	20.4%	20.2%	18.3%	18.0%	17.3%	17.7%	19.2%	20.6%	20.0%	20.3%	18.3%	12.8%	**5.0%**	15.9%	14.0%	39/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Nov-23	9,910	8,561	6,515	4,807	4,867	4,762	4,528	4,332	4,888	5,078	5,393	4,842		5,068	-	18,140	94,563	-
	Total incomplete Referral to Treatment (RTT) pathways	Nov-23	336,835	343,092	340,484	344,912	360,819	361,747	362,417	367,634	375,312	372,005	376,230	369,440		330,621	-	1,080,292	7,609,941	-
	Patients waiting more than 6 weeks for a diagnostic test	Nov-23	24.3%	24.9%	19.1%	18.9%	22.1%	20.9%	21.2%	21.8%	23.3%	23.0%	20.0%	16.0%		14.9%	**10.0%**	23.2%	23.3%	12/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Oct-23	82.6%	60.5%	69.8%	70.3%	68.1%	65.9%	66.9%	70.7%	70.3%	71.3%	70.1%			70.0%	**85.0%**	65.6%	63.1%	6/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Oct-23	96.7%	92.5%	94.8%	94.5%	94.7%	93.3%	95.3%	93.9%	94.7%	94.1%	93.4%			96.0%	**96.0%**	92.1%	89.4%	7/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Oct-23	64.3%	66.9%	71.6%	67.1%	67.0%	67.7%	69.9%	70.3%	69.5%	68.6%	70.0%			70.8%	**75.0%**	71.1%	71.3%	29/42
Mental Health	Access rate to community mental health services for adults with severe mental illness	Oct-23	44.0%	76.0%	78.0%	81.0%	94.0%	100.0%	106.0%	95.0%	98.0%	101.0%	103.0%			100.0%	**100.0%**	101.3%	97.6%	10/42
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Oct-23	67.0%	64.0%	55.0%	59.0%	66.0%	71.0%	70.0%	67.0%	65.0%	68.0%	70.0%			60.0%	**60.0%**	74%	70.0%	16/42
	Access rate for Talking Therapies services	Oct-23	51.0%	67.0%	58.0%	70.0%	60.0%	62.0%	59.0%	61.0%	63.0%	60.0%	72.0%			100.0%	**100.0%**	71.7%	69.7%	20/42
	Dementia Diagnosis Rate	Nov-23	65.2%	64.5%	64.5%	65.1%	65.2%	65.2%	65.6%	65.8%	66.0%	66.2%	66.5%	66.9%		66.7%	**66.7%**	69.6%	64.7%	15/42
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Nov-23	100	100	100	105	100	105	110	110	110	105	105	105		≤ 60	-	300	1,820	34/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Oct 23 YTD	43.3%	54.8%	68.5%	80.4%	2.8%	6.6%	11.3%	16.0%	21.3%	26.9%	34.8%			29.3%	**75%** by Year end	33.8%	33.3%	19/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Nov-23	73.9%	80.6%	83.3%	78.7%	86.5%	83.2%	83.4%	87.0%	86.0%	84.0%	85.0%	79%		70.0%	**70.0%**	83.0%	84.0%	34/42
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Nov-23	72.6%	80.0%	86.5%	97.7%	56.9%	75.4%	76.1%	81.7%	87.3%	71.2%	80.9%	94.9%		100.0%	**100.0%**	103.0%	97.2%	21/42
	Number of General Practice appointments delivered against baseline (corresponding month same period last	Oct-23	107.1%	115.5%	107.1%	102.4%	98.7%	98.4%	111.8%	105.5%	105.9%	106.9%	102.7%			-	-	104.7%	106.9%	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in	Sep-23	7.68%	7.51%	7.42%	7.35%	7.34%	7.32%	7.32%	7.34%	7.31%	7.29%				10.0%	**10.0%**	7.38%	7.75%	10/42
	Total volume of antibiotic prescribing in primary care	Sep-23	1.045	1.071	1.087	1.093	1.088	1.086	1.084	1.079	1.082	1.081				0.871	**0.871**	1.089	0.986	33/42

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Local Trajectory	National Target	Region value	National value	Latest Rank
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)	Sep-23	80.7	81.2	75.4	86.9	79.8	85.9	79.1	78.6	80.1	78.3				-	-	-	67.2	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Oct-23	91.9%	92.0%	92.3%	92.3%	92.7%	92.8%	92.5%	92.8%	92.7%	92.5%	92.4%			-	-	92.4%	93.1%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)	Sep-23	207.7	183.7	172.2	173.2	170.7	202.8	153.8	166.2	175.6	169.1				-	-	-	150.7	-
Health Inequalities & Improvement	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by	Sep-23	59.8%	60.8%	58.4%	58.8%	61.8%	61.5%	56.8%	61.3%	60.1%	56.6%				70.0%	75% by 2028	55.5%	57.7%	14/21
	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1-23	60.8%	66.7%			66.0%									77.0%	77.0%	-	66.7%	-
	Children and young people accessing mental health services as % of LTP trajectory (planned number)	Oct-23	65.2%	78.6%	80.2%	82.0%	83.2%	84.0%	86.0%	87.0%	87.4%	89.0%	90.0%			100.0%	100.0%	106.0%	88.30%	16/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Dec-23												13.4%	13.4%	12.0%	12.0%	-	12.7%^	-
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Aug-23	3.16	3.05	3.25	2.76	2.80	3.30	3.30	3.33	3.14					-	-	-	-	-
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	Oct-23	131.0%	132.7%	134.4%	134.0%	144.4%	142.4%	143.8%	135.8%	132.3%	130.3%	132.8%			100%	100%	147.0%	129.8%	26/42
	Healthcare Acquired Infections: E.Coli (Hospital onset)	Oct-23	129.4%	128.9%	133.9%	131.2%	141.7%	142.1%	150.6%	150.4%	153.1%	150.4%	148.5%			100%	100%	145.7%	125.1%	38/42
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Jul-23	1.027	1.033	1.029	1.033	1.026	1.027	1.027	1.030						0.887 to 1.127 *		-	1.000	-
	Never Events	Nov-23	5	5	2	2	2	2	2	0	0	5	3	3		0	0	-	-	-
	21+ day Length of Stay	Dec-23	1,377	1,528	1,485	1,449	1,365	1,425	1,244	1,260	1,295	1,227	1,273	1,187	1,368	1,621	-	-	-	-
Workforce / HR (ICS total)	Staff in post	Oct-23	70,568	71,141	71,504	71,766	72,150	72,089	72,205	71,950	72,298	71,902	72,324			71,504	-	198,623	-	-
	Bank	Oct-23	4,785	4,977	4,956	5,340	4,798	4,596	4,633	5,036	5,372	5,386	5,425			3,778	-	16,424	-	-
	Agency	Oct-23	1,815	1,881	1,656	1,524	1,182	1,434	1,381	1,252	1,363	1,274	1,260			1,107.8	-	4,206	-	-
	Sickness	Sep-23	6.3%	6.2%	6.1%	6.0%	5.8%	5.8%	5.8%	5.6%	5.6%	5.6%				6.3%	-	6.0%	4.6%	35/42
	Turnover	Aug-23	14.4%	14.1%	14.0%	13.3%	13.1%	12.2%	12.4%	12.3%	12.2%					13.3%	-	12.3%	-	-
Note/s	* National average upper and lower control limits (UCL and LCL) for SHMI across all non-specialist trusts. This gives an indication of whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, for C&M was as expected when compared to the national baseline. This "rate" is different to the SHMI "banding" used for trusts on slide 8, therefore a comparison cannot be drawn between the two. ^ National figure is the latest ONS figure from 2022. local data is directly from GP systems. this has been reviewed against historic ONS data for LA's and the variation ranges from -0.9% to +5.9%																			

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Nov-23	-71.9	-63.6	-47.8	-29.6	-	48.2	-75.3	-103.0	-123.7	-128.2	-143.9	-80.8	-73.9	↓	0.0	0.0	0.0
	Financial position £ms (ICS) VARIANCE	Nov-23	-36.9	-29.6	-14.0	0.7	-	-7.8	-20.5	-38.1	-49.9	-56.7	-70.0	-42.2	-	↓	-	-	-
	Efficiencies £ms (ICS) ACTUAL	Nov-23	240.1	263.6	288.0	335.6	-	43.2	68.7	97.9	132.7	158.0	192.9	227.0	241.0	↑	388.7	389.0	0.2
	Efficiencies £ms (ICS) VARIANCE	Nov-23	5.6	-3.0	-10.8	4.7	-	-7.3	-8.2	-7.7	-4.6	-11.0	-12.2	-14.0	-	↑	-	-	-
	Capital £ms (ICS) ACTUAL	Nov-23	110.6	112.8	169.1	237.5	-	15.3	24.0	38.8	42.8	53.9	77.3	110.8	113.6	↑	288.3	292.8	4.5
	Capital £ms (ICS) VARIANCE	Nov-23	42.1	62.6	29.6	-12.7	-	2.6	6.3	6.0	16.8	41.2	17.8	2.8	-	↓	-	-	-

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

Category	Metric	Latest period	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Vs Target expenditure (Current)	Vs Target expenditure (Previous)	Dir. Of Travel
Finance	Mental Health Investment Standard met/not met (MHIS)	Nov-23	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Yes**	**Yes**	↔
	BCF achievement (Places achieving expenditure target)	Nov-23	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	**9/9**	n/a	↔

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																		ICB *
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts					Net OOA/ Other	
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	SHLA	MCFT	CWP		
Urgent care	4-hour A&E waiting time	Dec-23	49.4%	49.6%	60.9%	62.5%	61.3%	65.8%	68.3%	84.5%	-	91.3%		-	95.1%	95.3%		86.6%		-	69.4%
	A&E 12 hour waits from arrival	Dec-23	20.0%	17.6%	14.3%	18.7%	24.3%	18.3%	14.1%	0.2%	-	**	-	-	-	-	-	-	-	-	16.1%
	Adult G&A bed occupancy	Dec-23	98.4%	94.4%	93.5%	93.9%	95.9%	94.1%	97.4%		77.7%	53.4%	80.5%	76.7%						-	95.3%
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Dec-23	18.0%	11.9%	22.3%	11.4%	23.1%	20.1%	18.4%											-	18.3%
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Nov-23	742	84	699	286	1,314	159	652	185	30	277	2	26	-	-	-	-	-	642	4,842
	Total incomplete Referral to Treatment (RTT) pathways	Nov-23	31,955	13,476	36,044	42,551	33,013	76,888	79,133	25,689	5,194	20,311	1,241	15,741	3,201	121	-	43	-	36,192	369,440
	Patients waiting more than 6 weeks for a diagnostic test	Nov-23	21.9%	29.2%	19.5%	5.3%	17.3%	5.9%	20.7%	9.7%	10.2%	3.2%	0.0%	0.5%	42.1%	0.0%	-	0.0%	-	-	16.0%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for	Oct-23	74.0%	67.7%	56.4%	70.2%	79.6%	67.7%	78.5%	100.0%	55.6%	35.7%	85.5%	0.0%	87.0%					-	70.1%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Oct-23	93.6%	84.9%	80.0%	94.1%	98.8%	87.7%	90.2%	100.0%	75.0%	72.7%	99.3%	100.0%	100.0%					-	93.4%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Oct-23	62.7%	73.0%	71.2%	70.0%	79.0%	71.9%	73.0%	94.4%	60.0%	26.6%	86.7%	100.0%	87.6%					-	70.0%
Mental Health Community	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Oct-23	Mental Health service providers only														-	68.0%	81.0%	-	70.0%
	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Nov-23	70.0%	82.0%	85%	Community Service Providers only									82.0%	86.0%	*	73.0%	-	-	79.0%
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Aug-23	3.14	-	4.08	3.13	3.59	-	3.50	-	-	2.58	-	-							0.00
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	Oct-23	130.4%	200.0%	151.6%	164.8%	130.6%	117.3%	117.6%	400.0%	150.0%	0.0%	100.0%	183.3%							0.0%
	Healthcare Acquired Infections: E.Coli (Hospital onset)	Oct-23	128.6%	129.6%	237.5%	166.0%	133.3%	150.3%	135.5%	175.0%	100.0%	100.0%	250.0%	100.0%							0.0%
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Jun-23	0.9599	1.1912	0.9818	1.0722	0.9618	1.0503	1.0198												1.030
	Never Events (rolling 12 month total)	Nov-23	2	3	2	2	5	6	3	1	0	1	0	1	1	0		0	0	4***	31
	21+ day Length of Stay (ave per day)	Dec-23	100	41	126	159	134	470	256	3	22	1	23	33							0
Workforce / HR (Trust Figures)	Staff in post	Oct-23	4,499	2,349	4,808	5,844	4,167	13,818	9,373	4,006	1,843	1,625	1,754	1,478	1,372	1,481	-	10,144	3,763	-	72,324
	Bank	Oct-23	270.8	278.6	478.0	409.1	399.9	1,092.8	955.1	200.3	55.1	73.4	31.1	100.5	5.2	48.2	-	878.4	148.2	-	5,425
	Agency	Oct-23	36.2	79.3	105.6	55.8	112.3	191.6	235.2	5.3	8.9	6.0	20.3	3.4	44.3	7.9	-	246.6	101.1	-	1,260
	Sickness (via Ops Plan Monitoring Dashboard)	Sep-23	5.4%	5.5%	5.0%	6.0%	5.7%	6.5%	3.7%	6.0%	4.7%	6.6%	4.9%	5.9%	5.6%	6.1%	-	7.8%	6.6%	-	5.6%
	Turnover	Aug-23	13.2%	12.5%	11.4%	11.7%	12.1%	11.5%	11.0%	11.6%	13.7%	12.7%	14.7%	13.9%	12.8%	20.4%	-	11.3%	13.1%	-	12.2%
Finance	Overall Financial position Variance (£m)	Nov-23	-2.96	0.00	-3.70	-1.41	-3.14	-4.30	0.02	0.03	0.75	-1.96	1.00	1.88	0.01	0.01	0.02	0.00	-0.73	-27.70	0.00
	Efficiencies (Variance)	Nov-23	-3.26	0.00	0.10	-0.59	0.10	-2.79	0.00	-1.27	-1.47	-1.13	0.00	0.00	-0.00	-1.37	0.00	0.00	-0.31	-2.10	0.00
	Capital (Variance)	Nov-23	10.43	0.51	-0.62	1.11	2.18	-16.68	5.36	0.40	2.63	1.56	-1.73	1.90	-3.06	0.95	0.30	-4.04	1.63	0.00	0.00

Note/s

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

** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two.

*** Independent Providers / Other providers (1 at Alternative Futures - Weaver Lodge, 1 at Fairfield Independent Hospital and 2 at Isight Clinic – Southport)

4. Place Aggregate Position

NHS
Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time	Dec-23	56.6%	53.9%	53.1%	54.4%	64.3%	58.4%	66.8%	67.5%	56.0%		69.4%	71.1%	76% by Year end
	Ambulance category 2 mean response time	Dec-23	00:54:06		01:07:22	01:05:56	01:08:19	01:12:41	01:12:56	01:09:57	01:07:20		01:04:31	00:33:00	00:30:00
	A&E 12 hour waits from arrival	Dec-23	15.7%	18.0%	18.0%	23.6%	15.5%	15.0%	14.5%	21.0%	12.8%		16.1%	-	-
Planned Care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Nov-23	492	797	335	893	390	315	162	560	149		4,842	5,068	-
	Total incomplete Referral to Treatment (RTT) pathways	Nov-23	32,866	36,409	46,793	31,019	66,905	30,429	26,032	22,337	42,357		369,440	330,621	-
	Patients waiting more than 6 weeks for a diagnostic test	Nov-23	23.8%	21.0%	5.6%	14.2%	7.7%	21.1%	16.1%	27.5%	9.8%		16.0%	14.9%	10%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Oct-23	60.8%	67.7%	68.6%	79.6%	65.8%	81.4%	81.0%	83.9%	64.1%		70.1%	70.0%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Oct-23	82.0%	89.4%	93.9%	97.0%	94.5%	94.6%	93.3%	94.1%	92.4%		93.4%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Oct-23	70.9%	65.5%	69.0%	79.1%	65.6%	70.7%	72.6%	72.4%	73.4%		70.0%	70.8%	75.0%
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Oct-23	77.0%		100.0%	75.0%	62.0%	38.0%	92.0%	79.0%	67.0%	86.0%	70.0%	60.0%	60.0%
	Access rate for Talking Therapies services	Oct-23	89.0%		84.0%	53.0%	61.0%	102.0%	73.0%	73.0%	41.0%		72.0%	100.0%	100.0%
	Dementia Diagnosis Rate	Nov-23	66.8%		67.1%	73.1%	63.5%	70.8%	59.7%	66.8%	67.1%		66.9%	66.7%	66.7%
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Jul-23	30		5	5	25	10	5	10	10		105	-	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Oct-23	36.6%		38.5%	34.7%	36.1%	21.9%	40.1%	31.3%	30.5%		34.8%	29.3%	75% by Year end
Primary Care	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Oct-23	102.0%	94.4%	104.5%	106.7%	104.3%	103.4%	112.9%	98.0%	104.2%		102.7%	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Sep-23	6.92%		8.99%	6.26%	7.58%	5.76%	6.90%	6.18%	8.10%		7.29%	10.0%	10.0%
	Total volume of antibiotic prescribing in primary care	Sep-23	0.979		1.151	0.986	1.100	1.172	1.222	1.157	1.140		1.081	0.871	0.871
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q2 23/24	175.0	188.0	213.8	225.2	343.5	265.5	306.1	277.1	209.3		-	-	-
	Percentage of people who are disc harged from acute hospital to their usual place of residence ***	Oct-23	88.8%	88.8%	94.2%	94.6%	93.5%	93.4%	94.3%	94.5%	92.4%		0.0%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q2 23/24	588.4	623.7	508.6	380.6	655.4	629.9	732.7	428.7	519.3		-	-	-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 23/24	68.64%		65.03%	64.63%	64.82%	67.00%	62.41%	66.20%	58.92%	69.02%	66.0%	77.0%	77.0%
	Improve access rate to Children and Young People's Mental Health Services (CYPMH) (12 Month Rolling) ****	Sep-23	44.8%		42.9%	81.5%	49.9%	60.5%	78.4%	93.0%	88.6%	93.4%	n/a ****	-	-
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Dec-23	11.6%	13.1%	14.6%	9.0%	17.1%	14.2%	17.5%	18.1%	13.8%		0.0%	12%	12%
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation	Oct-23	136.5%		131.3%	137.8%	105.2%	123.4%	97.9%	118.2%	98.0%		0.0%	100.0%	100.0%
	Healthcare Acquired Infections: E.Coli (Hospital onset)	Oct-23	119.1%		152.2%	144.6%	132.9%	108.0%	120.0%	130.3%	122.2%		0.0%	100.0%	100.0%
Finance	Overall Financial position Variance (£m)	Nov-23	-10.86	-12.70	-9.34	-12.31	-2.16	-2.99	-3.40	0.85	-8.60		8.40	0.0	0.0
	Efficiencies (Variance)	Nov-23	1.51	-1.75	-1.40	-0.79	0.00	-1.05	0.00	1.54	0.09		0.00	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	Nov-23	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Nov-23	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9		9/9	9/9	9/9
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories **** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is different to the NHS Oversight Framework indicator used in the ICB table														

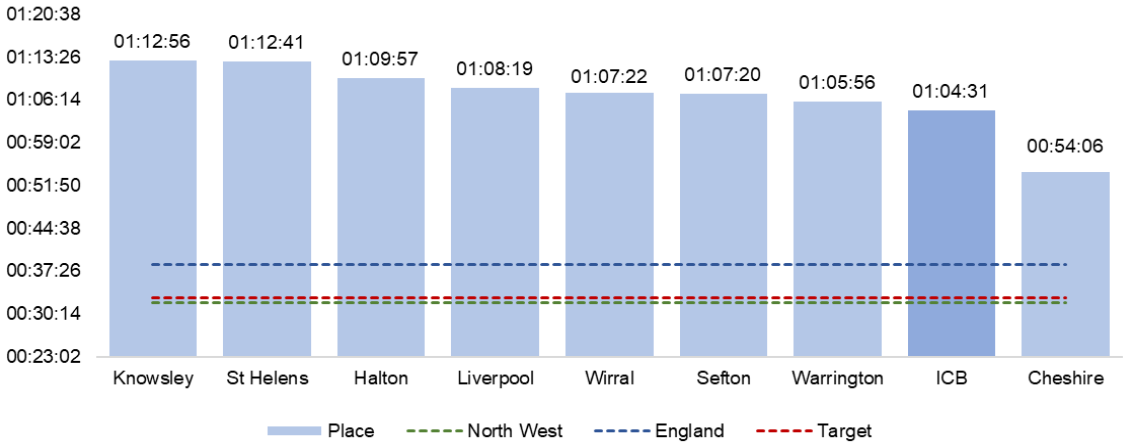
5. Exception Report – Urgent Care

Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (Dec-23)	01:04:31	National Ranking	n/a

Place Breakdown (Dec-23)



Issue
National category 2 mean response time target for 2023/24 is <30 minutes. NWAS has set a plan to achieve 33 minutes. Ambulance handover is a key dependency.

Action
ICB Medical Directors have agreed shared principles for managing ambulance handover delays to release crews, where necessary accepting that this may cause increased waits in A&E and 'corridor care', in order to manage the wider risk to patients in the community. Particular challenges noted at COCH, LUFT, WUTH, and the Whiston Site of MWL:

- COCH: ICB co-ordinating national service improvement resource to focus on handover.
- LUFT: Rapid Flow Model developed to address ambulance handover times alongside deployment of national improvement resource to improve processes, flow and discharge.
- Whiston Site of MWL: Focus on admission avoidance via Urgent Community Response (UCR). Focus on discharge, NCTR and flow continues.
- WUTH: Ambulance Turnaround Improvement Plan in place, agreed by system partners. Ambulance Arrival Zone implemented with focus on staffing of cohorting areas.

Delivery

- Achieve 30 minutes by March 2024

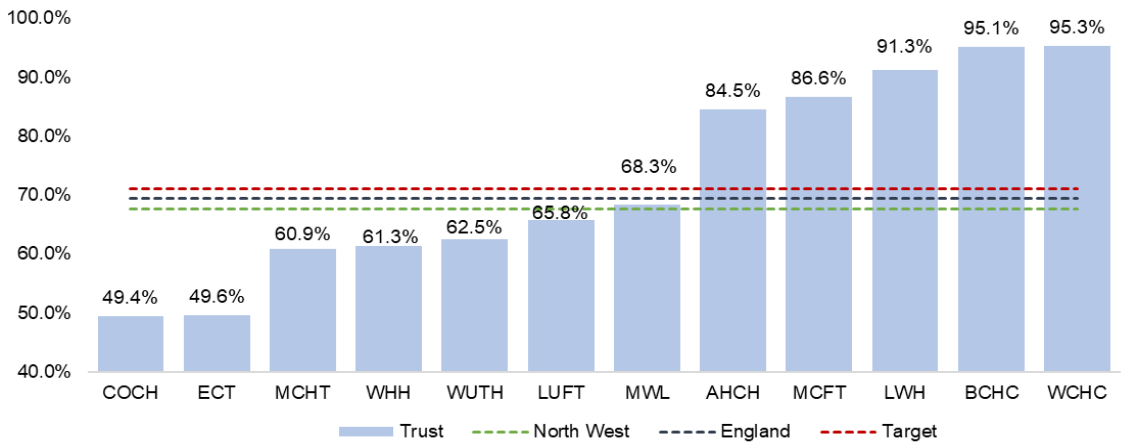
5. Exception Report – Urgent Care

Cheshire and Merseyside

A&E 4 hour waits from arrival

Latest ICB Performance (Dec-23)	69.4%	National Ranking	23/42

Provider Breakdown (Dec-23)



Issue
- Cheshire and Merseyside performance has been below trajectory since September, and currently falls 1.7% short of the in-year operational planning trajectory of 71.1% for the month.

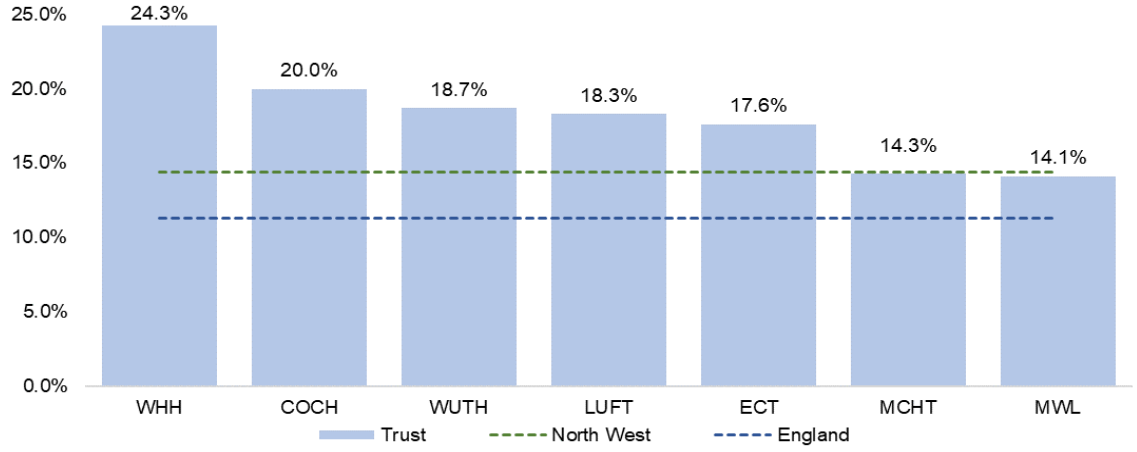
Action
- Wirral: An improvement plan led by WUTH is in place with oversight by the Unscheduled Care board. Focus is on attendance and admission avoidance initiatives, Urgent Community Response (UCR) and 'Front Door' in reach.
- West Cheshire: Performance is impacted due to a lack of flow through the hospital and discharge delays. There continues to be a considerable Investment and support from place continues for additional resources to provide the care at home required to enable discharges. ICB/NHSE in liaison with NHS Wales regarding discharge.
- East Cheshire: Cheshire East Home First workstream and UEC improvement work streams in place with focus on streaming to Same Day Emergency Care (SDEC), reablement and frailty.

Delivery
- C&M continues to plan for achievement of 76% by March 2024, this remains a challenging trajectory within the context of emerging winter pressures and ongoing industrial action.

A&E 12 hour waits from arrival

Latest ICB Performance (Dec-23)	16.1%	National Ranking	38/42

Provider Breakdown (Dec-23)



Issue
- 16.1% of Cheshire & Merseyside A&E patients were delayed over 12 hours compared to the England average of 11.3%.

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

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

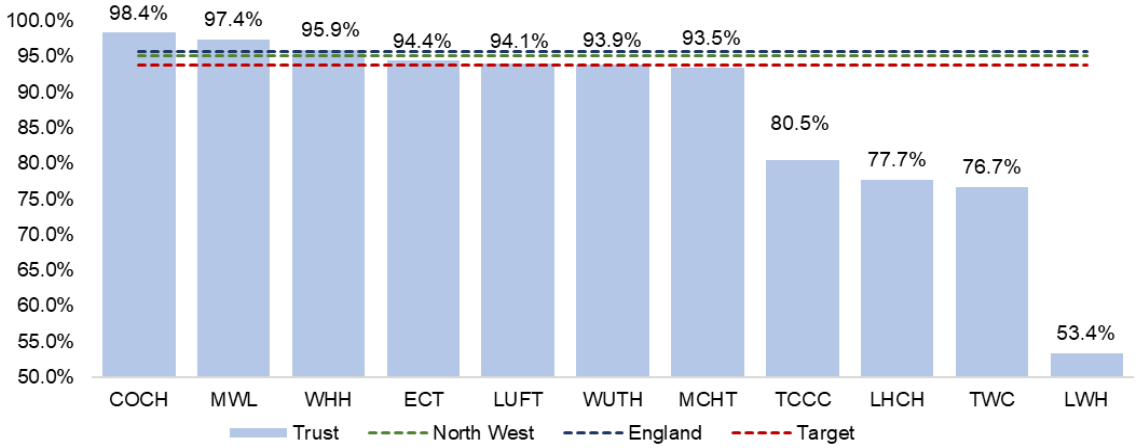
5. Exception Report – Urgent Care

Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (Dec-23)	95.3%	National Ranking	28/42

Provider Breakdown (Nov-23)



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

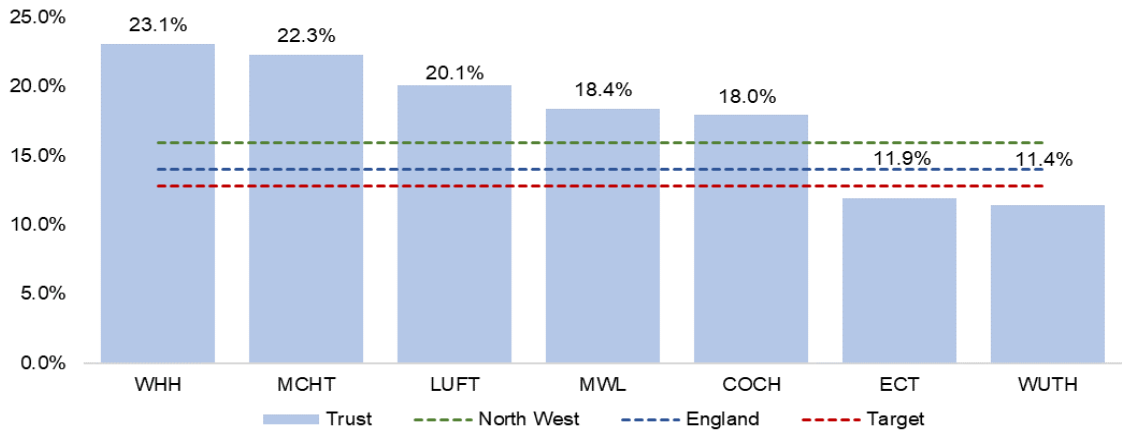
Action
- Place and providers have worked together to update winter demand and capacity assumptions, these indicate that providers plan to achieve 93.4%, but this is predicated on the improved NCTR position being maintained.

Delivery
- Achieve 93.4% bed occupancy by March 2024

No Criteria To Reside (NCTR)

Latest ICB Performance (Dec-23)	18.3%	National Ranking	39/42

Provider Breakdown (Dec-23)



Issue
- NCTR is at 18.3%, higher than England (14.0%) and NW (15.9%)

Action
- LUFT has a dedicated improvement work stream including national Emergency Care Improvement Support Team (ECIST) resource to focus on hospital process and discharge and operational management of the NCTR patient list at the Aintree site. Intensive work is ongoing to streamline and test the process from ward to Care Transfer Hub.
- C&M Places and Providers have reviewed their assumptions and plans regarding NCTR and winter plans are aligned to Tier 1 / 10 high impact UEC interventions.
- This includes aligning processes across the 9 C&M care transfer hubs, addressing capacity gaps in intermediate care, improving community bed productivity, and deploying this year's discharge fund to improve staffing e.g. in care transfer hubs and care arranging teams.

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

5. Exception Report – Virtual Wards

Cheshire and Merseyside

Number of open beds

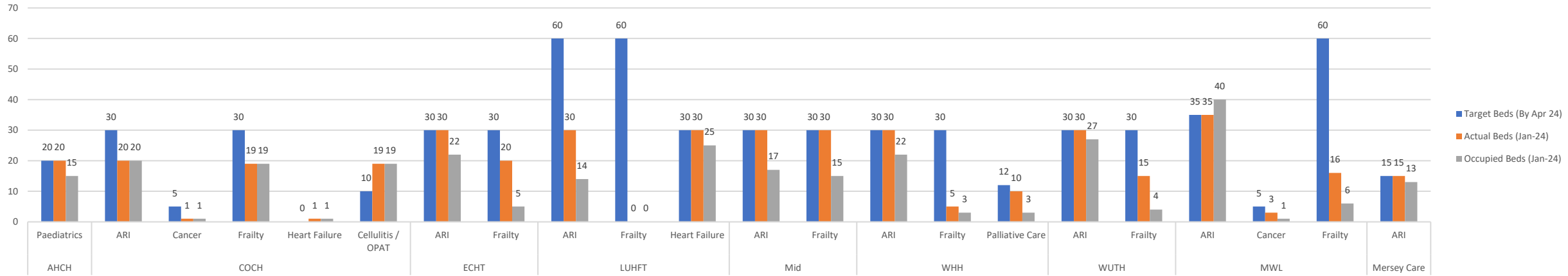
Latest ICB Performance (Dec-23)	419	Target	535

Provider Breakdown

Utilisation

Latest ICB Performance (Dec-23)	69.7%	Target	80%

Provider Breakdown



Issue
- Recruitment to funded posts has been challenging due to national staffing shortages
- Data anomalies persist between local and national data due to the Foundry data collection process. This is recognised regionally and nationally
- The additional 60 Frailty beds in Liverpool are not yet open due to staffing /recruitment constraints

Action
- Discussions with ICB executive regarding ongoing funding allocation
- Work with regional team on data quality and establishment of provider collab data quality group
- Go live date for Liverpool frailty beds set for February 2024

Delivery
- Site-by-site reviews being scheduled with site leads and providers
- Monitoring delivery of site action plans
- Locally agreed target to achieve 590 beds by 1st April

Issue
- All sites have specialty level bed targets, but demand is variable across the different providers
- The opportunity for step up hospital avoidance pathways has not yet been fully explored due to conversations regarding the clinical governance of this patient cohort

Action
- Site by site recovery plan
- Joint provider pharmacy team due to commence in February
- Improved case finding and expansion of current acceptance criteria.
- Clinical engagement strategy being taken forward by the VW clinical advisory group, working across acute and community
- Senior operational engagement including with Acute COOs and strengthening operational presence in meetings
- Working with neighbouring ICBs to share best practice

Delivery
- Target to achieve 80% utilisation.

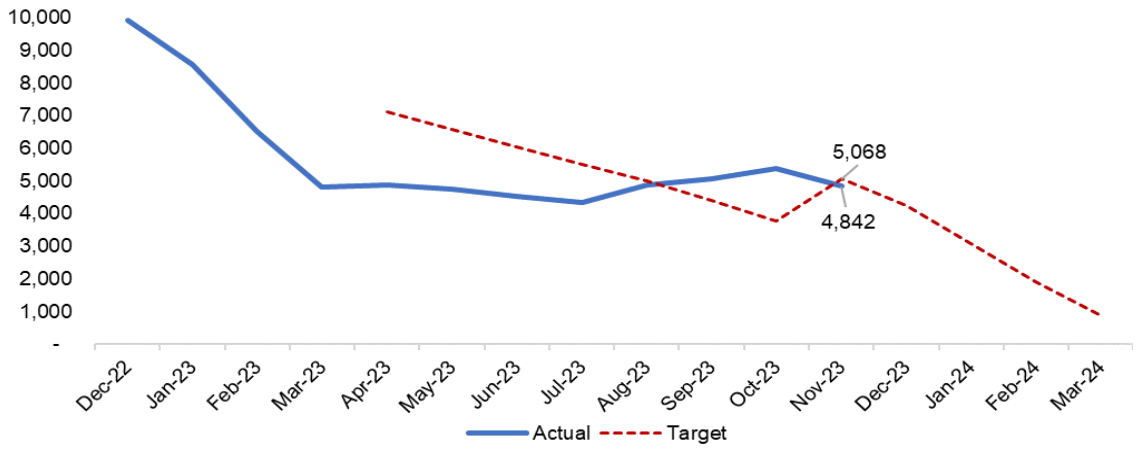
5. Exception Report – Planned Care

Cheshire and Merseyside

ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Nov-23)	4,842	National Ranking	n/a

ICB Trend (Nov-23)



Issue
- As of 3rd January 2024 C&M is on track with clearance of 65 week cohort, with less than 23,000 to clear by end of March.
- There are currently 4,842 patients waiting over 65 weeks, which is a reduction since the last reporting period.

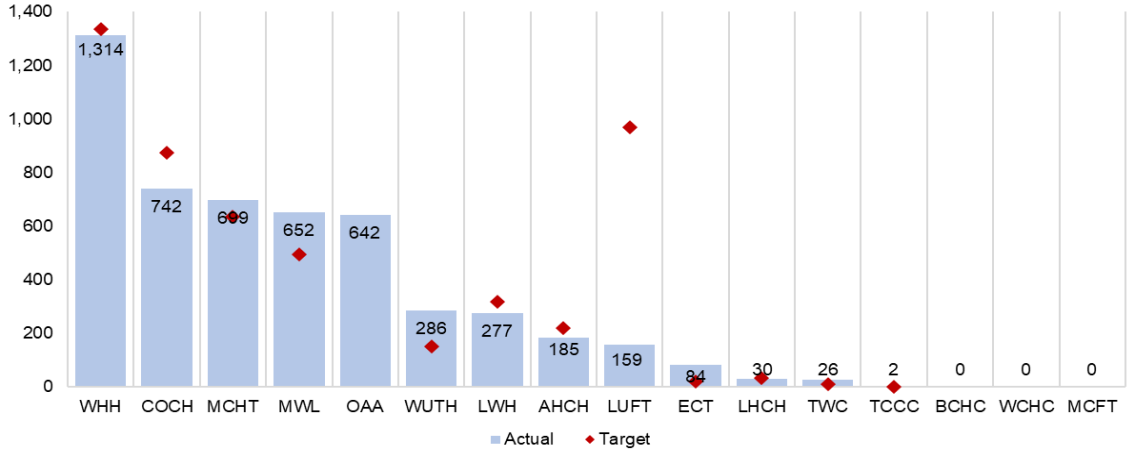
Action
- Over 154,000 patients cleared from the "potential breach" since March 2023.
- Focus on maximising local capacity within current cost base.
- Regular Patient Tracking List (PTL) meetings and oversight at trust and system level.
- Mutual aid, tailored support, and elective hub utilisation programmes ongoing.
- Managing key challenges for Gynae, Ear Nose and Throat (ENT), Dermatology, Trauma & Orthopaedics and Colorectal.

Delivery
- Remain on track in terms of clearing all 65 week waits by end of March 2024.

Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Nov-23)	4,842	National Ranking	n/a

Provider Breakdown (Nov-23)



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

Action
- WHH – Capacity problems continue to be experienced which have been escalated to surrounding trusts. The Independent Sector (IS) is also supporting with c1500 patients identified as suitable for transfer.
- MCHT – Insourcing is in place for Dermatology. Capacity issues across other specialties. Mutual aid arrangements are ongoing with the IS and NHS providers.
- COCH – Operational challenges within ENT have been experienced and an insourcing solution now identified. Delivery monitored through weekly PTL meetings.
- Out of Area (OOA) – Monitored through partnership calls with region. A meeting between NW providers is being launched in January. Consideration being given to use of Patient Initiated Digital Mutual Aid System (PIDMAS) to enable patients to move to a different hospital to receive their treatment if they wish.

Delivery
- Trusts remain committed to achieving the 65 week target, however MCHT are a high risk.

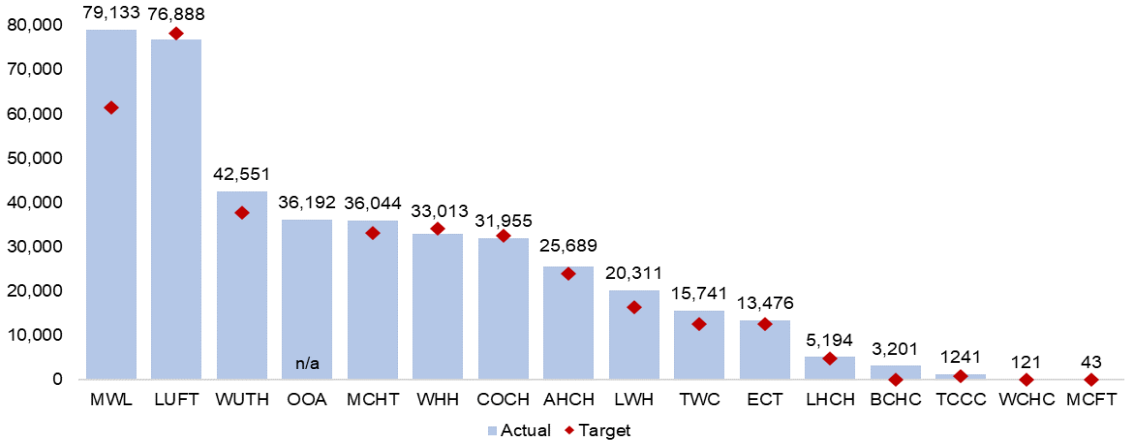
5. Exception Report – Planned Care and Diagnostics

Cheshire and Merseyside

Total incomplete Referral to Treatment (RTT) pathways

Latest ICB Performance (Nov-23)	369,440	National Ranking	n/a

Provider Breakdown (Nov-23)



Issue
- The number of incomplete pathways in C&M 2.4% higher than in April 2023 compared with 2.6% nationally.
- Year on year 12-month growth in total referrals is 4.9% year to date (5.4% for England).

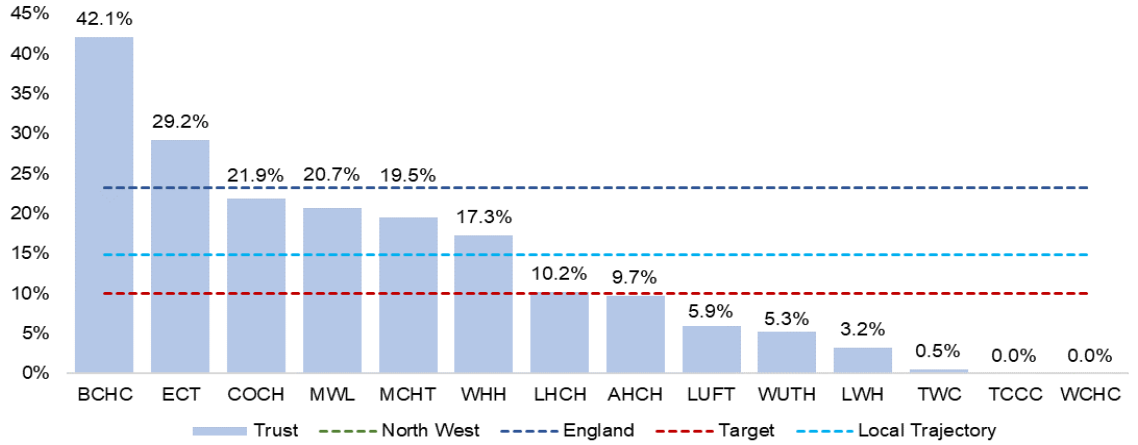
Action
- Trusts are delivering higher levels of Value Weighted Activity (VWA) compared to 19/20 baseline, despite industrial action (IA). National targets have been adjusted to reflect the impact of IA down from 105% to 103% for C&M.
- Trusts have been proactive in rebooking activity cancelled due to IA.
- The elective recovery programme has been focusing eliminating 65 week waits by March 2024, and is on track with under 23,000 patients in the “potential breach” cohort left to clear.

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

Patients waiting more than 6 weeks for a diagnostic test

Latest ICB Performance (Nov-23)	16.0%	National Ranking	12/42

Provider Breakdown (Nov-23)



Issue
- C&M is not yet achieving the 10% 6-week standard required by end of March 2024.

Action
- Oct year to date activity is at 8% above plan driven by imaging tests. Weekly data shows improvement in Oct-23, particularly for ultrasound which will be seen in Nov 23 data.
- Community Diagnostic Centre (CDC) activity remains above plan and steadily growing. 10 C&M CDCs are open, 5 of which opened in 2023/24.
- BCHC: performance relates to audiology waiting lists, additional support to be offered.
- MWL: 28.3% of patients waiting longer than 6 weeks. This is a good improvement on Sept position and will continue to improve based on weekly data seen.
- Deep dive in endoscopy to understand on-going issues with performance however performance within 6 weeks has improved in October.
- Recovery plan in place for Echocardiograms due to staffing issues at 4 Trusts and October performance has shown improvement.

Delivery
- C&M expect to meet the target for 90% of patients seen within 6wks by 31st March 2024.

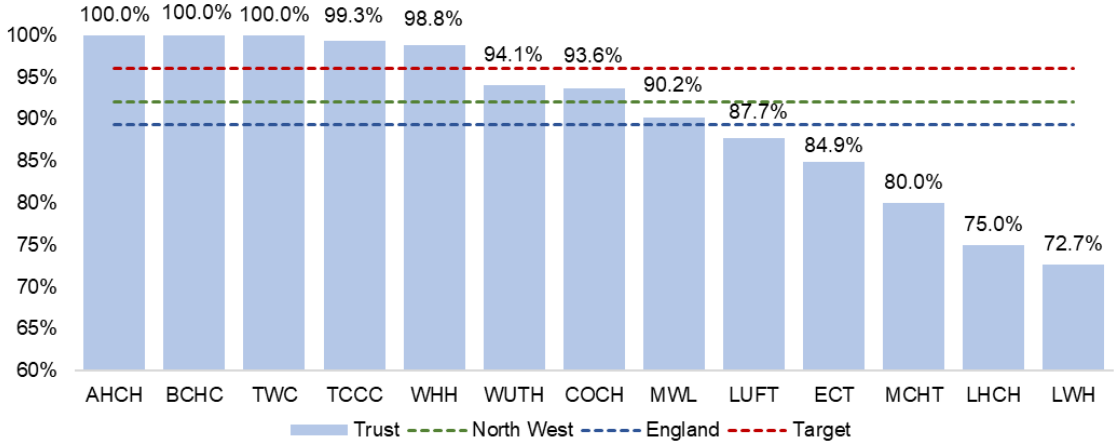
5. Exception Report – Cancer Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (Oct-23)	93.4%	National Ranking	7/42

Provider Breakdown (Oct-23)



Issue
- C&M did not meet the 96% standard in October 2023; however, this was an improved position from September 2023.

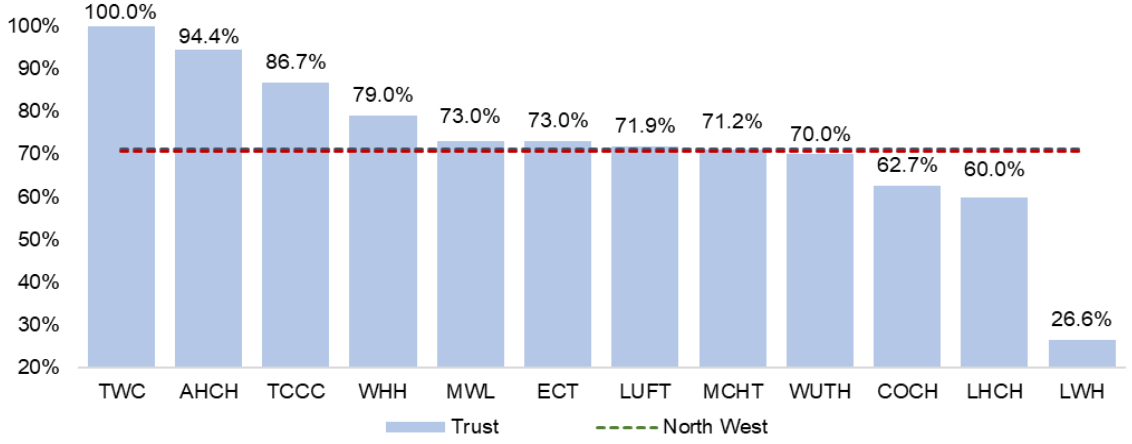
Action
- LWH: CMCA funded additional analyst to be recruited to help with capacity visualisation and planning, new Cancer Coordinator & Support worker recruited to support off-site surgery and patients with additional needs to reduce waiting times for the most complex patients started on 6th November, 2 Consultant posts advertised and 1 Agency Locum started on 23rd October, additional general Gynaecologist started on 2nd October.
- LUFT: additional theatre sessions including weekend operating and increased robotic lists.
- MCHT: recruited additional colorectal surgeon, undertaken high-risk pre-operative assessment clinic (POAC) capacity review to increase decision to treat (DTT) compliance and have additional capacity funded through regional bids.
- Additional investments secured as noted opposite.

Delivery
- C&M expects to meet the 96% performance standard by the end of Q3 23/24.

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

Latest ICB Performance (Oct-23)	70.0%	National Ranking	29/42

Provider Breakdown (Oct-23)



Issue
- C&M Faster Diagnosis Standard (FDS) is below target but has met the 70% threshold which is an improvement.

Action
- CMCA acted on behalf of providers to produce and present bids for additional transactional funding schemes to address FDS problem areas, including:
  - COCH: admin staff funding to address skin, specifically FDS letters.
  - LWH: additional hysteroscopes and pathway analysis, funding for the NHSTU.
  - MCHT: continue colorectal recovery plan and pathway transformation for a Triage Nurse, Nurse Consultant for LGI and CSW, and Nurse funding for the Haematuria pathway.
- Improvement should be supported by the improved backlog position in C&M, which is significantly ahead of trajectory and meeting Mar 24 target.
- Further submissions now successful: LCL histology, WHH gynae, COCH colon capacity, LUHFT radiology, LWH further hysteroscopy capacity.

Delivery
- C&M expect to achieve 75% by March 24 in anticipation of a rise to 80% in the next 2 years.

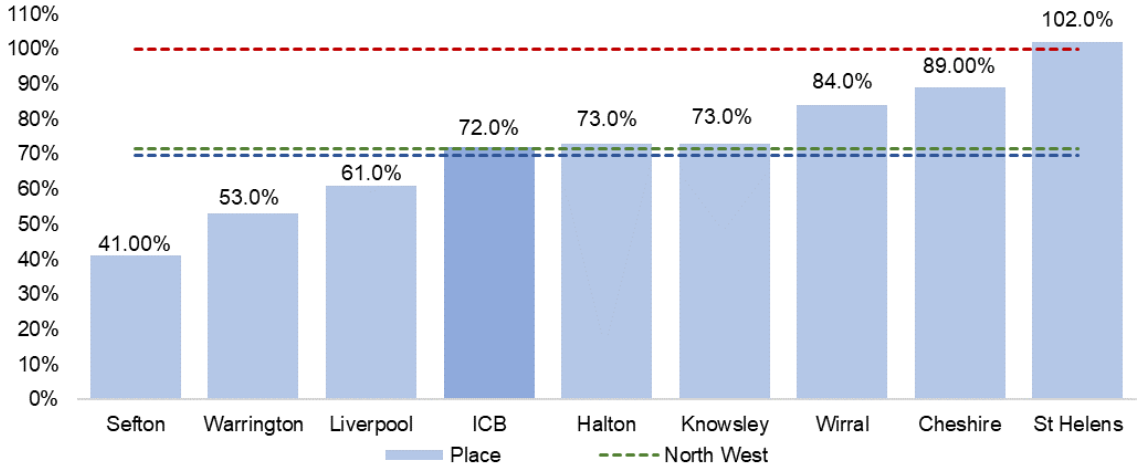
5. Exception Report – Adult Mental Health and Learning Disabilities

Cheshire and Merseyside

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

Latest ICB Performance (Oct-23)	72.0%	National Ranking	20/42

Place Breakdown (Oct-23)



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

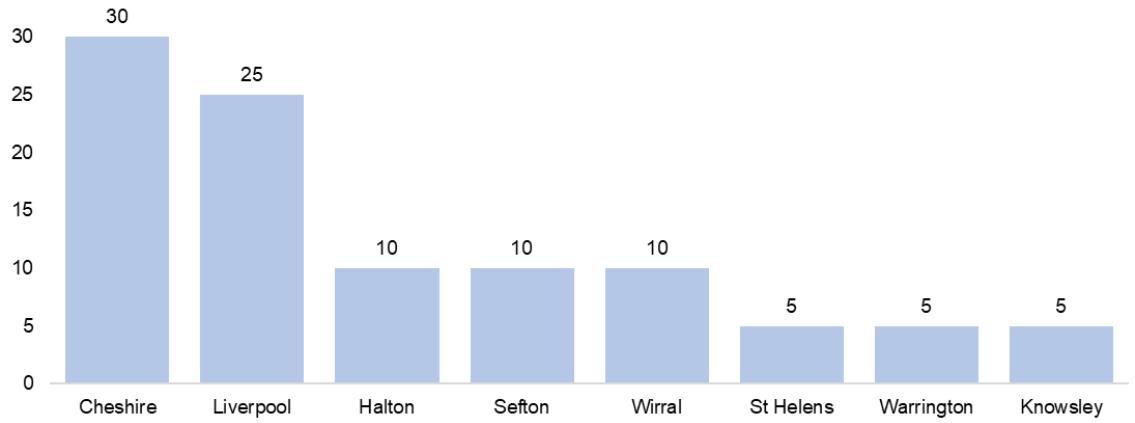
Action
- Comms: Increase awareness of TT services, supported by a Q4 National Campaign, simplify self-referral and pathways for people with long term conditions, prioritising cancer pathways.
- Service Models: Share learning between services, develop optimum service model and improve efficiency with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

Delivery
- C&M has a recovery access target of 72,724 based on a reprofiled national trajectory, recognising services have experienced workforce recruitment and retention challenges. Longer term plans relate to workforce: increase trainee numbers in 24/25 by identifying wider resource/recruitment pools, increase High Intensity Therapist (HIT) trainee numbers and Psychological Wellbeing Practitioner (PWP) apprenticeships.

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Nov-23)	105 *	National Ranking	34/42

Place Breakdown (Oct-23 – slight lag)



Issue
- There are currently 100 adult inpatients, of which 55 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 45 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 60 or fewer by the end of Q4 2024.

Action
- All previous actions are continuing to progress.
- Data quality checks to be completed on Assuring Transformation to ensure accuracy.
- Weekly C&M system calls ongoing to address Delayed Discharges.
- Housing Lead continues to work with Housing Providers to find voids which can accommodate delayed discharges.

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

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

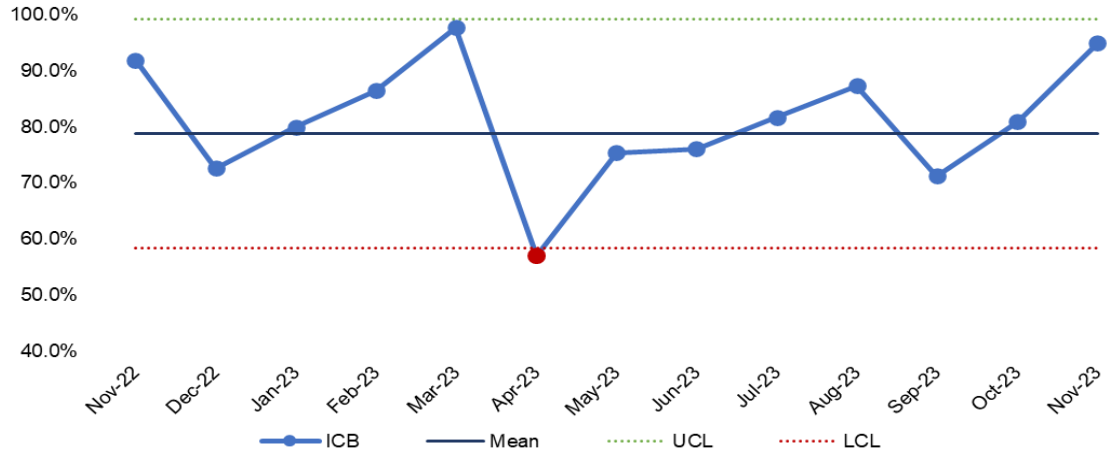
5. Exception Report – Primary Care

Cheshire and Merseyside

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

Latest ICB Performance (Nov-23)	94.9%	National Ranking	21/42

ICB Trend (Nov-23)



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

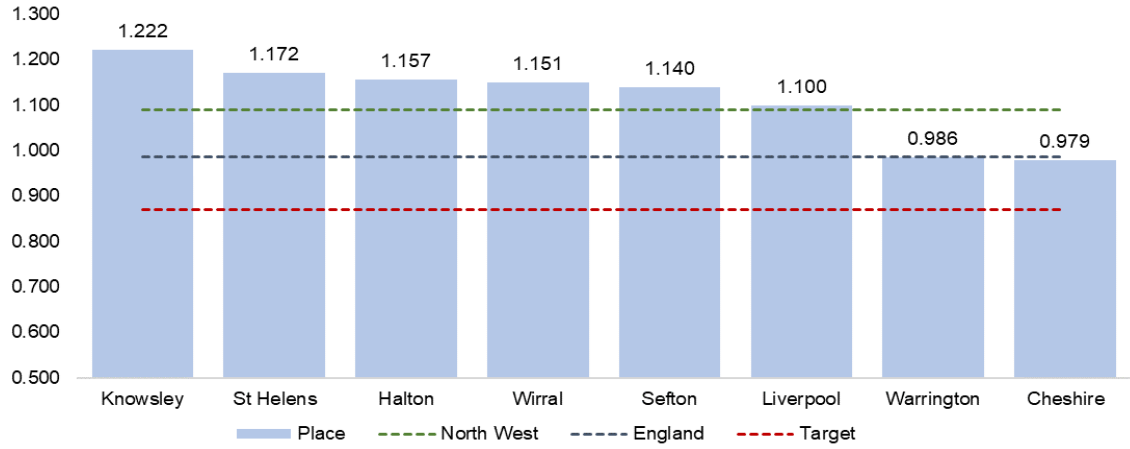
Action
- Support contractors to step up activity in primary care using the mid-year and end of year national contracting process and commission additional activity where providers are in agreement.
- Implement latest NHSE guidance (October 23) on flexible commissioning approaches and make additional contract delivery attractive to providers.
- Focus delivery on areas of highest need where there is poor oral health.
- Recruitment and retention of dentist and wider dental workforce in line with the C&M Workforce Strategy and NHS Workforce Plan.

Delivery
- Work is ongoing to establish a forecast trajectory for March 2024.
- Continued implementation of Dental Improvement Plan 2023-2025.
- Fluctuations in delivery of target are expected throughout the year and based on previous years performance.

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Sep-23)	1.081	National Ranking	33/42

Place Breakdown (Sep-23)



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

Action
- All places are continuing to work with primary care on the cascading of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- A C&M antibiotic prescribing data dashboard is being utilised and shared with prescriber consistently across C&M to support targeted work and monitor outcomes.
- A C&M Antimicrobial Stewardship Working Group enables the sharing of good practice across primary and secondary care, including wider learning and agreeing actions.
- There is ongoing with the ICB communications team to support communication to the citizens of C&M about the appropriate use of antibiotics.

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

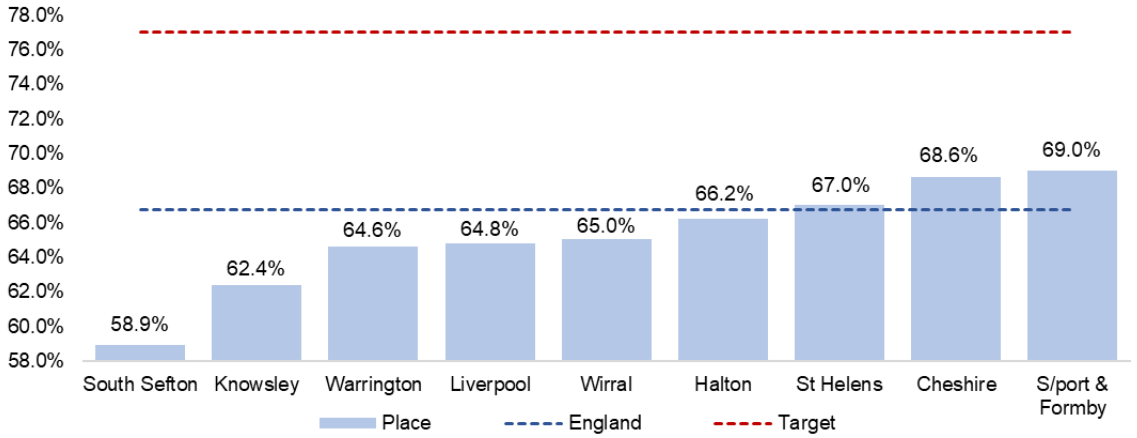
5. Exception Report – Health Inequalities & Improvement

Cheshire and Merseyside

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

Latest ICB Performance (Q1-23)	66.0%	National Ranking	n/a

Place Breakdown (Q1-23)



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

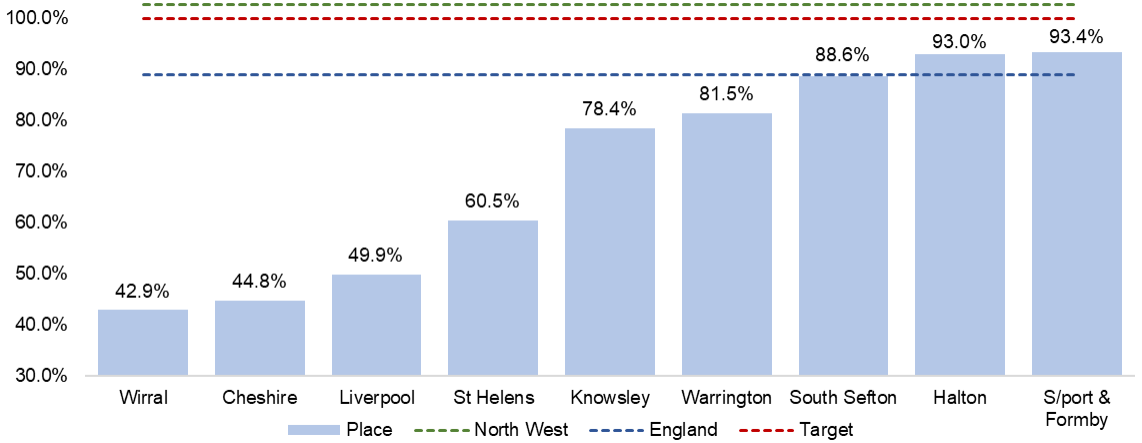
Action
- National and local initiatives are underway to improve existing pathways and expand detection & case finding via new pathway partners (e.g. NWAS & Cheshire Fire & Rescue).
- Happy Hearts website is being refreshed, collaboration underway with British Heart Foundation to develop a BP Information Toolkit for use by clinicians and patients.
- Support being provided to Place to deliver their CVD Prevention Plans, and to bolster collaboration between Public Health, NHS, and VCFSE Place leaders.
- Establish system solutions to improve performance over the current timescales.

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

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

Latest ICB Performance (Oct-23)	90.0% *	National Ranking	16/42

Place Breakdown (Sep-23 – slight lag) **



Issue
- The CYP Access target is 36,072 to be achieved by 31st March 24 (LTP Period), the national NHS Mental Health Service Data Set (MHSDS) indicates that the C&M CYP Access target is not currently being met.

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

Delivery
- In August 2023, ICB data reported via MHSDS illustrates 31,821 1+ contacts against a plan of 31,858. This is the highest access level for C&M over the last 2 years and continues to increase.

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

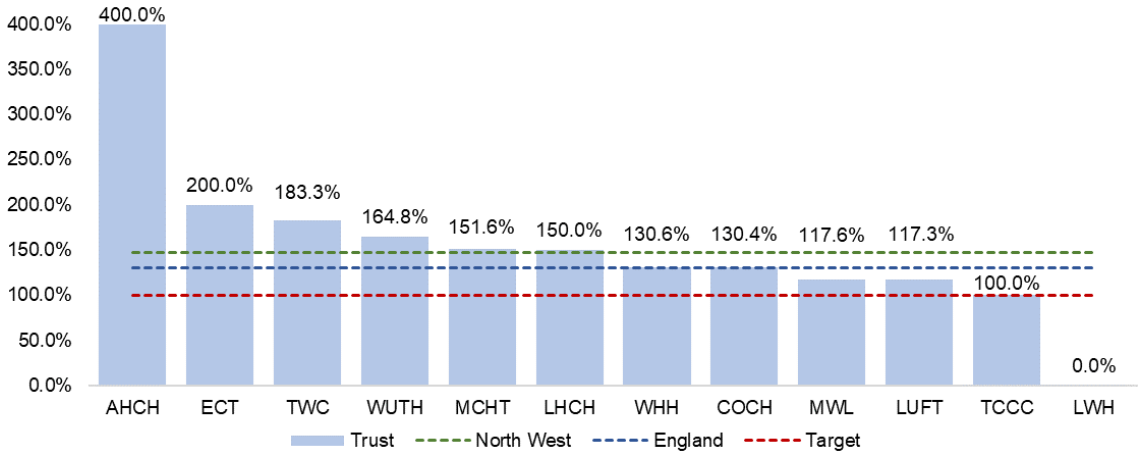
5. Exception Report – Quality

Cheshire and Merseyside

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (Oct-23)	132.8%	National Ranking	26/42

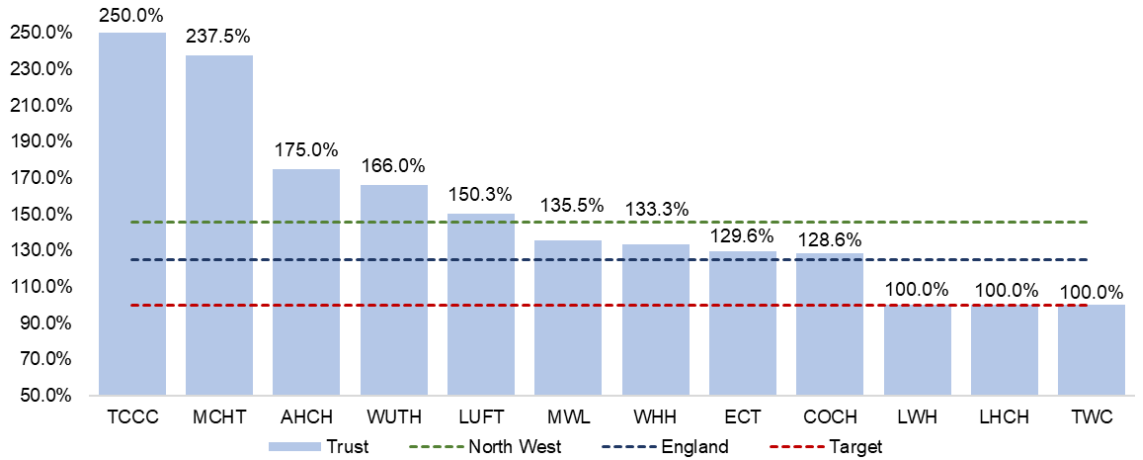
Provider Breakdown (Oct-23)



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

Latest ICB Performance (Oct-23)	148.5%	National Ranking	38/42

Provider Breakdown (Oct-23)



Issue

- Majority of C&M trusts are worse than national and regional performance, it should be noted that where expected numbers are low, e.g. 1 (one) or 0 (zero) on or two infections will impact the percentages reported adversely.

Action

- All place-based teams are receiving assurance from those Trusts identified as outliers (full Q2 position awaited at time of writing).
- All Trusts undertaking post infection reviews, with some Trusts suggesting an absence of avoidability (ECT) in reviewed cases.
- ECT is implementing a diarrhoea management plan in Q3 and a relaunch of their updated anti-microbial guidelines.
- Trusts undertaking review and refresh of aseptic non-touch techniques.
- LUFT reviewing a range of measures based upon learning from reviews that include use of isolation and a 'gloves off campaign'.
- MCHT focus is on infection prevention and control (IPC) fundamentals- education and training, aseptic technique, focus on safe and clean environment, AMS, relaunch of HOUDINI catheter care and hydration.

Delivery

- Performance will be monitored on a monthly basis via place-based reporting into Quality & Performance Committee and improvement plans assessed for efficacy and impact at end of Q3 23/24.

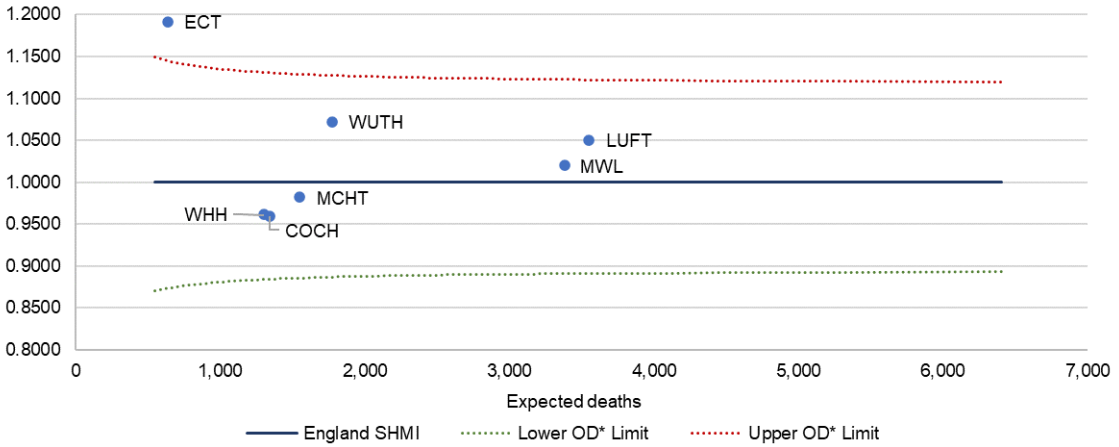
5. Exception Report – Quality

Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Jul-23)	1.030	National Ranking	n/a

Provider Breakdown (Jun-23 – slight lag) *



Issue
- C&M trusts are within expected tolerances except ECT, with a current value of 1.1912 against the upper control limit for ECT of 1.1445.

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

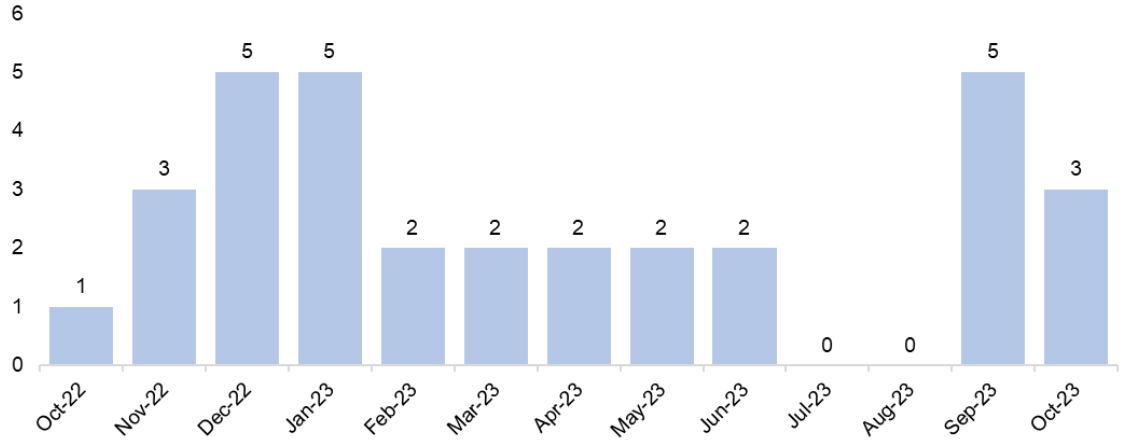
Delivery
- Measurable improvement by Q3 2023/24.

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

Never Events

Latest ICB Performance (Oct-23)	3	National Ranking	n/a

ICB Trend (Oct-23)



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

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

Delivery
- Measurable improvement by Q4 2023/24.

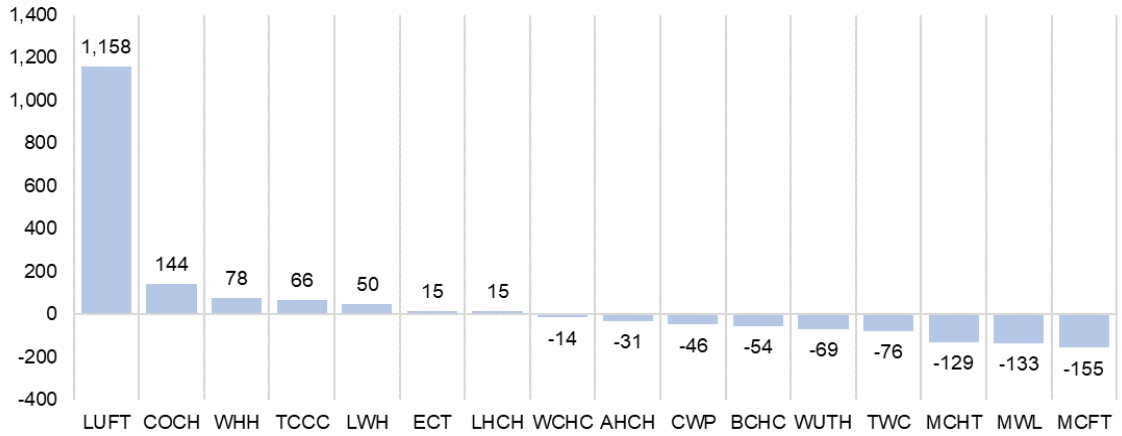
5. Exception Report – HR/Workforce

Cheshire and Merseyside

Staff in post (WTE)

Latest ICB Performance (Oct-23)	+422.2	National Ranking	n/a

Provider Breakdown (Oct-23)



Issue
- There are a number of Trusts with a variance to the original workforce plan, due to a range of issues, including the in housing of facilities management staff, the opening of additional community diagnostic centres and the proactive recruitment of substantive posts to reduce bank and agency use and reduce long standing vacancies.

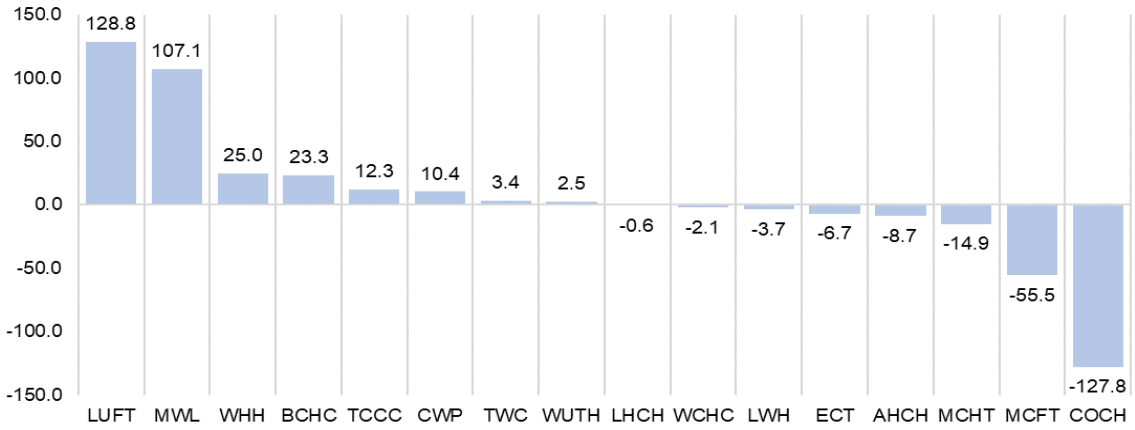
Action
- The Trusts have in place robust vacancy authorisation processes. Greater scrutiny of workforce and productivity data at organisational and system level is now taking place. A workforce dashboard has been developed and shared with Trusts on a monthly basis.

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

Agency Usage (WTE)

Latest ICB Performance (Oct-23)	-14.3	National Ranking	n/a

Provider Breakdown (Sep-23)



Issue
- Agency staff usage has reduced overall this month, reducing from 1,958 WTE 12 months ago to 1,260 WTE in October which is positive.

Action
- Trusts with significant reductions in agency use have seen increases in substantive staff or bank staff which is positive.
- The Trusts have in place robust authorisation processes for the use of agency staff.
- Trust are required to use 'on framework' agencies wherever possible and to adhere to price cap limits. This is monitored regularly.

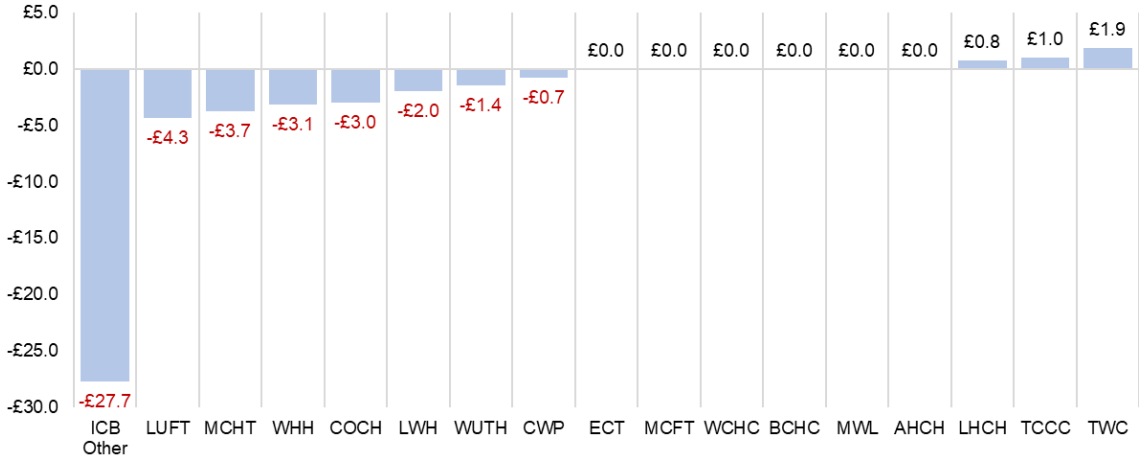
5. Exception Report – Finance

Cheshire and Merseyside

Overall Financial position Variance (£m)

Latest ICB Performance (Oct-23)	- 42.2	National Ranking	n/a

Provider Breakdown (Oct-23)



Issue

- The ICS is £42.2m adverse to plan at the end of November.
- The ICB adverse variance YTD (£27.7m) is primarily driven by prescribing inflation outstripping national planning assumptions and inflation and growth in CHC budgets and packages of care exceeding planned levels.
- The Provider adverse variance YTD (£14.5m) is driven by 7 Trusts where key pressures include - Unachieved CIP, Pay Awards, Emergency pressures and other costs including excess inflation.

Action

- The ICB has submitted additional detailed reports to NHSE in relation to these key, high-risk areas. In addition, both place and provider recovery plans have been submitted and are currently being reviewed.

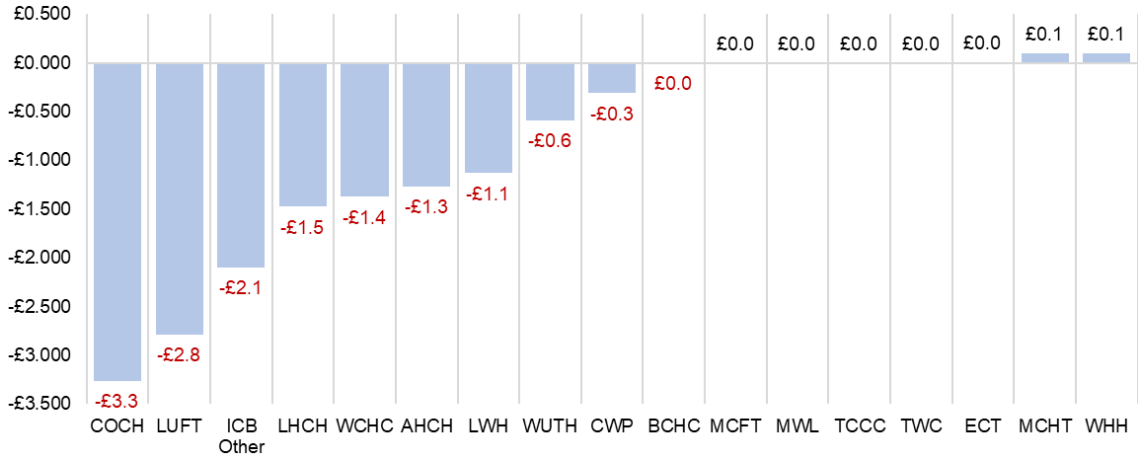
Delivery

- Revised ICS forecast submitted to NHSE at M8.

Efficiencies Variance (£m)

Latest ICB Performance (Oct-23)	- 14.0	National Ranking	n/a

Provider Breakdown (Oct-23)



Issue

- £227m achieved YTD, £14m away from planned levels. Forecast achievement of £389m total system efficiencies in line with plan.
- Recurrent efficiency is £50.2m away from planned levels overall, partially offset by £36.2m of non-recurrent efficiency delivered in excess of plan.

Action

- concerns over level of recurrent v non recurrent CIP identified, need to be monitored to ensure forecast trajectories are met.
- Expenditure Controls Group set up to ensure providers off plan are implementing grip and control measures.

Delivery

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

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

Agenda Item No: ICB/01/24/13

Report approved by: Tony Foy, Non-Executive Member

NHS
Cheshire and Merseyside

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

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	14 December 2023

Key escalation and discussion points from the Committee meeting

Alert

The committee received reports at its meeting on 14th December 2023 which highlighted the following areas of concern. They were noted and mitigations were discussed.

Maternity/LMNS
Midwifery band 5/6 staff shortages is a consistent theme since the onset of eSITREP reporting in September 2022 and was highlighted in the last Local Maternity Network System (LMNS) report (impact on Induction of Labour procedures requiring 1:1 care). Operational pressures and short-term absence are most likely contributory factors – further information requested from Providers for review at the next LMNS meeting and report to QPC in February.

Maternity and Neonatal Safety Investigation (MNSI)
Liverpool Women's Hospital (LWH) has received a letter of concern (dated 1st December 2023) following their investigations into two maternal deaths.

The ICB is engaged with LWH in gaining assurance as to the work underway in response to feedback from Maternal and Newborn Safety Investigations team in relation to two Patient Safety Incident Investigations that have occurred in the Trust in recent months

All-age Continuing Care
Variable performance against the key standard of 28-day completion of assessment was reported with Halton, Knowsley, Warrington and Wirral compliant but Liverpool, Sefton, St Helens and Cheshire around or below 50% - Cheshire also has 24 assessments waiting beyond 12 weeks.

Advise

Quality Performance Dashboard/Performance Report
Key Issues reviewed

- **A&E 4hr waits from arrival.**
  Cheshire and Merseyside performance dipped in October and is falling 2.6% short of the in-year operational planning trajectory of 72.3% for the month, although performance is close to the median for ICBs across England.
  Performance has been particularly challenged in the Wirral and Cheshire systems
- **A&E 12 hour waits from arrival.**

17.0% of Cheshire & Merseyside A&E patients are delayed over 12 hours compared to the England average of 10.7%.

- Positive performance for **65 week waiters** was noted but the number of incomplete pathways in C&M has risen by 4% since April 2023 compared with 4.4% nationally.
- **Dementia diagnosis rates** is a new feature of the report pack. Variable performance was reported with performance in Knowsley and Liverpool a significant challenge.

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

Anti-microbial prescribing

- Cheshire and Merseyside (C&M) ICB is currently not meeting the SOF target set for the overall volume of prescribing of antibiotics in primary care. Within C&M ICB there is significant work being undertaken to improve quality and outcomes in relation to anti-microbial prescribing. Cross sector working, sharing of good practice, use of clinical evidence and data forms the foundation of the work undertaken to date and planned for the future. ICB wide assurance in relation to anti-microbial prescribing remains a challenge.

Assure

Maternity LMNS

- induction of Labour Delays of both >12 hours and >24 hours is linked to shortages in midwifery staffing , however assurance was received of some improvement.
- delays in Induction of labour decreased in October 2023.
  - 13% decrease in IOL delays >12 hours
  - 34% decrease in IOL delays > 24 hours from 80 in September to 53 in October 2023.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
All Age Continuing Healthcare	Further report including proposed improvements

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Place Director Update Report

Agenda Item No: ICB/01/24/14

Responsible Director: Laura Marsh, Interim Place Director (Cheshire West)
Mark Palethorpe, Place Director (St Helens)

Place Director Update Report

1. Purpose of the Report

1.1 To provide Board members with an update on and provide opportunity to seek further assurance on the work underway at Place in meeting the duties and ambitions of NHS Cheshire and Merseyside and the Integrated Care System.

2. Executive Summary

2.1 The appendices to this report provide Board members with recent update reports written by the Cheshire West Place Director and St Helens Place Director and which have been considered at the respective Partnership Boards of each Place.

2.2 The reports provide Place Partnership Board members, and subsequently ICB Board members, with updates on key areas of work being delivered by the ICB within each Place as well as work underway with wider partners.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **note** the Place Director update reports
- **consider** what information and in what format the Board would like to receive subsequent reports from the Directors of Place at future Board meetings.

4. Reasons for Recommendations

4.1 The ICB has aligned significant resource to Place and it is integral that Board is kept informed of, and receives assurance, regarding the delivery of the ICBs functions at each Place in pursuit of delivering the ICBs strategic objectives and statutory duties.

5. Officer contact details for more information

- Laura Marsh, Interim Place Director (Cheshire West)
  laura.marsh@cheshireandmerseyside.nhs.uk
- Mark Palethorpe, Place Director (St Helens)
  markpalethorpe@sthelens.gov.uk

6. Appendices

Appendix One: Place Director Update Report (Cheshire West)
Appendix Two: Place Director Update Report (St Helens)

Working together for better health and wellbeing in **Cheshire West**

NHS Cheshire and Merseyside | Cheshire West and Chester | Cheshire West Voluntary Action Championing the community sector | healthwatch Cheshire West

Cheshire West Place Committee

Place Director's Update Report

January 2024

Date of meeting:	18th January, 2024
Agenda Item No:	For Information Only
Report title:	Place Director's Update Report
Report Author & Contact Details:	Laura Marsh, laura.marsh@cheshireandmerseyside.nhs.uk
Report approved by:	Laura Marsh

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

Partner Organisation/s / Place Sub-Committee / Advisory Group previously presented

Integrated Transformation Steering Group
Integrated Operational Steering Group

Executive Summary and key points for discussion

This report collates a number of key updates from Place including from, Integrated Transformation Steering Group (ITSG) and Integrated Operational Steering Group (IOSG), as well as updates pertaining to the Cheshire and Merseyside Integrated Care Board (ICB).

Specifically, this report provides detail regarding the Integrated Transformation Steering Group Away Day that took place in November, the Integrated Operational Group that took place in November and December, the most recently reported Place financial position and any pertinent updates from Cheshire and Merseyside Integrated Care Board.

This report will also be shared with Cheshire West Partners and key stakeholders.

Recommendation/ Action needed:	The Place Committee is asked to note: ▪ The work that has been undertaken by the Integrated Transformation Group and the Place Priorities identified for 2024/25 and beyond, as will be discussed in an informal Committee development session. ▪ The key escalations brought to Place Committee by the Integrated Operational Group including a system response to OPEL 4 and Mental Health representation at relevant groups. ▪ The continuing and challenging Place finance position. ▪ The work of Cheshire and Merseyside Integrated Care Board.

Consideration for publication

Meetings of the Cheshire West Health and Care Partnership Committee will be held in public, and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:

The item involves sensitive HR issues	

Consideration for publication	
The item contains commercially confidential issues	
Some other criteria. Please outline below:	

Which purpose(s) of the Cheshire West Place Plan does this report align with?	
Please insert **'x'** as appropriate:	
1. To identify Cheshire West population health needs now and in the future, proactively detecting and preventing ill health, whilst promoting wellbeing and self-care to our residents.	X
2. To reduce health inequalities by continuing to develop our approach to population health management (PHM), using data and analytics to prevent ill-health, address health inequalities, and identify those residents who are at higher risk of their health deteriorating, enabling us to deliver preventive interventions.	X
3. Improving the quality of services that are delivered within Cheshire West, expanding on efficiencies, and delivering safe and effective care.	X

Document Development	Process Undertaken	Yes	No	N/A	Comments (i.e., date, method, impact e.g., feedback used)
	Financial Assessment/ Evaluation			X	
	Patient / Public Engagement			X	
	Clinical Engagement			X	
	Equality Analysis (EA) - any adverse impacts identified?			X	
	Legal Advice needed?			X	
	Report History – has it been to other groups/ committee input/ oversight (Internal/External)				ITSG, ITOG

Responsible Officer to take forward actions:	Laura Marsh, Interim Place Director for Cheshire West Place

Place Update Report

1. Place Introduction

This report is produced bi-monthly. At the request of Place Committee this report provides updates from within Place governance (ITSG, IOSG) as well as any key updates from the Cheshire & Merseyside Integrated Care System (ICS) that affect Cheshire West Place.

The paper is structured to reflect these key areas of update.

2. Integrated Transformation Steering Group (ITSG)

2.1 Overview

Since the previous Place Committee meeting, the Integrated Transformation Steering Group have met with each of the priority programme and workstream areas via an Away Day, to agree plans and potential resource requirements in 2024/25. This workshop was attended by representatives from all Place partners and enabled a transparent discussion around population needs and how working collaboratively between health, the local authority and community sector could lead to future benefits. In summary, the following updates and outcomes were agreed:

Home First – Summary:

Our Vision	Supporting people to stay at home in Cheshire West		
Our Principles	1. Supporting people to return home should be the default, with alternatives for those who cannot go home. 2. To deliver a discharge to assess model which has sufficient community capacity to negate the need for financial assessment or long-term assessment in hospital. 3. Avoid crisis (including hospital admission) where (clinically) safe to do so. 4. Move to proactive care through care community risk stratification and strong community services. 5. To join up health and social care teams, and wider partners, where there may be benefits to the outcomes of local people.		
Strategic Deliverables	Establish a fully funded, therapy led, intermediate care tier of services that meets the local demand	Achieve an integrated operating model for community care (including complex case management)	Realise the benefits of a joined-up workforce
Measures	1. Number of people discharged by Pathway 2. Long term care demand 3. Service User outcomes (improved experience etc) 4. Community Response Hub services average length of stay 5. Number & proportion of patient with Length of Stay of 7 days or more 6. Number & proportion of super stranded patients with Length of Stay 21 days or more 7. Proportion of Criteria to reside patients 8. Reduction in attendances of high intensity users 9. Numbers of people supported through virtual ward environment	1. Agreed joint strategy 2. Service User outcomes (reduced support, no ongoing support, increased support etc) 3. People supported on prevention pathways 4. Improved communication 5. Care at Home Waiting list 6. Permanent admission into a Care Home	1. Retention rates 2. Recruitment outcomes 3. Skill mix and competency spread
Projects	• High Intensity Users • Capacity & demand • Optica roll out • Virtual wards • Falls Prevention • Community Home First Contract Mobilisation • Community Response Hubs mobilisation • Effective Triage (COCH) • Pathway 3 re-design	• Community Care Strategy Delivery • Risk stratification and proactive case finding • Complex case management (MDTs) • Prevention pathway development • Community Team MDT model • Complex case management meeting enhancements • Trusted models of operation	• Enabled through all other projects

Work around this programme is continuing, and is still a focus for 2024/25. Priorities agreed were:

- Roll out Community Response Hubs across the Borough
- Enhance Transfer of Care Hubs
- Deliver year 1 workplan for integrated community care strategy
- Prevention pathway in the community
- Flexible and Sustainable multi-disciplinary teams
- Improved communication platforms
- Trusted models of operation
- Agreed approach to Complex case meetings
- Review of bed-based intermediate tier services
- Develop a night-time care model
- Expand our High Intensity User service
- Maximise digital solutions.

Integrated Brokerage – Summary:

Our Vision	A joint approach to sourcing care and support in Cheshire West		
Our Principles	1. Reduced cost – the market managed, and costs controlled. 2. Timelier turnaround (reduced waiting times) – care arranged quickly and prioritised based on the levels of risks. 3. Improved outcomes – care arranged quickly, easily and using a range of services 4. Better insight - a digitally enabled platform which will gather insight and intelligence across the system. 5. Better relationships – providers and partner communication enhanced through a single point of contact. 6. More time for health and care professionals to spend on core work – their cases brokered by a specialist team all in one place.		
Strategic Deliverables	Developing a new brokerage offer aligned to our Care Communities and Hospitals	Using a digital solution to improve care finding	Greater control of cost
Measures	• Care Connector(s) aligned to each Care Community/Hospital • Care Connector colleague feedback • Positive staff feedback (across health and social care) • Training log	• All care requests via e-brokerage system • Reduced wait time from referral to start date • Increased visibility of capacity and demand across the system	• Reduced utilisation of spot providers within care at home • Reduction in above contract spend for care homes • Increase in achieving contracted rate or as close to
Projects	Implementation of the neighbourhood model (care connectors aligned to care communities/hospitals) LD and Mental Health pathway delivery Training and development	Implementation of e-brokerage for care requests Performance dashboards and activity reporting Capacity and demand reporting	Negotiation training Developing relationships with providers Developing/shaping the market

Work around this programme is continuing, and is still a focus for 2024/25 but will move into BAU once team embedded.
Next step is to roll out Mental Health and Learning Disability Connectors so that all discharges are brokered through a single team.

Community Partnerships – Summary:

- ***Key Definition of Community Partnerships:***
- *"Community Partnerships are places that build relationships and connect capability to enable local people to flourish.*
- *Such communities are the places where change will happen and through which the Cheshire West Place Plan vision and ambitions will actually be realised."*

- ***Programme Aims:***
- *To connect capability and build relationships*
- *Around the socio-economic priorities of the local population*
- *To act upon these priorities where resource is available*
- *And to support and influence wider plans that will impact upon that community.*

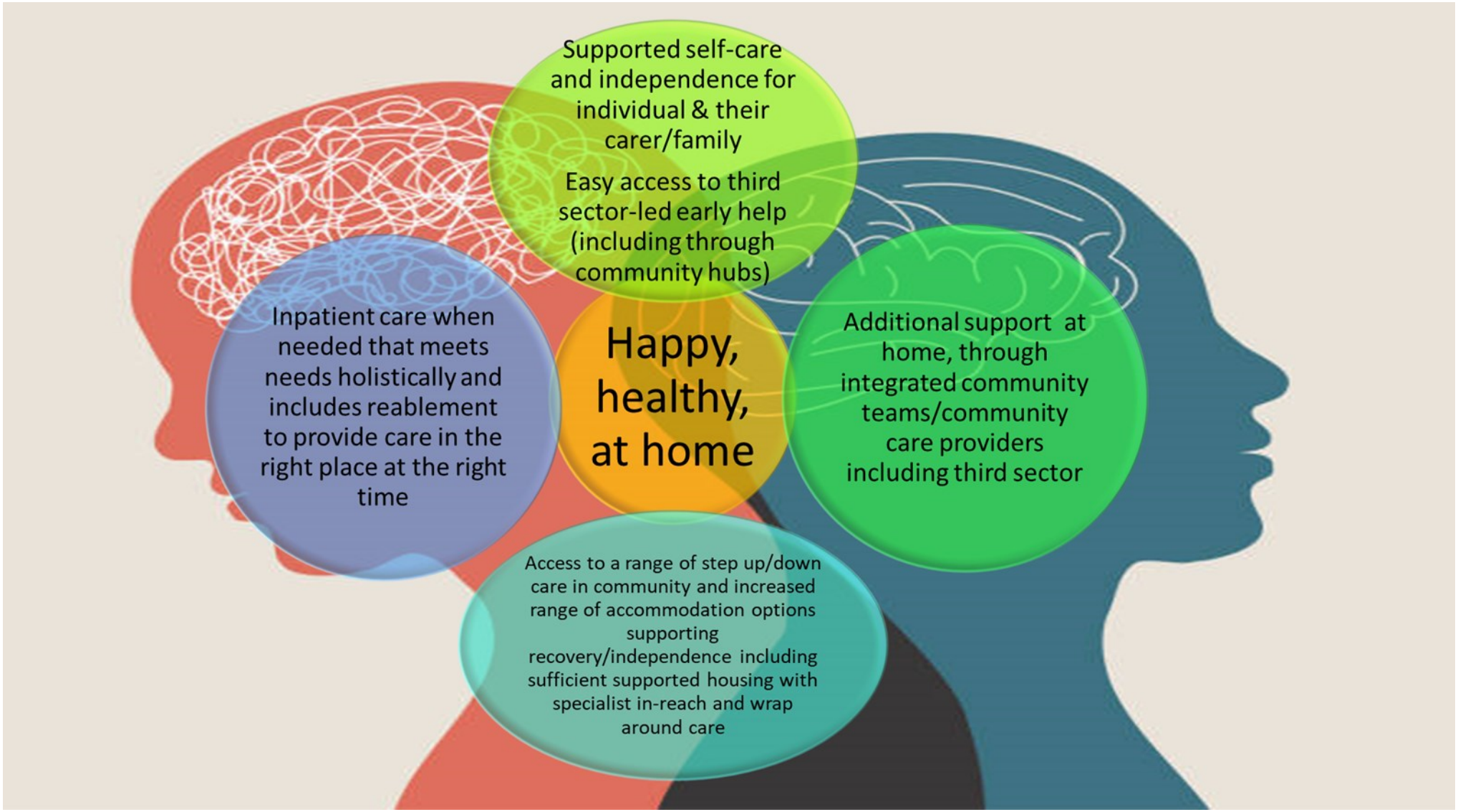
Along with individual achievements to date, future priorities for each Community Partnerships were agreed, based on evidenced and available data. These included:

Community Partnership	Priorities – Home First (Programme Dashboard)	Priority Themes (Place Plan) – Tartan Rug	Mapping to Existing Priority Projects	Tartan Rug Metrics
Chester East	Falls	Road Safety, Climate Change & Respiratory Disease Emergency Admission for CYP Lone Pensioner Households	MH First Aid Training Social Isolation Chester wide café 71 CP Awareness Pay as you feel Café Healthy Hearts Youth Group	RTAs, CO2 Emissions, Energy Efficiency Respiratory Prevalence, Respiratory Admissions Emergency Admissions CYP Lone Pensioner Households
Chester South	Community Care Team MDTs	Road Safety, Climate Change, Respiratory & Circulatory Disease Poverty, Education & Employment (CYP & Families)	Autism Hub Incredible edible Dementia Café and end of life partnership MH First Aid Training Healthbox CP Awareness Health box Walking Group Health box Chester wide café 71	RTAs, CO2 Emissions, Energy Efficiency Respiratory Prevalence, Respiratory Admissions Economically Active, Free School Meals, Fuel Poverty, Unemployment, NEET Respiratory & Circulatory Prevalence, Respiratory & Circulatory Admissions
Chester Central	Community Care Team MDTs	Anti-Social Behaviour & Crime Circulatory & Respiratory Disease Poverty & Employment	Crisis Café Chester wide café 71 *spilt between 3 areas Social Prescriber Event with CWVA	Anti-Social Behaviour Rates, Crime Rates Respiratory & Circulatory Prevalence, Respiratory & Circulatory Admissions Economically Active, Free School Meals, Fuel Poverty, Unemployment, NEET
Ellesmere Port	Falls	Anti-Social Behaviour & Crime Poverty, Education & Employment (CYP & Families) Circulatory & Respiratory Disease	HENRY Families Programme Physical Activity / Exercise Classes Dementia Support Group Lunch Club Leaflet / Booklet for Older People Joy Social Prescribing	Anti-Social Behaviour Rates, Crime Rates Emergency Admissions CYP Economically Active, Free School Meals, Fuel Poverty, Unemployment, NEET Respiratory & Circulatory Prevalence, Respiratory & Circulatory Admissions
Rural Together	Community Response Hubs	Road Safety & Climate Change Fuel Poverty Digital Exclusion & Long Pensioner Households	Sensory Garden Run Rural Run Befriending Service Community Transport	RTAs, CO2 Emissions, Energy Efficiency Fuel Poverty Digital Access / Broadband Access Lone Pensioner Households

Community Partnership	Priorities – Home First	Priority Themes (Place Plan) – Tartan Rug	Mapping to Existing Priority Projects	Tartan Rug Metrics
Frodsham, H&E	Community Care Team MDTs	Road Safety & Climate Change Education & Employment (CYP & Families) Lone Pensioner Households	Allotment Project The Hive Bereavement Scheme Bee Friends MH First Aid Training Mindfulness in Nature Memory café	RTAs, CO2 Emissions, Energy Efficiency Unemployment, NEET Lone Pensioner Households
Neston & Willaston	Falls Community Led Support Innovation Area	Road Safety, Climate Change & CYP Overweight Poverty, Education & Employment (CYP & Families) Lone Pensioner Households	MH First Aid Training Peer Support Groups Young People's Steering Group Young People's Counselling Auto De-Fib Older People's Lunch Club	RTAs, CO2 Emissions, Energy Efficiency CYP Overweight Economically Active, Free School Meals, Fuel Poverty, Unemployment, NEET Lone Pensioner Households
Winsford	Community Response Hubs & Falls	Anti-Social Behaviour & Crime Poverty, Education & Employment (CYP & Families) Cancer, Respiratory and Circulatory Disease Obesity	Art Activities Youth Zone Physical Activity for Carers Physical Activity for those with chronic pain Men in Sheds Chronic Pain Activities Website for young people CBT – parent led Foodbank Litter pickers	Anti-Social Behaviour Rates, Crime Rates Economically Active, Free School Meals, Fuel Poverty, Unemployment, NEET Respiratory & Circulatory Prevalence, Respiratory & Circulatory Admissions Deaths from Cancer Obesity
Northwich	Falls	Road Safety & Climate Change Anti-Social Behaviour & Crime Poverty, Education & Employment (CYP & Families) Cancer, Respiratory and Circulatory Disease Obesity	Sculpture Trail Dementia support Marketing Pedal away	RTAs, CO2 Emissions, Energy Efficiency Anti-Social Behaviour Rates, Crime Rates Economically Active, Free School Meals, Fuel Poverty, Unemployment, NEET Respiratory & Circulatory Prevalence, Respiratory & Circulatory Admissions Deaths from Cancer Obesity

It was agreed that Cheshire West Voluntary Action would take the lead for this Programme in 2024/25, to enable greater ownership by local communities

Mental Health – Care Model Summary:



Integrated priorities for 2023-2025 were agreed as follows:

Prevention/Early intervention

- Develop and plan to mobilise a comprehensive offer across health / care / education to maintain emotional wellbeing for Children and Young People in Cheshire West including through schools, ensuring we meet the needs of particular cohorts.
- Map provision and enable easy signposting to resources that can maintain emotional wellbeing for adults.
- Mobilise further wave of Mental Health Support Teams in Schools focusing on 6th form/colleges
- Neurodiversity pathway for Children and Young People

Crisis

- Mobilise enhanced crisis line
- Work with Cheshire police on go live of Right Care Right Person
- Mobilise MH ambulances
- Develop crisis alternatives for Children and Young People
- Pursue temporary s136 suite/mobilise Urgent Care Centre
- Mobilise additional mental health social care capacity to reduce delayed discharges

Supported discharge (and admission avoidance)

- Develop specific housing solutions (including wrap around support) in Cheshire West / CWP footprint that will enable reduced delays to discharge.
- Mobilise evidence-based interventions that can reduce/avoid admissions for Children and Young People including 'The Nook'.

Transition

- Undertake a consultation/engagement with Children, Young People, and their families regarding their experiences of transition and take forward priorities for improvement.

Learning Disabilities
Complex Accommodation and Care Models:

Our Vision	'Adults in Cheshire West and Chester (16-64) have access to the right health and social care at the right time in the right place through the delivery of the most suitable accommodation with care and support'.		
Our Principles	1. Safe – "I am supported to be as safe as possible, and will be supported to take positive risks, in order to live my life as independently as possible". 2. Caring – "Services adopt a caring approach towards me and my family, and afford me compassion, dignity and respect". 3. Outcome focused – "I am supported to achieve my goals, wishes and aspirations". 4. Personalised – "Services are delivered around me and how I wish to live my life" 5. Healthy – "I am supported to stay healthy in all aspects of my life, including my physical, mental and emotional well-being". 6. Inclusive – "I am supported to be an important part of my local and wider community". 7. Accessible – "Services are available to me when I need them and are accessible" 8. Affordable – "Services are affordable to help me achieve the things that I want to achieve in my daily life within my personal budget" 9. Joined up and local – "Services and agencies involved in my care, work together in order to effectively meet my needs".		
Strategic Deliverables	Accommodation – Specialist Housing Strategic Development and delivery Plan	Care Models – Progression Model of Care	Autism/Neurodiversity – Action plan to support local strategic delivery
Measures	• Reduced number of 'out of area' placements • Increasing percentage of 'Better Lives Framework Measure 1.3. Proportion of key partners organisations in the care, support, health, and housing system formally committed to the local vision, shared statement of values and joint strategy to support adults with learning disability' • Supported accommodation used by working age adults with care/ support needs is of a good quality, achieves positive outcomes for people and represents value for money. • People with care/ support needs have access to good quality information and advice about their housing options.		

Projects	• Tactical Accommodation:
	  ○ New ways of working – end to end process redesign to develop more effective consistent pathways
	  ○ Repatriate out of borough placements where possible
	• Complex Accommodation: Coproduce and design local joint specialist housing strategy and long-term delivery plan
	• Work with regional and housing partners to support implementation of Supported Housing (Regulatory Oversight) Act 2023
		• Progression Model/Building Independence embedding/maturity:
		  ○ Functional Assessments for all incl. Inbound strategy
		  ○ System-wide shared risk management approach
		  ○ Technology First approach
		  ○ Day Service review
		• Optimise funding approach transport and personal health budgets
			• Local delivery plan for National all-age autism strategy
			• Implementation of all age autism partnership board

Priorities for 2024/25 were agreed as follows:

- Complete full Better Lives Framework – develop requirements for future dashboard reporting
- Coproduce / design local specialist accommodation strategy

- Work with Cheshire and Merseyside property pipeline project to support implementation of Supported Housing (Regulatory Oversight) Act 2023
- Embed Progression Model adopting functional assessments, technology first community led support models and ensuring that practice informs commissioning
- Develop local action plan to support implementation of all age national autism strategic aims.

Workstreams:

In addition to the work of the priority programmes, each enabling workstream was invited to present and update on their work, their interaction with the Place Priorities and their future plans.

Work is now continuing to ensure resource is agreed and in place to progress these priorities within 2024/25.

2.2 Integrated Operational Steering Group (ITOG)

The Group met on the 9th November and 14th December and have fed-back the following key points for information at Place Committee:

- The Group were keen to see the system financial summit meeting being held, to understand the impact of financial challenges across partners on service delivery. Partners agreed to share Cost Improvement Plans as standing agenda items to escalate Quality Impact Assessments at PLACE level with PLACE committee.
- System response to OPEL 4 escalation is not clear, there is a request for ICB colleagues to lead those discussions and to be signed off at Urgent Care Board in February 2024.
- CWP Mental health representation is being sorted to attend System Ops Group.
- A system performance dashboard is being developed to provide assurance and direction to target gaps in service provision for PLACE priorities. Draft dashboard to be presented at March meeting.
- The Integrated Brokerage roll out plan was presented by CWAC colleagues, the group were assured by progress, but requested specific work to be undertaken in terms of visibility of KPIs for sourcing care, approach for self-funding residents, Care Connectors to develop relationships with VSCE and care communities. KPIs will also be shared at Urgent Care Board
- A request for enabling workstreams People, Finance, Estates and Digital to attend System Ops on a rolling basis to align with Operational requirements. Priority to be estates with pressure on Primary care estate for Community services and opportunities with new estate for Community expansion.

2.3 Place Finance Update

The Cheshire West Place financial position continues to remain on target in achieving's its collective planned deficit of £58.7m, as per the latest reported position for November 2023. The system continues to manage financial risks of circa £31m which it believes will worsen the financial position unless mitigated over the next 4 months. These risks range in pressures arising from Industrial Action, Inflationary pressures re Medicines and Continuing Healthcare, increased demand for Care Costs and shortfall in delivering all of the required efficiency requirements. Further work is planned during December to review both the risks and the underlying assumptions across the wider ICB based on

latest updates from NHS England prior to the completion of the following Month 9 position.

2.4 Cheshire and Merseyside Update

The Cheshire and Merseyside ICB (Integrated Care Board) has met once since the last Place Committee meeting. At the meeting on 30th November, 2023, a number of key updates and decisions via the Chief Executive's Report were given including:

- The launch of a new Provider Selection Regime,
- A new "slow-stream" neurodisabilty contract award for the people of Cheshire and Merseyside,
- An update on the work happening locally around virtual wards for heart failure receiving national recognition,
- Leading the way for work on anti-racism and improving social value,
- Improve support for working carers,
- Delivering the continued work around COVID 19.

For a full update, please see the Chief Executive's Report via the following webiste: https://www.cheshireandmerseyside.nhs.uk/media/4gcettof/updated-board-meeting-pack-public-nov23-v11.pdf

3 Recommendations

6.1 The Place Committee is asked to note:

6.1.1 The work that has been undertaken by the Integrated Transformation Group and the Place Priorities identified for 2024/25 and beyond, as will be discussed in an informal Committee development session,
6.1.2 The key escalations brought to Place Committee by the Integrated Operational Group including a system response to OPEL 4 and Mental Health representation at relevant groups,
6.1.3 The continuing and challenging Place finance position, and
6.1.4 The work of Cheshire and Merseyside Integrated Care Board.

NHS
Cheshire and Merseyside

St Helens Cares Place Partnership Board

Date of meeting:	23rd January 2024
Agenda Item No:	
Report Title:	Place Director's Report - St Helens Cares
Report Author (Name, Role & Contact Details):	Mark Palethorpe – Place Director: St Helens/ Executive Director People (Adult Social Care, Children & Young People and Public Health)
Report approved by:	Mark Palethorpe – Place Director: St Helens/ Executive Director People (Adult Social Care, Children & Young People and Public Health)

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

Committee/Advisory Group previously presented	
N/A	
Executive Summary and key points for discussion	
Purpose of this paper This report apprises partners of the latest developments regarding the St Helens Cares partnership, the Cheshire and Merseyside Integrated Care Board (ICB) and Cheshire and Merseyside Health Care Partnership (ICP).	
Recommendation/ Action needed:	Place Partnership Board members to: • **REVIEW** report and feedback comments

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	X
2. Tackle health inequality, improving outcome and access to services	X
3. Enhancing quality, productivity and value for money	X
4. Helping the NHS to support broader social and economic development	X
C&M ICB (St Helens Place) Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X
2. Recovery	X
3. Getting Upstream	X
4. Building systems for integration and collaboration	X

Governance and Risk						
	Does this report provide assurance against any of the risks identified in the Board Assurance Framework or any other corporate risk? (*please list*) N/A					
	What level of assurance does it provide? **This report gives assurance that St Helens has a mature approach to integration, excellent relationships with the Local Authority, providers, and wider partners. We have a focused place plan and clear alignment with the ICB priorities.**					
	Limited		**Reasonable**		**Significant**	X

	Any other risks? ~~Yes~~ / **No**.
	Is this report required under NHS guidance or for statutory purpose? (*please specify*) **N/A**
	Any Conflicts of Interest associated with this paper? If Yes please state what they are and any mitigations. **No**
	Any current services or roles that may be affected by issues within this paper? **N/A**

Document Development	**Process Undertaken**	**Yes**	**No**	**N/A**	**Comments (i.e. date, method, impact e.g. feedback used)**
	Financial Assessment/ Evaluation			X	
	Patient / Public Engagement			X	
	Clinical Engagement			X	
	Equality Analysis (EA) - any adverse impacts identified?			X	
	Legal Advice needed?			X	
	Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External)			X	

Next Steps:	See recommendations above
Responsible Officer to take forward actions:	Mark Palethorpe – Place Director: St Helens/ Executive Director People (Adult Social Care, Children & Young People and Public Health)
Appendices:	

Place Director Report – St Helens

1. Executive Summary

Report to Place Partnership Board members highlighting the recent activity across both St Helens Cares (Place of NHS Cheshire and Merseyside ICB), NHS Cheshire and Merseyside Integrated Care Board (ICB) and Cheshire and Merseyside Health Care Partnership (HCP).

2. Place Director Updates

2.1 St Helens Cares Place Based Partnership

2.1.1 – ICB Place Review Meeting:

The St Helens Place Review meeting took place on Wednesday 10th January 2024.

The focus of the meeting was:

- Performance against the Place winter plan metrics to include Mental Health, Social Care, Primary Care.
- Numbers of NCR patients and any acute performance issues.
- Use of the monies that were provided to Local Authorities for Winter and what has it delivered in terms of capacity for place.

At the meeting we reported some key developments such as:

Primary Care

- Increase in appointments offered from 493 to 532 per 100,000 patients (70% FTF) despite being lowest number of doctors per 100,000 and low number of Practice Nurses. St Helens are in line with the C&M average for appointments booked within 14 days at 80.8%.
- Several winter schemes funded via short term monies, urgent care hubs and children's hubs in PCNs, winter proactive management of vulnerable incentive scheme and development of enhanced access appointments.
- Workforce initiatives to try and recruit and retain General Practice staff in the borough.
- Practice support through a series of Support Level Framework visits.
- Enhancements to telephone access such as call back roll out.

Acute Hospital Flow

- Reduced numbers of attendances at A&E since 22/23 but 15% increase in admissions, indicating a greater acuity of those attending.
- Good use of UCR (69 referrals last week that could alternatively have been an A&E attendance.
- Good use of virtual wards on the St Helens and Knowsley catchment footprint.
- A good level of discharges weekly, but against a backdrop of increasing admissions this still remains a significant challenge.
- Issues with use of Intermediate Care beds by other boroughs, placing challenges on St Helens when needing these beds (being addressed with the other boroughs).

Social Care

- Additional domiciliary care to support earlier discharges of patients back home.
- Enhanced support into care homes through additional leadership training to support timely discharges and reduce admissions of complex patients.
- Additional staffing within social work, contact cares and brokerage to increase capacity to support discharges from hospital and step down units.
- Additional occupational therapy to reduce assessment delays

- Additional Learning Disability and Mental Health accommodation.
- End of Life training across all providers to support reduction in ambulance admissions for EoL residents.
- Additional equipment to support same day and next day discharges including emergency care line packs and bariatric equipment.
- Current average LoS for patients is around 3.8 days. The increase in rapid response is working well and increasing discharges from pathway 1 and 2. Patients are going home 24/48 hours sooner.
- Early discharges and high acuity of patients being discharged has increase LA social care spend considerably.
- Still some reliance on beds which has resulted in increased occupancy rates within care homes in particular Dementia care.

We also reported on the challenges that we are facing with growing ADHD referral levels. It was recognised that St Helens is the highest performing borough for discharging patients from MWL hospitals, although it was recognised that Whiston Hospital has been the most challenged in Cheshire and Merseyside recently.

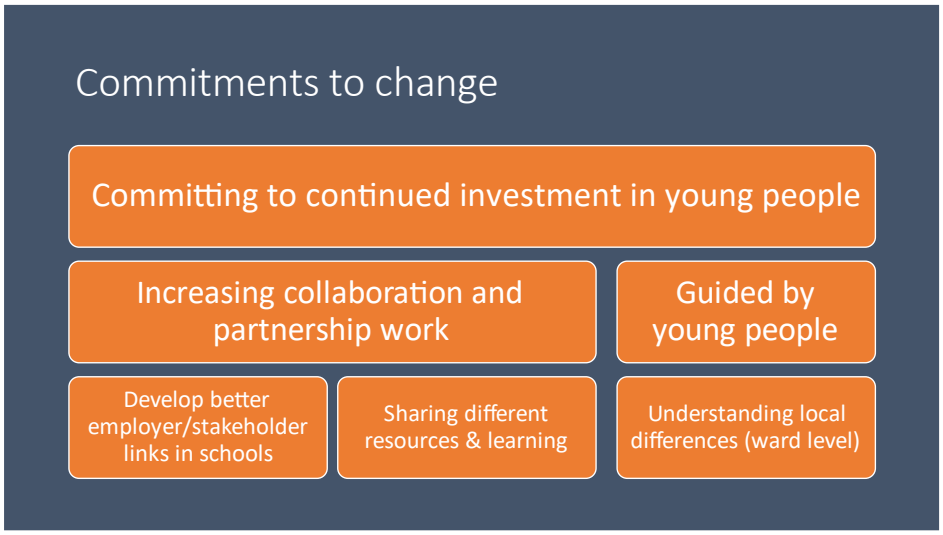
Finance
The financial challenges across C&M NHS and the Local Authority remain significant and very challenging. We continue to work as a system at Place across the NHS and Local Authority on commissioning and transformation activity and prioritise need and manage risk on a daily basis.

The Local Government settlement that arrived in December offers no additional investment and therefore further budget savings are being proposed and will be finalised in February and March by Cabinet and Council.

2.1.2 – St Helens Cares Governance:
From January 2024, the Partnership Board agenda will change in format. Part One will follow the traditional format with a resident story, presentations, and updates on St Helens priorities. Part Two will look to at more business as usual and tractional work and will align more closely to Cheshire and Merseyside. The part one and part two agendas will operate on alternate months. January 2024 is a part two agenda and in February it will be part two, and so on. We will be trialing the format during 2024 to ensure it works and adjustments will be made as necessary.

2.1.3 – Health Inequalities:
The Health Inequalities Commission held a workshop on 13 December, it was very well attended, and we had a number of presentations from national and local speakers. Young people were also in attendance. The Vibe research revealed that there are 16 barriers to fulfilling aspirations for young people in St Helens, the top three were: 1) Mental Health, 2) Lack of Opportunities and 3) Money.

Actions flowing from the workshop are:
- Creation of a focused “Task and Finish” group.
- Future and in-progress actions in the Borough.
- Lessons learnt from running the first workshop.



2.1.4 – Care Communities:
The North care community has identified over 50 patients that will benefit from a care communities' model. A meeting is in the diary early January to finalise arrangements with partners, how the Multi-Disciplinary Team meetings will work such as practicalities of which system they use to record actions or how teams can refer a challenging patient or resident into the MDT for that wider discussion about care. It is expected that following that regular care community MDT meetings can be arranged.

Central PCN are also trialling this wider care community team approach with a complex patient as a way to start to consider how they can make this business as usual, and although they weren't planning to be part of an initial trial, the challenges of one particular patient has led to them 'testing' out this care community model.

In addition, Newton and Haydock PCN are keen to roll out wider multi-disciplinary reviews for some of their most challenged patients and they are reviewing how they can learn lessons from North and develop a similar model as quickly as possible. It is likely to be 24/25 when the other care communities other than North really start to develop this model but they are all keen to work with wider partners to manage these challenges and are developing their plans in response to needs of patients.

2.1.5 - Primary Care:
As noted in section 2.1.1 one of the key challenges in primary care remains workforce. An extraordinary primary care group was held in November, focusing on workforce, and as a result a series of actions was highlighted to attempt to recruit and retain General Practice staff in the borough. There is a workforce group in place, led by the primary care team and the GP training hub, and attended by clinicians, that will take forward the plans discussed at that meeting. Things in place to support workforce include:

- Care navigation training for all practices
- Primary Care involvement in the Skills Academy 'Expo' event, aimed at care navigation and social prescriber posts
- Practice manager development programmes
- Recruitment and rostering support through a digital flexible pool, MIAA recruitment support and the potential for a Primary Care staff bank in future
- Workforce drop in sessions with the training hub
- Funding to support improvement initiatives
- Links to local colleges on apprenticeships within primary care
- First 5 and Last 5 groups developed

- SDF funding set aside to develop further initiatives such as career conversations, health and wellbeing hubs, creating learning environments.

Whilst it is recognised that the recruitment issue is a national problem, the aim is to try to make St Helens a more attractive place to work in primary care by having a holistic offer of support.

Access plans continue to develop and as noted above appointment numbers are increasing. Plans for roll out of call back in the telephone systems are in place and will be implemented over the next 6 months. However, access obviously depends on workforce, hence why the above actions are crucial to success of plans to improve primary care access.

A series of visits to practices is in place, known as Support level Framework visits. The aim of the visits is to encourage practices to develop and own action plans to address their challenges.

St Helens has secured section 106 funding for primary care infrastructure that means that a new housing development is approved on the caveat that the developer funds the primary care estate. The first one was approved in the Rainford area recently, but many other bids have been submitted that await an outcome.

2.1.6 – Quality Update:

Junior Dr Strike
This ran from 7am on 3rd January 2024 until 7am on the 9th of January 2024, the longest in the history of the NHS. National messages for patients have been widely shared. Daily urgent care meetings were taking place.

Leaning in arrangements.
The Associate Director of Quality Safety & Improvement was supporting the patient safety agenda on a part time secondment basis. Due to the volume of work needed in this area it was not sustainable on a part time basis. National guidance has been received requesting ICBs have a 1 wte dedicated patient safety specialist resource and a deputy available for support. Therefore the ADQ has stepped back from this role. The Associate Director is now supporting the team in Knowsley Place whilst the substantive ADQ supports the vacancy in Liverpool.

2.1.7 – Children & Young People Services Update:
Hilary Brooks – Director of Childrens Services has decided that she will be retiring in July 2024. Hilary has described how proud she is to have made St Helens her last job and of the success she has led in getting us to Good, and Outstanding for Care Leavers, in our recent Ofsted inspection.

We are all grateful to Hilary for all she has done for our children and young people, and her support to our staff and the wider Council and she will be missed by many. Recruitment to the DCS post has already started and the advert is live.

Families First for Children Pathfinder
Children's Services submitted a bid on Monday 6th November. The FFC pathfinder is part of the government's children's social care implementation strategy, Stable homes, built on love. It responds to recommendations from the independent review of children's social care, the Child Safeguarding Practice Review Panel report on child protection in England and the Competitions and Market Authority's market study of children's social care provision. The pathfinder will test delivery of key strategy commitments.

From July 2023 to March 2025, the programme is investing over £45 million to design and test radical reforms in a number of local areas, across the following policies:

- family help
- child protection
- family network support packages (FNSPs)
- safeguarding partners

The assessment of applications will take place throughout November and December 2023 with bidders informed of the decision in January 2024.

Sufficiency project - Millersdale
The Council has secured £1.4 million over 2023/24 and 2024/25 from the Staying Close fund, in part to support staffing and running costs over those two years. The bid was largely centred around the existing Council commitment to develop the Millersdale scheme, accommodation for care leavers. Quarterly performance reports to demonstrate progress will be submitted to the Department for Education (the funding body).

Torus has estimated the refurbishment cost at £430,000 (May 2023) and an annual rental, payable by the Council of £27,500. The rental cost will be funded from the Staying Close grant for the grant funding period and from Year 3 onwards, the annual cost of the lease will be met from efficiencies within the cost of leaving care provision and the avoidance of commissioning out of borough places for up to six care leavers. The average cost of a leaving care placement is currently £77k, avoiding six out of Borough placements could realise a saving of £462,000 per year.

Torus has held this property vacant for the Council over a number of years. It had indicated that the current refurbishment costs can only be held until the 13 October, the council has now signed and agreed to proceed with Millersdale.

Schools
Education - Attendance
In keeping with the DFE guidance, working together to improve school attendance, teams across Education and Learning have continued to work collaboratively with schools to ensure attendance remains a priority area. Extensive training has been delivered to teams across children's services to highlight that attendance is everyone's responsibility and to ensure that a collective effort is made to improve overall attendance and reduce persistent absenteeism.

A spotlight review has been conducted which afforded the opportunity to share good practice and identify solutions for areas of concern. Where appropriate, some schools have received intensive support to address attendance issues, e.g., frequent meetings to discuss strategies and analyse data trends.

Achievement and Improvement meetings have focused on school attendance and the analysis of data relating to vulnerable groups such as pupils entitled to free school meals, pupils with identified SEND and children with a social worker. Locality cluster meetings are operational as are various interventions and projects aimed at improving overall attendance such as the attendance quality mark for all secondary schools.

Innovative practice, involving the use of social prescribing and use of outreach workers, is beginning to show impact and plans to build on this are already in motion, e.g. use of external support through Maximum Edge. Feedback from headteachers illustrates the need for a current arrangement to be reviewed: reducing the period of absence before fixed penalty notice from 10 to 5 - this is now under review.

SEND
The SEND Partnership Board is in the process of reviewing the current SEND Strategy 2021-24 A Life of Equal Chances in preparation for the production of the new Strategy for next year. Preparation for this includes an evaluation of our current position, a shared understanding of children's experiences and impact and consideration of key priorities for the coming year.

The SEND team are working alongside the DfE, and CIPFA on Delivering Better Value (DBV) in the SEND programme. This programme will support the local authority, NHS and its partners to improve delivery of SEND services for children and young people whilst working towards financial sustainability. The team has now moved to 'Module 2' of the programme, which will engage with the wider SEND partnership through a series of case studies, deep dives and listening forums which will be used to inform the final grant application, which is due for submission mid December.

The new joint St Helens/Halton Free School, The Raise Academy, is now finally under construction with an anticipated opening date of September 2024. The new school will cater for pupils 11-16 with social, emotional and/or mental health (SEMH) needs and will complement existing provision in Willow Bank and the new primary SEMH resourced provision at Ashurst Primary School.

The volume of EHCPs produced by the SEND team has continued to increase as the additional capacity has taken effect, with a complement of 10 caseworkers and 1651 EHCPs maintained by the Local Authority.

The number of new Education Health and Care Plans (EHCPs) issued this year is now the highest that has been achieved since the implementation of the reforms in 2014. While the 20 week indicator has improved, the poor start to the year coupled with a slight plateau in performance due to the impact of the cyber incident and the gaps in Educational Psychology, means that this remains a significant challenge for the Local Authority.

Levels of parental satisfaction also appear to be returning; 84% of parents who returned their EHCP survey in 2023 agreed that they were fully involved in the assessment process, and 86% agreed the local authority listened to their views.

SEND partners across the local area continue to prepare for the new local area SEND inspection, which is anticipated early in 2024.

2.1.8 – Adult Social Care Update:

Director General of Adult Social Care visits Cheshire and Merseyside
The national Director General for Adult Social Care paid a visit to Cheshire and Merseyside on Wednesday 6th December 2023.

Michelle Dyson was in St Helens to learn more about how local health and care integration is supporting residents to experience better care and better outcomes. Read more
Adult Social Care Vision
Adult Social Care has continued to work with residents and staff to co-produce a vision for the future of Adult Social Care in St Helens. "Capacity" is the organisation facilitating conversations with individuals and groups and helping us to listen better to what is really important to people who require support from Adult Social Care. These conversations will be turned into a vision and a way of embedding taking co-production and co-design going forward.

Hospital Discharge:
Pressure on MWL Hospital leading up to the Christmas period was significant and escalation levels remain at OPEL Level 3. There is an increase in the acuity of patients coming into

hospital and having slightly longer lengths of stays due to this as well as requiring higher packages of care.

Social Care teams are working closely with the trust and support with daily discharge meetings as well as weekly senior escalation meetings. Alongside this a meeting is in place to focus on long length of stay patient to support a multi-agency approach to early discharge.
Work is ongoing with all boroughs and MWL to continue to refine the pathway referral process from wards to discharge teams and this work is expected to conclude and the new process to go live in January 24.

St Helens Integrated Discharge team have maintained an average of 53 discharges each week with the support of the Emergency Dept Social Workers and the Front Door and Brokering teams despite rises in referrals. St Helens Integrated discharge team (IDT) participated in a Home for Christmas and Home for New Year workshop with the Hospital Trust, commissioners and neighbouring Local Authorities. St Helens IDT were able to discharge 64 St Helens patients with support in time for Christmas. Social care discharge cover over weekends and Bank Holidays commenced Christmas week to help alleviate hospital pressure following periods when full social care assessment cover has historically been unavailable.

Work is also under way to discharge patients' home with wrap around care who may historically have been admitted into a care home particularly those diagnosed with dementia.

Front Door:
The number of telephone calls and contacts to Contact Cares Front Door remains high with an average of 1700 calls and 1000 emails per week. Recruitment to 4 of the 6 temporary (2 years) Contact Cares Advisors has been successful with only two remaining vacant post. Inductions are in progress for the new staff.

Urgent Community Response referrals also remain high with 69 referrals received last week. The Urgent Community Response Service undertakes both clinical and social care assessments and responds within 2 hours to help reduce pressure on hospital admissions. The UCR partnership/integration between STHK and St Helens Council has been a success and the integrated working within the service has received multiple compliments from service users and families/other professionals praising the care they have received.

Occupational Therapy:
OT services are still in the process of recruiting to an adult and paediatric OT post. The single-handed care project continues but the agency OT in post finishes in February 2024 so recruitment will recommence for this post. It has been raised with the provider collaboratives the opportunity to look at sharing OT staff across acute, community and Local Authorities as an opportunity to work together.

Brookfield & Transport:
Brookfield and extended college provision (community participation services) – we have now been able to restart the work experience programme at Brookfield, with 2 students who started in September 2023.

The work placements offer opportunities for identified students with a learning disability to work alongside Brookfield staff in the areas of domestic, kitchen and activity support.

Each student will experience all the areas of work over the 24-week placement to gain valuable skills and knowledge in preparation for employment.

An initiative to employ entrance level apprentices for care leavers to clerical roles in Brookfield and the Front Door has been pursued and a candidate appointed for Brookfield is due to start January 24, offering opportunities to experience this area of work in a supportive environment.

Brookfield CQC inspection December 2023- unannounced inspection undertaken overall outcome “Good” awaiting formal report.

Feedback from the inspector’s report - "During the inspection we spoke and spent time with 12 people about their experience of the care provided. We also observed interactions between staff and people who used the service. We spoke with 8 members of staff including the registered manager, duty managers, carers and members of the domestic team. We reviewed a range of records. This included people's care records and medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed. Following the visits to the service, we spoke with the registered provider's human resources department and viewed recruitment records electronically."

2.1.9 - Public Health Update:

Cheshire and Merseyside are putting on a series of workshops re Social Determinants of Health in Jan and Feb 2024 a number of collegues have booked on to these.

Schools and Food Project - Following on from a successful pilot in seven schools in St Helens, we are planning to offer all primary schools the opportunity to have free fruit in year groups 3,4,5 and 6 every day for five weeks during the first half-term of the year. We will also offer each primary school £1000 to do a food project, such as a breakfast club, and each secondary school or special school the offer of £2000. We will also provide practical advice and support to promote this initiative. The aim of this is to ensure children have access to healthy fruit and vegetables, at the most challenging time of year for families in terms of financial pressures.

Healthy Weight and Food:

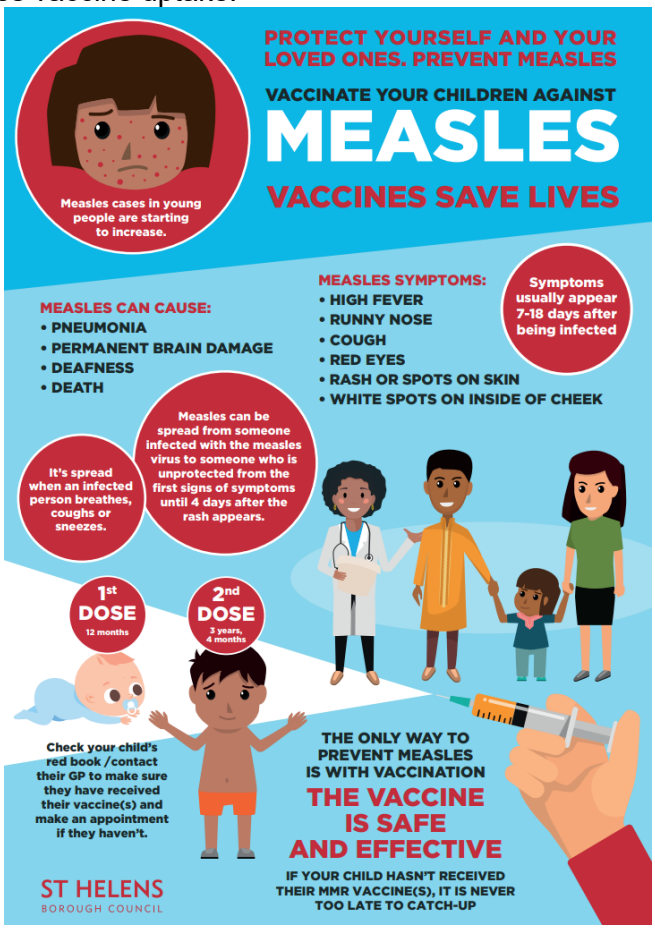
January launches the start of two healthy weight initiatives; a training programme and a delivery programme.

The training programme is called ‘Why Weight to Talk’ and aims to upskill practitioners and enhance their confidence to have a conversation around healthy weight and obesity. The training is for practitioners who are working with children, young people, and families. Public Health have allocated services to the training, including two designated sessions for local authority staff.

HENRY Randomised Control Trial will also start in January. The trial has seen a range of partners come together to ensure this programme can be delivered – Public Health, 0-19 Team, Family Hub team and St Helens Wellbeing Service. HENRY Randomised Control Trial is an 18-month programme aimed at families who have children under 5 years old. The programme aims to provide education around healthy eating, exercise and nutrition.
St Helens involvement forms part of a wider national trial.

Food Pantries:
Teams from the council and St Helens Place C&M NHS collected 320kg worth of food. Staff from Regulatory services collected, dated and delivered the food a week before Christmas. The food bank would like to extend its thanks and gratitude to all the staff who donated.

Measles Vaccination – Vaccination rates have fallen, and cases of measles are increasing in England. UK Health Security Agency (HAS) North West have been notified recently of a small number of confirmed measles cases in Greater Manchester and Lancashire. They believe there to be community transmission. With the support of our steering group, we have produced posters, pull-ups and leaflets to promote uptake of the measles vaccination. These are being shared with health visitors and school nurses, nurseries and children's centers and GP practices. We have also engaged with primary and secondary care colleagues and care home staff to promote measles vaccine uptake.



2.2 Other St Helens Projects

The establishment of a Skill Academy in St Helens took another step forward with the signing of a delegated executive decision to purchase the former Clickworks building in Hardshaw Street St Helens. It is envisaged that the acquisition will complete in a matter of weeks.

We are also holding a "Career in Care Expo" on the Whiston Site on **Saturday 23 March 2024**. This will build on the success of a similar venture in July 2023, however, the second element will be an on the day assessment process to undertake recruitment on site.

2.3 NHS Cheshire & Merseyside ICB Updates

The next Cheshire and Merseyside Integrated Board Meeting will be held on Tuesday 25th January 2024 at 9am at the Floral Pavilion Theatre & Conference Centre, New Brighton.

2.4 Cheshire and Merseyside Health Care Partnership (HCP) Updates

2.4.1 – The next HCP meeting will take place on 19th March 2024.

3. Recommendations

Place Partnership Board members to:

- **review** report and feedback comments

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/01/24/15

Report approved by: Neil Large, Non-Executive Member

Highlight report of the Chair of the ICB Audit Committee

Committee Chair	Neil Large
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	05 December 2023

Key escalation and discussion points from the Committee meeting

Alert

There are no alert items.

Advise

The Audit Committee:

- received a financial policies update, outlining which policies needed further review following the ICBs implementation of a new accounting system. Committee members also received a new financial policy to review and approve. Committee approved the ICBs Supplier Set Up Policy.
- received an update paper on the ongoing work to strengthen the ICBs arrangements for the management of Conflicts of Interest. Committee members were informed of the 'go live' date for the ICBs new system (Civica Declare) for staff to declare their interests, gifts, hospital and sponsorship declaration and the impending launch of the national Module 1 conflicts of interest training provided by NHS England. This will be hosted on the ICB ESR training system and will form part of the ICBs statutory and mandatory training for all staff and Board members. Committee also approved minor amends to the ICBs Management of Conflicts of Interest Policy and approved publication on the ICB website.
- received an update report from the ICBs Risk Committee. This report outlined the work underway to finalise the ICB Corporate Risk Register (CRR) and updates underway for the Board Assurance Framework before both go to the ICB Board meeting in January 2024. Committee also approved minor amends to the Terms of Reference for the ICBs Risk Committee and its publication on the ICB website.
- Received and reviewed the Committees Risk Register. The report provided details on the risk aligned to the Committee and work underway to mitigate these risks. A new risk (G10) has been escalated to the Audit Committee and further detail was provided on the work still underway with the ICBs Counter fraud specialist regarding the seven thematic risk areas for ICBs around fraud. It was outlined that a final position statement on these thematic areas will be presented to the Audit Committee at its March 2024 meeting. The Committee noted the Risk Register report and supported the inclusion of the new risk to the register.

Assure

The Audit Committee:

- received an update paper on the Freedom to Speak arrangements within the ICB. Committees members heard about key achievements including the roll out of FTSU e-learning for all staff, development of the ICB FTSU Ambassadors network which includes staff representatives from a range of diverse backgrounds, confirmation of the lead NED for FTSU (Erica Morriss), increased promotion of FTSU and the role of Guardians including through staff communications, the staff hub, 'we are one' session and face to face staff events, celebration of FTSU speak

up month in October 23 and the establishment of the FTSU summit (November 23), a forum to review FTSU data and triangulate with other business intelligence from across the organisation. Committee members also heard that there has not been any FTSU cases raised so far within the ICB. Committee members noted the report and the intention for a paper to go to the Board in January 2024 and that part of a future Board development session be used to support the Board's involvement and engagement with FTSU

- received an update paper that provided an update to Audit Committee on the tender and quotation waivers approved in line with the Scheme of Reservation and Delegation between 1st August and 31st October 2023. During this time, there were 4 tender waivers and 9 quotation waivers approved. Committee members were also provided an update on the new Procurement Act 2023 which introduces new requirements for non-healthcare procurement and the introduction of the new 'Provider Selection Regime' (PSR) specifically for healthcare services. The Committee noted the update and that the ICB would be publishing its updated procurement decision register on its public facing website following the December Audit Committee meeting
- received an update paper on the progress made by the ICB against the recommendations from the Internal and External Audits undertaken during the 2022-23 period. Committee members received information and assurance on progress against 19 External and 7 Internal audit recommendations and noted that the majority of recommendations had been addressed and implemented by the ICB and that plans were ongoing to implement those recommendations not yet fully addressed
- received an update report from the ICBs Internal Auditor.Committee members were provided with an update on the internal audits already completed (Complaints and DSPT both receiving substantial assurance) and progress against the remaining internal audits, with 6 audits anticipated to be completed and reported to Committee in March 2024. Committee members noted the report
- received an updated report from the ICBs External Auditors. Committee members received an update on the work underway around value for money arrangements, Mental Health Investment Standard, planning around the 2023/24 audit, and sector news. The Committee noted the report
- received an update report from the ICBs counter fraud specialist. Committee members received information identifying that there were no local concerns of note, that there had been 16 referral queries received within the reporting period with 6 of these closed, and none so far progressed to investigation. Committee members were also informed that Phillip Leong was now the named Anti-Fraud specialist for the ICB. The ICBs website and policies have now been updated to reflect this. Committee noted this report.
- received the quarterly Information Governance Report for the ICB. Key areas that the Committee was updated on included the changes to the 2023-2024 Data Security and Protection Toolkit (DSPT), with the main change being around training and awareness and organisational IG Culture, update on the number of data breaches and resolutions, progress around asset recording, data protection impact assessments undertaken and completed, data sharing and data processing agreements undertaken, and activity undertaken by the Data Protection Officer for the ICB.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
G1 - non-compliance with information governance policies leads to reportable data security and protection incident resulting in financial loss and / or reputational damage.	Committee was informed that this risk has been mitigated from extreme (20) to moderate (6) and no longer meets the threshold for escalation to the committee. It will continue to be monitored and reviewed as part of the ACE Directorate risk register.
G2: Commissioning support or other data processors acting on the ICB's behalf breach statutory or regulatory requirements, resulting in financial loss and / or reputational damage, currently rated as high (9).	Risk mitigated from extreme (20) to high risk (9), through policies and the Data Security and Protection Toolkit Plan being in place, but the remaining controls remaining as amber, recognising that the IG assurance process for the procurement and contracting of services from suppliers that handle personal information requires review and strengthening. Key planned actions are to update the procedures during quarter 4 of 2023/24, which will be applied to all new procurements and contract renewals, and to consider requirements to review any high-risk contracts not due for renewal
G5: The inconsistent adherence to a core set of governance, financial and operational policies and procedures across the ICB leads to control failures, poor audit outcomes and reputational damage, currently rated as high (9).	Risk mitigated from extreme (20) to high risk (9), through the progress made in completing, implementing and communicating the key ICB policies via the Staff Hub. Key further action is to secure approval to the draft policy for the development and management of policies which has been drafted and is awaiting approval, which will ensure that roles and responsibilities, and the process and standards for producing and maintaining documents are clear.
G10 (New): Re-procurement of information governance services de-stabilises existing arrangements resulting in adverse financial and reputational impacts, currently rated as high (9).	Risk mitigated from extreme (20) to high risk (9), through the range of controls in place, with policies rated as green, recognising that we have Standing Financial Instructions and a Procurement Policy in place. The remaining controls are rated as amber and relate to the procurement project - plan, processes, mobilisation planning, engagement, and reporting. The project plan is currently on track, with a new contract planned to be in place ready for 1st July 2024.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/01/24/16

Report approved by: Tony Foy, Non-Executive Member

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	12 December 2023

Key escalation and discussion points from the Committee meeting

Alert

The Remuneration Committee has reviewed and updated its Terms of Reference (TOR) (Appendix One). Amendments to the TOR cover the following areas:

- general tidying up of the TOR format and structure
- inclusion of references to areas of authority and responsibility of the Committee that feature within the ICBs Constitution, SORD and SFIs that did not feature in the TOR previously
- amendments to the Committees membership
- amendments outlining how a Committee can be called when considering the remuneration of Non-Executive Directors.

The Committee recommends that the amended Terms of Reference are approved by the Board.

Advise

The Remuneration Committee:

- received a paper that provided an updated Very Senior Manager (VSM) Pay Framework. The paper outlined the changes that had resulted due to the Governments acceptance of the National Pay Review Body recommendations in full and the ICB implementing the application of a 5% uplift on VSM salaries. The paper highlighted where the application of the 5% uplift resulted in taking an individual over the relevant pay threshold and whether approval was needed from NHS England or not. Committee considered the report and approved the recommendation regarding the pay case application to NHS England for one individual.
- received a paper on and decided on the status of the VSM pay award for the ICBs Director of Population Health
- received a paper providing the Committee with the ICBs Fit and Proper Persons Test (FPPT) Policy to review and approve. The Policy provided Committee members with the details regarding the process and timeframes that will be required to be undertaken to implement the FPPT arrangement for the ICB and the roles/individuals who will be in scope of the Policy. The Committee approved the policy.
- the Committee received a paper outlining the proposed role and contractual terms of conditions for the ICB Associate Non Executive Director position. Committee members discussed and approved key areas including remuneration, time commitment, contract length and contract status.

Assure

The Remuneration Committee:

- received an update on the conclusion of the ICBs Mutually Agreed Resignation Scheme (MARs) including the number of people who applied, agreed applications and cost implications for the ICB. The committee received assurance regarding the process and its organisational impact on behalf of the Board and did not identify any significant concerns. The Committee noted the report.
- received an update on the conclusion of the ICBs On-Call Consultation, which outlined the feedback received during the consultation, the ICB responses and position, as well as next steps. The Committee noted the report.

Appendices

Appendix One: Committee Terms of Reference v1.3

NHS
Cheshire and Merseyside

NHS Cheshire & Merseyside ICB

Remuneration Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
1 July 2022	1.0	Initial ToRs		Ben Vinter
29 September 2022	V1:1	Changes made by Remuneration Committee at its September 2022 meeting		Matthew Cunningham
13 October 2022	V1.2	Changes made by Remuneration Committee at its October 2022 meeting		Matthew Cunningham
12 September 2023 12 December 2023	V1.3	Changes made by Remuneration Committee at its September and December 2023 meeting		Matthew Cunningham

Review due:
1 September 2024

Tbc - V1:3 approved by the C&M ICB Board (to add)

Remuneration Committee

Terms of Reference

Introduction

NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside') has been established to:

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

1. Purpose

The Remuneration Committee (the Committee) is established by NHS Cheshire and Merseyside as a Committee of the Board in accordance with its Constitution.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006.

The Committee will:

- adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective
- advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.

2. Responsibilities / duties

The Board has delegated the following functions and duties to the Committee:

For the Chief Executive, Directors and other Very Senior Managers:

- determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, allowances, pensions and cars
- determine arrangements for termination of employment and associated severance payments, and other contractual terms and non-contractual terms
- advise on and propose the appointment process for the ICBs Chief Executive, in line with the national process.

For Partner Members on the Board:

- approve any ICB Pay and Allowances/Benefits policies and frameworks for Partner Members on the ICB Board

For Non-Executive Directors of the Board:

- determine the ICB remuneration policy (including the adoption of pay frameworks)
- oversee contractual arrangements.

None of the ICBs Non-Executive Directors will be involved in the decision making regarding the determination of their renumeration and any other allowances. On the occasion where this is required the Committee membership be composed of the ICB Chair and up to two Non-Executive Directors drawn from NHS Providers or neighbouring ICBs.

For all staff:

- determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change).
- oversee contractual arrangements
- determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.
- approve disciplinary arrangements for employees, including the Chief Executive (where he/she is an employee of the ICB).

Additional functions that the ICB has chosen to include in the scope of the committee include:

- functions in relation to nomination and appointment of Board members through the convening an ICB Appointments Panel, and as outlined within the ICB Constitution
- functions in relation to the performance review/oversight and appraisals for Executive Directors/Senior Directors, including the Chief Executive and the Chair in line with NHSE guidance on appraisals for Chairs and Chief Executives
- oversight of the succession planning for the Board member positions and Executive Directors
- assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation and including such things as Fit and Proper Person Regulation (FPPR).

3. Authority

The Remuneration Committee is authorised by the Board to:

- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may /not delegate any decisions to such groups without the approval of the ICB Board

- commission, review and authorise policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

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

4. Membership & Attendance

Membership
The Committee members shall be appointed by the Board in accordance with the ICB Constitution and as outlined within these Terms of Reference.

The Board will appoint no fewer than three members of the Committee, drawn from the Non-Executive Directors of the Board. All Non-Executive Directors of the ICB may be members of the committee recognising that there may be times when the ICB Audit Chair needs to abstain from taking part in the meeting. Other members of the Committee need not be members of the Board, but they may be.

The Committee may also choose to appoint other individuals to be members of the Committee, drawn from:

- up to two Non-Executive Directors drawn from NHS Providers or neighbouring ICBs, ideally with experience of remuneration committees and / or remuneration decisions for members of Board.

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

The ICB Chair will also receive a standing invitation to attend and will only sit as a member when there is a need to maintain quoracy or when a decision involving ICB Non-Executive Director remuneration or allowances is to be made.

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

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

- Chief People Officer or their nominated deputy
- Director of Finance or their nominated deputy
- Chief Executive or their nominated deputy
- Associate Director of Corporate Affairs and Governance.
- Independent HR Advisors.

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

Management of Conflicts of Interest

No individual should be present during any discussion or decisions relating to:

- any aspect of their own remuneration
- any aspect of the remuneration of others when it has a direct impact on them.

5. Meetings

5.1 Leadership

In accordance with the constitution, the Committee will be chaired by a Non-Executive Director of the Board. Committee members may appoint a Deputy Chair from amongst the standing ICB Non-Executive Directors , with the exclusion of the Non-Executive Director undertaking the role of the ICB Audit Chair.

In the absence of the Chair, or Deputy Chair, the remaining ICB Non-Executive Directors present shall elect one of their number to Chair the meeting recognising that this may not be the ICB Chair, or Audit Chair.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

For a meeting to be quorate a minimum of two Non-Executive Directors of the Board are required, including either the named Chair or the Deputy Chair of the Committee. ICB Board members must form the majority of the membership at a meeting of the Committee, with the exception only being when the Committee is determining the remuneration and allowances of the ICBs Non-Executive Directors .

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If on an occasion a Committee meeting is due to start but the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. Alternatively, the meeting can be called to a halt and an agreement reached to rearrange an additional meeting.

5.3 Decision-making and voting

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

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

Only members of the Committee may vote. Each member is allowed one vote, and a majority will be conclusive on any matter.

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

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

5.4 Frequency and meeting arrangements

The Committee will be held in private.

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

The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice or agreement.

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

5.5 Administrative Support

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

- the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- records of conflicts of interest members' appointments and renewal dates. Provide prompts to renew membership and identify new members where necessary
- good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual, and agreed with the chair. Keep a record of matters arising, action points and issues to be carried forward. Minutes of the meeting will be circulated to all Committee members within 10 working days of the meeting, highlighting actions by individual members
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

5.6 Accountability and Reporting Arrangements

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

The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information.

The Committee will provide the Board with an Annual Report timed where possible to support finalisation of the ICB Annual Report and Accounts. The report will summarise its conclusions from the work it has done during the year.

6. Behaviours and Conduct

Benchmarking and guidance
The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England, and the wider NHS in reaching their determinations.

ICB values
Committee Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

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

7. Review

The Committee will review its effectiveness at least annually

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Highlight report of the Chair of the ICB System Primary Care Committee

Agenda Item No: ICB/01/24/17

Committee Chair: Erica Morris, Non-Executive Member

Highlight report of the Chair of the ICB System Primary Care Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	22 December 2023

Key escalation and discussion points from the Committee meeting

Alert

The Committee

- were advised that the regulations on EPR procurement from NHS England have allowed an additional four providers to enter the market and that we are potentially looking at di-vergence against the generally recognised forward strategy of digital convergence. Risks were discussed around transfer to new systems and maintaining a wider range of systems across Cheshire and Merseyside.

Advise

The Committee:

- agreed a number of digital capital bids and approval for practices under the Tech Innovation Framework Early Adopter Programme
- agreed recommendations for a dental procurement, in line with the scheme of delegation and standing financial instructions.
- agreed requests for increased spending within the overall ICB envelope for Liverpool Place, in respect of Additional Roles, the national scheme for practices to recruit more staff aligned to the Directed Enhanced Service for Primary Care Networks
- ratified the APMS (Alternative Provider of Medical Services) procurement decision made by Cheshire West Place, which was required to be agreed at the committee in line with current scheme of delegation/standing financial instructions
- received and agreed the Minutes of PSRC (Pharmaceutical Services Regulations Committee)
- received a report in relation to the ongoing actions to support outcomes from a Safeguarding/Quality analysis of the national general practice E-Declaration.
- received challenges in respect of current system pressures including input from all four contractor groups and their representatives – paying particular note to the challenge of the current industrial action by junior doctors
- noted the approval by the ICB Board of the Access Improvement Plan, and the place levels plans contained therein – noting there will be a by exception update to Board in March and to this Committee in April
- received an update on the Primary Care Strategic Framework, noting that the remainder of the framework required staffing resources to complete and that this was currently under discussion.

Assure

The Committee

- received assurance around Pharmacy closures and ongoing actions under the national contract in relation to provision of services.
- received an update/assurance in relation to the work to standardise and streamline reporting in respect of primary care quality. It had been already agreed that

reporting would go direct from the relevant operational groups direct to Quality and Performance via standard templates, with a periodic summary and deep dive received by the Committee, for assurance purposes.

- received a Finance report which included an update on the work of the finance task and finish group. A more in-depth presentation on the work of this group was requested in respect in particular in understanding any differences in the current levels, scope and financial envelope of primary care (General practice) services commissioned locally.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
Patient Safety/Quality	An update was given to offer further assurances in respect of primary care quality and actions to assure and standardise reporting.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
BAF P1//P6/P9 Annual Plan Primary Care.	Approval of the Access Improvement Plan Further updates requested in respect of place spend/resources and overall priorities, under the work of the Finance Task and Finish Group

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Internal Audit for Contracting and Commissioning underway	Will be reported now at the February Meeting
Finance Update	SPCC reviewed all the budgets and have a task & finish finance group that will look for consistency / efficiencies across the Places in C&M.
Capital Update	Digital allocations discussed and agreed
Recovering Access to Primary care & Dental Improvement Plan	As above. Dental Improvement Plan to be updated at the February meeting.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Highlight report of the Chair of the ICB Transformation Committee

Agenda Item No: ICB/01/24/18

Report approved by: Clare Watson, Assistant Chief Executive

Highlight report of the Chair of the ICB Transformation Committee

Committee Chair	Clare Watson
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date:	23 November 2023

Key escalation and discussion points from the Committee meeting

Alert

The Transformation Committee considered reports on Pulmonary Rehabilitation and Personal Health Budgets, both relating to programme funding proposals. Committee is escalating to the ICB Board:

- the need to align the national and ICB position on funding availability with clinical networks and the challenges this presents in delivering long term plan commitments; and
- the need for better communications out to front line clinical teams
  - around the financial position of the ICB and the wider ICS and the
  - impact this has on service development and expansion.

Advise

The Transformation Committee considered:

- a paper to request supporting the ringfencing of £150k for 2024/25 to roll out projects that enable the national trajectories to increase Personal Health Budgets (PHB) across C&M was presented. Committee supported and agreed to the approach taken and the prioritisation of the request for £150K to be ring fenced against this as part of the ICB's planning process against the budget line for personalised care.
- the Pulmonary Rehabilitation Business Plan for 2023/24 was presented to the Transformation Committee. The Respiratory Programme Board oversees the funding that is received annually from NHS England. Committee agreed to support the recommendations detailed in the report relating to retrospective implementation of the service specification across all nine places and that recurrent funding will be considered as part of the planning process for 2024/25. Committee also agreed for further conversations at Digital Transformation and Clinical Improvement on how the outcomes and the performance against the investment for Pulmonary Rehabilitation is reported on.
- a request for the release of Transformation Programme funding to mobilise the 'Saving tomorrow's lives today' programme for 2023/24 was not agreed by the committee. The service will now be mobilised from April 2024.
- the committee supported the proposal for the implementation of Verto as a single PMO solution software for C&M. The investment of £82.5K for 2024/25 would be mainly for additional licences for an at scale approach across C&M.
- the committee considered a paper relating to the Individual Funding Requests as part of the wider review of the MLCSU contracts being undertaken, with a decision to in-house the service having been previously agreed by Finance Investments & Resource Committee. Transformation Committee agreed to support the proposed operating model. However, further work is needed to understand any further

governance and implications in developing and agreeing for C&M transferring a full at scale model into C&M to deliver a North West offer across the three ICBs.

Assure

The Transformation Committee considered:

- a report on the approach to developing the committee's Risk Register was received. Members will be requested to consider any risks pertaining to the committee to help develop a Risk Register Heat Map and this will be presented at the next meeting.
- an update on Specialised Services, which will be the responsibility of C&M ICS from April 2024, was given and the focus is now on the Target Operating Model. The committee's Risk Register will now include risks for Specialised Commissioning relating to resourcing and finance. Committee recognised the challenge of being responsible and accountable for the budgets and the services and the need for NHS England to work as part of C&M's agenda and priorities.
- a presentation on 'Planning for 2024 – Developing our Plans' was delivered, focusing on how to better coordinate across C&M to have a single plan, highlighting the need to delivering more efficiently and looking at opportunities to do things once at a Place Plus or C&M level. Work is ongoing to capture plans that are relevant and possibly replicated in other parts of the system to look at aligning them as part of the Joint Forward Plan.

The Transformation Committee is currently undertaking a review and refresh of its Terms of Reference. Further work will be required around clarifying and confirming the role, purpose and responsibilities. The scope of the committee will also consider how the work of both provider collaboratives are linked in and to ensure there is no duplication. The finalised version will be presented at the next committee meeting.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
Not discussed at committee	

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P1 - The ICB is unable to progress meeting its statutory duties to address health inequalities due to failure to secure inward investment or influence partners priorities.	The Committee received a report on work being undertaken to mitigate the risks

Board Assurance Framework Risks	
P2 - The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities.	
P6 - The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services.	

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Transformation Committee Governance	Discussions around the Committee's governance arrangements to support the enabling of assurance to be given on transformation programmes meeting objectives. Further work to be undertaken.
Pulmonary Rehabilitation Business Plan	As outlined earlier in report
Development of 2024-25 priorities within our Joint Forward Plan	The approach to developing an aligned plan across our nine Places was discussed. In addition investment into a standard programme management software solution was approved.
Delivery of the nationally set trajectory to increase use of Personal Health Budgets	As outlined earlier in report

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

ICB Board Assurance Framework Q3

Agenda Item No: ICB/01/24/19

Responsible Director: Clare Watson, Assistant Chief Executive

ICB Board Assurance Framework Q3

1. Purpose of the Report

1.1 The purpose of the report is to provide an update on the Board Assurance Framework (BAF).

2. Executive Summary

2.1 The 2023-24 BAF and principal risks were approved by the Board in May 2023 and updates were received in July and November 2023. The principal risks are those which, if realised, will have the most significant impact on the delivery of the ICB's strategic objectives.

2.2 There are currently 10 principal risks, including four extreme risks, five high risks, and one moderate risk. The most significant risks are:

- P5 - Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience, currently rated as extreme (20).
- P6 - Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population, currently rated as extreme (16).
- P7 - The Integrated Care System is unable to achieve its statutory financial duties, currently rated as extreme (16).
- P3 - Acute and specialist providers across Cheshire and Merseyside may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. 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, currently rated as extreme (15).

2.3 There have been no changes to the risk scores since the November 2023 report.

2.4 The report and appendices set out the controls in place, an assessment of their effectiveness and further control actions planned in relation to all principal risks. Planned assurances have been identified in relation to each principal risk and these will be provided through the work of the Committees and through Board reports over the course of the year.

2.5 The priority activity over the last quarter has continued to be the strengthening and implementation of controls with the aim of reducing the likelihood or potential impact. As progress is made in implementing and strengthening controls, with resulting reductions in the level of risk, the focus will shift to assuring that key controls are embedded and effective in continuing to mitigate the risk to an acceptable level.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **NOTE** the current risk profile, progress in completing mitigating actions, assurances provided and priority actions for the next quarter; and consider any further action required by the Board to improve the level of assurance provided or any new risks which may require inclusion on the BAF.

4. Reasons for Recommendations

4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

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

5. Background

5.1 As part of the annual planning process the Board undertakes a robust assessment of the organisation's emerging and principal risks. This aims to identify the significant external and internal threats to the achievement of the ICB's strategic goals and continued functioning. The principal risks identified for 2023-24 were approved for adoption by the Board in May 2023 and form the basis of the BAF reported quarterly to the Board.

5.2 The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. Risks will be taken in a considered and controlled manner, and the Board has determined the level of exposure to risks which is acceptable in general, and this is set out in the core risk appetite statement.

5.3 The Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The Board BAF is a key component of this. The Board is supported through the work of the ICB

Committees in reviewing risks, including these BAF risks, and providing assurance on key controls. The outcome of their review is reported through the reports of the committee chairs and minutes elsewhere on the agenda.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic development**

6.1 The BAF supports the objectives and priorities of the ICB through the identification and effective mitigation of those principal risks which, if realised, will have the most significant impact on delivery.

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

7.1 The Annual Delivery Plan sets out linkages between each of the plan's focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks. The Annual Delivery Plan and its associated risks can be found at: https://www.cheshireandmerseyside.nhs.uk/media/2kvcnuzm/summary-version-of-the-jfp-delivery-plan-260623.pdf

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
Theme Two: **Integration**
Theme Three: **Leadership**

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the BAF underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability:
"We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment, and support. We act on the best information about risk, performance, and outcomes, and we share this securely with others when appropriate."

9. Risks

9.1 There are currently four extreme risks, five high risks and one moderate risk. There has been no movement in current risk scores since the November report,

but progress has been made in completing actions to improve both controls and assurances.

9.2 The most significant risks are:

9.2.1 **P5 - Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience**, currently rated as extreme (20). This is to be mitigated through the delivery of operational plans spanning urgent and emergency care, virtual wards, admissions avoidance, no criteria to reside, and bed occupancy. The national delivery plan for recovering urgent and emergency care spans the next 3 years to 2024/25 e.g. an improvement to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvements in 24/25. The risk is expected to diminish over this timeframe and the target score for 23/24 (15) reflects that improvement to pre-pandemic constitutional standards e.g. 95% of patients being admitted, transferred or discharged within four hours will span multiple years. Oversight and assurance will be provided through the work of the C&M Urgent Care Improvement Group.

9.2.2 **P6 - Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population**, currently rated as extreme (16). This is to be mitigated through the development and delivery of the Primary Care Strategic Framework, Primary Care Access Recovery Plan, and Dental Improvement Plan over a 2- to 3-year period. This is in the context of significant and increased post Covid-19 demand which continues to exceed supply despite the substantial progress in recovering activity levels. Oversight and assurance will be provided through the System Primary Care Committee supported by the work of the programme delivery governance structure.

9.2.3 **P7 - The Integrated Care System is unable to achieve its statutory financial duties**, currently rated as extreme (16). This is to be mitigated in the short term through the 23-24 System Financial Plan which has now been agreed and approved. During the course of the year cost improvement plans and a long-term financial strategy will be developed. This is in the context of a significant underlying system deficit which is reflected in the risk score. Oversight and assurance will be provided through the work of the Finance, Investment and Our Resources Committee and the monthly system finance reports to the Board.

9.2.4 **P3 - Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. 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, currently rated as extreme (15). This is to be mitigated through the delivery of operational plans, including the elective recovery programme, diagnostics programme, Cancer Alliance programme and place delivery plans. The updated description reflects that capacity constraints are currently the key driver and this is reflected in the risk score. The national delivery plan for tackling the COVID-19 backlog of elective care spans the next 3 years to 2024/25 and the risk is expected to diminish over this timeframe. Oversight and assurance will be provided through the work of the Quality and Performance Committee and Transformation Committee and the monthly performance reports to the Board. External assurance with be through the NHS System Oversight Framework.

9.3 Mitigation strategies are having an impact in relation to a number of the risks as illustrated by the heat map at Appendix Two and summarised below:

9.3.1 **P1 - the ICB is unable to progress meeting its statutory duties to address health inequalities**. Mitigated from extreme (16) to high (12) through strategy and plans to implement Marmott principles and focus on Core 20+5 supported by ringfenced funding for health inequalities & transformational programmes. Key further actions are to finalise and seek partner sign off to the Population Health Vision and strategic programme approach for C&M ICB / ICS, and finalise and implement the public health operating model.

9.3.2 **P2 - The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities**. Mitigated from high (12) to moderate (6) through the Digital and Data Strategy 2022-25 and key contracts for population health management and shared care record integrated health and care data platform and analytical services. This is now in line with the target score and the focus will shift to assurance that controls continue to be effective.

9.3.3 **P4 - Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience**. Mitigated from extreme (15) to high (10) through contractual standards and extensive infrastructure for quality review, analysis, learning and assurance. Key further actions include development of clinical quality strategy, standardised quality contracting model and further improvement of existing controls.

9.3.4 **P8 - The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services**. Currently rated as high (12). Planned mitigations through the transformation programmes in Liverpool, East Cheshire, and Sefton and for women's services and clinical pathways. Key further actions are to develop the clinical improvement

hub, establish governance and progress the Liverpool urgent care pathways.

9.3.5 **P9 - Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives**. Mitigated from extreme (16) to high (12) through a range of programmes developed and supported by the Cheshire and Merseyside People Board. Key further actions are to develop and enhance system workforce planning, deliver the C&M retention plan and maximise apprenticeships.

9.3.6 **P10 - ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population**. Mitigated from extreme (16) to high (9) through the development of the Interim HCP Strategy and the Joint Five-Year Forward Plan, together with the associated consultation and engagement. Key actions are the next iterations of the HCP Strategy and Joint 5-Year Forward Plan and concluding the ICB operating model.

Further detail is provided in the risk summaries at Appendix Four.

9.4 The priority activity over the last quarter has been the strengthening and implementation of controls with the aim of reducing the likelihood or potential impact. The significant actions to improve controls completed since November are:

- Shadow Data into Action Board established and will report into ICB Board (P2)
- Enhanced system for diagnostics mutual aid targeted at reducing health inequalities and increasing system performance in terms of 6 week waits agreed by C&M Chief Operating Officers (P3)
- Implementation of revised national OPEL Framework for acute trusts completed (P5)
- Procurement and implementation of supplier for real time urgent care reporting completed (P5)
- Primary Care Strategic Framework - Stage One, comprising general practice and community pharmacy, approved (P6)
- Primary Care Access Recovery Plan approved (P6).

9.5 As progress is made in implementing and strengthening controls, with resulting reductions in the level of risk, the focus will shift to assuring that key controls are embedded and effective in continuing to mitigate the risk to an acceptable level. Planned and actual assurances have been identified in relation to each principal risk and these are summarised in Appendix Three and detailed in the risk summaries at Appendix Four.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the report does cover a number of financial risks which are described in section 9 of this paper and detailed in the appendices.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 Principal risks P3, P4, P5, P6, P8 and P9 have the potential to impact on equality, diversity and inclusion in service delivery, outcomes or employment. The mitigations in place and planned are described in more detail in the risk summaries at Appendix Four.

12.2 Principal risks P1 and P2 have the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at Appendix Four.

13. Climate Change / Sustainability

13.1 There are no identified impacts in the BAF on the delivery of the Green Plan / Net Zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 Senior responsible leads and operational leads for each risk will continue to develop and improve the controls in line with the targets and progress the priority actions and assurance activities as identified in Appendix One and in the individual risk summaries at Appendix Four. Updates will be provided through the regular BAF report to the Board.

15. Officer contact details for more information

Dawn Boyer
Head of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB

16. Appendices

Appendix One: Board Assurance Framework Summary
Appendix Two: Heat Map
Appendix Three: Risk Assurance Map
Appendix Four: Risk Summaries

NHS
Cheshire and Merseyside

Board Assurance Framework 2023/24 – Quarter 3 review

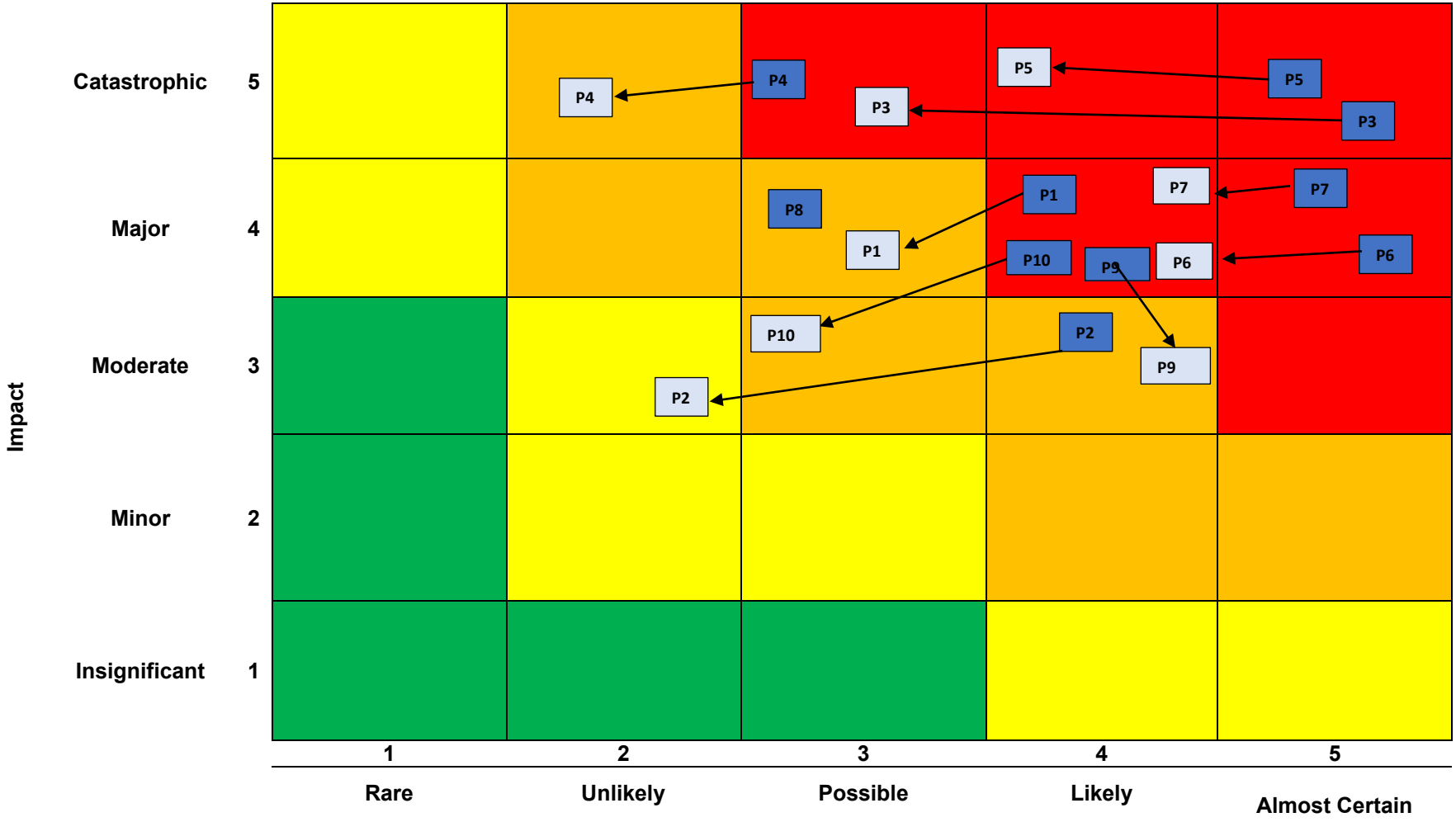
Appendix One – Summary

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score	Priority Actions / Assurance Activities
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience						
P1: The ICB is unable to meet its statutory duties to address health inequalities	Transformation Committee Clare Watson	**4x4=16**	**3x4=12**	No change	**2x4=8**	Further action to strengthen controls. Key actions are to finalise and seek partner sign off to the Population Health Vision and strategic programme approach for C&M ICB / ICS, and finalise and implement the public health operating model.
P2: The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities	Transformation Committee Rowan Pritchard-Jones	**4x3=12**	**2x3=6**	No change	**2x3=6**	Currently at target score. Key focus should be on assurance. It is planned that this is provided through Intelligence into Action programme governance and reporting via Transformation Committee.
Strategic Objective 2: Improving Population Health and Healthcare						
P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency	Quality & Performance Committee Anthony Middleton	**5x5=25**	**3x5=15**	No change	**2x5=10**	Further action to strengthen controls. Key actions are the Elective Recovery Team and increasing diagnostics capacity through Community Diagnostic

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score	Priority Actions / Assurance Activities
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						Centres and elective capacity through elective hubs
P4: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience	Quality & Performance Committee Chris Douglas / Rowan Pritchard-Jones	**3x5=15**	**2x5=10**	No change	**1x5=5**	Significant controls in place with some actions for further improvement, including development of clinical quality strategy and standardised quality contracting model. Priority will be to provide assurance on continuing effectiveness of control framework.
P5: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience	Quality & Performance Committee Anthony Middleton	**5x5=25**	**4x5=20**	No change	**3x5=15**	Further action to strengthen controls. Key actions are implementing operational plan for urgent emergency care, virtual wards, admissions avoidance, no criteria to reside, and bed occupancy; and C&M UEC Recovery Programme.
P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	Primary Care Clare Watson	**5x4=20**	**4x4=16**	No change	**3x4=12**	Further action to strengthen controls. Key actions are to conclude and establish delivery of primary care plans.

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score	Priority Actions / Assurance Activities
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money						
P7: The Integrated Care System is unable to achieve its statutory financial duties	Finance, Investment & Our Resources Committee Claire Wilson	**5x4=20**	**4x4=16**	No change	**2x4=8**	Further action to strengthen controls. Key actions are to finalise cost improvement plans and a long-term financial strategy.
P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services	Transformation Committee Rowan Pritchard-Jones	**3x4=12**	**3x4=12**	No change	**2x3=6**	Further action to implement and strengthen controls. Key actions are to develop the clinical improvement hub, establish governance and progress the Liverpool urgent care pathways.
P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives	Finance, Investment & Our Resources Committee Chris Samosa	**4x4=16**	**4x3=12**	No change	**2x3=6**	Further action to implement and strengthen controls. Key actions are to develop and enhance system workforce planning and deliver the C&M Retention Plan.
Strategic Objective 4: Helping the NHS to support broader social and economic development						
P10: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population	ICB Executive Graham Urwin	**4x4=16**	**3x3=9**	No change	**3x3=9**	Further action to strengthen controls. Key actions are the next iterations of the HCP Strategy and Joint 5-Year Forward Plan and the ICB operating model.

Appendix Two – Heat Map



Appendix Three – Risk Assurance Map

Principal Risks	Current Risk Score	Controls					1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
		Policies	Processes	Plans	Contracts	Reporting				
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience										
P1: The ICB is unable to meet its statutory duties to address health inequalities	**12**	**G**	**A**	**A**	**A**	**G**	Management oversight of the development & implementation of the prioritisation framework. Appraisal of health inequalities funding bids / allocations.	Progress reports to C&M HCP Board on delivery & implementation of programmes and projects aligned to Marmott principles - ***In place***	Core 20+5 & health inequalities stocktakes by NHSE/I reported to Population Health Board & C&M HCP Board - ***Planned***	**Reasonable**
P2: The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities	**6**	**G**	**G**	**G**	**A**	**G**	Management scrutiny and prioritisation of requests. Management oversight of programme delivery.	Approval of 'intelligence into action' investment case by ICB Board – ***In place*** Data into Action Board to report into ICB Board – ***Planned***		**Reasonable**

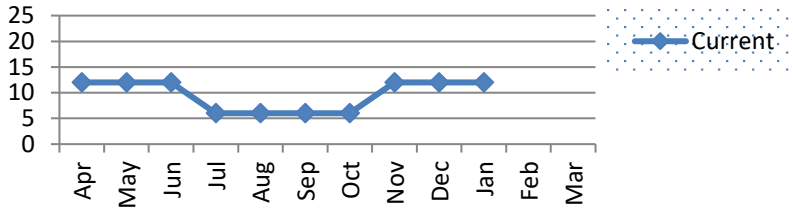
Principal Risks	Current Risk Score	Controls					1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
		Policies	Processes	Plans	Contracts	Reporting				
Strategic Objective 2: Improving Population Health and Healthcare										
P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. 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	**15**	**G**	**A**	**G**	**G**	**G**	Executive sign off to the operational plan Management oversight of operational and programme planning and delivery	Performance reporting to Quality & Performance Committee, ICB Board – ***In place*** Programme delivery reporting to Transformation Committee, ICB Board – ***In place***	NHSE/I Systems Oversight Framework – ***In place***	**Reasonable**
P4: Major quality failures may occur in commissioned services resulting in inadequate care compromising	**10**	**A**	**A**	**A**	**A**	**G**	Executive oversight through system-wide quality governance structure and reporting	Executive Nurse report to ICB Board – ***In place*** Quality reporting and dashboard to Quality	Regional Quality Group reporting - ***Planned***	**Reasonable**

Principal Risks	Current Risk Score	Controls					1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
		Policies	Processes	Plans	Contracts	Reporting				
population safety and experience								and Performance Committee – ***In place***		
P5: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care)results in patient harm and poor patient experience	**20**	**G**	**A**	**A**	**G**	**A**	Executive sign off to the operational plan Management oversight of activity and performance	Urgent Care Recovery and Improvement Group - ***In place*** Performance reporting to Quality & Performance Committee, ICB Board – ***In place***	Oversight by NHSE national UEC team, NHSE NW region team and ECIST director - ***In place***	**Reasonable**
P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	**16**	**G**	**A**	**A**	**G**	**G**	Executive sign off to the primary care strategic framework and plans and to the operational plan Management oversight of operational and programme planning and delivery	ICB Board approval of primary care strategic framework and plans – ***Planned*** Programme delivery reporting to System Primary Care Committee, ICB Board – ***In place*** Performance reporting to Quality & Performance Committee, ICB Board – ***In place***	NHSE/I Systems Oversight Framework – ***Planned*** NW Regional Transformation Board oversight - ***Planned***	**Reasonable**

Principal Risks	Current Risk Score	Controls					1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
		Policies	Processes	Plans	Contracts	Reporting				
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money										
P7: The Integrated Care System is unable to achieve its statutory financial duties	**16**	**G**	**G**	**A**	**A**	**G**	Management oversight of financial planning & budget setting Management oversight of contract development & negotiation	System Finance Reports to ICB Board – ***In place*** ICB Board approval of 23-24 Financial Plan – ***In place***	NHSE/I Systems Oversight Framework – ***Planned***	**Reasonable**
P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services	**12**	**G**	**G**	**A**	**A**	**A**	ICB Executive & Place representation on programme boards	Programme delivery reporting to Transformation Committee, ICB Board – ***Planned*** ICB Women's Services Committee oversight of LCSR - ***Planned***	NHSE/I Major Service Change Process - ***Planned***	**Reasonable**
P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives	**12**	**A**	**A**	**A**	**G**	**A**	Executive sign off of workforce plans Management oversight of operational and programme planning and delivery	Workforce performance reporting to the People Board – ***Planned***	CQC Well Led Review – ***Planned*** NHSE/I Systems Oversight Framework – ***Planned***	**Reasonable**

Principal Risks	Current Risk Score	Controls					1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
		Policies	Processes	Plans	Contracts	Reporting				
Strategic Objective 4: Helping the NHS to support broader social and economic development										
P10: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population	**9**	**G**	**G**	**A**	**A**	**G**	Executive oversight of strategic planning process & associated engagement activity	Review and approval of joint strategy & plans by ICB & HCP Boards – ***Interim approved***	NHSE/I Systems Oversight Framework – ***Planned*** CQC Well Led Review - ***Planned***	**Reasonable**

Appendix Three -

ID No: P1	Risk Title: The ICB is unable to meet its statutory duties to address health inequalities			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	**16**	
Current Risk Score	3	4	**12**	
Target Risk Score	2	4	**8**	
Risk Appetite	Our longer-term aim is to limit to a moderate level of risk, but this is unlikely before 2024/2025 due to resource allocation and capacity implementation agreed.			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Prof. Ian Ashworth-Director of Population Health	Assistant Chief Executive	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services	Transformation	C – beyond the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	04/01/2024	13/03/24

Risk Description

There are longstanding social, economic and health inequalities across Cheshire and Merseyside, when comparing outcomes both between different communities in our area and the national average for HI. Population health is shaped by the social, economic, and environmental conditions in which people are born, grow, live, and work. This can only be addressed through collective systemwide effort and investment across the partnership, our communities, the NHS, Local Government, and Voluntary and Private sectors. This risk relates to the potential inability of the ICB to secure the necessary investment and influence priorities across the multiple organisations, agencies and the communities covered by the ICB.

Linked Operational Risks	The ICB receives national Health Inequalities funding. This funding has been ring fenced to ensure the financial investment occurs in each financial year to support addressing the Health Inequalities that the ICS, and local places face within their populations. The ICB and the Cheshire and Merseyside health and care partnership also faces significant financial challenges, which presents a significant and real risk of worsening health inequalities and may also impact on the decision-making priorities and resource allocation towards investments within this area.	
Current Controls		**Rating**
Policies	Constitution, membership & role of HCP Partnership Board, 'All Together Fairer' (Marmot Review), Core 20+5, Prioritisation Framework, Public Engagement / Empowerment Framework.	**G**
Processes	Strategic planning, consultation & engagement, HCP & Place-based partnership governance, financial planning, and workforce planning for Population Health Team of the Director of Population Health will provide greater capacity to support system wide work on Health Inequalities with recruitment due to commence in January 2024. The Population Health Board is part of the Transformation committee, advising the ICB, but also the engine room/enabler for HCP priorities.	**A**
Plans	C&M HCP Interim Strategy, Joint 5-year Forward Plan, Joint Health & Wellbeing Strategies x 9 places, ringfenced funding for health inequalities & transformational programmes, continued focus on Core 20+5 for adults and children, implementation of Marmot principles within formal ICB documentation. The Director of Population Health's vision and programmes (Social Determinants, Healthy Behavior's Health Care Inequalities (Core20Plus5), Strategic Intelligence, Cross Cutting enablers – Communications, Workforce Development, Research & Development programmes), have all been approved by the ICB Board meeting and the All Together Fairer Board. This follows extensive engagement with Population Health board stakeholders and LA DsPH.	**A**
Contracts	The use of NHS Standard Contracts includes requirements on our service providers to also focus on addressing health inequalities. An initial meeting (November 2023) and follow-up meeting (January 2024) have been held to review the existing NHS Contract schedule to support reducing Health Inequalities with the ambition to refresh and implement this in NHS Contracts from April 2024-25. A draft document to support NHS providers has been produced and will now be reviewed and progressed to a final version for stakeholder engagement and formal governance approval. In November 202 under duty s. 13SA of the National Health Service (NHS) Act 2006 NHS England is now required to publish a Statement on Information on Health Inequalities (Statement). The duty seeks for relevant NHS bodies to use inequalities data to shape and monitor improvement activity. The Statement will help drive improvement in the provision of good quality services and in reducing healthcare inequalities, helping to ensure equitable access, experience and outcomes for all. A review of the relevant metrics for the ICB to include is taking place as part of the contracting schedule development and with Business intelligence leads.	**A**

Reporting	C&M HCP Partnership Board has oversight of health inequalities, Population Health Board, Place-Based Partnership Boards, and the ICB Board.	G

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Work underway to form a Strategic Population Health Board, and Programme Group meetings. The Strategic Board will commence in the new financial year April 2024 – 2025 and will report to the Cheshire & Merseyside ICB Transformation Board. The current board will hold its last meeting 14/03/24 and its extended membership will convert to a Population Health Alliance Network. This will enable system wide distribution of population health information and professional network development. There will also be programme group meetings in line with programmes set out in plans section above. These will be initiated during spring / early summer pending population health team recruitment progression.

Approval to recruit to the ICB's Director of Population Health's target operating model has been agreed through Corporate Directors of the ICB with recruitment scheduled to commence early 2024.This will provide the capacity to expedite programme growth, along with the provision of strategic leadership that will enable transformation programmes to be informed by C&M population health intelligence, best evidence-based practice, that achieves a return on investment, as well as reductions in the Health Inequalities experienced at place and community levels.

Until the TOM recruitment is achieved, including the agreement, and scoping of the health inequalities investment allocation priorities, the risk ratings of delivery against the associated programmes and responsibilities will remain high and above the target score.

Actions planned	Owner	Timescale	Progress Update
Finalise Joint 5-year Forward Plan	Neil Evans	Completed	Approved by ICB Board in June.
Re-focus Population Health Board	Ian Ashworth	31/03/24	Director of Population Health commenced in post 26/06/23. Plans for a Strategic Population Health Board were formed in September. Engagement with the current Population Health board and LA DsPH has taken place in September and October 2023. This covered priorities and proposals around the new structure of programme oversight. The Population Health Board will remain a key system assurance board for the ICB and a driver for the HCP work programme, linking strongly with the new CYP Committee. It will continue to be focal point within any review of ICB Governance structures.
Agree All Together Fairer and Health Inequalities approaches with place-based partnerships	Ian Ashworth	31/03/24	The Director of Population Health Target Operating model has been developed and is currently under review for programme approval. Following this recruitment of the Population Health team will be undertaken and scoping of the delivery of core population health

			priority areas will be commenced. Consultation with the nine place directors on the process of health inequalities investment arrangements will be planned alongside the ICB Corporate Director team in January 2024. We will also develop guidance and forms for reporting and performance monitoring of financial investment at place through the Health Inequalities ring fenced funding which must be in line with our ICS All Together Fairer recommendations.
Finalise & secure partner sign off to the Population Health Vision and strategic programme approach for C&M ICB / ICS	Ian Ashworth	31/03/24	A formal programme report was presented at the HCP Board July 2023 on this programme. This board will receive regular updates on Population Health themes, this has included a Health and Housing workshop in September Board meeting, and a CYP workshop delivered at November HCP. A full stocktake and progress on All Together Fairer is scheduled for the January 2024 HCP meeting.
Develop & implement prioritisation framework	Neil Evans	Completed	Prioritisation framework completed to inform investment bids for transformation programme funding during the financial year 2023-24. This framework will also inform the approach to Health Inequality investment at place. The prioritisation framework is monitored to ensure the latest data and any change is reflected in the prioritization framework. This framework will also be shared with place.

Assurances		
Planned	**Actual**	**Rating**
ICB Board approval to Joint 5 Year Forward Plan	Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24 – 29/6/23 (reasonable) Completed.	**Reasonable**
Progress reports to C&M HCP Board on delivery & implementation of programmes and projects aligned to Marmot principles (place & system where appropriate) (quarterly)	Regular reporting to the HCP Board on Population Health and progress in reducing health inequalities is established and will continue for each Board that occurs. The intention to realign the HCP strategy with the All Together Fairer Strategy document. Stocktake report and review due for January 2024 HCP meeting.	

Core 20+5 & Health Inequalities Stocktake by NHSE/I reported to Population Health Board & C&M HCP Board (quarterly)	Quarterly submissions made to NHSE – to be reported to the Population Health Board and Health and Care Partnership through the Director of Population Health's report.	

Gaps in assurance

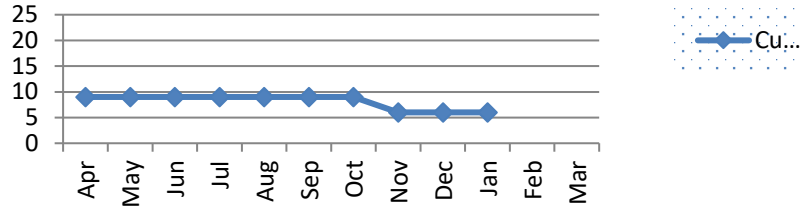
[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Addressed as the Strategic Population health Board will now establish from April 2024 and report into the ICB Transformation committee.

The Director of Population Health's target operating model requires agreed investment (proposed through the health inequalities investment fund) and recruitment processes in line with ICB recruitment policies will enable recruitment and capacity of the population health team.

Actions planned	Owner	Timescale	Progress Update
Finalise & seek approval to population health strategy & plans	Ian Ashworth	Completed	Reported to the HCP Board July 2023. Completed.
Population Health programme resource allocation paper.	Ian Ashworth	31/03/24	Paper shared with Corporate Director team for initial engagement and feedback and formal reporting occurring December 2023. Engagement with Place Directors on Health inequalities investment process and allocation will be planned for spring. Population Health priorities also shared and informed by the 9 LA DsPH and at the new Data into Action Board.
Further develop business intelligence monitoring processes to assess the impact of our work on outcomes and report this through ICB governance structures to provide assurance.	Ian Ashworth	31/03/2024	Reporting to track delivery has been developed over recent years. This will be reviewed and updated to provide assurance on progress and to allow mitigating action where required.

ID No: P2	Risk Title: The ICB is unable to address inadequate digital and data infrastructure and interoperability, which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	3	**12**	
Current Risk Score	2	3	**6**	
Target Risk Score	2	3	**6**	
Risk Appetite	In the short term (3 months) the ICB can accept the risk because existing arrangements are supporting a reduced capability for data and intelligence. In the medium and longer term The ICB cannot accept the risk at the current level because resolution is required to fulfil its core objectives.			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard-Jones	John Llewelyn	Medical	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services	Transformation	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	12/01/24	

Risk Description

Understanding the health and care needs of our population and our ability to bring focused and meaningful interventions to those who most need it, and therefore improve health and care outcomes of our population in an equitable way, is dependent on a robust interoperable infrastructure to deliver high quality data and intelligence. Developing consistent at scale capabilities will require a levelling up, and rationalisation, of our digital and data infrastructure across places, communities, partner and provider organisations. This risk relates to the potential inability of the ICB to deliver equitable access to a common set of technologies and services across the whole system.

Linked Operational Risks	

Current Controls		Rating
Policies	What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies, Data Saves Lives	**G**
Processes	Digital and data maturity assessment, programme & project management, training, communication & engagement, academic validation,	**G**
Plans	Digital and Data Strategy 2022-2025, System P programme, 2 year funding plan now approved and associated procurements are progressing well.	**G**
Contracts	IT provider contracts, data sharing agreements, AGEM CSU Data Services for Commissioners Regional Office (DSCRO), CIPHA (Graphnet contract for: population health management and shared care record integrated health and care data platform; Johns Hopkins Population Health risk stratification tools; and analytic services) Liverpool University Civic Health Innovation Lab (CHIL) including Civic Data Cooperative and analytic resource from Faculty of Health and Life Sciences , C2Ai tools,	**A**
Reporting	Digital Transformation & Clinical Improvement Assurance Group, Transformation Committee	**G**

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Gaps in data coverage – eg social care

Actions planned	Owner	Timescale	Progress Update
Complete shared governance arrangements, including pipeline process for analytics requests, prioritization process and progress reporting.	John Llewelyn	November 23	Draft Governance being consulted on. Recommended Proposal for Governance model to be presented to Digital Transformation and Clinical Improvement Assurance board in July 2023 On 7th July, a Data into Action meeting agreed a T.O.R.for the new DiA Board including T.o.R. for all DiA sub-groups. On 2nd August, Medical Director chaired a shadow DiA board. On 22 August a meeting of senior stakeholders discussed prioritization and delivery mechanism of the programme Meeting planned for 6 September to follow up with stakeholders and agree Governance route to formally establish the programme.

			Paper formalizing Data into Action programme will be taken to Executive Team in September, prior to extended socialization. Will come to Transformation Committee in November . Data into Action shadow Board met 27/11/23 and 18/12/23. Medical Director confirmed to Board that the programme will report directly to the ICB Trust Board with reporting arrangements in place for other governance groups in the ICB governance. The Board has agreed a broad plan of work and a significant focus on work to develop evidence for impacts and opportunities for the ICB to inform transformation and future commissioning (shift left) intentions.
Conduct review of data and intelligence assets (including Social Care) and platforms to identify rationalization opportunities	John Llewelyn/Anthony Middleton	Dec 2023	Initial desk-based assessment complete. More detailed review and consultation with users is in planning stage July 23 Opened discussion with DDAS C&M lead around alignment with Digital & Data Strategy and increased data sharing. December 2023 – this work forms part of the work plan for the Data into Action programme as it reviews all data assets
Establish C&M Digital Design Authority	John Llewelyn	Sept 2023	Draft T.O.R written Meeting scheduled for November C&M CIO Away day September – session planned to agree scope of DDA and supporting process. Interim CTO will subsequently take forward to establish the group. **Completed**
Appoint Chief Technical Officer (CTO)	John Llewelyn	Sept 2023	Digital TOM and Org structure under staff consultation until end April. Structure agreed and establishment approved. Some key posts (inc. CTO) under vacancy control consideration.

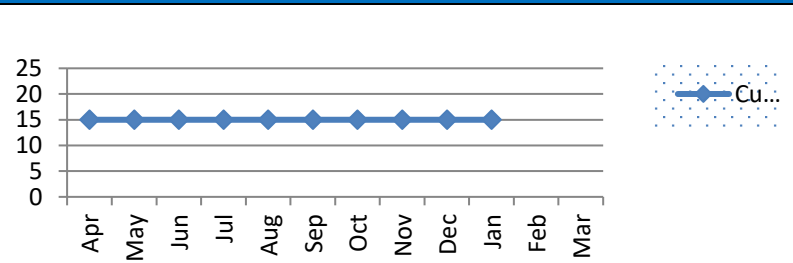
			p/t CTO appointed on an interim p/t basis. Perm requirements for role will be refined over next few months. **Completed**

Assurances		
Planned	**Actual**	**Rating**
ICB Board April 2023 Board to consider the 'intelligence into action' investment case with recommendation from FIRC to approve.	ICB Finance Investment and Resources Committee (FIRC)agreed the 'data into action' investment case to continue 2 further years funding of the Graphnet contract, System and C2AI. FIRC recommendations approved at ICB Board **Complete** Full review of Existing BI Solution contracts to be completed.	**Reasonable**
Through the Medical Director establish a collaborative programme of delivery for 'intelligence into action' that will maximize the use of existing analytic and transformation resource across ICB, Academia and Providers. The ICB will use this programme to set objectives consistent with CM joint forward plan and receive assurances on delivery through Transformation Committee, Quality and performance Committee and Population Health Board.	ICB Medical Director appointed Senior Academic from University of Liverpool as Associate Director of Research. Programme architecture developing in draft. Approval in August/Sept. ICB Director of Population Health in post mid July 2023 and engaged with governance design work. Shadow Board Data into Action established – meetings on 27/11 and 18/12 resolution to report directly to ICB Board **Complete**	

Gaps in assurance
[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Actions planned	Owner	Timescale	Progress Update
ICB Board April 2023 – Board to consider the intelligence into action 'investment case with recommendation from FIRC to approve	Rowan Pritchard-Jones	n/a	Investment case has been approved by FIRC. FIRC recommendations approved by ICB Board in April. **Completed**
Due Diligence and IG compliance work underway alongside procurement process to secure PTL risk stratification capability.	Rowan Pritchard-Jones	n/a	IG model agreed for continuation of PTL work. With system IG leads for consideration and approval at next IG steering Group. **Completed**
Establish a collaborative programme of delivery for 'intelligence into action' that will maximize the use of existing analytic and transformation resource across ICB, Academia and Providers.	Rowan Pritchard Jones	n/a	Draft proposition for discussion at existing 'data into action' meeting on 21 April 2023 Paper to be prepared for Corporate Executives meeting before end of April 2023 Programme to be established during May 2023. Programme Board has been established in and is agreeing the T.O.R. and outline programme of work for 2023/24 and beyond. Arrangements will be ratified Sept 6th and reported through DTCIAG and Transformation Committee New Governance established. Initial Board met during October **Completed**
Socialise the governance model and establish pipeline and delivery methodology across wider C&M system	Rowan Pritchard Jones	Dec 2023	Once ratified the Governance, outline programme and pipeline management process will be communicated through the appropriate channels across the ICS JL presenting governance model to CMAST CEOs 3rd November. Shadow Data into Action Board on 18/12 agreed that the programme would report directly into ICB Board with reporting arrangements in place for other governance groups in the ICB governance

ID No: P3	Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. 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

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	5	**25**	
Current Risk Score	3	5	**15**	
Target Risk Score	2	5	**10**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Andy Thomas	Finance	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Performance	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	10/01/2024	10/02/2024

Risk Description

The COVID 19 pandemic generated significant backlogs due to reduced capacity and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes.

Supply side constraints, in particular the ongoing impact of industrial action, impact on the available capacity in the system to tackle the longest waits. There is evidence that C&M has been relatively more impacted by industrial action than most other ICBs in terms of the volumes of elective activity that have been cancelled.

The Cheshire and Merseyside Operational Plan sets out service recovery plans to deliver significantly more elective care and diagnostic activity to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards and to improve timely access to primary care.

This risk relates to the potential inability of the ICB in this context to deliver these plans against national targets for recovery of electives, diagnostics and cancer services, which may result in patient harm and increased health inequalities.

Linked Operational Risks		
Current Controls		**Rating**
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, NHS elective recovery plan published February 2022 '**Delivery plan for tackling the COVID-19 backlog of elective care'**	**G**
Processes	System level operational planning, performance monitoring, contract management, system oversight framework	**A**
Plans	C&M Operational Plan, Elective Recovery Programme and Plans, Diagnostics Programme and Plans, Cheshire & Merseyside Cancer Alliance work programme, Place Delivery Plans, Winter Plan	**G**
Contracts	NHS Standard Contract – contracting round for 23/24 concluded	**G**
Reporting	Programme level reporting, Quality & Performance Committee, Primary Care Committee, ICB Board, Regional Elective Board (chaired by NHSE)	**G**

Gaps in control

- Industrial Action: IA to date in 2023/24 has had significant impact, with evidence that C&M has been been relatively more impacted by industrial action than most other ICBs in terms of the volumes of elective activity that have been cancelled, and performance on planned care would have been better if not for this impact.
- The scale and frequency of IA going forward is unknown. We work to mitigate through EPRR processes on days of IA, and Trusts/programmes seek to mitigate impact overall through a range of measures to maintain elective activity levels to the best of their ability.
- Winter Pressures: All Trusts and the wider system have winter plans which seek to mitigate urgent care demand, but depending on the level of urgent care winter pressures, elective care bed capacity will be impacted at times in order for Trusts to meet UEC demand.
- On overall elective activity, despite industrial action C&M providers have continued to deliver more activity than in the baseline year 2019/20 (value weighted)
- On elective long waits (65+ weeks) C&M has managed to remain ahead of trajectory from April-August 2023, but since September the number of patients waiting over 65 weeks has exceeded trajectory, and in October the number of patients waiting over 65 weeks rose for the first time in 2023/24..
- Further to operational guidance issued by NHE England requiring all NHS organisations to review and restate their financial plans for the second half of 2023/24, there is a focus within elective care on driving productivity from core capacity, and on reviewing insourcing/outsourcing and waiting list initiatives within a balanced financial plan. Consequently it has been necessary for Mid Cheshire to restrict the use of outsourced activity that was operating at a significant financial loss. The impact of this is that 880 potential 65 week breaches as at March 2024 have been identified. The provider collaborative, through the elective recovery programme is working with the Trust to mitigate these long waits as far as possible by year end. There has been no impact on cancer care as a result of this.
- Delivery remains on track at present in terms of clearing all 65 week waits by the end of March for the rest of C&M.

- In relation to reducing the cancer treatment backlog, overall C&M remains ahead of trajectory as at September 2023, providing some contingency against both IA and winter pressures

n elective plan that is refocused on

Actions planned	Owner	Timescale	Progress Update
Elective Recovery Improvement Team	AM	Ongoing	23/24 Plans set out in operational plans, winter plans in development, finalised 31/08/2023
Increasing diagnostics capacity through CDCs and elective capacity through elective hubs	AM	Ongoing	23/24 Plans set out in operational plans, winter plans in development, finalised 31/08/2023
Self assessment against the OP letter (Jim Mackey)	AM	Completed	Self-assessment undertaken by trusts, submitted to region mid-September.

Assurances

Planned	Actual	Rating
Implementation of C&M NOF Framework in 23/24	New 23/24 framework not published or expected imminently. C&M is implementing its approach to the existing NHS Oversight Framework from Q3 23/24	**Reasonable**
Performance reporting to Quality & Performance Committee, ICB Board (monthly)	Reporting against 23/24 trajectories incorporated into Q&P/Board report	
Programme delivery reporting to Transformation Committee, ICB Board	Programme reporting in place	

Gaps in assurance

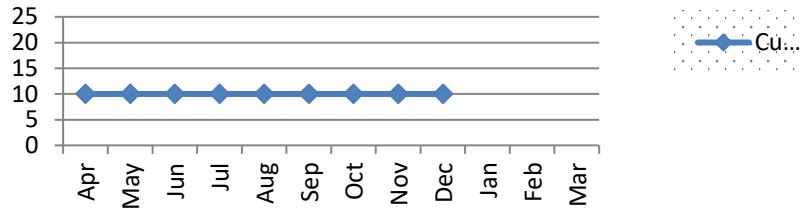
OP follow up target of 25% reduction has not been signed up to by trusts and is deemed unachieveable for most specialties. Mitigations in place to implement effective PIFU and personalised follow up pathways.

The ICB has reasonable assurance in relation to long waits for elective activity undertaken by C&M providers via the CMAST Elective Recovery Programme, however for patients who are referred to and treated at hospitals outside the ICB area, performance at these trusts is not directly managed by the C&M Elective Recovery Programme and therefore assurance is dependent upon assurance processes within those areas.

Actions planned	Owner	Timescale	Progress Update
Modelling around OP conversion rates, to target high conversion specialties to avoid breaches at end of March.	AM	Ongoing	Trusts to work on progressing new OP during September and October, particularly specialties with high conversion rates.

Development of mutual aid mechanisms for diagnostics to support achievement of faster diagnosis standard (FDS) in cancer and 90% of patients being seen within 6 weeks by March 2024.	Diagnostics Programme	Ongoing	C&M Chief Operating Officers agreed on 1 Dec 2023 to an enhanced system for diagnostics mutual aid targeted at reducing health inequalities and increasing system performance in terms of 6 week waits.
Targeted investments and support to the most challenged trusts to deliver accelerated progress on cancer recovery and operational performance improvement	Cancer Alliance	Ongoing	

ID No: P4	Risk Title: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	5	**15**	
Current Risk Score	2	4	**10**	
Target Risk Score	2	3	**5**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Chris Douglas / Rowan Pritchard-Jones	Kerry Lloyd	Nursing & Care / Medical	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	11/01/24	25/02/24

Risk Description

The ICB has a statutory responsibility to improve the quality of commissioned services and safeguard the most vulnerable, the quality governance framework that has been established supports early identification and triangulation of risks to quality and safety. This risk pertains to the potential failure of the established framework, with the consequence of a major impact on the safety and experience of services by our population. The current score is reflective of the mitigations in place which support in reducing the likelihood and potential impact of a major quality failure.

Linked Operational Risks	QU08 - Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience. WSC7 - Patient safety and quality risks cannot be sufficiently mitigated. 6PDAF - East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm

Current Controls		Rating
Policies	National Quality Board guidance on risk management and escalation Safeguarding legislation and policy alignment Patient Safety policy alignment - Patient Safety Incident Response Framework and Serious Incident Framework	**A**
Processes	System Quality Group Place based quality partnership groups Place based serious incident panels (Maternity panel at C&M level) Quality Assurance Visits Rapid Quality Review Desktop reviews Responses to national enquiries and investigations Safeguarding practice reviews and serious adult reviews Multi- agency safeguarding boards/partnerships. Clinical effectiveness group Infection Prevention Control/Anti-Microbial Resistance Board Independent Investigations Emerging Concerns Group Established 09/23 Establishment of System Oversight Group 10/23	**A**
Plans	Development of clinical quality strategy Development of Clinical and Care Professional Leadership Framework & Associated Steering Group Approach to NHS Impact	**A**
Contracts	Place based quality schedule within NHS standard contract Development of standardized C&M quality schedule Service specifications Safeguarding commissioning standards	**A**
Reporting	Quality & Performance Committee System Oversight Board Quality and Performance Dashboard National quality reporting requirements	**G**

Gaps in control
1. *Alignment and maturity of PSIRF development* 2. *Development of ICB governance and interface with place based governance*

3. *Clinical quality strategy not yet in place*
4. *C&M wide quality schedule under development in 23/24, with full implementation planned in 24/25*
5. *Development of data and intelligence platforms to identify and triangulate quality concerns / failures*

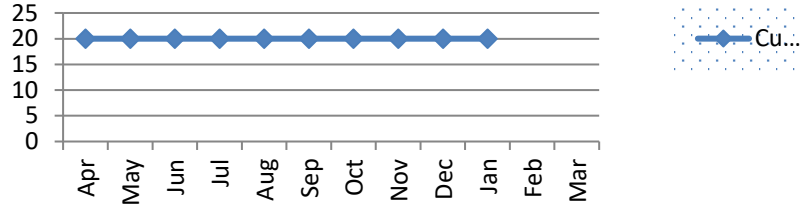
Actions planned	Owner	Timescale	Progress Update
Oversight and implementation of PSIRF, with close down of Serious Incident Framework	CD	April 2024	C&M steering group established. Panel process to sign off individual organization priorities pan underway Closing down of legacy serious incidents in progress Dates listed for organizational sign off, first organization goes live in July 2023, assurance given to QPC re organizational readiness. • 4 organisations have now undergone ICB sign off for PSIRF, with others scheduled by end of 11/23 • Delay noted nationally in introduction of Learning from Patient Safety Events (LFPSE) and double running of STEIS system until October 2024 • Thematic Workshop convened to learn from maternity safety events in 08/23 – outputs to QPC in 10/23 • Quarterly update to Quality & performance Committee for assurance on progress 19th October 2023 • 12 organisations have now undergone ICB sign off for PSIRF implementation, timelines on track for end of November 2023 completion of all large providers. • ICB compliant with national directive to 'double run' STEIS and LFPSE system until October 2023 • Close down of Serious Incident Framework continues to be managed by place based teams, with additional resource provided for administrative support by Midlands and Lancashire Commissioning Support Unit until 03/24 13th December 2023

			• All NHS organisations will be signed off by end of December 2023 • Proportionate approach being taken to support independent providers to develop PSIRF response using AHSN inout and support. Ongoing work to close down to Serious Incidents still open across each of th 9 places being undertaken by place based teams.
Ongoing and iterative maturity of ICB level and place based roles and responsibilities	CD/RPJ	Completed	Continuous review and evaluation of governance, with place based maturity assessment in development MIAA audit submitted April 2024 Participation in Grant Thornton VFM Audit completed – findings to 0923 Audit Committee
Development of clinical quality strategy	RPJ	January 2023	Initial meeting of senior system clinical leaders (primary care, ICB corporate and CMAST) took place on 17.4.23 with next meeting planned for May 23. A review of Provider Trust clinical strategies is underway to look for themes and to assess alignment between system strategy and provider strategies. A Clinical and Care Constitution has been developed which outlines the principles that will underpin our Clinical Strategy. This document on a page is currently being socialised and refined based on feedback. It will be presented to ICB board in September. Clinical and Care constitution finalised and on agenda for ICB Board in September. Ongoing discussions re development of clinical strategy led by ICB Medical Director. Presentation to and discussion with System MDs and Directors of Strategy in September. Oct 23 update: Clinical and Care Constitution signed off by board in September and a Clinical and Care professional leaders conference is taking place on 1st November 2023 to launch the constitution into wider system. Outputs from the conference will inform next steps in writing clinical strategy.

C&M group established to standardize quality contracting model for NHS Standard Contract for 2024/2025.	CD/KL	April 2024	C&M group mapping exercise completed 09/23 Strategic and ops group established and meeting monthly with target date for standardized quality schedule for April 2024 Standardisation reviews completed. Streamlining reporting requirements Provider forum to be established in Quarter 3 23/24 13th December 2023 • Standardised approach to quality schedule within contract on track to be implemented in 2024/25 • Assurance being delivered to Executive Nurse via Senior Leadership Forum. Engagement with providers underway to agree priority areas.
Ongoing review and alignment of quality reporting requirements	CD/AM	Ongoing	Iterative review of national, regional and local quality reporting requirements National Quality Board updated in July 2023 was considered in annual review of Quality & Performance committee meeting in 08/23 Development of sentinel quality metrics/dashboard for Board and QPC reporting 08/23 – completed and presented to Quality & Performance Committee in 10/23. October 10/23: Standardisation of Place Based Quality Related Governance to align to National Oversight Framework and Proportionate to Risk for Implementation Q1 2024/25 Further refinement of risk management approach – implementation Q1 2023/24 13th October 2023 • Establishment and alignment of quality governance with NOF methodology • Executive review of approach being undertaken on 14th December 2023 • Place based quality score card under development

Assurances			
Planned	**Actual**		**Rating**
Executive Director of Nursing & Care report to ICB	Executive Director of Nursing & Care report to ICB – Apr to Nov (reasonable)		**Reasonable**
Monthly quality report to Quality & Performance Committee	Monthly quality report to Quality & Performance Committee – Apr to Nov (reasonable)		
Monthly quality and performance dashboard to quality and performance committee	Monthly quality and performance dashboard to quality and performance committee – Apr to Nov (reasonable)		
Regional quality group reporting (quarterly)			
Board Development Sessions	June and September 2023		
Establishment of Emerging Concerns Governance & System Oversight Group	September 2023		
Development of National Oversight Framework Governance (end of Q4 2023/24)			
Gaps in assurance			
Work to strengthen quality, safety and experience reporting through intelligence led approach			
Actions planned	**Owner**	**Timescale**	**Progress Update**
Development of digital strategy and alignment of place based reporting	CD/RPJ	April 2024	

ID No: P5	Risk Title: 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.

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	5	**25**	
Current Risk Score	4	5	**20**	
Target Risk Score	3	5	**15**	
Risk Appetite				

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Claire Sanders	Finance	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	08/01/2024	17/02/2023

Risk Description

- The wider urgent and emergency care system, spanning primary care, community and mental health care and social care is under significant pressure with similar demand, capacity and flow challenges impacting on the ability of patients to access the right urgent or emergency care at the right time in the right place.
- Within the acute sector, high bed occupancy, driven by excess bed days due to delayed discharges and increased length of stay compared to pre-COVID is resulting in reduced flow from emergency departments into the acute bed base, and is in turn impacting on waiting times in ED, ambulance handover delays and failure to meet ambulance response time standards.
- Delays in ambulance response times and delays in ED are associated with patient harm and poor patient experience, and increased health inequalities as people living in more deprived areas are more likely to present at E.Ds.

Linked Operational Risks	As acute hospitals must accommodate urgent and emergency care this may impact on the delivery of elective care and cancer care.	
Current Controls		**Rating**
Policies	NHS Delivery plan for recovering urgent and emergency care services ("the recovery plan") Jan 2023, UEC Tiering, Winter Planning Guidance (Annex A ten high impact interventions and Annex B System Roles and Responsibilities) (Aug 2023), SCC Review of Standards (Aug 2023), revised OPEL framework (July 2023)	**G**
Processes	System Coordination Centre, ICB level operational plans, provider and Place level plans, performance monitoring, contract management, NHS Oversight Framework, national UEC Tiering and associated support including ECIST, GIRFT, national UEC Universal Improvement Offer, 23/24 Winter Planning process.	**A**
Plans	C&M Operational Plan, Place Delivery Plans – 23/24 operational planning round concluded, and plans signed off 04/05/2023. Plans in development in response to national discharge visit/UEC tiering, 3 initial priorities agreed between NHSE and ICB in response to Tier 1. Overall UEC recovery programme of work is in development and includes the 10 high impact interventions running through provider, place and reports into the new UEC Recovery and Improvement Group Winter plans developed for 23/24, final plan submitted to NHSE on 27September 2023	**A**
Contracts	NHS Standard Contract – contracting round for 23/24 concluded	**G**
Reporting	SCC reporting; Winter Plan reporting; UEC Recovery Programme level reporting via UEC Recovery and improvement Group (sitting under Transformation Committee), UEC operational performance reported via Quality & Performance Committee, ICB Board; regular touch points with regional/national NHSE teams regarding Tier 1 actions.	**A**

Gaps in control

- Industrial Action. IA to date has had significant impact thus far primarily on elective care, as resource has been redirected to support the UEC pathway. The scale and frequency of IA going forward is unknown. We work to mitigate through EPRR processes on days of IA, and Trusts seek to mitigate impact overall
- Demand exceeds planned capacity levels in a range of sectors, and fuller understanding of demand and capacity across all sectors is required
- Variation in processes C&M wide, e.g. application of patient choice, discharge processes

Actions planned	Owner	Timescale	Progress Update
UEC and wider actions within operational plans, spanning UEC, Virtual Wards, Admissions Avoidance, NCTR, Bed occupancy	Provider, Place and ICB	23/24	Operational plans signed off 04/05/2023, contracting round completed

Further to operational plans, national discharge visit, Tier 1 and wider UEC recovery plan ask, a C&M UEC Recovery Programme has been established to address the ten high impact interventions, with a particular focus on 5 specific areas (1,2,3,5 & 9 as agreed with NHSE as part of Tier 1 (SDEC, Frailty, Inpatient Flow and Length of Stay, Care Transfer Hubs and Single Point of Access for care coordination.	Provider, Place and ICB	Q2 23/24	• C&M UEC Recovery Programme established. Second meeting held December 2023. Next meeting scheduled for Jan 9th 2024. • 5 of the 10 high impact areas agreed and improvement work under way in conjunction with NHSE/ECIST as part of Tiering . • Prioritisation of Tier 1 trusts (LUHFT and WHH) agreed • ECIST report for LUFT and WHH (acute diagnostic) received 22/08, with ongoing work plans. • Weekly checkpoints with ECIST to monitor progress. • Fortnightly Tiering meeting in place with NHSE national UEC team, NHSE NW region team and ECIST director • Discharge works stream under the UEC recovery program progressing. • Alongside in hospital flow and community flow work streams • Operational resilience focus is on compliance of SCC, implementation of SHREWD and the 2023/24 OPEL framework
C&M 23/24 Winter Plan in development – completed	Provider, Place and ICB	Q2 23/24	ICB Winter Planning Group established, working to 11 September initial submission and end of September final submission to NHSE, **now completed**

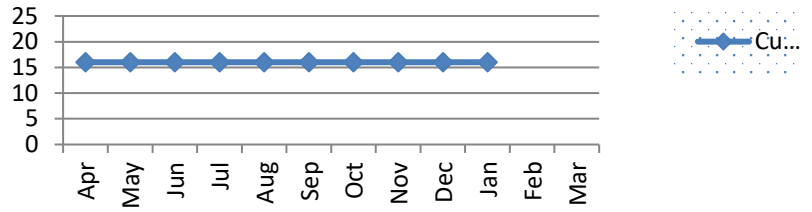
Assurances		
Planned	**Actual**	**Rating**
C&M Urgent Care Recovery and Improvement Group is being established from November	Chair and governance agreed Aug 2023, first meeting November 2023. Ongoing meetings	**Reasonable**
Winter Plan in development and to be brought to September Execs and Board	Winter plan went to execs and Board in September, further update to come to Board on 30/11/2023 - **COMPLETE**	
Performance reporting to Quality & Performance Committee, ICB Board (monthly)	Reporting against 23/24 trajectories incorporated into Q&P/Board report	

Gaps in assurance

Actions planned	**Owner**	**Timescale**	**Progress Update**
Implementation of revised national OPEL Framework for acute trusts	Claire Sanders	COMPLETE	Working closely with Acute providers and NWAS to set up automated data flows for each OPEL parameter. On target to deliver. Each Acute

			Trust has revised their escalation plans to reflect the new OPEL framework and work is underway to produce the ICS escalation policy.
Automated action cards to support OPEL (SHREWD)	Claire Sanders	Mid-February 2024	First meeting 15th January 2024 working with all Acute providers/Place to develop localised action cards
Phase 2 of SHREWD implementation	Claire Sanders	Mid-March 2024	Phase 2 of rollout includes Mental health providers, Community Providers and Social Care
Implementation of Requirement of Standards (RoS) for System Coordination Centre	Claire Sanders	1st February 2024	As at Phase 2 of compliance C&M at 80%, key dependency is production of system wide escalation policy, go live with OPEL framework and real time reporting. System wide escalation policy is now in draft
Procurement and implementation of supplier for real time reporting in line with SCC RoS	Claire Sanders	Complete	SHREWD implementation underway with Phase 1 focus on Acute providers and OPEL parameters. Ontarget to deliver by 13th December 2023. Phase two will then commence with Mental Health Trusts and Community Partners.

ID No: P6	Risk Title: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	**20**	
Current Risk Score	4	4	**16**	
Target Risk Score	4	3	**12**	
Risk Appetite	Our longer-term aim is to limit to a moderate level of risk over the life cycle of the access recovery plans			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Chris Leese & Tom Knight	Assistant Chief Executive	Primary Care

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Primary Care	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
10/05/23	03/01/24	10/02/24

Risk Description

The COVID 19 pandemic generated significant backlogs due to reduced capacity to meet routine healthcare needs and people delaying seeking healthcare interventions. There is evidence that this has exacerbated existing inequalities in access to care and health outcomes. While general practice is delivering more appointments than pre-pandemic, this increase is not keeping pace with demand and there are financial sustainability pressures in general practice in some places. Primary Care dentistry is slowly recovering and patients are presenting in greater need than pre-COVID. Access for new patients seeking an NHS dentist remains an ongoing issue. Community Pharmacy continues to play a key role in managing patient demand and creating additional GP capacity but is also under considerable pressure. The national delivery plan for recovering access to primary care focuses initially on streamlining access to care and advice. This risk relates to the potential inability of the ICB to ensure that local plans are effective in delivering against national targets for recovery of primary care access, which may result in poorer outcomes and inequity for patients. We continue to work with optometry colleagues to understand risk in this area. Recognising that majority of Primary Care resources sit in Place the need to understand aggregate Place actions to understand this risk.

Linked Operational Risks	PC1, PC6, PC7	
Current Controls		**Rating**
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, National Stocktakes and Guidance in relation to Primary Care, Primary Care Access Recovery Plan, Core 20 plus 5	**G**
Processes	System and place level operational planning, performance monitoring, contract management, system oversight framework, place maturity / assurance framework, dental reporting mid year/end year performance	**A**
Plans	Primary Care Strategic Framework version 1, Developing Primary Care Access Recovery Plan , System Development Funding Plan, Dental Improvement Plan, ICS Operational Plan, Place Level Access Improvement Plans x 9	**A**
Contracts	GMS PMS APMS Contracts (note no specific ask in terms of number of appointments), Local Enhanced/Quality Contracts (poss stretch asks within), Directed Enhanced Services – Primary Care Networks – Enhanced Access, GDS PDS Contracts nationally determined	**G**
Reporting	System Primary Care Committee, NW Regional Transformation Board, Quality & Performance Committee, ICB Board, HCP Board	**G**

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Primary Care Strategic Framework version 2 to be completed & formally signed off

Ongoing successful delivery of the access recovery / improvement plans required over a 2-3 year period to close gap

Actions planned	Owner	Timescale	Progress Update
Secure approval to Primary Care Strategic Framework – Stage One.	Jonathan Griffiths	Complete	General Practice & Community Pharmacy are part of Stage One Approved.
Secure approval to Primary Care Strategic Framework – Stage Two	Jonathan Griffiths	TBC	

Complete & secure approval to Primary Care Access Recovery Plan	Chris Leese	COMPLETED	
Delivery of Access Recovery and Improvement Plans	Corporate & Place Primary Care Leads	Ongoing to 2025	
Dental Improvement in place agreed and progressing	Tom Knight		Implementation slowed down due to financial impact. Dental ringfence removed nationally which has resulted in the implementation aspirations

Assurances		
Planned	**Actual**	**Rating**
Sign off plans by ICB Board	System Primary Care Committee & ICB Board approval to Primary Care Strategic Framework & Dental Improvement Plan (June) (reasonable)	**Reasonable**
Reporting on delivery to System Primary Care Committee & ICB Board	System Primary Care Committee & ICB Board reports, Dental Improvement Plan Update – Oct 2023 (reasonable) New update due in February 2024.	
Performance Reporting to ICB Board (monthly)	Performance reporting Q&P reporting showing progress on delivery of on target of UDA	
Monthly access improvement and related transformation actions reporting template in place reporting monthly till end of March	In place first report due end of December.	
Implementation of Pharmacy First Contracept Service and Hypertension	Pharmacy First to be launched January 31st 2024 Contracept Service and Hypertension already commenced	

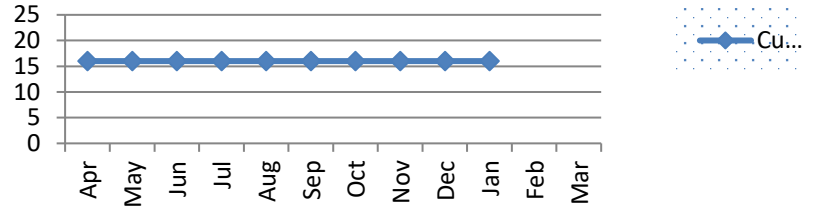
Gaps in assurance

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Plans yet to be approved

Actions planned	Owner	Timescale	Progress Update
Secure approval to plans	Jonathan Griffiths,	April 2024	Primary Care Strategic Framework will be going to ICB Board in June and System Primary Care Committee in August. Dental Improvement Plan will

	Chris Leese & Tom Knight		be going to System Primary Care Committee in February. Primary Care Access Recovery Plan is in development for completion in November. Framework now agreed in September 2023 but stage two still requires development (dental and opthom).

ID No: P7	Risk Title: The Integrated Care Board is unable to achieve its statutory financial duties			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	20	
Current Risk Score	4	4	16	
Target Risk Score	2	4	8	
Risk Appetite				

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Claire Wilson	Rebecca Tunstall	Finance	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Finance	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	12/01/24	12/02/24

Risk Description

There is a substantial underlying financial gap across the Cheshire and Merseyside healthcare system between current spending levels and the national formula-based allocation. If the ICB is unable to secure agreement to and deliver a long-term financial strategy which eliminates this gap whilst also enabling delivery of statutory requirements and strategic objectives, then it will fail to meet its statutory financial duties. This is further exacerbated by the relative' distance from target' and convergence adjustments for both core ICB allocations and future specialised services and inflationary pressures anticipated in the short -medium term compared to funding settlements.

Linked Operational Risks	

Current Controls		Rating
Policies	Standing Financial Instructions, Scheme of Reservation & Delegation, Delegation Agreements (ICB / Place), Financial Policies	G

Processes	Financial planning	**G**
Plans	23-23 System Financial Plan, Cost Improvement Plans	**A**
Contracts	NHSE/I Funding allocations (Revenue & Capital), NHS Standard Contracts	**A**
Reporting	ICB Executive Team, Finance Investment and Resources Committee, ICB Board, NHSE/I	**G**

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

23-24 Contracts yet to be signed

ICB / ICS Long Term Financial Strategy

Operational scheme of reservation and delegation (SoRD) doesn't yet reflect final structures

Cost improvement plans need to be fully identified

Actions planned	Owner	Timescale	Progress Update
Finalise 23-24 System Financial Plan	Claire Wilson	Complete	Now agreed
Conclude 23-24 contracts	Claire Wilson	Jan 24	Still ongoing, target date deferred from Nov 23 to Jan 24. Financial values have been agreed so for purposes of this risk, substantially complete.
Update Operational SoRD	Rebecca Tunstall	Complete	Approved by Audit Committee 5/9/23.
Finalise cost improvement plans	Place Directors	Jan 24	Still ongoing, target date deferred from Nov 23 to Nov 24. Places are working to confirm their final cost improvement plans including recurrent delivery
Develop long term financial strategy	Claire Wilson	Dec 23	Project initiated and system working group confirmed to support development of strategy

Assurances

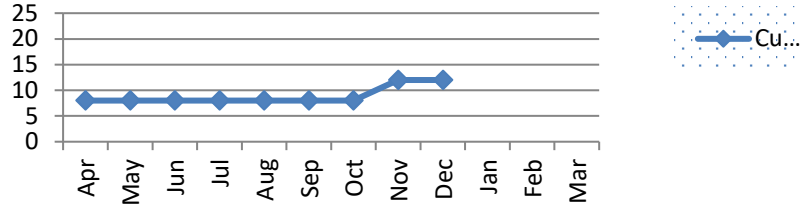
Planned	Actual	Rating
ICB Board approval of 23-24 Financial Plan (annual)	ICB Board approved 23-24 Financial Plan – 25/5/23 (Reasonable)	**Reasonable**
System Finance Reports to ICB Board (monthly)	System Financial Report to ICB Board – 29/6/23 (Reasonable)	

NHSE/I ICB Assessment (annual)		

Gaps in assurance
[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Actions planned	Owner	Timescale	Progress Update
ICB Board & system partners sign off to 23-24 System Financial Plan	Claire Wilson	Complete	The system financial plan is now finalised and agreed

ID No: P8	Risk Title: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	4	**12**	
Current Risk Score	3	4	**12**	
Target Risk Score	2	3	**6**	
Risk Appetite	The ICB has a low appetite for risk that impacts on patient outcomes.			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard Jones	Fiona Lemmens	Medical	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	14/01/24	14/02/24

Risk Description

There are significant service sustainability challenges across the Cheshire and Merseyside system.

- The Liverpool Clinical Services Review (LCSR) identified significant clinical risks for Women's, Maternity and Neonatal Services both locally in secondary care services provided to the population of Liverpool and North Mersey, and for specialist tertiary services provided to the whole C&M population, due to the configuration of hospital services in Liverpool.
- The LCSR also identified challenges with both timely access and poor outcomes in the urgent and emergency care pathways particularly in acute cardiology which affects the entire C&M population.
- Liverpool University Hospital Foundation Trust (LUHFT) is at SOF4 indicating critical quality and / or finance issues
- 4 other trusts in C&M are at SOF3 indicating significant support needs.

- Southport and Ormskirk Hospital (S&O) Trust has several services classed as fragile due to workforce issues and service configurations that do not meet national specifications
- East Cheshire Trust (ECT) has several services classed as fragile due to workforce issues and service configurations that do not meet national specifications.
- There are a number of services identified as fragile due to national workforce shortages and require providers to work collaboratively to identify mitigations.

This risk concerns the potential inability to maintain services in their current configuration and inability to deliver the necessary transformational business cases in relation to our most challenged services.

Linked Operational Risks	

Current Controls		**Rating**
Policies	NHSE Major Service Change Guidance NHSE Standard Operating Framework	**G**
Processes	NHSE Major Service Change Process	**G**
Plans	C&M Clinical Improvement Hub and NHS Impact programme under development Liverpool Place Provider collaboration on Urgent care pathways CMAST Clinical Pathways Programme Shaping Care Together Programme in Sefton Place (to oversee the S&O services transformation). ECT/Stockport Foundation Trust (SFT) Programme in East Cheshire Place Women's Services Programme in Liverpool Place	**A**
Contracts	Provider contracts held at Place. NHSE Specialist Commissioning Contracts held at NHSE region	**A**
Reporting	Provider Boards and internal governance arrangements, Programme Boards, Liverpool Provider Joint Committees, ICB Women's Services Committee, ICB Transformation Committee, ICB Board	**A**

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

The C&M ICB Clinical Improvement Hub (C&M IMPACT) is still under development and the Medical Directorate currently does not have capacity to progress this at the speed it would like.

NHSE regional team re-organisation means there is uncertainty over the transfer of NHSE regional improvement team staff into the ICB to support Improvement Hub. December update: NHSE regional team have still not released final Improvement team structures although key posts have apparently been appointed to.

Actions planned	Owner	Timescale	Progress Update
Clinical Improvement Hub (C&M IMPACT) Development	RPJ	January 2024	C&M IMPACT is developing in line with National IMPACT guidance. Regular communications established with NHSE Improvement Team, clinical network colleagues and local provider improvement leads. Baseline assessments have been completed for all C&M providers in line with national guidance and the ICB IMPACT team will be reviewing these throughout October. Next step is completion of NHS IMPACT self- assessments which we expect will be sent out from national team during October. An update is scheduled for Executive Team and Board ICB in January. Resource within the medical directorate is constrained further due to sickness in the senior team until the end of November. December update: The national requirement for all providers to complete a self assessment has been removed and made optional. The Medical directorate and people directorate have met with AQUA to scope out a piece of work to assess system readiness , reviewing all of the baseline assessments. This mitigates the risk of constraints within medical directorate team. The ICB board discussed the IMPACT principles on 30/11/23 and have asked for an update to March Board.
AMD for Transformation and East Cheshire Place team to support the ECT programme	Fiona Lemmens (FL) Mark Wilkinson (MW)	Complete	ECT/SFT Programme Board established and meeting bimonthly, attended by ICB representatives. The SHS Board has agreed a revised scope for the programme. The Pre Consultation Business Case (PCBC) will include General surgery, T&O, Emergency Department, Imaging, and critical care services, with an estimated timeline for completion of PCBC by June 2024. ICB Director of Finance and CEO meeting with GM ICS to discuss financial implications of proposed service moves which will cross ICS boundaries.
AMD for Transformation and Sefton Place team to work with provider to re-launch the SCT programme	Deb Butcher	Complete	StHK and S&O transaction complete and new Mersey and West Lancs Hospital Trust established. SCT Programme Board in place and meeting regularly, with ICB representatives in attendance.

	Fiona Lemmens		Revised scope of programme agreed and will focus on urgent and emergency care. An internal system stakeholder workshop is planned for 20th October to update leads in the three organisations. A paper for ICB boards in C&M and LSC that explains the scope and programme plan, is expected over the next 2-3 months.
Establish Women's Services Committee	Chris Douglas/ Fiona Lemmens	Complete	Committee now established, chaired by Raj Jain. Programme working groups have been established, as subgroups of the Committee, and have now all met and discussed their TOR and workplans.
Revise governance arrangement for Women's Services Programme	Chris Douglas/ Fiona Lemmens	November 2023 Complete	A Programme Director and an independent Clinical SRO are now in post. James Sumner was appointed as interim CEO of LWH and will commence on 1/12/23. Liverpool Place has identified some admin support for the programme. Programme planning now progressing with executive teams at both LWH and LUHFT. The WSC was cancelled on 26/9/23 in order to allow a review of current governance arrangements. A proposal to establish a Programme Board separate to the Womens services committee is being developed and will be presented to ICB Board meeting on 30.11.23 for approval. In the meantime subgroups are continuing with tasks to progress the work of the programme. December update: Revised governance approved by ICB board on 30/11/23. Meeting of the revised WSC is on 17th January 24. Womens services programme board now established and chaired by LUHFT/LWH CEO.
Liverpool Place Team to support the development of the programmes of work and governance arrangements to progress the urgent care pathway improvements	Mark Bakewell Fiona Lemmens	April 2024	A single integrated UEC plan for Liverpool developed with oversight from a Liverpool Urgent Care Executive Group, which is established and meets monthly. Cardiology Partnership Board meets bimonthly chaired by Fiona Lemmens to consider 4 workstreams 3 of which related strongly to Urgent care pathways. 3 pilots currently live. Liverpool Trusts Joint committee established and 3 site based sub committees set up, responsible for implementing the urgent care

			pathway improvements recommended in the Liverpool Clinical Services Review. LUHFT SOF4 rating enabled national support from ECIST, GIRFT and Newton Europe, all of which are in progress.

Assurances		
Planned	**Actual**	**Rating**
ICB Womens Services Committee	Report of the Chair of the Women's Services Committee to the ICB Board – 28/9/23 (reasonable)	**Reasonable**
ICB Exec (FL) and Place Director (DB) attendance at SCT Programme Board ICB Exec (FL) and Place Director (MW) attendance at ECT/SFT Programme Board		
Programme plans approval – Transformation Committee		
Programme Delivery reporting – Programme Boards for S&O, ECT and Clinical Pathways to report to the ICB - Transformation Committee		
NHSE Major Service Change Process is being followed in all these programmes which includes compliance with gateway reviews.	Secretary of State approval to transactions to create Mersey and West Lancashire Hospital (WMLH)	

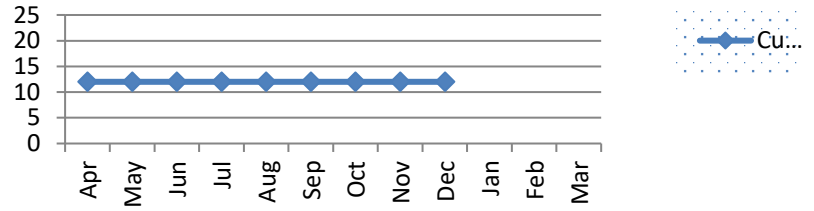
Gaps in assurance

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Issues in relation to affordability and timescales will need to be addressed in pre consultation business cases for key programmes

Actions planned	**Owner**	**Timescale**	**Progress Update**
Discussion at ICB Execs re LCSR SRO Role	FL C.Watson	Complete	
SCT Programme Board to confirm programme scope and delivery plans	FL & DB	Complete	
ECT Programme Board to confirm programme scope and delivery plans	FL & MW	Complete	
Oversight and assurance of pre consultation business cases	FL, DB, MW & MB	TBC	ICB represented on relevant programme boards and work on PCBCs is progressing

ID No: P9	Risk Title: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	**16**	
Current Risk Score	3	4	**12**	
Target Risk Score	2	3	**6**	
Risk Appetite				

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Chris Samosa	Vicki Wilson	Nursing & Care	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity & Value for Money	Workforce	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	12/01/24	02/02/24

Risk Description
Ensuring that we have a workforce with the necessary skills and experience, and that is reflective of our local population, is essential to the delivery of our strategic objectives. The C&M system has significant workforce challenges including recruitment, retention and sickness absence

Linked Operational Risks	

Current Controls		Rating
Policies	Provider Recruitment & Selection, Apprenticeship, Retention Strategies.	**A**
Processes	Organisational development, workforce planning, PDR, training & development, communication & engagement, recruitment, demographic profiling, international recruitment, apprenticeship levy, C&M retention forum	**A**
Plans	C&M People Plan, NHS People Promise, provider workforce plans	**A**

Contracts	TRAC, ESR, Occupational Health, Payroll, EAP	**G**
Reporting	WRES, WDES, Staff survey, reporting to People Board. System workforce dashboard (manual).	**A**

Gaps in control

System Workforce dashboard in development. Manual dashboard has been developed, need still exists for broader automated options.

Maturity of collaborative working at system level

Inconsistent workforce planning process/methodology across the system

Links to educational institutions and local authorities

Technology and inconsistent use of workforce systems across the region (ESR, ERoster, TRAC, NHS jobs, OH system)

Actions planned	Owner	Timescale	Progress Update
Develop workforce dashboard framework	Paul Martin	July 2023 Completed	Current available data being reviewed along with the metrics reported within provider Trusts. Following benchmarking, first draft dashboard will be developed. Draft Dashboard is complete. Timetable is ready for collating and analysing data in collaboration with Trusts. Online tools to capture Trust narrative and share data has been developed.
Data on available supply through NHSE/ HEIs	Emma Hood	September 2023 Completed	Data on attrition from programmes available – ongoing promotion and training of the NHSE Workforce Intelligence Portal which provides training supply trends and future workforce investments through the NHS Education Contract.
Develop and enhance workforce planning capabilities across the system	Emma Hood	April 2024	New posts to support development of workforce planning capability funded by People Board, delayed - job matching complete awaiting confirmation to go out to recruitment. CMPB funding on hold – request to FIRC to release in 2023/24 to be able to progress.
Delivery of the C&M retention plan	Paul Martin	April 2024 (Ongoing)	Good progress continues to be made in line with retention plan. Retention strategy developed, shared and agreed with Trusts. Timetable of regular meetings scheduled with all Trusts coupled with a quarterly forum to review progress. In addition, subgroups for Legacy Mentors and People Promise Exemplar leads are well established. Regular e-newsletter for updates/case studies etc. is under development and first edition is due early November.

Maximise the use of apprenticeship levy	Emma Hood / Paul Martin	April 2024	In progress - NHS England WTE funding in 2023/24 ringfenced for a C&M Trust to develop a proposal to expand & develop a C&M model for Apprenticeships in H&SC across C&M, in line with the LTWP commitments.

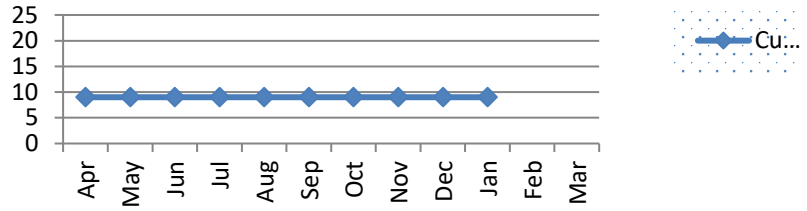
Assurances		
Planned	**Actual**	**Rating**
CQC Well Led review (annual)	People Board	**Reasonable**
	ICB Integrated Performance Report	
	WRES & WDES reporting (annual)	
	NHS Equality Diversity and inclusion improvement plan	

Gaps in assurance

Actions planned	**Owner**	**Timescale**	**Progress Update**

ID No: P10	Risk Title: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population			
		Likelihood	Impact	Risk Score
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*		4	4	**16**
Current Risk Score		3	3	**9**
Target Risk Score		3	3	**9**
Risk Appetite	Our longer term aim is to limit to a moderate level of risk, but this is unlikely before 2025/26			

Trend



Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Graham Urwin	Clare Watson	Assistant Chief Executive	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Helping the NHS to support broader social & economic development	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	11/01/24	11/12/24

Risk Description

Delivery of our shared aims, strategy and 5-year plan is dependent on collective ownership and collaborative effort by communities and organisations across Cheshire & Merseyside. The ICB has a key role in system leadership and promoting greater collaboration across the NHS and with local partners. This risk relates to the potential that focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of the population. This is in the context of the changing operating model of NHSE and the ICB, and current national and local quality, safety, performance and financial pressures during the post COVID recovery period and the impact this is having on patients.

Linked Operational Risks	

Current Controls		Rating
Policies	Constitution & membership of ICB Board & HCP, Public Engagement / Empowerment Framework, Prioritisation Framework	**G**
Processes	Strategic planning, consultation & engagement, public / stakeholder / local media communications & campaigns, programme & project management, culture & organisational development, Provider Collaboratives, CQC well led review, attendance at C&M wide and/or sub regional leadership / partnership forums & networks	**G**
Plans	C&M HCP Interim Strategy, Joint 5-year Forward Plan, Joint Health & Wellbeing Strategies x 9 places, Operational Plan, Communications & Engagement Plan, Provider Collaborative business plans, allocation of resources for health inequalities & transformation programmes, , Dental Improvement Plan	**A**
Contracts	MOU with NHSE for system oversight	**A**
Reporting	C&M HCP Partnership Board, Place-based partnership boards & H&WB Boards, ICB Board	**G**

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Work is still ongoing to finalise & secure agreement to the strategy

MOUs with place-based partnerships / ICB operating model to be agreed in relationship to delivery at place

Joint committee with Cheshire and Merseyside local authorities to be formally established in 2023

Actions planned	Owner	Timescale	Progress Update
Planning for next iterations of HCP Strategy & ICB Joint Forward Plan & Health Inequalities investment proposals	Neil Evans & Ian Ashworth	30/11/23	Board Development session & ICB Executives presentation. Report will be taken to ICB Board in November.
Continue to evolve HCP governance in conjunction with partners	Matthew Cunningham	30/11/23	Updated terms of reference reviewed and approved at HCP in November. Will go to ICB Board in November.
Conclude Primary Care Access Recovery Plan	Clare Watson	30/11/23	Board on 30/11/23. Further iteration in March.
Agree MOUs with place-based partnerships / proposed ICB operating model	Clare Watson	31/01/24	Executive Team workshop mid-November Thursday on ICB operating model. Communications and engagement plan on proposed model with staff, partners and wider stakeholder over next 2 months. Following this engagement it is planned to bring the operating model to the ICB Board in January.

Identify ICB health inequalities funding that could be overseen by the HCP Committee to support delivery of Marmott	Clare Watson	31/01/24	Work is underway to determine the extent of the ICB Health Inequalities funding that could identified as pot that would be under the authority of the HCP Committee to decide on how to allocate

Assurances		
Planned	**Actual**	**Rating**
C&M ICB Quality & Performance Report to ICB Board (bi-monthly)	C&M ICB Quality & Performance Report - 27/4/23, 25/5/23, 29/6/23, 27/7/23, 28/9/23 (reasonable)	**Reasonable**
Joint Overview & Scrutiny (as required)		
Approval and review of joint strategy & plans (annual)	C&M HCP Interim Draft Strategy – 26/1/23, Joint Forward Plan – 29/6/23, Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24 – 29/6/23 (reasonable)	
NHSE Systems Oversight Framework (annual in June)		
CQC ICB review (annual TBC 24/25)		

Gaps in assurance

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Work is still underway to finalise HCP strategy & plan

CQC approach to assessing integrated care systems is still evolving

Actions planned	Owner	Timescale	Progress Update
Planning for next iterations of HCP Strategy & ICB Joint Forward Plan & Health Inequalities investment proposals	Neil Evans & Ian Ashworth	30/11/23	Report will be taken to ICB Board in November.
Respond to CQC framework as it evolves & build evidence base as required	Clare Watson	Ongoing	Not be participating in pilots of CQC assessment in Q3. A number of other assessments underway – working with regional and national teams on segment 2 to 3 assessment & ICB partnership governance self-assessment. Plans developing for CQC review in 24/25.
Further dental improvement plan being presented to SPCC in February – focus on	Clare Watson	Feb 2024	Will be targeted at areas of greatest need and most vulnerable population

improved access, prevention and inequalities.			
Start planning to invest ICB ring-fenced Health Inequalities budget in 24/25 and beyond – using inequalities formula. Focus on Marmott and wider determinant priorities, at scale and within Places, including worklessness, health and housing, smoke free C&M and obesity/active and healthy eating.	Clare Watson	End 2024	

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

ICB Corporate Risk Register

Agenda Item No: ICB/01/24/20

Responsible Director: Graham Urwin, Chief Executive

ICB Corporate Risk Register

1. Purpose of the Report

1.1 The purpose of the report is to present the Corporate Risk Register (CRR) for review by the Board.

2. Executive Summary

2.1 The ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 12+ in relation to ICB wide impact. This will include any risks aggregated from multiple places and having a current score of 12+ in relation to ICB wide impact.

2.2 There are currently 8 risks on the CRR at Appendix one, including 5 extreme risks and 3 high risks. The most significant risks are:

- QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm, currently rated as extreme (20).
- QU09 - East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm, currently rated as extreme (20).
- QU08 - Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience, currently rated as extreme (16).
- PC1 - Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy, Dental Services, Optometry), currently rated as extreme (16).
- F2 - Health inequalities continue to drive increased demand for services with financial pressures resulting in failure to achieve financial duties, currently rated as extreme (16).

2.3 Further details of the mitigation strategies are provided in section 9 below and in the individual risk summaries at appendix three. All of the risks on the CRR have been subject to scrutiny and review by the relevant ICB Committee and further information is included in the highlight reports elsewhere on the agenda.

2.4 Risk QU09 was first reported to the Quality and Performance Committee, followed by the Risk Committee, in December 2023 and has since been reviewed and updated to reflect feedback and is therefore draft pending approval to the changes at the Quality and Performance Committee meeting in March 2024.

2.5 Further work has been undertaken to collate the varying level of risk for PC1 across each place at the request of the System Primary Care Committee. At the time of writing a review of the aggregate score is pending and may result in

some reduction subject to agreement of the System Primary Care Committee at its next meeting.

2.6 In addition, there are a number of corporate and place risks 'in the pipeline' which may meet the criteria for inclusion on the Corporate Risk Register, but which have yet to be reported to and scrutinised by the ICB's Committees. It is anticipated that further risks will be escalated to the CRR from the Women's Services Committee (potentially 7 risks); the Digital Services Board (potentially 4 risks) via the Quality and Performance Committee and the Transformation Committee (potentially 1 risk) in the next reporting cycle.

2.7 There are a further 15 potential unique place quality risks awaiting local reporting and sign off prior to escalation to Quality and Performance Committee. In addition, significant risks have been identified at place, mainly in relation to finance, which don't on their own meet the criteria for escalation to the CRR, but ICB Committees and the Risk Committee will need to consider whether the aggregate risk across multiple places justifies escalation to the CRR.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **NOTE** the Corporate Risk Register, progress in completing mitigating actions, further action planned, and assurances provided; and consider any further action required by the Board to improve the level of assurance provided.

4. Reasons for Recommendations

4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

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

5. Background

5.1 The ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 12+ in relation to ICB wide impact. This will include any risks aggregated from multiple places and having a current score of 12+ in relation to ICB wide impact.

5.2 The Corporate Risk Register is distinct from the BAF as it reflects the significant risks escalated up from across the organisation for the attention of the Board (bottom up). These require additional scrutiny and potentially cross organisational response by virtue of their potential to disrupt achievement of the ICB's strategic and operational objectives. The scale of the corporate risk register reflects the current risk environment and covers the full scope of organisational activity. The BAF in contrast reflects a smaller number of principal risks (6-10) identified by the Board as the significant strategic challenges to delivery of the ICB's strategic objectives (top down).

5.3 Managers and executive leads across the ICB have reviewed legacy CCG and HCP risks and identified additional risks in relation to delivery of the ICB's strategic and operational objectives. The resulting risks have been assessed and reported to and scrutinised by the ICB's Committees.

5.4 The draft Corporate Risk Register has been compiled from these Committee and Directorate Risk Registers and was presented for review, moderation and approval by the Risk Committee in June 2023, November 2023 and December 2023. The changes recommended by the Committee have been completed and it has endorsed and recommended the CRR to the Board.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic development**

6.1 The CRR supports the objectives and priorities of the ICB through the identification and effective mitigation of the most significant risks across the organisation which, if realised, may impact on delivery.

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

7.1 The effective mitigation of the most significant risks across the organisation supports the achievement of the Annual Delivery Plan.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
Theme Two: **Integration**
Theme Three: **Leadership**

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the CRR underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability.

9. Risks

9.1 There are currently 8 risks on the CRR, including 5 extreme risks and 3 high risks. A summary of the current and proposed mitigations in respect of each risk is set out below with further detail provided in the individual risk summaries at appendix three.

9.1.1 **QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm**, currently rated as extreme (20). Risk score across the ICB remains at 20. Variation of scores across the 9 places are primarily due to changing demand across each local authority area (demand includes children, young people and adults). Clarity of a 'lead commissioner' or transformational development lead is currently limiting the ability of the ICB to standardise any joint strategy, including collaboration with system partners.

9.1.2 **QU09 - East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm, currently rated as extreme (20).** This is specific to Cheshire East Place and improvement plans are currently being developed between East Cheshire Trust and partners. Local ECT assurance meetings, supported by analytical data and report scrutiny, are established and running. Commissioner assurance being obtained through Clinical Quality Performance Meetings, with upward reports to be received into the Q&P Committee of the ICB.

9.1.3 **QU08 - Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience**, currently rated as extreme (16). Risk score across the ICB has reduced from 25 down to 16. This includes a range across Place of 12-25. Plans to address gaps in controls remain developmental, with work on-going to establish reporting dashboards to support assurance and oversight. ICB Business Intelligence Team are developing Power BI tools to facilitate this work.

9.1.4 **PC1 - Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy, Optometry & Dental Services)**, currently rated as extreme (16). This is to be mitigated primarily through ICB and place level recovery plans and workforce plans, led by the Primary Care Workforce Steering Group.

9.1.5 **F2 - Health inequalities continue to drive increased demand for services with financial pressures resulting in failure to achieve financial duties**, currently rated as extreme (16). Planned actions include completion of the financial strategy, development of reporting dashboard, and a recurrent health inequalities fund aligned to the work plan of the Health Inequalities lead and linked to the place allocation toolkit.

9.1.6 **QU07 - CHC delivery is impacted due to inadequate compliance with the CHC National Framework workforce which leads to delays in assessment and unmet need**, currently rated as high (12). Risk score across the ICB remains at 12, with the 9 places reporting scores in the range of 8-16. The development of a target operating model is still on-going (the aim being to standardise the service delivery model). Assurances and controls are now being gained through the System Oversight Group (SOG) which has responsibility for All Age Continuing Healthcare and onward reporting from the SOG to the System Oversight Board (SOB).

9.1.7 **G7 - Incident arising from unsafe working practices or environment leads to death or injury for which ICB is liable resulting in financial loss and / or reputational damage**, currently rated as high (12). This is to be mitigated through seeking approval of ICB wide policies and procedures, the delivery of fire warden training, completing the Violence Prevention and Reduction self-assessment and overseeing delivery of the re-framed contract for services provided by Midlands and Lancashire Commissioning Support Unit. Assurance will be provided through an Annual Health and Safety Report being presented to the Executive Committee.

9.1.8 **W8 - Lack of workforce diversity may impair the effectiveness of the ICB response to our populations needs exacerbating health inequalities and damaging our reputation**, currently rated as high (12). This has been mitigated from extreme (20) to high (12) through policy commitments, processes and plans. Key further actions are organisational self-assessment, review of training capability and needs and review of key policies, process and documentation.

9.2 All committees and sub-committees of the ICB are responsible for ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed. Each of these risks has been scrutinised and reviewed by the relevant ICB Committee. Risks considered and actions / decisions taken are detailed in the highlight reports elsewhere on the agenda. Sources of assurance in relation to

key controls are summarised in Appendix Two and detailed in the individual risk summaries in Appendix Three.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the report does include a financial risk (F2) which is described in section 9 above and detailed in the appendices.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

11.2 Risks QU05, QU07, PC1, F2 and W8 have the potential to impact on equality, diversity and inclusion in service delivery, outcomes or employment. The mitigations in place and planned are described in more detail in the risk summaries at appendix three.

11.3 Risks QU09, QU08, PC1 and W8 have the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at appendix three.

13. Climate Change / Sustainability

13.1 There are no risks currently on the CRR which impact on the delivery of the Green Plan / Net Zero obligations, but there is a risk 'in the pipeline' which, subject to review by the Transformation Committee, will meet the criteria for escalation.

14. Next Steps and Responsible Person to take forward

14.1 Senior responsible leads and operational leads for each risk will continue to develop and improve the controls in line with the targets and progress the mitigation actions described in section 9 above and in the individual risk summaries at appendix three. Updates will be provided through the regular CRR report to the Board.

12. Officer contact details for more information

Dawn Boyer
Head of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB

13. Appendices

Appendix One: Corporate Risk Register
Appendix Two: Risk Assurance Map
Appendix Three: Risk Summaries

Appendix One

Corporate Risk Register – January 2024

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
Assistant Chief Executive Directorate								
PC1	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy, Optometry & Dental Services)	Primary Care	Clare Watson	**16**	**16**	**16**	9	A – Within current quarter
G7	Incident arising from unsafe working practices or environment leads to death or injury for which ICB is liable resulting in financial loss and / or reputational damage	ICB Executive	Clare Watson	**16**	**12**	**12**	8	A – Within current quarter
Finance Directorate								
F2	Health inequalities continue to drive increased demand for services with financial pressures resulting in failure to achieve financial duties	Finance, Investment & Our Resources	Claire Wilson	**16**	**16**	**16**	9	C – Beyond financial year
Medical								
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm	Quality & Performance	Rowan Pritchard-Jones	**20**	**20**	**20**	10	A – Within current quarter
Nursing and Care								
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	Quality & Performance	Christine Douglas	**20**	**20**	**20**	8	A – Within current quarter
QU07	CHC delivery is impacted due to inadequate compliance with the CHC National Framework	Quality & Performance	Christine Douglas	**12**	**12**	**12**	8	A – Within current quarter

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
	workforce which leads to delays in assessment and unmet need.							
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	Quality & Performance	Christine Douglas	**25**	**16**	**25**	10	A – Within current quarter
W8	Lack of workforce diversity may impair the effectiveness of the ICB response to our populations needs exacerbating health inequalities and damaging our reputation	Finance, Investment & Our Resources	Christine Samosa	**20**	**12**	**12**	9	C – Beyond financial year

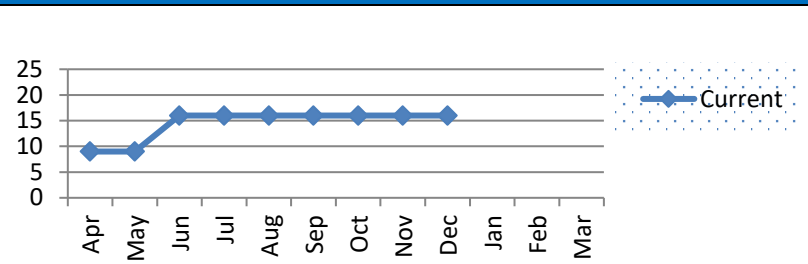
Appendix Two

Corporate Risk Register – Risk Assurance Map – January 2024

Risk ID	Risk Title	Current Risk Score	Controls					Assurances			
			Policies	Processes	Plans	Contracts	Reporting	1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
PC1	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)	16	G	G	A	G	G	Place contract oversight – ***In place***	System pressures updates to Primary Care Committee – ***In place*** Primary Care Workforce Steering Group – ***In place***		**Reasonable**
G7	Incident arising from unsafe working practices or environment leads to death or injury for which ICB is liable resulting in financial loss and / or reputational damage	12	A	A	G	A	A	Management oversight of policy development Management oversight of safe systems of work	Corporate oversight of H&S controls – ***In place***		**Reasonable**
F2	Health inequalities continue to drive increased demand for services with financial pressures resulting in failure to achieve financial duties	16	G	G	A		G	Management oversight of financial planning, budget setting & control Appraisal of health inequalities funding bids / allocations.	System Finance Reports to ICB Board – ***In place*** Progress reports to C&M HCP Board on delivery & implementation of programmes and projects aligned to Marmott principles – ***In place***	NHSE/I Systems Oversight Framework – ***Planned***	**Reasonable**
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which	20	G	G	G	A	G	Regular reporting/ updates to CQPM	Reporting to Quality & Performance		

Risk ID	Risk Title	Current Risk Score	Controls					Assurances			
			Policies	Processes	Plans	Contracts	Reporting	1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
	could be an indicator of sub-optimal care of patients resulting in avoidable harm							Bi-monthly SHMI quality improvement meetings	Committee – ***Planned***		
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	**20**	**A**	**G**	**A**	**R**	**A**		Key issues reporting to Quality & Performance Committee – ***In place***		**Reasonable**
QU07	CHC delivery is impacted due to inadequate compliance with the CHC National Framework workforce which leads to delays in assessment and unmet need. market and workforce which leads to delays in assessment and unmet need	**12**	**A**	**A**	**A**	**A**	**G**	Weekly operational meetings System Oversight Group	Reporting to Quality & Performance Committee – ***In place***		
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	**16**	**A**	**A**	**A**	**A**	**A**				
W8	Lack of workforce diversity may impair the effectiveness of the ICB response to our populations needs exacerbating health inequalities and damaging our reputation	**12**	**A**	**A**	**A**		**A**	Management oversight of policy development Management oversight of delivery of plan	Organisation Equality Objectives approved & monitored by ICB Board – ***In place*** EDI Reporting to ICB Board – ***In place***	NHSE Oversight & monitoring of WRES, WDES, EDS2022 – ***In place***	**Reasonable**

Appendix Three
Risk Summaries

ID No: PC1	Risk Title Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	3	16	
Current Risk Score	3	4	16	
Risk Appetite/Target Risk Score	1	3	9	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christopher Leese, Associate Director of Primary Care/ Tom Knight, Head of Primary Care	Place Primary Care Leads ICB PC Manager (JJ) Senior Commissioning Mgr (LD)	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee Report to Finance Committee

Strategic Objective	Function	Risk Proximity	ICB Executive	ICB Executive
	Quality, performance, transformation, commissioning.	A– Within current quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
01/07/2022* *Legacy CCG Risk*	16/01/24	10/02/24

Risk Description

Resilience and sustainability of Primary Care in terms of demand, workforce pressure and external factors such as industrial action, peaks in public concern such as (A Strep). Almost all previous CCG risk registers for Primary Care had a variation of this risk for GPs on their risk register; which has been further expanded in April 2023 to include similar pressures across Community Pharmacy and General Dental Service provision. National issue and risk contractual performance is reduced as GPs, dental practices and Pharmacies struggle to recruit suitably qualified and experienced staff. Workforce pressures impacting on opening hours and access to services. Individual examples of place based practice resilience and operational concerns should be captured on local place risk registers, but this combined issue needs

capturing on the overall corporate ICB risk register so that there can be assurances in respect of the overall resilience and sustainability of primary care – and that enabling factors should as workforce are included. At **June 2023**: This risk has been **increased** to reflect the ongoing pressures in general across Community Pharmacy, Dental and General Practice, where a lack of key trained primary professional staff, in particular GPs, Pharmacists and Dentists (in the NHS family) is causing issues. This increase follows further discussions at both the System Primary Care Committee in April and the new Primary Care Workforce Steering Group in May, and reflects a number of place-level related risks across C&M.		
Linked Operational Risks		
Current Controls		**Rating**
Policies	National Stocktakes and Guidance in relation to Primary Care Delivery Plan for recovering access to Primary Care https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/	G
Processes	System Primary Care Committee Managed operationally at place level through place structures/ governance. Escalation to System PCC Working with National Team and DH on workforce issues and support. Primary Care Workforce Steering Group reporting	G
Plans	Primary Care Strategic Framework – ICB level and Place level Place workforce plans Clinical Strategy Workforce/ People plans via People Board inc Primary Care Workforce Strategy ICB engagement with HEE and Liverpool Dental School Dental Improvement Plan GP retention plan (submitted May 2023) ICB Access Recovery plan (to Board October)	A
Contracts	GMS PMS APMS GDS PDS Contracts updated Local Enhanced/Quality Contracts/ Directed Enhanced Services Community Pharmacy Contracts	G
Reporting	Primary Care workforce Steering Group/ Community Pharmacy National Workforce Development Group NHSE National Teams (looking at wider workforce issues across Primary Care) Place reporting to place primary care structures/ forums Place reporting to System Primary Care Committee through reporting template already agreed noting a clearer risk principle escalation process is to be developed System Primary Care Committee reporting through to North West Regional Structures Reporting to PSRC Committee and through community pharmacy commissioning Team	G

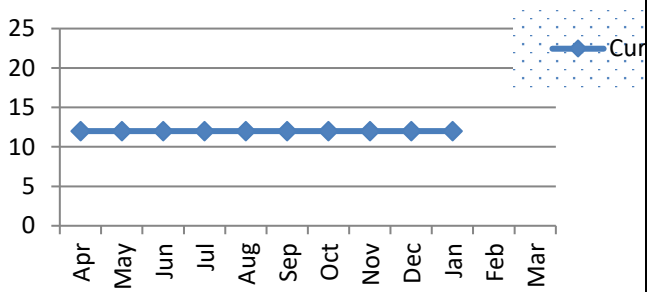
Gaps in control
Risk escalation process to be refined further between place and system – have all place got Integrated Workforce Groups Reporting between People Board and SPCC to be developed Consistent single set of data to be discussed at WSG and reported to People Board/ SPCC

Actions planned	Owner	Timescale	Progress Update
Risk escalation principles	PC Leads/ CL	January 2024	Place risk levels established and the risk summary to be updated to reflect distribution of risk across places and collaborative actions to mitigate
Primary Care Workforce Steering Group	JG/ CL	Complete	Established from May
Dental Improvement Plan workforce actions	TK	Ongoing	Improvement Plan submitted to SPCC June 23/ work underway Update to SPCC February 24 on Q4 23/24 progress and seek approval for new 24/25 plan
ICB PCARP response	CWatson	Ongoing	Programme board set up and meeting from June Primary Care Access Recovery Improvement Plan approved by ICB Board in November

Assurances		
Planned	**Actual**	**Rating**
Closing BI data gaps for Workforce (Ongoing)	Regular updates at SPCC on System Pressures	G
	First meeting of PC workforce steering group held May 2023	G

Gaps in assurance
Some BI data gaps remain

Actions planned	Owner	Timescale	Progress Update
Working with National Team and DH on workforce issues and support.	JJ	Ongoing	
Working locally with LPCs and contractors to understand & quantify issues and where required managing risk via contractual compliance routes/ local arbitration processes.	JJ	Ongoing	
Tracking the C&M risk against national and regional closure rates for comparison.	JJ	Ongoing	

ID No: G7	Risk Title: Incident arising from unsafe working practices or environment leads to death or injury for which the ICB is liable resulting in financial loss and / or reputational damage			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	16	
Current Risk Score	3	4	12	
Risk Appetite/Target Risk Score	2	4	8	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Matthew Cunningham	Assistant Chief Executive	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
	Governance	A – Within current quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
24/11/22	09/01/24	09/02/24

Risk Description

[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]

The ICB has statutory duties to ensure the health and safety of its workforce and of visitors to its premises. These are discharged through its policies, processes, contracts and roles across the corporate and governance, estates and human resources teams. This risk concerns the potential for a breakdown in these controls leading to safety issues being identified by inspections, possible injury to staff or visitors, as well as an impact on reputation of the ICB and the NHS. Failure to maintain proper controls and abide by regulations could result in criminal and / or civil penalties. Based on existing controls this risk is assessed as the likelihood of harm being possible with potential major harm.

Current Controls		Rating
Policies	Health & Safety Policy, Alcohol & Substance Misuse Policy, Bullying & Harassment Policy, Lone Worker Policy, Smoke Free Policy, DSE Policy, Safe Driving at Work Policy	A
Processes	Risk assessments, H&S audits, testing, inspections & drills, mandatory & other training, staff supervision & support, staff wellbeing & welfare offer, incident management & investigation	A

Plans	H&S Action Plan based on agreed service specification, Place action plans following H&S audits and fire risk assessments	**G**
Contracts	MLCSU Contract for Health & Safety and Human Resources, Occupational Health Service	**A**
Reporting	Health & Safety Annual Report to ICB Executive, quarterly report to Associate Director, local office H&S audit reports to place leadership, sickness absence reports to management teams, H&S contract meetings with MLCSU, quarterly reporting by MLCSU to H&S lead, to include any H & S issues via Occupational Health Service	**A**

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]
Fire Policy to be concluded, approved & uploaded to Staff Hub.
Further awareness raising of H & S, DSE, Safe Driving at Work policies, to include Fire Policy once concluded and approved.
ICB cannot demonstrate compliance with the Violence Prevention and Reduction Standards compliance assessment.
Review of process for staff to access ergonomic equipment required to ascertain effectiveness and cost

Actions planned	Owner	Timescale	Progress Update
Conclude, approve & upload updated policies'	Rebecca Knight	31/01/24	Draft Fire Policy updated by MLCSU. Further amends are required to reflect Place arrangements. Checks are underway with a view to update the Policy and gain approval from the Executive Committee, hence November date moved to January 2024.
Conclude, approve & upload updated policies'	Rebecca Knight	FY 23/24 Quarter 4	Whilst updating the H&S policies, it was apparent that all Places have different incident reporting arrangements and there is no composite incident reporting policy for the ICB. Policy to be developed and agreement in place for MLCSU to retain oversight of all H&S incidents. This will take longer than originally anticipated due to system considerations, hence change in timescale to Quarter 4 23/24.
Ensure awareness raising of new policies is provided to all staff via relevant communication channels'	Rebecca Knight	31/01/24	Awareness raising of H & S, DSE, Safe Driving at Work via Governance Place Leads commenced while awaiting finalisation and approval of the draft Fire Policy, hence November date now moved to align with the readiness of that policy date above.
Approval of service specification and associated cost for 2024/2025 MLCSU Contract by relevant committee	Matthew Cunningham	31/03/24	Specification agreed at meeting held on 21/07/23 but cost discussions still underway for 2024/2025. FIRC will be in receipt of costing for approval as part of wider MLCSU contract decision.

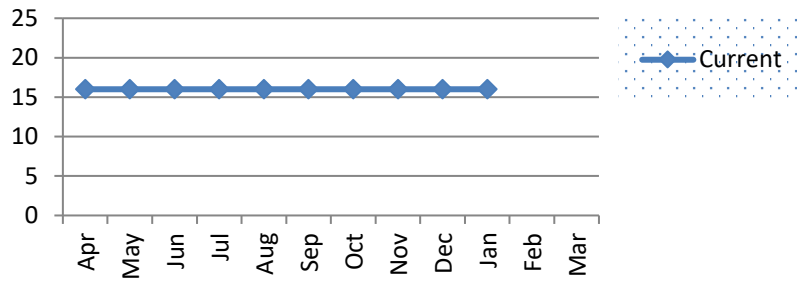
			Update report on progress to be provided to the Oversight Group.
Completion of the Violence Prevention and Reduction self-assessment'	MLCSU Rebecca Knight	TBC	Continue to await update from MLCSU on the self-assessment and strategy following updated guidance issued by NHSE, hence unable to meet the November date and now showing as TBC.
Review the process for staff to access ergonomic equipment (currently via MLCSU and Posturite) to ascertain cost and effectiveness'	Rebecca Knight / Sallyanne Hunter	FY 23/24 Quarter 4	MLCSU H&S have provided details of costs, goods and services relating to Posturite, other providers to be contacted to compare.

Assurances		
Planned	**Actual**	**Rating**
Identified person for H&S, will receive regular reports from MLCSU and have oversight across C&M ICB.	July and August 2023 reports received from MLCSU and discussed at monthly meeting. First quarterly report for September to December 2023 also received.	**Reasonable**
Annual Report for Health, Safety, Security and Fire to the ICB Executive Committee.	Annual Report received and content being checked before it goes to ICB Executive Committee.	
All H&S posters as required by legislation, to be displayed	All posters checked in October and present. Included in report to the Executive Team November 2023.	
Oversight (via software package - Cardinus) of staff completing DSE assessments, and any staff needing further support will be directed to MLCSU, and this information can be captured in the monthly and annual reports.	DSE module on ESR covers DSE assessments and reporting to manager in the meantime.	
Oversight of actions required at Place following H&S audits and fire risk assessments.	Process in development to gain assurance that actions have been completed when identified via audit process.	

Gaps in assurance
[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness] Annual Report to present to the ICB Executive Committee

Actions planned	**Owner**	**Timescale**	**Progress Update**
Development of Health & Safety Annual Report for presentation to the ICB Executive Committee'	MLCSU / Matthew Cunningham	30/04/24	Draft report received and under review before final version goes to Executive Committee.

ID No: F2	Health inequalities continue to drive increased demand for services with financial pressures resulting in failure to achieve financial duties

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	**16**	
Current Risk Score	4	4	**16**	
Risk Appetite/Target Risk Score	3	3	**9**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Wilson	Rebecca Tunstall	Finance	Finance, Investment and Resources

Strategic Objective	Function	Risk Proximity	ICB Executive	ICB Executive
	Finance	C – beyond financial year	Corporate Risk	Manage

Date Raised	Last Updated	Next Update Due
7/10/22	13/12/23	10/01/24

Risk Description

There are longstanding inequalities in health both within between Cheshire and Merseyside (C&M) and England as a whole, and between and within the 9 places that make up C&M. Unless effective action is taken to reduce inequalities and improve outcomes, health inequalities will continue to drive increased demand for health treatment resulting in higher cost and the potential that the ICB will fail to meet its statutory financial duties.

Linked Operational Risks		
Current Controls		**Rating**
Policies	Standing Financial Instructions, Scheme of Reservation & Delegation, Financial Policies	**G**
Processes	Financial Planning, Budget monitoring & control	**G**
Plans	Local Place Strategies, Health & Wellbeing Board Oversight at local level, Financial Strategy	**A**
Contracts		
Reporting	ICB Executive Team, Finance Investment and Resources Committee, ICB Board, NHSE/I	**G**

Gaps in control

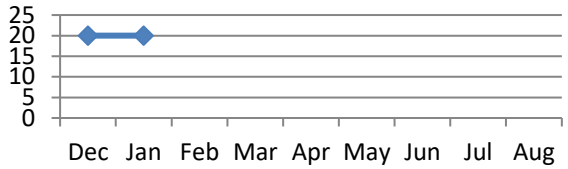
Actions planned	Owner	Timescale	Progress Update
Finance /Performance / Outcomes Reporting Dashboard / Development	Claire Wilson	Completed	Integrated performance report has been developed and was presented to Quality & Performance Committee in October will be presented to Board in November.
Recruit Health Inequalities Lead	Clare Watson	Completed	Now in post
Plans to utilise recurrent health inequalities fund	Clare Watson	January 2024	Will be aligned to work plan of Health Inequalities lead and linked to the place allocation toolkit currently underway.
Development of ICB/ ICS Long Term Financial Strategy	Claire Wilson	January 2024	Project initiated and system working group confirmed to support development of strategy

Assurances

Planned	Actual	Rating
NHSE System Planning Requirements 23/24 financial year		

Gaps in assurance

Actions planned	Owner	Timescale	Progress Update

ID No: QU09	Risk Title: East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	5	20	
Current Risk Score	4	5	20	
Risk Appetite/Target Risk Score	2	5	10	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard- Jones	Medical Director	Medical	Quality and Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/09/23	27/12/2023	27/01/2024

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]

The SHMI is the ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge. A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance and instead should be viewed as a 'smoke alarm' which requires further investigation. SHMI is not a direct measure of quality of care and cannot be directly used to identify avoidable deaths, however, it may be an indication of poor quality of care which could lead to increased avoidable harm and avoidable deaths.

Current Controls		Rating
Policies	Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalization, England, May 2022 to April 2023; National Guidance on learning from deaths, National Quality Board, 2017;	G

	Acutely ill adults in hospital: recognizing and responding to deterioration NICE clinical guideline (CG50); Acute Kidney injury: prevention, detection, and management NICE (NG148); Sepsis: recognition, diagnosis and early management NICE (NG51); Intravenous fluid therapy in adults in hospital NICE (CG174); Acute Hospital Discharge '100 day challenge', Letter David Sloman July 2022; Hospital discharge and community support guidance, NHS England, July 2022	
Processes	Rapid Quality Review (RQR) and subgroups **(RQR stepped down and now moved to bimonthly SHMI Quality Improvement Meeting)**; Quarterly mortality reports to East Cheshire Trust (ECT) Safety and Quality standards committee and ECT Board; Contract Quality and performance Meeting (CQPM) to monitor performance of NHS commissioned services; Reports to Cheshire and Merseyside Quality and Performance Committee Quality leads meetings and Quality and Performance Assurance Group at Place; C2Ai monthly analytics and reports	**G**
Plans	CQPM workplan to ensure ongoing mortality/ SHMI reporting and oversight; ECT SHMI reduction action plan; ECT deteriorating patient group established; Winter Plan to support timely discharge and admission avoidance. SHMI driver diagrams and improvement plan	**G**
Contracts	NHS Cheshire and Merseyside ECT contract; Quality schedules- Mortality Reviews	**A**
Reporting	SHMI Quality Improvement Meeting reporting into NHS Cheshire and Merseyside Quality and Performance Committee; ECT reporting into Safety and Quality Standards Committee and ECT Board; Mortality and SHMI performance oversight through CQPM and Place Quality and Performance Assurance Group- escalations to NHS Cheshire and Merseyside Quality and Performance Committee made through Place Key Issues report	**G**

Gaps in control ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

RQR SHMI Improvement Plan- developed and being refined. Driver diagrams now in place. These have been informed through work within the 'In hospital' and 'out of hospital' subgroups (which have now been stood down). Quality improvement work in ECT on hydration and deteriorating patient has started. Mortality Reviews/ Structured Judgement reviews (SJR) are being rolled out across medicine. Development of the SHMI dashboard is ongoing. Some assurance has been received around: coding of palliative care- this is being done in general practice. The analysis showed more work required to prevent dehydration of frail elderly and recognition and timely escalation of deteriorating patient. No care delivery issues identified with out of hospital care and support. The Trust regularly report to their board on learning from deaths. This is being strengthened as part of the improvement plan.

C2Ai data is now being reported monthly. Analysis and case review of people who die out of hospital within 30 days of discharge has been completed.

Actions planned	Owner	Timescale	Progress Update
RQR SHMI Improvement Plan (in development)	John Hunter	December 2023	SHMI improvement plan in place. This has been supplemented by SHMI driver diagrams.
Subgroups to meet to complete analysis of issues and agree diagnostic actions	Paul Bishop/ John Hunter	November 2023	Review of people dying within 30 days of discharge has been completed. This showed no lapses of care and that most were expected to die. Areas for improvement around discharge planning (seen in two cases) is being followed with through Place quality leads meetings.
RQR meetings to continue until assurance that the issues are understood and agreement of the improvement plan	Rowan Pritchard-Jones	November 2023	It was agreed in November to close down the rapid quality review meetings and replace them with a SHMI quality improvement meeting which will meet bimonthly. The first meeting was held on 15th December 2023.
Improvement plan to be developed	Amanda Williams	Draft by September Final by November 2023	As above: Improvement plan and driver diagrams completed. Ongoing review of progress to be through the SHMI Quality Improvement Meeting.
Quality improvement work around hydration and deteriorating patient to be progressed	Kate Daly-Brown	October 2023	Quality Improvement work agreed and commenced with medical wards. This is part of the SHMI Improvement Plan.
Monthly data analysis/ scrutiny of report from C2Ai	John Hunter/ Rowan Prtichard-Jones	ongoing	Monthly reports are now being received, analysed and will inform the SHMI dashboard.
Case review of out of hospital deaths within 30 days of discharge	Paul Bishop	November 2023	Case reviews were completed and reported back to the RQR group in November 2023.
Peer review of mortality reviews in ECT	John Hunter	tbc	These are no longer required.

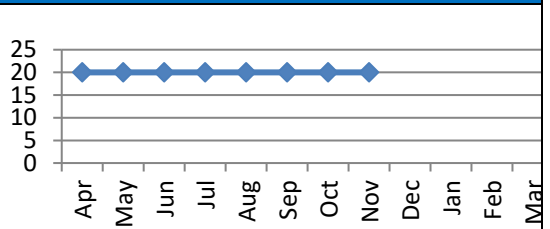
Assurances		
Planned	**Actual**	**Rating**

Need a regular focus and report to NHS Cheshire and Merseyside Quality and Performance Committee- frequency to be agreed	SHMI quality improvement meetings bimonthly to monitor progress against improvement plan. Updates will inform reports to Quality and performance Committee.	
Ongoing oversight and scrutiny of improvement plan both within ECT and across the system at Place through CQPM	Regular reporting/ updates to CQPM, however, the oversight will be through SHMI quality improvement meetings until assurance of progress received.	

Gaps in assurance ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

Some assurance given around:
Mortality review process being embedded in all divisions.
Reporting of avoidable harm being routinely measured and reported (C2AI data)
Evidence of Quality Improvement methodology relating to fundamentals of care.
However, ongoing oversight required until improvements seen.

Actions planned	Owner	Timescale	Progress Update

ID No: QU05	Risk Title: Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	20	
Current Risk Score	5	4	20	
Risk Appetite/Target Risk Score	2	4	8	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
16 n	16 n	8 n	8 ▼	16 n	16 n	15 n	8 n	16 n

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Douglas	Lisa Ellis	Nursing and Care	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/11/2022	04/12/2023	04/01/2024

Risk Description *[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]*

ASD and ADHD services have suffered from demand outstripping capacity causing significantly long waiting times. There is a risk of harm due to the significant, adverse impact of long waiting times on children, young people and adults with suspected Autism and/or ADHD. The impact includes:

1. Crisis leading to poorer individual outcomes and avoidable acute and mental health hospital admissions.
2. Increased risk of self-harm and suicide (people with Autism are 16 times more likely die because of suicide than the general population
3. Poorer mental health and wellbeing outcomes and greater risk of school exclusion and family breakdown.

4. Perpetuating the risk of health inequalities for people with neurodevelopmental and other co-existing conditions including learning disabilities.

There is a financial risk due to the increased costs/ spend in the system due to the increasing demand. There is an increase in non-contract spend on private providers as more people seek access via Right to Choose and opt out of long NHS waiting lists.

Current Controls		**Rating**
Policies	Autism Assessment Framework; The assessment pathways for Autism and ADHD are governed by NICE Clinical Guidelines. Autism: CG128 (CYP) and CG142 (Adults) and ADHD: CG72; Transforming Care Programme.	**A**
Processes	CQPGs/ CQPMs to monitor performance of NHS commissioned services; Reports to Cheshire and Merseyside Quality and Performance Committee; Close working with Parent Carer Forums at Place- co-production; Performance reports presented to Quality and Performance Committee; Quality and Performance Groups at Place; LD focus area at Cheshire and Merseyside System Quality Group- April 2023; Quality schedules- long wait harm reviews	**G**
Plans	Cheshire Neurodevelopmental Clinical Network - strategic plans and implementing best practice; ASD/ ADHD included in SEND improvement plans at Place; Quality schedules- long wait harm reviews	**A**
Contracts		**R**
Reporting	Quality and Performance reported through: CQPG/ CQPM, Quality and Performance Groups at Place/ C&M Quality and Performance Committee, SEND/ LA reporting- SEND scorecards and dashboards at Place. Reporting from SEND Sub-Group to System Oversight Board (SOB)	**A**

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

C&M ICB Commissioners developing joint and strategic approach to commissioning for Autism and ADHD; No lead across C&M for ASD/ ADHD; Increased investment for both assessment and evidence-based support required - but difficult in current financial climate.

Actions planned	**Owner**	**Timescale**	**Progress Update**
Multiple strategic actions across health & education and to reduce waiting times.	TP Programme Leads/ DCOs		

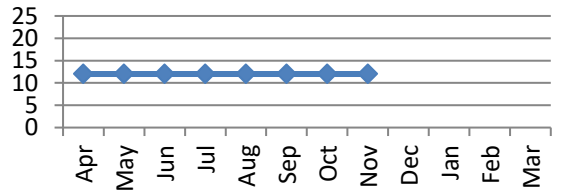
Assurances

Planned	**Actual**	**Rating**
NHSE Baseline assessment of demand, data, demographics etc.	Q&P key issues reporting- monthly standard agenda item	**A**

Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Quality & Performance Committee require regular reporting for oversight and assurance.

Actions planned	Owner	Timescale	Progress Update
SEND Lead to provide focus report to Q&P Committee (frequency to be agreed)	Julie Hoodless	TBC	

ID No: QU07	Risk Title: CHC delivery is impacted due to inadequate compliance with the CHC National Framework which leads to delays in assessment and unmet need.			
	Likelihood	**Impact**	**Risk Score**	**Trend**
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	4	**12**	
Current Risk Score	3	4	**12**	
Risk Appetite/Target Risk Score	2	4	**8**	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
16 n	16 n	12 n	8 ▼	12 n	16 n	12 ▲	12 n	12 n

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Douglas	Lorna Quigley	Nursing and Care	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
01/03/2023	04/12/2023	04/01/2024

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]

Quality risk/potential patient harm impact on people eligible for CHC and their families due to uncertainty and impact on personal financial arrangements for individuals. Unreasonable waits for assessment impacting on threshold to self-fund including sale of personal property, irrespective of back dating funding following subsequent eligibility decision.

Wider risk of financial pressure on the care home/marketplace where delay in payment from families initially deemed self-funders and back payment due to variance in costs. Poor patient/carer experience due to extended pathway and potential for individuals not in receipt of appropriate care leading to unmet need and potential harm.
Future forecasting and accurate financial position unclear due to backdated payments and backlogs. Potential overfunding of packages of care. Failure to meet timescales set out in National CHC Framework and consequences of non-compliance include regulator scrutiny, legal

challenges and referral to Health Service Ombudsman. Delays in assessment lead to media interest and complaints from MPs on behalf of families and constituents.

Current Controls		Rating
Policies	National CHC Framework – supported by place level suite of policies; MH Act 1983 (Section 117); Suite of local frameworks to monitor; C&M Policy	**A**
Processes	CQPG / CQRM meetings (monthly and across all place areas); Weekly operational meetings in place; System Oversight Groups in place for AACHC, Safeguarding and Send.	**A**
Plans	Provider Improvement Plan (where remedial breach notice is issued); Workforce plan actioned.	**A**
Contracts	Contract with MCFT, M&L CSU (Liverpool & Sefton only - in-house models for Cheshire (x2), Halton& Warrington, St Helens; Service commissioned model for Knowsley	**A**
Reporting	Reporting from AACHC Group to System Oversight Board; Place quality report from Liverpool and Sefton – tabled to the ICB Quality & Performance Committee (monthly); Review of Operating Model overseen by Finance, Investment & Resources Committee; Reporting at each place (9) by exception reporting;	**G**

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

Target Operating Model for AACHC to be developed and implemented (pending conclusion of AACHC Review); Vacancy control process (filling staff vacancies to deliver model of care);

Actions planned	Owner	Timescale	Progress Update
All Age Continuing Healthcare Review expected to frame future Target Operating Model	Andy Davies	TBC	Phase 3 (implementation) underway

Assurances

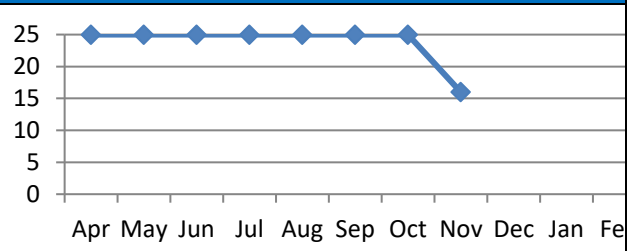
Planned	Actual	Rating

Gaps in assurance *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

Internal process (business system) of providers; Lack of assurance of robustness of internal processes / systems from external providers (reassurance rather than assurance); Collaboration and discussions needed re: CHC internal operational issues and multi-provider operating model

Actions planned	Owner	Timescale	Progress Update

ID No: QU08	Risk Title: Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	5	**25**	
Current Risk Score	4	4	**16**	
Risk Appetite/Target Risk Score	2	5	**10**	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
16 ▼	16 n	12 n	25 ▲	16 n	16 n	12 ▼	12 n	20 n

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Douglas	Lorna Quigley	Nursing and Care	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health	Quality	**A – within next quarter**	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/11/2023	04/12/2023	04/01/2024

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]

Demographic issues aging population & global pandemic and underinvestment in workforce, latent harm through pandemic, increasing demand, capacity issues, retention issues due to stress / pressure, social care impact preventing flow out of Trusts, under investment social care, market forces, delays to follow ups.

Current Controls		Rating
Policies	Discharge Policy; UEC Standards; Long waits guidance; National FNC / CHC Framework; D2A guidance; SCC guidance, Fuller Report;	**A**

Processes	C&M ICB SCC, Local harm review process, Incident reporting, pathways; Risk stratification; CQRM / CQPG at place;	**A**
Plans	Urgent Care Recovery Plan 2023; People Cell; Workforce Recruitment and Retention Programme (including international recruitment); Virtual Ward Expansion; Winter Plans; Local delivery of plans to mitigate workforce shortage.	**A**
Contracts	NHS Standard Contract;	**A**
Reporting	System Quality Group; Quality Dashboard Reporting to Q&P Committee; Q&P Group at each 'Place';	**A**

Gaps in control ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

Synthesis & consistency of policy into action; Maturity of processes and shift from 9 CCGs to single entity; Quality dashboard not fully established & inconsistency between places.

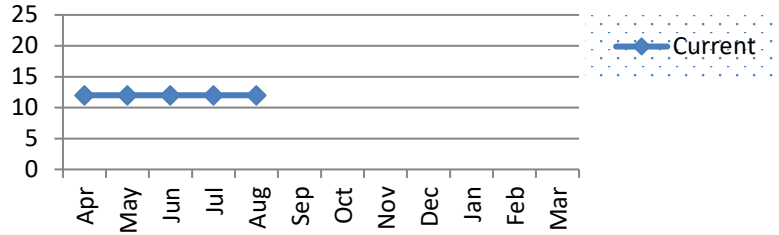
Actions planned	Owner	Timescale	Progress Update

Assurances

Planned	Actual	Rating

Gaps in assurance ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

Actions planned	Owner	Timescale	Progress Update

ID No: W8	Lack of workforce diversity may impair the effectiveness of the ICB response to our populations needs exacerbating health inequalities and damaging our reputation			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	**20**	
Current Risk Score	3	4	**12**	
Risk Appetite/Target Risk Score	3	3	**9**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Samosa	Thomasina Afful	People	Finance Investment Resources Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
All 4 objectives	Workforce	C – Beyond financial year	Corporate	Manage

Date Raised	Last Updated	Next Update Due
17/03/2023	28/12/2023	15/02/2024

Risk Description

Source: Inclusive NHS workforce is not achieved
Effect: Workforce is not reflective of the communities it serves particularly at senior levels.
Impact: Risk to the delivery of the 4 ICB strategic objectives in the absence of lived experience skillsets of underrepresented groups to inform service redesign **and inclusive practice**, and a lack of culturally competent senior leaders to lead it / lack of, or reduced, ability to recruit and or retain a diverse workforce/ lowered productivity / increase in sickness absence / organisational reputational, legal and or financial risk due to lack of regard to the Public Sector Equality Duty.

Current Controls		Rating
Policies	EDI Policy, EIA Policy, Workforce Race Equality Standards, Workforce Disability Equality Standards, Public Sector Equality Duty, NHS EDI Improvement Plan, Messenger Review, Altogether Fairer, Broken Ladders Review	**A**
Processes	HR Dashboard / workforce profiling/ planning, Training & development (specific re cultural competence, inclusive leadership, Board development – or in gaps / actions if yet to do?), Engagement & involvement,	**A**

	Equality Impact Assessment, Freedom to Speak Up process, Staff networks, NHS BAME Anti-Racism Framework, Navajo Accreditation, Disability Confidence Accreditation	
Plans	EDI Improvement Plan, EDI Communications Strategy	**A**
Contracts	None	
Reporting	People Committee, ICB Board	**A**

Gaps in control

HR policies to be reviewed
Organisational self-assessments prior to Navajo and Anti-Racism Frameworks
Staff networks development
Training needs analysis required, linking in with OD programme
Further work required to improve HR dashboard, further de-aggregation of protected characteristics and other relevant groups subject to ESR functionality
Reasonable adjustment processes require review

Actions planned	Owner	Timescale	Progress Update
Review HR policies	Thomasina Afful	March 2024	Delayed until 'in-housing' of HR Central functions complete.
Establishment of Freedom to Speak Up Champions	Suzanne Burrage	January 2024	Champions recruited and FTSU Summit (Oversight Group) established.
Organisational self-assessment – Anti-Racism Framework	Thomasina Afful & Place Directors	January 2024	Most assessments have been completed by places and functions. Organizational base line position has been determined. Plans to be developed to work towards achievement of Bronze level of the Anti-racism framework. Delivery of Anti-racism board development to commence February 2024.
Review training capability & needs to develop workforce cultural competence	Thomasina Afful & Taira Shaffi	February 2024	On-going Draft Cultural Competence Framework developed
Building staff network capability	Thomasina Afful	August 2024	Equality Networks established. Priority focus for supporting improvement of inclusive practices and standards agreed. Work in train to increase memberships. Development needs of chairs/co-chairs to be identified.
Navajo self-assessment	Staff network &	September 2024	Work plan to be agreed with LGBTI Staff Network.

	HR (MLCSU)		
Review policy / process regarding reasonable adjustments	Thomasina & MLCSU	TBC	Delayed until 'in-housing' of HR Central functions complete – Identified as a priority focus for the Disability Staff Network
Review EIA process & documentation	Thomasina	Ongoing (dependent Equality & Human Rights Commission)	On going
Keep under review HR dashboard in light of NHS Digital	Thomasina / HR	Ongoing	Ongoing

Assurances		
Planned	**Actual**	**Rating**
EDI Reporting to ICB Board	ICB Equality, Diversity and Inclusion Update Report – 29/11/22 (reasonable), Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023 – 23/2/23 (reasonable)	**Reasonable**
ICB Board commitment to NW BAME Anti-Racism Framework	Northwest BAME Assembly Anti-Racism Framework – 27/7/23 (reasonable)	
NHSE Oversight & monitoring of WRES, WDES, EDS2022 of ICB & ICS reported to ICB Board (annually)	WRES and WDES Annual Reports – 5/2/2023	
Gender pay gap reporting to Board & publication (annually)		
Organisation Equality Objectives approved & monitored by ICB Board (Review & then 4 yearly)	EDI Annual Report – 16/2/2023	

Gaps in assurance
None

Actions planned	**Owner**	**Timescale**	**Progress Update**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Northwest BAME Assembly Anti-Racism Framework Progress Update

Agenda Item No: ICB/01/24/21

Responsible Director: Christine Douglas, Director of Nursing and Care

Northwest BAME Assembly Anti-Racism Framework Progress Update

1. Purpose of the Report

1.1 To provide an update to Board on the work undertaken to progress implementation of the BAME Assembly Anti-Racism Framework and to introduce the proposed implementation plan

2. Executive Summary

2.1 The Northwest BAME Assembly Anti-Racism Framework[1] 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. It recognises that this intention requires committing to undertaking a journey that involves the continuous review of progress and being intentional about actions for change.

2.2 The Framework is organised into three levels of achievement: Bronze, Silver, and Gold. Each level builds upon the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination.

2.3 To demonstrate its commitment to becoming anti-racist the Board of NHS Cheshire and Merseyside issued and published an anti-racism statement in September 2023[2] proclaiming its commitment to race equality in the Cheshire and Merseyside Integrated Care System (ICS). In addition to this, the ICB Chief Executive was named as the executive champion/sponsor for the anti-racism agenda.

2.4 Work undertaken to implement fully the framework will have direct impacts on improving the health and wellbeing outcomes of our workforce, and indirect improvements in health outcomes for patients within communities. It will do this by tackling discriminatory practice and attempting to breakdown structural and systemic barriers that prevent access to culturally appropriate services and information.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **note** the contents of the report and progress made so far.

[1] https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2023/07/The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf
[2] https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/anti-racism-pledge/

4. Reasons for Recommendations

4.1 It is important that the Board is kept informed of the work underway within the ICB and across the ICS in implementing the Framework, any risks, lessons learned and resulting changes and impact made.

5. Background

5.1 **Readiness Self-Assessment / diagnostic.** During the months of September and December key functions and places were provided with the opportunity to complete the Anti-racism self-assessment in order to assess the ICB's, understanding of, and readiness to do work needed to implement the anti-racism framework; and what we might already be doing to contribute towards it.

5.2 The key areas examined in self-assessment were:
- Mission, Values, and Culture
- Leadership and Staff Morale
- Engagement and Decision Making
- Tracking Racial Disparities
- External Relationships.

5.3 Each ICB Place and Team were invited to score their own individual assessment and allocate themselves a score of between1 (Inadequate/Not addressed/Not achieved) to 4 (Exemplary practice), based on the extent to which they could evidence that they met the assessment criteria. Table One, shows the scores for the three highest scoring functions/place and the overall score for the ICB.

Table One

Key Themes Examined in Assessment	Theme Scores		CM ICB Overall Score	Highest Scoring Functions / Place		
	Minimum Score Possible	Maximum Score Possible		ACE Directorate	People Team	Warrinton Place
Mission, Values, and Culture	5	20	6	11	11	8
Leadership and Staffing	4	16	5	8	9	5
Engagement and Decision Making	4	16	5	8	8	7
Access to Employment/Training/learning/Commissioned Services and other Opportunities and Tracking Disparities	5	20	5	10	7	4
External Relationships and Advocacy	3	12	5	6	4	8
Total Assessment Scores	**21**	**84**	**26**	**43**	**39**	**32**

5.4 Organisationally, all themed areas require significant development in order to claim that criteria had been sufficiently met. The main weaknesses identified in the completed assessments was a failure to provide adequate evidence to

support responses and a lack of awareness of any adopted approaches or practices that may be in place that would evidence themes. Places, in particular, stated their inability to adequately respond to many of the questions posed, as it was assumed that they related to corporate functions and that there would be a corporate approach. No areas of good practice could be drawn from the any of the responses provided. **NB:** Completed assessments were not received from: Digital/Finance/Medical Directorate /Quality /Performance/ Cheshire East Place/Liverpool Place/Sefton Place. These functions /places were therefore allocated the minimum score available.

5.5 **NW BAME Assembly Anti-racism Framework.** Whilst the readiness self-assessment/diagnostic suggests that much work is needed to improve on the overall organisational scores, the ICB can demonstrate that work has started to meet the direct deliverables of the Bronze status of the NW BAME Assembly's Anti-racism Framework (Table Two)**.** Bronze status signifies that an organisation has taken initial steps towards becoming an intentionally anti-racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.

Table Two

Key Drivers	Direct Deliverable	Supporting Actions	CM ICB Evidence
Leading from the front	The appointment of an executive or director level EDIsponsor with a commitment to advancing anti-racism withinthe organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism.	CEO is the Exec sponsor for the Race Agenda
		• Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make antiracism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.	Antiracism statement has been published on CM ICB website
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.	
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.	
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures	

5.6 Additionally, a Cheshire and Merseyside BAME Staff Network has now been established. Network membership is open to ICB staff and the Primary Care workforce. To date the network has met twice and has agreed its Charter

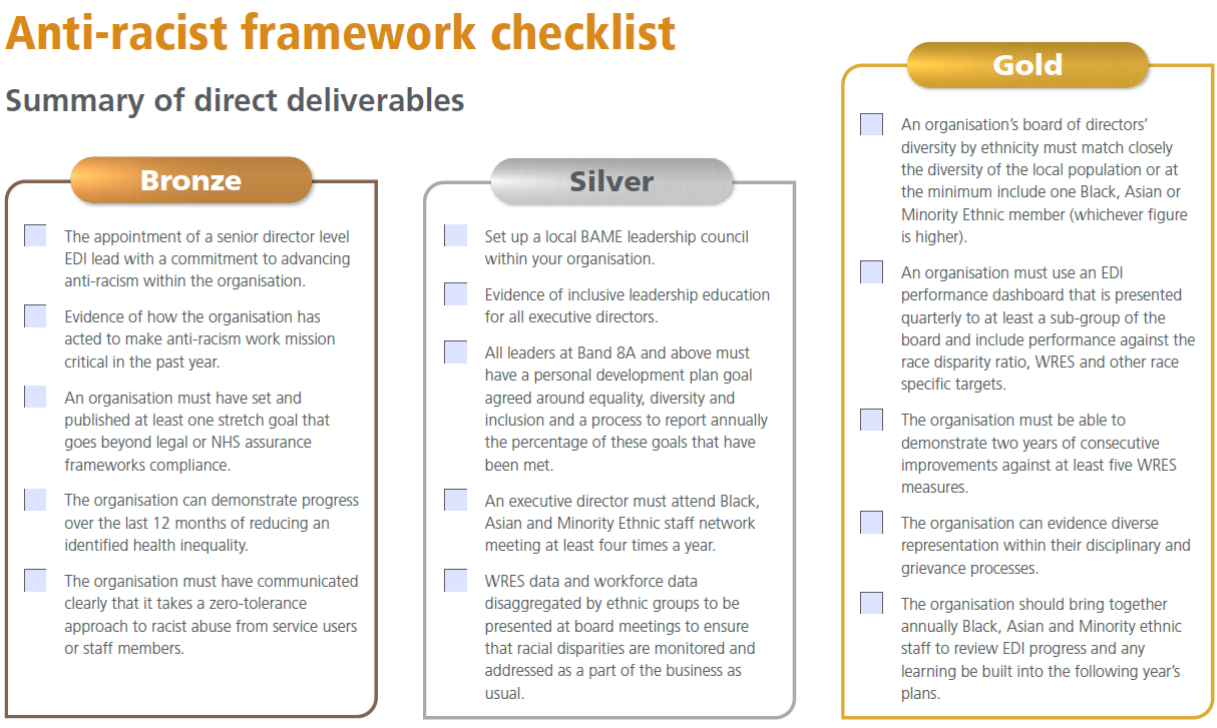
(Appendix One) and its areas of focus for the coming 12 months. These support the implementation of the Anti-racism Framework.

5.7 Work to be undertaken to achieve outstanding deliverables will include:

- development of the BAME Staff Network chair(s) to build capability to effectively influence and engage in decision making processes.
- development and implementation of an organisational cultural competency framework
- identification of raced based KPIs
- review of current disciplinary processes through a race lens with the view of making recommendations for improvement where appropriate.
- race based board development (see below).
- identify and agree health inequity to be targeted and identify actions to reduce disparities with key stakeholders e.g., BAME Staff Network, MHFA ambassadors, FTSU Guardians, HR, Staff wellbeing forum etc.

5.8 It is anticipated that all Bronze deliverables will be achieved by end quarter 4, 2025. Alongside this, work will also commence on achieving deliverables for the Silver status (Diagram One).

Diagram One



5.9 **CM ICB Board Anti-racism Development.** BRAP, a leading charitable organisation with considerable experience of supporting NHS and other public sector Board development in anti-racism, equality, diversity and human rights, (https://www.brap.org.uk/about), has been commissioned to deliver a board leadership development on anti-racism starting in February 2024. The purpose of the development opportunity is to help the board to achieve: a shared

understanding of anti-racism, to understand the implications of an anti-racist approach; and to develop its understanding of the purpose of its leadership in this area and how it holds itself accountable for change.

5.10 **Cheshire and Merseyside System Commitment to Implementing the Anti-racism Framework.** To date, 13 Trusts have committed, or expressed their intention, to implement the Anti-Racism Framework (highlighted in the Table Three). Trusts may access support from the Cheshire and Merseyside Patient/Workforce Equality Focus Forum and /or the North West Anti-racism Programme drop-in sessions.

Cheshire & Merseyside ICB Hospital Trusts
1. Alder Hey Children's NHS Foundation Trust
2. Bridgewater Community Healthcare NHS Foundation Trust
3. Cheshire and Wirral Partnership NHS Foundation Trust
4. Clatterbridge Cancer Centre NHS Foundation Trust
5. Countess of Chester Hospital NHS Foundation Trust
6. East Cheshire NHS Trust
7. Liverpool Heart and Chest Hospital NHS Foundation Trust
8. Liverpool University Hospitals NHS Foundation Trust
9. Liverpool Women's Hospital NHS Foundation Trust
10. Mersey and West Lancashire Teaching Hospitals NHS Trust
11. Mersey Care NHS Foundation Trust
12. Mid Cheshire Hospitals NHS Foundation Trust
13. The Walton Centre NHS Foundation Trust
14. Warrington and Halton Hospitals NHS Foundation Trust
15. Wirral Community Health & Care NHS Foundation Trust
16. Wirral University Teaching Hospital NHS Foundation Trust

5.11 Trust representatives attend the North West Anti-Racism drop-in sessions for support. Additional support is provided via the monthly meetings of the Cheshire and Merseyside Patient/Workforce Equality Focussed Forum.

5.12 Representatives within primary care have expressed a strong interest in adopting the framework, however in its current form it is not fit for purpose. The ICB EDI Associate Director is currently working with the North West BAME Assembly's Race Equality Lead and the GP Race Equality Lead for Central Liverpool Primary Care Network to adapt the framework to work for Primary Care Networks (PCNs).

5.13 During November and December 2023 initial work to identify potential adaptations to be made was undertaken, alongside identifying the levels of support available to complete this work.

5.14 In February 2024, a working group of colleagues comprising representatives from PCNs in Cheshire and Merseyside, Greater Manchester and Lancashire

and South Cumbria, as well as Local medical Committee colleagues, will be brought together to contribute to shaping this framework.

5.15 In addition to this, ICB EDI Associate Director is leading work to establish a GP EDI Network to help socialise and support the implementation of the adapted framework and to help identify priorities for tackling key issues impacting workforce retention particularly in areas of high deprivation. Local Medical Councils covering the CM footprint have agreed in principle, to support this work.

5.16 The proposed timeline for the work is:

- February 2024: explore the needs of PCNs as it relates to antiracism and begin the process of tailoring the framework deliverables for PCN adoption.
- March 2024: draft adapted framework to be reviewed, further tailoring, agreement on final deliverables.
- April 2024: agree final framework.

5.17 10 pilot primary care / health care sites within Cheshire and Merseyside will be identified, monitored, and supported to implement the adapted framework. Its impact within those settings will be evaluated and learning shared.

5.17 **Targeted Anti-racism development - Allied Health Practitioners (AHPS).** A programme of targeted anti-racism development will be made available to up to 120 AHPs from across the system from February 2024. The aim of the training is to build the confidence of practitioners to become anti-racist allies and develop their capability to embed EDI and anti-racism into their practice. The development package will include:

- Race Awareness Training
- Unconscious Bias Training
- Anti-racist Ally training
- Enhanced EDI Training
- Equality Impact Analyses Training – understanding risk.

5.18 **Workstream Alignment.** This work aligns with the following national, regional, and local drivers outlined below. Work is ongoing to ensure that duplication with other workstreams is kept to a minimum through collaborative working and the effective sharing of available resources.

- NHS Constitution
- NHS People's Promise
- Messenger Review
- Broken Ladders Report
- NHSE EDI Improvement Plan
- Workforce Race Equality Standards
- NW NHSE Anti-racism Programme

6. Next Steps and Responsible Person to take forward

6.1 Work will continue to progress in implementing

7. Officer contact details for more information

Thomasina Afful, Associate Director for Equality, Diversity, and Inclusion
Thomasina.afful@cheshireandmerseyside.nhs.uk

8. Appendices

Appendix One: BAME Staff Network Charter

NHS
Cheshire and Merseyside

BAME STAFF NETWORK CHARTER

This document describes the network charter that Cheshire and Merseyside (CM) ICB will adopt to take forward work to support Black, Asian and Minority Ethnic (BAME) staff.

Purpose

There is recognition that more work needs to be done to support BAME staff across the Cheshire and Merseyside footprint. As a newly established organisation and system it is important that we also work to strengthen the voices, and support the engagement and wellbeing, of our BAME colleagues. The BAME Staff Network is a community for staff members who self-identify as BAME, as well as those colleagues (Allys) who have a positive interest in driving forward racial equality.

This network therefore has a key role to play in:

- Improving equality considerations during the recruitment process.
- Sharing the lived experience of BAME staff to drive organisational change to tackle institutional racism.
- Improving the experience of BAME workforce within the organization
- Reaching seldom heard voices.
- Identifying aspirant and future leaders.
- Improving perceptions of BAME staff talent and capability.
- Leaning BAME voices / insights into key decision-making spaces of the ICB
- Advising on differing cultural needs.
- Helping the ICB and Primary care organisations to work in ways that unlock the full potential of diversity and inclusion to support the design, development and delivery of culturally competent health and care services.
- Collaborating on strategic areas of work to coproduce culturally competent solutions.

The network aims to do this by:

- Offering constructive challenge to key decision makers.
- Supporting the organisation to attract, recruit and retain talented BAME staff members.

- Promoting the interests of BAME staff employed by CM ICB/Primary Care.
- Raising awareness of BAME issues by CM ICB/Primary care.
- Monitoring and reviewing the effective implementation of actions in relation to the workforce race equality standard (WRES), including implementation of the NHS BAME Assembly's Anti-Racism Framework, and to assist in the review of race equality in the day-to-day operations.
- Supporting the CM ICB/Primary Care to work towards eliminating unlawful discrimination, harassment, victimisation, and/or bullying.
- Acting as a channel for communication and consultation between BAME staff and senior management / leadership.
- Lobbying for, and supporting relevant campaigns, programmes and initiatives, as required to progress issues facing BAME staff.
- Identifying ways to challenge discrimination and stereotyping among colleagues, peers, students, stakeholders and customers.
- Working in partnership with other BAME networks from across the system to progress improvements in experience for our BAME colleagues and populations and to challenge discriminatory practices that we collectively may identify.
- Providing peer support, guidance and signposting to appropriate services both within and outside the organisation, where appropriate.
- Working intersectionally and collectively to identify and dismantle structures, systems and processes that perpetuate inequities within the workplace.
- Supporting BAME staff to access opportunities to participate in a range of targeted social and professional activities and relevant training.
- Celebrating collaborative working and collective achievements.

Membership

The network is open to all BAME staff working within the Cheshire and Merseyside ICB and those working within primary care settings.

The network will use existing staff forums and communications channels as well as other meetings and network interfaces so membership can be increased.

Operating Model

The network will appoint a chair and vice chair to support with the organisation and running of the network.

All members will have an equal part to play in helping set the agenda, develop a workplan and driving the delivery of the workplan.

If required, smaller working groups may be developed to take forward projects that will be overseen by the network.

The structure of the meetings will be divided into two distinct parts: one for discussing network business; Allys and other non-BAME colleagues may be invited to this section of the meeting. The second part of the meeting will provide staff with the opportunity to share or raise any concerns and issues that they may have encountered and to seek and offer peer support.

Behaviours

Members of the BAME Network will commit to:

- Attending all scheduled network meetings.
- Respect the confidentiality of meeting discussions and what is shared.
- Champion the network within and outside of the organisation.
- Share all communications and information across BAME Network members.
- Making timely decisions and take action so as to not hold up any particular workstreams/project.
- Allys will undertake appropriate and relevant development to ensure they are effectively able to support the purpose and aims of the network. This development will be evidenced on request.

It is expected that members will:

- Respect each other's views and to challenge in respectful ways when appropriate.
- Value each other's contributions.
- Contribute to the discussion and decision making.

Resources

Time will be managed by individuals attending the meeting. Line managers will recognise the importance of this network and the need to release on-job time to attend meetings and undertake the any assigned responsibilities.

Resources required (e.g., training will be managed via the usual SLT processes).

Key topics

Immediate areas of focus for the network will be:

- Implementation of WRES actions.
- Implementation of the Anti- Racism Framework.
- Raising awareness of issues faced by BAME staff.
- Supporting identification for training for the ICB employees and Network Allys.
- Mentoring/ sponsoring for BAME staff

Working together

- We will meet bi-monthly using MS Teams (but we will aim to have at least one annual face to face meeting)
- We will communicate with the wider ICB to keep the organisation abreast of the work that is undertaken by the BAME group.

How we will measure our impact

- Year on year improvements in our WRES results.
- Achievement of the Bronze (minimum) standard of the Anti-Racism Framework.
- Delivery of workplan.
- Increase in network membership.

This document will be reviewed Annually.

Date: 9th October 2023

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Amendments to the Constitution of NHS Cheshire and Merseyside

Agenda Item No: ICB/01/24/22

Responsible Director: Graham Urwin, Chief Executive

Amendments to the Constitution of NHS Cheshire and Merseyside

1. Purpose of the Report

1.1 The purpose of the report is to present for consideration by the Board the proposed amendments to the Constitution of NHS Cheshire and Merseyside, and to provide an outline of the process that is required of Integrated Care Boards to seek and receive approval of any changes.

2. Executive Summary

2.1 Every Integrated Care Board (ICB) must have a Constitution approved by NHS England and it must be published on its website and made available to members of the public. It sets out various matters including the arrangements to allow NHS Cheshire and Merseyside including its Board to discharge its functions. It includes details on the establishment and composition of NHS Cheshire and Merseyside, its Board and relevant committees and includes the Standing Orders for the ICB.

2.2 Prior to its establishment on the 01 July 2022, the content of the Constitution of NHS Cheshire and Merseyside had been consulted on with the former Clinical Commissioning Groups and partners across Cheshire and Merseyside prior to approval by NHS England. The Constitution came into effect from 01 July 2022 and other than some minor technical amendments which ICBs were instructed to make following publication of the final version of the Health and Social Care Act there have been no further amendments to the Constitution.

2.3 Constitutions can only be amended through instruction by NHS England or following approval by NHS England following receipt of an application to vary its Constitution by the ICB, following approval of the ICB Board of any amendments. When considering any amendments to the Constitution the Board is required to consider whether to engage on the changes with the Integrated Care Partnership or other key stakeholders such as the public. Engagement should be undertaken if the Board believes the changes materially affect the operation of the ICB or its relationship with partners.

2.4 18 Months on from its establishment and following a review of the Constitution a number of amendments are being proposed that fall in the following key areas:

- formatting – tidying up of the document
- terminology – seeking to be consistent when referring to the ICB, NHS Cheshire and Merseyside and Board
- flexibility – removal of content that may unintentionally inhibit flexibility of the ICB to make changes that are within its existing authority

- redundant content – removal of content that featured in the model constitution that was relevant to areas related to issues specific to the timings around establishment of the ICB and which are no longer relevant
- inclusion of the intent of NHS Cheshire and Merseyside to appoint to its Board a Partner Member drawn from the Voluntary, Charitable, Faith and Social Enterprise Sector (VCFSE)
- inclusion of the authority of the Chair to appoint a Deputy Chair of the ICB Board, drawn from ICB Non-Executive Members
- updated Partner names – recognition of the establishment of Mersey and West Lancashire NHS Teaching Trust
- refinement of wording around authority of the Board and its Committees in the discharge of the powers of the ICB
- enhanced content regarding the ICB receiving and considering petitions
- enhanced content regarding the ability of the ICB to undertake meetings virtually.

2.5 NHS England are also due to instruct further amendments to ICB Constitutions following the publication of the Provider Selection Regime Regulations in January 2024. This will not require ICB Board approval, and the amendments will be implemented following receipt of the text that will need to be included. NHS England have also provided early sight of other minor draft changes in keeping with and have been incorporated with the proposed amendments within the v1.2 of NHS Cheshire and Merseyside Constitution. A date has not yet been confirmed as to when these amendments will be received from NHS England.

2.6 Subject to the approval of the Board to the proposed amendments and proceeding with the application for variation of the Constitution to NHS England, it is also recommended that the Board delegates responsibility to the Chief Executive to approve any further minor amendments to the Constitution following feedback from NHS England. Any substantial changes will require the Constitution to be brought back to the Board for its approval.

2.7 Following approval of the application to vary its Constitution by NHS England, the revised constitution, and any necessary changes to supplementary governance documents within the ICB's Corporate Governance Handbook, should be published on the ICB website.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **consider** the proposed amendments to the ICB Constitution and whether it believes the proposed amendments are such that engagement with the Cheshire and Merseyside Health and Care Partnership and other stakeholders is required
- **approve** the proposed amendments to the Constitution
- **approve** progressing the process to submit an application to vary the Constitution to NHS England

- **note** that there will be additional amendments to the Constitution following receipt of guidance from NHS England
- **approve** the recommendation to delegate authority to the Chief Executive to approve any minor changes to the Constitution following any feedback from NHS England.

4. Reasons for Recommendations

4.1 The Board is required to approve any amendments to the ICB Constitution that have been put forward by the ICB, and approve the submission of the amended Constitution to NHS England for review and approval.

4.2 Only following approval from NHS England will the changes to the Constitution come into effect.

5. Further information

5.1 In submitting requests to NHS England to vary their Constitions, ICBs are required to follow the guidance outlined with the NHS England publication *'Guidance to integrated care boards on applying to NHS England to amend their constitution*.'[1]

5.2 ICBs are expected to discuss their proposed changes with the NHS England regional team in advance of the submission of the application to vary the Constitution. Following this discussion and agreement to progress, an application should be submitted outlining:

- the reason for why the change is being sought
- assurance on and details of meaningful engagement with all relevant stakeholders that has been undertaken if required and as proportionate to the nature of the changes proposed, and how the ICB has given proper consideration to the views and feedback received
- confirmation of Board level approval to the proposed changes
- assurance that the ICB has considered any need for legal advice on the implications of the proposed changes
- an impact assessment of the proposed changes
- the proposed revised Constitution with the amended clauses clearly identified.

5.3 Upon receipt of the application to vary, NHS England will consider:

- whether the revised constitution meets the requirements of legislation
- whether the revised constitution complies with the policy requirements set out in any guidance on varying the Constitutions
- whether the ICB has made appropriate arrangements to ensure it is able to discharge its functions following any proposed change

[1] https://www.england.nhs.uk/wp-content/uploads/2021/06/B1650-guidance-to-integrated-care-boards-on-constitutional-change.pdf

- whether the Board of the ICB affected by the proposed changes would be correctly constituted in accordance with the legislation and statutory guidance
- whether the process for appointing partner members, and any other ordinary members, would comply with the Act, relevant statutory guidance and policy as set out in the ICB model constitution
- whether the likely impact of the proposed change on the persons for whom the ICB has responsibility has been given proper consideration, including on equalities and health inequalities
- whether the likely impact of the proposed change on the discharge of NHS England's functions has been given proper consideration5
- whether the support, or otherwise, for the proposed change from the integrated care partnership (ICP) affected by it has been given proper consideration
- whether the views of patients and the public have been sought on the proposed change where appropriate and the ICB has given proper consideration to those views, as part of a transparent process open to the public.

5.4 It is for the ICB to determine what information, in addition to the requirements set out in the application process above, it should submit to help NHS England decide on the application for constitution change.

5.5 NHS England may ask for clarification or additional information at any stage. Additionally, NHS England may consider any other material it considers relevant to making its decision, not just material submitted by the ICB. All stages of the procedure will involve communication between NHS England

5.6 NHS England will acknowledge all applications for changes to ICB constitutions within two weeks of receipt. Typically, NHS England will notify the ICB in writing of its decision on the ICB's application to change its constitution within four weeks of receipt. Where applications relate to changes of a minor or administrative nature, NHS England will expect to notify the ICB of its decision well within this timescale. However, should NHS England require supplementary information from an ICB before reaching its decision, such information must be provided in a timely fashion, and the final decision may take longer

5.7 It is expected that decisions regarding applications for changes are taken within NHS England regional teams at a level proportionate to the change requested. There is no appeal or review process for the decision.

6. Finance

6.1 There are no financial implications arising directly from the recommendations of the report.

7. Communication and Engagement

7.1 Subject to the decision of the Board regarding the materiality of the changes to the Constitution. Members of the public and stakeholders have opportunity to comment on the proposed changes through the publication of this paper an revised Constitution on the ICB website and consideration at the meeting of the Board held in public.

8. Equality, Diversity and Inclusion

8.1 It is not envisaged that the proposed changes to the Constitution is likely to have any detrimental impact on or potentially discriminate against people from different characteristics groups

9. Climate Change / Sustainability

9.1 There are no implications arising directly from the recommendations of the report.

10. Next Steps and Responsible Person to take forward

10.1 Subject to the approval of the proposed amendments to the Constitution and progressing the application to NHS England to vary the Constitution, the Chief Executive with support from the Associate Director of Corporate Affairs and Governance will liaise with the NHS England Regional team and progress the formal application. Upon confirmation of approval to the proposed changes to the Constitution, Board members will be informed and confirmation provided within the Chief Executives Report to Board.

11. Officer contact details for more information

Matthew Cunningham
Associate Director of Corporate Affairs & Governance / Board Secretary
NHS Cheshire and Merseyside ICB

12. Appendices

Appendix One: draft ICB Constitution v1.2

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
V1.0	N/A	1 July 2022
V1.1	N/A	
V1.2	25 January 2024	tbc

CONTENTS

1. Introduction

1.1 Background/ Foreword

1.1.1 NHS England has set out the following as the four core purposes of ICSs:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

1.1.2 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.1.3 This Constitution describes how we are governed, where and how decisions are made and where more information can be found on our work.

We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer. Through NHS Cheshire and Merseyside Integrated Care Board's (~~ICB~~NHS Cheshire and Merseyside) work with our Health and Care Partnership, we are committed to tackling health inequalities and improving the lives of our poorest fastest. We believe we can do this best by working together to realise our shared ambitions to reduce health inequalities and improve the health of the 2.7 million people who live in our area and improving the quality of their health and care services.

To create the conditions for this to happen we must support and enable integrated working within our places and through our wider partnership. Sometimes we will be required to work across places or at system-level. When we work at a bigger scale than place we must be clear on our rationale for doing so.

Place is where our residents live their lives and receive the majority of their care, meaning it is where we, and partners, need to operate primarily and by default. Therefore, our approach to collaboration begins in our local communities, with our primary care networks in which GP practices work together, with community and social care services, to offer integrated health and care services to local people.

Our focus must be to move away from simply treating ill health to preventing it, to reducing health inequalities, and tackling the wider determinants of health. We want to work with the widest range of partners to achieve our ambitions. Not only statutory organisations but also the voluntary, community, faith and social enterprise sector.

NHS Cheshire and Merseyside is a statutory body charged with specific legal duties and functions. Our work is underpinned by the duty for NHS bodies and local authorities to co-operate, and it supports the triple aim - requiring NHS bodies to consider the effects of their decisions on the health and wellbeing of people and communities, the quality of services and the sustainable and efficient use of resources.

NHS Cheshire and Merseyside has been established to:

- develop a plan to meet the health and care needs of the population
- allocate resources to deliver the plan across the system
- ensure value for money, manage incidents and delegations from NHS England and Improvement
- deliver the NHS Constitution.

We are leaders of our organisation, our places and of our system, Cheshire and Merseyside.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Cheshire and Merseyside Integrated Care Board ("~~the ICB~~ NHS Cheshire and Merseyside").

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ~~ICB~~NHS Cheshire and Merseyside is co-terminous with the Borough of Cheshire East, Borough of Cheshire West and Chester, Borough of Halton, Borough of Knowsley, City of Liverpool, Borough of Sefton, Borough of St Helens, Borough of Warrington, and Borough of Wirral.

1.4 Statutory Framework

1.4.1 ~~The ICB~~ NHS Cheshire and Merseyside is established by order made by NHS England under powers in the 2006 Act.

1.4.2 ~~The ICB~~ NHS Cheshire and Merseyside is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of ~~the ICB~~ NHS Cheshire and Merseyside to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. ~~The ICB~~ NHS Cheshire and Merseyside is required to publish its constitution (section 14Z29). This constitution is published at www.cheshireandmerseyside.nhs.uk

1.4.5 ~~The ICB~~NHS Cheshire and Merseyside must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to all ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which ~~the ICB~~NHS Cheshire and Merseyside must comply with when exercising its functions. These duties include but are not limited to:

a) having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
b) exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
d) adult safeguarding and carers (the Care Act 2014);
e) equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); and
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000);
g) provisions of the Civil Contingencies Act 2004.

1.4.6 ~~The ICB~~ NHS Cheshire and Merseyside is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well ~~the ICB~~NHS Cheshire and Merseyside has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research),
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from ~~the ICB~~NHS Cheshire and Merseyside (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that ~~the ICB~~ NHS Cheshire and Merseyside is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 ~~The ICB~~NHS Cheshire and Merseyside was established on 1 July 2022 by the Integrated Care Boards (Establishment) Order 2022, which made provision for its constitution by reference to this document.

1.5.2 This constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England. ~~set out in writing at establishment.~~

1.5.3 Changes to this constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The constitution can only be varied in two circumstances:

a) where ~~the CB~~NHS Cheshire and Merseyside applies to NHS England in accordance with NHS England's published procedure and that application is approved; and

b) where NHS England varies the constitution of its own initiative, (other than on application by ~~the ICB~~NHS Cheshire and Merseyside).

1.6.2 The procedure for proposal and agreement of variations to the constitution is as follows:

a) the Chief Executive or Chair may periodically propose amendments to the constitution.
b) the Chief Executive, in consultation with the Chair, will present all proposed amendments to the ~~ICB~~ Board of NHS Cheshire and Merseyside so Board members can consider whether engagement with the Integrated Care Partnership (ICP) is required in accordance with 1.6.2(c).
c) ~~the ICB~~NHS Cheshire and Merseyside shall engage its partners, via the ICP, to discuss any proposed amendments that any Board member believes may materially affect:
   i) the operation of ~~the ICB~~NHS Cheshire and Merseyside or
   ii) its relationship with partners.
d) the proposed amendments shall be considered and approved by the ~~ICB~~ Board of ~~ICB~~NHS Cheshire and Merseyside before an application is submitted to NHS England. In considering the proposed amendments, Board Members are expected to apply knowledge of and a perspective from their sectors.
e) proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in ~~the ICB~~NHS Cheshire and Merseyside will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing orders**– which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published:

a) **The Scheme of Reservation and Delegation (SoRD)**– sets out those decisions that are reserved to the Board of ~~the ICB~~NHS Cheshire and Merseyside and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to. In support of the SORD an 'Operational Limits' SORD (OSoRD) has also been produced in order to help with the implementation of the agreed delegations at an operational level and setting out the limits for committees/officers as part of agreeing the approach to decision making in NHS Cheshire and Merseyside.

b) **Functions and Decision map** - a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ~~ICB's~~ financial affairs of NHS Cheshire and Merseyside.

d) **The ICB Corporate Governance Handbook**– this brings together all ~~the ICB's~~ of NHS Cheshire and Merseyside's governance documents so it is easy for interested people to navigate. It includes:

- the ~~above~~ documents as described in 1.7.3 a) – ~~c~~d)
- Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.
- delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- the up-to-date list of eligible providers of primary medical services under clause 3.6.2
- Committee Handbook.

e) Key policy documents which should also be included in the Corporate Governance Handbook or linked to it including:
   - Standards of Business Conduct Policy
   - Conflicts of Interest Policy and Procedures
   - Policy for Public Involvement and Engagement

2 Composition of the Board of the NHS Cheshire and Merseyside

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Board of NHS Cheshire and Merseyside ~~Integrated Care Board~~. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.cheshireandmerseyside.nhs.uk

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the Board" and members of the ICB are referred to as "Board Members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary Members.

2.1.4 The membership of the Board ~~ICB (the board)~~ of NHS Cheshire and Merseyside shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England policy requires ~~the ICB~~ NHS Cheshire and Merseyside to appoint the following additional Ordinary Members:

a) three executive members, namely:
   - Director of Finance
   - Medical Director
   - Director of Nursing.

b) at least two Non-Executive Members. The ICB has determined that it will have up to an additional 3 Non-Executive Members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below:

a) NHS Trusts and Foundation Trusts who provide services within the ICB's geographical area and are of a prescribed description;
b) the primary medical services (general practice) providers within the geographical area of the ICB and are of a prescribed description;
c) the local authorities which are responsible for providing social care and whose geographical area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board of NHS Cheshire and Merseyside membership

2.2.1 This ICB has the following ~~6~~ Partner Members:

a) 2 from section 2.1.6a - providing the ICB with access to a perspective and experience from acute or specialist and mental health care settings
b) 2 from section 2.1.6b - providing the ICB with access to a perspective and experience from primary care and general practice (as prescribed)
c) 2 from section 2.1.6c - providing the ICB with access to a perspective and experience from local authorities drawing upon the range of context, circumstance and communities that make up Cheshire and Merseyside.

2.2.2 ~~The ICB~~ NHS Cheshire and Merseyside has also ~~decided~~ determined that it will have an additional Ordinary Member (Partner Member) bringing the perspective of the Voluntary, Charitable, Faith and Social Enterprise (VCFSE) Sector. ~~to appointed the following further Ordinary Members to its Board:~~

~~a) 2 additional Non Executive Members~~

2.2.3 The Board of NHS Cheshire and Merseyside is therefore composed of the following members:

a) Chair
b) Chief Executive
c) ~~2~~ Partner member(s) NHS Trusts and Foundation Trusts
d) ~~2~~ Partner member(s) Primary Medical Services
e) ~~2~~ Partner member(s) Local Authorities
f) Partner member Voluntary, Charitable, Faith and Social Enterprise Sector
g) ~~4~~ Non-Executive Members
h) Director of Finance
i) Medical Director
j) Director of Nursing (known locally as the Director of Nursing and Care).

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The Board of NHS Cheshire and Merseyside will keep under review the skills, knowledge, and experience that it considers necessary for members of the Board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.2.6 Through its recruitment, nomination and appointment processes the Board of NHS Cheshire and Merseyside will be mindful of the benefit that a range of perspectives and breadth of geographical insights and experiences will secure and bring to its work and discussions. ~~The ICB~~ NHS Cheshire and Merseyside is committed to securing the broadest range of perspectives through its recruitment ensuring that ~~the~~ its Board is as representative of the communities it serves as practical and possible.

2.3 Regular participants and observers at the Board meetings of NHS Cheshire and Merseyside

2.3.1 The Board of NHS Cheshire and Merseyside may invite specified individuals to be regular participants or observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advance copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Participants will be seated at the Board table at Board meetings along with Board Members. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote. Named and equal participants will include:

a) an individual bringing knowledge of ~~Director of~~ Public Health / Population Health;
b) an individual bringing knowledge and perspective of Healthwatch;
~~An individual bringing knowledge and a perspective of the voluntary, community, faith and social enterprise sector;~~
c) ICB Executive Team members ~~– to be determined when roles and portfolios are agreed; and~~
d) ICB Place Directors ~~leads~~ as required and through rotation.

2.3.3 Observers will receive advance copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote. Observers will not be seated at the Board table for Board meetings unless invited to do so by the Chair.

2.3.4 Participants and / or observers may be asked to leave the meeting or part of a meeting by the Chair in the event that the Board passes a resolution to exclude the public (including representatives of the press) in accordance with the Public Bodies (Admission to Meetings) Act 1960 as per the Standing Orders.

3 Appointments process for the Board of NHS Cheshire and Merseyside

3.1 Eligibility criteria for Board membership:

3.1.1 Each member of the ~~ICB~~ Board of NHS Cheshire and Merseyside must:

a) comply with the criteria of the "fit and proper person test".
b) be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles).
c) fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification criteria for Board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a Board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

a) in or the United Kingdom of any offence which would constitute a criminal offence and the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office;

b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings;
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest; or
d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A Health Care Professional or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:
a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated;
b) the person's erasure from such a register, where the person has not been restored to the register;
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded; or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:
a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:
a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities); or
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:
a) the Chair will be independent.

3.3.3 Individuals will not be eligible if:
a) they hold a role in another health and care organisation within the ICB geographical area.
b) any of the disqualification criteria set out in 3.2 apply.

3.3.4 The usual term of office for the Chair will be three years and the total number of terms a Chair may serve is three terms.

3.3.5 In the first instance, at the time of ICB establishment, the Chair will be appointed for four years.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by and accountable to the Chair of NHS Cheshire and Merseyside with the approval of NHS England in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to the approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 In addition to criteria specified at 3.1, the Chief Executive must fulfil the following additional eligibility criteria:
a) be an employee of NHS Cheshire and Merseyside or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act.

3.4.4 Individuals will not be eligible if:
a) any of the disqualification criteria set out in 3.2 apply.
b) subject to clause 3.4.3(a), they hold any other employment or executive role.

3.5 Partner Member(s) - NHS Trusts and Foundation Trusts

3.5.1 These Partner Members are jointly nominated by the NHS Trusts and/or Foundation Trusts which provide services for the purposes of the health service within the geographical area of NHS Cheshire and Merseyside and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition. Those Trusts and Foundation Trusts are:
a) Alder Hey Children's NHS Foundation Trust;
b) Bridgewater Community Healthcare NHS Foundation Trust;
c) Cheshire and Wirral Partnership NHS Foundation Trust;
d) The Clatterbridge Cancer Centre NHS Foundation Trust;
e) Countess of Chester NHS Foundation Trust;
f) East Cheshire NHS Trust;
g) Liverpool Heart and Chest Hospital NHS Foundation Trust;
h) Liverpool University Hospitals NHS Foundation Trust;
i) Liverpool Women's Hospital NHS Foundation Trust;
j) Mersey Care NHS Foundation Trust;

k) Mersey and West Lancashire Teaching Hospitals NHS Trust
l) Mid Cheshire Hospital NHS Foundation Trust;
m) North West Ambulance Service NHS Foundation Trust
n) ~~St Helens and Knowsley Teaching Hospitals NHS Trust;~~
o) ~~Southport and Ormskirk Hospital NHS Trust~~;
p) The Walton Centre NHS Foundation Trust;
q) Wirral University Teaching Hospital NHS Foundation Trust;
r) Wirral Community NHS Foundation Trust; and
s) Warrington and Halton Hospitals NHS Foundation Trust.

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an Executive Director of one of the NHS Trusts or Foundation Trusts within the geographical area of NHS Cheshire and Merseyside.
b) one shall have specific knowledge, skills and experience of the provision of acute or specialist services
c) one shall have specific knowledge, skills and experience of the provision of mental health services such that the ICB complies with clause 2.2.4 of this constitution.
d) any other criteria as may be set out in any NHS England guidance.
e) any other criteria as may be agreed by NHS Cheshire and Merseyside.

3.5.3 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply.
b) any other criteria as may be set out in any NHS England guidance apply.
c) any locally determined exclusion criteria agreed by NHS Cheshire and Merseyside apply including:
   i. Compliance with the ICB Board Member Appointments Policy.

3.5.4 These members will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one Non-Executive Board Member and be supported by an HR professional.

3.5.5 The appointment process will be as follows:

a) NHS Cheshire and Merseyside will produce a role description and person specification for the roles. This will establish the requirement that the individual(s) must:
   i) bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board but they are not to act as delegates of those sectors; and
   ii) have the skills, knowledge, experience and attributes required to fulfil the role of board Member
b) NHS Cheshire and Merseyside will issue the role description and person specification to the Partner Member organisations listed at section 3.5.1 and establish a timeline for a selection and appointment process.
c) Joint nomination:
   - when a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make two nominations.

- the nomination of an individual must be seconded by one other eligible organisation.
- eligible organisations may nominate individuals from their own organisation or another organisation
- all eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within seven working days being deemed to constitute agreement. If they do agree, the list will be put forward to step d) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

d) Assessment, selection, and appointment subject to approval of the Chair under e):
- the full list of nominees will be considered by a panel convened by the Chair ~~Chief Executive~~
- the panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
- in the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

e) Chair's approval:
- the Chair will determine whether to approve the appointment of the most suitable nominee as identified under d).

3.5.6 The term of office for this Partner Member will be three years, however appointments may be for a shorter period to allow future appointments to be staggered and support continuity of Board membership on the Board. There is no limit on the number of terms an individual may serve but there is no automatic reappointment and an appointment process will be undertaken at the end of each term.

~~Initial appointments, on the creation of the ICB, may be for a shorter period than the usual three years. This will allow future appointments to be staggered and support continuity of membership on the board.~~

3.5.7 The appointment/reappointment process will be initiated by the Chair who will engage with the individual on their continuing availability before the process set out in 3.5.4 - 3.5.5 is commenced.

3.6 Partner Member(s) - Providers of Primary Medical Services.

3.6.1 These Partner Members are jointly nominated by providers of primary medical services for the purposes of the health service within the geographical ~~ICB's~~ area of NHS Cheshire and Merseyside, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Corporate Governance Handbook. The list will be kept up to date but does not form part of this Constitution

3.6.3 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) any other criteria as may be set out in any NHS England guidance
b) any other criteria as may be agreed by NHS Cheshire and Merseyside, including a requirement that:
   i. at least one of the Cheshire and Merseyside Primary Medical Services members will meet the criteria of the Primary Medical Services Partner Member as a General Practitioner and:
      a) hold a license to practice as a GP (on the GMC GP register) and be registered on the Performers List for England
      b) be a current provider of such services (practicing in Cheshire and Merseyside and for a period of not less than the preceding 24 months); and
      c) in accordance with b) work at least two sessions per week
   ii. one of the Cheshire and Merseyside Primary Medical Services members may be a practising primary care clinician or care professional[1] and:
      a) be a current provider of services (practicing in Cheshire and Merseyside and for a period of not less than the preceding 24 months).

3.6.4 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply.
b) any other criteria as may be set out in any NHS England guidance apply.
c) any locally determined exclusion criteria agreed by NHS Cheshire and Merseyside apply, including:
   i. compliance with the ICB Board Member Appointments Policy.

3.6.5 This member will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one Non-Executive Board Member and be supported by an HR professional.

3.6.6 The appointment process will be as follows:

a) NHS Cheshire and Merseyside will produce a role description and person specification for the roles. This will establish the requirement that the individual(s) must:
   i) bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board but they are not to act as delegates of those sectors; and
   ii) have the skills, knowledge, experience and attributes required to fulfil the role of board Member
b) NHS Cheshire and Merseyside will issue the role description and person specification to the Partner Member organisations listed at section 3.6.1 and establish a timeline for a selection and appointment process.
c) Joint nomination:

[1] Pharmacist, Physiotherapist, Dentist, Optometrist, Allied Health Professional, Social Care or other registered care professional

- when a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Corporate Governance Handbook will be invited to make two nominations.
- the nomination of an individual must be seconded by one other eligible organisation.
- eligible organisations may nominate individuals from their own organisation or another organisation.
- all eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within seven working days being deemed to constitute agreement. If they do agree, the list will be put forward to step d) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

d) Assessment, selection, and appointment subject to approval of the Chair under e)
- the full list of nominees will be considered by a panel convened by the Chair ~~Chief Executive~~
- the panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
- in the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

e) Chair's approval
- the Chair will determine whether to approve the appointment of the most suitable nominee as identified under d).

3.6.7 The term of office for this Partner Member will be three years, however appointments may be for a shorter period to allow future appointments to be staggered and support continuity of Board membership on the Board. There is no limit on the number of terms an individual may serve but there is no automatic reappointment and an appointment process will be undertaken at the end of each term.

~~Initial appointments, on the creation of the ICB, may be for a shorter period than the usual three years. This will allow future appointments to be staggered and support continuity of membership on the board.~~

3.6.8 The appointment / reappointment process will be initiated by the Chair who will engage with the individual on their continuing availability before the process set out in 3.6.4 - 3.6.5 is commenced.

3.7 Partner Member(s) - local authorities

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the geographical area of NHS Cheshire and Merseyside. Those local authorities are:

a) Borough of Cheshire East
b) Borough of Cheshire West and Chester

c) Borough of Halton
d) Borough of Knowsley
e) City of Liverpool
f) Borough of Sefton
g) Borough of St Helens
h) Borough of Warrington
i) Borough of Wirral.

3.7.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1.
b) any other criteria as may be set out in any NHS England guidance.
c) any other criteria as may be agreed by NHS Cheshire and Merseyside.

3.7.3 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply.
b) any other criteria as may be set out in any NHS England guidance apply.
c) any locally determined exclusion criteria agreed by NHS Cheshire and Merseyside apply including:
   i. Compliance with the ICB Board Member Appointments Policy.

3.7.4 This member will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one non-executive board Member and be supported by an HR professional.

3.7.5 The appointment process will be as follows:

a) NHS Cheshire and Merseyside will produce a role description and person specification for the roles. This will establish the requirement that the individual(s) must:
   i) bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the Board but they are not to act as delegates of those sectors; and
   ii) have the skills, knowledge, experience and attributes required to fulfil the role of Board member.
b) NHS Cheshire and Merseyside will issue the role description and person specification to the Partner Member organisations listed at section 3.7.1 and establish a timeline for a selection and appointment process.
c) Joint Nomination:
   - when a vacancy arises, each eligible organisation listed at 3.7.1. will be invited to make two nominations.
   - the nomination of an individual must be seconded by one other eligible organisation.
   - eligible organisations may nominate individuals from their own organisation or another organisation
   - all eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure

to confirm within seven working days being deemed to constitute agreement. If they do agree, the list will be put forward to step d) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

d) Assessment, selection, and appointment subject to approval of the Chair under e)
   - the full list of nominees will be considered by a panel convened by the Chair ~~Chief Executive~~
   - the panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
   - in the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

e) Chair's approval
   - the Chair will determine whether to approve the appointment of the most suitable nominee as identified under d).

3.7.6 The term of office for this Partner Member will be three years, however appointments may be for a shorter period to allow future appointments to be staggered and support continuity of Board membership on the Board. There is no limit on the number of terms an individual may serve but there is no automatic reappointment and an appointment process will be undertaken at the end of each term.

~~Initial appointments, on the creation of the ICB, may be for a shorter period than the usual three years. This will allow future appointments to be staggered and support continuity of membership on the board.~~

3.7.7 The appointment / reappointment process will be initiated by the Chair who will engage with the individual on their continuing availability before the process set out in 3.7.4 - 3.7.5 is commenced.

3.8 Partner Member – Voluntary, Charitable, Faith and Social Enterprise Sector (VCFSE)

3.8.1 These Partner Members are jointly nominated by VCFSE organisations who provide services for the purposes of improving the health and care of the population of Cheshire and Merseyside.

3.8.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be the Chief Executive or hold a relevant senior leadership level role with significant experience of health and care in a VCFSE organisation as listed in 3.8.1.
b) any other criteria as may be set out in any NHS England guidance.
c) any other criteria as may be agreed by NHS Cheshire and Merseyside.

3.8.3 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply.

b) any other criteria as may be set out in any NHS England guidance apply.
c) any locally determined exclusion criteria agreed by the ICB apply including:
ii. Compliance with the ICB Board Member Appointments Policy.

3.8.4 This member will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one Non-Executive Board Member and be supported by an HR professional.

3.8.5 The appointment process will be as follows:

a) NHS Cheshire and Merseyside will produce a role description and person specification for the role. This will establish the requirement that the individual(s) must:
   i) bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the Board but they are not to act as delegates of those sectors; and
   ii) have the skills, knowledge, experience and attributes required to fulfil the role of Board member.

b) NHS Cheshire and Merseyside will issue the role description and person specification to the partner member organisations within scope as listed at section 3.8.1 and establish a timeline for a selection and appointment process.

c) Joint Nomination:
   - when a vacancy arises, each eligible organisation listed at 3.8.1. will be invited to make two nominations.
   - the nomination of an individual must be seconded by one other eligible organisation.
   - eligible organisations may nominate individuals from their own organisation or another organisation
   - all eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within seven working days being deemed to constitute agreement. If they do agree, the list will be put forward to step d) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

d) Assessment, selection, and appointment subject to approval of the Chair under e)
   - the full list of nominees will be considered by a panel convened by the Chair
   - the panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3
   - in the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

e) Chair's approval:
   - the Chair will determine whether to approve the appointment of the most suitable nominee as identified under d).

3.8.6 The term of office for this Partner Member will be three years, however appointments may be for a shorter period to allow future appointments to be staggered and support continuity of Board membership on the Board. There is no limit on the number of terms an individual may serve but there is no automatic reappointment and an appointment process will be undertaken at the end of each term.

3.8.7 The appointment / reappointment process will be initiated by the Chair who will engage with the individual on their continuing availability before the process set out in 3.8.4 - 3.8.5 is commenced.

3.9 Medical Director

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an employee of NHS Cheshire and Merseyside or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) be a registered Medical Practitioner.
c) any other criteria as may be set out in any NHS England guidance.
d) any other criteria as may be agreed by NHS Cheshire and Merseyside, including:
   i. be a member of a recognised professional medical body.

3.9.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply.
b) any other criteria as may be set out in any NHS England guidance apply.
c) any locally determined exclusion criteria agreed by NHS Cheshire and Merseyside apply including:
   i. compliance with the ICB Board Member Appointments Policy.

3.9.3 This member will be appointed by an ICB appointments panel subject to the approval of the Chief Executive ~~Chair~~. Membership of the appointments panel should be determined by the Chief Executive in consultation with the ICB Chair ~~and Chief Executive~~ but must include at least one Non-Executive Board Member and be supported by an HR professional.

3.10 Director of Nursing and Care

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an employee of NHS Cheshire and Merseyside or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) be a registered Nurse
c) any other criteria as may be set out in any NHS England guidance.
d) any other criteria as may be agreed by NHS Cheshire and Merseyside including:
   i. be a member of a recognised professional nursing body.

3.10.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply.
b) any locally determined exclusion criteria agreed by NHS Cheshire and Merseyside apply including:
   i. compliance with the ICB Board Member Appointments Policy
c) Any other criteria as may be set out in any NHS England guidance apply.

3.10.3 This member will be appointed by an ICB appointments panel subject to the approval of the Chief Executive ~~Chair~~. Membership of the appointments panel should be determined by the Chief Executive in consultation with the ICB Chair ~~and Chief Executive~~ but must include at least one Non-Executive Board Member and be supported by an HR professional.

3.11 Director of Finance

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) be an employee of NHS Cheshire and Merseyside or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) any other criteria as may be set out in any NHS England guidance.
c) any other criteria as may be agreed by NHS Cheshire and Merseyside, including:
   i. be a member of a recognised professional accountancy body.

3.11.2 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply.
b) any locally determined exclusion criteria agreed by NHS Cheshire and Merseyside apply including:
   i. compliance with the ICB Board Member Appointments Policy
c) Any other criteria as may be set out in any NHS England guidance apply.

3.11.3 This member will be appointed by an ICB appointments panel subject to the approval of the Chief Executive ~~Chair~~. Membership of the appointments panel should be determined by the Chief Executive in consultation with the ICB Chair ~~and Chief Executive~~ but must include at least one Non-Executive Board Member and be supported by an HR professional.

3.12 ~~Four~~ Non-Executive Members

3.12.1 NHS Cheshire and Merseyside will appoint a minimum of ~~four~~ two Non-Executive Members.

3.12.2 These members will be appointed by an ICB appointments panel subject to the approval of the Chair. Membership of the appointments panel should be determined by the Chair and Chief Executive but must include at least one Non-Executive Board member and be supported by an HR professional.

3.12.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) not be employee of NHS Cheshire and Merseyside or a person seconded to the ICB.
b) not hold a role in another health and care organisation in the ICS area.
c) one shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee.
d) another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.
e) meet the requirements as set out in the Non-Executive Member Person Specification
f) any other criteria as may be set out in any NHS England guidance.
g) any other criteria as may be agreed by NHS Cheshire and Merseyside.

3.12.4 Individuals will not be eligible if:
a) any of the disqualification criteria set out in 3.2 apply.
b) they hold a role in another health and care organisation within the ICB area.
c) any locally determined exclusion criteria agreed by NHS Cheshire and Merseyside apply including:
i. compliance with the ICB Board Member Appointments Policy.
d) any other criteria as may be set out in any NHS England guidance apply.

3.12.5 The term of office for a Non-Executive member will be three years however appointments may be for a shorter period to allow future appointments to be staggered and support continuity of Board membership on the Board. The total number of terms an individual may serve is three (up to a total of nine years).

~~Initial appointments, on the creation of the ICB, may be for a shorter period than the usual three years. This will allow future appointments to be staggered and support continuity of membership on the board.~~

3.12.6 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-Executive Member up to the maximum number of terms permitted for their role.

3.12.7 One of the Non-Executive Members, other than the Chair of the Audit Committee, will be appointed to the position of Deputy Chair of the ICB Board. Appointment to the position of Deputy Chair will be undertaken by the Chair following an application and interview process. The term of office will be agreed with the Chair and individual and will be in line with the existing agreed term of the individual. A key role for the Deputy Chair will be to undertake the appraisal of the ICB Chair and to collate the multi-stakeholder feedback for the Regional NHS England Director to undertake and sign off the appraisal conversation It is also expected that the Deputy Chair will take responsibility for ensuring the compliance of the Chair with the Fit and Proper Person Test and making the return to the Regional NHS England Director for their sign-off.

3.13 Board members: removal from office.

3.13.1 Arrangements for the removal from office of Board members is subject to the term of appointment, and application of the relevant policies and procedures of NHS Cheshire and Merseyside. In accordance with 3.12.3, the Chief Executive

may suspend the membership of any Board Member other than the Chair if they believe any of the criteria outlined at 3.12.3 apply. If any of these criteria apply to the Chair, the Chief Executive shall inform NHS England which shall determine the necessary steps to suspend the Chair and undertake any necessary investigation.

3.13.2 With the exception of the Chair, Board Members shall be removed from office if any of the following occurs:

a) if they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance
b) if they fail to attend a minimum of 50% of the meetings to which they are invited over a six-month period unless agreed with the Chair in extenuating circumstances
c) if they are deemed to not meet the expected standards of performance at their annual appraisal
d) if they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of NHS Cheshire and Merseyside and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any Board or employees of NHS Cheshire and Merseyside (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) if they are deemed to have failed to uphold the Nolan Principles of Public Life
f) if they are subject to disciplinary action by a regulator or professional body.

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.12.2 apply. Such investigations will be undertaken by a Panel convened by the Chief Executive and Chair, the membership of which must include an HR professional. The outcome of any such investigation will be reported to the Board of NHS Cheshire and Merseyside for approval.

3.13.4 Executive Directors (including the Chief Executive) will cease to be Board Members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.5 The Chair of NHS Cheshire and Merseyside may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.6 If NHS England is satisfied that NHS Cheshire and Merseyside is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

3.13.6.1 terminate the appointment of the ICB's Chief Executive; and

3.13.6.2 direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of appointment of Board members

3.14.1 With the exception of the Chair, arrangements for remuneration and any allowances will be agreed by the ICB Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published at www.cheshireandmerseyside.nhs.uk and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-Executive Members will be set by Remuneration Committee members other than the Non-Executive Members of the ICB.

3.14.2 Other terms of appointment will be determined by the Remuneration Committee.

3.14.3 Terms of appointment of the Chair will be determined by NHS England.

~~3.15 Specific arrangements for appointment of Ordinary Members made at establishment~~

~~3.15.1 Individuals may be identified as "designate Ordinary Members" prior to the ICB being established.~~

~~3.15.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5-3.7~~

~~3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate Ordinary Members should follow, as far as possible, the processes set out in section 3.5-3.12 of this constitution. However, a modified process, agreed by the Chair, will be considered valid.~~

~~3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and one other will appoint the Ordinary Members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.~~

~~3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial Ordinary Members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12~~

4 Arrangements for the exercise of our functions.

4.1 Good governance

4.1.1 NHS Cheshire and Merseyside will, 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.

4.1.2 NHS Cheshire and Merseyside has agreed standards of business conduct which set out the expected behaviours that members of the Board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB Standards of Business Conduct Policy is published in the Corporate Governance Handbook.

4.2 General

4.2.1 NHS Cheshire and Merseyside will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care;
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England;
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England; and
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 NHS Cheshire and Merseyside will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Corporate Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to act

4.3.1 NHS Cheshire and Merseyside is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees.
b) a committee or sub-committee of NHS Cheshire and Merseyside.

4.3.2 Under section 65Z5 of the 2006 Act, NHS Cheshire and Merseyside may arrange with another ICB, an NHS Trust, NHS Foundation Trust, NHS England, a Local Authority, Combined Authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where NHS Cheshire and Merseyside and other body(s) enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, NHS Cheshire and Merseyside may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the Board of NHS Cheshire and Merseyside must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 NHS Cheshire and Merseyside has agreed a scheme of reservation and delegation (SoRD) which is published in full at www.cheshireandmerseyside.nhs.uk

4.4.2 Only the Board of NHS Cheshire and Merseyside may agree the SoRD and amendments to the SoRD may only be approved by the Board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the Board of NHS Cheshire and Merseyside;
b) those functions that have been delegated to an individual or to committees and sub committees of NHS Cheshire and Merseyside; and
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 NHS Cheshire and Merseyside remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 NHS Cheshire and Merseyside has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published at www.cheshireandmerseyside.nhs.uk

4.5.3 The map includes:

a) key functions reserved to the Board of NHS Cheshire and Merseyside;
b) commissioning functions delegated to committees and individuals;
c) commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; and
d) functions delegated to NHS Cheshire and Merseyside (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 NHS Cheshire and Merseyside may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees ~~and sub-committees~~ are listed in the SoRD. Sub-committees with delegated decision making authority will also be listed in the SORD.

4.6.3 Each committee ~~and sub-committee~~ established by the Board of NHS Cheshire and Merseyside operates under terms of reference agreed by the Board. All terms of reference are published in the Corporate Governance Handbook. All sub-committee terms of reference will need to be agreed by the relevant Committee of the Board.

4.6.4 NHS Cheshire and Merseyside remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:

a) submit regular reports of their business to the Board or Committees of NHS Cheshire and Merseyside.
b) make minutes of their meetings available to the ICB.
c) prepare an annual report outlining how it has delivered its responsibilities and submit this to the ICB.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not Board Members or employees of NHS Cheshire and Merseyside.

4.6.6 All members of committees and sub-committees that exercise the commissioning functions of NHS Cheshire and Merseyside will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the Standing Financial Instructions and any other relevant NHS Cheshire and Merseyside policy.

4.6.8 The following statutory committees will be maintained:

a) **Audit Committee:** This committee is accountable to the Board of NHS Cheshire and Merseyside and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.
The Audit Committee will be chaired by a Non-Executive Member of NHS Cheshire and Merseyside (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee:** This committee is accountable to the Board of NHS Cheshire and Merseyside for matters relating to remuneration, fees and

other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.
The Remuneration Committee will be chaired by a Non-Executive Member of NHS Cheshire and Merseyside other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Corporate Governance Handbook.

4.6.10 The Board of NHS Cheshire and Merseyside has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Corporate Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 NHS Cheshire and Merseyside may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS Trust, NHS Foundation Trust, Local Authority, Combined Authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the NHS Cheshire and Merseyside Scheme of Reservation and Delegation (SoRD) and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board of NHS Cheshire and Merseyside.

4.7.4 The Board of NHS Cheshire and Merseyside remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Corporate Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, NHS Cheshire and Merseyside may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for making decisions

5.1 Standing Orders

5.1.1 NHS Cheshire and Merseyside has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB;
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of NHS Cheshire and Merseyside unless specified otherwise in terms of reference which have been agreed by the Board of NHS Cheshire and Merseyside.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 NHS Cheshire and Merseyside has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published at www.cheshireandmerseyside.nhs.uk.

6 Arrangements for conflict of interest management and standards of business conduct

6.1 Conflicts of interest

6.1.1 As required by section 14Z30 of the 2006 Act, NHS Cheshire and Merseyside has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 NHS Cheshire and Merseyside has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website at www.cheshireandmerseyside.nhs.uk

6.1.3 All Board, committee and sub-committee members, and employees of NHS Cheshire and Merseyside, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by NHS Cheshire and Merseyside.

6.1.4 All delegation arrangements made by NHS Cheshire and Merseyside under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of NHS Cheshire and Merseyside and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy.

6.1.6 NHS Cheshire and Merseyside has appointed one of its Non-Executive Members to be the Conflicts of Interest Guardian. In collaboration with the ICB's most senior governance lead, their role is to:

a) act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation; and
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions NHS Cheshire and Merseyside will abide by the following principles. All NHS Cheshire and Merseyside staff and members will:

a) comply with the requirements of the NHS Constitution and NHS Cheshire and Merseyside Constitution and be aware of the responsibilities outlined within them;
b) act in good faith and in the interests of the Cheshire and Merseyside ICS – including NHS Cheshire and Merseyside and place-based partnerships;
c) adhere to the 'Seven Principles of Public Life (the Nolan Principles), and the NHS Code of Conduct and Code of Accountability (2004)2, maintaining strict ethical standards; and
d) comply with NHS Cheshire and Merseyside policies on Business Conduct and managing Conflicts of Interest.

6.3 Declaring and registering interests

6.3.1 NHS Cheshire and Merseyside maintains registers of the interests of:

a) members of the Board of NHS Cheshire and Merseyside.
b) members of NHS Cheshire and Merseyside committees and sub-committees
c) its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published at www.cheshireandmerseyside.nhs.uk

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1.

6.3.6 NHS Cheshire and Merseyside will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board members, employees, committee and sub-committee members of NHS Cheshire and Merseyside will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;
b) follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles); and
c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Board Members are expected to commit to:

a) the values of the NHS Constitution.
b) promoting equality, diversity, inclusion
c) promoting human rights in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible.
d) acting strategically while being informed by operational context.
e) being open to challenge and when challenging delivering this in a supportive way.
f) acting in a supportive and empowering way.
g) being approachable and open.

6.4.3 Individuals contracted to work on behalf of NHS Cheshire and Merseyside or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7 Arrangements for ensuring accountability and transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 The ICB will:

- publish its intentions and operating procedures for involving people and communities.
- involve people and communities in commissioning services for NHS patients, in accordance with our duties under section 14Z2 of the 2006 Act, and as set out in more detail in the ICB's Engagement and Communications strategy.
- undertake and oversee public consultation in line with legal duties.

7.3 Meetings and publications

7.3.1 NHS Cheshire and Merseyside Board and committee meetings which are composed entirely of Board members or which include all Board members will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 NHS Cheshire and Merseyside will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and Corporate Governance Handbook will be published as well as other key documents including but not limited to:

- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Registers of interests
- Scheme of Reservation and Delegation
- Key policies.

7.3.8 NHS Cheshire and Merseyside will publish, with our partner NHS Trusts and NHS Foundation Trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how NHS Cheshire and Merseyside proposes to discharge its duties under:

- section 14Z34 to 14Z45 (general duties of integrated care boards), and

- sections 223GB and 223N (financial duties).

and

- proposed steps to implement the Cheshire East, Cheshire West and Chester;; Halton; Knowsley; Liverpool City; Sefton; St Helens; Warrington and Wirral joint local health and wellbeing strategies.

7.4 Scrutiny and decision-making

7.4.1 ~~Five~~ Non-Executive Members will be appointed to the Board of NHS Cheshire and Merseyside including the Chair; and all of NHS Cheshire and Merseyside's Board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Regulation ~~Test~~.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 NHS Cheshire and Merseyside will comply with the requirements of the NHS Provider Selection Regime ~~once it is introduced~~, and will comply with existing procurement rules until the Provider Selection Regime comes into effect including:

a) following NHS policy
b) promoting the NHS and its statutory partners.
c) achieving best value.
d) delivering for Cheshire and Merseyside while utilising and drawing upon the expertise within the ICS and securing the best possible outcomes for residents.

7.4.4 NHS Cheshire and Merseyside will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 NHS Cheshire and Merseyside will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007

8 Arrangements for determining the terms and conditions of employees.

8.1.1 NHS Cheshire and Merseyside may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The Board of NHS Cheshire and Merseyside has established a Remuneration Committee which is chaired by a Non-Executive Member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the Board. Committee members must never consider their own remuneration or allowances so the committee membership must be sufficiently broad to enable it to operate while effectively managing such conflicts of interest. No employees may be a member of the Remuneration Committee but the Board ensures that the Remuneration Committee has access to appropriate advice by:

a) ~~ICS~~ ICB HR team or their suppliers.
b) Independent HR advisers being in attendance to support the committee.

8.1.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board of NHS Cheshire and Merseyside.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published at www.cheshireandmerseyside.nhs.uk

8.1.6 The duties of the Remuneration Committee include:

a) setting the ICB pay policy (or equivalent) and standard terms and conditions;
b) making arrangements to pay employees such remuneration and allowances as it may determine;
c) setting remuneration and allowances for members of the board;
d) setting any allowances for members of NHS Cheshire and Merseyside committees or sub-committees ~~of the ICB~~ who are not members of the Board;
e) consideration of the evaluation and appraisal of the Executive Directors;
f) consideration and approval of any severance payments on termination of office;
g) ensuring compliance with the requirements for disclosure of directors' remuneration in the annual report and accounts; and
h) any other relevant duties.

8.1.7 NHS Cheshire and Merseyside may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for public involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act NHS Cheshire and Merseyside has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the ICB
b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them
c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act NHS Cheshire and Merseyside has made the following arrangements to consult its population on its system plan:

a) engagement with local Healthwatch.
b) engagement with the Voluntary, Community and Faith Sector.
c) public engagement via Place-based communications and engagement networks.
d) engagement with Health and Wellbeing Boards and Local Authority Health Scrutiny Committees.

9.1.3 NHS Cheshire and Merseyside has adopted the ten principles set out by NHS England for working with people and communities:

a) put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
d) build relationships with excluded groups – especially those affected by inequalities.
e) work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
f) provide clear and accessible public information about vision, plans and progress to build understanding and trust.
g) use community development approaches that empower people and communities, making connections to social action.
h) use co-production, insight and engagement to achieve accountable health and care services.
i) co-produce and redesign services and tackle system priorities in partnership with people and communities.
j) learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements, include collaborating with ICS system partners to develop appropriate mechanisms for the involvement of people and communities such as but not limited to:

- ICS wide and Place-Based Citizens' Panels;
- experts-by-Experience and Patient Leadership roles;
- Health Champions' networks;
- engagement forums; and
- co-production groups.

Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution
Committee	A committee created and appointed by the ICB board.
Director of Nursing and Care	The ICB role that satisfies the requirement for a "Director of Nursing" as stated at section 2.1.5
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
ICB Board	~~Members of the ICB~~ Board of NHS Cheshire and Merseyside Integrated Care Board
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
NHS Cheshire and Merseyside	The name of the Integrated Care Board covering the geographical area of Cheshire and Merseyside and its nine places within
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve as a minimum representatives of the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.

Partner Member	Some of the Ordinary Members will also be known as Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area. • organisations from the Voluntary, Charitable, Faith and Social Enterprise (VCFSE) Sector who provide services for the purposes of improving the health and care of the population of Cheshire and Merseyside.
Sub-Committee	A committee created and appointed by and reporting to a committee of the ICB

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside') so that NHS Cheshire and Merseyside can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of ~~the ICB's~~ Constitution of NHS Cheshire and Merseyside.

2. Amendment and review

2.1. The Standing Orders are effective from 1 July 2022.

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per section 1.6 of the ~~ICB's~~ Constitution.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These standing orders apply to all meetings of the Board of NHS Cheshire and Merseyside, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the Board, members of committees and sub-committees and all employees of NHS Cheshire and Merseyside, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the ICB Chair, supported with advice from the ICB's senior governance lead, will provide a settled view which shall be final.

3.5. All members of the board, its committees and sub-committees and all employees of NHS Cheshire and Merseyside have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the

circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of NHS Cheshire and Merseyside for action or ratification and the Audit Committee for review.

4. Meetings of the ~~Integrated Care~~ Board of NHS Cheshire and Merseyside

4.1. Calling Board meetings

4.1.1. Meetings of the Board of NHS Cheshire and Merseyside shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2. In normal circumstances, each member of the Board of NHS Cheshire and Merseyside will be given not less than one month's notice in writing of any meeting to be held. However:

a) the Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) a majority of the members of the Board of NHS Cheshire and Merseyside may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) in emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of NHS Cheshire and Merseyside and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board of NHS Cheshire and Merseyside.

4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair of the ICB Board ~~a non-executive member of the ICB board other than the Audit Committee Chair~~ will take on the role and responsibility of chairing the Board meeting or agenda item in question. The ~~non executive member~~ Deputy Chair will not be expected to undertake the other duties of the ICB Chair when deputising in this way. If both the Chair and Deputy Chair are disqualified at the same time from participating by a conflict of interest the one of the other Non-Executive members on the ICB board other

than the Audit Committee Chair will take on the role and responsibility of chairing the Board meeting or agenda item in question.

4.2.3 The Board of NHS Cheshire and Merseyside shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.cheshireandmerseyside.nhs.uk

4.4. Petitions

4.4.1 ~~Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board in accordance with the ICB policy as published in the Governance Handbook.~~ NHS Cheshire and Merseyside welcomes petitions and recognises that petitions are one way in which the citizens of Cheshire and Merseyside and those accessing services commissioned by NHS Cheshire and Merseyside can let us know of their concerns. The ICB will treat as a petition any communication which is signed by or sent to it on behalf of a number of people and which relates specifically to services that the ICB is responsible for commissioning. For practical purposes, the ICB sets the following requirements before considering a valid petition:

Category	Brief Description	Signatory Threshold
Ordinary petition	A petition requesting action by the ICB	1,000
Petition requiring response	Any petition above a set threshold which requests an action or response by the Executive Team of NHS Cheshire and Merseyside	10,000
Petition requiring debate	Any petition above a set threshold which will require the petition to be considered for debate at the next available meeting of the Board or System Primary care Committee of NHS Cheshire and Merseyside	50,000

4.4.2 Written petitions can be sent to: Board Secretary, NHS Cheshire and Merseyside, No1 Lakeside, Centre Park, Warrington,WA1 1QY

4.5. Nominated deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Director Members and regular participants may nominate a deputy to attend a meeting of the Board of NHS Cheshire and Merseyside that they are unable to attend. Executive Director Members and regular participants should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. For Executive Director Members on the Board the deputy may speak and vote on their behalf.

4.5.2 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6. Virtual attendance at meetings

4.6.1 ~~The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means, when necessary, unless the terms of reference prohibit this.~~ Use of video, telephone or other electronic communication means to conduct meetings of the Board of NHS Cheshire and Merseyside, its committees and sub-committees are permissible with prior agreement of the Chair of the meeting. The Chair of the meeting will take into account the difficulties that might be posed to ensure proper access by attendees to the meeting should it, on occasion, be necessary to hold remote meetings and will make adjustments where possible.

4.7. Quorum

4.7.1 The quorum for meetings of the Board of NHS Cheshire and Merseyside will be a majority of members (eight), including:

a) the Chair and Chief Executive or their designated deputies;
b) at least one Executive Director (in addition to the Chief Executive or their nominated deputy);
c) at least one Non-Executive Member;
d) at least one Partner Member; and
e) at least one member who has a clinical background or qualification.

4.7.2 For the sake of clarity:

a) no person can act in more than one capacity when determining the quorum.
b) an individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum as outlined in 4.7.1 (or the figure required to achieve a majority in accordance with 4.9.2, should that be required).

4.7.3 For all committees and sub-committees of NHS Cheshire and Merseyside, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8. Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB Board is not affected by any vacancy among members of the Board of NHS Cheshire and Merseyside or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

- the Chair, in agreement with at least one Non-Executive Board Member, may nominate a suitably qualified / experienced person to cover a vacant position on the Board until a full selection and appointment process can be undertaken.
- any such nomination shall be subject to endorsement by the Board.
- should there be a vacancy in the Chair position, the ICB shall seek approval from NHS England to appoint a suitably qualified / experienced person to cover the position on the board until a full selection and appointment process can be undertaken.

4.9. Decision-making

4.9.1 NHS Cheshire and Merseyside has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally it is expected that decisions of the ICB Board will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) all members of the Board of NHS Cheshire and Merseyside who are present at the meeting and are not precluded from taking part in a decision by reason of a conflict of interest will be eligible to cast one vote each.

b) in no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) for the sake of clarity, any additional participants and observers (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.

d) a resolution will be passed if more votes are cast for the resolution than against it.

e) if an equal number of votes are cast for and against a resolution, then the ICB Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful, NHS Cheshire and Merseyside may draw on third-party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case of urgent decisions being required to be undertaken on areas where the powers to make decisions are reserved or delegated to the Board of NHS Cheshire and Merseyside, and in extraordinary circumstances, every attempt will be made for the Board of NHS Cheshire and Merseyside to meet virtually. Where this is not possible the following will apply.

4.9.5 The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director, having consulted the lead Non-Executive Member in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the Board of NHS Cheshire and Merseyside for formal ratification and the Audit Committee for oversight.

4.10. Minutes

4.10.1 The names and roles of all members of and regular participants present to the Board meetings of NHS Cheshire and Merseyside shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the Board of NHS Cheshire and Merseyside and all meetings of its committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2 NHS Cheshire and Merseyside may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest

by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting suppress to prevent disorderly conduct or behaviour. In circumstances of disorderly conduct or behaviour the Chair of the meeting reserves the right to cease the meeting.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the Members of the Board of NHS Cheshire and Merseyside.

5. Suspension of Standing Orders

5.1.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members of the Board of NHS Cheshire and Merseyside.

5.1.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.1.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents.

6.1.1 NHS Cheshire and Merseyside may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

- the Chief Executive;
- the ICB Chair; and
- the Director of Finance.

6.1.2 The ICB senior Governance Lead shall keep a register of every sealing made and numbered consecutively in a book for that purpose. A report of all sealings shall be made to the Board of NHS Cheshire and Merseyside ~~ICB~~ at least bi-annually.

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Women's Hospital Services in Liverpool – Revised Committee Terms of Reference

Agenda Item No: ICB/01/24/23

Responsible Directors: Chris Douglas, Director of Nursing and Care

Women's Hospital Services in Liverpool Committee Terms of Reference

1. Purpose of the Report

1.1 Further to the 'Women's Hospital Services in Liverpool – Governance Refresh' paper received by Board in November 2023, this paper requires the Board to approve a new set of Terms of Reference for the Women's Hospital Services in Liverpool Committee, a subcommittee of NHS Chesire & Merseyside.

1.2 On 17 January 2024, the Women's Hospital Services in Liverpool Committee received and approved a paper about the Programme Definition and Governance Arrangements, and the Terms of Reference for the new provider-led Programme Board. which will work on behalf of the Committee to develop long term plans for women's hospital services in Liverpool.

1.3 The Programme Board will work on behalf of the Committee to develop long term plans and proposals for women's hospital services in Liverpool. Consequently, the Committee now has a more focussed Terms of Reference and these need to be authorised and approved by the Board.

2. Executive Summary

2.1 The primary purpose of the Women's[1] Hospital Services in Liverpool Programme is to:

Develop a clinically sustainable model of care for hospital-based maternity and gynaecology services that are delivered in Liverpool.

2.2 This will involve:

- understanding all the clinical sustainability challenges hospital-based maternity and gynaecology services in Liverpool face;
- exploring potential solutions for how those challenges can be addressed and resolved in the short, medium, and long term;
- undertaking an options appraisal of the viable solutions for making these hospital services clinically sustainable for the future; and
- making recommendations to the Board of NHS Cheshire and Merseyside (C&M).

[1] It is important to acknowledge that it is not only people who identify as women (or girls) who access women's health and reproductive services to maintain their sexual and reproductive health and wellbeing. The terms 'woman' and 'women's health' are used for brevity, on the understanding that transmen and non-binary individuals assigned female at birth also require access to these services. Delivery of care must therefore be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

2.5 The Women's Services Committee, a subcommittee of NHS Cheshire & Merseyside, was established in February 2023 to oversee the programme.

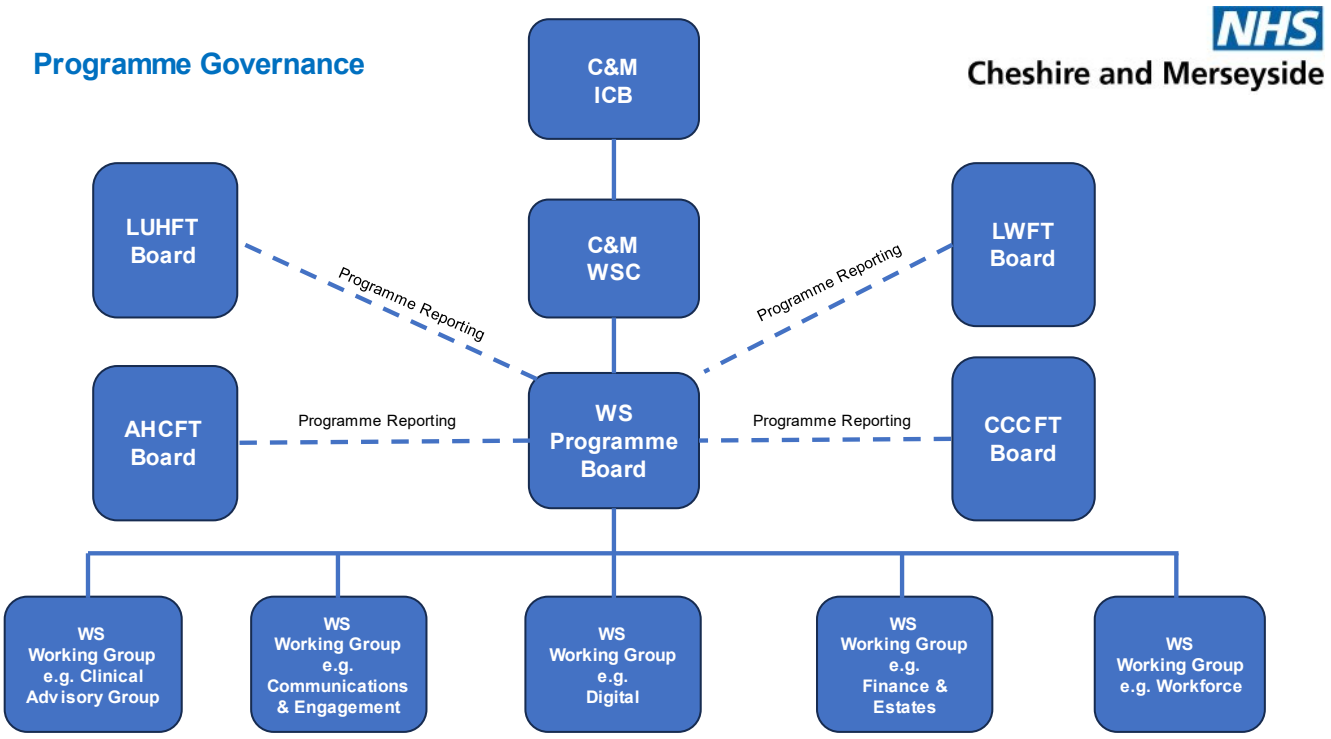
2.6 The Committee has since established a provider-led Programme Board and approved the Programme Board's Terms of Reference and the Programme Definition and Governance Arrangements, at its meeting on 17.01.24.

2.7 The Committee has revised Terms of Reference given the establishment of the Programme Board; these now require authorisation and approval from the ICB.

2.8 The Terms of Reference for the Committee are attached at Appendix 1.

2.9 The paper 'Programme Definition and Governance Arrangements' is attached at Appendix 2 and is for information.

2.10 The programme governance is illustrated below.



3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- note the establishment of the Programme Board and the Programme Definition and Governance Arrangements.
- approve the revised Terms of Reference for the Women's Hospital Services in Liverpool Committee.

4. Reasons for Recommendations

4.1 The Terms of Reference for the Women's Hospital Services in Liverpool Committee have been revised to reflect the establishment of the Programme Board and the separation of programme delivery and assurance functions.

4.2 The Committee can therefore focus on:

- seeking assurance on the work of the programme board including delivery of the programme plan and following due process.
- managing the commissioner aspects of the service change assurance process.
- engaging with system stakeholders including local authorities and OSCs.
- appraising the programme business case including the case for change, proposed model of care, options appraisal, financial modelling, and impact assessments.

5. Background

5.1 NHS Cheshire and Merseyside Integrated Care Board (C&M ICB) is the lead commissioner for hospital-based maternity and gynaecology services in Liverpool, along with specialised commissioners from NHS England.

5.2 A Women's Services Committee (WSC) – now the Women's Hospital Services in Liverpool Committee - a sub-committee of the Cheshire and Merseyside ICB, was set up in February 2023 to oversee the women's services work programme, following the recommendations of the Liverpool Clinical Services Review. The Committee is chaired by Raj Jain, who is also chair of the ICB. The original Terms of Reference for the WSC were approved by the C&M ICB on 25 May 2023.

5.3 In August 2023, an Independent Clinical Lead and Programme Director were appointed and have been supporting mobilisation of the programme, including developing the draft programme definition and considering the operational arrangements for delivery.

5.4 In September, the interim Chief Executive arrangements for Liverpool Women's FT were confirmed, and it was agreed that these arrangements also need to be considered in the organisation of the programme.

5.5 During October 2023, further discussions were held to reflect on the current programme structure and governance and to consider how these could be improved to ensure clarity of roles and responsibilities and ultimately successful delivery of the programme. A draft proposal for changes to the governance was shared with Committee members for comment and this resulted in a paper to be considered by the ICB.

5.6 The proposals for changes to governance were presented to, and approved by, the Board of NHS Cheshire & Merseyside in November 2023.

5.7 The revised Terms of Reference for the Committee now need approval.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience

The key purpose of the programme is about improving access, outcomes and experience in /to women's services (specifically maternity and gynaecology hospital services) and the other acute hospital services that women need. Liverpool is the only city in the country that has women's hospital services delivered separately from other acute hospital services; this has created a unique and significant gender inequality for the women and families accessing these services from Cheshire and Merseyside and beyond.

Objective Two: Improving Population Health and Healthcare

Women make up 50% of the population; improving women's hospital services (maternity and gynaecology) in Liverpool will therefore have a significant impact on the population health and healthcare for women across Chesire and Merseyside. There are opportunities through the programme to improve the integration of women's services with other acute hospital services such as A&E and intensive care.

Objective Three: Enhancing Productivity and Value for Money

There are likely to be some opportunities to enhance productivity and value for money in the operational delivery of women's services if they are more integrated with other acute hospital services e.g., reducing transfers of women from hospital to hospital to access services, more rapid access to intensive care.

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

7.1 This programme of work supports delivery of the following ICB objectives:

7.2 Women's Health & Maternity – in particular, reducing maternal mortality.

7.3 Liverpool Place objectives:

- implement the opportunities identified in the Liverpool Clinical Services Review of acute and specialist services. The objective of the Liverpool Clinical Services review is to realise opportunities for greater collaboration between acute and specialised trusts to optimise clinical pathways in acute care in Liverpool. There are three critical priorities out of the twelve opportunities, one of which is resolving the clinical sustainability challenges faced by women's hospital services.

- strengthen integrated working arrangements at place with system partners to align plans, resources, governance to support delivery.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
Resolving the clinical sustainability challenges in maternity and gynaecology hospital services will improve the quality and safety of those services for women and their families.

Theme Two: Integration
The programme will be seeking to improve the clinical integration of women's hospital services and other hospital services in Liverpool.

9. Risks

9.1 The programme is concerned with managing, mitigating and wherever possible, resolving, the clinical risks and issues that currently exist in women's hospital services.

9.2 A programme risk register is in development and will be managed by the programme board.

9.3 Programme risks and issues will be reported to the Committee at regular intervals and escalated, as necessary.

10. Finance

10.1 Proposed changes to women's hospital services are likely to have some financial consequences, both revenue and capital, however as noted above there may be opportunities to drive out productivity gains through greater clinical integration.

10.2 It is expected that there will be a finance and estates subgroup of the programme board. This group would be responsible for supporting the financial analysis and modelling of any proposed solutions to changes in services.

11. Communication and Engagement

11.1 The Women's Hospital Services in Liverpool programme is already of significant interest to the public, patient groups, staff, and stakeholders.

11.2 A comprehensive communications, engagement and involvement plan will be developed as part of the programme.

12. Equality, Diversity, and Inclusion

12.1 Any proposed changes will be subject to the relevant impact assessments.

12.2 It will also be important for the programme to identify the current equality issues faced by women and their families accessing women's hospital services in Liverpool. This baseline position will be integral to the case for change and the future model of care. The future model of care should be aiming to improve equality, diversity, and inclusion and to drive out health inequalities.

13. Climate Change / Sustainability

13.1 The future model of care, and particularly any proposals relating to NHS estate, will consider climate change and sustainability.

14. Next Steps and Responsible Person to take forward.

14.1 The Women's Hospital Services in Liverpool Committee will operate under its new Terms of Reference from March 2024.

15. Officer contact details for more information

Clare Powell, Programme Director clare.powell2@nhs.net

16. Appendices

Appendix One: Women's Hospital Services in Liverpool Committee - Terms of Reference

Appendix Two: Programme Definition and Governance Arrangements

NHS
Cheshire and Merseyside

Appendix One

NHS Cheshire & Merseyside Integrated Care Board

Women's Hospital Services In Liverpool Committee

Terms of Reference V2.2

Document revision history

Date	Version	Revision	Comment	Author / Editor
10.03.23	1.1		Revision following first shadow meeting of the Committee on 28.02.23	Matthew Cunningham
08.11.23	2.0	Revisions to reflect the programme definition and the establishment of a programme board		Clare Powell
06.12.23	2.1	Track changes accepted. Minor amends and revisions to membership section.		Clare Powell
20.12.23	2.2	Updates to membership and duties sections following feedback from the Chair		Clare Powell

Review due:
November 2024

Women's Hospital Services in Liverpool Committee

Terms of Reference

1. Purpose

The Women's[2] Hospital Services in Liverpool Committee (the Committee) is established by NHS Cheshire and Merseyside as a Committee of the Integrated Care Board (ICB) in accordance with its constitution.

The Committee and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The Liverpool Clinical Services Review report, published in January 2023,[3] recommended that a sub-committee of the ICB be established 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. The Review was informed by and built on the considerable work undertaken by other reviews over several years. The recommendation to take a whole-system approach to addressing the clinical risks and sustainability challenges affecting women's hospital services in Liverpool was accepted and therefore NHS Cheshire and Merseyside ICB will be responsible for overseeing this programme of work.

The primary focus of the work will be hospital-based maternity and gynaecology services and although these services are delivered in Liverpool they include tertiary services for Cheshire and Merseyside. Any 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.

The Committee will be established with a diverse membership, drawn from a variety of partner organisations, and will include other representatives in attendance, drawn from the NHS Trusts with a role in delivering these services.

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.

[2] It is important to acknowledge that it is not only people who identify as women (or girls) who access women's health and reproductive services to maintain their sexual and reproductive health and wellbeing. The terms 'woman' and 'women's health' are used for brevity, on the understanding that transmen and non-binary individuals assigned female at birth also require access to these services. Delivery of care must therefore be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

[3] https://www.cheshireandmerseyside.nhs.uk/media/vz2na242/cm-icb-board-public-260123.pdf

2. Responsibilities / duties

The Committee, through delegated authority from the ICB, will develop recommendations for safe, high quality and sustainable services.

The Committee will:

- Ensure that a clinically led programme of work is established to identify options for delivery of safe, high quality and sustainable services. This will include:
    - approving the strategic case for change.
    - agreeing the programme governance arrangements, that ensures robust development of options and evidence of how conclusions have been reached.
    - establishing a programme board to lead the development of the case for change and future model of care for women's hospital services in Liverpool.
    - gaining assurance that proposals for future delivery of these services are clinically led, informed by clinical evidence, research, and intelligence, and can demonstrate that they meet the needs of women and their families.
    - approving the programme board's workplan.
    - receiving regular progress reports from the programme board and seeking assurance about programme delivery.
    - involving and engaging NHS and wider partners, managing strategic dependencies across Cheshire and Merseyside (and beyond) and resolving any conflicts.
    - ensuring the programme has sufficient resources drawn from all partners, with the right skills and capacity to deliver a large-scale, complex programme.
- Ensure that the voice of the patient, public and stakeholders is heard.
    - It will develop and maintain processes to ensure that there is meaningful involvement of the public, patients, carers, and stakeholders in the development of proposals.
    - It will ensure that OSC and appropriate local, regional and national bodies are engaged.
- Ensure that the financial impact of proposals / options is robustly assessed so that it can present costed recommendations to the ICB for decision.
- Ensure that all significant proposals undertake Health Inequality, Quality and EDI assessments so that their impact can be assessed against the objectives of the ICB.
- Ensure that the programme complies with statutory and regulatory requirements, in particular the duties of consultation should any major service reconfiguration be recommended.

- Make recommendations to the ICB, keep the ICB appraised of progress and identify significant risks to the delivery of the programme work plan.

3. Authority

The Committee will oversee the development 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 families.

The Committee is authorised by the ICB to:

- request further investigation or assurance on any area within its remit
- bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- make recommendations to the ICB Board
- escalate issues to the ICB Board
- approve an annual work plan to discharge its responsibilities
- approve the terms of reference of the programme board
- delegate responsibility for specific aspects of its duties to sub-groups, sub-committees or individuals.

Decisions on areas, functions, or budgets outside of the authority or scope of the ICB is discharged through the authority that is delegated to the individual members of the Committee by their respective organisations.

For the avoidance of doubt, in the event of any conflict when making any decisions or recommendations, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

4. Membership & Attendance

Membership

The Committee membership shall be appointed by the ICB in accordance with the ICB Constitution. Membership of the Committee may be drawn from the membership of the Board of NHS Cheshire and Merseyside; the ICB' executive leadership team; officers of the ICB; members or officers of other bodies in the wider health and social care system; other individuals/representatives as deemed appropriate.

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

The Committee Membership will be composed of:

- Committee Chair - Chair of the ICB

- an Independent Clinical SRO, from outside the Cheshire and Merseyside ICB footprint
- the ICB Women's Services Programme SRO, who will be an ICB Executive
- the ICB Associate Medical Director (Transformation)
- an ICB Non-Executive member
- the ICB Director of Finance
- an ICB Primary (GP) Care Partner representative
- a representative from the Local Maternity and Neonatal System
- the Liverpool Place Director
- the Sefton Place Director
- the Knowsley Place Director
- a representative from CMAST
- Non-Executive / Lay representatives
- a representative from the North West Specialised Commissioning team.

Attendees
Only members of the Committee have the right to attend Committee meetings, but the Chair will invite relevant staff members for all or part of a meeting as necessary in accordance with the business of the Committee.

Members of the Programme Board will be routinely invited to attend to provide progress reports and to be part of the Committee discussions. These attendees can include but are not limited to:

- the ICB Associate Medical Director – Transformation
- Representative(s) from Liverpool Women's Hospital NHS FT
- Representative(s) from Liverpool University Hospitals NHS FT
- Representative(s) from Alder Hey NHS FT
- Representative(s) from Clatterbridge Cancer Centre NHS FT
- Women's Services Programme Director
- Programme Support Officer(s).

The programme director and any other dedicated staff will support the operation of both the Committee and the Programme Board.

The Chair may also invite specified individuals to be regular participants at meetings of the Committee to inform its decision-making and the discharge of its functions as it sees fit.

Participants will receive advance copies of the notice, agenda, and papers for Committee meetings. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote. Named regular participants may include:
a) a Director of Public Health.
b) a representative from Healthwatch Liverpool on behalf of all the Cheshire and Merseyside Healthwatch organisations.
c) an individual bringing knowledge and a perspective of the voluntary, community, faith, and social enterprise sector.
d) individual(s) representing the Local Medical Committee.

e) individual(s) representing Primary Care (Pharmacy, Dentistry).
f) a representative from the University of Liverpool.

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

5. Meetings

5.1 Leadership

The Chair of the Committee will be the Chair of NHS Cheshire and Merseyside ICB.

A Deputy Chair will be identified from within the standing membership of the Committee by the Chair.

The Chair will be responsible for agreeing the agenda with the Senior Responsible Officer for the Programme, and the Programme Director, ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.2 Quorum

For a meeting or part of a meeting to be quorate a minimum of five Committee members must be present, including:

- the Committee Chair or Deputy Chair
- at least one clinically qualified member
- at least one ICB Executive member.

Committee members may identify a deputy to represent them at meetings of the Committee when they are absent. Committee members should inform the Committee Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of any clinical members). When in attendance, a deputy of a Committee member has the same right to vote as that of the member.

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken within the remit of the Committee.

5.3 Decision-making and voting

The Committee will ordinarily reach its conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

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

5.4 Frequency and meeting arrangements

The Committee will meet in private.

The Committee will meet at least four times each year. Additional meetings may take place as required.

In normal circumstances, each member of the Committee will be given not less than one month's notice in writing of any meeting to be held. However:

- the Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
- a majority of the members of the Committee may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting.
- in emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

As a Committee of the ICB, meetings maybe conducted virtually using telephone, video, and other electronic means, when necessary.

5.5 Administrative Support

The Committee shall be supported with a secretariat function, which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair with the support of the SRO of the programme;
- good quality minutes are taken in accordance with the standing orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- the Chair is supported to prepare and deliver reports to the Integrated Care Board;
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

5.6 Accountability and Reporting Arrangements

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

A summary of key issues discussed and concluded shall be produced and formally submitted to the Board of NHS Cheshire and Merseyside. Reporting will be appropriately sensitive to personal circumstances and will not contain personally sensitive or personally identifiable information.

The Committee will provide the Board of NHS Cheshire and Merseyside with an Annual Report for each year it is in place. The report will summarise its conclusions from the work it has done during the year.

Members of the Committee who are not ICB members or employees have the responsibility to inform their respective organisations prior to and post the meetings with respect to the business undertaken by the Committee and seek their support for any recommendations being considered by the Committee and the Board.

6. Behaviours and Conduct

Benchmarking and guidance

The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England, and the wider NHS in reaching their determinations.

ICB values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Management of Conflicts of Interest

All members shall comply with the ICB's Managing Conflicts of Interest Policy / their relevant organisation COI policy at all times. In accordance with best practice on managing conflicts of interest, members should:

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

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

- Uphold the Nolan Principles of Public Life.
- Attend meetings, having read all papers beforehand.
- Arrange an appropriate deputy to attend on their behalf, if necessary.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity and inclusion implications of any recommendations and decisions they make.

7. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required.

Any proposed amendments to the terms of reference will be submitted to the Board of NHS Cheshire and Merseysdie for approval.

Appendix Two: Programme Definition and Governance Arrangements

Women's Hospital Services in Liverpool

Programme Definition & Governance Arrangements

Draft 3 – 15 January 2024

1. What is this programme about?

The primary purpose of the Women's[4] Hospital Services in Liverpool Programme is to:

*Develop a clinically sustainable model of care for **hospital-based** maternity and gynaecology services that are delivered in **Liverpool**.*

This will involve us understanding all the clinical sustainability challenges hospital-based maternity and gynaecology services in Liverpool face (the clinical case for change) and exploring how those challenges can be addressed and resolved over the short, medium and long term.

The work will involve undertaking an options appraisal of the potential solutions for making these hospital services clinically sustainable for the future. Any recommendations for change will be made to the Board of NHS Cheshire and Merseyside.

A wide range of stakeholders will be involved in the work to ensure that there are no unintended consequences for women, their families and other Cheshire and Merseyside providers that are served by Liverpool's tertiary (specialised) services, and a full impact assessment will be completed on any future proposals.

The programme will follow the process set out in the NHS England Guidance for Planning, Assuring and Delivering Service Change (2018)[5].

2. Why do we need this programme?

The way hospital-based maternity and gynaecology services are currently organised in Liverpool does not provide women with the best possible care and experience.

[4] It is important to acknowledge that it is not only people who identify as women (or girls) who access women's health and reproductive services to maintain their sexual and reproductive health and wellbeing. The terms 'woman' and 'women's health' are used for brevity, on the understanding that transmen and non-binary individuals assigned female at birth also require access to these services. Delivery of care must therefore be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

[5] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

The Liverpool Women's NHS Foundation Trust (LWFT) main hospital site at Crown Street is isolated from other acute hospital services in Liverpool meaning it is less able to manage acutely ill or rapidly deteriorating patients, women with complex surgical needs or significant medical co-morbidities.

Most acute and emergency services are not available at the Crown Street site but are provided at other hospitals. This means that women needing these services must be transferred for that care and treatment, often when they are at their most sick and vulnerable. For example, most women who need intensive care are transferred to the Royal Liverpool Hospital.

Similarly, other acute hospital sites in Liverpool do not have co-located maternity and gynaecology services and are therefore less able to meet women's medical needs when they present at the emergency department or when they are inpatients at these other acute sites.

Liverpool Women's Hospital is the only remaining specialist maternity and gynaecology service provider in the country in such an isolated position; this is unique to Liverpool and has created significant gender inequality in access to services.

The current organisation of adult hospital services results in delays to care which impacts on the quality of care women and their families experience and increases risks for clinical and care staff to manage; this includes a lack of immediate availability of expertise, as well as facilities for specialist medical care and radiological procedures.

The current risks and issues have a multitude of impacts not only to women but also to staff at the Liverpool Women's Hospital including difficulties in recruitment and retention, particularly for consultant gynaecologists and anaesthetists, and an inability to meet national care standards.

In 2022, NHS Cheshire & Merseyside commissioned a review of the way services are organised across the Liverpool hospitals. The objective of the review was to realise opportunities for greater collaboration between acute and specialised trusts to optimise clinical pathways in acute care in Liverpool, with an aim to improve care and reduce clinical risks.

Overwhelmingly, the most important challenge identified by stakeholders during the review was the clinical sustainability of services for women in Liverpool and the associated clinical risk.

If the challenges in hospital-based maternity and gynaecology services are not addressed, the avoidable risks for women who require co-located acute services will rise as co-morbidities and complexity continue to increase; in addition, the gender inequalities in healthcare will widen.

A broader risk, particularly for maternity services, is that we may start to lose some of these services from Liverpool. Some women are already needing to attend providers outside Cheshire and Merseyside to receive specialist co-located care which cannot safely be provided in Liverpool.

Making changes to these services will improve their sustainability, reduce patient risk, and ensure that women with complex and specialist maternity and gynaecology conditions can continue to be cared for within Liverpool and the wider Cheshire and Merseyside area.

3. Which services are we talking about?

The primary focus for the programme is hospital-based maternity and gynaecology services.

This includes:

- acute, emergency and planned maternity and gynaecology hospital services provided in Liverpool; and
- secondary, tertiary and specialised maternity and gynaecology hospital services provided in Liverpool.

4. What other services will be or could be impacted by any proposals coming from the programme?

Neonatology

Neonatal services (services for newborn babies), by their nature, need to be provided alongside maternity services. Whilst the programme does not intend to make any proposals about how neonatal services are delivered, they could be affected by proposals for how hospital maternity services are provided in the future.

Liverpool Women's FT and Alder Hey Children's FT have led the Liverpool Neonatal Partnership (LNP), a formal operational and strategic partnership between the two organisations, since 2018. The LNP will be a key stakeholder group in the development and delivery of any future proposals for women's hospital services, and it will be essential to ensure that any future developments are aligned with LNP plans. Colleagues from the LNP will be directly involved in the programme governance to ensure we achieve this alignment.

If the programme presents opportunities to improve neonatal services as part of proposals, these will be developed with the LNP and highlighted and referred to the Neonatal Operational Delivery Network.

In addition, NHS England is currently leading a review of specialised Neonatal Intensive Care services in the Northwest region; dependencies with this review will also need to be managed with specialised commissioning colleagues.

Other hospital-based services for adults

The programme will not be making proposals about how other hospital-based services for adults will be provided; however, the clinical quality and safety issues the programme is trying to solve will include how maternity and gynaecology services can integrate more closely with other services that may be needed during a woman's care and treatment.

For example, a woman may need to receive urgent care or opinion from other specialities during her maternity or gynaecology episode due to a deterioration in a known chronic condition or the acute development of a new condition; specialities required may include critical care, cardiology, neurology, renal, haematology, oncology general surgery, colorectal, urology, and vascular surgery.

There are also services that pregnant women or women with gynaecology needs may have to access that are technically unrelated to their maternity or gynaecological condition such as ENT, A&E, orthopaedics. These specialities may not be aware of specific requirements for pregnant and postnatal women.

All these other acute hospital services would also benefit from maternity and gynaecology hospital services being more integrated with them.

C&M Cancer Alliance

The Cheshire and Merseyside Cancer Alliance has an active gynaecology cancer programme underway. At this stage there are no conflicts between the scope of the Alliance programme of work and the intended scope of the Women's Hospital Services Programme, however, it will be critical to ensure that the programmes remained aligned and representatives from the Alliance will be part of the programme governance.

Maternal Medicine Network (MMN)

LWFT is the Maternal Medicine Centre for Cheshire and Merseyside as part of the North West region MMN. The MMN seeks to ensure that key clinical standards in the MMN service specification are met for all women requiring these specialised services. The aims and objectives of the MMN are entirely consistent with the aims of the women's hospital services programme in Liverpool. This alignment will be kept under review through the women's services programme governance arrangements and stakeholder engagement.

North West Ambulance Service (NWAS)

NWAS is a key provider of clinical services in Liverpool. Women's hospital services rely heavily on NWAS for the transfer of women from one hospital site to another. The programme will be aiming to reduce the numbers of ambulance transfers between sites and NWAS will therefore be a key stakeholder when we come to modelling options for the future.

Cheshire & Merseyside Critical Care Network (CCN)

One of the key clinical issues the programme is attempting to resolve is a lack of comprehensive critical care services at the Crown Street site. The Critical Care Network will therefore be a key stakeholder in the design of any future model of care.

Other dependencies

As we develop our proposals, and before any changes are made, we will do a full impact assessment on the proposed changes and identify any potential consequences for women and their families, service providers inside and outside Liverpool, and other programmes of work such as those being led by the Local Maternity and Neonatal System (LMNS).

In the meantime, we will make sure we are involving a wide range of stakeholders to ensure that our plans and proposals are aligned with other work and do not have any unintended consequences.

We will develop a comprehensive stakeholder engagement plan that will include all the relevant providers and clinical networks. In addition, there will be several working groups including a clinical advisory group; this will enable us to manage all the clinical service interdependencies as we develop our plans.

5. What is the programme not focussing on?

The programme needs to be focussed on hospital-based maternity and gynaecology services delivered in Liverpool; this is an important and complex set of services with lots of dependencies as described above.

It is therefore, quite deliberately, not focussing on:

- Children's services.
- Neonatology – except in relation to the dependency with hospital-based maternity services.
- Adult services – except in relation to their dependency with hospital-based women's services.
- Primary care and community services.
- Mental health services.
- Hospital-based maternity and gynaecology services provided outside of Liverpool.
- Other women's and maternity work being managed in Cheshire and Merseyside by the Local Maternity and Neonatal System (LMNS) and the Women's Health and Maternity Programme (WHAM) programme.

As noted above, a wide range of stakeholders will be involved in the work to ensure that there are no unintended consequences for other services and a full impact assessment will be completed on any future proposals.

6. Who could be affected by future changes?

Women and families accessing women's hospital services in Liverpool may be affected by these changes; that means, women using the hospital-based maternity and gynaecology services provided by the Liverpool Women's FT at Crown Street Hospital and those women with maternity or gynaecology needs who access services at other hospitals in the city e.g. A&E, critical care, cardiology etc.

About 70% of women using these services come from Liverpool, Sefton, and Knowsley and the other 30% come from other parts of Cheshire and Merseyside and places further afield such as North Wales and the Isle of Man.

Staff might also be affected if there are changes to how hospital-based maternity and gynaecology services are delivered in Liverpool in future.

A full impact assessment will be completed for any proposals that come from the programme.

7. Who is leading this work?

NHS Cheshire and Merseyside Integrated Care Board (ICB) is leading this work; they are the lead commissioners for hospital-based maternity and gynaecology services in Liverpool, along with specialised commissioners from NHS England.

A Women's Hospital Services in Liverpool Committee (WSC), a sub-committee of the ICB, has been set up to oversee and assure delivery of the work programme. This Committee is chaired by Raj Jain, who is also chair of the ICB. (See Appendix 1 for further detail).

A provider-led Programme Board will be established and will be chaired by James Sumner, the interim Chief Executive of LWFT and the substantive Chief Executive of Liverpool University Hospitals FT. The Programme Board will be tasked with developing proposals for women's hospital services that will reduce the risks and issues currently being experienced in these services. The core member providers represented on programme board are Liverpool University Hospital FT (LUHFT), Liverpool Women's FT (LWFT), Alder Hey Children's FT (AHCFT) and Clatterbridge Cancer Centre FT (CCCFT); other providers will be invited to attend as the programme determines. (See Appendix 2 for further detail.)

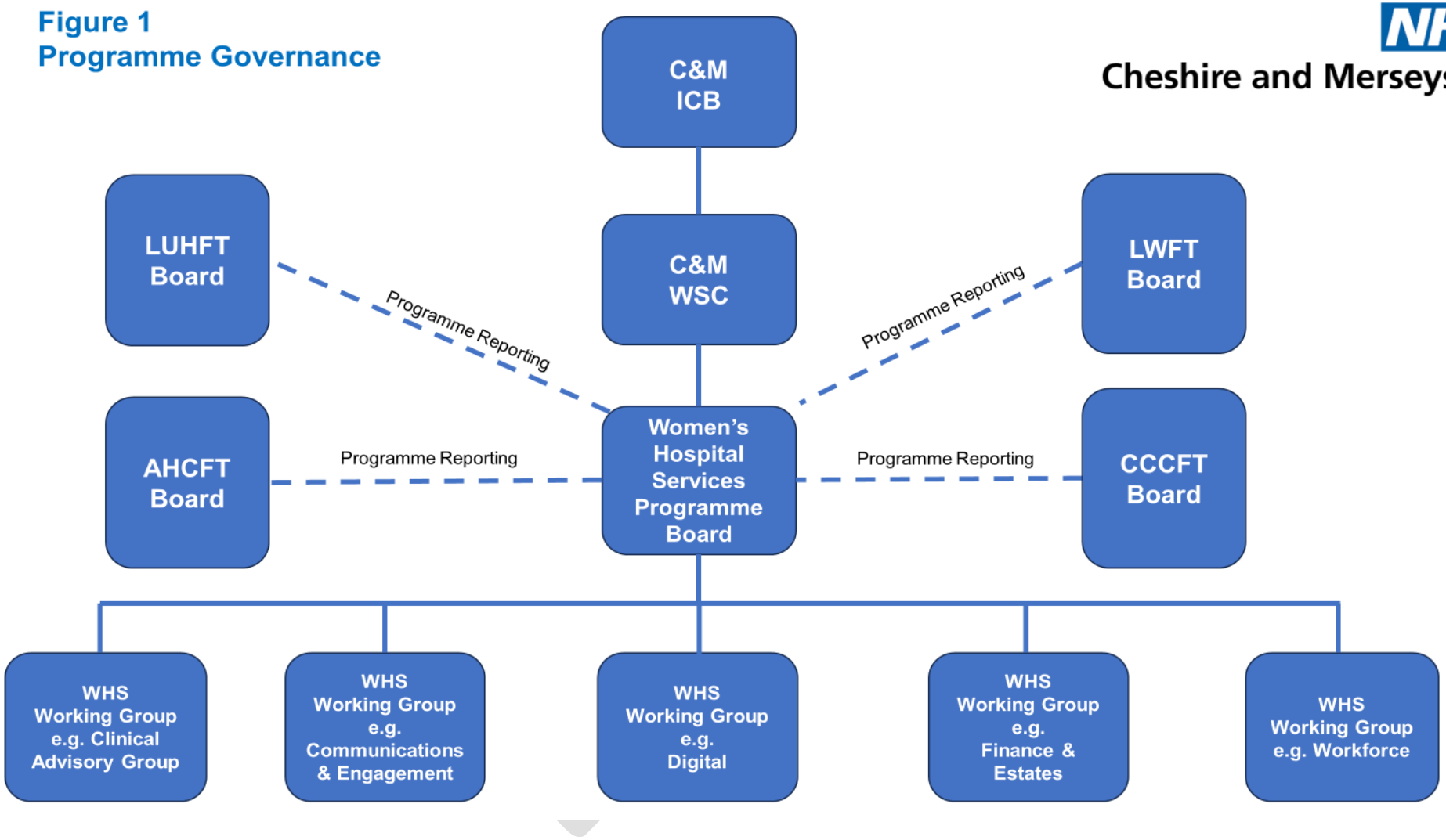
The programme governance is set out in figure 1 below.

8. Who else will be involved?

A detailed stakeholder engagement and involvement plan will be developed to ensure that all key stakeholders, including staff, patients, and the public, are involved, engaged, and communicated with on a regular basis.

Figure 1
Programme Governance

NHS
Cheshire and Merseyside



Appendix 1 – Women's Hospital Services in Liverpool Committee

Led by: Commissioners – NHS Cheshire and Merseyside (C&M ICB)

Chair: Raj Jain

Accountable to: The Board of NHS Cheshire and Merseyside (C&M ICB)

Reports to: The Board of NHS Cheshire and Merseyside (C&M ICB)

Focus: Medium to Long Term

Key functions:

- Ensure that a clinically led programme of work is established to identify options for delivery of safe, high quality and sustainable services. This will include:
    - approving the strategic case for change.
    - agreeing the programme governance arrangements, that ensures robust development of options and evidence of how conclusions have been reached.
    - establishing a programme board to lead the development of the case for change and future model of care for women's hospital services in Liverpool.
    - gaining assurance that proposals for future delivery of these services are clinically led, informed by clinical evidence, research, and intelligence, and can demonstrate that they meet the needs of women and their families.
    - approving the programme board's workplan.
    - receiving regular progress reports from the programme board and seeking assurance about programme delivery.
    - involving and engaging NHS and wider partners, managing strategic dependencies across Cheshire and Merseyside (and beyond) and resolving any conflicts.
    - ensuring the programme has sufficient resources drawn from all partners, with the right skills and capacity to deliver a large-scale, complex programme.
- Ensure that the voice of the patient, public and stakeholders is heard.
    - It will develop and maintain processes to ensure that there is meaningful involvement of the public, patients, carers, and stakeholders in the development of proposals.

  - It will ensure that OSC and appropriate local, regional and national bodies are engaged.

- Ensure that the financial impact of proposals / options is robustly assessed so that it can present costed recommendations to the ICB for decision.
- Ensure that all significant proposals undertake Health Inequality, Quality and EDI assessments so that their impact can be assessed against the objectives of the ICB.
- Ensure that the programme complies with statutory and regulatory requirements, in particular the duties of consultation should any major service reconfiguration be recommended.
- Make recommendations to the ICB, keep the ICB appraised of progress and identify significant risks to the delivery of the programme work plan.

Appendix 2 – Programme Board

Led by: Providers – LUHFT, LWFT, AHCFT, CCCFT

Chair: James Sumner

Accountable to: C&M ICB Women's Services Committee

Also reports to: LUHFT, LWFT, AHCFT, CCCFT Boards

Focus: Medium to Long Term

Key functions:

- Develop the programme plan for the Women's Hospital Services in Liverpool Programme.
- Establish the operational arrangements for programme delivery including any working groups.
- Identify the key clinical risks and issues in women's hospital services in Liverpool.
- Explore the medium and long term solutions to managing the identified risks and issues.
- Lead the development of the case for change for women's hospital services in Liverpool.

- Lead the development of the future model of care for women's hospital services in Liverpool including identifying service dependencies.
- Lead the option appraisal process to identify potential solutions to delivering the future model of care.
- Lead the production of business case(s) as required.
- Complete equality, quality and sustainability impact assessments on proposals for the future delivery of women's hospital services in Liverpool.
- Ensure there is fair and equitable access to women's hospital services in Liverpool.
- Ensure the future model of care and options to deliver it seek to reduce health inequalities.
- Seek external clinical and professional advice where specialist or independent review is required, including involvement from an NHS Clinical Senate.
- Make recommendations to the Women's Services Committee about the future delivery of women's hospital services in Liverpool; proposals will be informed by clinical evidence, research, and intelligence, and will demonstrate how they meet the needs of women and their families.
- Communicate and engage with clinical services stakeholders such as clinical networks, the C&M local maternity and neonatal system (LMNS) and CMAST (C&M acute and specialist trusts provider collaborative).
- Communicate and engage with other key stakeholders e.g., Liverpool Providers Joint Committee, Place leads.
- Support consultation and engagement processes with staff, stakeholders, patients, and the public.
- Ensure that lay perspectives are considered and reflected throughout the work of the programme.
- Support the Women's Services Committee with the formal change assurance process with NHSE.
- Manage the overall programme risks, issues and dependencies.
- Regularly report progress to the Women's Services Committee, escalating risks and issues as necessary.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

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

Agenda Item No: ICB/01/24/24

Responsible Director: Prof Rowan Pritchard Jones, Medical Director

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

1. Purpose of the Report

1.1 In line with NHS England's guidance on Maximising the Benefits of Research[1] as well as the statutory responsibility for Integrated Care Boards (ICBs) to deliver research and innovation under the Health and Social Care Act 2022 the Cheshire and Merseyside Research and Innovation Leadership team ask the Board of NHS Cheshire and Merseyside to **approve the establishment an Integrated Research and Innovation System (IRIS) that aligns with both local and national research and innovation priorities**.

1.2 IRIS will add value to the healthcare environment within Cheshire and Merseyside by attracting research investment, strongly supporting innovation, and enabling the ICS to evolve into a world class system of research and innovation excellence. **The Board is also asked to approve the key aims, objectives, focus areas, and proposed governance structure for IRIS.**

2. Executive Summary

2.1 This paper sets out plans for establishing the Cheshire and Merseyside Integrated Research and Innovation System (IRIS) that aligns with both local and national research and innovation priorities. The paper outlines the key objectives, focus areas, and proposed governance structure for IRIS.

2.2 The plan is in line with NHS England's guidance on Maximising the Benefits of Research and highlight the statutory responsibility for ICBs to deliver research and innovation under the Health and Social Care Act 2022.

2.3 The plans have had considerable input from a wide range of stakeholders including patient and public involvement.

2.4 It highlights how IRIS will add value to the healthcare environment within Cheshire and Merseyside by attracting research investment, strongly supporting innovation and enabling the Cheshire and Merseyside Integrated Care System (ICS) to evolve into a world class system of research and innovation excellence.

2.5 IRIS will support the formation of a research and innovation strategy for Cheshire and Merseyside, will help bring together the legal and other duties around research and innovation in a coherent way, and help the ICS understand its local research and innovation capability, workforce, activity, and needs. It will set ambitions around research and innovation and maximise the benefits associated with commercial research.

[1] https://www.england.nhs.uk/publication/maximising-the-benefits-of-research/

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **approve** the establishment an Integrated Research and Innovation System, including establishing a Research and Innovation Committee of the ICB
- **approve** the key aims, objectives, focus areas, and proposed governance structure for IRIS.

4. Reasons for Recommendations

4.1 The 2022 Health and Social Care Act introduced specific legal duties for Integrated Care Boards requiring them to facilitate and promote research relevant to health service. The Explanatory Notes to the Act suggest that ICBs have board-level discussions on research activity.

4.2 These duties have been emphasised in NHS England's subsequent guidance to ICBs on Maximising the Benefits of Research which makes a number of recommendations on how best to embed a culture of research and innovation within Integrated Care System. Our recommendations follow this guidance.

4.3 IRIS will support ICB priorities and add value to the healthcare environment within Cheshire and Merseyside by attracting research investment, strongly supporting innovation, and enabling the ICS to evolve into a world class system of research and innovation excellence. Examples include successfully receiving funding for the ICS Research Engagement Network (REN) Programmes, the NIHR Capital Investment award for NIHR infrastructure in the region and supporting the development of the award-winning collaborations at place such as the Wirral Research Collaborative.

4.4 If the Board of NHS Cheshire and Merseyside did not support the recommendation, it would be at risk of not fulfilling its obligations to support research and innovation under the Health and Social Care Act 2022. It would also impact on NHS England requirements regarding delivery of the Joint Forward Plan.

5. Background

5.1 The proposals are also fundamental to the delivery of the strategic objectives of the ICB. NHS England have stated that Joint Forward Plans must explain how the ICB will discharge its duties around research, and the ICB must report on the discharge of its research duties in its annual report.

5.2 Like the health and care system, the research environment is complex. IRIS will support the formation of a research and innovation strategy that will help bring together the legal and other duties around research in a coherent way, and help

the ICS understand its local research and innovation capability, workforce, activity, and needs, set ambitions around research and innovation and maximise the benefits associated with commercial research. It will help demonstrate the benefit of research and innovation locally, nationally, and internationally, and guide the production of clear strategic delivery plans.

5.3 The proposal presented here has been co-designed by the Cheshire and Merseyside ICB Research and Innovation Leadership Team (Professor Rowan Pritchard-Jones, Dr Terry Jones, Dr Greg Irving), Iain Buchan and Ian Hennessey. It has also had input from a wide range of stakeholder including, but not limited to, the NIHR North West Coast Clinical Research Network, NIHR NWC Applied Research Collaboration, Innovation Agency North West Coast, Liverpool Health Partners, CHAMPS research lead, University of Liverpool, LSTM, Edge Hill University, LJMU, University of Chester, Cheshire and Merseyside ICB Place-based research leads, NHS Trust Research Lead representative, VCFSE leads and patient and public representatives. They have supported the proposals outlined here and recommend that the Board approves.

5.4 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.

5.5 The functions of IRIS are detailed in Appendix One. These include but are not limited to convening stakeholders; Research and innovation planning; Identifying and Addressing Research and Innovation Priorities; Influencing the National and International Research and Innovation Agenda: Expanding Research and Innovation: Expand research and innovation; Promote Evidence-Based Practice; Harmonising and coordinating research and innovation Activities; Cultivate a learning environment; Leverage commercial contract research and innovation; Developing the research and innovation workforce and infrastructure; Coordinating research and evaluation of interventions to support the delivery of a more sustainable health and social care system; Improve health and social care quality and outcomes through research and innovation.

5.6 It is intended that IRIS will be a **cross-cutting theme** within the ICB and will function within the following structure:

- **Research and Innovation (R&I) Committee:** Accountable to and reporting into the Board of NHS Cheshire and Merseyside. It is proposed that a Non-Executive Director will Chair the R&I committee. Membership of the committee will consist of the C&M ICB Medical Director (Professor Rowan Pritchard-Jones), ICB Research Leadership Team (Professor Terry Jones, Professor Greg Irving, Professor Ian Buchan and Mr Ian Hennessey).

- **Research and Innovation (R&I) Steering Group:** Reporting directly to the R&I committee, ensuring transparency, accountability, and alignment with the overarching healthcare strategy. The steering group would initially meet bi-

monthly. The intention would be to move to quarterly meetings over time. The meeting will be Chaired by the ICB Medical Director or their nominated deputy. It is proposed that a Non-Executive Director will also be invited to be on the steering group. Membership includes but is not limited to representatives from NIHR North West Coast Clinical Research Network, NIHR North West Coast Applied Research Collaboration, Innovation Agency North West Coast, Liverpool Health Partners, CHAMPS research lead, University of Liverpool, LSTM, Edge Hill University, LJMU, University of Chester, Cheshire and Merseyside ICB Place-based research leads, VCFSE lead and patient and public representatives. will be invited.

- **Working Groups.** Reporting into the R&I Committee. Specialised groups responsible for specific research and innovation areas and initiatives, e.g., knowledge exchange working group.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience

Policymakers and commissioners need evidence to support their decision-making around the delivery and system-wide transformation of health and care services, including how health inequalities will be reduced. Research can give a better understanding of local populations and the wider determinants of health, and with this the steps to maintain health and narrow health inequalities.

Objective Two: Improving Population Health and Healthcare

IRIS will create opportunities for research to inform and be informed by population health management. **Tools such as CIPHA will play key role within IRIS for enabling data integration and population health action.**

Objective Three: Enhancing Productivity and Value for Money

The development of IRIS will provide an opportunity to consider research delivery within the ICS and across ICS boundaries, increasing flexibility of workforce or recruitment while reducing bureaucracy and improving research productivity and value for money.

Objective Four: Helping to support broader social and economic development

An active research ecosystem working in a coordinated way and to national standards brings revenue and jobs to regions. IRIS will leverage and help to improve the scale and pace of commercial contract research and innovation. It will maximise the economic and patient benefits of commercial contract research working closely with the Innovation Agency North West Coast and NIHR Clinical Research Network North West Coast.

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

7.1 IRIS has the potential to support all objectives stated in the Annual Delivery Plan. The ICB must also report on the discharge of its research duties in its

annual report. These inclusions will raise the profile of research at Board level and help embed research as a business-as-usual activity.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
There is growing evidence that engaging in research activity can improve a range of patient's outcomes such as cancer survival and mortality rates. IRIS will look to expand research across the ICS. Improving the quantity, quality, and diversity of research initiatives. It will cultivate a learning environment, valuing intellectual contributions and encouraging knowledge-sharing. Cultivating a culture that values learning, adaptation, and the pursuit of innovation to promote improvements in quality and safety.

Theme Two: Integration
IRIS will help to collate existing system-wide R&I activities and capacity and by doing so, identify existing strengths that may be leveraged whilst identifying areas for targeted intervention and improvement. It will help to harmonise and coordinate research and innovation activities between localities. Joint Research Offices will play a key role here to support the development and growth of high-quality clinical research portfolio.

Theme Three: Leadership
IRIS will support activity that Well-led framework across the ICS. It will help provides incorporate plans for supporting clinical research activity as a key contributor to best patient care. It will ensure service users and carers given the opportunity to participate in or become actively involved in clinical research studies. IRIS will endeavour to become a national leader in the delivery of R&I in ICS frameworks. This will be achieved by developing targeted exemplars – data integration, population health etc, for example and by national leadership, e.g, via UKRD (TMJ, ICS lead) feeding into NHSE coordinating committees.

9. Risks

9.1 IRIS has the potential to help mitigate all of the principle risks identified in the Board Assurance Framework and can support the associated priority actions and assurance activities.

9.2 While research can address local priorities, it typically operates across ICS boundaries and at national and international levels. Health and social care research is governed by a range of laws, policies, and international, national, and professional standards. The ICBs and partner organisations should have processes for the set up and delivery of research that comply with national laws and systems and does not duplicate them.

10. Finance

10.1 For the formation of IRIS no new funding is being requested as funding for the activity of the ICB research leadership team is already in place. However further

resource may be required in the future. Were feasible to do so we will look to leverage resource with partner organisations to grow the IRIS agenda.

10.2 It is important to note the financial benefits of supporting the formation of IRIS for the ICB and its potential to directly contribute additional funding to support ICS priorities. For example, between 2016/17 and 2018/19 the NHS received on average £9,000 per patient recruited to a commercial clinical trial and saved over £5,800 in drug costs for each of these patients. This equates to income of £355 million and cost savings of £26.8 million in 2018/19.

11. Communication and Engagement

11.1 The proposal presented here has been co-designed by the C&M ICB Research Leadership Team (Professor Rowan Pritchard-Jones, Dr Terry Jones, Dr Greg Irving), Iain Buchan and Ian Hennessey. It has also input from a wide range of stakeholder including but not limited to the NIHR North West Coast Clinical Research Network, NIHR NWC Applied Research Collaboration, Innovation Agency North West Coast, Liverpool Health Partners, CHAMPS research lead, University of Liverpool, LSTM, Edge Hill University, LJMU, University of Chester, Cheshire and Merseyside ICB Place-based research leads, NHS Trust Research Lead representative, VCFSFE leads and patient and public representatives such as Healthwatch England. They have supported the proposals outlined here and recommended that the Board approves.

11.2 In developing the first system-wide research and innovation strategy we will set out their approach to diverse public and patient involvement (PPI) in relation to research and innovation working closely with partners such as the NIHR Applied Research Collaboration North West Coast.

12. Equality, Diversity and Inclusion

12.1 The Integrated Research and Innovation System (IRIS) will align with both local and national research and innovation priorities on tackling health and social care inequalities.

12.2 CIPHA will play key role within IRIS for demand signaling, designing, and delivering research and innovation that takes impactful action on health and social care inequalities.

12.3 We will promote the use of the NIHR Focus On Research and Equity (FOR EQUITY) tools and resources to help make research and innovation evidence more relevant for action to reduce social and health inequalities.

13. Climate Change / Sustainability

13.1 Research and innovation are key enablers to ensuring the sustainability of our health and care system and are critical for achieving improved and joined up health and social care services.

13.2 Many of the priorities and ambitions reported in the Green Plan identify the need for research and innovation. IRIS can help to ensure these priorities are effectively addressed.

14. Next Steps and Responsible Person to take forward

14.1 We have plans to develop, in collaboration with system stakeholders, a Cheshire and Merseyside research and innovation strategy that will help bring together the legal and other duties around research and innovation in a coherent way, and help the ICS understand its local research and innovation capability, workforce, activity and needs, set ambitions around research and innovation and maximise the benefits associated with commercial research. It will help demonstrate the benefit of research and innovation locally, nationally, and internationally, and guide the production of clear plans. We will look to align the strategy with the Joint Forward Plan.

14.2 We will look to communicate and socialise IRIS. This will include the need for effective engagement with individuals and groups at place. We will need to highlight the meaningful purpose of IRIS and how it interacts with already existing activity. be mindful of how IRIS is understood.

14.3 A further update on the establishment of IRIS will be provided to the Board at its meeting in March 2023 including the draft Terms of Reference for Research and Innovation Committee its approval by the Board.

15. Officer contact details for more information

15.1 Professor Rowan Pritchard-Jones, ICB Medical Director
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16. Appendices

Appendix One: IRIS Plan

Appendix One

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

Background:

In line with NHS England's guidance on Maximising the Benefits of Research, the ICBs statutory responsibility for research delivery under the Health and Social Care Act 2022 and feedback from across the system, the Cheshire and Merseyside ICB is committed to establishing an Integrated Research and Innovation System (IRIS) that aligns with both local and national research and innovation priorities including Tackling Health Inequalities in access, outcomes and experience, Improving Population Health and Healthcare, Enhancing Productivity and Value for Money and Helping to support broader social and economic development/. . IRIS will add value to the healthcare environment within Cheshire and Merseyside by attracting research investment, supporting open innovation nurtures intellectual value, and enabling the ICS to evolve into a world class system of excellence. This document outlines the key objectives, focus areas, and governance structure for IRIS.

Aims:
The primary aim of IRIS is to create a research and innovation - driven healthcare ecosystem that benefits the entire population by enhancing healthcare quality, fostering innovation, and improving patient outcomes.

Objectives:
To establish the Cheshire and Merseyside Integrated Research and Innovation System (IRIS) to 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:

- **Convene Stakeholders:** Act as a central entity to bring together stakeholders from across the ICS. The ICB will forge partnerships with existing local infrastructure, such as the Materials Innovation Facility, STFC Daresbury, and the Digital Innovation Facility in Cheshire and Merseyside. Collaborating with established groups like Health Innovation North West and Liverpool Health Partners, these steps will ensure a comprehensive and integrated approach to advancing healthcare research and innovation
- **Research and Innovation Planning:** Develop a coherent and legitimate research plan aligned Maximising the benefits of Research and the Health Care Partnership Strategy. The plan involves forming strategic partnerships with tech companies and startups to leverage advanced tools and methodologies. Patient-centered design thinking will be a cornerstone of the innovation process, complemented by enhanced data analytics capabilities for informed decision-making.
- **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. Generate research questions and champion research activities across health and social care ensuring strategic alignment with the NHS C&M Joint Forward Plan. It is anticipated that tools such as the CIPHA will play key role here.
- **Influence the National and International Research and Innovation Agenda:** Proactively participate in shaping the NIHR and international 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. The ICB will support innovation incubators for nurturing healthcare ideas, supported by rapid prototyping mechanisms for testing and developing new technologies. A strong focus will be placed on cross-disciplinary collaboration, fostering creative problem-solving across different healthcare specialties.
- **Promote Evidence-Based Practice:** Advocate for the use of research evidence to drive commissioning, quality improvement and evidence-based practices in line with the NHS Cheshire & 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.

- **Cultivate a learning environment:** Foster an environment valuing intellectual contributions and encouraging knowledge-sharing. Cultivating a culture that values learning, adaptation, and the pursuit of innovation will be key, including a system to recognize and reward innovative contributions.
- **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 North West Coast.
- **Develop the Research and Innovation Workforce and Infrastructure:** Coordinate and develop the research workforce and infrastructure across all health and social care settings within each ICB place.

- **Sustainability:** Coordinate research and evaluation of interventions to support the delivery of a more sustainable UK health and care system.
- **Improve Healthcare Quality and Outcomes:** Utilise research evidence to enhance the quality of health and care services, benefiting all residents within Cheshire and Merseyside.

Governance Structure:

It is intended that IRIS will be a cross-cutting theme within the ICB and will function within the following structure:

- **Executive Group:** To make recommendations to the Board. Membership to consist of the C&M ICB Research Leadership Team (Rowan Pritchard-Jones, Terry Jones, Greg Irving), Ian Buchan and Ian Hennessey
- **R&I Steering Group:** Reporting directly to Executive Group, ensuring transparency, accountability, and alignment with the overarching healthcare strategy. Membership includes but is not limited to representatives from NIHR North West Coast Clinical Research Network, NIHR NWC Applied Research Collaboration, Innovation Agency North West Coast, Liverpool Health Partners, CHAMPS research lead, University of Liverpool, LSTM, Edge Hill University, LJMU, University of Chester, C&M ICB Place-based research leads, VCFSE lead and patient and public representatives.
- **Working Groups.** Reporting into Executive Group. Specialised groups responsible for specific research and innovation areas and initiatives, e.g., knowledge exchange working group.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Freedom to Speak Up (FTSU) Update

Agenda Item No: ICB/01/24/25

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

Freedom to Speak Up (FTSU) Update

1. Purpose of the Report

1.1 Freedom to Speak Up (FTSU) guardians play a crucial role in providing an alternative channel for workers to voice their suggestions, concerns, or any other matter. They also work in partnership throughout the organisation to foster an environment that normalises speaking up as an integral part of everyday work.

1.2 The ICB is required, by January 2024, to use the FTSU Self-Assessment tool to help the Board reflect on its current position and the improvement needed to meet the expectations of NHSE and the NGO. This report provides an overview of the ICBs self-assessment including areas for further development.

2. Executive Summary

2.1 NHS England has outlined its current expectations of integrated care boards (ICBs) and integrated care systems (ICSs) in relation to Freedom to Speak Up and they are working with the National Guardians Office (NGO) and plan to share further information by 31 March 2024 about the precise expectations of ICBs in regard to Freedom to Speak Up for primary care workers and workers across their system.

2.2 This paper focuses on the ICB's organisational responsibilities, in relation to which NHS England requires that *"ICBs must ensure their own ICB staff have access to routes for speaking up including Freedom to Speak Up guardian(s), and associated arrangements."*

2.3 Updates have been regularly provided to the ICBs People Committee and Audit Committee explaining the organisation's responsibilities in relation to FTSU and setting out the intended approach to developing FTSU arrangements across the ICB, and progress made against those plans.

2.4 Freedom to speak up is referenced in Care Quality Commission (CQC) ICS theme three, leadership QS12 and links to the ICB Board Assurance Framework risk P9. When people speak up, everyone benefits. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and treatment and improved patient experience.

2.5 The ICB has used the self-assessment and reflection tool to help develop its FTSU arrangements (**Appendix One**). The initial assessment overall showed a low baseline for current FTSU arrangements in the ICB, and whilst this was not unexpected given the transition of arrangements from Clinical Commissioning Groups (CCGs), the ICB was and remains keen to improve this position.

2.6 A number of key areas for improvement were identified and actions have been taken to address these. Good progress has been made in developing internal

FTSU arrangements and updates are now reported through the People Committee, with annual report on effectiveness of arrangements to the Audit Committee. The FTSU Action Plan is included at **Appendix Two**.

2.7 Current reporting for 2023/24 remains at nil, however it is anticipated that the number of FTSU cases reported will increase as we continue to raise the profile of FSTU across the organisation.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **note** the overall progress in relation to developments of FTSU.
- **note** current reporting for FTSU cases within the organisation (5.1)
- **note** the self-assessment, in particular the areas where further development has been identified
- **endorse** the action plan to further develop the position in relation to FTSU.
- **decide** how often it would want to be updated on progress against the identified actions.

4. Background

4.1 Updates have been regularly provided to the People Committee and Audit Committee explaining the organisation's responsibilities in relation to FTSU and setting out the intended approach to developing FTSU arrangements across the ICB, and progress made against those plans. An annual report on the effectiveness of FTSU arrangements is provided to the Audit Committee.

5. Freedom to Speak up within NHS Cheshire & Merseyside

Strategy for FTSU in Cheshire and Merseyside

5.1 Our mission is to develop an open and learning culture and make speaking up part of the usual way we work together in the ICB, and support the development of speaking up across the wider integrated care system.

5.2 Our vision is that everyone, regardless of their role or employing organisation, feels that they have a voice and therefore feel safe to raise a concern with anyone, and know that they will be listened to, taken seriously and that the issue will be acted upon appropriately.

5.3 Our most immediate concern is ensuring that speaking up works well now so that our health and care workforce feels empowered and listened to. It is acknowledged that levels of speaking up within the ICB are low, with successive quarters of nil reporting, so our focus is to understand more about why this is.

5.4 We want to develop a culture were speaking up is part of normal business, but we know there will be times when people will welcome the alternative route and support that FTSU provides.

5.5 We want to see increased levels of speaking up across the organisation and be able to share positive examples of how this has contributed to improvements in patient and staff experience, but also show a positive experience of speaking up.

Self-Assessment and progress to date.

5.6 The ICB has used the self-assessment and reflection tool to help develop its FTSU arrangements. The initial assessment overall showed a low baseline for current FTSU arrangements in the ICB. Whilst this was not unexpected given the transition of arrangements from CCGs, the ICB is keen to quickly improve this position.

5.7 A number of key areas for improvement were identified following the self-assessment and actions have been taken to address these, for example the appointment of the FTSU NED and planned recruitment to a dedicated Guardian.

5.8 The ICB has made good progress in developing its FTSU arrangements and updates are now reported through the People Committee. Key achievements to highlight include;

- roll out of FTSU e-learning for all staff (May 23).
- development of the FTSU strategy, approved in July 2023
- development of a clear process for dealing with any speak up cases.
- development of the FTSU Ambassadors network which includes staff representatives from a range of diverse backgrounds.
- identification of a lead NED for FTSU, Erica Morriss.
- increased promotion of FTSU and the role of Guardians including through staff communications, the staff hub, ‘we are one’ session and face to face staff events.
- celebration of FTSU speak up month in October 23 and the theme of breaking barriers.
- establishment of the FTSU summit (November 23), a forum to review FTSU data and triangulate with other business intelligence from across the organisation.

Reporting

5.9 On a quarterly basis, FTSU Guardians are expected to share non-identifiable information with the NGO about the speaking up cases raised with them. The ICB has reported for Q1 and Q2. Reporting for Q3 opened on Monday 08 January 2024 and has been submitted. Final reporting for Q4 opens on 08 April and closes on 07 May 2024.

5.10 Clarification has been received that ICB reporting figures should only include those cases raised by employees or workers of the ICB and which relate to the ICB.

5.11 Current reporting for 2023/24 is therefore nil however it is anticipated that the number of FTSU cases reported will increase as we continue to raise the profile of FSTU across the organisation.

Total Numbers of cases 2023/24	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24
0	0	0	0	

6. Link to meeting CQC ICS Themes and Quality Statements

6.1 Freedom to speak up is referenced in theme three, leadership QS12 - We foster a positive culture where people feel that they can speak up and that their voice will be heard.

6.2 It also has broader links to both quality & safety, and integration. When people speak up, everyone benefits. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and treatment and improved patient experience.

7. Risks

7.1 **Lack of Guardian capacity** – lack of Guardian capacity was identified, and it has been agreed to recruit to a dedicated Guardian role. It is expected a new Guardian will be appointed in Q4.

7.2 **Low levels of FTSU reporting** – to date the ICB has experienced very low levels of reporting, and it is important to understand why this is and what could be done to strengthen our position. There has been a session held with FTSU Ambassadors focused on understanding potential barriers to speaking up, which built upon activity during national 'Speak Up Month' (Oct 23), which this year had the theme of breaking barriers. A short survey has been sent to staff to build upon the high-level feedback we will receive via staff survey which will give us greater insight. We continue to promote FTSU and engage with staff.

8. Communication and Engagement

8.1 Communication and engagement has taken place throughout the year including We are One sessions, FTSU Lead/Guardian attending local staff meetings, FTSU Ambassadors network, Executive Team meeting discussions, Operations group, People Committee and Audit Committee.

8.2 There are also strong links between the FTSU Lead/Guardian and neighbouring ICBs and the regional and national leads with regular joint meetings and attendance at regional and national network meetings.

9. Equality, Diversity and Inclusion

9.1 Improving the ICB's speaking-up culture will form part of wider culture improvement work. A healthy speaking-up culture is also one where people feel safe and confident to:

- share their thoughts, experiences and improvement ideas
- participate in health and wellbeing conversations
- call out incivility, discrimination or bullying.

9.2 It is recognised that that minority groups or those with protected characteristics can often experience greater barriers in having their voice heard. Compassionate and inclusive working environments also have a positive impact on staff engagement. Work is ongoing with the Associate Director EDI and the Associate Director of OD in relation to wider cultural improvement and this will align with the development of a healthy speak up culture. Consideration of how people might raise concerns in relation to health inequalities, or inequality in the workforce, potential barriers to doing so and the potential disproportionate impact on minority groups will be a key consideration of this work.

10. Next Steps and Responsible Person to take forward

10.1 The Associate Director of Workforce / FTSU Lead and Guardian will continue to take forward the FTSU agenda and work with colleagues to support the development of broader cultural improvement across the organisation. There will be a strong focus on increasing levels of speak up.

10.2 Actions outlined in the self-assessment (Appendix One) and action plan (Appendix Two) will be progressed and updates provided through to the ICB's People Sub-Committee.

10.3 Further reflection and discussion on how the Board can support speaking up within the organisation will take place during a future Board development session (date tbc).

10.4 The organisation is required to complete the self-assessment and reflection tool every two years. Whilst we will continue to use this to guide our improvements, this will be formally reviewed again and presented to Board no later than January 2026.

11. Officer contact details for more information

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12. Appendices

Appendix One: FTSU Self-Assessment – NHS Cheshire & Merseyside (January 24)
Appendix Two: FTSU Action Plan – NHS Cheshire & Merseyside (January 24)

National Guardian
Freedom to Speak Up

NHS
Cheshire and Merseyside

Freedom to Speak up

Reflection and planning tool (January 2024)

Introduction

As the senior lead for FTSU in the organisation, the Associate Director of Workforce has overseen completion of this reflection tool, which has been supported by engagement with and input from the FTSU NED Lead, Head of Staff Experience, Engagement and Wellbeing (Guardian), the Associate Director of EDI (Guardian), the Associate Director of OD, the Executive Team, and FTSU Ambassadors.

This improvement tool is designed to help you identify strengths and any gaps that need work and will demonstrate the progress that has been made developing Freedom to Speak Up arrangements.

The self-reflection tool is set out in three stages, set out below.
Stage 1 – Consider the statements for reflection under the eight principles outlined in the guide and rate how your own FTSU arrangements.
Stage 2 - This stage involves summarising the high-level actions you will take to develop your Freedom to Speak Up arrangements
Stage 3 - Summarise the high-level actions you need to take to share and promote your strengths.

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks
  2 = concern or risk which warrants discussion to evaluate and consider options
  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach
  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on
  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	4
I am confident that the board displays behaviours that help, rather than hinder, speaking up	4
I effectively monitor progress in board-level engagement with the speaking-up agenda	3
I challenge the board to develop and improve its speaking-up arrangements	3
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	2
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	3

Enter summarised evidence to support your score.

Good relationship built between NED and current FTSU Lead / Guardian and mutual support given. Concerns identified regarding Guardian capacity and support given to recruit dedicated Guardian. FTSU NED chairs the FTSU Summit and is regularly updated on FTSU matters. Assurance reporting via People Committee and Audit Committee.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Board development session to look at leadership responsibilities for FTSU and how these can be role modelled to support a psychologically safe culture within the organisation and clearly articulate protection from detriment.
2. Support recruitment of dedicated Guardian.
3. Further face to face engagement with NED and Guardian and FTSU Ambassadors

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	3
We regularly and clearly articulate our vision for speaking up	3
We can evidence how we demonstrate that we welcome speaking up	3
We can evidence how we have communicated that we will not accept detriment	2
We are confident that we have clear processes for identifying and addressing detriment	2
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	2
We regular discuss speaking-up matters in detail	2

Enter summarised evidence to support your score.

- Update and discussion with Execs in May 23 setting out expectations of senior leaders to role model speaking up,
- Strategy developed outlining organisational intent and commitment – reviewed by People Operations Group (June 23) and approved by People Committee (July 23)
- FTSU update included in We Are One – May, June, July, August, September , October.
- Extraordinary We are One held in August dedicated to FTSU, led by CEO and Chief People Office
- Not able to evidence clear communication that we will not accept detriment so this needs greater explicit focus.
- Lack of speak ups to date mean unable to evidence. Not able to evidence feedback from staff

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

4. Board development session to look at leadership responsibilities for FTSU and how these can be role modelled to support a psychologically safe culture within the organisation and clearly articulate protection from detriment.

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	No
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	No
We support our guardian(s) to make effective links with our staff networks	3
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	3

Enter summarised evidence to support your score.

NHS C&M does not currently have a culture improvement plan. The organisation has yet to understand, review and develop further baseline metrics on which to platform cultural improvement priorities. Currently, we are focused on developing the organisation's purpose, vision, mission and values. Once we have the basics in place, we will then focus on creating the conditions for the realisation of a just culture as we develop plans to mature organisational identity and ways of working.

FTSU Lead has established the FTSU Summit, Chaired by the FTSU NED to review and triangulate data from across the organisation. The FTSU Guardian and Ambassadors are linked to staff networks with a number holding dual roles and an annual joint network event is planned.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

5. Review of the organisation's cultural metrics and development of an improvement plan where needed

6. Development of a culture programme responsive to the needs of a new organisation and its cultural metrics, inclusive of our commitment to a just culture built around our FTSU process

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	3
We have reviewed the ringfenced time our Guardian has in light of any significant events	3
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	3
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	3
Enter summarised evidence to support your score. Current Guardian doesn't have dedicated time and is required to balance competing demands of an already demanding portfolio. Agreement to recruit dedicated Guardian given following discussions at Executive team and with Corporate Directors. Relevant local and national data fed into these discussions in order for appropriate capacity to be identified.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
7. Recruitment of dedicated FTSU Guardian (planned for Q4)	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	3
Enter summarised evidence to support your score. National 2022 policy updated adopted in NHS C&M. Policy is available alongside other HR policies on the staff hub. Although lots of communication has taken place to promote FTSU and the policy, unable to evidence that staff know how to find the policy. Soft intelligence would suggest that many can, however there may be some groups who do not.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
8. Seek assurance that staff can access the policy – FTSU survey Jan 24.	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	3
We have an annual plan to raise the profile of Freedom to Speak Up	3
We tell positive stories about speaking up and the changes it can bring	2
We measure the effectiveness of our communications strategy for Freedom to Speak Up	2

Enter summarised evidence to support your score.

We have an annual plan and use a variety of regular communications including staff profiles to promote our FTSU arrangements including the Guardian, NED and Ambassadors roles.

We cannot evidence effectiveness of our communications mechanisms.

As we have not had cases of staff speaking up, we do not have local staff stories to tell. We have sought to use some of the national resources, which include staff stories, in place of this however recognise that local stories would likely be more relatable for our staff.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

9. Consider how we can measure effectiveness of communications mechanisms – link to communications team for support.

10. Continue to promote positive stories and look to use local cases when available.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	2
Our HR and OD teams measure the impact of speaking-up training	2

Enter summarised evidence to support your score.

NGO training implemented in June 23, current compliance is 80%
Additional training available for managers
Uptake of training monitored in monthly workforce reports and promoted via staff comms.

New induction programme (including requirement for local inductions) in development and includes FTSU

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

11. Ensure FTSU features in new induction programme which includes local team based induction requirements.

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	3
All managers and senior leaders have received training on Freedom to Speak Up	3
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2
Enter summarised evidence to support your score. Training available for all managers and support available from Guardian and wider HR team where required. Lack of speaking up cases means it's not possible to evidence managers learning from speaking up.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
12. Ensure lessons learnt from speaking up are shared across organisation and incorporated into cultural improvement programme.	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	3
We use triangulated data to inform our overall cultural and safety improvement programmes	2

Enter summarised evidence to support your score.

Guardian well placed and receives support to identify potential areas of concern and to follow up on them. FTSU summit set up to triangulate data, however lack of organisational data and FTSU data currently available has hindered this. Associate Director of OD working on wider cultural improvement.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

13. Continue to develop FTSU to be able to triangulate data, consider lessons learned and share good practice across the organisation.

14. Cultural improvement work to be clearly defined.

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	3
We use this information to add to our Freedom to Speak Up improvement plan	3
We share the good practice we have generated both internally and externally to enable others to learn	2

Enter summarised evidence to support your score.

FTSU Lead / Guardian part of regional and national networks and has links to Guardians and FTSU Leads in a number of organisations. Regular meetings with neighbouring ICB leads and regional lead to discuss and share ideas and concerns. Lack of internal FTSU cases impacts ability to reflect on lessons learnt and/or share good practice.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

15. Continue to link with external colleagues to use good practice to develop our own approach.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	3
Our guardian(s) has been trained and registered with the National Guardian Office	4
Enter summarised evidence to support your score. Existing Guardian role trained and registered with the NGO. Existing Guardian not recruited to however new dedicated guardian will be recruited via fair and transparent, competitive process.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
(7) Complete recruitment to dedicated guardian role in fair and transparent way.	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	No
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	Yes
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes

Enter summarised evidence to support your score.

Quarterly reports all completed and submitted via NGO portal in line with required timescales. Current Guardian can access appropriate support from the CEO, other Executive colleagues including the Chief People Officer and Executive Director of Nursing and Care. Guardian also has access to external mentor guardian for reflective support. Current Guardian doesn't have performance and development objectives in place but these will be agreed with the newly appointed dedicated guardian.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

16. Agree performance and development objectives with the newly appointed Guardian.

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	3
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	3
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	3

Enter summarised evidence to support your score.

Case-handling procedures are documented and there are robust arrangements in place to maintain confidentiality and ensure cases are progressed in a timely manner. Lack of speak up cases mean that we can't evidence that we have tested the effectiveness of these with internal staff however using the same approach for non-ICB workers this has proved effective. Follow up and feedback from people speaking up is built into our process and recording arrangements.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

17. Ensure that when speak up cases are received, we consider the effectiveness of current arrangements so that we can be assured that that if people speak up, confidentiality is maintained, cases are progressed in a timely manner and they will have a consistently positive experience.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	3
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	4
We have evaluated the impact of actions taken to reduce barriers?	2

Enter summarised evidence to support your score.

We had a focus on the theme of breaking barriers during speak up month (Oct 23) and a follow up session with FTSU ambassadors to explore this topic. We have some understanding of potential barriers but need to do further work to fully understand this. We have taken action to try and reduce barriers where these have been identified, for example in response to potential barrier of people feeling uncomfortable reaching out to the FTSU Guardian, creating network of local FTSU Ambassadors so that people have a greater range of people they can approach, which may include a local familiar person, someone independent from a different area, someone from a minority background or group with a protected characteristic. Much of this work to reduce barriers is in the early stages so it's not yet been possible to evaluate impact.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

18. Continue to identify actions to reduce barriers and evaluate the impact of any actions taken.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	3
We monitor whether workers feel they have suffered detriment after they have spoken up	3
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	3

Enter summarised evidence to support your score.

We have carried out work with Ambassadors to understand what detriment for speaking up looks and feels like and also utilised regional and national network intelligence and feedback. We have processes in place to identify and monitor this but due to the lack of speak up cases we are not able to evidence that this has been robustly tested. Our NED is closely linked to the Guardian and would oversee any allegations of detriment.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

19. Ensure that when cases are reported we follow our process to take reasonable steps to ensure detriment is not suffered and identify any detriment that does arise.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	4
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	3
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	3
Our improvement plan is up to date and on track	2
Enter summarised evidence to support your score. FTSU Strategy approved by People Committee in July 23. The organisation doesn't currently have a cultural improvement strategy but the Associate Director of OD is working on this. Freedom to speak up summit (chaired by the FTSU NED) will consider a range of qualitative and quantitative measures, however this group is in it's infancy. Regular updates are also provided to the People Committee.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
(14) Cultural improvement work to be clearly defined.	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	3
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	3
Our speaking-up arrangements have been evaluated within the last two years	Yes

Enter summarised evidence to support your score.

Staff survey feedback and local staff experience information will provide data to help us measure whether there is an improvement in how safe and confident people feel to speak up. A staff experience dashboard (as a subset of the workforce dashboard) is in development. This work needs further focus and development, linked to the cultural improvement work mentioned above.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

20. Ensure measurement of how safe and confident people feel to speak up as part of staff experience dashboard.

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	2
We have we evaluated the content of our guardian report against the suggestions in the guide	2
Our guardian(s) provides us with a report in person at least twice a year	2
We receive a variety of assurance that relates to speaking up	2
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	2

Enter summarised evidence to support your score.

Guardian reports to date have focused on development of arrangements and compliance with reporting. As we develop FTSU arrangements and culture, further engagement from Board and senior leaders is required. Guardian reports to date have been via People Committee and Audit Committee but the Board should consider if it should receive these directly. Lack of speaking up prevents us from being able to benefit from learning as a result.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

(4) Board development session to look at leadership responsibilities for FTSU and how these can be role modelled to support a psychologically safe culture within the organisation and clearly articulate protection from detriment.

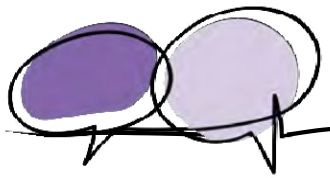
National Guardian
Freedom to Speak Up

NHS
Cheshire and Merseyside

Freedom to Speak Up Action Plan

This plan sets out the key actions to develop our FTSU arrangements and a culture of speaking up in NHS C&M ICB. We must ensure that when speak up cases are received, cases are progressed in a timely manner, confidentiality is maintained where required, and all those who speak up have a consistently positive experience. We will also ensure that when cases are reported we follow our process to take reasonable steps to ensure detriment is not suffered and that we can identify if any detriment does arise. We will continue to link with external colleagues to use good practice to develop our own approach. Monitoring of reporting is via the People Committee, with an annual report on the effectiveness of arrangements to the Audit Committee.

ID	Action	Timescale	Lead	Progress	RAG
1.	Ensure all staff are aware of FTSU provisions, understand the role of FTSU and their responsibility to speak up. Promote the variety of ways that staff can speak up about any concerns they may have and encourage a culture of accountability and openness.	May 23	VW	FTSU update included in We Are One – May, June, July (Training), August, September , October. Staff Hub (as above) and external website reviewed and updated. Communications materials and templates developed – poster format, email signature, visual branding/identity, screen savers.	Ongoing
2.	Develop procedure for dealing with concerns raised via FTSU which ensures matters raised are consistently and thoroughly investigated through the appropriate processes, appropriate actions are taken, feedback is given and learning is shared across the ICB/ICS to support the development of an open culture.	May 23	VW	Procedure developed.	
3.	Promote FTSU e-learning for all staff and enhanced FTSU training for leaders.	June 23	VW	NGO training implemented in June 23, current compliance is 80%. Additional training available for managers. Uptake of training monitored in monthly workforce reports and promoted via staff comms.	Ongoing
4.	Clearly articulate to managers and leaders their roles and responsibilities when handling concerns, and ensure they receive appropriate support to do so effectively.	June 23	VW	VW briefing to execs May 23. Promotion of FTSU policy via comms and staff hub. Presentation at People Operations Group. Enhanced training available for managers. Support from Guardians and HR team provided.	Ongoing
5. *	Identify lead NED for FTSU.	June 23	VW/MC	Erica Morriss confirmed as FTSU NED	
6. *	Development of FTSU Strategy outlining ambition for speaking up.	July 23	VW	Draft strategy developed outlining organisational intent and commitment, engagement with key managers and those involved in FTSU in legacy CCGs. Strategy reviewed by People Operations Group June 23 and	



ID	Action	Timescale	Lead	Progress	RAG
				approved by People Committee July 23. Copy of the Strategy available on the Staff Hub and external website.	
7. *	Develop an FTSU Ambassador Network, led by the FTSU Guardian	Sep 23	VW/SB	FTSU Ambassador role profile developed Call out for additional Ambassadors on WAO/Weekly Bulletin July – Sept 23. Meeting of new Ambassador Network on 4th September to review role, plans, communications materials. 14 current Ambassadors – contact directory developed and promotional materials (poster, email signature). Briefing / training session delivered to Ambassadors.	
8. *	Establishment of FTSU Summit to review reporting of FTSU data (anonymised) and triangulation with other business intelligence to inform actions to promote patient and staff safety and quality of clinical services.	Sep 23	VW	Summit established with agreed terms of reference and membership including CEO and senior leaders from medical, nursing & quality, EDI, OD, HR and Governance as well as FTSU Ambassador representatives. Chaired by FTSU NED. First meeting of summit took place on 9th Oct.	
9.	Promotion of Speak Up Month in October with the theme of 'Breaking Barriers'	Oct 23	VW	Comms plan commenced in Oct to support Speak Up month. Key messages include; importance of Speak Up – what impacts you doing a good job, cultural change, FTSU Training, promotion of FTSU Email Account & Staff Hub information, introducing key roles Guardian, NED lead, Feedback from FTSU Summit, focus on promoting inclusion and breaking down the barriers to enable all workers to feel safe and speak up and be heard, #SpeakUpForInclusion, WAO – Wear Green Wednesdays to support Speak Up, focus on no detriment #SpeakUpForSafety, introducing the Ambassadors, focus on being kind to colleagues and not forgetting to be kind to yourself #SpeakUpForCivility, focus on the aim of making speaking up business as usual for everyone.	
10.	Seek assurance that staff know about FTSU and how they can raise concerns.	Jan 24	VW	Short FTSU survey (4 questions) launched in January to test if staff know about FTSU, if they know how to speak up through FTSU, and how they feel about using FTSU. Results to be reviewed and any actions arising to be identified and incorporated into plan.	

ID	Action	Timescale	Lead	Progress	RAG
11.	Review effectiveness and measure impact of current FTSU communications.	Feb 24	VW/MA	Review comms data/metrics to understand level of staff accessing materials and reach of current comms.	
12.	Identify positive staff stories to promote the benefits of speaking up and share the experience of staff who have spoken up.	Feb 24	VW/SB	Using national resources initially and will look to use local cases when available. Pool of staff stories being put together to be used in a rolling programme of comms.	
13. *	Recruitment of dedicated Guardian.	Mar 24	VW	Case for dedicated Guardian role discussed at Execs in Oct 23. Support given in Nov. Recruitment to commence in January 24.	
14. *	Development of a culture improvement plan responsive to the needs of a new organisation and inclusive of our commitment to a just culture.	Mar 24	TS / VW		
15.	Continue to identify actions to reduce barriers and evaluate the impact of any actions taken. Session with Ambassadors and Staff Engagement Group to reflect on results of FTSU survey (and info from staff survey results).	Mar 24	VW		
16.	Increase profile of NED through face to face engagement with Ambassadors	April 24	EM	EM to attend FTSU Ambassador network in April.	
17.	Ensure FTSU features in new induction programme which includes local team based induction requirements	April 24	SB / Guardian	New induction programme in development and due for launch in April 24.	
18. *	Dedicated FTSU session at Senior Leadership Forum.	May 24	VW / TS / Guardian	Planning for session underway.	
19.	Personal pledges from senior leaders to demonstrate commitment to supporting speaking up. Leaders to be visible and vocal (as part of normal business) in demonstrating that they welcome and encourage speaking up.	June 24	VW / Guardian		
20. *	Board development session to look at leadership responsibilities for FTSU and how these can be role modelled to support a psychologically safe culture within the organisation and clearly articulate protection from detriment. Use self assessment tool to reflect on areas for development.	June 24	VW / TS / MC	Planning of session underway. Originally agreed Feb 24 but advised likely need to reschedule due to other priorities. Timescale updated and date to be agreed.	

ID	Action	Timescale	Lead	Progress	RAG
21. *	Ensure measurement of how safe and confident people feel to speak up as part of staff experience dashboard.	July 24	VW	Staff experience dashboard under development as part of development of improved workforce dashboard.	
22.	Develop programme of activities for Speak Up Month - October 24	Oct 24	Guardian		
23. *	Ensure lessons learnt from speaking up are shared across organisation and incorporated into cultural improvement programme. Annual review of all lessons learnt and reflection of changes/improvements implemented as a result.	Oct 24	Guardian		
24. *	Review first year of FTSU Summit. Reflect on role of Summit and developments in relation to FTSU including effectiveness of it's role in triangulating data, considering lessons learned and sharing good practice across the organisation.	Oct 24	VW / Guardian		

Key

* Key actions / milestones

RAG	Description
	Completed
	In progress / On track
	Overdue / behind schedule
	Not yet started

Initial	Name / Role
VW	Vicki Wilson, Associate Director of Workforce / FTSU Lead & Guardian
SB	Suzanne Burrage, Head of Staff Experience, Engagement & wellbeing / FTSU Guardian
TS	Taira Shaffi, Associate Director of OD
MC	Matthew Cunningham, Associate Director of Governance
MA	Maria Austin, Associate Director of Communications

Meeting of the Board of NHS Cheshire and Merseyside

25 January 2024

Consent Items

Agenda Item No: ICB/01/24/27

Minutes of ICB Committees

Click on the links below to access the minutes

- **ICB Audit Committee** – September 2023
- **ICB Transformation Committee** – September 2023
- **ICB System Primary Care Committee** – October 2023
- **ICB Finance, Investment and Our Resources Committee** – November 2023
- **ICB Quality and Performance Committee** – November 2023